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**STATE OF CONNECTICUT
PURCHASE OF SERVICE CONTRACT
("POS", "Contract" and/or "contract")
Revised September 2011**

The State of Connecticut DEPARTMENT OF SOCIAL SERVICES

Street: 55 FARMINGTON AVENUE

City: HARTFORD State: CT Zip: 06105

Tel#: (800) 842-1508 ("Agency" and/or "Department"), hereby enters into a Contract with:

Contractor's Name: St. Vincent's Medical Center

Street: 2800 Main Street

City: Bridgeport State: CT Zip: 06606

Tel#: (203) 576-6000 FEIN/SS#: DUNS:

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

Contract Term	This Contract is in effect from 1/1/2017 through 12/31/2017.
Statutory Authority	The Agency is authorized to enter into this Contract pursuant to § 4-8 17b-3, 17b-11, 17b-260, and 17b-263c of the Connecticut General Statutes ("C.G.S.").
Set-Aside Status	Contractor <input type="checkbox"/> IS or <input checked="" type="checkbox"/> IS NOT a set aside Contractor pursuant to C.G.S. § 4a-60g.
Effective Date	This Contract shall become effective only as of the date of signature by the Agency's authorized official(s) and, where applicable, the date of approval by the Office of the Attorney General ("OAG"). Upon such execution, this Contract shall be deemed effective for the entire term specified above.
Contract Amendment	Part I of this Contract may be amended only by means of a written instrument signed by the Agency, the Contractor, and, if required, the OAG. Part II of this Contract may be amended only in consultation with, and with the approval of, the OAG and the State of Connecticut, Office of Policy and Management ("OPM").

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

If to the Agency: STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES 55 FARMINGTON AVENUE HARTFORD, CT 06105 Attention: Marcia McDonough, Marcia.mcdonough@ct.gov or (860) 560-6389	If to the Contractor: St. Vincent's Medical Center 2800 Main Street, Bridgeport, CT 06606 Attention: Vincent Caponi, President & CEO vccaponi@stvincent.org or (475) 210-5455
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A party may modify the addressee or address for Notices by providing fourteen (14) days' prior written Notice to the other party. No formal amendment is required.

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PART I. SECTION ONE - OVERVIEW, SECTION TWO - SCOPE OF WORK, SECTION THREE - CONTRACT AMOUNT AND PAYMENT METHODOLOGY DISTRIBUTION OF SHARED SAVINGS

The Contractor shall provide the following specific services for the **Person-Centered Medical Home Plus (PCMH+) Program** and shall comply with the terms and conditions set forth in this Contract as required by the Agency, including, but not limited to, the requirements and measurements for Scope of Services, Contract performance, quality performance standards and measures of under-service. Please reference the following hyperlink for [PCMH+ UNDER-SERVICE UTILIZATION MONITORING STRATEGY](#).

No sections in this Part I shall be interpreted to negate, supersede or contradict any section of Part II. In the event of any such inconsistency between Part I and Part II, the sections of Part II shall control.

SECTION ONE – OVERVIEWS

A. SIM OVERVIEW

In the State, the State Innovation Model (SIM) is a multi-payer approach to promote improved health care delivery. The development of the SIM initiative has been led by the SIM Project Management Office (PMO), located within the Office of the Healthcare Advocate, which serves under the leadership of the Lieutenant Governor. The development of SIM is supported by consultants and statewide advisory committees composed of payers, providers, consumers, and advocates.

In March 2013, the State received a planning grant from the Center for Medicare and Medicaid Innovation (CMMI) to develop a State Healthcare Innovation Plan (SHIP). Through the planning process, the PMO brought together a wide array of stakeholders who worked together to design a model for health care delivery supported by value-based payment methodologies with the goal of impacting care delivered to at least 80% of the entire State population within five years. The resultant SHIP outlines the goals and anticipated pathway to promote the Triple Aim for everyone in the State: better health while eliminating health disparities, improved health care quality and experience, and reduction of growth in health care costs.

SIM was established as a means to ensure that health care reform initiatives are informed by the diversity and expertise that exists within Connecticut's stakeholder community—consumers, consumer advocates, employers, health plans, providers, and state agencies. The SIM governance structure and advisory process promotes multi-payer alignment so that payers and providers are pushing to achieve the same goals. SIM promotes alignment on methods and requirements where this makes sense (e.g., quality measures, medical home, and community integration), while also promoting flexibility and innovation.

B. PCMH+ OVERVIEW

The Department will participate in the Connecticut SIM by implementing PCMH+. The goals of PCMH+ are to further improve health outcomes and care experience for Medicaid beneficiaries who are assigned to PCMH+ using the methodology described below, through these efforts containing the growth of Medicaid expenditures. Specifically, PCMH+ will build on DSS' existing PCMH model by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to community supports that can assist beneficiaries in utilizing their Medicaid benefits. Typical barriers that inhibit the use of Medicaid benefits include housing instability, food insecurity, lack of personal safety, limited office hours at medical practices, chronic conditions, and low literacy. Enabling connections to organizations that can support PCMH+ members in resolving these access barriers

will further the Department's interests in preventative health. Further, partnering with providers on this transformation will begin to re-shape the paradigm for care coordination in a direction that will support population health goals for individuals who face the challenges of substance abuse and mental health, limited educational attainment, poverty, homelessness, and exposure to neighborhood violence. However, it is not expected—nor is it possible—for any PCMH+ Participating Entity to address all of these barriers for each individual PCMH+ member. Rather, PCMH+ is designed to help further the process of broader transformation of the health care system to begin to address these barriers in a more systematic manner, without the expectation the PCMH+ program could necessarily resolve such barriers for any specific PCMH+ members. Similarly, there is no expectation that the Contractor is solely responsible for the health outcome of any PCMH+ member.

As part of participating in PCMH+, all of the Contractor's services related to PCMH+ will be person-centered. DSS defines person-centeredness as an approach that:

- provides the individual with needed information, education and support required to make fully informed decisions about his or her care options and to actively participate in his or her self-care and care planning;
- supports the individual, and any representative(s) whom he or she has chosen, in working together with his or her non-medical, medical and behavioral health providers and care manager(s) to obtain necessary supports and services; and
- reflects care coordination under the direction of and in partnership with the individual and his/her representative(s), that is consistent with his or her personal preferences, choices and strengths, and that is implemented in the most integrated setting.

To the extent Contractor might elect to pay, using the Contractor's funds, for services to Medicaid beneficiaries that are not covered by Medicaid, in an effort to promote improved quality of care and/or reduced cost of care, the Contractor's choice to make such expenditures is permissible under this Contract, provided that: (1) the Department will not reimburse the Contractor for such expenditures, (2) the Contractor is responsible for ensuring compliance with all statutes, regulations and other requirements that apply to such expenditures, and (3) the Contractor agrees to use reasonable diligence in preventing any potential negative consequences to individuals that may result from such expenditures, such as any potential impact on those individuals' eligibility for Medicaid and/or other public benefit program(s).

NOTEWORTHY:

Medicaid State Plan Amendment. The Department of Social Services (DSS) has been working with the Centers for Medicare and Medicaid Services (CMS) to obtain State Plan Amendment (SPA) approval for the PCMH+ program under SPA 17-002. The Medicaid state plan is an agreement between the State and Federal government which gives assurances that the State will abide by Federal rules. The state plan allows for the claiming of Federal matching funds, outlines individuals and services to be covered, and how the State administers the Medicaid program. The State is in the process of proposing Medicaid State Plan Amendment (SPA) authority to CMS through SPA 17-002. Effective January 1, 2017, SPA 17-002 will amend the Medicaid State Plan in order to establish the PCMH+ program as part of the Medicaid state plan, which may be further amended by one or more SPA(s), waiver(s), demonstration(s), and/or other applicable federal legal authority that DSS determines are necessary to receive federal financial participation (FFP) for the PCMH+ program (collectively, the "PCMH+ FFP Authority"). The PCMH+ program is being added to the Medicaid State Plan as an Integrated Care Model within section 1905(a)(29) of the Social Security Act (Act), which is the Medicaid benefit category for "any other medical care, and any other type of remedial care recognized under State law, specified by the [HHS] Secretary." As part of the SPA, the Enhanced Care Coordination Activities (and for FQHCs, the Care Coordination Add-On Payment

Activities) that are required as part of PCMH+ are described as primary care case management (PCCM) services as defined in section 1905(t) of the Act.

The PCMH+ FFP Authority, as ultimately approved by CMS and for the effective dates set forth therein, is incorporated by reference into this Contract as if fully set forth herein. This Contract and any payments to be made pursuant to this Contract are expressly conditioned on CMS approval of the PCMH+ FFP Authority. Accordingly, the Contractor agrees that this Contract and any payments to be made pursuant to this Contract are expressly conditioned on CMS approval of the PCMH+ FFP Authority. If the PCMH+ SPA and/or any other applicable PCMH+ FFP Authority are not approved by CMS in a manner that DSS determines necessary to obtain FFP for payments made pursuant to PCMH+, DSS expressly reserves the right to terminate this Contract. DSS may enforce the provisions of the PCMH+ FFP Authority to the full extent as provisions set forth in the Contract. To the extent there is any conflict between the provisions of the Contract and the PCMH+ FFP Authority, except as specifically specified otherwise in this Contract, the provisions of the PCMH+ FFP Authority shall supersede all such conflicting provisions. As soon as practicable after the PCMH+ FFP Authority, including any revisions thereto has been approved by CMS, DSS will send a copy of such document(s), which shall be added as an Attachment to this Contract. To the extent feasible, the Department will use reasonable efforts to provide written notice to the Contractor of any changes to the PCMH+ FFP Authority as soon as possible after such changes are known to the Department, and an opportunity to review and comment on any such proposed change. If the Contractor does not notify the Department in writing that it has any objection to said changes less than 10 days after the Contractor receives such changes, then the Contractor shall be deemed to have agreed to all such changes to the PCMH+ FFP Authority.

SIM Model Test Grant: In addition to the planning grant referenced above, the State received a SIM model test grant from CMMI. Among other things, those model test grant funds support the model design and related actuarial analysis for PCMH+. Accordingly, continued receipt of CMMI model test grant funds in the amounts as determined by DSS to be necessary for design and administration of PCMH+ is a condition precedent to this Contract and any payments made pursuant to this Contract. If the CMMI SIM model test grant funds are reduced or eliminated in a manner that DSS determines no longer make it possible for DSS to properly administer the PCMH+ Program, DSS expressly reserves the right to terminate this Contract.

Operational Policy and Regulations: DSS is in the process of adopting regulations governing both the PCMH program and also the PCMH+ program. In accordance with Conn. Gen. Stat. § 17b-263c, DS is implementing policies and procedures (also known as an operational policy) in regulation form, with the legal force of regulations, while the regulation making process of Conn. Gen. Stat. ch. 54 is pending. While the regulation making process is still pending for each regulation, the Contractor agrees to comply with each of the PCMH and the PCMH+ operational policies. After each such operational policy has been fully adopted as a regulation, the Contractor agrees to comply with each regulation. To the extent there is any conflict between the PCMH operational policy and the PCMH+ operational policy, the PCMH+ operational policy shall supersede the PCMH operational policy. To the extent there is any conflict between (a) either or both of the PCMH and/or PCMH+ operational policy or regulation, as applicable, and (b) this Contract and/or the PCMH+ FFP Authority, then the PCMH or PCMH+ operational policy or regulation, as applicable, shall supersede this Contract and/or the PCMH+ FFP Authority.

Because PCMH+ builds upon the PCMH program, PCMH+ Participating Entities are required to continue complying with all requirements of the PCMH program, including the various activities required as part of the PCMH external accreditation or certification (currently, NCQA PCMH Level 2 or Level 3 accreditation for primary care practices within an Advanced Network and, for FQHCs, either such NCQA accreditation or PCMH certification from The Joint Commission). In addition to providing the services required for PCMH, as part of the PCMH+ program, the Contractor agrees to provide the care coordination services required under this Contract.

In addition to complying with the provisions of the PCMH+ FFP Authority, the Contractor also agrees to comply with section 1905(t) of the Social Security Act and 42 C.F.R. § 440.168 regarding the provision of primary care case management (PCCM) services in connection with its participation in the PCMH+ program. These PCCM requirements include several basic protections enumerated in the above-cited statute and regulation. As detailed in this Contract, the Enhanced Care Coordination Activities (and for FQHCs, also the Care Coordination Add-On Payment Activities) are more specific and detailed than the broader requirements described in the above-cited PCCM statute and regulation.

Under PCMH+, the Department will contract with qualified provider organizations to be PCMH+ Participating Entities in the Performance Period beginning January 1, 2017.

PCMH+ will build on DSS' existing PCMH program by incorporating new Enhanced Care Coordination Activities and Care Coordination Add-On Activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid beneficiaries with complex medical conditions and disability needs, and promoting linkages to community supports that can assist beneficiaries in utilizing their Medicaid benefits.

Under PCMH+, PCMH+ Participating Entities will provide Enhanced Care Coordination Activities to improve the quality, efficiency, and effectiveness of care. FQHCs will also provide Care Coordination Add-On Payment Activities that are in addition to the Enhanced Care Coordination Activities and the care coordination activities that are already required for their participation in the DSS PCMH program ([link to DSS PCMH program](#)). All PCMH+ Participating Entities (both FQHCs and Advanced Networks) that meet identified benchmarks on quality performance standards and measures of under-service will be eligible to participate in shared savings. DSS will also make Care Coordination Add-On Payments to PCMH+ Participating Entities that are FQHCs to support the Care Coordination Add-On Payment Activities.

1. Eligibility

Eligible Population

All Connecticut Medicaid beneficiaries are eligible for potentially being assigned to a PCMH+ Participating Entity (in accordance with the assignment methodology described below), except for the beneficiary categories listed below:

- Behavioral Health Homes participants (Section 1945 of the Social Security Act).
- Only to the extent authorized by CMS, full and partial Medicaid/Medicare dual eligibles (as explained in more detail below).
- Home- and Community-Based Services Section 1915(c) waiver, Section 1915(i) and Section 1915(k) participants.
- Money Follows the Person participants.
- Members who are enrolled in a hospice benefit.
- Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities, and other long-term care institutions that are required to coordinate care for their residents.
- Members who are enrolled in Connecticut Medicaid solely to receive a limited benefit package (current limited benefit packages include family planning and tuberculosis). Similarly, members who are enrolled

in Connecticut Medicaid solely because they have breast or cervical cancer will also be excluded from PCMH+.

These beneficiaries will not be assigned to the PCMH+ since these beneficiaries have another source of health care coverage, a limited Medicaid benefit, or receive care coordination through other programs.

Subject to CMS approval, in addition to the categories specifically listed above, DSS anticipates that partial Medicaid/Medicare dual eligibles, as well as dual eligibles being served by Medicare Accountable Care Organizations (ACOs) or on Medicare managed care (such as a Medicare Advantage plan), will be excluded from PCMH+. Also subject to CMS approval, other dual eligibles that neither fall within one of those categories nor one of the other categories of excluded categories listed above will be excluded from PCMH+ only for purposes of calculating the Care Coordination Add-On Payments (for FQHCs) and from shared savings calculations, but the Contractor must provide such individuals with the opportunity to receive Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities (for FQHCs) to the same extent as all other PCMH+ members.

2. Retrospective Attribution and Prospective Assignment Methodology

Identifying Medicaid members who will participate in PCMH+ is a two-step process. First, the Department will use its existing retrospective attribution methodology to associate members with PCMH practices from which they have sought care. Second, the Department will prospectively assign those members to PCMH practices that are, or are part of, PCMH+ Participating Entities.

Eligible Medicaid beneficiaries will be assigned to PCMH+ Participating Entities using DSS' existing retrospective attribution methodology – this method is used to associate members with Connecticut Medicaid participating primary care providers and Person Centered Medical Home (PCMH) providers adapted as necessary for PCMH+. Beneficiaries may affirmatively select a PCMH practice as their primary care provider. In the absence of beneficiary selection, the PCMH attribution methodology retrospectively assigns beneficiaries to primary care practitioners based on claims volume. If a beneficiary receives care from multiple providers during a given period, the beneficiary is assigned to the practice that provided the plurality of care and if there is no single largest source of care, to the most recent source of care.

A Participating Entity's assigned beneficiaries are the beneficiaries attributed to its PCMH practices using this methodology less beneficiaries that are not eligible for PCMH+. Even if a practice includes other providers, only the beneficiaries attributed to the PCMHs (or a PCMH practice entity) will be assigned to the PCMH+ Participating Entity. Eligible Medicaid beneficiaries will be assigned to a PCMH+ Participating Entity on or around November 2016 for the Performance Year starting January 1, 2017.

Beneficiaries will not be "enrolled" in, or limited to receiving services from, a PCMH+ Participating Entity. PCMH+ Members will retain the right to see any participating Medicaid provider. Members were notified of this right through a member notice letter. PCMH+ Members will continue to be eligible for all services covered by the Connecticut Medicaid program, including those not included in the shared savings calculation.

Eligible Medicaid beneficiaries have the right to opt-out of prospective assignment to a PCMH+ practice. An eligible Medicaid beneficiary can opt-out either before the implementation date of PCMH+, or at any time throughout the Performance Year. If an eligible Medicaid member opts-out of PCMH+, then that member's claim costs will be removed from the assigned PCMH+ Participating Entity's shared savings calculation. If an eligible Medicaid beneficiary opts-out of the PCMH+ and that beneficiary's assigned PCMH+ Participating Entity is a FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that beneficiary for all months in the Performance Period beginning with the calendar month after the member's opt-out request was processed by DSS. Participating Entities will be notified ahead of assignment by DSS.

3. **Quality Strategy and Quality Measure Set**

The Department's PCMH+ goals are to further improve quality of care and care experience of Medicaid beneficiaries. The Department worked with stakeholders to build a PCMH+ quality strategy that is rooted in national best practices and Connecticut-specific data, including historical PCMH quality data. The PCMH+ quality strategy, including a quality measure set that includes measures of under-service, will be used to evaluate PCMH+ Participating Entities' performance and overall program success. The PCMH+ Participating Entity's ability to receive shared savings will be contingent on its quality scores.

The applicable PCMH+ quality measure set is embedded as a hyperlink and as an attachment to this Contract. Data for the majority of quality measures will be collected from PCMH+ member claims and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), conducted annually by DSS. Hybrid Healthcare Effectiveness Data and Information Set (HEDIS) measures (those measures that can be collected using both administrative data and medical record abstraction) will only be evaluated using administrative data at this time, although in the future the Department could move towards medical record abstraction. Quality measures used to determine shared savings payments in the first Performance Year will be limited to these claims-based measures. Quality Measures will be continuously evaluated and may be updated or revised for the second Performance Year and before the beginning of each Performance Year thereafter. The Department will provide at least 30 days' advanced written notice to the Contractor of any proposed update or revision of the quality measures, provided that such notice may be included within one or more unrelated documents sent by the Department, such as a public notice document as long as the Department individually notifies the Contractor in writing that a proposed update or revision of the quality measures is included in such unrelated document(s).

PCMH+ Participating Entities will only be eligible to receive a shared savings payment if they: (1) demonstrate savings (as described below), (2) meet identified benchmarks on quality performance standards, (3) meet and comply with measures of under-service, and (4) provide all required Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities).

4. **Provisions to Prevent Under-Service**

Providers will be disqualified from receiving shared savings if the Department determines that they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. The specific criteria for identifying systemic under-service and panel manipulation are still under development, however, the Department's overall approach to monitoring and preventing under-service is documented at the following hyperlink for PCMH+ UNDER-SERVICE UTILIZATION MONITORING STRATEGY, and provided as an attachment to this Contract.

If the Department detects that any potential under-service has occurred regarding the PCMH+ Participating Entity, the Department will use best efforts to notify the Contractor in writing as soon as possible. The Department will give the Contractor an opportunity to respond to such findings and to take corrective action to prevent any future under-service or potential under-service.

If the Department determines that one or more providers within the PCMH+ Participating Entity and/or the PCMH+ Participating Entity overall have engaged in repeated or systematic under-service, the Department will send the Contractor such findings in writing. The Department will give the Contractor an opportunity to respond to such findings and to take corrective action. Depending on the nature, extent, and/or severity of such under-service, the Department may take a variety of sanctions against the Contractor to enforce the requirement to prevent under-service, including, but not limited to, a corrective action plan with defined steps and timeframes to correct and prevent future under-service, denial of all or a reasonable portion of shared savings payments (if applicable) and/or

Care Coordination Add-On Payments (for FQHCs), and/or such other actions as the Department reasonably determines are necessary to protect PCMH+ members from under-service.

To the extent the Contractor objects to Department's determination, the Contractor may use the desk review process described in section III.E below.

5. Overview of Payment Methodology

Advanced Networks will be reimbursed for Enhanced Care Coordination Activities using the shared savings payment methodology. Advanced Networks will not be eligible to receive the Care Coordination Add-On Payment. Primary care providers within an Advanced Network can receive a portion of the PCMH+ Participating Entity's shared savings only for program years for which such provider has maintained full DSS PCMH+ recognition throughout the program year.

Advanced Networks will continue to receive standard payments under the Connecticut Medicaid program using the standard payment methodology or methodologies applicable to the provider for services provided to Medicaid beneficiaries.

6. Benefits Included in the Shared Savings Calculation

The PCMH+ Participating Entity's shared savings calculation is based on the cost of a defined set of benefits that is the same for all PCMH+ Participating Entities. It is not expected that PCMH+ Participating Entities would directly provide each and every one of the included benefits, but they may have the opportunity to impact the cost of these benefits through the provision of Enhanced Care Coordination Activities (and for PCMH+ Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) and by addressing the social determinants of health via linkages to community partners.

All Medicaid claim costs for covered benefits will be included in the shared savings calculation for the PCMH+ Participating Entity, with the exception of:

- Hospice;
- Long-term services and supports, including institutional and community-based services; and
- Non-emergency medical transportation.

PCMH+ Members will continue to be eligible for all benefits covered by the Connecticut Medicaid program, including those listed above that are excluded from the shared savings calculation, and will retain free choice of all qualified Medicaid providers.

7. Shared Savings Payment Methodology

The shared savings payment methodology will adhere to the following guiding principles:

- Only PCMH+ Participating Entities that meet identified benchmarks on quality standards and measures of under-service will be eligible to participate in shared savings.
- A provider within a PCMH+ Participating Entity will be disqualified from receiving any shared savings (if applicable) if such provider is found to be systematically underserving or manipulating his or her patient panel. The Department may also take additional corrective action against the PCMH+ Participating Entity in response to any under-service occurring within the entity, as described above.

- In addition to absolute quality scores, maintaining and improving quality will also factor into the calculation of shared savings.
- Higher quality scores will allow a PCMH+ Participating Entity to receive more shared savings.
- PCMH+ Participating Entities that demonstrate losses (i.e., increased expenditures incurred by Connecticut Medicaid) will not be required to share in losses (i.e., will not be required to return any portion of such increased expenditures to the Department).
- PCMH+ Participating Entities will be benchmarked for quality and cost against a comparison group determined by the Department.

If a PCMH+ Participating Entity generates savings for the Connecticut Medicaid program and meets applicable measures of quality and under-service, that PCMH+ Participating Entity will share in the savings achieved. Savings will be available to PCMH+ Participating Entities through two savings “pools.” The first pool will be an individual savings pool, through which each PCMH+ Participating Entity that meets the quality benchmarks will receive a portion of the savings it achieved individually. The second pool will be a challenge pool that will aggregate all savings not awarded to individual PCMH+ Participating Entities in the individual pool, such as because of less than perfect scores on the applicable quality measures.

a. Individual Savings Pool

Each PCMH+ Participating Entity’s individual savings pool is calculated based on the savings attributed to each PCMH+ Participating Entity, in accordance with the shared savings calculation methodology. The PCMH+ Participating Entity’s shared savings payment in the individual pool will be affected by the PCMH+ Participating Entity’s aggregate quality score. The aggregate quality score will be developed based on the PCMH+ Participating Entity’s performance on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of nine quality measures, the current version of which is listed in the following hyperlink, [PCMH+ quality measure set](#) and as an attachment to this Contract. A PCMH+ Participating Entity will receive its savings from the individual savings pool as determined by DSS in accordance with the model described below:

- **Prior Year:** The twelve month time period for the Prior Year will be January 1, 2016 through December 31, 2016.
- **Performance Year:** The twelve month time period for the Performance Year will be January 1, 2017 through December 31, 2017.
- **Minimum Savings Rate:** In order to be eligible to receive any shared savings payments, a Participating Entity’s risk-adjusted savings (i.e., reductions in expected Performance Year costs) must meet the Minimum Savings Rate (MSR) requirement, which is 2% of the Participating Entity’s expected Performance Year costs, as determined by the Department. Losses (i.e., increases in expected Performance Year costs) will not be considered credible when determining the aggregate PCMH+ program savings.
- **Savings Cap:** Each individual savings pool will be limited to ten percent (10%) of the PCMH+ Participating Entity’s expected Performance Year costs, as determined by the Department.
- **Sharing Factor:** A sharing factor (the amount of savings shared between a PCMH+ Participating Entity and DSS) of fifty percent (50%) will apply to each PCMH+ Participating Entity’s savings.

- **Claims Truncation:** The annual claims cost for each eligible Medicaid beneficiary assigned to a PCMH+ Participating Entity will be truncated at \$100,000, so that costs above \$100,000 will not be included in the shared savings calculation.
- **Expected Cost Trends and Comparison Group:** Expected cost trends will be developed from a comparison group, as determined by the Department. The expected cost trends from the comparison group will be based upon both the Performance Year and the Prior Year, described above.
- **Risk Adjustment:** Risk adjustment methods (based on existing Johns Hopkins Adjusted Clinical Groups (ACG) retrospective risk scores) will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden, as determined by the Department. The Comparison Group Trend is derived as the Risk Adjusted Performance Year Cost divided by the Risk Adjusted Prior Year Cost. A Participating Entity's Risk Adjusted Expected Performance Year costs will be developed by multiplying the Entity's Risk Adjusted Prior Year Cost by the Comparison Group Trend. A Participating Entity's savings will be the difference between its Risk Adjusted Expected Performance Year costs and its actual Risk Adjusted Performance Year costs.
- **Upside-Only Model:** The shared savings calculation is an upside-only model, meaning that a PCMH+ Participating Entity will not be required to share in costs that exceed their expected risk-adjusted Performance Year costs (i.e., the Participating Entity will not be required to return any portion of increased expenditures incurred by the Connecticut Medicaid program).
- **Quality Scoring:** The Participating Entity's shared savings payment in the Individual Savings Pool, if any, will be determined in part by the Participating Entity's total quality score. A Participating Entity's total quality score will be based on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of the nine quality measures. A maximum of one point is available for each component of quality measurement for each measure. To calculate each Participating Entity's total quality score, its points will be summed and then divided by a maximum score of 27 points (three possible points per quality measure with nine total quality measures). The total quality score, expressed as a percent, will be used in calculating the portion of a Participating Entity's Individual Savings Pool that will be returned to the Participating Entity as shared savings.
- The three components of quality measurement in the individual savings pool are:
 - **Maintain Quality**
 - For the Maintain Quality component of measurement, a PCMH+ Participating Entity will earn one point if its Performance Year quality score is greater than or equal to its Prior Year score. A threshold will be established based on historical quality measure data to account for annual variation that may result in a lower score.
 - **Improve Quality**
 - For the Improve Quality component of measurement, a PCMH+ Participating Entity will earn points on a sliding scale based on performance against the comparison group's quality trend.

Improvement above the comparison group's quality trend	Points Awarded
Less than or equal to comparison group's quality trend	0.00
Between 0% and 32%	0.25
Between 33% and 66%	0.50
Between 67% and 99%	0.75
100% or greater	1.00

o Absolute Quality

- For the Absolute Quality component of measurement, a PCMH+ Participating Entity will earn points on a sliding scale based on performance against the benchmarks developed from the comparison group's historical quality measure data.

Percentile	Points Awarded
Between 0 and 49.99	0.00
Between 50 and 59.99	0.25
Between 60 and 69.99	0.50
Between 70 and 79.99	0.75
Between 80 and 99.99	1.00

To determine if cost savings were generated during the Performance Year, for each PCMH+ Participating Entity, risk-adjusted Performance Year costs will be compared to expected Performance Year costs. A PCMH+ Participating Entity's expected Performance Year costs will be developed by applying the comparison group cost trend to the PCMH+ Participating Entity's Prior Year costs. If the PCMH+ Participating Entity's Performance Year costs are lower than its expected Performance Year costs, then the PCMH+ Participating Entity will have a risk-adjusted savings that will go to its individual savings pool. However, if such savings exceed ten percent (10%) of the of the PCMH+ Participating Entity's expected Performance Year costs, the amount above 10% will not be included in the pool. If there are savings in the individual savings pool, the sharing factor will be applied, and then the PCMH+ Participating Entity's aggregate quality score will be applied. The savings amount after both of these factors have been applied will be the PCMH+ Participating Entity's shared savings. If a PCMH+ Participating Entity has any savings that go unclaimed, such as due to performance on the quality measures (its aggregate quality score), then those unclaimed savings will be used to fund the challenge pool.

b. Challenge Pool

If the Department determines that the overall PCMH+ program demonstrates aggregate savings in a Performance Year, the challenge pool will be funded by all unclaimed credible savings from the individual savings pools. The Department will adjust the availability of challenge pool payments, if any, to ensure that the challenge pool payments will not exceed the aggregate savings for the PCMH+ program in a Performance Year minus the aggregate individual shared savings payments. Performance on four quality measures, listed in PCMH+ quality measure set and as an attachment to this Contract will inform the challenge pool payment through the use of a member-weighted distribution by PCMH+ Participating Entity. For each quality measure, a PCMH+ Participating Entity must achieve at least the median score of all PCMH+ Participating Entities that are participating in the challenge pool, for that measure to be counted within the member-weighted distribution. The four quality measures used for the challenge pool are a separate set of quality measures than the nine quality measures used in the individual savings pool.

The amount of the Participating Entity's Challenge Pool payment, if any, will be the product of the number of its assigned PCMH+ members times the number of Challenge Pool quality measures passed, divided by the sum of this statistic across all Participating Entities. As such, it is certain that the full Challenge Pool will be returned. It should be noted that the Challenge Pool payment to any particular Participating Entity is not directly related to its individual savings.

8. Monitoring and Oversight

PCMH+ Participating Entities shall comply with all statutes, regulations, and policies that apply to their participation in the PCMH+ program and to the provision of services required by and related to their participation in the PCMH+ program. The Contractor shall maintain such records and reports as are necessary to fully disclose and document that the Contractor has complied with all requirements under the PCMH+ program, including, but not limited to: provision of Enhanced Care Coordination Activities, Care Coordination Add-On Payment Activities (for FQHCs), and all other required activities, as well as information documenting the care experience and quality of care provided, as determined and specified by DSS.

DSS and its representatives will develop and implement methods to monitor delivery of Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities. PCMH+ Participating Entities shall report data to DSS as specified by DSS and not less than quarterly. DSS program staff and its representative(s) will review the reports and follow up with PCMH+ Participating Entities as needed regarding their performance. If DSS determines that a PCMH+ Participating Entity does not provide sufficient evidence of performing the required Enhanced Care Coordination Activities, as determined by DSS, or Care Coordination Add-On Payment Activities for FQHCs, the Department may: (1) require the Participating Entity to comply with a corrective action plan and/or (2) make the Participating Entity ineligible to receive all or part of shared savings payments for which the Participating Entity might otherwise be eligible to receive.

If DSS determines that a PCMH+ Participating Entity that is an FQHC does not provide sufficient evidence of performing either the FQHC Care Coordination Add-On Payment Activities and/or the Enhanced Care Coordination Activities, the Department may: (1) require the Participating Entity to comply with a corrective action plan, (2) make the Participating Entity ineligible to receive all or part of shared savings payments for which the Participating Entity might otherwise be eligible to receive, and/or (3) deny and/or recoup all or part of the Care Coordination Add-On Payments that the Participating Entity would otherwise be eligible to receive.

Upon request from the Department, not later than 21 days after receiving such request, the Contractor shall provide the Department with the following regarding the Contractor's performance of the Contract (and, if the Contractor is an Advanced Network, all such information and documentation that apply to each member entity within the

network): (1) policies and procedures regarding the performance of and compliance with the Contract; (2) explanation and documentation, as specified by the Department regarding how the Contractor provides the Enhanced Care Coordination Activities (and for FQHCs, the Care Coordination Add-On Payment Activities) and the other activities required to be performed under this Contract; and (3) other documentation and information requested by the Department regarding the Contractor's performance of this contract.

The Contractor acknowledges that the Department will be conducting periodic compliance reviews (not less than annually during each Performance Year) to evaluate the Contractor's performance of the activities required by the Contract. Such evaluations may include, but not limited to: a request for information and documentation, a review of PCMH+ members' clinical and care coordination records, and an on-site evaluation that includes interviews with the Contractor's PCMH+ staff, clinicians, and PCMH+ members. The Contractor agrees to provide the Department with access to its facilities and staff to enable the Department to perform such reviews, including that the Contractor shall ensure that its PCMH+ clinical director and senior leader participate and facilitate the Contractor's full cooperation and participation in such reviews.

