Addendum 1
Department of Social Services
Third Party Liability Request for Proposals #RFP #060208_TPL_RFP

The Department of Social Services is issuing Addendum 1 to the Third Party Liability Request for Proposals (RFP). Addendum 1 contains the following sections:

1. Section 1 - Revised Procurement Schedule

2. Section 2 - Responses to questions submitted regarding the RFP

Section 1 - Revised Procurement Schedule:

| Milestones | Original Period | Revised Period |
|---|---|---|
| Proposals due (no later than 3:00 p.m. eastern standard time) | July 22, 2008 | July 24, 2008 |
| Review of proposals and recommendations made to the Commissioners | TBD | August 25, 2008 |
| Announcement of awards for contract negotiation | TBD | September 8, 2008 |
| Contract negotiations/contract execution | TBD | September 25, 2008 |

Section 2 - Responses:

Questions submitted by interested bidders and the Department of Social Services' official responses follow. These responses shall clarify the requirements of the RFP. In the event of an inconsistency between information provided in the RFP and information in these responses, the information in these responses shall control.

1. **Question: The due date in the RFP itself is stated as July 22, 2008. The posting from the Web site indicated July 27, 2008. Which is correct?**

   **Response: To compensate for any confusion experienced by potential bidders, the Department of Social Services is extending the proposal due date by two days. See revised Procurement Schedule above. Proposals must be received at the Department of Social Services no later than 3:00 p.m. eastern standard time on July 24, 2008. The changed due date of July 24, 2008 is now listed on the Department of Administrative Services' Web site.**

2. Question: General - Describe and explain any Third Party Liability-related activities performed by parties other than the resultant Third Party Liability contractor that would duplicate the scope of work outlined in the RFP.

   Response:

   Related to the RFP's benefit recovery requirement: The Department of Social Services has a Medicare Advocacy Program for pursuing Medicare coverage for skilled nursing facility, chronic disease hospital, and home health care services.

   Related to the RFP's trauma recovery requirement: The Department of Social Services' Medicaid Management Information System identifies suspect accident/trauma cases. The Department of Social Services' eligibility workers and investigators learn about potential accident/trauma-related causes of action through contact with the clients. The Department of Administrative Services performs data matches with the insurance industry to identify clients who have personal injury claims. It also identifies clients that have filed a cause of action in Connecticut's court system.

   Related to the RFP's third party liability verification requirement: The Department of Social Services verifies client Medicare information.

3. Question: General - What is the total size of the Medicaid population covered by this contract? Are any recoveries limited to only the fee-for-service population?

   Response: According to the Active Recipients Report issued by the Department of Social Services' Information Technology Systems for April 2008, there are about 421,000 Medicaid recipients and 41,000 other medical (Refugee, Connecticut AIDS Drugs Assistance Program, Connecticut Department of Children and Families, Connecticut Home Care Program/1, Connecticut Home Care Program/2, and State Administered General Assistance Medical) recipients, totaling 462,000 recipients for which the Department of Social Services would expect the resultant Third Party Liability contractor to pursue benefit recovery, identification, verification, and update of third party liability health insurance, and perform other Third Party Liability activities as outlined in the RFP. Recoveries are not limited to the fee-for-service population.

4. Question: General - What are the recovery and cost avoidance statistics for the last three fiscal years?

   Response:

   Medicaid Cost Avoidance

   - State Fiscal Year 2005:
     - Health insurance - 271,383 claims at $145,157,301
     - Medicare - 281,748.00 claims at $47,535,090
   - State Fiscal Year 2006:
     - Health insurance - 193,561 claims at $133,537,465
     - Medicare - 199,078 claims at $40,721,852
   - State Fiscal Year 2007:
     - Health insurance - 114,503 claims at $66,348,958
     - Medicare - 99,837 claims at $27,477,718

   Medicaid Recovery

   - State Fiscal Year 2005: Health insurance and Medicare - $29,389,031
   - State Fiscal Year 2006: Health insurance and Medicare - $34,193,667
   - State Fiscal Year 2007: Health insurance and Medicare - $31,592,674

5. Question: General - What were the total recoveries generated in 2005, 2006, and 2007 for each of the following recovery areas: Casualty, Estate and Annuity, Health, and Medicare?

   Response:

   - State Fiscal Year 2005:
     - Casualty, Estate, and Annuity:
       - Accident liens - $4,326,138
       - Probate estates - $7,568,463
       - Probate inheritances - $642,306
     - Health Insurance - $6,876,103
     - Medicare - $5,289,334
     - Provider Audit Projects (both health insurance and Medicare) - $17,223,594
   - State Fiscal Year 2006:
     - Casualty, Estate, and Annuity:
       - Accident liens - $6,449,535.03
       - Probate estates - $10,501,601.63
       - Probate inheritances - $976,288.75
     - Health Insurance - $11,085,071
     - Medicare - $6,152,819
     - Provider Audit Projects (both health insurance and Medicare) - $16,955,776

- State Fiscal Year 2007:
  - Casualty, Estate and Annuity:
    - Accident liens - $3,579,234.95
    - Probate estates - $9,105,557.89
    - Probate inheritances - $445,955.31
  - Health Insurance: $8,518,408
  - Medicare: $4,716,071
  - Provider Audit Projects (both health insurance and Medicare) - $18,358,195

6. Question: General - What is the monthly average number of new insurance policies identified currently? What is the average number of insurance policy updates per month?

   Response: The Department of Social Services' tracking system does not differentiate between new insurance policies and updates. In State Fiscal Year 2007, the Division of Fraud and Recoveries received (and completed) about 14,000 referrals. This number includes both new policies and updates to existing policies. The average is 1,167 per month.

7. Question: Page 11, Item 1.c - When does the State plan on changing to an At-Risk model for Medicaid Managed Care Organizations?

   Response: The Department of Social Services plans to implement an at-risk model for Medicaid Managed Care tentatively July 1, 2008.

8. Question: Page 43, Item C.1 - How will the bidder receive encounter claims data?

   Response: Medicaid Managed Care Organizations (MCO) will be required to provide the Department of Social Services with an electronic record of every encounter between a provider and a client in a coding and format specified by

the Department of Social Services. Subsequently, the Department of Social Services or its agent will provide the Third Party Liability contractor with MCO encounter data.

9. Question: Page 44, Item C.1.a - "The bidder's proposal and procedures to perform benefit recovery work under this requirement shall not duplicate, affect, or otherwise hinder similar or like work already being performed by the Department of Social Services." Specifically, what recovery work is already being done by the Department of Social Services?

   Response: The Department of Social Services has a Medicare Advocacy Project for pursuing Medicare coverage for services provided in Skilled Nursing Facilities, Chronic Disease Hospitals, and Home Health Services.

10. Question: Page 60 - What access will the bidder have to the Eligibility Management System for manual updates of Third Party Liability records? Does Electronic Data Systems Corporation provide 3270 access to the Medicaid Management Information System for data retrieval and update? What software is used to access the Electronic Data Systems Corporation FA systems?

    Response: The Third Party Liability records are updated on the Eligibility Management System, not directly on the Medicaid Management Information System. The Department of Social Services expects the resultant contractor to have inquiry and update access to the Department of Social Services' Eligibility Management System for manual updates of Third Party Liability records. The resultant contractor will be expected to provide its own 3270 emulation software and licenses for this access and may need to provide a direct data line. The Department of Social Services expects the resultant contractor to have inquiry only access to the Electronic Data Systems Corporation's Medicaid Management Information System, interChange. The interChange is a Web-based system, so the user would need access to the public internet. Electronic Data Systems provides the necessary software to enroll the user as a CISCO EDS VPN client. Users will be expected to sign confidentiality agreements required by the Department of Social Services before access will be authorized.

11. Question: Page 61, Item C.2 - May an automated process be used to "manually update" third party information on the Medicaid database using user emulation technology?

    Response: The Department of Social Services is open to an automated process to update as much third party information as possible. However, some information (for example, detailed information on long-term care/skilled nursing coverage referenced in the RFP) cannot be transmitted via the automated process and is expected to have to be entered manually. The bidder may propose to automate as much as possible.

12. Question: Page 68, Item C.4 - How is the current vendor notifying providers when Third Party Liability information has changed?

    Response: The current vendor contacts providers via telephone or fax to report the results of the verification in response to the Third Party Liability Information Form.

13. Question: Page 73 - RFP language states: Contact organizations and arrange for the data matches (The resultant contractor shall be responsible for payment of any and all costs incurred in securing necessary files from the Department of Social Services and the Department of Social Services' Medicaid Management Information System contractor, performing the data matches, ensuring the third party liability billings do not duplicate those generated by the Medicaid Management Information System contractor, and returning the output of data matches to the Department of Social Services for input on the Eligibility Management System). Does the Medicaid Management Information System vendor create Third Party Liability billings? Elaborate on this relationship as it pertains to Third Party Liability billing data.

    Response: The Medicaid Management Information System vendor, Electronic Data Systems Corporation, ceased generating third party liability billings and will not perform this task when the work contained in the RFP is implemented.

14. Question: Page 77, Item 6 - Does "Trauma Recovery" as described in the RFP include all first party and third party liability accident, Workers' Compensation, commercial liability, and medical malpractice situations?

    Response: Yes.

15. Question: Page 77, Item 6 - Is there any circumstance where the vendor is expected to do any recovery or collection work within the Trauma Recovery process as set forth in the RFP?

    Response: Yes. The Department of Social Services expects the resultant contractor to perform Workers' Compensation recoveries or collections.

16. Question: Page 77, Item 6 - Would the State ever consider outsourcing both the investigation and recovery of Trauma/Casualty-related claims?

    Response: At this time, the Department of Social Services is not considering outsourcing both the investigation and recovery of Trauma/Casualty-related claims.

17. Question: Page 77, Item 6 - What is the percentage of trauma claims identified by the current vendor for the Department of Administrative Services in comparison to the total population of claims identified by both the Department of Administrative Services and the Department of Administrative Services' Third Party Liability vendor?

    Response: The current Third Party Liability vendor identifies about 4 percent of the total accident-related and trauma cases pursued by the Department of Administrative Services.