9. PCMH+ FFP Authority (including the State Plan Amendment (SPA))

The draft SPA for the PCMH+ Program is provided in the following hyperlink. <http://www.ct.gov/dss/pcmh+>. The PCMH+ FFP Authority, as defined above and as ultimately approved by CMS and for the effective dates set forth therein, is incorporated by reference into this Contract as if fully set forth herein. DSS may enforce the provisions of the PCMH+ FFP Authority to the full extent as provisions set forth in the Contract. To the extent there is any conflict between the provisions of the Contract and the PCMH+ FFP Authority, except as specifically specified otherwise in this Contract, the provisions of the PCMH+ FFP Authority shall supersede all such conflicting provisions. As soon as practicable after the PCMH+ FFP Authority, including any revisions thereto has been approved by CMS, DSS will send a copy of such document(s), which shall be added as Attachment to this Contract.

10. Compliance with Regulations and Operational Policies

While the regulation making process is still pending for the PCMH regulation and the PCMH+ regulation, the Contractor agrees to comply with each of the PCMH and the PCMH+ operational policies that are being implemented by the Department with the force of regulations pursuant to Conn. Gen. Stat. § 17b-263c. After each such operational policy has been fully adopted as a regulation, the Contractor agrees to comply with each regulation. To the extent there is any conflict between the PCMH operational policy and the PCMH+ operational policy, the PCMH+ operational policy shall supersede the PCMH operational policy. To the extent there is any conflict between (a) either or both of the PCMH and/or PCMH+ operational policy or regulation, as applicable, and (b) this Contract and/or the PCMH+ FFP Authority, then the PCMH or PCMH+ operational policy or regulation, as applicable, shall supersede this Contract and/or the PCMH+ FFP Authority.

11. ABBREVIATIONS/ACRONYMS/DEFINITIONS

a. Abbreviations/Acronyms

ACO	Accountable Care Organization
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CCIP	Community and Clinical Integration Program
CMS	Centers for Medicare & Medicaid Services (U.S.)
CMM	Comprehensive Medication Management
CMMI	Center for Medicare & Medicaid Innovation (U.S.)
CT	State of Connecticut
CYSHCN	Children and Youth with Special Health Care Needs
Department	State of Connecticut Department of Social Services
DME	Durable Medical Equipment
DSS	State of Connecticut Department of Social Services
HRSA	Health Resources and Services Administration (U.S.)
PCMH+	Medicaid Quality Improvement and Shared Savings Program
NCQA	National Committee for Quality Assurance
PCMH	Person-Centered Medical Home
PHSA	Public Health Service Act
PMO	Project Management Office
SHIP	State Healthcare Innovation Plan

b. Definitions

Advanced Network

A provider organization or group of provider organizations that provide Enhanced Care Coordination Activities to PCMH+ Members. At a minimum, an Advanced Network must include a practice currently participating in DSS' PCMH program (other than a Glide Path practice). Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health and oral health providers;
3. One or more DSS PCMH practice(s) plus specialist(s) (which could include physical health, behavioral health and oral health providers) and one or more hospital(s); or
4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s).

Please Note: This definition is unique to PCMH+ and differs from the general Connecticut SIM definition of Advanced Network. For purposes of PCMH+, the Advanced Network must meet the definition described above but, unlike the general SIM definition, is not required to have risk-bearing contracts for providing health services.

Advanced Network Lead Entity

A provider or provider organization that contracts with the Department on behalf of the Advanced Network and fulfills all required functions. The Advanced Network Lead Entity must be a participating provider in the Advanced Network.

Care Coordination

The deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care. Care coordination does not mean that any individual has a legal right to any particular level or amount of services.

Care Coordination Add-On
Payment

Payments paid prospectively on a monthly basis to PCMH+ Participating Entities that are FQHCs for providing Care Coordination Add-On Payment Activities to PCMH+ Members.

Care Coordination Add-On
Payment Activities

Care coordination activities that PCMH+ Participating Entities that are FQHCs will be required to provide to PCMH+ Members in order to receive the Care Coordination Add-On Payment. The Care Coordination Add-On Payment Activities are in addition to the Enhanced Care Coordination Activities required of all PCMH+ Participating Entities. The specific required Care Coordination Add-On Payment Activities are specified in the attached document that has been incorporated by reference into this Contract. The care coordination services provided by the Contractor fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Contractor's available resources for providing care coordination to that individual as well as all individuals for which the Contractor is responsible for providing care coordination.

Community and Clinical
Integration Program

The Community and Clinical Integration Program (CCIP) is comprised of a set of care delivery standards and technical assistance that is intended to enable Advanced Networks and FQHCs to deliver care that results in better health outcomes at lower costs for Medicare, Medicaid, and commercial plan enrollees. CCIP participants will receive free technical assistance, as well as peer support through a learning collaborative.

Comparison Group	The comparison group is the group of health providers that DSS has determined will be used to analyze the expected cost trends in connection with analyzing whether or not the Participating Entities generated savings for the Medicaid program in a given performance year. For the Performance Year from January 1, 2017 through December 31, 2017, DSS anticipates that the Comparison Group will consist of all FQHCs and non-FQHC full DSS PCMH practices that have at least 2,500 attributed PCMH+ eligible Medicaid members and have full PCMH status in the DSS PCMH program but are not participating in PCMH+. Based on the number of eligible FQHCs and PCMHs that elect to participate in the PCMH+ Program in Performance Years occurring after calendar year 2017, the Comparison Group may be adjusted to include additional practices to provide a Comparison Group that is sufficiently large to be statistically valid. The comparison group will be used as part of determining the PCMH+ shared savings calculation.
Contractor	See PCMH+ Participating Entity.
Contract	PCMH+ Participating Entity agreement.
Day	Calendar day.
Enhanced Care Coordination Activities	Required care coordination activities that all PCMH+ Participating Entities must provide. The specific required Enhanced Care Coordination Activities are specified in the attached document that has been incorporated by reference into this Contract. The care coordination services provided by the Contractor fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Contractor's available resources for providing care coordination to that individual as well as all individuals for which the Contractor is responsible for providing care coordination.
Federally Qualified Health Center	An entity that meets the definition of an FQHC in section 1905(l)(2)(B) of the Social Security Act and meet all requirements of the HRSA Health Center Program, including both organizations receiving grants under Section 330 of the Public Health Service Act and also FQHC Look-Alikes, which are organizations that meet all of the requirements of an FQHC but do not receive funding from the HRSA Health Center Program.
Joint Commission	Over body that certifies FQHC.

PCMH+ Member	Medicaid beneficiaries prospectively assigned to PCMH+ Participating Entities using the Department's PCMH retrospective attribution process, which has been adapted for PCMH+.
PCMH+ Participating Entity	A FQHC or Advanced Network (represented by the Advanced Network Lead Entity) contracted by the Department to participate in PCMH+. Also referred to as Contractor.
PCMH+ Quality Measures	The set of quality measures used to evaluate the performance of PCMH+ Participating Entities and the performance of the PCMH+ as a whole. Specific quality measures may be for reporting purposes only, or may be utilized to calculate a PCMH+ Participating Entity's quality performance as part of the shared savings calculations. The current version of the <u>PCMH+ quality measure set</u> embedded as a hyperlink and as an attachment to this Contract.
PCMH+ Provider Website	http://www.ct.gov/dss/cwp/view.asp?a=4769&q=587210
Performance Year or Performance Period	The time period in which PCMH+ Participating Entities will provide Enhanced Care Coordination Activities and improve the quality of care. This is also the time period that the performance of the PCMH+ Participating Entities will be evaluated for the purpose of the shared savings calculation.
Prior Year	The time period preceding the Performance Year for purposes of establishing the PCMH+ Participating Entities' and comparison group's cost baseline and quality measure benchmarks.
RFP	The Request for Proposals for the PCMH+ program Performance Year(s) that is/are the subject of this Contract.

State Innovation Model

An initiative created by the Center for Medicare & Medicaid Innovation (CMMI) to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that is designed to improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program beneficiaries - and for all residents of participating states. For additional information, see <http://innovation.cms.gov/initiatives/state-innovations/>.

Transition Age Youth

Commonly defined as individuals between the ages of 16 and 25 years. The age range for transition age youth (TAY) can vary to include children as young as 12 years of age.

SECTION TWO - SCOPE OF WORK

The Contractor is the Advanced Network Lead Entity in an Advanced Network comprised of the members of Value Care Alliance, LLC ("VCA"), namely St. Vincent's Medical Center, Western Connecticut Health Network, Griffin Hospital and Middlesex Hospital (each, a "VCA Member" and together, the "VCA Members"). Reference is made to the Contractor's response dated July 29, 2016, to the Department's Medicaid Quality Improvement and Shared Savings Program participating Entities Request for Proposals (the "Contractor's Response to RFP"), which is incorporated by reference herein pursuant to Section A.5 below and describes the basis on which, under the Contractor's administration, the VCA Members will provide Enhanced Care Coordination Activities to PCMH+ Members. The Department acknowledges that certain responsibilities of the Contractor hereunder will be fulfilled by the VCA, and consents to the delegation of responsibilities hereunder to the VCA as a subcontractor of Contractor hereunder. The Department further acknowledges that, pursuant to its agreement with the Contractor, each VCA Member will be an Advanced Network participant and a subcontractor of Contractor hereunder, and agrees to be bound by the provisions herein applying to the Contractor as they relate to the VCA Member as if each VCA Member were a signatory hereto, and agrees to be directly liable to the Department with respect to any breach by such VCA Member of any such provision of this Contract.

A. PCMH+ PARTICIPATING ENTITY REQUIREMENTS AND RESPONSIBILITIES

1. Organizational Requirements of PCMH+ Participating Entities

- a. **Attributed PCMH+ Members.** The Contractor shall have a minimum of 2,500 DSS PCMH Program beneficiaries who are eligible to participate in PCMH+ that have been attributed to the Contractor prior to the start of the Performance Year in accordance with the PCMH+ attribution methodology.
- b. **Connecticut Medicaid.** The Contractor shall use reasonable efforts within its control to ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to PCMH+ Members ([link to Connecticut Medical Assistance Program Provider Enrollment website](#)).
- c. **Oversight Body.** The Contractor shall have an oversight body that may, but is not required to, overlap with a governing board or advisory body that existed prior to the Performance Year. The oversight body must include substantial representation by PCMH+ Members assigned to the PCMH+ Participating Entity and at least one individual provider (i.e., health care practitioner) who is participating in the PCMH+ Participating Entity. The type and number of providers on the oversight body need not be proportional to PCMH+ Participating Entity participating providers, but must be generally representative of the variety of providers participating in the PCMH+ Participating Entity (e.g., primary care, other physical health providers, behavioral health providers, oral health providers, etc.).

The Contractor shall provide assistance (e.g. transportation and childcare) to PCMH+ Members to enable them to attend oversight body meetings. Making such payments and/or rendering such services is permissible under this Contract, provided that: (1) the Department will not reimburse the Contractor for such expenditures or services, (2) the Contractor is responsible for ensuring compliance with all statutes, regulations and other requirements that apply to such expenditures, and (3) the Contractor agrees to use reasonable diligence in preventing any potential negative consequences to individuals that may result from such expenditures, such as any potential impact on those individuals' eligibility for Medicaid and/or other public benefit program(s).

The Contractor shall circulate relevant written reports and materials in advance to the members of the oversight body for its review and comment.

The Contractor shall have formal procedures through which to receive feedback from the oversight body and documentation of this communication.

The Contractor shall maintain detailed documentation regarding the existence, governance, and activities of the oversight body. Upon request, the Contractor shall provide DSS with documentation regarding all aspects of the governance, activities, and communications of the oversight body.

The oversight body must:

- 1) Meet at least once each calendar quarter and provide meaningful feedback to the PCMH+ Participating Entity on a variety of topics, including quality improvement, member experience, prevention of underservice, implementation of PCMH+, and distribution of shared savings;
- 2) Have a transparent governing process;
- 3) Have bylaws that reflect the oversight body's structure as well as define its ability to support the PCMH+ objectives; and
- 4) Have a conflict of interest policy calling for disclosure of relevant financial interests and a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

d. **Advanced Network.** The Contractor shall include one or more practice(s) that is/are currently participating in the DSS PCMH program as a PCMH and hold/holds Level 2 or 3 Patient-Centered Medical Home recognition from NCQA. Practices with Glide Path designation, which is a step towards DSS PCMH recognition, do not count as meeting this requirement. Individuals attributed to a Glide Path practice will not be assigned to the Participating Entity for purposes of PCMH+ and the Participating Entity shall not receive any shared savings payments based on individuals attributed to a Glide Path practice. Each PCMH practice may participate in only one Advanced Network and cannot change during a Performance Year. Advanced Networks are encouraged to include additional providers and are required to include signed letters of intent for each provider included in the Advanced Network. In the case of group practice entities, the letter may be signed by the entity on behalf of all individual providers employed by or under contract to such entity. Acceptable options for Advanced Network composition include:

- 1) or more DSS PCMH practice(s);
- 2) One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;
- 3) One or more DSS PCMH practice(s) plus specialist(s) (which could include physical health, behavioral health and oral health providers) and one or more hospital(s); or
- 4) A Medicare ACO that includes one or more DSS PCMH practice(s).

The Contractor shall require any non-DSS PCMH primary care practices within the Advanced Network to become a DSS PCMH practice within eighteen (18) months of the start of the first PCMH+ Performance Year. This is a multi-step process. First, any non-DSS PCMH primary care practices must apply to the DSS PCMH Glide Path at the start of the first Performance Year. In general, this process includes three steps: (1) the primary care practice completes a readiness review questionnaire; (2) within 30 days, the practice completes the PCMH program application; (3) within 30 days, the practice completes a detailed Glide Path application that includes high levels steps and timeline to achieving PCMH recognition for the practice. The target date for a primary care practice to complete these steps is February 28, 2017. Additional information about the DSS PCMH program, including resources and supports for practices on the Glide Path can be found at

<http://www.huskyhealthct.org/providers/pcmh.html>. DSS retains the right to extend the timeframe for PCMH recognition based on good cause shown by a practice for why it needs additional time. Practices that do not achieve this milestone will be issued a corrective action plan. A copy of the corrective action plan will be provided to the Participating Entity. The corrective action plan will establish timeframes for the practice(s) to address gaps in order to become a DSS PCMH. DSS will monitor compliance with the corrective action plan until DSS PCMH status has been reached. Non-compliance with corrective action plans will result in termination of the Advanced Network's Contract with DSS, and loss of shared savings for that performance year.

The Contractor, as the Advanced Network Lead Entity shall:

- a) Identify a clinical director and a senior leader to represent the Advanced Network and champion PCMH+ goals. These positions are not required to be full time or solely dedicated to PCMH+. The appointment and removal of the clinical director and senior leader must be under the control of the Advanced Network's oversight body;
- b) Ensure that the required Enhanced Care Coordination Activities are implemented as intended, including but not limited to: ensuring required staff are hired and appropriately trained, monitoring of day-to-day practice, establishment of linkages with community partners, and any required reporting to DSS;
- c) Not limit a member's ability to receive services from a provider that is not affiliated with the Advanced Network;
- d) Receive any shared savings achieved and distribute the shared savings to Advanced Network participating providers, using a written distribution methodology that is subject to review and approval by the Department; and
- e) If the Advanced Network is comprised of more than one provider organization, have a Contractual relationship with all other Advanced Network participating providers for the purposes of PCMH+. The Contract must at a minimum contain:
 - (1) An explicit requirement that each Advanced Network participating provider agrees to participate in and comply with the applicable requirements of the PCMH+;
 - (2) A description of the Advanced Network participating provider's rights and obligations in, and representation by, the Contractor, including language giving the Advanced Network Lead Entity/Contractor the authority to terminate a provider's participation in the Advanced Network for its non-compliance with the Advanced Network participation agreement or any of the requirements of Connecticut Medicaid;
 - (3) Language that Advanced Network participating providers must allow PCMH+ Members freedom of choice of provider and may not require that members be referred to providers within the Advanced Network; and
 - (4) A description of the methodology for distributing any shared savings between the Advanced Network Lead Entity/ Contractor and Advanced Network participating providers. The shared savings distribution methodology must not include any factors that would reward a provider for specific contributions to the overall savings of the network. Non-DSS PCMH primary care practices (such as Glide Path practices) in the Advanced

Network may not receive a portion of any shared savings achieved by the Advanced Network. This methodology is subject to review and approval by the Department.

2. **Linkages with Community Partners to Address Social Determinants of Health**

In an effort to meaningfully impact the social determinants of health, promote physical and behavioral health integrated care, and assist beneficiaries in utilizing their Medicaid benefits, the Contractor shall implement and maintain contractual relationships or informal partnerships with local community partners. The purpose of these partnerships is to develop and implement initiatives to identify and actively refer members with behavioral health conditions that require specialized behavioral health treatment to appropriate sources of care, address social determinants of health, and facilitate rapid access to care and needed resources. It is not expected that these partnerships will solve or fully address any individual PCMH+ member's social determinants of health, but rather, to help foster broader collaboration and broader perspectives that are collectively designed to result in overall long-term improvements in health. As part of these relationships, the Contractor and/or, as applicable one or more providers within the PCMH+ Participating Entity, will meet with various community partners to improve collaboration. Upon request, the Contractor shall provide the Department with documentation of such contractual relationships and/or informal partnerships, as applicable, including the role of such relationships in enabling the Contractor to improve the care experience, quality of care, and cost of care for PCMH+ members assigned to the Contractor.

The Contractor shall implement and maintain contractual relationships or informal partnerships including:

- a. Community-based organizations including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, elder support services, etc.;
 - b. Behavioral health organizations, including those providing substance use services;
 - c. Child-serving organizations;
 - d. Peer support services and networks;
 - e. Social services agencies;
 - f. The criminal justice system;
 - g. Local public health entities;
 - h. Specialists and hospitals (in cases where the Advanced Network does not already include these entities);
and
 - i. Other State and local programs, both medical and non-medical.
3. **Quality.** The Contractor shall have a planned and documented approach to monitor and improve the quality of care provided to PCMH+ members, including a plan to monitor, prevent, and address under-utilization of medically necessary services. The Contractor shall maintain such documentation and shall provide it to DSS upon request. The contractor shall update such approach as necessary to continue monitoring and improving the quality of care provided to PCMH+ members.
4. The specific **Enhanced Care Coordination Activities** that the Contractor is required to perform are embedded as a hyperlink and as an attachment to this Contract. The Contractor shall provide Enhanced

Care Coordination Activities to PCMH+ Members. The Enhanced Care Coordination Activities leverage national best practices in care coordination and exceed the FQHC, HRSA, and Patient-Centered Medical Home recognition requirements as defined by NCQA or ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission, which the Contractor shall also continue to be required to perform. These activities go beyond the formal definition of care coordination because PCMH+ requires providers to begin providing care coordination services designed to address both medical care and behavioral health conditions—as well as to help address social determinants of health. However, it is not expected that the Contractor will completely address or resolve any PCMH+ member's social determinants of health, including those determinants that have a negative impact on health.

As part of participating in PCMH+, each PCMH+ Participating Entity is required to perform Enhanced Care Coordination Activities (and for FQHCs, also Care Coordination Add-On Payment Activities) for the PCMH+ Members that are assigned to each PCMH+ Participating Entity. The care coordination services provided by the Contractor fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Contractor's available resources for providing care coordination to that individual as well as all individuals for which the Contractor is responsible for providing care.

Notwithstanding any other provision in the Contract and any language to the contrary in the PCMH+ FFP Authority, this Contract does not create any entitlement for any PCMH+ Member or any other individual to receive any particular level or amount of services, nor does this Contract give any legal rights to any PCMH+ Members or any other third-party beneficiaries. PCMH+ Members do not have a right to receive any particular level or amount of Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities) and PCMH+ Participating Entities are not required to provide any specific level or amount of Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities) to each PCMH+ Member. The Contractor is required to provide Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities) only to the extent desired by PCMH+ members and only to the extent feasible within the Contractor's available resources for providing such services, as determined by the Department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

The Contractor shall provide the following Enhanced Care Coordination Activities:

a. Behavioral Health/Physical Health Integration

- 1) Employ a care coordinator with behavioral health education, training, and/or experience who participates as a member of the interdisciplinary team;
- 2) Use standardized tools to expand behavioral health screenings beyond depression;
- 3) Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high risk;
- 4) Obtain and maintain a copy of a member's psychiatric advance directive in the member's file; and
- 5) Obtain and maintain a copy of a member's Wellness Recovery Action Plan (WRAP) in the member's file.

b. Culturally Competent Services

- 1) Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities;
 - 2) Expand any individual care plan currently in use to include an assessment of the impact culture has on health outcomes; and
 - 3) Require compliance with culturally and linguistically appropriate services (CLAS) standards as defined by the U.S. Department of Health and Human Services, Office of Minority Health.
- c. Care Coordinator Staff Requirements: Availability – The Contractor must select at least one of these options based on the model(s) that fit their practice:
- 1) Employ a full time care coordinator dedicated solely to care coordination activities;
 - 2) Assign care coordination activities to multiple staff within a practice; and
 - 3) Contract with an external agency to work with the practice to provide care coordination.
- d. Care Coordinator Staff Requirements: Education
- 1) Define minimum care coordinator education and experience requirements and determine if leveraging non-licensed staff such as community health workers is desired.
- e. Children and Youth with Special Healthcare Needs¹ (CYSHCN): Age 0–17 Years
- 1) Require advance care planning discussions for CYSHCN. Advance care planning is not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, that significantly impact the quality of life of the child/youth and his/her family;
 - 2) Develop advance directives for CYSHCN; and
 - 3) Include school-related information in the member's health assessment and health record, such as: the individualized education plan or 504 plan, special accommodations, assessment of patient/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition, and documenting the school name and primary contact.
- f. Competencies in Care of Individuals with Disabilities (inclusive of physical, intellectual, developmental and behavioral health needs)
- 1) Expand the health assessment to include questions about: durable medical equipment (DME) and DME vendor preferences, home health medical supplies and home health vendor preferences, home and vehicle modifications, prevention of wounds for individuals at risk for wounds, and special physical and communication accommodations needed during medical visits.
 - 2) Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities.

¹ Maternal Child and Health Bureau definition of CYSHCN: "Those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." This definition is broad and inclusive, and it emphasizes the characteristics held in common by children with a wide range of diagnoses. Examples include children with diagnoses such as diabetes or asthma that is not well controlled. <http://mchb.hrsa.gov/cshcn05/>

Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.

- 3) Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.
 - 4) Acquire accessible equipment to address physical barriers to care (e.g., wheelchair scales, a high/low exam table and/or transfer equipment, and lifts to facilitate exams for individuals with physical disabilities).
 - 5) Address communication barriers to care (e.g., offer important medical information and documents in Braille or large print, implement policies to ensure services animals are permitted into an appointment). Providers may coordinate with the Department's medical Administrative Services Organization to obtain available materials.
 - 6) Expand the resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g., mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a patient with cerebral palsy who experiences spasticity or tremors during a physical examination).
- g. Evaluate and utilize the results of provider profile reports, to the extent available, on a quarterly basis to improve quality of care.
5. **Request for Proposals.** The Contractor's Response to the RFP is incorporated by reference into this Contract as if fully set forth herein. If there is any conflict between the provisions of this Contract and the Contractor's RFP response, the provisions of this Contract shall supersede the provisions of the Contractor's RFP response. The Department may enforce the Contractor's compliance with the RFP response to the same extent as any provision in this Contract.

6. Assurances

The following beneficiary protections in section 1905(t) of the Social Security Act apply to PCMH+. The Contractor shall adhere to the following:

- a. Section 1905(t)(3)(A) of the Social Security Act, which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of Medicaid providers.
- b. Section 1905(t)(3)(C) of the Social Security Act, which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high-quality care in a prompt manner, is met because beneficiaries are afforded free choice of Medicaid providers and because the PCMH+ assignment methodology ensures that only patients who have a relationship with providers in a Participating Entity are assigned to that Participating Entity.
- c. Section 1905(t)(3)(D) of the Social Security Act, which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because Participating Entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status. In accordance with said requirement, the Contractor shall not engage in any activities designed to result in selective recruitment and/or attribution of individuals with more favorable health status.
- d. Section 1905(t)(3)(F) of the Social Security Act, which refers to section 1932 and requires notification to beneficiaries of the program, including how personal information will be used, and disclosure of any correlative payment arrangements, is met because the Department will notify beneficiaries that they

have been assigned to a PCMH Participating Entity prior to the start of the Performance Year. Copies of the form of notice will be provided to Participating Entities not later than 10 days after mailing.

7. General Federal Funding Requirements

i. Federal Funding Requirements

1. In addition to the provisions of Part II of this contract concerning Federal Funds, the Contractor shall administer the Program in accordance with Title V, Section 511, 42. USC § 711 of the Social Security Act as amended; pertinent regulations are outlined in the SSA website http://www.ssa.gov/OP_Home/ssact/title05/0511.htm.

2. The Contractor shall not seek reimbursement from the Federal Government for any of the services offered by the Program.

ii. Federal Office of Management and Budget Requirements.

1. This contract includes Federal Financial Assistance, and therefore such funds shall be subject to the Federal Office of Management and Budget Cost Principles codified in the OMB Super Circular as set forth in 2.CFR Part 200 and as updated from time to time.

2. Federal funding shall be released by the Department contingent upon receipt of federal monies by the Department in compliance with the Federal Cash Management Improvement Act (CMIA), 31 U.S.C. § 6501 et seq. of (1990).

iii. Federal Funding Accountability and Transparency Act (FFATA):

1. The Contractor shall register with the Federal System for Award Management (SAM) at <https://www.sam.gov> to assist the Department with meeting its obligation to comply with the Federal Funding Accountability and Transparency Act (FFATA).

2. The Contractor shall ensure that it shall remain active in SAM by updating its SAM profile at least every 12 months. Upon notification by the Department that its SAM status is not active, the Contractor shall update its SAM profile within five business days of such notification. The Contractor's failure to comply may impact future issuance of payments by the Department.

iv. Cost Standard:

1. All costs are subject to federal cost policy guidance and the standards developed by the State Office of Policy and Management for determining the cost of contracts, grants, and other agreements with organizations that receive funding from the State. In the event of any inconsistency, the federal cost policy guidance shall supersede the OPM cost standards. The applicable federal cost policy guidance is available at Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards <https://www.federalregister.gov/articles/2013/12/26/2013-30465/uniform-administrative-requirements-cost-principles-and-audit-requirements-for-federal-awards>, and Office of Community Services Information Memorandum, Transmittal No. 02-2008.

8. **Group Communications to Members.** Not less than fifteen (15) business days before planning to send any group communication to Medicaid members regarding PCMH+, the Contractor shall send DSS a copy of the intended communication for review and approval. The Contractor shall not send any such communication to Medicaid members before receiving written approval from DSS.

B. DEPARTMENT RESPONSIBILITIES - To assist the Contractor in the performance of the duties herein, the Department shall:

1. Monitor the Contractor's performance and request updates, as appropriate;
2. Respond to written requests for policy interpretations not later than 30 days after the receipt of such request;
3. Provide limited technical assistance to the Contractor, as needed and as determined by DSS, to help assist the Contractor in accomplishing the expected outcomes;
4. Schedule and hold program meetings with the Contractor;
5. Provide a process for and facilitate open discussions with DSS Staff and Contractor personnel to gather information regarding recommendations and suggestions for improvement;
6. As determined by DSS, make DSS staff available to assist with training regarding the program policies and procedures to provide ongoing technical assistance in all aspects of the program; and
7. Provide billing instructions and be available to provide assistance with the billing process.

Specific Department responsibilities are:

- a. Program Management: A Program Lead will be appointed by DSS. This individual will be responsible for monitoring program progress and will have authority to approve/disapprove program deliverables.
- b. Staff Coordination: The Program Lead will coordinate all necessary contacts between the Contractor and Department staff.
- c. Approval of Deliverables: The Program Lead will review, evaluate, and approve all deliverables prior to the Contractor being released from further responsibility.
- d. The Department of Social Services retains the ultimate decision-making authority required to ensure program tasks are completed.
- e. The Department will provide the Participating Entity with reasonable access to individual and aggregate claims data for PCMH+ members assigned to the Participating Entity (which, for an advanced network, would include PCMH+ members assigned to any eligible PCMH practice within the network), such as through a portal or through other means as determined by the Department.
- f. To the extent possible, the Department will provide periodic performance reports to the Participating Entity.

SECTION THREE – CONTRACT AMOUNT AND PAYMENT METHODOLOGY AND DISTRIBUTION OF SHARED SAVINGS

- A. CONTRACT AMOUNT** - The total cost of the Contract cannot be determined at contract execution, January 1, 2017.

If the Contractor generates savings for the Connecticut Medicaid program and meets applicable measures of quality and under-service, the Contractor will share in the savings achieved. Savings will be available through two savings “pools.” The first pool will be an individual savings pool, where each PCMH+ Participating Entity that meets the quality benchmarks will receive a portion of the savings it achieved individually. The second pool will be a challenge pool that will aggregate all savings not awarded to individual PCMH+ Participating Entities in the individual pool due to failure to meet identified benchmarks on quality performance standards.

- B. SHARED SAVINGS** - The Contractor may be eligible to receive shared savings payments in accordance with the methodology described above if DSS determines that: (1) the Contractor generated savings for the Connecticut Medicaid program for PCMH+ members assigned to the Contractor and (2) the Contractor meets all applicable requirements for said payments, as described above, including, but limited to, quality measures, measures of under-service and provision of Enhanced Care Coordination Activities.

- C. PAYMENT METHODOLOGY.** Shared savings payments will be paid if the criteria described above are met. Shared savings payments that apply for a Performance Year, if any, will be paid not later than the last day of the calendar year following the Performance Year. Advanced Networks will not be eligible to receive the Care Coordination Add-On Payment. Primary care providers within an Advanced Network can receive a portion of the PCMH+ Participating Entity’s shared savings only for program years for which such provider has maintained full DSS PCMH recognition throughout the program year.

Advanced Networks will continue to receive standard payments under the Connecticut Medicaid program using the standard payment methodology or methodologies applicable to the provider for services provided to Medicaid beneficiaries.

D. DISTRIBUTION OF SHARED SAVINGS

All shared savings payments (if any) that are paid by the Agency to the Contractor (including both any individual pool shared savings payments and also any challenge pool shared savings payments) will be distributed within the Contractor's Advanced Network in accordance with this section.

1. A small portion of shared savings payments will be paid to VCA, as the subcontractor of the Contractor, for administering the terms of this Agreement, including, but not limited to, ensuring that the Advanced Network complies with PCMH+ requirements, supporting the provision of enhanced care coordination activities, supporting the development and implementation of linkages with community partners, monitoring quality of performance, data aggregation, data analytics, administration of the Contract, and other relevant activities in connection with administering and implementing the requirements of this Agreement.
2. A small portion of shared savings payments will be paid to the Pods (each VCA Member hospital system constitutes a “Pod” made up of the PCMH+ participating physician groups (identified by their respective tax identification numbers [TINS]) affiliated with each hospital) on a uniform per member per month (PMPM) basis for PCMH+ members attributed to the physician group(s) within each Pod to cover expenses incurred in administering the terms of this Agreement, including, but not limited to, the provision of enhanced care coordination activities, developing and implementing linkages with community partners, improving the quality of performance, measuring quality, identifying PCMH+ members, developing and implementing care management plans, and

other relevant activities in connection with administering and implementing the requirements of this Agreement.

3. After amounts have been distributed in accordance with Sections A and B above, the remaining shared savings payments--which will be a substantial majority of the payments--will be distributed to the Pods based on Efficiency and Quality performance. Efficiency will be measured using a calculation intended to mirror the calculation of savings in the PCMH+ Program on a Pod by Pod basis, to be determined to the best of VCA's ability with available data. The calculation will compare performance of each Pod against the targets specified by the PCMH+ Program. Quality will be measured based on two quality targets taken from the quality measures used as part of the PCMH+ program. After the Pod has received these funds, each Pod will attribute a portion of its shared savings payment to recover costs related to the provision of care coordination services and other costs directly related to implementation of this Contract, and distribute the remaining shared savings payment as incentive payments to individual primary care providers for quality of performance. For purposes of this section, a "primary care provider" is defined as an individual primary care physician, advanced practice registered nurse, or physician assistant. Each Pod will have discretion to determine how best to distribute any funds received, however all distributions will be consistent with all of the requirements of this Contract.

The shared savings payment distribution methodology will ensure that there is no factor within the methodology that would reward any individual provider for his or her specific contribution to the overall savings of the network or to the savings of the Pod. Efficiency calculations will be performed on a per Pod basis, so an individual's actual savings will not be specifically rewarded. Instead, Pod performance will be measured. As of the execution date of this Contract, each Pod has not fewer than 8 individual primary care providers who are part of a practice with full DSS PCMH status (not Glide Path). If, at any time during the Performance Year or at any other time prior to receiving shared savings payments applicable to such Performance Year, if any, any Pod has fewer than 8 individual primary care providers who are part of a practice with full DSS PCMH status, the Contractor must notify the Department in writing. The Department reserves the right to revise the shared savings payment distribution methodology if the number of primary care providers affiliated with a Pod falls below 8 in order to ensure that payments are not made in a manner that rewards an individual primary care provider's specific contributions to a Pod's allocation of shared savings payments. Additionally, there will be PMPM components which are paid out to the Pods regardless of performance and quality based measures.

Shared savings payments will also be allocated based on quality performance, using those quality measures selected by the Department in the PCMH+ program.

Shared savings payments will not be distributed to primary care providers who are not affiliated with a practice that has full PCMH status (not Glide Path) in the DSS PCMH program.

The Shared Savings distribution methodology uses available data to identify Pods and to track Pod performance. The Contractor, through the VCA as its subcontractor, will safeguard against, monitor for, and remedy unintended consequences associated with its means of allocating shared savings, including, but not limited to, under-service, denial of service, and steering of actual transfer of patients within or outside the network, through (i) the measurement of quality measures and payment of savings based on these measures, (ii) through requirements in each VCA Member hospital's participation agreement with the Contractor that each PCMH+ provider meet the under-service requirements of this Agreement, and (iii) through the engagement of care coordinators who will be responsible for ensuring patients will receive appropriate care. The Contractor, through the VCA as its subcontractor, will hold PCMH+ providers accountable for quality, outcomes, and compliance to ensure that unintended consequences are minimized.

E. DESK REVIEW PROCESS

Not later than October 31 of the year following the Performance Year, the Department will provide the Contractor with a written description of the Contractor's results regarding performance on quality measures, applicable Medicaid expenditures for PCMH+ members assigned to the Contractor, and calculation of savings or increased expenditures, as applicable for said individuals. After receiving said description from the Department, the Contractor may respond to any calculations, results, or decisions contained therein. Such response must be in writing, must be received by the Department not later than thirty days after the Contractor receives the written description from the Department, and must include all supporting documentation. The Department shall issue a written decision not later than thirty days after receiving the Contractor's response. The Contractor agrees that there is no further right to review the Department's decisions regarding said written description, other than as described in this paragraph, and that there is no right to review the final distribution of shared savings payments, if any, among the various Participating Entities.

If the Department makes any decision specific to the Contractor's participation in PCMH+, but not including any of the circumstances described in the paragraph immediately above and not including any Department decisions that apply to the entire PCMH+ program or any component thereof, after receiving said written decision, the Contractor may respond in writing to said decision. Such response must be in writing, must be received by the Department not later than fifteen days after the Contractor receives the written decision from the Department, and must include all supporting documentation. The Department shall issue a written final decision not later than thirty days after receiving the Contractor's response. The Contractor agrees that there is no further right to review the Department's decisions described in this paragraph, other than in accordance with this paragraph.

The Contractor shall comply with the following terms and conditions.

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

1. **"Bid"** shall mean a bid submitted in response to a solicitation.
2. **"Breach"** shall mean a party's failure to perform some contracted-for or agreed-upon act, or his failure to comply with a duty imposed by law which is owed to another or to society.
3. **"Cancellation"** shall mean an end to the Contract affected pursuant to a right which the Contract creates due to a Breach.
4. **"Claims"** shall mean all actions, suits, claims, demands, investigations and proceedings of any kind, open, pending or threatened, whether mature, unmaturing, contingent, known or unknown, at law or in equity, in any forum.
5. **"Client"** shall mean a recipient of the Contractor's Services.
6. **"Contract"** shall mean this agreement, as of its effective date, between the Contractor and the State for Services.
7. **"Contractor Parties"** shall mean a Contractor's members, directors, officers, shareholders, partners, managers, principal officers, representatives, agents, servants, consultants, employees or any one of them or any other person or entity with whom the Contractor is in privity of oral or written contract (e.g. subcontractor) and the Contractor intends for such other person or entity to perform under the Contract in any capacity. For the purpose of this Contract, vendors of support services, not otherwise known as human service providers or educators, shall not be considered subcontractors, e.g. lawn care, unless such activity is considered part of a training, vocational or educational program.
8. **"Data"** shall mean all results, technical information and materials developed and/or obtained in the performance of the Services hereunder, including but not limited to all reports, survey and evaluation tools, surveys and evaluations, plans, charts, recordings (video and/or sound), pictures, curricula, electronically prepared presentations, public awareness or prevention campaign materials, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents, whether finished or unfinished, which result from or are prepared in connection with the Services performed hereunder.
9. **"Day"** shall mean all calendar days, other than Saturdays, Sundays and days designated as national or State of Connecticut holidays upon which banks in Connecticut are closed.
10. **"Expiration"** shall mean an end to the Contract due to the completion in full of the mutual performances of the parties or due to the Contract's term being completed.
11. **"Force Majeure"** shall mean events that materially affect the Services or the time schedule within which to perform and are outside the control of the party asserting that such an event has occurred, including, but not limited to, labor troubles unrelated to the Contractor, failure of or inadequate permanent power, unavoidable casualties, fire not caused by the Contractor, extraordinary weather conditions, disasters, riots, acts of God, insurrection or war.
12. **"Personal Information"** shall mean any name, number or other information that may be used, alone or in conjunction with any other information, to identify a specific individual including, but not limited to, such individual's name, date of birth, mother's maiden name, motor vehicle operator's license number, Social Security number, employee identification number, employer or taxpayer identification number, alien

registration number, government passport number, health insurance identification number, demand deposit account number, savings account number, credit card number, debit card number or unique biometric data such as fingerprint, voice print, retina or iris image, or other unique physical representation. Without limiting the foregoing, Personal Information shall also include any information regarding clients that the Department classifies as "confidential" or "restricted." Personal Information shall not include information that may be lawfully obtained from publicly available sources or from federal, state, or local government records which are lawfully made available to the general public.

13. **"Personal Information Breach"** shall mean an instance where an unauthorized person or entity accesses Personal Information in any manner, including but not limited to the following occurrences: (1) any Personal Information that is not encrypted or protected is misplaced, lost, stolen or in any way compromised; (2) one or more third parties have had access to or taken control or possession of any Personal Information that is not encrypted or protected without prior written authorization from the State; (3) the unauthorized acquisition of encrypted or protected Personal Information together with the confidential process or key that is capable of compromising the integrity of the Personal Information; or (4) if there is a substantial risk of identity theft or fraud to the client, the Contractor, the Department or State.
14. **"Records"** shall mean all working papers and such other information and materials as may have been accumulated and/or produced by the Contractor in performing the Contract, including but not limited to, documents, data, plans, books, computations, drawings, specifications, notes, reports, records, estimates, summaries and correspondence, kept or stored in any form.
15. **"Services"** shall mean the performance of Services as stated in Part I of this Contract.
16. **"State"** shall mean the State of Connecticut, including any agency, office, department, board, council, commission, institution or other executive branch agency of State Government.
17. **"Termination"** shall mean an end to the Contract affected pursuant to a right which the Contract creates, other than for a Breach.

B. Client-Related Safeguards.

1. Inspection of Work Performed.

- (a) The Agency or its authorized representative shall at all times have the right to enter into the Contractor or Contractor Parties' premises, or such other places where duties under the Contract are being performed, to inspect, to monitor or to evaluate the work being performed in accordance with Conn. Gen. Stat. § 4e-29 to ensure compliance with this Contract. The Contractor and all subcontractors must provide all reasonable facilities and assistance to Agency representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. The Contractor shall disclose information on clients, applicants and their families as requested unless otherwise prohibited by federal or state law. Written evaluations pursuant to this Section shall be made available to the Contractor.
 - (b) The Contractor must incorporate this section verbatim into any Contract it enters into with any subcontractor providing services under this Contract.
2. **Safeguarding Client Information.** The Agency and the Contractor shall safeguard the use, publication and disclosure of information on all applicants for and all Clients who receive Services under this Contract with all applicable federal and state law concerning confidentiality and as may be further provided under the Contract.
 3. **Reporting of Client Abuse or Neglect.** The Contractor shall comply with all reporting requirements relative to Client abuse and neglect, including but not limited to requirements as specified in C.G.S. §§ 17a-

101 through 103, 19a-216, 46b-120 (related to children); C.G.S. § 46a-11b (relative to persons with mental retardation); and C.G.S. § 17b-407 (relative to elderly persons).

4. **Background Checks.** The State may require that the Contractor and Contractor Parties undergo criminal background checks as provided for in the State of Connecticut Department of Public Safety Administration and Operations Manual or such other State document as governs procedures for background checks. The Contractor and Contractor Parties shall cooperate fully as necessary or reasonably requested with the State and its agents in connection with such background checks.

C. Contractor Obligations.

1. **Cost Standards.** The Contractor and funding state Agency shall comply with the Cost Standards issued by OPM, as may be amended from time to time. The Cost Standards are published by OPM on the Web at: http://www.ct.gov/opm/cwp/view.asp?a=2981&Q=382994&opmNav_GID=1806
2. **Credits and Rights in Data.** Unless expressly waived in writing by the Agency, all Records and publications intended for public distribution during or resulting from the performances of this Contract shall include a statement acknowledging the financial support of the State and the Agency and, where applicable, the federal government. All such publications shall be released in conformance with applicable federal and state law and all regulations regarding confidentiality. Any liability arising from such a release by the Contractor shall be the sole responsibility of the Contractor and the Contractor shall indemnify and hold harmless the Agency, unless the Agency or its agents co-authored said publication and said release is done with the prior written approval of the Agency Head. All publications shall contain the following statement: "This publication does not express the views of the [insert Agency name] or the State of Connecticut. The views and opinions expressed are those of the authors." Neither the Contractor nor any of its agents shall copyright Data and information obtained under this Contract, unless expressly previously authorized in writing by the Agency. The Agency shall have the right to publish, duplicate, use and disclose all such Data in any manner, and may authorize others to do so. The Agency may copyright any Data without prior Notice to the Contractor. The Contractor does not assume any responsibility for the use, publication or disclosure solely by the Agency of such Data.
3. **Organizational Information, Conflict of Interest, IRS Form 990.** During the term of this Contract and for the one hundred eighty (180) days following its date of Termination and/or Cancellation, the Contractor shall upon the Agency's request provide copies of the following documents within ten (10) Days after receipt of the request:
 - (a) its most recent IRS Form 990 submitted to the Internal Revenue Service, and
 - (b) its most recent Annual Report filed with the Connecticut Secretary of the State's Office or such other information that the Agency deems appropriate with respect to the organization and affiliation of the Contractor and related entities.

This provision shall continue to be binding upon the Contractor for one hundred and eighty (180) Days following the termination or cancellation of the Contract.

4. **Federal Funds.**
 - (a) The Contractor shall comply with requirements relating to the receipt or use of federal funds. The Agency shall specify all such requirements in Part I of this Contract.
 - (b) The Contractor acknowledges that the Agency has established a policy, as mandated by section 6032 of the Deficit Reduction Act (DRA) of 2005, P.L. 109-171, that provides detailed information about the Federal False Claims Act, 31 U.S.C. §§ 3729-3733, and other laws supporting the detection and prevention of fraud and abuse.

- (1) Contractor acknowledges that it has received a copy of said policy and shall comply with its terms, as amended, and with all applicable state and federal laws, regulations and rules. Contractor shall provide said policy to subcontractors and shall require compliance with the terms of the policy. Failure to abide by the terms of the policy, as determined by the Agency, shall constitute a Breach of this Contract and may result in cancellation or termination of this Contract.
- (2) This section applies if, under this Contract, the Contractor or Contractor Parties furnishes, or otherwise authorizes the furnishing of health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the Agency.
- (c) Contractor represents that it is not excluded, debarred, suspended or otherwise ineligible to participate in federal health care programs.
- (d) Contractor shall not, for purposes of performing the Contract with the Agency, knowingly employ or contract with, with or without compensation: (A) any individual or entity listed by a federal agency as excluded, debarred, suspended or otherwise ineligible to participate in federal health care programs; or (B) any person or entity who is excluded from contracting with the State of Connecticut or the federal government (as reflected in the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, Department of Health and Human Services, Office of Inspector General (HHS/OIG) Excluded Parties list and the Office of Foreign Assets Control (OFAC) list of Specially Designated Nationals and Blocked Persons List). Contractor shall immediately notify the Agency should it become subject to an investigation or inquiry involving items or services reimbursable under a federal health care program or be listed as ineligible for participation in or to perform Services in connection with such program. The Agency may cancel or terminate this Contract immediately if at any point the Contractor, subcontractor, or any of their employees are sanctioned, suspended, excluded from or otherwise become ineligible to participate in federal health care programs.

5. Audit Requirements.

- (a) The State Auditors of Public Accounts shall have access to all Records for the fiscal year(s) in which the award was made. The Contractor shall provide for an annual financial audit acceptable to the Agency for any expenditure of state-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The Contractor shall comply with federal and state single audit standards as applicable.
- (b) The Contractor shall make all of its and the Contractor Parties' Records available at all reasonable hours for audit and inspection by the State, including, but not limited to, the Agency, the Connecticut Auditors of Public Accounts, Attorney General and State's Attorney and their respective agents. Requests for any audit or inspection shall be in writing, at least ten (10) days prior to the requested date. All audits and inspections shall be at the requester's expense. The State may request an audit or inspection at any time during the Contract term and for three (3) years after Termination, Cancellation or Expiration of the Contract. The Contractor shall cooperate fully with the State and its agents in connection with an audit or inspection. Following any audit or inspection, the State may conduct and the Contractor shall cooperate with an exit conference.
- (c) For purposes of this subsection as it relates to State grants, the word "Contractor" shall be read to mean "nonstate entity," as that term is defined in C.G.S. § 4-230.
- (d) The Contractor must incorporate this section verbatim into any Contract it enters into with any subcontractor providing services under this Contract.

6. **Related Party Transactions.** The Contractor shall report all related party transactions, as defined in this section, to the Agency on an annual basis in the appropriate fiscal report as specified in Part I of this Contract. "Related party" means a person or organization related through marriage, ability to control, ownership, family or business association. Past exercise of influence or control need not be shown, only the potential or ability to directly or indirectly exercise influence or control. "Related party transactions" between a Contractor or Contractor Party and a related party include, but are not limited to:
- (a) Real estate sales or leases;
 - (b) leases for equipment, vehicles or household furnishings;
 - (c) Mortgages, loans and working capital loans; and
 - (d) Contracts for management, consultant and professional services as well as for materials, supplies and other services purchased by the Contractor or Contractor Party.
7. **Suspension or Debarment.** In addition to the representations and requirements set forth in Section D.4:
- (a) The Contractor certifies for itself and Contractor Parties involved in the administration of federal or state funds that they:
 - (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental agency (federal, state or local);
 - (2) within a three year period preceding the effective date of this Contract, have not been convicted or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (federal, state or local) transaction or contract under a public transaction; for violation of federal or state antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;
 - (3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (federal, state or local) with commission of any of the above offenses; and
 - (4) Have not within a three year period preceding the effective date of this Contract had one or more public transactions terminated for cause or fault.
 - (b) Any change in the above status shall be immediately reported to the Agency.
8. **Liaison.** Each Party shall designate a liaison to facilitate a cooperative working relationship between the Contractor and the Agency in the performance and administration of this Contract.
9. **Subcontracts.** Each Contractor Party's identity, services to be rendered and costs shall be detailed in Part I of this Contract. Absent compliance with this requirement, no Contractor Party may be used or expense paid under this Contract unless expressly otherwise provided in Part I of this Contract. No Contractor Party shall acquire any direct right of payment from the Agency by virtue of this section or any other section of this Contract. The use of Contractor Parties shall not relieve the Contractor of any responsibility or liability under this Contract. The Contractor shall make available copies of all subcontracts to the Agency upon request.
10. **Independent Capacity of Contractor.** The Contractor and Contractor Parties shall act in an independent capacity and not as officers or employees of the state of Connecticut or of the Agency.

11. Indemnification.

- (a) The Contractor shall indemnify, defend and hold harmless the state of Connecticut and its officers, representatives, agents, servants, employees, successors and assigns from and against any and all:
 - (1) claims arising directly or indirectly, in connection with the Contract, including the acts of commission or omission (collectively the "Acts") of the Contractor or Contractor Parties; and
 - (2) liabilities, damages, losses, costs and expenses, including but not limited to attorneys' and other professionals' fees, arising, directly or indirectly, in connection with Claims, Acts or the Contract. The Contractor shall use counsel reasonably acceptable to the State in carrying out its indemnification and hold-harmless obligations under this Contract. The Contractor's obligations under this section to indemnify, defend and hold harmless against Claims includes Claims concerning confidentiality of any part of or all of the bid or any records, and intellectual property rights, other propriety rights of any person or entity, copyrighted or uncopyrighted compositions, secret processes, patented or unpatented inventions, articles or appliances furnished or used in the performance of the Contract.
- (b) The Contractor shall reimburse the State for any and all damages to the real or personal property of the State caused by the Acts of the Contractor or any Contractor Parties. The State shall give the Contractor reasonable notice of any such Claims.
- (c) The Contractor's duties under this Section shall remain fully in effect and binding in accordance with the terms and conditions of the Contract, without being lessened or compromised in any way, even where the Contractor is alleged or is found to have merely contributed in part to the Acts giving rise to the Claims and/or where the State is alleged or is found to have contributed to the Acts giving rise to the Claims.
- (d) The Contractor shall carry and maintain at all times during the term of the Contract, and during the time that any sections survive the term of the Contract, sufficient general liability insurance to satisfy its obligations under this Contract. The Contractor shall name the State as an additional insured on the policy and shall provide a copy of the policy to the Agency prior to the effective date of the Contract. The Contractor shall not begin performance until the delivery of the policy to the Agency.
- (e) The rights provided in this section for the benefit of the State shall encompass the recovery of attorneys' and other professionals' fees expended in pursuing a Claim against a third party.
- (f) This section shall survive the Termination, Cancellation or Expiration of the Contract, and shall not be limited by reason of any insurance coverage.

12. Insurance. Before commencing performance, the Agency may require the Contractor to obtain and maintain specified insurance coverage. In the absence of specific Agency requirements, the Contractor shall obtain and maintain the following insurance coverage at its own cost and expense for the duration of the Contract:

- (a) Commercial General Liability. \$1,000,000 combined single limit per occurrence for bodily injury, personal injury and property damage. Coverage shall include Premises and Operations, Independent Contractors, Products and Completed Operations, Contractual Liability, and Broad Form Property Damage coverage. If a general aggregate is used, the general aggregate limit shall apply separately to the services to be performed under this Contract or the general aggregate limit shall be twice the occurrence limit;
- (b) Automobile Liability. \$1,000,000 combined single limit per accident for bodily injury. Coverage extends to owned, hired and non-owned automobiles. If the vendor/contractor does not own an automobile, but one is used in the execution of this Contract, then only hired and non-owned

coverage is required. If a vehicle is not used in the execution of this Contract then automobile coverage is not required.

- (c) Professional Liability. \$1,000,000 limit of liability, if applicable; and/or
- (d) Workers' Compensation and Employers Liability. Statutory coverage in compliance with the Compensation laws of the State of Connecticut. Coverage shall include Employer's Liability with minimum limits of \$100,000 each accident, \$500,000 Disease – Policy limit, \$100,000 each employee.

13. Choice of Law/Choice of Forum, Settlement of Disputes, Claims Against the State.

- (a) The Contract shall be deemed to have been made in the City of Hartford, State of Connecticut. Both Parties agree that it is fair and reasonable for the validity and construction of the Contract to be, and it shall be, governed by the laws and court decisions of the State of Connecticut, without giving effect to its principles of conflicts of laws. To the extent that any immunities provided by federal law or the laws of the State of Connecticut do not bar an action against the State, and to the extent that these courts are courts of competent jurisdiction, for the purpose of venue, the complaint shall be made returnable to the Judicial District of Hartford only or shall be brought in the United States District Court for the District of Connecticut only, and shall not be transferred to any other court, provided, however, that nothing here constitutes a waiver or compromise of the sovereign immunity of the State of Connecticut. The Contractor waives any objection which it may now have or will have to the laying of venue of any Claims in any forum and further irrevocably submits to such jurisdiction in any suit, action or proceeding.
- (b) Any dispute concerning the interpretation or application of this Contract shall be decided by the Agency Head or his/her designee whose decision shall be final, subject to any rights the Contractor may have pursuant to state law. In appealing a dispute to the Agency Head pursuant to this section, the Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. Pending final resolution of a dispute, the Contractor and the Agency shall proceed diligently with the performance of the Contract.
- (c) The Contractor agrees that the sole and exclusive means for the presentation of any claim against the State arising from this Contract shall be in accordance with Title 4, Chapter 53 of the Connecticut General Statutes (Claims Against the State) and the Contractor further agrees not to initiate legal proceedings, except as authorized by that Chapter, in any state or federal court in addition to or in lieu of said Chapter 53 proceedings.

14. Compliance with Law and Policy, Facility Standards and Licensing. Contractor shall comply with all:

- (a) pertinent local, state and federal laws and regulations as well as Agency policies and procedures applicable to contractor's programs as specified in this Contract. The Agency shall notify the Contractor of any applicable new or revised laws, regulations, policies or procedures which the Agency has responsibility to promulgate or enforce; and
- (b) applicable local, state and federal licensing, zoning, building, health, fire and safety regulations or ordinances, as well as standards and criteria of pertinent state and federal authorities. Unless otherwise provided by law, the Contractor is not relieved of compliance while formally contesting the authority to require such standards, regulations, statutes, ordinance or criteria.

15. Representations and Warranties. Contractor shall:

- (a) perform fully under the Contract;

- (b) pay for and/or secure all permits, licenses and fees and give all required or appropriate notices with respect to the provision of Services as described in Part I of this Contract; and
 - (c) adhere to all contractual sections ensuring the confidentiality of all Records that the Contractor has access to and are exempt from disclosure under the State's Freedom of Information Act or other applicable law.
- 16. Reports.** The Contractor shall provide the Agency with such statistical, financial and programmatic information necessary to monitor and evaluate compliance with the Contract. All requests for such information shall comply with all applicable state and federal confidentiality laws. The Contractor shall provide the Agency with such reports as the Agency requests as required by this Contract.
- 17. Delinquent Reports.** The Contractor shall submit required reports by the designated due dates as identified in this Contract. After notice to the Contractor and an opportunity for a meeting with an Agency representative, the Agency reserves the right to withhold payments for services performed under this Contract if the Agency has not received acceptable progress reports, expenditure reports, refunds, and/or audits as required by this Contract or previous contracts for similar or equivalent services the Contractor has entered into with the Agency. This section shall survive any Termination of the Contract or the Expiration of its term.
- 18. Record Keeping and Access.** The Contractor shall maintain books, Records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this Contract. These Records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the State or, where applicable, federal agencies. The Contractor shall retain all such Records concerning this Contract for a period of three (3) years after the completion and submission to the State of the Contractor's annual financial audit.
- 19. Protection of Personal Information.**
- (a) Contractor and Contractor Parties, at their own expense, have a duty to and shall protect from a Personal Information Breach any and all Personal Information which they come to possess or control, wherever and however stored or maintained, in a commercially reasonable manner in accordance with current industry standards.
<http://www.ct.gov/doit/cwp/view.asp?a=1245&q=253968>
<http://www.ct.gov/doit/cwp/view.asp?a=1245&q=253968>
 - (b) Each Contractor or Contractor Party shall implement and maintain a comprehensive data security program for the protection of Personal Information. The safeguards contained in such program shall be consistent with and comply with the safeguards for protection of Personal Information, and information of a similar character, as set forth in all applicable federal and state law and written policy of the Department or State concerning the confidentiality of Personal Information. Such data-security program shall include, but not be limited to, the following:
 - (1) A security policy for employees related to the storage, access and transportation of data containing Personal Information;
 - (2) Reasonable restrictions on access to records containing Personal Information, including access to any locked storage where such records are kept;
 - (3) A process for reviewing policies and security measures at least annually;
 - (4) Creating secure access controls to Personal Information, including but not limited to passwords; and
 - (5) Encrypting of Personal Information that is stored on laptops, portable devices or being transmitted electronically.

- (c) The Contractor and Contractor Parties shall notify the Department and the Connecticut Office of the Attorney General as soon as practical, but no later than twenty-four (24) hours, after they become aware of or suspect that any Personal Information which Contractor or Contractor Parties possess or control has been subject to a Personal Information Breach. If a Personal Information Breach has occurred, the Contractor shall, within three (3) business days after the notification, present a credit monitoring and protection plan to the Commissioner of Administrative Services, the Department and the Connecticut Office of the Attorney General, for review and approval. Such credit monitoring or protection plan shall be made available by the Contractor at its own cost and expense to all individuals affected by the Personal Information Breach. Such credit monitoring or protection plan shall include, but is not limited to reimbursement for the cost of placing and lifting one (1) security freeze per credit file pursuant to Connecticut General Statutes § 36a-701a. Such credit monitoring or protection plans shall be approved by the State in accordance with this Section and shall cover a length of time commensurate with the circumstances of the Personal Information Breach. The Contractors' costs and expenses for the credit monitoring and protection plan shall not be recoverable from the Department, any State of Connecticut entity or any affected individuals.
 - (d) The Contractor shall incorporate the requirements of this Section in all subcontracts requiring each Contractor Party to safeguard Personal Information in the same manner as provided for in this Section.
 - (e) Nothing in this Section shall supersede in any manner Contractor's or Contractor Party's obligations pursuant to HIPAA or the provisions of this Contract concerning the obligations of the Contractor as a Business Associate of the Department.
- 20. Workforce Analysis.** The Contractor shall provide a workforce Analysis Affirmative Action report related to employment practices and procedures.
- 21. Litigation.**
- (a) The Contractor shall require that all Contractor Parties, as appropriate, disclose to the Contractor, to the best of their knowledge, any Claims involving the Contractor Parties that might reasonably be expected to materially adversely affect their businesses, operations, assets, properties, financial stability, business prospects or ability to perform fully under the Contract, no later than ten (10) days after becoming aware or after they should have become aware of any such Claims. Disclosure shall be in writing.
 - (b) The Contractor shall provide written Notice to the Agency of any final decision by any tribunal or state or federal agency or court which is adverse to the Contractor or which results in a settlement, compromise or claim or agreement of any kind for any action or proceeding brought against the Contractor or its employee or agent under the Americans with Disabilities Act of 1990 as revised or amended from time to time, Executive Orders Nos. 3 & 17 of Governor Thomas J. Meskill and any other requirements of federal or state law concerning equal employment opportunities or nondiscriminatory practices.
- 22. Sovereign Immunity.** The Contractor and Contractor Parties acknowledge and agree that nothing in the Contract, or the solicitation leading up to the Contract, shall be construed as a modification, compromise or waiver by the State of any rights or defenses of any immunities provided by Federal law or the laws of the State of Connecticut to the State or any of its officers and employees, which they may have had, now have or will have with respect to all matters arising out of the Contract. To the extent that this Section conflicts with any other Section, this Section shall govern.

D. Changes to the Contract, Termination, Cancellation and Expiration.

1. Contract Amendment.

- (a) No amendment to or modification or other alteration of this Contract shall be valid or binding upon the parties unless made in writing, signed by the parties and, if applicable, approved by the OAG.
- (b) The Agency may amend this Contract to reduce the contracted amount of compensation if:
 - (1) the total amount budgeted by the State for the operation of the Agency or Services provided under the program is reduced or made unavailable in any way; or
 - (2) federal funding reduction results in reallocation of funds within the Agency.
- (c) If the Agency decides to reduce the compensation, the Agency shall send written Notice to the Contractor. Within twenty (20) Days of the Contractor's receipt of the Notice, the Contractor and the Agency shall negotiate the implementation of the reduction of compensation unless the parties mutually agree that such negotiations would be futile. If the parties fail to negotiate an implementation schedule, then the Agency may terminate the Contract effective no earlier than sixty (60) Days from the date that the Contractor receives written notification of Termination and the date that work under this Contract shall cease.

2. Contractor Changes and Assignment.

- (a) The Contractor shall notify the Agency in writing:
 - (1) at least ninety (90) days prior to the effective date of any fundamental changes in the Contractor's corporate status, including merger, acquisition, transfer of assets, and any change in fiduciary responsibility;
 - (2) no later than ten (10) days from the effective date of any change in:
 - (A) its certificate of incorporation or other organizational document;
 - (B) more than a controlling interest in the ownership of the Contractor; or
 - (C) the individual(s) in charge of the performance.
- (b) No such change shall relieve the Contractor of any responsibility for the accuracy and completeness of the performance. The Agency, after receiving written Notice from the Contractor of any such change, may require such contracts, releases and other instruments evidencing, to the Agency's satisfaction, that any individuals retiring or otherwise separating from the Contractor have been compensated in full or that allowance has been made for compensation in full, for all work performed under terms of the Contract. The Contractor shall deliver such documents to the Agency in accordance with the terms of the Agency's written request. The Agency may also require, and the Contractor shall deliver, a financial statement showing that solvency of the Contractor is maintained. The death of any Contractor Party, as applicable, shall not release the Contractor from the obligation to perform under the Contract; the surviving Contractor Parties, as appropriate, must continue to perform under the Contract until performance is fully completed.
- (c) Assignment. The Contractor shall not assign any of its rights or obligations under the Contract, voluntarily or otherwise, in any manner without the prior written consent of the Agency.
 - (1) The Contractor shall comply with requests for documentation deemed to be appropriate by the Agency in considering whether to consent to such assignment.
 - (2) The Agency shall notify the Contractor of its decision no later than forty-five (45) Days from the date the Agency receives all requested documentation.

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

3. Breach.

- (a) If either party Breaches this Contract in any respect, the non-breaching party shall provide written notice of the Breach to the breaching party and afford the breaching party an opportunity to cure within ten (10) Days from the date that the breaching party receives the notice. In the case of a Contractor Breach, the Agency may modify the ten (10) day cure period in the notice of Breach. The right to cure period shall be extended if the non-breaching party is satisfied that the breaching party is making a good faith effort to cure, but the nature of the Breach is such that it cannot be cured within the right to cure period. The Notice may include an effective Contract cancellation date if the Breach is not cured by the stated date and, unless otherwise modified by the non-breaching party in writing prior to the cancellation date, no further action shall be required of any party to effect the cancellation as of the stated date. If the notice does not set forth an effective Contract cancellation date, then the non-breaching party may cancel the Contract by giving the breaching party no less than twenty four (24) hours' prior written Notice after the expiration of the cure period.
- (b) If the Agency believes that the Contractor has not performed according to the Contract, the Agency may:
 - (1) withhold payment in whole or in part pending resolution of the performance issue, provided that the Agency notifies the Contractor in writing prior to the date that the payment would have been due in accordance with the budget;
 - (2) temporarily discontinue all or part of the Services to be provided under the Contract;
 - (3) permanently discontinue part of the Services to be provided under the Contract;
 - (4) assign appropriate State personnel to provide contracted for Services to assure continued performance under the Contract until such time as the contractual Breach has been corrected to the satisfaction of the Agency;
 - (5) require that contract funding be used to enter into a subcontract with a person or persons designated by the Agency in order to bring the program into contractual compliance;
 - (6) take such other actions of any nature whatsoever as may be deemed appropriate for the best interests of the State or the program(s) provided under this Contract or both; or
 - (7) any combination of the above actions.
- (c) The Contractor shall return all unexpended funds to the Agency no later than thirty (30) calendar days after the Contractor receives a demand from the Agency.
- (d) In addition to the rights and remedies granted to the Agency by this Contract, the Agency shall have all other rights and remedies granted to it by law in the event of Breach of or default by the Contractor under the terms of this Contract.
- (e) The action of the Agency shall be considered final. If at any step in this process the Contractor fails to comply with the procedure and, as applicable, the mutually agreed plan of correction, the Agency may proceed with Breach remedies as listed under this section.

4. **Non-enforcement Not to Constitute Waiver.** No waiver of any Breach of the Contract shall be interpreted or deemed to be a waiver of any other or subsequent Breach. All remedies afforded in the Contract shall be taken and construed as cumulative, that is, in addition to every other remedy provided in the Contract or at law or in equity. A party's failure to insist on strict performance of any section of the Contract shall only be deemed to be a waiver of rights and remedies concerning that specific instance of performance and shall not be deemed to be a waiver of any subsequent rights, remedies or Breach.
5. **Suspension.** If the Agency determines in its sole discretion that the health and welfare of the Clients or public safety is being adversely affected, the Agency may immediately suspend in whole or in part the Contract without prior notice and take any action that it deems to be necessary or appropriate for the benefit of the Clients. The Agency shall notify the Contractor of the specific reasons for taking such action in writing within five (5) Days of immediate suspension. Within five (5) Days of receipt of this notice, the Contractor may request in writing a meeting with the Agency Head or designee. Any such meeting shall be held within five (5) Days of the written request, or such later time as is mutually agreeable to the parties. At the meeting, the Contractor shall be given an opportunity to present information on why the Agency's actions should be reversed or modified. Within five (5) Days of such meeting, the Agency shall notify the Contractor in writing of his/her decision upholding, reversing or modifying the action of the Agency head or designee. This action of the Agency head or designee shall be considered final.
6. **Ending the Contractual Relationship.**
 - (a) This Contract shall remain in full force and effect for the duration of its entire term or until such time as it is terminated earlier by either party or cancelled. Either party may terminate this contract by providing at least sixty (60) days prior written notice pursuant to the Notice requirements of this Contract.
 - (b) The Agency may immediately terminate the Contract in whole or in part whenever the Agency makes a determination that such termination is in the best interest of the State. Notwithstanding Section D.2, the Agency may immediately terminate or cancel this Contract in the event that the Contractor or any subcontractors becomes financially unstable to the point of threatening its ability to conduct the services required under this Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, suffers or permits the appointment of a receiver for its business or its assets.
 - (c) The Agency shall notify the Contractor in writing of Termination pursuant to subsection (b) above, which shall specify the effective date of termination and the extent to which the Contractor must complete or immediately cease performance. Such Notice of Termination shall be sent in accordance with the Notice provision contained on page 1 of this Contract. Upon receiving the Notice from the Agency, the Contractor shall immediately discontinue all Services affected in accordance with the Notice, undertake all reasonable and necessary efforts to mitigate any losses or damages, and deliver to the Agency all Records as defined in Section A.14, unless otherwise instructed by the Agency in writing, and take all actions that are necessary or appropriate, or that the Agency may reasonably direct, for the protection of Clients and preservation of any and all property. Such Records are deemed to be the property of the Agency and the Contractor shall deliver them to the Agency no later than thirty (30) days after the Termination of the Contract or fifteen (15) days after the Contractor receives a written request from the Agency for the specified records whichever is less. The Contractor shall deliver those Records that exist in electronic, magnetic or other intangible form in a non-proprietary format, such as, but not limited to ASCII or .TXT.
 - (d) The Agency may terminate the Contract at any time without prior notice when the funding for the Contract is no longer available.
 - (e) The Contractor shall deliver to the Agency any deposits, prior payment, advance payment or down payment if the Contract is terminated by either party or cancelled within thirty (30) days after receiving demand from the Agency. The Contractor shall return to the Agency any funds not expended in

accordance with the terms and conditions of the Contract and, if the Contractor fails to do so upon demand, the Agency may recoup said funds from any future payments owing under this Contract or any other contract between the State and the Contractor. Allowable costs, as detailed in audit findings, incurred until the date of termination or cancellation for operation or transition of program(s) under this Contract shall not be subject to recoupment.