18. Question: Page 77, Item 6 - What are your Trauma Recovery reporting requirements?

    Response: The Department of Social Services requires detailed and summary reports containing, but not limited to, the following information:

    - Number of inquiries sent
    - Number of positive responses
    - Number of negative responses
    - Number with no responses
    - Number of second requests

- Number of cases referred to the Department of Administrative Services
- Number of cases that the Department of Administrative Services is not pursuing
- Number of cases that the Department of Administrative Services is pursuing
- Number of cases the Department of Administrative Services recovered on
- Dollar amount recovered
- Type of trauma recovery (e.g., accident, work-related illness/injury)

This information will be provided at a frequency to be determined by the Department of Social Services.

19. Question: Page 77, Item 6 - Does the Department of Administrative Services require the vendor's Trauma Recovery staff to be located in the State?

Response: No.

20. Question: Page 77, Item 6 - What were the total amounts of Trauma-related liability recoveries made by the Department of Administrative Services in fiscal years 2005, 2006, and 2007?

Response: The Department of Administrative Services does not code their recoveries to specifically track cases that were identified by trauma coding. We have included all accident-related and trauma recoveries in the following figures. In State Fiscal Year 2004-05, the Department of Administrative Services recovered $4,326,137. In State Fiscal Year 2005-06, the Department of Administrative Services recovered $6,449,535. In State Fiscal Year 2006-07, the Department of Administrative Services recovered $3,579,235 in accident-related and trauma claims.

21. Question: Page 77, Item 6 - Did any other vendor supplement the Department of Administrative Services in recovering Trauma-related claims dollars? What were those recovery amounts for fiscal years 2005, 2006, and 2007?

    Response: The current Third Party Liability vendor supplemented the Department of Administrative Services in recovering trauma-related claims dollars. The recoveries attributed to the Third Party Liability vendor's identification of trauma cases are $101,017 in State Fiscal Year 2004-05, $198,174 in State Fiscal Year 2005-06, and $67,214 in State Fiscal Year 2006-07.

22. Question: Page 77, Item 6 - What were total paid claim dollars spent in 2005, 2006, and 2007, not including dental, vision, or mental health claims?

    Response:

    - Calendar Year 2005: $3,540,998,331
    - Calendar Year 2006: $3,378,974,228
    - Calendar Year 2007: $3,333,652,606

23. Question: Page 77, Item 6 - Does the Department of Social Services have any current agreements with the Connecticut Department of Transportation or the Connecticut Industrial Commission to obtain data related to accidents?

    Response: No.

24. Question: Page 78, Item 6 - What percentage of questionnaires or potential accident claims are dismissed or written off because a full investigation could not be completed for lack of response?

    Response: Ninety percent of accident claims are dismissed because a full investigation could not be completed for lack of response to the Electronic Data Systems Corporation questionnaire.

25. Question: Page 78, Item 6 - Does Electronic Data Systems Corporation ever send investigation questionnaires to Medicaid recipients or are the questionnaires just sent to the billing providers to gather information on potential accident liability claims?

    Response: Electronic Data Systems Corporation sends investigation questionnaires to the billing providers to gather information on potential accident liability claims. Electronic Data Systems Corporation does not send questionnaires to Medicaid recipients.

26. Question: Page 78, Item 6 - What is the response rate for questionnaires sent?

    Response: Ten percent of questionnaires are received from providers.

27. Question: Page 78, Item 6 - Does the term “client” used in Section 6 under Trauma Recovery mean Medicaid recipient? If not, clarify the term “client.”

    Response: The Department of Social Services uses the term “client” and “recipient” interchangeably. The term “client” used in Section 6 under Trauma Recovery means not only a Medicaid recipient, but a recipient of any of the Department of Social Services’ state-funded medical programs as well.

28. Question: Page 80, Item 6.a.4 - The bidder shall propose a project that will supplement the Department of Social Services’ trauma recovery procedures by identifying and recovering casualty insurance recoveries. Will the successful bidder be allowed to recover on all cases they identify that have not been previously identified by the Department of Administrative Services? Will the vendor be able to charge a contingency fee on all money recovered?

    Response: The resultant contractor does not perform the actual recovery on the cases they identify. Rather, the Department of Administrative Services performs the actual recovery and reserves the right to reject a case identified by the resultant contractor. The resultant contractor may charge a contingency fee on all accident-related medical recoveries received.

29. Question: Page 83 - How many Child Support Enforcement hits does the Department of Social Services allow each month under the current contract?

    Response: The Department of Social Services allows about three hundred unique policy hits each month.

30. Question: Page 86, Item C.7 - Will the Child Support Program provide the National Medical Support Notice letters to the vendor for issuing and follow-up?

    Response: It is not necessary for the Child Support Program to provide the National Medical Support Notice letters. The National Medical Support Notice is a Federal standardized form (Form OMB-0970-0222 National Medical Support Notice, Part A and Form OMB-1210-0113, Part B). These forms are available from the U.S. Department of Health and Human Services, Administration for Children and Families.

31. Question: Attachment 10 - Provide current pricing for all RFP services.

    Response:

    Bidders must consider the current Third Party Liability pricing information provided in the following table as a guide only and propose their own costs to be considered and evaluated.

| | Current Third Party Liability Pricing Item | Contingency Fee (%), Fixed Price ($), or Administrative Cost |
|---|---|---|
| 1. | Third Party Liability Billings/Disallowances | 8.10% |
| 2. | On-site Hospital Audits | 8.10% |
| 3. | Nursing Home Self-reporting | 7.30% |
| 4. | On-site Nursing Home Audits | 9.00% |
| 5. | Special Recovery Projects | 8.10% |
| 6. | Trauma and Casualty Recoveries | 12.00% |
| 7. | Workers' Compensation Recoveries | 15.00% |
| 8. | Absent Parent Identification | $75.00 [1] |

| | Current Third Party Liability Pricing Item | Contingency Fee (%), Fixed Price ($), or Administrative Cost |
|---|---|---|
| 9. | Third Party Liability Project | 9.90% and 12.90% [2] |
| 10. | Information Technology Programming | $120.00 [3] |

[1] $75 per unique health insurance policy verification of noncustodial parent health insurance for children having medical support orders

[2] 9.90% for cumulative reports up to $4,000000 and 12.90% for recoveries exceeding $4,000,001

[3] As part of expanding the contract scope of work and in excess of an initial one hundred free programming hours, an all-inclusive per hour fee for altering, adjusting, or augmenting existing reports

32. Question: General - For identical requirements across Scope of Work components (e.g., "Describe any formal arrangements or technology it currently has in place to obtain information from various sources of third party liability" is required in RFP Sections C.2.a.3, C.3.a.4, C.4.a.4, etc.), may the bidder reduce the number of pages of its response by utilizing a cross-reference system to direct evaluators to a single response?

    Response: Identical requirements do exist across some of the Scope of Work components. Where the exact requirement language occurs across components, a bidder may use a cross-reference system to direct evaluators to a single response and thereby reducing the number of pages in its response.

33. Question: RFP Section II.C (Page 18) - Will the Department of Social Services provide the names of vendors who submitted the mandatory Letter of Intent?

    Response: The following bidders submitted Letters of Intent by the stated due date and time:

    - ACS Government Solutions Group
    - HMS
    - Other Party Liability, Inc.

34. Question: RFP Section IV.A.7 (Page 29) - If an employee of the bidder operates out of a home office in Connecticut, would this location be

considered a “Connecticut worksite” to be described in RFP Appendix 3, “Workforce Analysis Form”?

Response: Yes.

35. Question: RFP Section IV.B.3, Items 3 - 7 (Page 36) - Do these requirements refer to contracts described in response to Item 2 of RFP Section IV.B.3.a only (i.e., work performed in the last five years)?

Response: Yes.

36. Question: RFP Section I.F (Page 16) - In the interest of full disclosure, would bidders who propose to use the services of a parent company, a wholly-owned subsidiary company, and/or a sister company (i.e., a company sharing the same parent company as the bidding company) to contribute to and/or fulfill any part of the scope of service included the RFP be required to consider such parent, subsidiary, or sister company a subcontractor?

Response: “Subcontractor" means a party to a subcontract with a contractor who has agreed to provide some or all of the goods and services the original contractor is required to provide. To the extent that the relationship between the bidder and the parent company, wholly owned subsidiary, and/or sister agency meets the definition of subcontractor provided here, the bidder must comply with the RFP requirements.

37. Question: RFP Section IV.B.3.a (Page 36) - Our company currently performs services similar to those described in the RFP to many Medicaid agencies. Given the depth of detail that bidders are required to provide for all current contracts, such a list will consume many pages. Given that the Organizational Capability and Structure chapter is limited to fifty pages, citing the contractual details of every contract we currently maintain will force us to limit the depth of our answers to the other requirements of this Section. Consequently, our depth of contractual experience may unfairly advantage bidders with less contractual experience to disclose. Would the Department of Social Services be amenable to bidders submitting the information pertaining to current and past contract experience in an appendix that is outside of the fifty-page limit imposed on this Section?

    Response: The Department of Social Services has changed the page limitation of the Organizational Capability and Structure section from fifty pages to sixty pages.

38. Question: RFP Section IV.B.3.b (Page 37) - If the bidder utilized a subcontractor in order to fulfill some or all of the scope of work of the programmatic reference provided, must the bidder disclose how much was subcontracted to the third parties?

    Response: The bidder shall provide only three programmatic references for each proposed subcontractor. References must include the organization's name, address, current telephone number, and name of a specific contact person.

39. Question: RFP Section IV.B.5 (Page 38) - Will the Department of Social Services clarify what it means when it says, "special consideration will be given to those bidders who document their use of a certified small business or show the bidder's commitment to…use a certified small business"? I.e., will the Department of Social Services award additional points commensurate with each bidder's promised utilization levels of such businesses or will preference be given only in the event of a tie between two bidders?

    Response: The bidder's response to this Item will be evaluated and scored along with other evaluation criteria. If the bidder does not choose to use a certified small business, it will not eliminate the bidder from the bid process. However, the bidder will be awarded 0 points for this criterion.

40. Question: RFP Section IV.C.1.a.8 (Page 45) - Our company currently performs services similar to those described in the RFP to many Medicaid agencies. Accordingly, for this Section, would the Department of Social Services be amenable to our including the pertinent details for a representative sample of our client contracts instead of an exhaustive list?

    Response: No.