7. Transition after Termination or Expiration of Contract.

- (a) If this Contract is terminated for any reason, cancelled or it expires in accordance with its term, the Contractor shall do and perform all things which the Agency determines to be necessary or appropriate to assist in the orderly transfer of Clients served under this Contract and shall assist in the orderly cessation of Services it performs under this Contract. In order to complete such transfer and wind down the performance, and only to the extent necessary or appropriate, if such activities are expected to take place beyond the stated end of the Contract term then the Contract shall be deemed to have been automatically extended by the mutual consent of the parties prior to its expiration without any affirmative act of either party, including executing an amendment to the Contract to extend the term, but only until the transfer and winding down are complete.
- (b) If this Contract is terminated, cancelled or not renewed, the Contractor shall return to the Agency any equipment, deposits or down payments made or purchased with start-up funds or other funds specifically designated for such purpose under this Contract in accordance with the written instructions from the Agency in accordance with the Notice provision of this Contract. Written instructions shall include, but not be limited to, a description of the equipment to be returned, where the equipment shall be returned to and who is responsible to pay for the delivery/shipping costs. Unless the Agency specifies a shorter time frame in the letter of instructions, the Contractor shall affect the returns to the Agency no later than sixty (60) days from the date that the Contractor receives Notice.

E. Statutory and Regulatory Compliance.

1. Health Insurance Portability and Accountability Act of 1996.

- (a) If the Contractor is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as noted in this Contract, the Contractor must comply with all terms and conditions of this Section of the Contract. If the Contractor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contractor for this Contract.
- (b) The Contractor is required to safeguard the use, publication and disclosure of information on all applicants for, and all clients who receive, services under the Contract in accordance with all applicable federal and state law regarding confidentiality, which includes but is not limited to HIPAA, more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, and E; and
- (c) The State of Connecticut Agency named on page 1 of this Contract ("Agency") is a "covered entity" as that term is defined in 45 C.F.R. § 160.103; and
- (d) The Contractor is a "business associate" of the Agency, as that term is defined in 45 C.F.R. § 160.103; and
- (e) The Contractor and the Agency agree to the following in order to secure compliance with the HIPAA, the requirements of Subtitle D of the Health Information Technology for Economic and

Clinical Health Act (“HITECH Act”), (Pub. L. 111-5, §§ 13400 to 13423)², and more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C, D and E (collectively referred to herein as the “HIPAA Standards”).

(f) Definitions

- (1) “Breach” shall have the same meaning as the term is defined in section 45 C.F.R. 164.402 and shall also include an use or disclosure of PHI that violates the HIPAA Standards.
- (2) “Business Associate” shall mean the Contractor.
- (3) “Covered Entity” shall mean the Agency of the State of Connecticut named on page 1 of this Contract.
- (4) “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 C.F.R. § 164.501.
- (5) “Electronic Health Record” shall have the same meaning as the term is defined in section 13400 of the HITECH Act (42 U.S.C. §17921(5)).
- (6) “Individual” shall have the same meaning as the term “individual” in 45 C.F.R. § 160.103 and shall include a person who qualifies as a personal representative as defined in 45 C.F.R. § 164.502(g).
- (7) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and part 164, subparts A and E.
- (8) “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 C.F.R. § 160.103, and includes electronic PHI, as defined in 45 C.F.R. 160.103, limited to information created, maintained, transmitted or received by the Business Associate from or on behalf of the Covered Entity or from another Business Associate of the Covered Entity.
- (9) “Required by Law” shall have the same meaning as the term “required by law” in 45 C.F.R. § 164.103.
- (10) “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.
- (11) “More stringent” shall have the same meaning as the term “more stringent” in 45 C.F.R. § 160.202.
- (12) “This Section of the Contract” refers to the HIPAA Provisions stated herein, in their entirety.
- (13) “Security Incident” shall have the same meaning as the term “security incident” in 45 C.F.R. § 164.304.
- (14) “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. part 160 and part 164, subpart A and C.
- (15) “Unsecured protected health information” shall have the same meaning as the term as defined in 45 C.F.R. 164.402.

(g) Obligations and Activities of Business Associates.

- (1) Business Associate agrees not to use or disclose PHI other than as permitted or required by this Section of the Contract or as Required by Law.
- (2) Business Associate agrees to use and maintain appropriate safeguards and comply with applicable HIPAA Standards with respect to all PHI and to prevent use or disclosure of PHI other than as provided for in this Section of the Contract and in accordance with HIPAA standards.
- (3) Business Associate agrees to use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.
- (4) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of this Section of the Contract.
- (5) Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Section of the Contract or any security incident of which it becomes aware.
- (6) Business Associate agrees, in accordance with 45 C.F.R. 502(e)(1)(ii) and 164.308(d)(2), if applicable, to ensure that any subcontractors that create, receive, maintain or transmit protected health information on behalf of the business associate, agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;
- (7) Business Associate agrees to provide access (including inspection, obtaining a copy or both), at the request of the Covered Entity, and in the time and manner designated by the Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. Business Associate shall not charge any fees greater than the lesser of the amount charged by the Covered Entity to an Individual for such records; the amount permitted by state law; or the Business Associate's actual cost of postage, labor and supplies for complying with the request.
- (8) Business Associate agrees to make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. § 164.526 at the request of the Covered Entity, and in the time and manner designated by the Covered Entity.
- (9) Business Associate agrees to make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created, maintained, transmitted or received by, Business Associate on behalf of Covered Entity, available to Covered Entity or to the Secretary in a time and manner agreed to by the parties or designated by the Secretary, for purposes of the Secretary investigating or determining Covered Entity's compliance with the HIPAA Standards..
- (10) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.

- (11) Business Associate agrees to provide to Covered Entity, in a time and manner designated by the Covered Entity, information collected in accordance with subsection (g)(10) of this Section of the Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder. Business Associate agrees at the Covered Entity's direction to provide an accounting of disclosures of PHI directly to an individual in accordance with 45 C.F.R. § 164.528 and section 13405 of the HITECH Act (42 U.S.C. § 17935) and any regulations promulgated thereunder.
- (12) Business Associate agrees to comply with any state or federal law that is more stringent than the Privacy Rule.
- (13) Business Associate agrees to comply with the requirements of the HITECH Act relating to privacy and security that are applicable to the Covered Entity and with the requirements of 45 C.F.R. §§ 164.504(e), 164.308, 164.310, 164.312, and 164.316.
- (14) In the event that an individual requests that the Business Associate
 - (A) restrict disclosures of PHI;
 - (B) provide an accounting of disclosures of the individual's PHI;
 - (C) provide a copy of the individual's PHI in an electronic health record; or
 - (D) amend PHI in the individual's designated record set,the Business Associate agrees to notify the Covered Entity, in writing, within five business days of the request.
- (15) Business Associate agrees that it shall not, and shall ensure that its subcontractors do not, directly or indirectly, receive any remuneration in exchange for PHI of an Individual without
 - (A) the written approval of the covered entity, unless receipt of remuneration in exchange for PHI is expressly authorized by this Contract and
 - (B) the valid authorization of the individual, except for the purposes provided under section 13405(d)(2) of the HITECH Act, (42 U.S.C. § 17935(d)(2)) and in any accompanying regulations
- (16) Obligations in the Event of a Breach.
 - (A) The Business Associate agrees that, following the discovery by the Business Associate or by a subcontractor of the Business Associate of any use or disclosure not provided for by this section of the Contract, any breach of unsecured protected health information, or any Security Incident, it shall notify the Covered Entity of such breach in accordance with Subpart D of Part 164 of Title 45 of the Code of Federal Regulations and this Section of the Contract.
 - (B) Such notification shall be provided by the Business Associate to the Covered Entity without unreasonable delay, and in no case later than 30 days after the breach is discovered by the Business Associate, or a subcontractor of the Business Associate, except as otherwise instructed in writing by a law enforcement official pursuant to 45 C.F.R. 164.412. A breach is considered discovered as of the first day on which it is, or reasonably should have been, known to the Business Associate or its subcontractor. The notification shall include the identification and last known address, phone number and

email address of each individual (or the next of kin of the individual if the individual is deceased) whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during such breach.

- (C) The Business Associate agrees to include in the notification to the Covered Entity at least the following information:
1. A description of what happened, including the date of the breach; the date of the discovery of the breach; the unauthorized person, if known, who used the PHI or to whom it was disclosed; and whether the PHI was actually acquired or viewed.
 2. A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).
 3. The steps the Business Associate recommends that Individual(s) take to protect themselves from potential harm resulting from the breach.
 4. A detailed description of what the Business Associate is doing or has done to investigate the breach, to mitigate losses, and to protect against any further breaches.
 5. Whether a law enforcement official has advised the Business Associate, either verbally or in writing, that he or she has determined that notification or notice to Individuals or the posting required under 45 C.F.R. 164.412 would impede a criminal investigation or cause damage to national security and; if so, contact information for said official.
- (D) If directed by the Covered Entity, the Business Associate agrees to conduct a risk assessment using at least the information in subparagraphs 1 to 4, inclusive of (g) (16) (C) of this Section and determine whether, in its opinion, there is a low probability that the PHI has been compromised. Such recommendation shall be transmitted to the Covered Entity within 20 business days of the Business Associate's notification to the Covered Entity.
- (E) If the Covered Entity determines that there has been a breach, as defined in 45 C.F.R. 164.402, by the Business Associate or a subcontractor of the Business Associate, the Business Associate, if directed by the Covered Entity, shall provide all notifications required by 45 C.F.R. 164.404 and 45 C.F.R. 164.406.
- (F) Business Associate agrees to provide appropriate staffing and have established procedures to ensure that individuals informed of a breach have the opportunity to ask questions and contact the Business Associate for additional information regarding the breach. Such procedures shall include a toll-free telephone number, an e-mail address, a posting on its Web site and a postal address. Business Associate agrees to include in the notification of a breach by the Business Associate to the Covered Entity, a written description of the procedures that have been established to meet these requirements. Costs of such contact procedures will be borne by the Contractor.
- (G) Business Associate agrees that, in the event of a breach, it has the burden to demonstrate that it has complied with all notifications requirements set forth above, including evidence demonstrating the necessity of a delay in notification to the Covered Entity.

(h) Permitted Uses and Disclosure by Business Associate.

- (1) General Use and Disclosure Provisions Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use or disclosure would not violate the HIPAA Standards if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.
- (2) Specific Use and Disclosure Provisions
 - (A) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.
 - (B) Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
 - (C) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).

(i) Obligations of Covered Entity.

- (1) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 C.F.R. § 164.520, or to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
- (2) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual(s) to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- (3) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

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

(k) Term and Termination.

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

infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

- (2) Termination for Cause Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
 - (A) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity; or
 - (B) Immediately terminate the Contract if Business Associate has breached a material term of this Section of the Contract and cure is not possible; or
 - (C) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
- (3) Effect of Termination.
 - (A) Except as provided in (k)(2) of this Section of the Contract, upon termination of this Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity. Business Associate shall also provide the information collected in accordance with section (g)(10) of this Section of the Contract to the Covered Entity within ten business days of the notice of termination. This section shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
 - (B) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon documentation by Business Associate that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Section of the Contract to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or federal law that the Business Associate maintains or preserves the PHI or copies thereof.
- (l) Miscellaneous Sections.
 - (1) Regulatory References. A reference in this Section of the Contract to a section in the Privacy Rule means the section as in effect or as amended.
 - (2) Amendment. The Parties agree to take such action as is necessary to amend this Section of the Contract from time to time as is necessary for Covered Entity to comply with requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
 - (3) Survival. The respective rights and obligations of Business Associate shall survive the termination of this Contract.
 - (4) Effect on Contract. Except as specifically required to implement the purposes of this Section of the Contract, all other terms of the Contract shall remain in force and effect.
 - (5) Construction. This Section of the Contract shall be construed as broadly as necessary to implement and comply with the Privacy Standard. Any ambiguity in this Section of the

Contract shall be resolved in favor of a meaning that complies, and is consistent with, the Privacy Standard.

- (6) **Disclaimer.** Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate's own purposes. Covered Entity shall not be liable to Business Associate for any claim, civil or criminal penalty, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, contractors or agents, or any third party to whom Business Associate has disclosed PHI contrary to the sections of this Contract or applicable law. Business Associate is solely responsible for all decisions made, and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.
 - (7) **Indemnification.** The Business Associate shall indemnify and hold the Covered Entity harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards and any statutory damages that may be imposed or assessed pursuant to HIPAA, as amended or the HITECH Act, including, without limitation, attorney's fees, expert witness fees, costs of investigation, litigation or dispute resolution, and costs awarded thereunder, relating to or arising out of any violation by the Business Associate and its agents, including subcontractors, of any obligation of Business Associate and its agents, including subcontractors, under this section of the contract, under HIPAA, the HITECH Act, and the HIPAA Standards.
2. **Americans with Disabilities Act.** The Contractor shall be and remain in compliance with the Americans with Disabilities Act of 1990 (<http://www.ada.gov/>) as amended from time to time ("Act") to the extent applicable, during the term of the Contract. The Agency may cancel or terminate this Contract if the Contractor fails to comply with the Act. The Contractor represents that it is familiar with the terms of this Act and that it is in compliance with the law. The Contractor warrants that it shall hold the State harmless from any liability which may be imposed upon the state as a result of any failure of the Contractor to be in compliance with this Act. As applicable, the Contractor shall comply with section 504 of the Federal Rehabilitation Act of 1973, as amended from time to time, 29 U.S.C. § 794 (Supp. 1993), regarding access to programs and facilities by people with disabilities.
 3. **Utilization of Minority Business Enterprises.** The Contractor shall perform under this Contract in accordance with 45 C.F.R. Part 74; and, as applicable, C.G.S. §§ 4a-60 to 4a-60a and 4a-60g to carry out this policy in the award of any subcontracts.
 4. **Priority Hiring.** Subject to the Contractor's exclusive right to determine the qualifications for all employment positions, the Contractor shall give priority to hiring welfare recipients who are subject to time-limited welfare and must find employment. The Contractor and the Agency shall work cooperatively to determine the number and types of positions to which this Section shall apply.
 5. **Non-discrimination.**
 - (a) For purposes of this Section, the following terms are defined as follows:
 - (1) "Commission" means the Commission on Human Rights and Opportunities;
 - (2) "Contract" and "contract" include any extension or modification of the Contract or contract;
 - (3) "Contractor" and "contractor" include any successors or assigns of the Contractor or contractor;
 - (4) "Gender identity or expression" means a person's gender-related identity, appearance or behavior, whether or not that gender-related identity, appearance or behavior is different from that traditionally associated with the person's physiology or assigned sex at birth, which gender-related identity can be shown by providing evidence including, but not limited to, medical history, care or treatment of the gender-related identity, consistent and uniform assertion of the

- gender-related identity or any other evidence that the gender-related identity is sincerely held, part of a person's core identity or not being asserted for an improper purpose.
- (5) "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations;
 - (6) "good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements;
 - (7) "marital status" means being single, married as recognized by the State of Connecticut, widowed, separated or divorced;
 - (8) "mental disability" means one or more mental disorders, as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", or a record of or regarding a person as having one or more such disorders;
 - (9) "minority business enterprise" means any small contractor or supplier of materials fifty-one percent or more of the capital stock, if any, or assets of which is owned by a person or persons: (1) who are active in the daily affairs of the enterprise, (2) who have the power to direct the management and policies of the enterprise, and (3) who are members of a minority, as such term is defined in subsection (a) of Connecticut General Statutes § 32-9n; and
 - (10) "public works contract" means any agreement between any individual, firm or corporation and the State or any political subdivision of the State other than a municipality for construction, rehabilitation, conversion, extension, demolition or repair of a public building, highway or other changes or improvements in real property, or which is financed in whole or in part by the State, including, but not limited to, matching expenditures, grants, loans, insurance or guarantees.

For purposes of this Section, the terms "Contract" and "contract" do not include a contract where each contractor is (1) a political subdivision of the state, including, but not limited to, a municipality, (2) a quasi-public agency, as defined in Conn. Gen. Stat. Section 1-120, (3) any other state, including but not limited to any federally recognized Indian tribal governments, as defined in Conn. Gen. Stat. Section 1-267, (4) the federal government, (5) a foreign government, or (6) an agency of a subdivision, agency, state or government described in the immediately preceding enumerated items (1), (2), (3), (4) or (5).

- (b)
 - (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, gender identity or expression, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the State of Connecticut; and the Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, gender identity or expression, mental retardation, mental disability or physical disability, including, but not limited to, blindness, unless it is shown by the Contractor that such disability prevents performance of the work involved;
 - (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that it is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the Commission;
 - (3) the Contractor agrees to provide each labor union or representative of workers with which the Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which the Contractor has a contract or understanding, a notice to be provided by the Commission, advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment;

- (4) the Contractor agrees to comply with each provision of this Section and Connecticut General Statutes §§ 46a-68e and 46a-68f and with each regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes §§ 46a-56, 46a-68e and 46a-68f; and
 - (5) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this Section and Connecticut General Statutes § 46a-56. If the contract is a public works contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works projects.
- (c) Determination of the Contractor's good faith efforts shall include, but shall not be limited to, the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative advertising, recruitment and training; technical assistance activities and such other reasonable activities or efforts as the Commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.
 - (d) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the Commission, of its good faith efforts.
 - (e) The Contractor shall include the provisions of subsection (b) of this Section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes §46a-56; provided if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.
 - (f) The Contractor agrees to comply with the regulations referred to in this Section as they exist on the date of this Contract and as they may be adopted or amended from time to time during the term of this Contract and any amendments thereto.
 - (g)
 - (1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or the State of Connecticut, and that employees are treated when employed without regard to their sexual orientation;
 - (2) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining Agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the Commission on Human Rights and Opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment;
 - (3) the Contractor agrees to comply with each provision of this section and with each regulation or relevant order issued by said Commission pursuant to Connecticut General Statutes § 46a-56; and
 - (4) the Contractor agrees to provide the Commission on Human Rights and Opportunities with such information requested by the Commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor which relate to the provisions of this Section and Connecticut General Statutes § 46a-56.

- (h) The Contractor shall include the provisions of the foregoing paragraph in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the State and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the Commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the Commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Connecticut General Statutes § 46a-56; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the State and the State may so enter.

6. Freedom of Information.

- (a) Contractor acknowledges that the Agency must comply with the Freedom of Information Act, C.G.S. §§ 1-200 *et seq.* ("FOIA") which requires the disclosure of documents in the possession of the State upon request of any citizen, unless the content of the document falls within certain categories of exemption, as defined by C.G.S. § 1-210(b).
- (b) Governmental Function. In accordance with C.G.S. § 1-218, if the amount of this Contract exceeds two million five hundred thousand dollars (\$2,500,000), and the Contractor is a "person" performing a "governmental function", as those terms are defined in C.G.S. §§ 1-200(4) and (11), the Agency is entitled to receive a copy of the Records and files related to the Contractor's performance of the governmental function, which may be disclosed by the Agency pursuant to the FOIA.
- 7. Whistleblowing.** This Contract is subject to C.G.S. § 4-61dd if the amount of this Contract is a "large state contract" as that term is defined in C.G.S. § 4-61dd(h). In accordance with this statute, if an officer, employee or appointing authority of the Contractor takes or threatens to take any personnel action against any employee of the Contractor in retaliation for such employee's disclosure of information to any employee of the Contracting state or quasi-public agency or the Auditors of Public Accounts or the Attorney General under subsection (a) of such statute, the Contractor shall be liable for a civil penalty of not more than five thousand dollars (\$5,000) for each offense, up to a maximum of twenty per cent (20%) of the value of this Contract. Each violation shall be a separate and distinct offense and in the case of a continuing violation, each calendar day's continuance of the violation shall be deemed to be a separate and distinct offense. The State may request that the Attorney General bring a civil action in the Superior Court for the Judicial District of Hartford to seek imposition and recovery of such civil penalty. In accordance with subsection (f) of such statute, each large state Contractor, as defined in the statute, shall post a notice of the relevant sections of the statute relating to large state Contractors in a conspicuous place which is readily available for viewing by the employees of the Contractor.
- 8. Executive Orders.** This Contract is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill, promulgated June 16, 1971, concerning labor employment practices, Executive Order No. Seventeen of Governor Thomas J. Meskill, promulgated February 15, 1973, concerning the listing of employment openings and Executive Order No. Sixteen of Governor John G. Rowland promulgated August 4, 1999, concerning violence in the workplace, all of which are incorporated into and are made a part of the Contract as if they had been fully set forth in it. The Contract may also be subject to Executive Order No. 14 of Governor M. Jodi Rell, promulgated April 17, 2006, concerning procurement of cleaning products and services and to Executive Order No. 49 of Governor Dannel P. Malloy, promulgated May 22, 2015, mandating disclosure of certain gifts to public employees and contributions to certain candidates for office. If Executive Order 14 and/or Executive Order 49 are applicable, they are deemed to be incorporated into and are made a part of the Contract as if they had been fully set forth in it. At the Contractor's request, the Client Agency or Connecticut Department of Administrative Services shall provide a copy of these orders to the Contractor.
- 9. Campaign Contribution Restrictions.** For all State contracts as defined in C.G.S. § 9-612(g) the authorized signatory to this Contract expressly acknowledges receipt of the State Elections Enforcement Commission's ("SEEC") notice advising state contractors of state campaign contribution and solicitation

prohibitions, and will inform its principals of the contents of the notice. See SEEC Form 11 reproduced below: www.ct.gov/seec



Notice to Executive Branch State Contractors and Prospective State Contractors of Campaign Contribution and Solicitation Limitations

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

CAMPAIGN CONTRIBUTION AND SOLICITATION LIMITATIONS

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

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

On and after January 1, 2011, no state contractor, prospective state contractor, principal of a state contractor or principal of a prospective state contractor, with regard to a state contract or state contract solicitation with or from a state agency in the executive branch or a quasi-public agency or a holder, or principal of a holder of a valid prequalification certificate, shall knowingly *solicit* contributions from the state contractor's or prospective state contractor's employees or from a *subcontractor or principals of the subcontractor* on behalf of (i) an exploratory committee or candidate committee established by a candidate for nomination or election to the office of Governor, Lieutenant Governor, Attorney General, State Comptroller, Secretary of the State or State Treasurer, (ii) a political committee authorized to make contributions or expenditures to or for the benefit of such candidates, or (iii) a party committee.

DUTY TO INFORM

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

PENALTIES FOR VIOLATIONS

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

Civil penalties—Up to \$2,000 or twice the amount of the prohibited contribution, whichever is greater, against a principal or a contractor. Any state contractor or prospective state contractor which fails to make reasonable efforts to comply with the provisions requiring notice to its principals of these prohibitions and the possible consequences of their violations may also be subject to civil penalties of up to \$2,000 or twice the amount of the prohibited contributions made by their principals.

Criminal penalties—Any knowing and willful violation of the prohibition is a Class D felony, which may subject the violator to imprisonment of not more than 5 years, or not more than \$5,000 in fines, or both.

CONTRACT CONSEQUENCES

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

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

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

Additional information may be found on the website of the State Elections Enforcement Commission, www.ct.gov/seec. Click on the link to "Lobbyist/Contractor Limitations."



DEFINITIONS

"State contractor" means a person, business entity or nonprofit organization that enters into a state contract. Such person, business entity or nonprofit organization shall be deemed to be a state contractor until December thirty-first of the year in which such contract terminates. "State contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Prospective state contractor" means a person, business entity or nonprofit organization that (i) submits a response to a state contract solicitation by the state, a state agency or a quasi-public agency, or a proposal in response to a request for proposals by the state, a state agency or a quasi-public agency, until the contract has been entered into, or (ii) holds a valid prequalification certificate issued by the Commissioner of Administrative Services under section 4a-100. "Prospective state contractor" does not include a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a state contractor or prospective state contractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a state contractor or prospective state contractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a state contractor or prospective state contractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a state contractor or prospective state contractor, which is not a business entity, or if a state contractor or prospective state contractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any state contractor or prospective state contractor who has managerial or discretionary responsibilities with respect to a state contract, (v) the spouse or a dependent child who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the state contractor or prospective state contractor.

"State contract" means an agreement or contract with the state or any state agency or any quasi-public agency, let through a procurement process or otherwise, having a value of fifty thousand dollars or more, or a combination or series of such agreements or contracts having a value of one hundred thousand dollars or more in a calendar year, for (i) the rendition of services, (ii) the furnishing of any goods, material, supplies, equipment or any items of any kind, (iii) the construction, alteration or repair of any public building or public work, (iv) the acquisition, sale or lease of any land or building, (v) a licensing arrangement, or (vi) a grant, loan or loan guarantee. "State contract" does not include any agreement or contract with the state, any state agency or any quasi-public agency that is exclusively federally funded, an education loan, a loan to an individual for other than commercial purposes or any agreement or contract between the state or any state agency and the United States Department of the Navy or the United States Department of Defense.

"State contract solicitation" means a request by a state agency or quasi-public agency, in whatever form issued, including, but not limited to, an invitation to bid, request for proposals, request for information or request for quotes, inviting bids, quotes or other types of submittals, through a competitive procurement process or another process authorized by law waiving competitive procurement.

"Managerial or discretionary responsibilities with respect to a state contract" means having direct, extensive and substantive responsibilities with respect to the negotiation of the state contract and not peripheral, clerical or ministerial responsibilities.

"Dependent child" means a child residing in an individual's household who may legally be claimed as a dependent on the federal income tax of such individual.

"Solicit" means (A) requesting that a contribution be made, (B) participating in any fund-raising activities for a candidate committee, exploratory committee, political committee or party committee, including, but not limited to, forwarding tickets to potential contributors, receiving contributions for transmission to any such committee or bundling contributions, (C) serving as chairperson, treasurer or deputy treasurer of any such committee, or (D) establishing a political committee for the sole purpose of soliciting or receiving contributions for any committee. Solicit does not include: (i) making a contribution that is otherwise permitted by Chapter 155 of the Connecticut General Statutes; (ii) informing any person of a position taken by a candidate for public office or a public official, (iii) notifying the person of any activities of, or contact information for, any candidate for public office; or (iv) serving as a member in any party committee or as an officer of such committee that is not otherwise prohibited in this section.

"Subcontractor" means any person, business entity or nonprofit organization that contracts to perform part or all of the obligations of a state contractor's state contract. Such person, business entity or nonprofit organization shall be deemed to be a subcontractor until December thirty first of the year in which the subcontract terminates. "Subcontractor" does not include (i) a municipality or any other political subdivision of the state, including any entities or associations duly created by the municipality or political subdivision exclusively amongst themselves to further any purpose authorized by statute or charter, or (ii) an employee in the executive or legislative branch of state government or a quasi-public agency, whether in the classified or unclassified service and full or part-time, and only in such person's capacity as a state or quasi-public agency employee.

"Principal of a subcontractor" means (i) any individual who is a member of the board of directors of, or has an ownership interest of five per cent or more in, a subcontractor, which is a business entity, except for an individual who is a member of the board of directors of a nonprofit organization, (ii) an individual who is employed by a subcontractor, which is a business entity, as president, treasurer or executive vice president, (iii) an individual who is the chief executive officer of a subcontractor, which is not a business entity, or if a subcontractor has no such officer, then the officer who duly possesses comparable powers and duties, (iv) an officer or an employee of any subcontractor who has managerial or discretionary responsibilities with respect to a subcontract with a state contractor, (v) the spouse or a dependent child who is eighteen years of age or older of an individual described in this subparagraph, or (vi) a political committee established or controlled by an individual described in this subparagraph or the business entity or nonprofit organization that is the subcontractor.

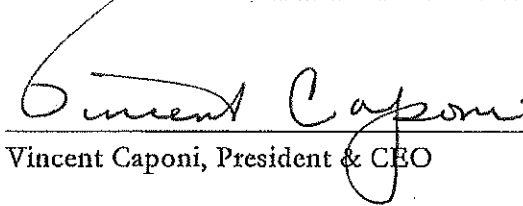
SIGNATURES AND APPROVALS

17DSS1203GP/015-3GP-MED-01

The Contractor IS NOT a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended

Documentation necessary to demonstrate the authorization to sign must be attached.

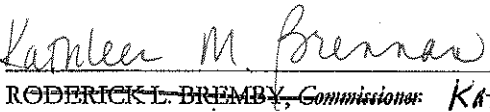
CONTRACTOR - St. Vincent's Medical Center



Vincent Caponi, President & CEO

2/14/17
Date

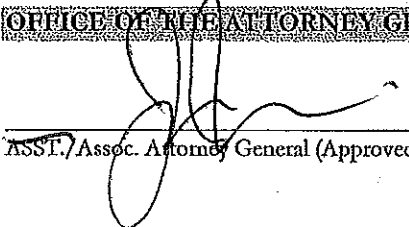
DEPARTMENT OF SOCIAL SERVICES



~~ROBERTICK L. BREMBY, Commissioner~~ Kathleen M. Brennan, Deputy Commissioner

2/15/17
Date

OFFICE OF THE ATTORNEY GENERAL



ASST./Assoc. Attorney General (Approved as to form) Joseph Rubin

2/24/17

PCMH+ Quality Measure Set

Scoring Measures	Measure Steward	National Quality Foundation #
Adolescent well-care visits	NCQA	NA
Avoidance of antibiotic treatment in adults with acute bronchitis	NCQA	0058
Developmental screening in the first three years of life	OHSU	1448
Diabetes HbA1c Screening	NCQA	0057
Emergency Department (ED) Usage	NCQA	NA
Medication management for people with asthma	NCQA	1799
PCMH CAHPS	AHRQ	NA
Prenatal care and Postpartum care	NCQA	1517
Well-child visits in the first 15 months of life	NCQA	1392

Challenge Measures	Measure Steward	National Quality Foundation #
Behavioral Health Screening 1-17	DSS	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	NA
Readmissions within 30 Days	MMDN	NA
Post-Hospital Admission Follow up	DSS	NA

Reporting Only Measures	Measure Steward	National Quality Foundation #
Annual fluoride treatment ages 0<4	DSS	NA
Annual monitoring for persistent medications (roll-up)	NCQA	2371
Appropriate treatment for children with upper respiratory infection	NCQA	0069
Asthma Medication Ratio	NCQA	1800
Breast cancer screening	NCQA	2372
Cervical cancer screening	NCQA	0032
Chlamydia screening in women	NCQA	0033
Diabetes eye exam	NCQA	0055
Diabetes: medical attention for nephropathy	NCQA	0062
Follow-up care for children prescribed ADHD medication	NCQA	0108
Human Papillomavirus Vaccine (HPV) for Female Adolescents	NCQA	1959
Oral evaluation, dental services	ADA	2517
Use of imaging studies for low back pain	NCQA	0052
Well-child visits in the third, fourth, fifth and sixth years of life	NCQA	1516

Notes:

-Updated November 10, 2016 and effective for dates of service on and after January 1, 2017.

Definitions:

- ADA: American Dental Association
- AHRQ: Agency for Healthcare Research and Quality
- DSS: Department of Social Services
- MMDN: Medicaid Medical Directors Network
- NA: Not Applicable
- NCQA: National Committee for Quality Assurance
- OHSU: Oregon Health & Science University

PCMH+ UNDER-SERVICE UTILIZATION MONITORING STRATEGY

October 6, 2016
Draft and Subject to Revision

Purpose

The goal of Person-Centered Medical Home Plus (PCMH+) is to improve the member experience, increase the quality of Medicaid primary care, and enhance care coordination activities such that medically unnecessary and inappropriate utilization is decreased and member health outcomes are improved. The Connecticut Department of Social Services (DSS) recognizes there is a potential risk in a shared savings model that members are diverted from a provider practice or discouraged from medically necessary services in an effort to drive increased savings or limit the number of high-risk members a provider may serve. The PCMH+ Under-Service Utilization Strategy was developed in response to this potential risk and is an approach designed to identify potential under-service utilization or inappropriate reductions in access to medically necessary care. It is important to also note that the Connecticut Medicaid fee-for-service model offers limited financial incentives to under-service utilization practices. At its core, the program is not a gate-keeper or managed care model, and members are allowed to self-refer to any participating provider. As part of their oversight of the PCMH+ program, DSS will implement the following five-pronged approach in an effort to identify underservice utilization practices within the program.

Five-Pronged Approach

DSS recognizes that identification of under-service utilization practices is complex, and no one strategy alone can adequately ameliorate the risk. For PCMH+, DSS proposes a strategy that encompasses several monitoring methods. These methods are demonstrated in the diagram on the right and represent an approach designed to provide the best opportunity to identify under-service utilization practices, inappropriate member-shifting (sometimes referred to as "cherry-picking"), diminished access to medically necessary services, or other early warning indicators of under-service utilization practices.