41. Question: RFP Section IV.C.1.a.8.b (Page 45) - Given that states operate on different fiscal year calendars, for the sake of effective comparisons, may bidders provide the information requested at the calendar year level?

    Response: No.

42. Question: Section IV.C.2 (Page 58) - How will unverified Third Party Liability information from regional offices and from other types of health insurance referrals received by Fraud and Recoveries, as depicted in this Section, be transmitted to the vendor? Will referrals be received electronically or via separate W-1685 "Medical Insurance Information" forms?

    Response: The current design is predicated on the vendor receiving hard copy referrals via the W-1685 form and documentation from other referral sources (Department of Children and Families and Support Enforcement Services).

43. Question: RFP Section IV.C.6 (Page 77) - Our company currently performs a very limited, come behind supplemental casualty identification project for the Department of Social Services. Will the Department of Social Services be expanding this limited service under the new contract?

    Response: Refer to RFP Section IV.C.6. This Section describes the scope of work and requirements for Trauma Recovery.

44. Question: RFP Section IV.C.7.a.12 (Page 86) - Would the bidder be assuming full National Medical Support Notice-generating responsibility or would this be to supplement the Department of Social Services' efforts? Further, does the Department of Social Services have a current annual volume of National Medical Support Notice generation that they can share?

    Response: Support Enforcement Services/Department of Social Services would only request that the resultant contractor send National Medical Support

Notices on those cases for which they identified insurance. Support Enforcement Services sent 1,920 National Medical Support Notices in State Fiscal Year 2006-07 based on work performed by the current Third Party Liability contractor.

45. Question: RFP Section V.F (Page 95) - Will the Department of Social Services confirm that the finalist that is ranked first will also be the bidder recommended to the Commissioner of Social Services for award?

Response: Recommendations along with pertinent supporting information will be conveyed to the Commissioner, which may or may not include the finalist that is ranked first. See RFP Section II.H.15, Rights Reserved (Proposal Most Advantageous).

Date Issued: June 25, 2008

Approved: _____
Chandra Yvette Williams
Grants and Contracts Manager
Department of Social Services
(Original signature on document in procurement file)

This Addendum must be signed and returned with your submission.

_____ _____
Authorized Signer Name of Company

State of Connecticut Department of Social Services
Office of Quality Assurance

# THIRD PARTY LIABILITY

# REQUEST FOR PROPOSALS

The Department of Social Services' Office of Quality Assurance is requesting proposals from qualified organizations to perform third party liability functions. Qualified organizations must have a minimum of five years of demonstrated experience with third party liability and program integrity work. Bidders that propose the use of subcontractors must present the same information about the proposed subcontractors as for bidders. Use of subcontractors is subject to the approval of the Department of Social Services.

The Department of Social Services is requesting proposals for Third Party Liability functions for the resultant contract period of October 1, 2008 to September 30, 2012. The resultant contract will be for a four-year period with the option for two one-year extensions at the discretion of the Department of Social Services. The Department of Social Services expects to award one resultant contract. The resultant contract will be performance-based where the resultant contractor will reduce the Department of Social Services' recoveries by their fee, which in most cases, is a small percentage of the money they recover in a particular area.

Interested bidders must submit a mandatory Letter of Intent to the Department of Social Services no later than 3:00 p.m. eastern standard time on June 17, 2008, Year. Failure to submit the mandatory Letter of Intent in a timely manner will preclude the bidder from further consideration.

Proposals must be received at the Department of Social Services no later than 3:00 p.m. eastern standard time on July 22, 2008. Proposals received after the stated due date and time may be accepted by the Department of Social Services as a clerical function but will not be evaluated. Those proposals that are not evaluated shall be retained for thirty days after the resultant contract is executed, after which the proposals will be destroyed. All proposals must be in sealed envelopes or sealed boxes clearly identified as "Third Party Liability RFP."

To download this Request for Proposals (RFP), access the State's Procurement/Contracting Portal at the Connecticut Department of Administrative Services' Procurement Services Home Page at http://www.das.state.ct.us/Purchase/Portal/Portal_Home.asp or call or write:

Chandra Yvette Williams
Department of Social Services
Contract Administration
25 Sigourney Street
Hartford, CT 06106
Telephone: 860-424-5361
Fax: 860-424-4953
E-mail: Chandra.Williams@ct.gov

The Department of Social Services is an Equal Opportunity/Affirmative Action Employer. Persons who are deaf or hard of hearing may use a TDD by calling 1-

800-842-4524. Questions or requests for information in alternative formats must be directed to the Contract Administration Office at 860-424-5693. The Department of Social Services reserves the right to reject any and all proposals or cancel this procurement at any time if it is deemed in the best interest of the State.

CONTENTS

## Acronyms, Abbreviations, and Definitions

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

1. Addendum - An addition to a completed written document

2. Americans with Disabilities Act (ADA) of 1990 - A comprehensive Federal civil rights law that prohibits discrimination against individuals with disabilities in employment, state and Federal government programs and activities, public accommodations, transportation, and telecommunications

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

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

5. Bidder - An individual or organization who submits a proposal in response to this Request for Proposals

6. Bureau of Child Support Enforcement (BCSE) - The bureau established within the Department of Social Services by General Statutes of Connecticut (C.G.S.) §17b-179(j) as the Title IV-D agency for the State of Connecticut (BCSE is responsible for enforcing the medical insurance component of a child support order)

7. Business day - A day during which State of Connecticut offices are open for business (Monday through Friday excluding State holidays)

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

9. Collaboration - The act of working jointly with others or together

10. Commissioner - The Commissioner of the Department of Social Services, as defined in Connecticut General Statutes (C.G.S.) §17b-3 (Michael P. Starkowski is the current Commissioner of the Department of Social Services)

11. Connecticut AIDS Drugs Assistance Program (CADAP) - A pharmaceutical assistance program (administered by the Department of Social Services) that pays for Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS) medications approved by the U.S. Food and Drug Administration and other drugs that may prevent the serious deterioration of the health of persons who have HIV or AIDS

12. Connecticut Behavioral Health Partnership Program - An integrated behavioral health service system for HUSKY A, HUSKY B, and Charter Oak members, children enrolled in the Voluntary Services Program operated by the Department of Children and Families, and may, at the discretion of the Commissioner of the Department of Children and Families and the Commissioner of the Department of Social Services, include other children, adolescents, and families served by the Department of Children and Families

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

14. Connecticut Community Health Care Initiative (CCHI) - The team responsible for program management and contractor oversight of the fifteen organizations which the Department of Social Services contracts to provide HUSKY Outreach services and Healthy Start Program services

15. Connecticut Home Care Program for Elders (CHCPE) - A State and Federally funded comprehensive home care program designed to enable elders at risk of institutionalization to receive the services they need to remain living in the community

16. Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (ConnPACE) - A program that assists eligible senior citizens and people with disabilities to afford the cost of most prescription medicines as well as insulin and insulin syringes

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

18. Customer - The organization that the staff worked with on a particular project

19. Deficit Reduction Act of 2005 (DRA) - A U.S. budget bill codified at Public Law No. 109-171, 120 Stat. 4 (February 8, 2006) DRA §6035, Enhancing Third Party Recovery, that requires that States have laws in place that clarify the State Medicaid Agency's right of recovery against any third party legally

responsible for payment of claim for a health item or service and obligates legally liable third parties to provide the State Medicaid Agency with coverage eligibility and claims data

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

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

22. Fee-for-service (FFS) - A reimbursement method for health services under which a provider charges separately for each client encounter or service rendered

23. Governor - Someone who has a controlling interest in the entity

24. Healthy Start Program - Program providing supportive services to low-income pregnant women

25. HUSKY A - Program providing Medicaid coverage and services to families and children through contracts with four Medicaid Managed Care Organizations (MCO)

26. HUSKY B - Program providing health insurance to uninsured children who do not qualify for the HUSKY A program

27. HUSKY Plus - Program providing supplemental coverage for children with special health care needs enrolled in the HUSKY B program

28. interChange - The State-owned and Federally certified Medicaid Management Information System (MMIS) implemented by the Department of Social Services in 2008 for the services provided under Medicaid Fee-for-service

29. Katie Beckett Waiver Program - A program which offers full Medicaid eligibility, case management, and home health services primarily to children with disabilities who would normally only qualify for Medicaid in an institution (the program currently serves one hundred twenty five people, which is the maximum funded under State law)

30. Managed Care - A system of health care that combines delivery and payment and influences use of services by employing management techniques designed to promote the delivery of cost-effective health care

31. Managed Care Plan (MCP) - An arrangement that integrates financing and management with the delivery of health care services to an enrolled population (an MCP employs or contracts with an organized system of service providers)

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

33. Medicaid Program provider manuals - Service-specific documents created by the Connecticut Medicaid Program to describe policies and procedures applicable to the Connecticut Medicaid Program generally and specific services

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

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

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

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

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

39. Medicare Modernization Act (MMA) - The act which amends Title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program and to modernize the Medicare

Program (also known as the Medicare Prescription Drug Improvement and Modernization Act of 2003 (Public Law 108-173))

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

41. National Medical Support Notice (NMSN) - A Notice to Withhold for Health Care Coverage, which informs the employer that the identified employee is obligated by a court or administrative child support order to provide health care coverage for the children identified on the Notice

42. Noncustodial parent - The parent who does not have physical custody of the child and who typically is paying child support for the child

43. Preferred Drug List (PDL) - A listing of prescription products recommended by the Pharmaceutical and Therapeutics Committee as efficacious, safe, and cost-effective choices when prescribing for Medicaid patients

44. Related party - Person or organization related through marriage, capability to control, ownership, family, or business association

45. Related-party transactions - Transactions between the resultant contractor and a related party that can include, but are not limited to, real estate sales or leases, leasing for vehicles, office equipment, or household furnishings, mortgages, loans, or working capital loans, and contracts for management services, consultant services, professional services (attorneys and accountants, or for materials, supplies, or other services purchased by the resultant contractor)

46. Social Security Act - The act (Public Law 74-271), originally approved August 14, 1935, and amended significantly since then, that provides for Medicare, Title XVIII of the Act, and Medicaid, Title XIX of the Act

47. State Administered General Assistance Program (SAGA) - The program that provides cash and medical assistance to persons who do not qualify for Federal or any other state assistance programs, such as SSI, Temporary Assistance to Needy Families, and Medicaid (SAGA also provides emergency assistance and will pay for the burial of indigent persons. Through the SAGA program, the Department of Social Services provides cash and/or medical assistance to individuals unable to work for medical or other prescribed reasons and to families that do not meet the blood-relationship requirements of the Temporary Family Assistance Program.)