1. Preventative and Access to Care Measures

Of the 27 PCMH+ Quality Measures, 21 track preventative care rates or monitor appropriate clinical care for specific health conditions. Tracking these measures, and comparing to historical rates, can provide actionable information regarding clinical quality and act as a bellwether for decreased access to medically necessary care. The preventative and access to appropriate clinical care measures include the following:

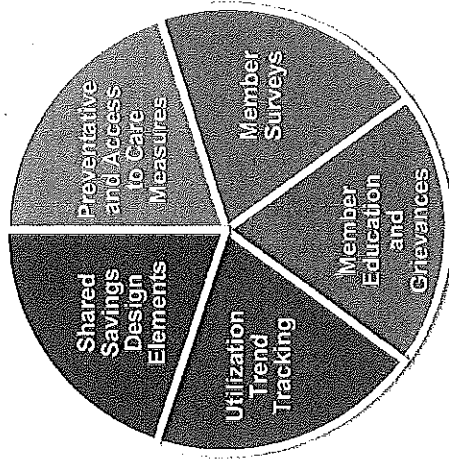


Table 1: Preventative Care and Access to Appropriate Clinical Care Measures

Adolescent Well Care Visits	Annual Fluoride Treatment Ages 0<4	Annual Monitoring for Persistent Medications
Asthma Medication Ratio	Behavioral Health Screening ages 1-17	Breast Cancer Screening
Cervical Cancer Screening	Chlamydia Screening in Women	Developmental Screening in First three Years of Life
Diabetes Eye Exam	Diabetes HbA1c Screening	Diabetes: Medical Attention for Nephropathy
Follow-up Care for Children Prescribed ADHD Medication	Human Papillomavirus Vaccine for Female Adolescents	Medication Management for People with Asthma
Metabolic Monitoring for Children and Adolescents on Antipsychotics	Oral Evaluation; Dental Services	Post-Hospital Admission Follow-up
Prenatal Care and Postpartum Care	Well-Child Visits in the first 15 Months of Life	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

2. Member Surveys

Person-Centered Medical Home (PCMH) Consumer Assessment of Healthcare Providers (CAHPS)¹ survey will be conducted in the spring of 2018 to gauge member experience for the 2017 performance year. PCMH CAHPS is a standardized member survey, conducted annually to determine member satisfaction with services and service providers. Many of the survey questions solicit information that may suggest under-service utilization practices. Below are a few examples of questions that may inform whether under-service utilization may be present.

- In the last 12 months, how many days did you usually have to wait for an appointment when you needed care right away?
- In the last 12 months, how often were you able to get the care you needed at your provider's office during evenings, weekends, or holidays?
- Did this provider's office give you the information about what to do if you needed care during evenings, weekends, or holidays?

In addition to the PCMH CAHPS survey, DSS may add specific questions from the CAHPS Cultural Competency Supplemental Item Set² as a mechanism to monitor PCMH+ cultural competency care coordination requirements. While not a direct indication of under-service utilization practices, they provide important information regarding the member experience that can discourage members from accessing needed care. (The number in parenthesis indicates the question number from the survey).

- In the last 12 months, how often have you been treated unfairly at this provider's office because of your race or ethnicity? (CU14)
- In the last 12 months, how often were you treated unfairly at the provider's office because you did not speak English very well? (CU24)

¹ PCMH Consumer Assessment of Healthcare Providers (CAHPS) Survey: https://cahps.ahrq.gov/surveys-guidance/survey4_0-docs/1314_About_PCMH.pdf

² CAHPS Cultural Competency Supplemental Item Set: https://cahps.ahrq.gov/surveys-guidance/survey4_0-docs/2312_about_cultural_comp.pdf

- An interpreter is someone who helps you talk with others who do not speak your language. Interpreters can include staff from the provider's office or telephone interpreters. In the last 12 months, was there any time when you needed an interpreter at this provider's office? (CU25)
- In the last 12 months, did anyone in this provider's office let you know that an interpreter was available free of charge? (CU26)
- In the last 12 months, how often did you use an interpreter provided by this office to help you talk with his provider? (CU27)

3. Member Education and Grievances

All PCMH+ assigned members will receive a Member Welcome Letter providing them information on the program and their opt-out rights. The notice will contain information sufficient to inform the member that their primary care provider has the opportunity to receive a portion of any avoided costs if the care provided meets minimum quality thresholds. All members retain all Medicaid grievance processes and are educated on the process to submit grievances through their Member Handbook. Grievances may be submitted in several ways, in writing, by fax, by email or by phone. In addition to submitting a grievance through the State of Connecticut's (State's) Administrative Services Organization, members are provided information on submitting a grievance directly to DSS, the Office of the Healthcare Advocate or to the Office of Civil Rights in Washington, DC. Monitoring these grievances is an oversight function currently incorporated in the program and will continue to be monitored and PCMH+ specific grievance reporting is being developed for DSS to identify issues and trends within the PCMH+ program specifically. DSS will also be providing Community Information Sessions prior to program go-live to provide an overview of the PCMH+ program, outline the enhanced care coordination available to members of participating providers, educate members on the grievance and opt-out process and allow for member and stakeholder questions. These Informational Sessions are planned for December 2016 in two locations in the State. Public notices will be sent out to invite attendance by members, families and community stakeholders.

4. Utilization Trend Tracking

DSS is working with their vendors to develop targeted utilization reporting to monitor trends for specific services and benefits within the program to identify shifts in service utilization within the population. In addition, DSS will monitor overall service cost reports, movement of members between providers, levels of member opting-out of PCMH+ and members moving into Long-Term Services and Supports services.

5. Shared Savings Design Elements

The PCMH+ model design has several elements that may act as deterrents to providers underserving members as a means of increasing potential shared savings. Elements in the model design include the following:

- Savings Cap: A Participating Entity will not be allowed to contribute more than 10% of its expected expenditures to their individual savings pool.
- Upside-only Model: As part of the individual savings pool, if a Participating Entity's performance year costs exceed their expected costs, then that Participating Entity will not be required to pay back the costs that exceed the expected costs.
- High Cost Claims Truncation: Annual claims costs for each PCMH+ member that exceeds \$100,000 will be excluded from the shared savings calculation.
- Concurrent Risk Adjustment Methodology: Risk scores will be calculated to compare a PCMH+ Participating Entity's level of risk relative to non-Participating Entities.

PCMH+ — ENHANCED CARE COORDINATION ACTIVITIES

Updated November 10, 2016 and effective for dates of service on and after January 1, 2017

The following grid presents the finalized set of enhanced care coordination activities required under the Connecticut Person-Centered Medical Home – *Plus* (PCMH+) program.

PCMH+ Participating Entities will provide Enhanced Care Coordination Activities to PCMH+ Members. The Enhanced Care Coordination Activities leverage national best practices in care coordination and exceed the FQHC, HRSA, and Patient-Centered Medical Home recognition requirements as defined by NCQA or ambulatory care entities with a Primary Care Medical Home certification from The Joint Commission.

- All PCMH+ Participating Entities must perform the required Enhanced Care Coordination Activities.
- PCMH+ Participating Entities that are FQHCs will provide both the Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities, which will be reimbursed through the Care Coordination Add-On Payment.

Enhanced Care Coordination Category	Enhanced Care Coordination Activities Required for Both FQHCs and Advanced Networks
Behavioral Health/ Physical Health Integration	<p>Care Coordinator:</p> <ol style="list-style-type: none"> Employ a care coordinator with behavioral health education, training and/or experience who participates as a member of the interdisciplinary team. <p>Screening for Behavioral Health Conditions:</p> <ol style="list-style-type: none"> Use standardized tools to expand behavioral health screenings beyond depression. Promote universal screening for behavioral health conditions across all populations, not just those traditionally identified as high-risk. Providers are encouraged to implement screening tools in both medical and behavioral health settings. <p>Psychiatric Advance Directives for Adults and Transition Age Youth:</p> <ol style="list-style-type: none"> Obtain and maintain a copy of the psychiatric advance directive in the member's file. <p>Wellness Recovery Action Plan (WRAP) or Other Behavioral Health Recovery Planning Tool:</p> <ol style="list-style-type: none"> Obtain and maintain a copy of the WRAP or other behavioral health recovery planning tool in the member's file.
Culturally Competent Services	<p>Training:</p> <ol style="list-style-type: none"> Require annual cultural competency training for all practice staff. Cultural competency training will include the needs of individuals with disabilities. <p>Care Plan:</p> <ol style="list-style-type: none"> Expand the individual care plan currently in use to include an assessment of the impact culture has on health outcomes.

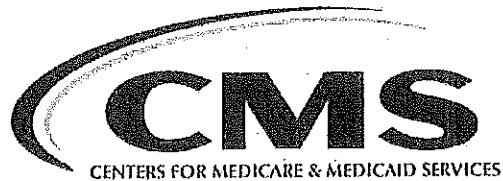
Enhanced Care Coordination Category	Enhanced Care Coordination Activities Required for Both FQHCs and Advanced Networks Cultural and Linguistically Appropriate Services (CLAS) Standards:
<p>Care Coordinator Staff Requirements: Availability</p>	<p>8. Require compliance with CLAS standards as defined by the Department of Health and Human Services, Office of Minority Health.</p> <p>Care Coordination Availability: Providers must select at least one of these options based on the mode(s) that fit their practice:</p> <p>9. Employ a full time care coordinator dedicated solely to care coordination activities.</p> <p>10. Assign care coordination activities to multiple staff within a practice.</p> <p>11. Contract with an external agency to work with the practice to provide care coordination.</p>
<p>Care Coordinator Staff Requirements: Education</p>	<p>Care Coordinator Education:</p> <p>12. Define minimum care coordinator education and experience and determine if leveraging non-licensed staff such as community health workers is desired.</p> <p>Staff minimums can vary nationally but generally include some of the following types of staff:</p> <p><i>Clinical and Non-Clinical Staff:</i></p> <ul style="list-style-type: none"> • Registered Nurse. • Medical Assistant. • Un/Licensed Social Worker. • Un/Licensed Community Health Worker. • Unlicensed Health Coach. • Child and Family Advocate.
<p>CYSHCN: Age 0–17 years</p>	<p>Advance Care Planning:</p> <p>13. Require advance care planning, by way of a Shared Plan of Care, or SPoC, for discussions for CYSHCN. Advance care planning, including SPoCs, are not limited to CYSHCN with terminal diagnoses. It can occur with CYSHCN with chronic health conditions, including behavioral health conditions, which significantly impact the quality of life of the child/youth and his/her family.</p> <p>14. Develop advance directives for CYSHCN.</p>

Enhanced Care Coordination Category	Enhanced Care Coordination Activities Required for Both FOHCs and Advanced Networks
<p>Health Assessment:</p> <p>15. Include information from other services that CYSHCN uses in the health assessment and health information record. Such information includes:</p> <ul style="list-style-type: none"> A. School information including school-based health center: The individualized education program or 504 Plan, special accommodation, assessment of member/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition and documenting the school name and primary contact. B. Early intervention information: Including individualized family service plan, evaluation results and other documentation of early intervention services. C. Home visiting information: Including documentation of screening results, needs identified and services provided. D. Early care and education (ECE) information: Including Head Start and other early care programs, screening results, accommodations made and general coordination of care with ECE consultants. E. Child welfare information; including multidisciplinary assessments and services. F. Behavioral health information including screening, evaluations and services. G. Disability services information. 	<p>Health Assessment:</p> <p>15. Include information from other services that CYSHCN uses in the health assessment and health information record. Such information includes:</p> <ul style="list-style-type: none"> A. School information including school-based health center: The individualized education program or 504 Plan, special accommodation, assessment of member/family need for advocacy from the provider to ensure the child's health needs are met in the school environment, how the child is doing in school and how many days have been missed due to the child's health condition and documenting the school name and primary contact. B. Early intervention information: Including individualized family service plan, evaluation results and other documentation of early intervention services. C. Home visiting information: Including documentation of screening results, needs identified and services provided. D. Early care and education (ECE) information: Including Head Start and other early care programs, screening results, accommodations made and general coordination of care with ECE consultants. E. Child welfare information; including multidisciplinary assessments and services. F. Behavioral health information including screening, evaluations and services. G. Disability services information.
<p>Competencies in Care for Individuals with Disabilities (Inclusive of physical, intellectual, developmental and behavioral health needs)</p>	<p>Health Assessment:</p> <p>16. In addition to information above, practices that serve CYSHCN will coordinate and document care using the following resources:</p> <ul style="list-style-type: none"> A. The Department of Public Health (DPH) medical home initiative for CYSHCN which includes regional care coordination entities to assist medical homes in caring for and meeting the needs of CYSHCN and their families. B. Training and other programs offered through the DPH regional care coordination collaboratives for CYSHCN. C. Participation in scheduled case reviews with CHN and CYSHCN program. D. Family respite services offered through the CYSHCN program. E. United Way's 211 Child Development Infoline and Help Me Grow services to connect CYSHCN to parent support and other community services. F. Shared Plan of Care developed under the efforts of the State Implementation Grant intended to promote enhanced coordinating services for CYSHCN and in collaboration with DPH, DSS, and CHN.
<p>Health Assessment:</p> <p>17. Expand the health assessment to include questions about:</p> <ul style="list-style-type: none"> A. Durable Medical Equipment (DME) and DME vendor preferences. B. Home health medical supplies (e.g. ventilator and tracheostomy supplies) and home health vendor preferences. C. Home and vehicle modifications. D. Prevention of wounds for individuals at risk for wounds. E. Special physical and communication accommodations needed during medical visits. 	<p>Health Assessment:</p> <p>17. Expand the health assessment to include questions about:</p> <ul style="list-style-type: none"> A. Durable Medical Equipment (DME) and DME vendor preferences. B. Home health medical supplies (e.g. ventilator and tracheostomy supplies) and home health vendor preferences. C. Home and vehicle modifications. D. Prevention of wounds for individuals at risk for wounds. E. Special physical and communication accommodations needed during medical visits.

Enhanced Care Coordination Category	Enhanced Care Coordination Activities Required for Both FQHCs and Advanced Networks
	<p>Appointment Times:</p> <p>18. Adjust appointment times for individuals who require additional time to address physical accommodations, communication needs, and other unique needs for individuals with disabilities. Individuals may be seen by the primary care physician and other members of the interdisciplinary team during these adjusted appointment times.</p> <p>Training:</p> <p>19. Develop and require mandatory disability competency trainings to address the care of individuals with physical and intellectual disabilities.</p> <p>Accessibility of Office Environment:</p> <p>20. Acquire accessible equipment to address physical barriers to care (e.g. wheelchair scales, a high/low exam table and/or transfer equipment and lifts to facilitate exams for individuals with physical disabilities).</p> <p>21. Address communication barriers to care (e.g. offer important medical information and documents in Braille or large print, implement policies to ensure service animals are permitted into an appointment). Providers may coordinate with the Department's medical Administrative Services Organization to obtain available materials.</p>
	<p>Resource List:</p> <p>22. Expand the provider resource list of community providers to include providers who specialize in or demonstrate competencies in the care of individuals with disabilities (e.g. mammography centers that can accommodate women who use wheelchairs, providers who will take the time to help a member with cerebral palsy that experiences spasticity or tremors during a physical examination).</p>
<p>Provider Profile Reports</p>	<p>Provider Profile Report Utilization:</p> <p>23. Evaluate and utilize results of the provider profile reports, to the extent available, on at least an annual basis to improve quality of care.</p> <p>Provider profile reports will analyze measures of health care and clinical quality measure results for PCMH+'s providers. The report will provide quantitative provider feedback at the statewide practice setting and individual provider/practice level that can be used to direct resources and inform policy.</p>

Enhanced Care Coordination Category	Care Coordination Add-On Payment Activities - FQHCs ONLY
Behavioral Health/Physical Health Integration – FQHCs ONLY	<p>Care Coordinator</p> <ol style="list-style-type: none"> Employ a care coordinator with behavioral health experience and assign them responsibility for tracking members, monitoring symptoms, providing member education, supporting treatment adherence, taking action when non-adherence occurs or symptoms worsen and delivers psychosocial interventions. <p>WRAP or Other Behavioral Health Recovery Planning Tool</p> <ol style="list-style-type: none"> Develop WRAPs or other behavioral health recovery planning tools in collaboration with the member and family.
	<p>Transition Age Youth:</p> <ol style="list-style-type: none"> Expand the development and implementation of the care plan for transition age youth (TAY) with behavioral health challenges (e.g. collaborative activities to achieve success in transition and/or referrals to and coordination with programs specializing in the care of TAY with behavioral health challenges).
	<p>Interdisciplinary Teams:</p> <ol style="list-style-type: none"> Require the use of an interdisciplinary team that includes behavioral health specialist(s), including the required behavioral health coordinator position. <ol style="list-style-type: none"> Demonstrate that the interdisciplinary team has the responsibility for driving physical and behavioral health integration, conducting interdisciplinary team case review meetings at least monthly, promoting shared appointments and developing a comprehensive care plan outlining coordination and physical and behavioral health care needs.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203



Division of Medicaid and Children's Health Operations / Boston Regional Office

January 18, 2017

Roderick L. Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

RE: CT SPA 17-0002 / Person-Centered Medical Home Plus (PCMH+) Program

Dear Commissioner Bremby:

We are pleased to enclose a copy of approved State plan amendment (SPA) No. 17-0002 with an effective date of January 1, 2017 as requested by your Agency.

This proposed SPA transmitted an amendment to the coverage and reimbursement sections of Connecticut's approved Title XIX State plan to establish the PCMH+ program. The PCMH+ program is being added as an Integrated Care Model within section 1905(a)(29) of the Social Security Act (Act). The PCMH+ program also involves shared savings payments and care coordination add-on payments for primary care case management services, as defined by section 1905(t) of the Act.

If you have any questions regarding this matter you may contact Robert Cruz at 617-565-1257 or by email at Robert.Cruz@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink that reads "Richard R. McGreal". The signature is written in a cursive style.

Richard McGreal
Associate Regional Administrator

Enclosure

cc: Kate McEvoy, Director of Medical Administration – Health Services and Supports

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 17-0002	2. STATE: CT
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: January 1, 2017	
5. TYPE OF STATE PLAN MATERIAL (Check One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT		

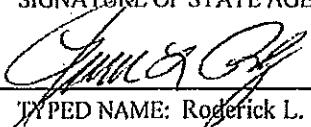
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Sections 1905(a)(29) and 1905(t) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2017 \$2.3 million (costs) b. FFY 2018 \$1.2 million (costs)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1-A, Page 13 Attachment 3.1-B, Page 12 Addendum Pages 16-25 to Attachments 3.1-A & 3.1-B Attachment 4.19-B, Pages 30-38	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (if applicable) New New New New

10. SUBJECT OF AMENDMENT: Effective from January 1, 2017 through December 31, 2017, this SPA amends Attachments 3.1-A, 3.1-B, and 4.19-B of the Medicaid State Plan in order to establish the Person-Centered Medical Home Plus (PCMH+) program, which is an Integrated Care Model being implemented in accordance with section 1905(a)(29) of the Social Security Act. This SPA involves shared savings payments and care coordination add-on payments for primary care case management (PCCM) services, as defined by section 1905(t) of the Act. The federal budget impact listed above is the Department's estimate of care coordination add-on per member per month payments that will be made to PCMH+ Participating Entities that are federally qualified health centers (FQHCs). It is not possible to predict the amount of shared savings payments that may be paid because such payments will be based on Medicaid expenditures, quality measures, and measures of under-service for dates of service in calendar year 2017.

11. GOVERNOR'S REVIEW (Check One):

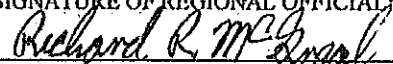
GOVERNOR'S OFFICE REPORTED NO COMMENT OTHER, AS SPECIFIED:
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: State of Connecticut Department of Social Services 55 Farmington Avenue - 9th floor Hartford, CT 06105 Attention: Ginny Mahoney
13. TYPED NAME: Roderick L. Bremby	
14. TITLE: Commissioner	
15. DATE SUBMITTED: December 29, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: December 29, 2016	18. DATE APPROVED: January 18, 2017
--------------------------------------	-------------------------------------

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2017	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Richard R. McGreal	22. TITLE: Associate Regional Administrator, Division of Medicaid and Children's Health Operations, Boston Regional Office

23. REMARKS: The state and CMS agreed to the following pen-and-ink changes to Box 8 on the Form 179:
 - the page number under Attachment 3.1-A was changed from 14 to 13
 - the page number under Attachment 3.1-B was changed from 14 to 12
 - the Addendum page numbers under Attachments 3.1-A and 3.1-B were changed from 16-24 to 16-25
 - the page numbers under Attachment 4.19-B were updated from 31-39 to 30-38

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Attachment 3.1-A
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State: Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated care models.

- Provided: No limitations With limitations*
 Not provided

* See Addendum to Attachment 3.1-A.

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State: Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

The overall goals of the Person-Centered Medical Home Plus (PCMH+) program are to improve health outcomes and care experience for Medicaid beneficiaries who are PCMH+ members, while building upon and preserving both the PCMH program in particular (as described in section 5 of Attachment 4.19-B), as well as overall improvement in quality, access, and cost control in Connecticut's Medicaid program. Participating Entities that meet identified benchmarks on quality measures, while also demonstrating shared savings (and complying with measures to prevent under-service) will be eligible to receive shared savings payments, all as described in more detail below and in Attachment 4.19-B.

I. Provider Qualifications

Under the PCMH+ program, the State will contract with PCMH+ Participating Entities (Participating Entities), which are Federally Qualified Health Centers (FQHCs) or Advanced Networks, each as defined below, to provide the care coordination services described below. Participating Entities must include primary care providers (primary care physicians, advanced practice registered nurses (APRNs) / nurse practitioners, and/or physician assistants) who provide primary care case management (PCCM) services in accordance with section 1905(t) of the Social Security Act (Act), which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A)-(B) of the Act, a Participating Entity must be, employ, or contract with a physician, a physician group practice, APRNs/nurse practitioners, physician assistants, or an entity employing or having other arrangements with physicians to provide such services. The Participating Entity provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, and pediatrics.

A. Federally Qualified Health Centers (FQHCs)

An FQHC is an entity, as defined in section 2 of Attachment 3.1-A, including an FQHC look-alike, which must:

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1. Meet all requirements of an FQHC under section 1905(I)(2)(B) of the Social Security Act.
2. Meet all requirements of the Health Resources and Services Administration (HRSA) Health Center Program and have either: (A) HRSA grant funding as an FQHC under Section 330 of the Public Health Services Act or (B) HRSA designation as an FQHC Look-Alike.
3. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
4. Be a current participant in the Department of Social Services (DSS) PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from The Joint Commission. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA or The Joint Commission PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time.
5. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

B. Advanced Networks

An Advanced Network is a provider organization or group of provider organizations that must include one or more physician group(s) (primary care physician(s), APRN(s), and/or physician assistant(s)), APRN group(s), individual physician(s), and/or individual APRN(s) (a "practice") that practices primary care and is currently participating in the DSS PCMH program (other than a Glide Path practice), as described in section 5 of Attachment 4.19-B. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time. Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;

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MEDICALLY NEEDY GROUP(S): ALL

3. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers, and one or more hospital(s); or
4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s).

Advanced Networks must designate an Advanced Network Lead Entity that is a provider or provider organization participating in the Advanced Network. The Advanced Network Lead Entity must designate a clinical director and a senior leader, ensure that the required Enhanced Care Coordination Activities are implemented as intended, and receive any shared savings achieved and distribute the shared savings to Advanced Network participating providers according to its plan, which must be approved by DSS. If the Advanced Network is comprised of more than one provider organization, the Advanced Network Lead Entity must have a contractual relationship with all other Advanced Network participating providers that meet requirements established by DSS.

C. Requirements for All Participating Entities

In addition to complying with the requirements specific to only FQHCs or Advanced Networks, all Participating Entities, whether FQHCs or Advanced Networks, must also demonstrate to DSS, through the state's procurement process, that they:

1. Have at least 2,500 DSS PCMH program attributed Medicaid beneficiaries who are eligible for PCMH+ at the time that DSS assigns beneficiaries to the Participating Entity using the methodology detailed in Attachment 4.19-B.
2. Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to PCMH+ members.
3. Meet DSS's requirements for maintaining an oversight body that monitors the Participating Entity's implementation of PCMH+.
4. Have appropriate organizational capacity, including governance and oversight, for implementing PCMH+.
5. Will ensure and promote transparency, community participation, and PCMH+ member participation in the operation of PCMH+.
6. Have a planned and documented approach for providing Enhanced Care Coordination Activities (see Section B) and, in the case of FQHCs, Care Coordination Add-On Payment Activities (see Section B).

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7. Will support the integration of behavioral health services and supports into existing operations.
8. Will develop and maintain contractual or informal written partnerships with local community partners in order to impact social determinants of health, promote physical and behavioral health integrated care, and assist beneficiaries in utilizing their Medicaid benefits.
9. Have a planned and documented approach to monitor and improve the quality of care provided to PCMH+ members, including a plan to monitor, prevent, and address under-utilization of medically necessary services.
10. Will participate in quality measurement activities as required by DSS.
11. Will participate in program oversight activities conducted by DSS or its designee to ensure compliance with program requirements.
12. Comply with all requirements of DSS's procurement process for PCMH+.
13. Will not limit a beneficiary's ability to receive services from a provider that is not affiliated with the Participating Entity.
14. Will require any non-DSS PCMH primary care practices within the Participating Entity to become a DSS PCMH practice within eighteen (18) months of the start of the first PCMH+ Performance Year. DSS may extend this timeframe for PCMH recognition based on good cause outside of the Participating Entity's control, including, but not limited to, NCQA approval delays, electronic health records (EHR) system vendor delays, or resignation of staff members who are key to the NCQA or other accreditation processes. Practices that do not achieve this milestone will be issued a corrective action plan. The corrective action plan will establish timeframes for the practice(s) to address gaps in order to become a DSS PCMH practice. DSS will monitor compliance with the corrective action plan until DSS PCMH status has been reached. Non-compliance with corrective action plans will result in termination of the Participating Entity's PCMH+ contract with DSS, and ineligibility to receive any PCMH+ shared savings payments for that performance year.
15. Will not distribute shared savings to any individual practitioner within the Participating Entity using any factors that would reward such individual for his or her specific contributions to the overall savings generated by the Participating Entity.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL

II. Service Description: Care Coordination

Participating Entities that meet quality benchmarks described below will be eligible to receive shared savings payments based on the shared savings calculation for their assigned PCMH+ members, as described in Attachment 4.19-B.

All Participating Entities provide Enhanced Care Coordination Activities to beneficiaries assigned to the Participating Entity to improve the quality, efficiency, and effectiveness of care delivered to PCMH+ members. Participating Entities that are FQHCs will also provide Care Coordination Add-On Payment Activities in addition to the Enhanced Care Coordination Activities. The Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those activities are posted on DSS's website at: <http://www.ct.gov/dss/pcmh+>.

The care coordination services provided by the Participating Entity are person-centered and fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Participating Entity's available resources for providing care coordination to that individual, as well as all individuals for which the Contractor is responsible for providing care. Each Participating Entity is required to provide Enhanced Care Coordination Activities (and, for Participating Entities that are FQHCs, also Care Coordination Add-On Payment Activities) only to the extent desired by PCMH+ members and only to the extent feasible within the Participating Entity's available resources for providing such services, as determined by the Department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

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State: Connecticut

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDED GROUP(S): ALL

III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards for quality measures, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: <http://www.ct.gov/dss/pcmh+>.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated as part of the Year 1 Program Evaluation.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures), service utilization and service cost reporting, and member movement to and from PCMH+ practices. DSS will also conduct a PCMH+ member survey to evaluate the first Performance Year. Participating Entities that are found to have systematically under-served members or manipulated their panel will not be eligible for shared savings payments.

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State: ConnecticutAMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): ALL**V. Covered Populations**

For the purposes of calculating shared savings payments and Care Coordination Add-On Payments, all Connecticut Medicaid beneficiaries attributed to an FQHC that is a PCMH+ Participating Entity or attributed to a DSS PCMH practice or practice entity within an Advanced Network are eligible for PCMH+, except for the following:

1. Behavioral Health Home (BHH) participants (authorized by section 1945), as detailed in Attachment 3.1-H are excluded from PCMH+ because those individuals are eligible to receive care coordination from the health home.
2. Partial Medicaid/Medicare dual eligible beneficiaries are excluded from PCMH+ because those individuals are not eligible to receive any Medicaid benefits other than specified Medicare cost sharing, as applicable. Individuals who are participating in a Medicare Accountable Care Organization (ACO) are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the ACO and because they are already participating in a shared savings program. Individuals who are enrolled in a Medicare Advantage plan are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the Medicare Advantage Plan.
3. Home and community-based services section 1915(c) waiver, section 1915(i) (as detailed in Attachment 3.1-i), and section 1915(k) participants (as detailed in Attachment 3.1-K) are all excluded from PCMH+ because those individuals are all eligible to receive care coordination services in connection with the service planning process that is part of each of those programs.
4. Money Follows the Person (MFP) participants are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the MFP program.
5. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and other long-term care institutions that are required to coordinate care for their residents are excluded from PCMH+ because those institutions are required to coordinate care for their residents and, as such, those individuals are eligible to receive such care coordination services.
6. Beneficiaries who are enrolled in Connecticut Medicaid solely to receive a limited benefit package (current limited benefit packages include family planning, breast and cervical cancer, and tuberculosis) are excluded from PCMH+ because those individuals are not eligible for the full package of Medicaid services and it is not appropriate for a PCMH+ Participating Entity to be measured for the impact of their interventions for those individuals

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MEDICALLY NEEDY GROUP(S): ALL

on Medicaid expenditures, as those individuals likely receive a variety of services from non-Medicaid sources.

7. Beneficiaries who are receiving hospice services are excluded from PCMH+ because hospice providers are required to coordinate the care of their patients and because it is not appropriate to provide incentives for shared savings within PCMH+ for individuals who are terminally ill.

The state assures that full Medicaid/Medicare dual eligible beneficiaries who do not fall within one or more of the categories listed immediately above have access to care coordination services included in PCMH+ if those individuals desire such services. Accordingly, the dual eligible individuals described in the previous sentence are excluded from PCMH+ only for purposes of calculating shared savings payments and Care Coordination Add-On Payments, but those individuals will receive Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities).

VI. Limitation

The provision of services under PCMH+ shall not duplicate the locating, coordinating, and monitoring of health care services provided under the PCMH program, as described in section 5 of Attachment 4.19-B or as Medicaid administrative services provided by one or more of DSS's Administrative Services Organizations.

VII. Assurances

The following beneficiary protections in section 1905(t) of the Act apply to PCMH+:

1. Section 1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of Medicaid providers.
2. Section 1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high-quality care in a prompt manner, is met because beneficiaries are afforded free choice of Medicaid providers and because the PCMH+ assignment methodology ensures that only patients who have a relationship with providers in a Participating Entity are assigned to that Participating Entity.

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3. Section 1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because Participating Entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.
4. Section 1905(t)(3)(F), which refers to section 1932 and requires notification to beneficiaries of the program, including how personal information will be used, and disclosure of any correlative payment arrangements, is met because DSS will notify beneficiaries that they have been assigned to a PCMH Participating Entity prior to the start of the Performance Year.

DSS makes the following assurances:

1. The PCMH+ program does not restrict members' free choice of provider as described in 42 C.F.R. § 431.51.
2. Any Advanced Network or FQHC that meets the qualifications established by DSS for a PCMH+ Participating Entity and submits a successful response to the request for proposals in accordance with DSS's procurement process will be allowed to participate in PCMH+.
3. Section 1903(d)(I), which provides for protections against fraud and abuse, is met in that all providers participating in a Participating Entity are enrolled as providers with Connecticut Medicaid and are bound by the rules of the Medicaid program.
4. Section 1902(a)(30)(A), which requires that services under PCMH+ are available to members at least to the extent they are available to the general population, is met because PCMH+ members will have free choice of Medicaid providers.

VIII. Monitoring and Reporting

PCMH+ includes a set of internal monitoring and reporting measures that will be collected and analyzed not less than quarterly. DSS will review the information and follow up with Participating Entities as needed regarding their performance. As a condition of continuing to implement PCMH+ beyond any expiration date specified in Attachment 4.19-B, if applicable, DSS will evaluate PCMH+ to determine if there has been improvement compared with past performance to determine whether the program has achieved, or needs revisions to achieve, the goals of the program, including improving health outcomes and the care experience for PCMH+ members, preserving the PCMH program in particular and the Medicaid program in general and preventing any harm to those programs and/or members of those programs.

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DSS will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the PCMH+ program against the goals of the program.
2. Provide CMS, at least annually, with updates, as conducted, to DSS's metrics.
3. Review and, if necessary, update or revise the payment methodology as part of the evaluation.
4. Make all necessary modifications to the methodology, including those determined based on the evaluation of program success. If changes to the methodology are different from the approved methodology in the applicable federal authority, then DSS will propose appropriate updates to the federal authority.

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MEDICALLY NEEDY GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated care models.

Provided: No limitations With limitations*
 Not provided

* See Addendum to Attachment 3.1-B.

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MEDICALLY NEEDED GROUP(S): ALL

29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

The overall goals of the Person-Centered Medical Home Plus (PCMH+) program are to improve health outcomes and care experience for Medicaid beneficiaries who are PCMH+ members, while building upon and preserving both the PCMH program in particular (as described in section 5 of Attachment 4.19-B), as well as overall improvement in quality, access, and cost control in Connecticut's Medicaid program. Participating Entities that meet identified benchmarks on quality measures, while also demonstrating shared savings (and complying with measures to prevent under-service) will be eligible to receive shared savings payments, all as described in more detail below and in Attachment 4.19-B.