48. State Agency Billing Agreements - Arrangements or contracts that the Department of Social Services has with legally liable third parties, which establish billing procedures enabling the State to receive reimbursement on behalf of recipients who have or had the third party coverage

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

50. State Medicaid Agency - The state agency (Department of Social Services) that administers the Medicaid program

51. State Fiscal Year (SFY) - The twelve-month period beginning July 1 used for calculating the State's annual (yearly) financial statements

52. State Wage Information Collection Agency (SWICA) - The State agency administering the State unemployment compensation law, a separate agency administering a quarterly wage reporting system, or a State agency administering an alternative system which has been determined by the Secretary of Labor, in consultation with the Secretary of Agriculture and the Secretary of Health and Human Services, to be as effective and timely in providing employment related income and eligibility data

53. Subcontract - Any written agreement between the resultant contractor and another party to fulfill any contract requirements

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

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

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

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

57. Title XIX - The provisions of 42 USC §1396 *et seq*. including any amendments thereto (See Medicaid)

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

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

60. U.S. Code (USC) - A compilation and codification of the general and permanent Federal law of the U.S.

## SECTION I - OVERVIEW OF THE DEPARTMENT OF SOCIAL SERVICES AND PROGRAM

### A. PURPOSE OF REQUEST FOR PROPOSALS

The Department of Social Services' Office of Quality Assurance is requesting proposals from qualified organizations to perform third party liability functions. Qualified organizations must have a minimum of five years of demonstrated experience with third party liability and program integrity work.

The purpose of this RFP is to ensure that the Department of Social Services is the payer of last resort if any legally liable third parties exist that will pay all or part of the cost of a client's health care provided under Connecticut's State Medicaid Plan. Although reference is made to Medicaid payments herein, the term should be interpreted to include State-funded medical programs as well. The RFP will meet this goal by:

- Enhancing the Department of Social Services' Medicaid paid claim and Managed Care at-risk encounter claim benefit recovery operations to maximize third party recovery dollars
- Identifying client third party liability using automated data match technology from both privately and publicly liable third parties
- Using data match, Web-based technologies, electronic commerce, and high-quality manual processes to identify and verify client health insurance information
- Working with the Connecticut Department of Administrative Services (DAS) to identify and assist in potential client trauma recoveries
- Soliciting new third party liability initiatives
- Ensuring proper payments from institutional providers

This procurement is for existing functions. The Department of Social Services currently contracts with Health Management Systems, Inc. (HMS). The current contract will expire on September 30, 2008. To ensure a fair, open, and competitive process, the Department of Social Services will not disclose the value of the existing contract. Under this RFP, the Department of Social Services expects to award one resultant contract to perform third party liability functions.

## B. OVERVIEW OF THE DEPARTMENT OF SOCIAL SERVICES

The Department of Social Services provides a broad range of services to older adults, persons with disabilities, families, and persons who need assistance in maintaining or achieving their full potential for self-direction, self-reliance, and independent living. It administers more than ninety legislatively authorized programs and about one-third of the State budget. By statute, it is the State agency responsible for administering human service programs sponsored by Federal legislation including the Rehabilitation Act, the Food Stamp Act, the Older Americans Act, and the Social Security Act. The Department of Social Services is also designated as a public housing agency for administering the Section 8 Program under the Federal Housing Act.

The Department of Social Services is headed by the Commissioner of Social Services and there are Deputy Commissioners for Administration and Programs. There is a Regional Administrator responsible for each of the three service regions. By statute, there is a Statewide Advisory Council to the Commissioner of Social Services and each region must have a Regional Advisory Council.

The Department of Social Services administers most of its programs at offices located throughout the State. Within the Department of Social Services, the Bureau of Rehabilitation Services provides vocational rehabilitation services for eligible persons with physical and mental disabilities throughout the State. For the other programs, services are available at offices located in the three geographic service regions, with central office support located in Hartford. In addition, many services funded by the Department of Social Services are available through community-based agencies. The Department of Social Services has out-stationed employees at participating hospitals and nursing facilities to expedite Medicaid applications and funds Healthy Start sites, which can accept applications for Medicaid for pregnant women and young children. Many of the services provided by the Department of Social Services are available via mail or telephone.

There are three entities attached to the Department of Social Services for administrative purposes only. They are the Commission on Deaf and Hearing-impaired, the Board of Education and Services for the Blind, and the Child Day Care Council.

## C. OVERVIEW OF THE OFFICE OF QUALITY ASSURANCE

The mission of the Office of Quality Assurance is to maximize the resources available to families and individuals that need assistance by assuring quality,

accuracy, efficiency, and effectiveness in the delivery of the Department of Social Services' programs. This mission is accomplished by ensuring:

- Adequate internal controls are in place and functioning
- Both client and provider fraud is deterred and pursued
- Overpayments to providers, grantees, contractors, and clients are reduced or recouped
- Unnecessary costs are avoided

In State Fiscal Year (SFY) 2007, the Office of Quality Assurance recovered and saved $135 million in third party cost avoidance and benefit recovery from legally liable third parties (including insurance companies and Medicare) who were responsible for paying for the cost of client medical care.