I. Provider Qualifications

Under the PCMH+ program, the State will contract with PCMH+ Participating Entities (Participating Entities), which are Federally Qualified Health Centers (FQHCs) or Advanced Networks, each as defined below, to provide the care coordination services described below. Participating Entities must include primary care providers (primary care physicians, advanced practice registered nurses (APRNs) / nurse practitioners, and/or physician assistants) who provide primary care case management (PCCM) services in accordance with section 1905(t) of the Social Security Act (Act), which includes location, coordination and monitoring of health care services. Pursuant to section 1905(t)(2)(A)-(B) of the Act, a Participating Entity must be, employ, or contract with a physician, a physician group practice, APRNs/nurse practitioners, physician assistants, or an entity employing or having other arrangements with physicians to provide such services. The Participating Entity provides services in the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine, and pediatrics.

A. Federally Qualified Health Centers (FQHCs)

An FQHC is an entity, as defined in section 2 of Attachment 3.1-A, including an FQHC look-alike, which must:

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1. Meet all requirements of an FQHC under section 1905(l)(2)(B) of the Social Security Act.
2. Meet all requirements of the Health Resources and Services Administration (HRSA) Health Center Program and have either: (A) HRSA grant funding as an FQHC under Section 330 of the Public Health Services Act or (B) HRSA designation as an FQHC Look-Alike.
3. Operate in Connecticut and meet all federal and state requirements applicable to FQHCs.
4. Be a current participant in the Department of Social Services (DSS) PCMH program (Glide Path practices are excluded) and hold current Level 2 or 3 Patient-Centered Medical Home recognition from the National Committee for Quality Assurance (NCQA) or Primary Care Medical Home certification from The Joint Commission. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA or The Joint Commission PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time.
5. Identify a clinical director and senior leader to represent the FQHC and champion PCMH+ goals.

B. Advanced Networks

An Advanced Network is a provider organization or group of provider organizations that must include one or more physician group(s) (primary care physician(s), APRN(s), and/or physician assistant(s)), APRN group(s), individual physician(s), and/or individual APRN(s) (a "practice") that practices primary care and is currently participating in the DSS PCMH program (other than a Glide Path practice), as described in section 5 of Attachment 4.19-B. Glide Path practices are excluded from PCMH+ because they provide some, but not all, of the Medicaid services required for NCQA PCMH recognition. In order to qualify for Glide Path, a practice must have demonstrated to DSS that it has begun providing a more advanced standard of primary care and has committed to achieving NCQA or The Joint Commission PCMH recognition in a set period of time. Acceptable options for Advanced Network composition include:

1. One or more DSS PCMH practice(s);
2. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers;

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3. One or more DSS PCMH practice(s) plus specialist(s), which could include physical health, behavioral health, and oral health providers, and one or more hospital(s); or
4. A Medicare Accountable Care Organization (ACO) that includes one or more DSS PCMH practice(s).

Advanced Networks must designate an Advanced Network Lead Entity that is a provider or provider organization participating in the Advanced Network. The Advanced Network Lead Entity must designate a clinical director and a senior leader, ensure that the required Enhanced Care Coordination Activities are implemented as intended, and receive any shared savings achieved and distribute the shared savings to Advanced Network participating providers according to its plan, which must be approved by DSS. If the Advanced Network is comprised of more than one provider organization, the Advanced Network Lead Entity must have a contractual relationship with all other Advanced Network participating providers that meet requirements established by DSS.

C. Requirements for All Participating Entities

In addition to complying with the requirements specific to only FQHCs or Advanced Networks, all Participating Entities, whether FQHCs or Advanced Networks, must also demonstrate to DSS, through the state's procurement process, that they:

1. Have at least 2,500 DSS PCMH program attributed Medicaid beneficiaries who are eligible for PCMH+ at the time that DSS assigns beneficiaries to the Participating Entity using the methodology detailed in Attachment 4.19-B.
2. Ensure that only providers enrolled in Connecticut Medicaid are providing Medicaid services to PCMH+ members.
3. Meet DSS's requirements for maintaining an oversight body that monitors the Participating Entity's implementation of PCMH+.
4. Have appropriate organizational capacity, including governance and oversight, for implementing PCMH+.
5. Will ensure and promote transparency, community participation, and PCMH+ member participation in the operation of PCMH+.
6. Have a planned and documented approach for providing Enhanced Care Coordination Activities (see Section B) and, in the case of FQHCs, Care Coordination Add-On Payment Activities (see Section B).

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7. Will support the integration of behavioral health services and supports into existing operations.
8. Will develop and maintain contractual or informal written partnerships with local community partners in order to impact social determinants of health, promote physical and behavioral health integrated care, and assist beneficiaries in utilizing their Medicaid benefits.
9. Have a planned and documented approach to monitor and improve the quality of care provided to PCMH+ members, including a plan to monitor, prevent, and address under-utilization of medically necessary services.
10. Will participate in quality measurement activities as required by DSS.
11. Will participate in program oversight activities conducted by DSS or its designee to ensure compliance with program requirements.
12. Comply with all requirements of DSS's procurement process for PCMH+.
13. Will not limit a beneficiary's ability to receive services from a provider that is not affiliated with the Participating Entity.
14. Will require any non-DSS PCMH primary care practices within the Participating Entity to become a DSS PCMH practice within eighteen (18) months of the start of the first PCMH+ Performance Year. DSS may extend this timeframe for PCMH recognition based on good cause outside of the Participating Entity's control, including, but not limited to, NCQA approval delays, electronic health records (EHR) system vendor delays, or resignation of staff members who are key to the NCQA or other accreditation processes. Practices that do not achieve this milestone will be issued a corrective action plan. The corrective action plan will establish timeframes for the practice(s) to address gaps in order to become a DSS PCMH practice. DSS will monitor compliance with the corrective action plan until DSS PCMH status has been reached. Non-compliance with corrective action plans will result in termination of the Participating Entity's PCMH+ contract with DSS, and ineligibility to receive any PCMH+ shared savings payments for that performance year.
15. Will not distribute shared savings to any individual practitioner within the Participating Entity using any factors that would reward such individual for his or her specific contributions to the overall savings generated by the Participating Entity.

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MEDICALLY NEEDY GROUP(S): ALL

II. Service Description: Care Coordination

Participating Entities that meet quality benchmarks described below will be eligible to receive shared savings payments based on the shared savings calculation for their assigned PCMH+ members, as described in Attachment 4.19-B.

All Participating Entities provide Enhanced Care Coordination Activities to beneficiaries assigned to the Participating Entity to improve the quality, efficiency, and effectiveness of care delivered to PCMH+ members. Participating Entities that are FQHCs will also provide Care Coordination Add-On Payment Activities in addition to the Enhanced Care Coordination Activities. The Enhanced Care Coordination Activities and Care Coordination Add-On Payment Activities have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those activities are posted on DSS's website at: <http://www.ct.gov/dss/pcmh+>.

The care coordination services provided by the Participating Entity are person-centered and fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the Participating Entity's available resources for providing care coordination to that individual, as well as all individuals for which the Contractor is responsible for providing care. Each Participating Entity is required to provide Enhanced Care Coordination Activities (and, for Participating Entities that are FQHCs, also Care Coordination Add-On Payment Activities) only to the extent desired by PCMH+ members and only to the extent feasible within the Participating Entity's available resources for providing such services, as determined by the Department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

All Medicaid claim costs for covered services will be included in the shared savings calculations described in Attachment 4.19-B, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

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III. Quality Measures

In addition to providing the Enhanced Care Coordination Activities (and for Participating Entities that are FQHCs, also the Care Coordination Add-On Payment Activities) in order to be eligible to receive shared savings payments, if applicable, each PCMH+ Participating Entity must also maintain and/or improve the quality of care and care experience for beneficiaries assigned to the Participating Entity, as measured by various quality measures. Specifically, in order to be eligible to receive shared savings payments, each PCMH+ Participating Entity must meet specified standards for quality measures, as described in Attachment 4.19-B. The PCMH+ quality measure set contains process and outcome measures that include measures of beneficiary experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in Attachment 4.19-B. All of the quality measures have been updated as of January 1, 2017 and apply to Performance Years beginning on or after that date and a description of those measures, including the use of each such measure in calculating shared savings payments, is posted to DSS's website at: <http://www.ct.gov/dss/pcmh+>.

The quality measure set will be reviewed annually and updated as deemed necessary by DSS. Changes in the measure set will be derived from recommendations generated as part of the Year 1 Program Evaluation.

IV. Measures to Prevent Under-Service

Participating Entities will be disqualified from receiving shared savings payments if they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel, whether or not there is evidence of intentionality. DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures), service utilization and service cost reporting, and member movement to and from PCMH+ practices. DSS will also conduct a PCMH+ member survey to evaluate the first Performance Year. Participating Entities that are found to have systematically under-served members or manipulated their panel will not be eligible for shared savings payments.

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V. Covered Populations

For the purposes of calculating shared savings payments and Care Coordination Add-On Payments, all Connecticut Medicaid beneficiaries attributed to an FQHC that is a PCMH+ Participating Entity or attributed to a DSS PCMH practice or practice entity within an Advanced Network are eligible for PCMH+, except for the following:

1. Behavioral Health Home (BHH) participants (authorized by section 1945), as detailed in Attachment 3.1-H are excluded from PCMH+ because those individuals are eligible to receive care coordination from the health home.
2. Partial Medicaid/Medicare dual eligible beneficiaries are excluded from PCMH+ because those individuals are not eligible to receive any Medicaid benefits other than specified Medicare cost sharing, as applicable. Individuals who are participating in a Medicare Accountable Care Organization (ACO) are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the ACO and because they are already participating in a shared savings program. Individuals who are enrolled in a Medicare Advantage plan are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the Medicare Advantage Plan.
3. Home and community-based services section 1915(c) waiver, section 1915(i) (as detailed in Attachment 3.1-i), and section 1915(k) participants (as detailed in Attachment 3.1-K) are all excluded from PCMH+ because those individuals are all eligible to receive care coordination services in connection with the service planning process that is part of each of those programs.
4. Money Follows the Person (MFP) participants are excluded from PCMH+ because those individuals are eligible to receive care coordination services through the MFP program.
5. Residents of nursing facilities, intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and other long-term care institutions that are required to coordinate care for their residents are excluded from PCMH+ because those institutions are required to coordinate care for their residents and, as such, those individuals are eligible to receive such care coordination services.
6. Beneficiaries who are enrolled in Connecticut Medicaid solely to receive a limited benefit package (current limited benefit packages include family planning, breast and cervical cancer, and tuberculosis) are excluded from PCMH+ because those individuals are not eligible for the full package of Medicaid services and it is not appropriate for a PCMH+ Participating Entity to be measured for the impact of their interventions for those individuals

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on Medicaid expenditures, as those individuals likely receive a variety of services from non-Medicaid sources.

7. Beneficiaries who are receiving hospice services are excluded from PCMH+ because hospice providers are required to coordinate the care of their patients and because it is not appropriate to provide incentives for shared savings within PCMH+ for individuals who are terminally ill.

The state assures that full Medicaid/Medicare dual eligible beneficiaries who do not fall within one or more of the categories listed immediately above have access to care coordination services included in PCMH+ if those individuals desire such services. Accordingly, the dual eligible individuals described in the previous sentence are excluded from PCMH+ only for purposes of calculating shared savings payments and Care Coordination Add-On Payments, but those individuals will receive Enhanced Care Coordination Activities (and, for FQHCs, also Care Coordination Add-On Payment Activities).

VI. Limitations

The provision of services under PCMH+ shall not duplicate the locating, coordinating, and monitoring of health care services provided under the PCMH program, as described in section 5 of Attachment 4.19-B or as Medicaid administrative services provided by one or more of DSS's Administrative Services Organizations.

VII. Assurances

The following beneficiary protections in section 1905(t) of the Act apply to PCMH+:

1. Section 1905(t)(3)(A), which requires primary care case managers to maintain reasonable hours of operation and 24-hour availability of referral and treatment, is met because beneficiaries are afforded free choice of Medicaid providers.
2. Section 1905(t)(3)(C), which requires primary care case managers to ensure the availability of a sufficient number of health care professionals to provide high-quality care in a prompt manner, is met because beneficiaries are afforded free choice of Medicaid providers and because the PCMH+ assignment methodology ensures that only patients who have a relationship with providers in a Participating Entity are assigned to that Participating Entity.

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3. Section 1905(t)(3)(D), which prohibits discrimination on the basis of health status in enrollment and disenrollment, is met because Participating Entities will be prohibited by contract from activities designed to result in selective recruitment and attribution of individuals with more favorable health status.
4. Section 1905(t)(3)(F), which refers to section 1932 and requires notification to beneficiaries of the program, including how personal information will be used, and disclosure of any correlative payment arrangements, is met because DSS will notify beneficiaries that they have been assigned to a PCMH Participating Entity prior to the start of the Performance Year.

DSS makes the following assurances:

1. The PCMH+ program does not restrict members' free choice of provider as described in 42 C.F.R. § 431.51.
2. Any Advanced Network or FQHC that meets the qualifications established by DSS for a PCMH+ Participating Entity and submits a successful response to the request for proposals in accordance with DSS's procurement process will be allowed to participate in PCMH+.
3. Section 1903(d)(1), which provides for protections against fraud and abuse, is met in that all providers participating in a Participating Entity are enrolled as providers with Connecticut Medicaid and are bound by the rules of the Medicaid program.
4. Section 1902(a)(30)(A), which requires that services under PCMH+ are available to members at least to the extent they are available to the general population, is met because PCMH+ members will have free choice of Medicaid providers.

VIII. Monitoring and Reporting

PCMH+ includes a set of internal monitoring and reporting measures that will be collected and analyzed not less than quarterly. DSS will review the information and follow up with Participating Entities as needed regarding their performance. As a condition of continuing to implement PCMH+ beyond any expiration date specified in Attachment 4.19-B, if applicable, DSS will evaluate PCMH+ to determine if there has been improvement compared with past performance to determine whether the program has achieved, or needs revisions to achieve, the goals of the program, including improving health outcomes and the care experience for PCMH+ members, preserving the PCMH program in particular and the Medicaid program in general and preventing any harm to those programs and/or members of those programs.

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DSS will:

1. Provide CMS, at least annually, with data and reports evaluating the success of the PCMH+ program against the goals of the program.
2. Provide CMS, at least annually, with updates, as conducted, to DSS's metrics.
3. Review and, if necessary, update or revise the payment methodology as part of the evaluation.
5. Make all necessary modifications to the methodology, including those determined based on the evaluation of program success. If changes to the methodology are different from the approved methodology in the applicable federal authority, then DSS will propose appropriate updates to the federal authority.

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29. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (continued)

g. Integrated Care Models

1. PERSON-CENTERED MEDICAL HOME PLUS (PCMH+) PROGRAM

I. Overview

Person-Centered Medical Home Plus (PCMH+) Participating Entities that generate savings for the Medicaid program and that meet identified benchmarks on quality performance standards will be eligible to receive shared savings payments in accordance with the methodology described below, so long as they comply with measures of under-service. Shared savings payments will be made to qualifying Participating Entities following the end of a Performance Year. Once data is collected and analyzed at the end of a performance year, savings payments will be made to qualifying Participating Entities no later than the last day of December following the end of that Performance Year. If the Participating Entity is an Advanced Network, the Advanced Network Lead Entity will receive the shared savings payment and distribute the payment among its participating providers according to their participation agreements, which must be approved by DSS before any payments are made.

Shared savings payments are available to eligible Participating Entities through two savings pools. The first pool is an Individual Savings Pool, where each Participating Entity that meets the quality benchmarks will receive a shared savings payment based on a portion of the savings it achieved individually. The second pool is a Challenge Pool that aggregates all savings not awarded to Participating Entities in the Individual Savings Pool such as due to failure to meet identified benchmarks on quality performance standards or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. To be eligible for a Challenge Pool payment, a Participating Entity must improve quality in total year-over-year and must meet DSS's benchmarks on four Challenge Pool quality measures.

In addition, Participating Entities that are FQHCs will receive monthly per-member-per-month (PMPM) payments for Care Coordination Add-On Payment Activities that the FQHC provides to PCMH+ members, as described below.

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PCMH+ does not change any other reimbursement methodology that is available to any provider, including providers that are PCMH+ Participating Entities (or providers that are included in PCMH+ Participating Entities, including one or more PCMH practices within a PCMH+ Participating Entity). Accordingly, applicable fee-for-service payments will continue to be made to all qualified Medicaid providers that provide any Medicaid covered service to a beneficiary assigned to a PCMH+ Participating Entity.

II. Covered Populations

For the purposes of calculating shared savings, all Connecticut Medicaid beneficiaries attributed to the Department of Social Services (DSS) PCMH program are eligible for PCMH+ except for the categories of individuals listed as excluded from PCMH+ in Attachment 3.1-A.

III. Assignment Methodology

Eligible beneficiaries (*i.e.*, excluding categories of beneficiaries listed as excluded from PCMH+ in Attachment 3.1-A) will be assigned to PCMH+ Participating Entities on the basis of the PCMH retrospective attribution methodology described in section 5 of Attachment 4.19-B. Beneficiaries may affirmatively select a PCMH practice as their primary care provider. In the absence of beneficiary selection, the PCMH attribution methodology retrospectively assigns beneficiaries to primary care practitioners based on claims volume. If a beneficiary receives care from multiple providers during a given period, the beneficiary is assigned to the practice that provided the plurality of care and, if there is no single largest source of care, to the most recent source of care.

A Participating Entity's assigned beneficiaries are the beneficiaries attributed to its PCMH practices using this methodology less beneficiaries that are not eligible for PCMH+ as provided in Attachment 3.1-A. Even if an Advanced Network includes other providers, only the beneficiaries attributed to the PCMHs (or a PCMH practice entity) in the Advanced Network will be assigned to the PCMH+ Participating Entity.

PCMH+ assignment will occur once annually, and will last for the entire Performance Year (unless during the course of the Performance Year, an individual opts out of PCMH+ or falls into a category of individuals excluded from PCMH+, as described in more detail below).

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Assignment will occur on or before November 30th for each entire Performance Year starting on each following January 1st. Beneficiaries will be assigned to only one Participating Entity for each Performance Year. Any change in the beneficiary's PCMH attribution will be reflected in the following year's PCMH+ assignment.

Beneficiaries may choose to opt-out of prospective assignment to a PCMH+ Participating Entity before the implementation date of PCMH+ and also at any time throughout the Performance Year. If a beneficiary opts out of PCMH+, then that beneficiary's claim costs will be removed from the assigned Participating Entity's shared savings calculation; however, this beneficiary's quality data and applicable data regarding measures of under-service (as described in Attachment 3.1-A) will not be excluded. If a beneficiary opts out of PCMH+, the Participating Entity is not required to provide Enhanced Care Coordination Activities to that beneficiary. Additionally, if the beneficiary's assigned Participating Entity was an FQHC, then that FQHC will no longer receive the Care Coordination Add-On Payment for that beneficiary.

If, over the course of a Performance Year, a PCMH+ member moves into a population that is not eligible for PCMH+ (see Attachment 3.1-A), that change has the same effect as if an individual opts out of assignment to a PCMH+ Participating Entity, as described immediately above.

IV. Benefits Included in the Shared Savings Calculation

All Medicaid claim costs for covered services will be included in the shared savings calculations described below, except for: hospice; long-term services and supports (LTSS), including institutional and home and community-based services; and non-emergency medical transportation (NEMT) services. Participating Entities do not need to deliver all defined benefits; rather, the cost of all benefits provided to an assigned PCMH+ member, regardless of the specific provider that performed each service, will be included in the shared savings calculation.

V. Shared Savings Payment Methodology: Individual Savings Pool

A. Individual Savings Pool Quality Measures

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The quality measures applicable to the payment methodology are described in Attachment 3.1-A. Specified quality measures apply to a Participating Entity's Individual Savings Pool payment, other specified quality measures will be used in calculating the Challenge Pool payment, and a final category of specified measures will be reporting-only measures and will not be included in the shared savings payment calculation.

B. Individual Savings Pool Quality Scoring

The Participating Entity's shared savings payment in the Individual Savings Pool will be determined in part by the Participating Entity's total quality score. A Participating Entity's total quality score will be based on three components of quality measurement (maintain quality, improve quality, and absolute quality) for each of the nine quality measures. A maximum of one point is available for each component of quality measurement for each measure:

1. Maintain Quality: One point is awarded if a Participating Entity's Performance Year quality score is greater than or equal to its Prior Year score. (A statistically significant threshold may be established based on historical quality measure data to account for annual variation, which results in lower scores).
2. Improve Quality: A Participating Entity will earn points in accordance with the sliding scale included below based on its year-over-year performance (quality improvement trend) against the comparison group's quality improvement trend.

Improvement Above the Comparison Group's Quality Trend	Points Awarded
Less than or equal to Comparison Group's quality trend	0.00
Between 0.00% and 32.99%	0.25
Between 33.00% and 66.99%	0.50
Between 67.00% and 99.99%	0.75
100.00% or greater	1.00

3. Absolute Quality: A Participating Entity will earn points in accordance with the sliding scale included below for its ability to reach absolute quality targets, derived from the Comparison Group's quality scores.

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Performance Measured as Percentile of Comparison Group Performance	Points Awarded
49.99% or less	0.00
Between 50.00% and 59.99%	0.25
Between 60.00% and 69.99%	0.50
Between 70.00% and 79.99%	0.75
80.00% or greater	1.00

To calculate each Participating Entity's total quality score, its points will be summed and then divided by a maximum score of 27 points (three possible points per quality measure with nine total quality measures). The total quality score, expressed as a percent, will be used in calculating the portion of a Participating Entity's Individual Savings Pool that will be returned to the Participating Entity as shared savings.

C. Individual Savings Pool Calculation

Each Participating Entity's Individual Savings Pool will be funded by savings it generated during the Performance Year. The 12-month period of the Performance Year will be January 1, 2017 through December 31, 2017, and the prior year will be January 1, 2016 through December 31, 2016. As described in more detail below, the calculated savings will be subject to a minimum savings rate (MSR), limited by a savings cap, and multiplied by a sharing factor to generate the available Individual Savings Pool shared savings payment amounts, if any.

For each Participating Entity, the calculation of savings will be based on the extent to which the Participating Entity achieved a lower cost trend than the Comparison Group. For the Performance Year from January 1, 2017 through December 31, 2017, the Comparison Group will consist of all FQHCs and non-FQHC full DSS PCMH practices that have at least 2,500 attributed PCMH+ eligible Medicaid members and have full PCMH status in the DSS PCMH program but are not participating in PCMH+, except that DSS may exclude one or more practices from the comparison group in order to ensure statistical validity. Based on the number of eligible FQHCs and PCMHs that elect to participate in the PCMH+ Program in Performance Years occurring after calendar year 2017, the Comparison Group may be adjusted to include additional practices to provide a Comparison Group that is sufficiently large to be statistically valid.

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Savings will only be calculated based on PCMH+ members who remain assigned for at least 11 months of the Performance Year. Cost data of members who opt out of PCMH+ will not be used in the calculation of shared savings. In addition, to avoid unwanted bias due to outlier cases, for each PCMH+ member, annual claims will be truncated at \$100,000, so that expenses above \$100,000 will not be included in the calculation.

The first step in calculating savings is to derive the Prior Year Cost and the Performance Year Cost for each Participating Entity and for the Comparison Group. Risk adjustment methods (based on existing Johns Hopkins Adjusted Clinical Groups (ACG) retrospective risk scores) will be used to adjust both Prior Year and Performance Year costs for underlying differences in illness burden. The Comparison Group Trend is derived as the Risk Adjusted Performance Year Cost divided by the Risk Adjusted Prior Year Cost.

A Participating Entity's Risk Adjusted Expected Performance Year costs will be developed by multiplying the Entity's Risk Adjusted Prior Year Cost by the Comparison Group Trend. A Participating Entity's savings will be the difference between its Risk Adjusted Expected Performance Year costs and its actual Risk Adjusted Performance Year costs. Participating Entities that demonstrate losses (i.e., higher than expected expenditures for beneficiaries assigned to the Participating Entity) will not return these losses.

*Savings = (Risk Adjusted Prior Year Costs * Comparison Group Trend) – Risk Adjusted Performance Year Costs*

Minimum Savings Rate: A Participating Entity's risk-adjusted savings must meet the MSR requirement, which is greater than or equal to 2% of the expected Performance Year Costs. If a Participating Entity meets the MSR requirement, then the first-dollar savings (i.e., all savings generated, including amounts below the MSR threshold) will be considered as savings. If a Participating Entity does not meet the MSR requirement, its savings will not be considered. Likewise, losses between 0% and -2% will not be considered credible when deriving the aggregate program savings.

*MSR Adj. Savings = IF (Savings ≥ 0.02 * Expected Risk Adj. Performance Year Costs, Savings, 0)*

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Savings Cap: A Participating Entity's savings will be capped at 10% of its Risk Adjusted Expected Performance Year Costs, so that any savings above 10% will not be included in its Individual Savings Pool.

*Capped MSR Adj. Savings = Min (MSR Adj. Savings, 0.10 * Expected Risk Adj. Performance Year Costs)*

Sharing Factor: If a Participating Entity has savings following the calculation steps above, these savings will be multiplied by a Sharing Factor of 50%. The resulting amount will form the Entity's Individual Savings Pool.

*Individual Savings Pool = Capped MSR Adj. Savings * 0.50*

D. Individual Pool Shared Savings Calculation

For each Participating Entity, the Individual Savings Pool Shared Savings payment, if any, is equal to the Individual Savings Pool times the Total Individual Pool Quality Score defined above.

*Individual Savings Pool Shared Savings = Individual Savings Pool * Total Quality Score*

VI. Shared Savings Payment Methodology: Challenge Pool

A. Challenge Pool Eligibility

To be eligible for a Challenge Pool payment, a Participating Entity must improve its overall performance year-over-year on the measures that apply to the Individual Savings Pool.

B. Challenge Pool Funding

It is expected that one or more Participating Entities may not receive 100% of their Individual Savings Pool as shared savings payments because of less than perfect scores on the applicable quality measures or because DSS determined that the Participating Entity systematically engaged in under-service for Medicaid members. The amounts not

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returned will be aggregated to form a target amount for the Challenge Pool. The Challenge Pool funding is limited so as to ensure that the Challenge Pool payments will not exceed the Aggregate Savings of the PCMH+ program less the Aggregate Individual Shared Savings payments. For this test, the Aggregate Savings of the PCMH+ program is defined as all credible savings and losses for all Participating Entities (*i.e.*, subject to the MSR requirement and subject to all other requirements for calculating available individual savings pool shared savings, as described above).

Aggregate Savings = \sum Savings and losses subject to the MSR for all Participating Entities

Challenge Pool Target = \sum Not Returned Individual Savings Pool Amounts

Challenge Pool Limit = Aggregate Savings – \sum Individual Savings Pool Shared Savings

Challenge Pool Funding = Minimum (Challenge Pool Limit, Challenge Pool Target)

Note: The Challenge Pool Funding cannot be negative.

C. Challenge Pool Quality Measure Scoring

For each of the four Challenge Pool quality measures, Participating Entities that achieve at least the median score (of all Participating Entities) for a Challenge Pool quality measure will pass or get credit for that measure.

D. Challenge Pool Distribution

The amount of the Participating Entity's Challenge Pool payment, if any, will be the product of the number of its assigned PCMH+ members times the number of Challenge Pool quality measures passed, divided by the sum of this statistic across all Participating Entities. As such, it is certain that the full Challenge Pool will be returned. It should be noted that the Challenge Pool payment to any particular Participating Entity is not directly related to its individual savings.

*Challenge Pool Distribution Participating Entity A = (Participating Entity A Number of Challenge measures passed * Number Assigned PCMH+ Members in Participating*

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*Entity A) / (\sum Participating Entity Number of measures passed * Participating Entity Number of Members)*

VI. Care Coordination Add-On Payment Methodology (FOHCs Only)

DSS will make Care Coordination Add-On Payments prospectively to Participating Entities that are FQHCs on a monthly basis using a per-member per-month (PMPM) amount for each beneficiary assigned to the FQHC, using the assignment methodology described above. DSS will factor the Care Coordination Add-On Payments in each FQHC's shared savings calculation. For the Performance Year for dates of service for calendar year 2017, except as otherwise provided below, the PMPM payment amount is \$4.50.

For the Performance Year for dates of service for calendar year 2017, the total pool of funds for making Care Coordination Add-On Payments is \$5.57 million. Notwithstanding the PMPM payment amount listed above, if DSS determines that this total pool of funds may be reached or exceeded in a calendar month, DSS shall reduce the PMPM amount for that month as necessary in order to remain within the total pool of funds and no PMPM payments will be made for any subsequent months in the performance year.

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State of Connecticut
Regulation of
Department of Social Services
Concerning
Person-Centered Medical Home Plus (PCMH+) Program

Section 1. The Regulations of the Connecticut State Agencies are amended by adding sections 17b-262-1095 to 17b-262-1108, inclusive, as follows:

(NEW) Sec. 17b-262-1095. Scope and Program Overview

(a) Pursuant to the authority of sections 17b-3, 17b-11, 17b-260 and 17b-263c of the Connecticut General Statutes, the department is implementing the PCMH+ program. Sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies set forth the department's requirements for the PCMH+ program.

(b) The goals of PCMH+ are to improve health outcomes and care experience for PCMH+ members, while building upon and preserving both the PCMH program and overall efforts to improve quality, access and contain the growth of health care costs in Medicaid.

(c) Participating entities that the department determines generate savings for Medicaid and meet identified benchmarks on quality performance standards will be eligible to receive individual shared savings payments in accordance with the applicable methodology, so long as they comply with measures of under-service. Challenge pool payments may also be available for participating entities that meet specified quality benchmarks. Participating entities that are FQHCs will receive care coordination add-on PMPM payments for providing additional specified care coordination activities.

(d) PCMH+ is an upside-only shared savings program. Accordingly, if the department finds that one or more participating entities generated increased costs for Medicaid, each such participating entity shall not be required to pay the department for any portion of increased costs.

(NEW) Sec. 17b-262-1096. Definitions

As used in sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Advanced network" means a provider organization or group of provider organizations that shall include primary care providers within one or more practices with PCMH status or PCMH accreditation, as applicable, but not including a glide path practice, and that complies with the composition specified in section 17b-262-1098 of the Regulations of Connecticut State Agencies;

(2) "Advanced network lead entity" means a provider or provider organization that contracts with the department on behalf of an advanced network. The department may require that an advanced network lead entity shall be a participating provider in the advanced network;

(3) "Advanced practice registered nurse" or "APRN" means an individual licensed pursuant to section 20-94a of the Connecticut General Statutes and practicing within the APRN's scope of practice under state law;

(4) "Care coordination" means the deliberate organization of patient care activities between two or more participants (including a member) involved in a member's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out required patient care activities and is often managed by the exchange of

information among participants responsible for different aspects of care. Care coordination does not mean that any individual has a legal right to any particular level or amount of services;

(5) "Care coordination add-on payment" means a PMPM payment paid prospectively on a monthly basis to participating entities that are FQHCs for providing care coordination add-on payment activities for PCMH+ members;

(6) "Care coordination add-on payment activities" means care coordination activities specified in writing by the department that participating entities that are FQHCs are required to provide to PCMH+ members in order to receive care coordination add-on payments for any given performance year;

(7) "Challenge pool shared savings payment" or "challenge pool payment" means a payment made by the department to a participating entity in accordance with subsection (c) of section 17b-262-1104;

(8) "CMMI" means the U.S. Center for Medicare and Medicaid Innovation;

(9) "CMS" means the U.S. Centers for Medicare and Medicaid Services;

(10) "Comparison group" means the group of health providers that the department has determined will be used to analyze the expected cost trends in connection with calculating each participating entity's quality of performance and savings for Medicaid, if any, in a given performance year;

(11) "Department" or "DSS" means the Department of Social Services or one or more of the department's agents;

(12) "Enhanced care coordination activities" means the care coordination activities specified in writing by the department that all participating entities shall provide to PCMH+ members assigned to them in any given performance year;

(13) "Federally qualified health center" or "FQHC" has the same meaning as provided in 42 USC 1396d(l) and which also includes an FQHC look-alike;

(14) "Federal financial participation" or "FFP" means the payments that CMS makes to the department to reimburse the department for payments made under Medicaid pursuant to 42 USC 1396b in accordance with the applicable FMAP;

(15) "Federal medical assistance percentage" or "FMAP" means the applicable percentage of department payments made under Medicaid, which is calculated in accordance with 42 USC 1396b and is the basis for calculation of FFP;

(16) "Glide Path" means the process by which a practice or an FQHC, as applicable, which does not yet meet the requirements for PCMH status or PCMH accreditation, as applicable, may receive initial financial and technical support from the department to assist the practice or FQHC in meeting the requirements to obtain PCMH status or PCMH accreditation, as applicable;

(17) "Hospital" means a short-term general hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions, including injuries or a short-term general hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care and treatment of a wide range of acute conditions among children, including injuries;

(18) "HRSA" means the U.S. Health Resources and Services Administration;

(19) "Intermediate care facility for individuals with intellectual disabilities" or "ICF/IID" means a residential facility for individuals with intellectual disabilities licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified and enrolled to participate in Medicaid as an intermediate care facility for individuals with intellectual disabilities pursuant to 42 CFR 442.101, as amended from time to time;

(20) "Individual pool shared savings payment" or "individual shared savings payment" means a payment made by the department to a participating entity in accordance with subsection (b) of section 17b-262-1104 of the Regulations of Connecticut State Agencies;

- (21) "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;
- (22) "Medicaid State Plan" means the plan describing Medicaid eligibility, coverage, benefits and reimbursement, including amendments thereto, which is established by the department and reviewed and approved by CMS pursuant to 42 CFR 430, Subpart B;
- (23) "Medical necessity" or "medically necessary" has the same meaning as provided in section 17b-259b of the Connecticut General Statutes;
- (24) "Medicare" means the program operated by CMS in accordance with Title XVIII of the Social Security Act;
- (25) "Medicare Accountable Care Organization" or "Medicare ACO" means a group of Medicare providers who participate in one or more CMS programs focused on improving the quality, efficiency and coordination of care provided to individuals served by such Medicare providers;
- (26) "Medicare Advantage plan" means a Medicare plan governed pursuant to Part C of Title XVIII of the Social Security Act;
- (27) "Member" means an individual eligible for goods and services under Medicaid;
- (28) "Minimum savings rate" or "MSR" means the threshold set forth in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, that a participating entity's savings or losses for Medicaid, as calculated by the department for PCMH+, needs to exceed before such savings or losses can affect the availability of shared savings payments;
- (29) "Money Follows the Person" means the demonstration project established by the department pursuant to section 17b-369 of the Connecticut General Statutes;
- (30) "Non-standard practice" means a practice setting that is: (A) Staffed by one or more primary care providers; (B) licensed as a separate health care facility by the Department of Public Health; (C) (i) for a practice seeking or that has obtained PCMH status, not eligible for PCMH Level 2 or PCMH Level 3 recognition or (ii) for an FQHC, not eligible, as applicable, for PCMH certification from the PCMH accreditation standard-setting authority or PCMH Level 2 or PCMH Level 3 recognition; and (D) determined by the department to provide primary care services consistent with the goals and purposes of the PCMH program;
- (31) "Nursing facility" has the same meaning as provided in 42 USC 1396r(a), as amended from time to time, is licensed pursuant to section 19-13-D8t of the Regulations of Connecticut State Agencies as a chronic and convalescent home or rest home with nursing supervision and is enrolled with the department as a nursing facility;
- (32) "Participating entity" means an advanced network or FQHC that is participating in PCMH+ in accordance with section 17b-262-1098 of the Regulations of Connecticut State Agencies;
- (33) "Performance year" or "performance period" means a calendar year of the operation of the PCMH+ program by the department, which is the time period that the department will evaluate the clinical and financial performance of participating entities for purposes of determining and calculating shared savings payments, if any;
- (34) "PCMH practice" means a practice other than an FQHC that the department has determined meets the requirements for PCMH status, but not including a glide path practice;
- (35) "PCMH accreditation" means the department's process for approving an FQHC to participate in PCMH that meets a high standard of person-centered primary care pursuant to the department's criteria, including PCMH Level 2 or PCMH Level 3 approval or PCMH certification from the PCMH accreditation standard-setting authority, as well as other requirements set forth by the department for PCMH accreditation;
- (36) "PCMH accreditation standard-setting authority" means one or more nationally recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to an FQHC, such as The Joint Commission (TJC), which sets standards for TJC's Primary

Care Medical Home program as part of TJC's Ambulatory Health Care accreditation program;

(37) "PCMH Level 2" means the second level of PCMH primary care quality standards or an equivalent to such level, each as established by the PCMH status standard-setting authority;

(38) "PCMH Level 3" means the third level of PCMH primary care quality standards or an equivalent to such level, each as established by the PCMH status standard-setting authority;

(39) "PCMH status" means the department's approval of a practice that meets a high standard of person-centered primary care pursuant to the department's criteria, including, but not limited to, PCMH Level 2 or PCMH Level 3 approval;

(40) "PCMH status standard-setting authority" means one or more nationally recognized PCMH standard-setting organizations selected by the department as an authority whose standards apply to practices seeking or maintaining PCMH status, such as the National Committee for Quality Assurance (NCQA), which sets standards for NCQA's Patient Centered Medical Home Program;

(41) "PCMH+ FFP authority" means applicable portions of the Medicaid State Plan, one or more waivers, demonstrations, other applicable federal legal authority or any combination thereof, as applicable, each as amended from time to time, and that the department determines are sufficient to receive FFP from CMS for operating PCMH+;

(42) "PCMH+ member" means a member assigned by the department to a participating entity for purposes of PCMH+ for a performance year;

(43) "Person-Centered Medical Home" or "PCMH" means the program operated by the department pursuant to section 17b-263c of the Connecticut General Statutes and which provides technical assistance and, when applicable, additional payments to eligible primary care practices and providers that meet the written criteria for PCMH set forth by the department;

(44) "Person-Centered Medical Home Plus" or "PCMH+" means the program operated by the department pursuant to section 17b-263c of the Connecticut General Statutes and sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies;

(45) "Physician" means an individual licensed pursuant to section 20-13 of the Connecticut General Statutes and operating within such individual's scope of practice under state law;

(46) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes and operating within such individual's scope of practice under state law;

(47) "PMPM" means per-member per-month;

(48) "Practice" means an individual practice site other than an FQHC that provides predominantly primary care services and: (A) Is (i) an independent physician group, (ii) a solo physician, (iii) an APRN group, (iv) an individual APRN or (v) a non-standard practice that is a satellite entity of one or more of the other practice settings set forth in this subparagraph; (B) is enrolled in Medicaid with a valid provider enrollment agreement on file with the department; (C) maintains all required licenses from the Department of Public Health; and (D) provides primary care services by or under the direction of one or more primary care providers;

(49) "Primary care provider" means a physician, APRN or physician assistant who: (A) Provides general pediatric, internal medicine, family practice or geriatric primary care services to a patient at the point of first contact; (B) takes continuing responsibility for providing the patient's care; and (C) has an active, unrestricted license from the Department of Public Health;

(50) "Prior year" means the calendar year immediately prior to the performance year;

(51) "Provider" means a health care provider enrolled in Medicaid with the department in good standing and with a signed provider agreement on file with the department;

(52) "Provider agreement" means the signed written agreement between the department and the provider;

(53) "Quality measures" means written quality performance standards for participating entities

established by the department to calculate shared savings payments, if any, which may include separate sets of measures for pediatric and adult patient populations and separate sets of measures for individual pool shared savings payments and challenge pool shared savings payments and may also include measures used by the department for evaluation of PCMH+, participating entities or both, but which are not directly connected to calculation of shared savings payments;

(54) "Social determinants of health" means the various conditions in which individuals are born, grow, work, live and age and the wider set of forces and systems shaping the conditions of daily life for individuals, including, but not limited to, environmental factors, housing, nutrition, education, social services, medical care and other such conditions;

(55) "Shared savings payments" means individual pool shared savings payments, challenge pool shared savings payments or both types of payments, as applicable to a participating entity for a performance year;

(56) "State innovation model" or "SIM" means the initiative created by CMMI to provide financial and technical support to states for the development and testing of state-led, multi-payer health care payment and service delivery models that is designed to improve health system performance, increase quality of care and decrease costs for various health care payers, including Medicaid;

(57) "Solo physician" means a practice comprised of only one physician;

(58) "Specialist" means a physician other than a primary care provider; and

(59) "Under-service" means actions taken by or on behalf of a participating entity that have the result of limiting, excluding or discouraging one or more members from seeking or receiving medically necessary Medicaid covered services, including actions taken with the express or implicit goal of increasing savings generated by the participating entity, reducing the number of high-risk members assigned to the participating entity or both.

(NEW) Sec. 17b-262-1097. Program Parameters

(a) The PCMH+ program shall not restrict members' free choice of provider pursuant to 42 USC 1396a(a)(23) and 42 CFR 431.51.

(b) In accordance with 42 USC 1396d(t)(3)(D), participating entities shall not engage in any activities designed to result in selective recruitment, attribution, or assignment of individuals with more favorable health status or any combination thereof.

(c) Any advanced network or FQHC may participate in PCMH+ if it: (1) meets all qualifications established by the department for a PCMH+ participating entity, including, but not limited to, the requirements set forth in section 17b-262-1098 of the Regulations of Connecticut State Agencies, (2) submits a successful response to the request for proposals in accordance with the department's procurement process for PCMH+ and (3) enters into a contract for PCMH+ with the department.

(d) All payments made by the department to participating entities pursuant to PCMH+ are subject to available appropriations.

(e) For one or more of the initial performance years of PCMH+, the department has been receiving funds from a SIM model test grant from CMMI to assist with design and administration of PCMH+. All PCMH+ payments, if any, are expressly conditioned on continued receipt of CMMI model test grant funds in the amounts as determined by the department to be necessary for design and administration of PCMH+.

(f) The department may, within available appropriations, provide technical assistance to participating entities in connection with their participation in PCMH+ and compliance with applicable requirements.

(g) Notwithstanding any provision to the contrary in any contract between the department and a participating entity regarding PCMH+ and notwithstanding any other provision to the contrary in

sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies, there is no entitlement for any PCMH+ member or any other individual to receive any particular level or amount of services, nor does any such contract create any legal rights for any PCMH+ members or any other third-party beneficiaries.

(1) PCMH+ members do not have a right to receive any particular level or amount of enhanced care coordination activities (and, for FQHCs, also care coordination add-on payment activities).

(2) Participating entities are not required to provide any specific level or amount of enhanced care coordination activities (and, for FQHCs, also care coordination add-on payment activities) to each PCMH+ member.

(3) Each participating entity is required to provide enhanced care coordination activities (and, for FQHCs, also care coordination add-on payment activities) only to the extent desired by PCMH+ members and only to the extent feasible within the participating entity's available resources for providing such services, as determined by the department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

(NEW) Sec. 17b-262-1098. Participating Entity Qualifications and Requirements

(a) Participating entities include both FQHCs and advanced networks that comply with all applicable requirements for participation in PCMH+, including, but not limited to, sections 17b-262-1095 to 17b-262-1108, inclusive, of the Regulations of Connecticut State Agencies.

(b) Participating entities shall include primary care providers who provide primary care case management services in accordance with 42 USC 1396d(t), which includes location, coordination and monitoring of health care services. Pursuant to 42 USC 1396d(t)(2)(A)-(B), a participating entity shall be, employ or contract with one or more physicians, physician groups, APRNs, APRN groups, physician assistants or an entity employing or having other arrangements with physicians to provide such services. The participating entity shall provide services in one or more of the following specialty areas: internal medicine, general medicine, geriatric medicine, family medicine and pediatrics. Accordingly, each participating entity shall comply with 42 USC 1396d(t) and 42 CFR 440.168, each as amended from time to time, regarding the provision of primary care case management services in connection with its participation in the PCMH+ program.

(c) Participating entities shall comply with all provisions of applicable PCMH+ FFP authority as ultimately approved by CMS and for the effective dates specified therein. All PCMH+ payments, if any, are expressly conditioned on CMS approval of the applicable PCMH+ FFP authority, as determined by the department to be sufficient to enable the department to implement PCMH+ and receive FFP for payments made under PCMH+.

(d) Requirements Specific to FQHCs. An FQHC shall:

- (1) Comply with all requirements of an FQHC under 42 USC 1396d(l)(2)(B);
- (2) Operate in Connecticut and meet all federal and state requirements applicable to FQHCs;
- (3) Comply with all PCMH accreditation requirements, as determined by the department; and
- (4) Receive shared savings payments, if any, and distribute those payments within the FQHC according to its written distribution plan. No FQHC may receive any shared savings payments, if applicable, prior to the department reviewing and approving its shared savings payments distribution plan.

(e) Requirements Specific to Advanced Networks. Each advanced network shall:

- (1) Be composed of one of the following:
 - (A) One or more PCMH practices;
 - (B) One or more PCMH practices plus specialists, which could include any combination of physical health, behavioral health and oral health providers;

(C) One or more PCMH practices plus specialists, which could include any combination of physical health, behavioral health and oral health providers, plus one or more hospitals; or

(D) A Medicare Accountable Care Organization that includes one or more DSS PCMH practices.

(2) Designate an advanced network lead entity, which the department may require shall be a provider or provider organization participating in the advanced network.

(3) The advanced network lead entity shall:

(A) Ensure that the required enhanced care coordination activities are implemented as intended, including, but not limited to: ensuring required staff are hired and appropriately trained, monitoring of day-to-day practice, establishment of linkages with community partners and any required reporting to the department; and

(B) Receive any shared savings payments, if applicable, and distribute such payments to advanced network participating providers according to its plan. No advanced network lead entity may receive any shared savings payments, if applicable, prior to the department reviewing and approving its shared savings distribution plan.

(4) If the advanced network is comprised of more than one provider organization, the advanced network lead entity shall have a contractual relationship with all other advanced network participating providers that meet requirements established by the department. Each such contract shall include, at a minimum:

(A) An explicit requirement that each advanced network participating provider agrees to participate in and comply with the applicable requirements of PCMH+;

(B) A description of the advanced network participating provider's rights and obligations in, and representation by, the advanced network lead entity, including language giving the advanced network lead entity the authority to terminate a provider's participation in the advanced network for its non-compliance with the advanced network participation agreement or any applicable requirements of PCMH+ in particular or Medicaid in general;

(C) Language that advanced network participating providers shall allow PCMH+ members freedom of choice of provider and may not require that members be referred to providers within the advanced network; and

(D) A description of the methodology for distributing any shared savings between the advanced network lead entity and advanced network participating providers. The shared savings distribution methodology shall not include any factors that would reward a provider for specific contributions to the overall savings of the network. Primary care practices within the advanced network that do not have PCMH status or PCMH accreditation, as applicable (such as glide path practices) shall not receive a portion of any shared savings payments, if any, that are paid to the advanced network lead entity. The advanced network's shared savings methodology is subject to review and approval by the department.

(5) Be eligible to receive a shared savings payment, if applicable and if all other requirements are met, only for members assigned to the advanced network based on attribution to one or more PCMH practices within the participating entity, each of which shall maintain all applicable PCMH and PCMH+ requirements for the entire performance year.

(f) Requirements for All Participating Entities. In addition to complying with the requirements specific to an FQHC in subsection (e) of this section or the requirements specific to an advanced network in subsection (f) of this section, as applicable, each participating entity shall comply, on an ongoing basis throughout its participation in PCMH+, with the following requirements:

(1) Have not fewer than 2,500 members eligible for PCMH+ who are attributed to primary care providers within the participating entity who have PCMH status or PCMH accreditation, as applicable, at the time that DSS assigns members to the participating entity in accordance with section 17b-262-1099 of the Regulations of Connecticut State Agencies;

- (2) Identify a clinical director and senior leader to represent the participating entity in its participation in PCMH+ and champion PCMH+ goals;
- (3) Use reasonable efforts within its control to ensure that only providers enrolled in Medicaid are providing Medicaid services to PCMH+ members;
- (4) Comply with the requirements for an oversight body as detailed in subsection (i) of this section;
- (5) Have appropriate organizational capacity, including governance and oversight, for implementing PCMH+;
- (6) Ensure and promote transparency, community participation and PCMH+ member participation in the operation of PCMH+;
- (7) Have a planned and documented approach for providing enhanced care coordination activities and, for FQHCs, also care coordination add-on payment activities, each as described in section 17b-262-1100 of the Regulations of Connecticut State Agencies;
- (8) Support the integration of behavioral health services and supports into existing operations;
- (9) Develop and maintain contractual or informal written partnerships with local community partners in order to impact social determinants of health, promote physical and behavioral health integrated care and assist members in utilizing their Medicaid benefits, as detailed in subsection (k) of this section;
- (10) Have a planned and documented approach to monitor and improve the quality of care provided to PCMH+ members, including a plan to monitor, prevent and address under-utilization of medically necessary services;
- (11) Participate in quality measurement activities as required by DSS;
- (12) Participate in program oversight activities conducted by DSS to ensure compliance with PCMH+ program requirements;
- (13) Comply with all requirements of DSS's procurement process for PCMH+ participating entities;
- (14) Not limit a member's ability to receive services from a provider that is not affiliated with the participating entity;
- (15) Require any primary care practices or FQHC sites that do not yet have PCMH status or PCMH accreditation, as applicable, within the participating entity to achieve PCMH status or PCMH accreditation, as applicable, not less than eighteen months after the start of the first PCMH+ performance year during which the participating entity is participating in PCMH+ and includes such practice as part of the participating entity. DSS may extend this timeframe for PCMH recognition based on good cause outside of the participating entity's control, including, but not limited to, accreditation or certification approval delays, electronic health records system vendor delays, resignation of staff members who are key to the applicable accreditation processes or such other reasons determined by the department to be sufficient good cause. If one or more practices or FQHC sites within a participating entity does not meet the requirements of this subdivision, the department shall issue a corrective action plan to the participating entity. The corrective action plan shall establish timeframes for the practice or practices or FQHC site or sites to address gaps in order to achieve PCMH status or PCMH accreditation, as applicable. DSS shall monitor compliance with the corrective action plan. Non-compliance with corrective action plan will result in termination of the participating entity's PCMH+ contract with the department and ineligibility to receive any PCMH+ shared savings payments for each applicable performance year;
- (16) Not distribute shared savings payments, if any, to any individual physician, APRN or physician assistant within the participating entity using any factors that would reward such individual for that individual's specific contributions to the overall savings generated by the participating entity; and

(17) Not engage in any activities designed to result in selective recruitment and attribution of individuals with more favorable health status.

(g) Response to Department's Procurement Process. In its response to the department's procurement process for PCMH+, each participating entity shall demonstrate compliance with applicable PCMH+ requirements, including the requirements set forth in this section. The department may enforce each participating entity's compliance with its response to the applicable request for proposals to participate in PCMH+.

(h) Oversight Body. Each participating entity shall have an oversight body that may, but is not required to, overlap with a governing board or advisory body for the participating entity that existed prior to the performance year. The oversight body shall include substantial representation by PCMH+ members assigned to the participating entity and at least one physician, APRN or physician assistant who is participating in the participating entity. The type and number of providers on the oversight body need not be proportional to participating entity providers, but shall be generally representative of the variety of providers participating in the participating entity, such as primary care providers, other physical health providers, behavioral health providers, oral health providers and other relevant types of providers.

(1) The participating entity shall provide assistance such as transportation and childcare to PCMH+ members to enable them to attend oversight body meetings. Making such payments, rendering such services or both is permissible to the extent of applicable statutes and regulations, provided that: (1) the department shall not reimburse the participating entity for such expenditures or services, (2) the participating entity is responsible for ensuring compliance with all statutes, regulations and other requirements that apply to such expenditures and (3) the participating entity shall use reasonable diligence in preventing any potential negative consequences to individuals that may result from such expenditures, such as any potential impact on those individuals' eligibility for Medicaid, other public benefit programs or any combination of such programs.

(2) The participating entity shall circulate relevant written reports and materials in advance to the members of the oversight body for its review and comment.

(3) The participating entity shall have formal procedures through which to receive feedback from the oversight body and documentation of this communication. The participating entity shall maintain detailed documentation regarding the existence, governance and activities of the oversight body. Upon request, the participating entity shall provide the department with documentation regarding all aspects of the governance, activities and communications of the oversight body.

(4) The oversight body shall:

(A) Meet at least once each calendar quarter and provide meaningful feedback to the participating entity on a variety of topics, including quality improvement, member experience, prevention of under-service, implementation of PCMH+ and distribution of shared savings payments, if any;

(B) Have a transparent governing process;

(C) Have bylaws that reflect the oversight body's structure as well as define its ability to support the department's PCMH+ objectives; and

(D) Have a conflict of interest policy calling for disclosure of relevant financial interests and a procedure to determine whether conflicts exist and an appropriate process to resolve conflicts.

(i) Group Communications to Members. Not less than fifteen business days before planning to send any group communication to Medicaid members regarding PCMH+, each participating entity shall send the department a copy of the intended communication for review and approval by the department. No participating entity may send any such communication to members before receiving written approval from the department.

(j) Linkages with Community Partners to Address Social Determinants of Health. In an effort to meaningfully impact the social determinants of health, promote physical and behavioral health

integrated care and assist members in utilizing their Medicaid benefits, each participating entity shall implement and maintain contractual relationships or informal partnerships with local community partners, as specified in this subsection. The purpose of such partnerships is to develop and implement initiatives to identify and actively refer members with behavioral health conditions that require specialized behavioral health treatment to appropriate sources of care, address social determinants of health and facilitate rapid access to care and needed resources. It is not expected that these partnerships will solve or fully address any individual PCMH+ member's social determinants of health, but rather, to help foster broader collaboration and broader perspectives that are collectively designed to result in overall long-term improvements in health. As part of these relationships, the participating entity, if applicable, one or more providers within the participating entity or both shall meet with various community partners to improve collaboration.

(1) Upon request, the participating entity shall provide the department with documentation of contractual relationships, informal partnerships or both as described in this subsection, as applicable, including the role of such relationships in enabling the participating entity to impact the social determinants of health, promote physical and behavioral health integrated care and assist members in utilizing their Medicaid benefits. In addition, the department may also request that the participating entity provide documentation, explanation or both regarding how such relationships improves the care experience, quality of care and cost of care for PCMH+ members assigned to the participating entity.

(2) The participating entity shall implement and maintain contractual relationships or informal partnerships with:

(A) Community-based organizations, including organizations that assist the community with housing, clothing, utility bill assistance, nutrition, food assistance, employment assistance, education, child care, transportation, language and literacy training, elder support services and other types of such organizations;

(B) Behavioral health organizations, including those providing substance use services;

(C) Child-serving organizations;

(D) Peer support services and networks;

(E) Social services agencies;

(F) The criminal justice system;

(G) Local public health entities;

(H) Specialists and hospitals (except for an advanced network that already includes such providers as part of its network, which may, but is not required to, develop such relationships beyond its network); and

(I) Other state and local programs, both medical and non-medical.

(NEW) Sec. 17b-262-1099. Eligible Members and Assignment Methodology

(a) Categories of Members Eligible to Participate in PCMH+. All members are eligible to participate in PCMH+, except for:

(1) Participants in a behavioral health home established by the department pursuant to 42 USC 1396w-4;

(2) The following categories of individuals who are eligible for both Medicare and Medicaid:

(A) Individuals who are eligible for Medicare and Medicaid but whose Medicaid benefits are limited to Medicare cost sharing, also known as a partial dually eligible individuals;

(B) Individuals who are participating in a Medicare Accountable Care Organization; and

(C) Individuals who are enrolled in a Medicare Advantage plan;

(3) Individuals receiving home and community-based services from a program operated pursuant to 42 USC 1396n(c), (i), (k) or any combination of such programs;

- (4) Participants in the Money Follows the Person program;
- (5) Residents of nursing facilities, ICF/IIDs and other long-term care institutions that are required by federal or state statute or regulation to coordinate care for their residents;
- (6) Individuals who are enrolled in Medicaid solely to receive a limited benefit package, such as a benefit package for family planning, breast and cervical cancer or tuberculosis; and
- (7) Individuals who are receiving hospice services.

(b) Each individual who is eligible for both Medicare and Medicaid but does not fall within any subdivision of subsection (a) of this section shall have access to care coordination services included in PCMH+ if that individual desires such services. Accordingly, the individuals described in the previous sentence are excluded from PCMH+ only for purposes of calculating shared savings payments and care coordination add-on payments. Each participating entity shall provide care coordination services included in PCMH+ to each individual described in this subsection if such individual desires to receive such services.

(c) Member Assignment Methodology. The department assigns eligible PCMH+ members as described in subsection (a) of this section to participating entities in accordance with this subsection.

(1) A member may affirmatively select a PCMH practice or FQHC as the member's primary care provider. In the absence of a member's selection, the department's written PCMH attribution methodology retrospectively attributes members to primary care providers based on claims volume. If a member receives care from multiple providers during a given period, the member is attributed to the practice or FQHC that provided the plurality of care and, if there is no single largest source of care, to the most recent source of care, each as determined by the department in accordance with its written PCMH attribution methodology.

(2) A participating entity's assigned members are the members attributed to its PCMH practices or, for an FQHC with PCMH accreditation, members attributed to such FQHC, by the department in accordance with subdivision (1) of this subsection less members that are not eligible for PCMH+ as described in subsection (a) of this section, as assigned by the department in accordance with subsection (d) of this section. If an advanced network includes primary care providers not within a PCMH practice or an FQHC with PCMH accreditation, only the members attributed to the PCMH practices or FQHCs with PCMH accreditation in the advanced network will be assigned to the PCMH+ participating entity.

(3) In accordance with 42 CFR 431.51, regardless of a member's assignment to a PCMH+ participating entity, each member will continue to have the choice to see any enrolled Medicaid provider.

(d) PCMH+ assignment will occur once annually and will last for an entire performance year (unless during the course of a performance year, a member opts out of PCMH+, loses eligibility for Medicaid or falls into a category of individuals excluded from PCMH+, in accordance with this section). The department shall assign members to participating entities on or before November 30th for each performance year starting the following January 1st. The department shall assign a member only to one participating entity for each performance year. If a member's PCMH attribution to a primary care provider changes during a performance year, that change will take effect for the following performance year's PCMH+ assignment.

(e) Member Notification. Prior to each performance year, DSS shall send each member that has been assigned to a PCMH+ entity written notice about such assignment, including a brief description of the PCMH+ program and an opportunity for the member to opt out from participating in PCMH+. The department will provide a copy of the form of such notice to each participating entity not later than ten days after distribution.

(f) Member Opt-Out from PCMH+. A member may opt out of assignment to a participating entity at any time. If a member opts out, then that member's claims costs will be removed from the

assigned participating entity's shared savings calculation, although this member's quality data and applicable data regarding measures of under-service will not be excluded. If a member opts out of PCMH+, the participating entity is not required to provide enhanced care coordination activities to that member. In addition, if the member's assigned participating entity was an FQHC, then that FQHC will no longer receive the care coordination add-on payment for that member for all months in the performance year beginning with the calendar month after the department processes the member's opt-out request.

(g) If, over the course of a performance year, a PCMH+ member loses eligibility for Medicaid or moves into a population that is not eligible for PCMH+ as detailed in subsection (a) of this section, that change has the same effect as if an individual opts out of PCMH+, as described in subsection (f) of this section.

(NEW) Sec. 17b-262-1100. Care Coordination Services

(a) As part of participating in PCMH+, each participating entity shall provide the services described in this section, as applicable to such participating entity. The care coordination services described in this section are designed to improve the quality, efficiency and effectiveness of care delivered to PCMH+ members, as well as improving such members' care experience.

(b) Care coordination services provided by the participating entity are person-centered and fall within a broad continuum that ranges from targeted referrals to more comprehensive supports, which are (1) individually determined for each PCMH+ member based on that individual's circumstances and level of need and (2) provided proportionally within the participating entity's available resources for providing care coordination to that individual, as well as all individuals for which the participating entity is responsible for providing care. Each participating entity is required to provide the care coordination services described in this section only to the extent desired by PCMH+ members and only to the extent feasible within the participating entity's available resources for providing such services, as determined by the department consistent with standards for the provision of care coordination services and in a manner sufficient to fulfill the applicable requirements of the PCMH+ program.

(c) Each participating entity shall provide enhanced care coordination services as detailed in the department's written list of such services and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable.

(d) Each participating entity that is an FQHC shall provide care coordination add-on payment activities as detailed in the department's written list of such services and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, which the department may update from time to time. Care coordination add-on payment activities are in addition to the enhanced care coordination activities.

(NEW) Sec. 17b-262-1101. Measuring Quality of Performance

(a) Purpose of Measuring Quality. In addition to providing the care coordination services required pursuant to section 17b-262-1100 of the Regulations of Connecticut State Agencies, in order to be eligible to receive shared savings payments, if applicable, each participating entity shall also maintain, improve or both maintain and improve the quality of care and care experience for members assigned to the participating entity, as measured by quality measures specified by the department in accordance with this section.

(b) The PCMH+ quality measure set contains process and outcome measures that include measures of member experience. Of those measures, a specified subset of measures will be used in calculating various payments, as described in section 17b-262-1104 of the Regulations of

Connecticut State Agencies. The department shall post such list on the department's website or otherwise distribute such measures in writing to participating entities.

(c) The department shall review and update the quality measures on a periodic basis as determined by the department. The department will provide participating entities not less than thirty days advanced written notice of any proposed update or revision of the quality measures.

(d) **Quality Scoring.** For purposes of calculating a participating entity's individual pool shared savings payment, a participating entity's total quality score will be based on three components of quality measurement (maintain quality, improve quality and absolute quality) for each of the quality measures that apply to the individual savings pool in any given performance year. To calculate each participating entity's total quality score, its points will be summed and then divided by a maximum score of the total number of points (three possible points per quality measure multiplied by the total number of quality measures for the individual savings pool in a performance year). The total quality score, expressed as a percent of the total potential quality score, will be used in calculating the individual pool shared savings payment, if any, as described in subsection (d) of section 17b-262-1103 of the Regulations of Connecticut State Agencies. A maximum of one point is available for each component of quality measurement for each measure, determined as follows:

(1) **Maintain Quality.** One point is awarded in this category for each quality measure in the individual savings pool if a participating entity's performance year quality score is greater than or equal to its prior year score. The department may establish a statistically significant threshold based on historical quality measure data to account for annual variation, which results in lower scores.

(2) **Improve Quality.** A participating entity will earn up to one full point for each quality measure in the individual savings pool in accordance with the department's written sliding scale for the performance year as specified in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, based on the participating entity's year-over-year performance (quality improvement trend) against the comparison group's quality improvement trend.

(3) **Absolute Quality.** A participating entity will earn up to one full point for each quality measure in the individual savings pool in accordance with the department's written sliding scale for the performance year as specified in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, based on the participating entity's ability to reach absolute quality targets, derived from the comparison group's quality scores.

(NEW) Sec. 17b-262-1102. Preventing, Monitoring and Remediating Under-Service

(a) DSS uses a multi-pronged approach to identify and prevent under-service of PCMH+ members. The data points that DSS monitors under this approach include, but are not limited to: PCMH+ member grievances, provider performance on quality measures (particularly preventive care service measures), service utilization and service cost reporting and member movement to, from and within participating entities. DSS will also conduct a PCMH+ member survey to evaluate the first performance year.

(b) Subject to subsections (e) and (f) of this section, participating entities will be disqualified from receiving shared savings payments if the department determines that they demonstrate repeated or systematic failure to offer medically necessary services or manipulate their member panel in a manner that results in under-service, whether or not there is evidence of intentionality.

(c) If the department detects that any potential under-service has occurred regarding a participating entity, the department shall use best efforts to notify the participating entity in writing as soon as possible. The department shall give the participating entity an opportunity to respond to such notification and to take corrective action to prevent any future under-service or potential under-service.

(d) If the department determines that one or more individual providers within the participating

entity, the participating entity overall or both may have engaged in repeated or systematic under-service, regardless of intentionality, the department shall send the participating entity such findings in writing. The department shall give the participating entity an opportunity to respond to such findings and to take corrective action.

(e) As appropriate based on the nature, extent and severity of under-service detected by the department, the department shall take appropriate sanctions against the participating entity to enforce the requirement to prevent under-service, including, but not limited to, issuing a corrective action plan with defined steps and timeframes to correct and prevent under-service, denial of all or a reasonable portion of shared savings payments (if applicable), denial of all or a reasonable portion of care coordination add-on payments for FQHCs, denial of all or a reasonable portion of a combination of both types of payments, such other actions as the department reasonably determines are necessary to protect members from under-service or any combination of the actions described in this subsection, as determined by the department.

(f) To the extent the participating entity objects to any determination of the department regarding under-service as specified in this section, the participating entity may use the desk review process described in section 17b-262-1105 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-1103. Shared Savings Calculation

(a) Overall Description. As described in more detail in this section and in section 17b-262-1104 of the Regulations of Connecticut State Agencies, participating entities that the department determines generate savings for Medicaid and that meet identified benchmarks on quality performance standards will be eligible to receive individual pool shared savings payments in accordance with this section, so long as they comply with measures of under-service.

(b) Comparison Group. For the performance year from January 1, 2017, through December 31, 2017, the comparison group consists of all FQHCs that have and maintain PCMH accreditation and non-FQHC practices with PCMH status, each of which is not a PCMH+ participating entity in a given performance year and each of which must have at least 2,500 members, except that the department may exclude one or more FQHCs or non-FQHC practices from the comparison group in order to ensure the statistical validity of the comparison group. Based on the number of eligible FQHCs and PCMHs that participate in PCMH+ in performance years occurring after calendar year 2017, the department may adjust the comparison group to include additional categories of FQHCs and non-FQHC practices beyond those described in this subsection as necessary to remain statistically valid.

(c) Benefits Included in Calculations. DSS will include all Medicaid claim costs for covered services provided by any provider to a PCMH+ member in the shared savings calculation described in subsection (a) of this section, except for: hospice; long-term services and supports, including institutional and home and community-based services; and non-emergency medical transportation services. Participating entities do not need to deliver all of the benefits received by PCMH+ members.

(d) Calculation of Individual Pool Shared Savings. For each participating entity, in each performance year of the PCMH+ program, the department shall calculate whether and to what extent the participating entity achieved a lower cost trend than the comparison group for the costs as detailed in subsection (c) of this section and in accordance with this subsection.

(1) Assigned Members. The expenditures for each participating entity will be measured only for a participating entity's assigned PCMH+ members who remain assigned for not fewer than eleven months of the performance year. Cost data of members who opt out of PCMH+ at any time before or during the performance year will also be excluded from the calculation of shared savings.

(2) Claims Truncation. In order to avoid unwanted bias due to outlier cases, for each PCMH+

member, annual claims will be truncated at a level specified in writing by the department for the performance year and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, so that expenses above that level will not be included in the calculation.

(3) Risk Adjustment.

(A) The department shall use risk adjustment methods to adjust for both prior year and performance year costs for underlying differences in illness burden for both participating entities and the comparison group.

(B) The comparison group trend is derived as the risk adjusted performance year cost divided by the risk adjusted prior year cost.

(4) Expected Performance Year Costs. A participating entity's risk adjusted expected performance year costs are developed by multiplying the participating entity's risk adjusted prior year costs by the comparison group trend described in subdivision (3) of this subsection.

(5) A participating entity's savings is the difference between its risk adjusted expected performance year costs described in subdivision (4) of this subsection and its actual risk adjusted performance year costs. Participating entities that demonstrate losses (i.e., higher than expected expenditures for PCMH+ members assigned to the participating entity) will not be required to return these losses to the department because PCMH+ is an upside-only shared savings program, as described in section 17b-262-1095 of the Regulations of Connecticut State Agencies.

(6) Minimum Savings Rate. A participating entity's risk-adjusted savings shall meet the MSR requirement, which is greater than or equal to the percentage of the expected performance year costs as specified in writing by the department and in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable. If a participating entity meets the MSR requirement, then the first-dollar savings (i.e., all savings generated, including amounts below the MSR threshold) will be considered as savings. If a participating entity does not meet the MSR requirement, its savings will not be considered. Likewise, losses between 0% and the negative MSR threshold will not be considered credible when deriving the aggregate program savings.

(7) Savings Cap. A participating entity's savings will be capped at the percentage of its risk adjusted expected performance year costs, as specified by the department in writing in accordance with the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable, so that any savings above the savings cap will not be included in its individual savings pool.

(8) Sharing Factor and Individual Savings Pool. A participating entity's individual savings pool, if any, will be multiplied by a sharing factor of the percent specified in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable. The resulting amount from all of the calculations and adjustments specified in subdivisions (1) through (8), inclusive, of this subsection, will form the participating entity's individual savings pool.

(9) Quality Scoring and Individual Pool Shared Savings Calculation. For each participating entity, the individual savings pool shared savings payment, if any, is equal to the individual savings pool as calculated in accordance with subdivision (8) of this subsection multiplied by the total individual pool quality score as specified in subsection (d) of section 17b-262-1101 of the Regulations of Connecticut State Agencies.

(NEW) Sec. 17b-262-1104. Reimbursement Methodology

(a) Care Coordination Add-on Payments. Participating Entities that are FQHCs are eligible to receive monthly PMPM payments for care coordination add on payment activities that the FQHC provides to PCMH+ members in accordance with the PMPM amount and methodology as described in the Medicaid State Plan or other applicable PCMH+ FFP authority, as applicable.

(b) Individual Pool Shared Savings Payments. For any given performance year, if the department determines that a participating entity has achieved savings for members assigned to it in accordance

with subsection (d) of section 17b-262-1103 of the Regulations of Connecticut State Agencies, then the department will make individual pool shared savings payments to the participating entity as specified in said subsection.

(c) Challenge Pool Shared Savings Payments.

(1) Challenge Pool Eligibility. To be eligible for a challenge pool payment, if any, a participating entity shall improve its overall performance year-over-year on the measures that apply to the individual savings pool.

(2) Challenge Pool Funding. The potential challenge pool funding, if any, includes shared savings calculated for one or more participating entity's individual shared savings pool pursuant to subsection (d) of section 17b-262-1104 of the Regulations of Connecticut State Agencies, but which were not paid to one or more participating entities such as because of less than perfect scores on the applicable quality measures or because the department determined that the participating entity systematically engaged in under-service.

(A) The department calculates the aggregate savings of the PCMH+ program for a performance year by adding together all credible savings and losses for all participating entities in accordance with all of the calculations and adjustments for calculating individual savings pool shared savings, as described in subsection (d) of section 17b-262-1104 of the Regulations of Connecticut State Agencies, but excluding the calculation of the individual pool shared savings payment quality score percentage for each participating entity.

(B) Total challenge pool payments to all participating entities for any performance year shall not exceed the aggregate savings of the PCMH+ program as detailed in subparagraph (A) of this subdivision less the total of all individual pool shared savings payments made pursuant to subsection (b) of this section.

(3) Challenge Pool Quality Measure Scoring. In any performance year, for each of the challenge pool quality measures, participating entities that achieve at least the median score (of all participating entities) for a challenge pool quality measure will pass or get credit for that measure.

(4) Challenge Pool Distribution. For any performance year, the amount of a participating entity's challenge pool payment, if any, for each participating entity that complies with subdivision (1) of this subsection will be the product of the number of its assigned PCMH+ members times the number of challenge pool quality measures passed as detailed in subdivision (3) of this subsection, divided by the sum of this statistic across all participating entities to arrive at the participating entity's portion of the challenge pool. This methodology ensures that the available challenge pool funds are exhausted for a performance year. The challenge pool payment, if any, to a participating entity is not directly related to its individual pool savings.

(NEW) Sec. 17b-262-1105. Monitoring Performance

(a) The department uses a set of internal monitoring and reporting measures that will be collected and analyzed not less than quarterly. DSS shall review the information and follow up with participating entities as needed regarding their performance.

(b) The department will develop and implement methods to monitor delivery of enhanced care coordination activities and, for FQHCs, care coordination add-on payment activities.

(c) Upon request from the department and not later than twenty-one days after receiving such request, each participating entity shall provide the department with information regarding the participating entity's participation in PCMH+, including, but not limited to: (1) policies and procedures regarding participation in PCMH+ and compliance with PCMH+ requirements; (2) explanation and documentation regarding how the participating entity provides the enhanced care coordination activities (and for FQHCs, also the care coordination add-on payment activities) and all other activities required to be performed by participating entities; (3) data requested by the

department regarding the activities related to the participation in PCMH+; and (4) all other documentation and information requested by the department regarding the participating entity's participation in PCMH+.

(d) The department will conduct one or more periodic compliance reviews during each performance year to evaluate the participating entity's performance of the activities required as part of participation in PCMH+. Such reviews may include, but are not limited to: a request for information and documentation, a review of PCMH+ members' clinical and care coordination records, an on-site evaluation that includes interviews with the participating entity's PCMH+ staff, clinicians and PCMH+ members and any other evaluation as determined by the department. Each participating entity shall provide the department with access to its facilities and staff to enable the department to perform such reviews, including, but not limited to, ensuring that each participating entity's PCMH+ clinical director and senior leader shall participate and facilitate the participating entity's full cooperation and participation in such reviews.

(e) If the department determines that a participating entity does not provide sufficient evidence of performing required enhanced care coordination activities or care coordination add-on payment activities for FQHCs, the department may: (1) require the participating entity to comply with a corrective action plan; (2) make the participating entity ineligible to receive all or part of shared savings payments for which the participating entity might otherwise be eligible to receive; or (3) a combination of such actions.

(f) Desk Review Process.

(1) Not later than October 31 of the year following each performance year, the department shall provide each participating entity with a written description of the participating entity's results regarding performance on quality measures, applicable Medicaid expenditures for PCMH+ members assigned to the participating entity and calculation of savings or increased expenditures, as applicable for said members. After receiving said description from the department, the participating entity may respond to any calculations, results, or decisions contained therein. Such response shall: be in writing, received by the department not later than thirty days after the participating entity receives the written description from the department and include all supporting documentation. The department shall issue a written decision not later than thirty days after receiving the participating entity's response. There is no further right to review the department's decisions regarding the written description described in this subdivision, other than as described in this subdivision. There is no right to review the final distribution of shared savings payments, if any, among the various participating entities.

(2) If the department makes any decision specific to a participating entity's participation in PCMH+, but not including any of the circumstances described in subdivision (1) of this subsection and not including any department decisions that apply to the entire PCMH+ program or any component thereof, after receiving said written decision, the participating entity may respond in writing to said decision. Such response shall: be in writing, be received by the department not later than fifteen days after the participating entity receives the written decision from the department and include all supporting documentation. The department shall issue a written final decision not later than thirty days after receiving the participating entity's response. There is no further right to review the department's decisions described in this paragraph, other than in accordance with this paragraph.

(NEW) Sec. 17b-262-1106. Documentation and Record Retention

(a) Each participating entity shall maintain documentation sufficient to document that the participating entity performed all activities related to its participation in PCMH+, including, but not limited to: provision of enhanced care coordination activities, care coordination add-on payment activities (for FQHCs) and all other required activities, as well as information documenting the care

experience and quality of care provided, as determined and specified by the department.

(b) Each participating entity shall preserve all required documentation in its original written or electronic form for a period of time not less than five years or the length of time required by statute or regulation, whichever is greater. Such documentation is subject to review by the department. If there is a dispute between the department and a participating entity concerning any aspect of the participating entity's participation in PCMH+, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is greater.

(c) The department may disallow and recover any amounts paid to a participating entity for which required documentation is not maintained and not provided to the department upon request.

(d) The department may audit all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with applicable regulatory and statutory requirements.

(NEW) Sec. 17b-262-1107. Reserved

(NEW) Sec. 17b-262-1108. Reserved

Statement of Purpose

The purpose of this regulation is to establish rules and parameters to enable the department to implement the PCMH+ program.

(A) The problems, issues or circumstances that the regulation proposes to address: SIM is a multi-payer approach to promote improved health care delivery. The development of the SIM initiative has been led by the SIM Project Management Office, located within the Office of the Healthcare Advocate, which serves under the leadership of the Lieutenant Governor. The development of SIM is supported by consultants and statewide advisory committees composed of payers, providers, consumers and advocates.

In March 2013, the State of Connecticut received a planning grant from CMMI to develop a State Healthcare Innovation Plan. Through the planning process, the SIM Program Management Office brought together a wide array of stakeholders who worked together to design a model for health care delivery supported by value-based payment methodologies with the goal of impacting care delivered to at least 80% of the entire State population within five years. The resultant State Healthcare Innovation Plan outlines the goals and anticipated pathway to promote the Triple Aim for everyone in the State: better health while eliminating health disparities, improved health care quality and experience and reduction of growth in health care costs.

The department is participating in SIM by implementing PCMH+. The goals of PCMH+ are to further improve health outcomes and care experience for Medicaid members who are assigned to PCMH+, through these efforts containing the growth of Medicaid expenditures. Specifically, PCMH+ will build on DSS' existing person-centered medical home (PCMH) model by incorporating new enhanced care coordination activities and care coordination add-on payment activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid members with complex medical conditions and disability needs and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits.

PCMH+ is open to two groups of providers (known as participating entities): FQHCs and advanced networks. If the participating entity meets identified benchmarks on quality measures, while also demonstrating shared savings for members assigned to the entity, then it will be eligible to receive individual pool shared savings payments. In addition, if the PCMH+ program demonstrates aggregate savings for the Medicaid program during the performance year and the participating entity meets specified benchmarks on quality measures for the challenge pool, while also maintaining or exceeding its performance on the quality measures for the individual shared savings pool, it may also be eligible to receive shared savings payments from the challenge pool.

(B) The main provisions of the regulation: (1) Describes the provider qualifications necessary for providers to become participating entities in the PCMH+ program, (2) describes the types of care coordination services that providers affiliated with participating entities are required to offer as part of the PCMH+ program, (3) sets forth the framework for measuring the quality of participating entities' performance, (4) describes the approach for preventing, monitoring and remedying under-service of Medicaid members participating in PCMH+, (5) sets forth the categories of Medicaid members who are eligible to participate in PCMH+, (6) describes the methodology for assigning Medicaid members to participating entities, (7) establishes the parameters for monitoring participating entities' adherence to PCMH+ requirements, (8) sets forth the framework for measuring Medicaid expenditures incurred by PCMH+ members, including inventorying the benefits and associated expenditures that are included in the calculation of shared savings payments, if earned by participating entities, (9) describes the reimbursement methodology for the PCMH+ program, including care coordination add-on payments, individual pool shared savings payments, and

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challenge pool shared savings payments, and (10) sets forth such additional details as are necessary for the department to implement the PCMH+ program.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation sets forth the parameters and requirements to enable the department to implement the PCMH+ program.

experience and quality of care provided, as determined and specified by the department.

(b) Each participating entity shall preserve all required documentation in its original written or electronic form for a period of time not less than five years or the length of time required by statute or regulation, whichever is greater. Such documentation is subject to review by the department. If there is a dispute between the department and a participating entity concerning any aspect of the participating entity's participation in PCMH+, documentation shall be maintained until the end of the dispute, five years or the length of time required by statute or regulation, whichever is greater.

(c) The department may disallow and recover any amounts paid to a participating entity for which required documentation is not maintained and not provided to the department upon request.

(d) The department may audit all relevant records and documentation and take any other appropriate quality assurance measures it deems necessary to assure compliance with applicable regulatory and statutory requirements.

(NEW) Sec. 17b-262-1107. Reserved

(NEW) Sec. 17b-262-1108. Reserved

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The department is participating in SIM by implementing PCMH+. The goals of PCMH+ are to further improve health outcomes and care experience for Medicaid members who are assigned to PCMH+, through these efforts containing the growth of Medicaid expenditures. Specifically, PCMH+ will build on DSS' existing person-centered medical home (PCMH) model by incorporating new enhanced care coordination activities and care coordination add-on payment activities related to the integration of primary care and behavioral health care, building provider competencies to support Medicaid members with complex medical conditions and disability needs and promoting linkages to community supports that can assist members in utilizing their Medicaid benefits.

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(B) The main provisions of the regulation: (1) Describes the provider qualifications necessary for providers to become participating entities in the PCMH+ program, (2) describes the types of care coordination services that providers affiliated with participating entities are required to offer as part of the PCMH+ program, (3) sets forth the framework for measuring the quality of participating entities' performance, (4) describes the approach for preventing, monitoring and remedying under-service of Medicaid members participating in PCMH+, (5) sets forth the categories of Medicaid members who are eligible to participate in PCMH+, (6) describes the methodology for assigning Medicaid members to participating entities, (7) establishes the parameters for monitoring participating entities' adherence to PCMH+ requirements, (8) sets forth the framework for measuring Medicaid expenditures incurred by PCMH+ members, including inventorying the benefits and associated expenditures that are included in the calculation of shared savings payments, if earned by participating entities, (9) describes the reimbursement methodology for the PCMH+ program, including care coordination add-on payments, individual pool shared savings payments, and

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challenge pool shared savings payments, and (10) sets forth such additional details as are necessary for the department to implement the PCMH+ program.

(C) The legal effects of the regulation, including all of the ways that the regulation would change existing regulations or other laws: The regulation sets forth the parameters and requirements to enable the department to implement the PCMH+ program.



**STATE OF CONNECTICUT
GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION**

Written or electronic certification to accompany a State contract with a value of \$50,000 or more, pursuant to C.G.S. §§ 4-250, 4-252(c) and 9-612(f)(2) and Governor Dannel P. Malloy's Executive Order 49.

INSTRUCTIONS:

Complete all sections of the form. Attach additional pages, if necessary, to provide full disclosure about any lawful campaign contributions made to campaigns of candidates for statewide public office or the General Assembly, as described herein. Sign and date the form, under oath, in the presence of a Commissioner of the Superior Court or Notary Public. Submit the completed form to the awarding State agency at the time of initial contract execution and if there is a change in the information contained in the most recently filed certification, such person shall submit an updated certification either (i) not later than thirty (30) days after the effective date of such change or (ii) upon the submittal of any new bid or proposal for a contract, whichever is earlier. Such person shall also submit an accurate, updated certification not later than fourteen days after the twelve-month anniversary of the most recently filed certification or updated certification.

- CHECK ONE:** Initial Certification 12 Month Anniversary Update (Multi-year contracts only.)
 Updated Certification because of change of information contained in the most recently filed certification or twelve-month anniversary update.

GIFT CERTIFICATION:

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

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

I, the undersigned, am a Principal or Key Personnel of the person, firm or corporation authorized to execute this certification on behalf of the Contractor. I hereby certify that, no gifts were made by (A) such person, firm, corporation, (B) any principals and key personnel of the person firm or corporation who participate substantially in preparing bids, proposals or negotiating state contracts or (C) any agent of such, firm, corporation, or principals or key personnel who participates substantially in preparing bids, proposals or negotiating state contracts, to (i) any public official or state employee of the state agency or quasi-public agency soliciting bids or proposals for state contracts who participates substantially in the preparation of bid solicitations or request for proposals for state contracts or the negotiation or award of state contracts or (ii) any public official or state employee of any other state agency, who has supervisory or appointing authority over such state agency or quasi-public agency.

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

CAMPAIGN CONTRIBUTION CERTIFICATION:

I further certify that, on or after January 1, 2011, neither the Contractor nor any of its principals, as defined in C.G.S. § 9-612(f)(1), has made any **campaign contributions** to, or solicited any contributions on behalf of, any exploratory committee, candidate committee, political committee, or party committee established by, or supporting or authorized to support, any candidate for statewide public office, in violation of C.G.S. § 9-612(f)(2)(A). I further certify that **all lawful campaign contributions** that have been made on or after January 1, 2011 by the Contractor or any of its principals, as defined in C.G.S. § 9-612(f)(1), to, or solicited on behalf of, any exploratory committee, candidate committee, political committee, or party committee established by, or supporting or authorized to support any candidates for statewide public office or the General Assembly, are listed below:

Lawful Campaign Contributions to Candidates for Statewide Public Office:

<u>Contribution Date</u>	<u>Name of Contributor</u>	<u>Recipient</u>	<u>Value</u>	<u>Description</u>

Lawful Campaign Contributions to Candidates for the General Assembly:

<u>Contribution Date</u>	<u>Name of Contributor</u>	<u>Recipient</u>	<u>Value</u>	<u>Description</u>

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

St. Vincent's Medical Center
Printed Contractor Name

Stuart G. Marcus, MD
Printed Name of Authorized Official


Signature of Authorized Official

Subscribed and acknowledged before me this 12 day of June, 2016.

Rolores M. Miele
Commissioner of the Superior Court (or Notary Public)

May 31 2021
My Commission Expires



STATE OF CONNECTICUT
CONSULTING AGREEMENT AFFIDAVIT

Affidavit to accompany a bid or proposal for the purchase of goods and services with a value of \$50,000 or more in a calendar or fiscal year, pursuant to Connecticut General Statutes §§ 4a-81(a) and 4a-81(b). For sole source or no bid contracts the form is submitted at time of contract execution.

INSTRUCTIONS:

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

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

This affidavit must be amended if there is any change in the information contained in the most recently filed affidavit not later than (i) thirty days after the effective date of any such change or (ii) upon the submittal of any new bid or proposal, whichever is earlier.

AFFIDAVIT: [Number of Affidavits Sworn and Subscribed On This Day: _____]

I, the undersigned, hereby swear that I am a principal or key personnel of the bidder or contractor awarded a contract, as described in Connecticut General Statutes § 4a-81(b), or that I am the individual awarded such a contract who is authorized to execute such contract. I further swear that I have not entered into any consulting agreement in connection with such contract, **except for the agreement listed below:**

_____ Consultant's Name and Title		_____ Name of Firm (if applicable)
_____ Start Date	_____ End Date	_____ Cost
Description of Services Provided: _____		

Is the consultant a former State employee or former public official? YES NO

If YES: _____
Name of Former State Agency Termination Date of Employment

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

St. Vincent's Medical Center		6/14/18
Printed Name of Bidder or Contractor	Signature of Principal or Key Personnel	Date
	Stuart G. Marcus, MD	DMHAS
	Printed Name (of above)	Awarding State Agency

Sworn and subscribed before me on this 14 day of June, 2016.

Commissioner of the Superior Court
or Notary Public
May 31, 2021
My Commission Expires



STATE OF CONNECTICUT
AFFIRMATION OF RECEIPT OF STATE ETHICS LAWS SUMMARY

Written or electronic affirmation to accompany a large State construction or procurement contract, having a cost of more than \$500,000, pursuant to Connecticut General Statutes §§ 1-101mm and 1-101qq

INSTRUCTIONS:

Complete all sections of the form. Submit completed form to the awarding State agency or contractor, as directed below.

CHECK ONE:

- I am a person seeking a large State construction or procurement contract. I am submitting this affirmation to the awarding State agency with my bid or proposal. [Check this box if the contract will be awarded through a competitive process.]
I am a contractor who has been awarded a large State construction or procurement contract. I am submitting this affirmation to the awarding State agency at the time of contract execution. [Check this box if the contract was a sole source award.]
I am a subcontractor or consultant of a contractor who has been awarded a large State construction or procurement contract. I am submitting this affirmation to the contractor.
I am a contractor who has already filed an affirmation, but I am updating such affirmation either (I) no later than thirty (30) days after the effective date of any such change or (II) upon the submittal of any new bid or proposal, whichever is earlier.

IMPORTANT NOTE:

Within fifteen (15) days after the request of such agency, institution or quasi-public agency for such affirmation contractors shall submit the affirmations of their subcontractors and consultants to the awarding State agency. Failure to submit such affirmations in a timely manner shall be cause for termination of the large State construction or procurement contract.

AFFIRMATION:

I, the undersigned person, contractor, subcontractor, consultant, or the duly authorized representative thereof, affirm (1) receipt of the summary of State ethics laws* developed by the Office of State Ethics pursuant to Connecticut General Statutes § 1-81b and (2) that key employees of such person, contractor, subcontractor, or consultant have read and understand the summary and agree to comply with its provisions.

* The summary of State ethics laws is available on the State of Connecticut's Office of State Ethics website.

Signature: Vincent C. Caponi; Date: December 14 2016; Title: PRESIDENT / CEO

Firm or Corporation (If applicable); Street Address; City; State; Zip

Awarding State Agency



STATE OF CONNECTICUT

Written or electronic PDF copy of the written certification to accompany a large state contract pursuant to P.A. No. 13-162 (Prohibiting State Contracts With Entities Making Certain Investments In Iran)

Respondent Name: ST. VINCENT'S MEDICAL CENTER

INSTRUCTIONS:

CHECK ONE: [] Initial Certification. [] Amendment or renewal.

A. Who must complete and submit this form. Effective October 1, 2013, this form must be submitted for any large state contract, as defined in section 4-250 of the Connecticut General Statutes. This form must always be submitted with the bid or proposal, or if there was no bid process, with the resulting contract, regardless of where the principal place of business is located.

Pursuant to P.A. No. 13-162, upon submission of a bid or prior to executing a large state contract, the certification portion of this form must be completed by any corporation, general partnership, limited partnership, limited liability partnership, joint venture, nonprofit organization or other business organization whose principal place of business is located outside of the United States. United States subsidiaries of foreign corporations are exempt. For purposes of this form, a "foreign corporation" is one that is organized and incorporated outside the United States of America.

Check applicable box:

[X] Respondent's principal place of business is within the United States or Respondent is a United States subsidiary of a foreign corporation. Respondents who check this box are not required to complete the certification portion of this form, but must submit this form with its Invitation to Bid ("ITB"), Request for Proposal ("RFP") or contract package if there was no bid process.

[] Respondent's principal place of business is outside the United States and it is not a United States subsidiary of a foreign corporation. CERTIFICATION required. Please complete the certification portion of this form and submit it with the ITB or RFP response or contract package if there was no bid process.

B. Additional definitions.

- 1) "Large state contract" has the same meaning as defined in section 4-250 of the Connecticut General Statutes;
2) "Respondent" means the person whose name is set forth at the beginning of this form; and
3) "State agency" and "quasi-public agency" have the same meanings as provided in section 1-79 of the Connecticut General Statutes.

C. Certification requirements.

No state agency or quasi-public agency shall enter into any large state contract, or amend or renew any such contract with any Respondent whose principal place of business is located outside the United States and is not a United States subsidiary of a foreign corporation unless the Respondent has submitted this certification.

Complete all sections of this certification and sign and date it, under oath, in the presence of a Commissioner of the Superior Court, a Notary Public or a person authorized to take an oath in another state.

CERTIFICATION:

I, the undersigned, am the official authorized to execute contracts on behalf of the Respondent. I certify that:

[] Respondent has made no direct investments of twenty million dollars or more in the energy sector of Iran on or after October 1, 2013, as described in Section 202 of the Comprehensive Iran Sanctions, Accountability and Divestment Act of 2010.

[] Respondent has either made direct investments of twenty million dollars or more in the energy sector of Iran on or after October 1, 2013, as described in Section 202 of the Comprehensive Iran Sanctions, Accountability and Divestment Act of 2010, or Respondent made such an investment prior to October 1, 2013 and has now increased or renewed such an investment on or after said date, or both.

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

ST. VINCENT'S MEDICAL CENTER
Printed Respondent Name

Vincent C. Caponi
Printed Name of Authorized Official

Signature of Authorized Official

Subscribed and acknowledged before me this 14 day of December, 2016.

Commissioner of the Superior Court (or Notary Public)

May 31, 2021



STATE OF CONNECTICUT
NONDISCRIMINATION CERTIFICATION – Affidavit
By Entity
For Contracts Valued at \$50,000 or More

Documentation in the form of an affidavit signed under penalty of false statement by a chief executive officer, president, chairperson, member, or other corporate officer duly authorized to adopt corporate, company, or partnership policy that certifies the contractor complies with the nondiscrimination agreements and warranties under Connecticut General Statutes §§ 4a-60 and 4a-60a, as amended

INSTRUCTIONS:

For use by an entity (corporation, limited liability company, or partnership) when entering into any contract type with the State of Connecticut valued at \$50,000 or more for any year of the contract. Complete all sections of the form. Sign form in the presence of a Commissioner of Superior Court or Notary Public. Submit to the awarding State agency prior to contract execution.

AFFIDAVIT:

I, the undersigned, am over the age of eighteen (18) and understand and appreciate the obligations of

an oath. I am Secretary of St. Vincent's Medical Center, an entity
Signatory's Title Name of Entity

duly formed and existing under the laws of Connecticut.
Name of State or Commonwealth

I certify that I am authorized to execute and deliver this affidavit on behalf of
St. Vincent's Medical Center and that St. Vincent's Medical Center
Name of Entity Name of Entity

has a policy in place that complies with the nondiscrimination agreements and warranties of Connecticut General Statutes §§ 4a-60 and 4a-60a, as amended.

Peter H. Struzzi
Authorized Signatory

Peter H. Struzzi
Printed Name

Sworn and subscribed to before me on this 14 day of JUNE 2016.

Roberto M. Miele
Commissioner of the Superior Court/ Notary Public

May 31 2021
Commission Expiration Date

MEMORANDUM OF LIABILITY INSURANCE Current as of: 7/1/2016

INSURED

ASCENSION HEALTH ALLIANCE
 and its subsidiaries
 1.1775 BORMAN DRIVE
 ST. LOUIS, MO 63146

THIS MEMORANDUM IS ISSUED AS A MATTER OF INFORMATION ONLY TO AUTHORIZED VIEWERS FOR THEIR INTERNAL USE ONLY AND CONFERS NO RIGHTS UPON ANY VIEWER OF THIS MEMORANDUM OTHER THAN THOSE PROVIDED FOR IN THE POLICY. THIS MEMORANDUM DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE DESCRIBED BELOW. THIS MEMORANDUM MAY ONLY BE COPIED, PRINTED AND DISTRIBUTED WITHIN AN AUTHORIZED VIEWER FOR ITS INTERNAL USE, ANY OTHER USE, DUPLICATION OR DISTRIBUTION OF THIS MEMORANDUM WITHOUT PRIOR WRITTEN CONSENT IS PROHIBITED.

COMPANIES AFFORDING COVERAGE		NAIC#
COMPANY A	Self-Insurance	N/A
COMPANY B	Endurance Specialty Insurance, Ltd.	AA-3194130
COMPANY C	ACE American Insurance Company	22667

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS MEMORANDUM MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO. LETTER	TYPE OF INSURANCE	ADDL INSD	SUB WVD	POLICY NUMBER	EFFECTIVE DATE	EXPIRATION DATE	LIMITS	
							LIMITS IN USD UNLESS OTHERWISE INDICATED	
A	COMMERCIAL GENERAL LIABILITY		Y	SELF-INSURED	07/01/2016	07/01/2017	EACH OCCURRENCE	\$1,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR						MED. EXPENSE (Any one person)	\$10,000
	<input checked="" type="checkbox"/> BLANKET CONTRACTUAL LIABILITY						PERSONAL & ADVERT. INJURY	\$1,000,000
	<input checked="" type="checkbox"/> HOST LIQUOR LIABILITY						GENERAL AGGREGATE	UNLIMITED
	<input checked="" type="checkbox"/> ALL OTHER PROFESSIONALS						PRODUCTS-COMP./OPS AGG.	UNLIMITED
B	COMMERCIAL GENERAL LIABILITY	Y	Y	P010894007	07/01/2016	07/01/2017	EACH OCCURRENCE	\$1,000,000
	<input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR						DAMAGES TO RENTED PREMISES (Each occurrence)	\$150,000
							MED. EXPENSE (Any one person)	\$5,000
							PERSONAL & ADVERT. INJURY	\$1,000,000
	GENERAL AGGREGATE APPLIES PER						GENERAL AGGREGATE	\$3,000,000
<input checked="" type="checkbox"/> Policy <input type="checkbox"/> Project <input type="checkbox"/> Loc						PRODUCTS-COMP./OPS AGG.	\$3,000,000	
C	AUTOMOBILE LIABILITY	Y	Y	ISA H0904341A	07/01/2016	07/01/2017	COMBINED SINGLE LIMIT, BODILY INJURY and PROPERTY DAMAGE (Each accident) - AUTOS	\$2,000,000
	<input checked="" type="checkbox"/> ANY AUTO						COMBINED SINGLE LIMIT, BODILY INJURY and PROPERTY DAMAGE (Each accident) - AMBULANCES	\$5,000,000
	<input checked="" type="checkbox"/> HIRED AUTOS			ISA H09043408				
	<input checked="" type="checkbox"/> NON-OWNED AUTOS							
C	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY		Y	WLR C48607615 (All Other)	07/01/2016	07/01/2017	WORKERS COMPENSATION LIMITS	STATUTORY
	PARTNERS/ EXECUTIVE OFFICERS:			WLR C48607603 (CA & MA)			E.L. EACH ACCIDENT	\$5,000,000
	<input checked="" type="checkbox"/> INCL. <input type="checkbox"/> EXCL.						E.L. DISEASE - EACH EMPLOYEE	\$5,000,000
							E.L. DISEASE - POLICY LIMIT	\$5,000,000
C	EXCESS WORKERS COMPENSATION		Y	WCUC48607603	07/01/2016	07/01/2017	WORKERS COMPENSATION LIMITS	STATUTORY
			Y				EMPLOYERS LIABILITY	\$5,000,000
							SELF-INSURED RETENTION	\$1,500,000

ADDITIONAL INFORMATION

THE FOLLOWING COVERAGE ENHANCEMENTS ARE PROVIDED, TO THE EXTENT REQUIRED BY THE TERMS OF OUR SIGNED CONTRACTS, LEASES, AND/OR AGREEMENTS:

Additional Insured: The landlord, landlord's agent(s), landlord's lender(s), lessor(s), vendors, clients, and any other party as required by the signed lease and/or agreement are listed as additional insured and/or mortgagee as required.

Coverage is primary and non-contributory as required by contract on applicable policies shown above.

A waiver of subrogation is included on the applicable policies shown above.

Blanket contractual liability is included on the applicable coverage shown above.

Liquor liability is included within the general liability shown above.

Except where otherwise required by law, all Insureds share the limits of liability.

The Memorandum serves solely to list insurance coverage/policies, limits and dates of coverage. Any modifications hereto are not authorized.

ADDITIONAL INFORMATION

Updated form can be found at http://www.ascensionhealth.org/index.php?option=com_content&view=article&id=362

For questions, contact: Ascension at certrequest@ascension.org

INSURED

ASCENSION HEALTH ALLIANCE and its subsidiaries

11775 Borman Drive
St. Louis, MO 63146

SUBSIDIARIES:

Company	City	St./Prov
2860 MAIN, LLC	BRIDGEPORT	CT
2900 MAIN STREET, LLC	BRIDGEPORT	CT
ASCENSION HEALTH ALLIANCE-CONNECTICUT		CT
ASCENSION HEALTH RESOURCE AND SUPPLY MANAGEMENT GROUP, LLC		CT
ASCENSION IS - CONNECTICUT LOC		CT
CARDIOLOGY PHYSICIANS OF FAIRFIELD COUNTY, LLC	BRIDGEPORT	CT
HAWLEY AVENUE HOLDINGS, LLC	BRIDGEPORT	CT
MAIN STREET PROPERTIES, LLC	BRIDGEPORT	CT
MEDXCEL FACILITIES MGMT, LLC-CT		CT
RESIDENTIAL HOLDINGS, LLC	BRIDGEPORT	CT
ST. VINCENT'S COLLEGE, INC.	BRIDGEPORT	CT
ST. VINCENT'S DEVELOPMENT, INC.	BRIDGEPORT	CT
ST. VINCENT'S HEALTH SERVICES CORPORATION	BRIDGEPORT	CT
ST. VINCENT'S MEDICAL CENTER	BRIDGEPORT	CT
ST. VINCENT'S MEDICAL CENTER FOUNDATION, INC.	BRIDGEPORT	CT
ST. VINCENT'S MULTISPECIALTY GROUP, INC	BRIDGEPORT	CT
ST. VINCENT'S SPECIAL NEEDS CENTER, INC.	TRUMBULL	CT
VINCENTURES, INC	BRIDGEPORT	CT