In the Office of Quality Assurance, the Division of Fraud and Recoveries (F&R) maintains third party liability operations including post-payment recovery, identification of liable third parties, and payment of claims/coordination of benefits. Third party liability functions improve the Department of Social Services' capability to reduce the benefit and administrative costs of providing Connecticut Medical Assistance Program services to Connecticut residents by using the third party resources of the clients so that Medicaid is the payer of last resort. This function works through a combination of cost avoidance methods and post-payment benefit recovery. This is accomplished by detecting, storing, and using client third party liability to coordinate benefits and recover paid Medicaid claims. In SFY 2007, the Department of Social Services served five hundred thousand Medicaid clients of which twenty-five thousand clients had health insurance.

The Connecticut Medical Assistance Program provides benefits defined under Title XIX of the Social Security Act (Medicaid) in both traditional fee-for-service (FFS) and managed care environments. In FFS, the Department of Social Services' Medicaid Management Information System (MMIS) contractor, Electronic Data Systems Corporation (EDS), presently administers third party liability claims processing. The MMIS coordinates third party resources by cost avoiding or denying Medicaid claims when third party liability is known. In addition to EDS, the Department of Social Services uses a third party liability vendor to perform the following recovery work:

- Health Insurance and Defense Enrollment Eligibility Reporting System (DEERS) Data Matches

- Third party benefit recovery to commercial insurance, Medicare, and TRICARE Management Activity (TMA)

- Trauma identification

- Hospital and skilled nursing facility credit balance/overpayment audits

- Other recovery projects, as identified

F&R works with the Department of Social Services' Managed Care Division incorporating third party liability requirements into Medicaid Managed Care Organization (MCO) coordination of benefit practices. Currently, the Department of Social Services administers Medicaid Managed Care through an Administrative Services Organization - Prepaid Inpatient Health Plan (ASO-PIHP) model. The ASO-PIHP is not at risk for the cost of client health care as its network providers receive Medicaid reimbursement through the traditional Medicaid FFS program. In the event that the Department of Social Services' Managed Care Program goes to an at-risk model, the MCO may be contractually afforded the same third party liability rights as the state agency in coordinating benefits and pursuing recovery of reimbursement from legally liable third parties. In effect, the MCO may either act like an intermediary in cost avoiding for health insurance reasons a network provider's claim or it may pay said claim and then seek recovery from the third party. In addition, MCOs may be allowed to retroactively recover their health care costs from client third party resources.

## D. OVERVIEW OF THE MEDICAL CARE ADMINISTRATION DIVISION

1. Overview - The Medical Care Administration Division oversees the administration, policy, regulations, and operations of the Medical Assistance Programs for the Department of Social Services' clients.

2. Medical Care Operations Division - The Medical Care Operations Division supports all activities related to the processing, authorizing, reporting, and monitoring of the medical assistance services the Department of Social Services pays for as required by Federal and State statutes. The Department of Social Service contracts with Electronic Data Systems Corporation (EDS) to perform as the fiscal agent responsible for designing, developing, implementing, and maintaining a State-owned and Federally certified MMIS for the services provided under Medicaid Fee-for-service (FFS). The MMIS also supports the Connecticut AIDS Drug Assistance Program (CADAP), Connecticut Pharmaceutical Assistance Contract to the Elderly and Disabled Program (ConnPACE), Katie Beckett Waiver Program, State Administered General Assistance Program (SAGA),

Connecticut Home Care Program, and Connecticut Behavioral Health Partnership Program. EDS provides full fiscal agent services including claims processing, provider relations and enrollment, ConnPACE participant relations and enrollment, Federal and State financial management reporting and surveillance, and utilization review reporting to the Department of Social Services.

The Medical Care Operations Division has four distinct functional areas:

a) The Medicaid Management Information System (MMIS) Team oversees, directs, and monitors EDS' operations. In addition, the MMIS Team coordinates and defines all system user requests, the oversight of system modifications and system maintenance, and the monitoring of contractor and system performance.

b) The Provider Relations Team responds to inquiries from providers, clients, and the public concerning the medical assistance programs. Provider Relations directs and coordinates all areas of the FFS provider enrollment process. Provider Relations also oversees claim processing issues and publication and update of the provider-specific fee schedules, provider billing manuals, and provider bulletins. Provider Relations triages multifaceted issues related to the Connecticut Medical Assistance Program and aids clients and providers by resolving complex billing problems and by assisting clients in locating FFS providers.

c) The Pharmacy Program Team directs the pharmacy benefits for CADAP, ConnPACE, and the Medicaid FFS Program. All CADAP application and eligibility determination processes and card issuance is performed within the Pharmacy Program Team. The Pharmacy staff also oversees and directs EDS in the application and eligibility determination process for the ConnPACE program, as well as the Medicare Part D enrollments and monthly premium payments. The Pharmacy staff coordinates the drug manufacturer rebate programs, monitors the contracts for the Retrospective Drug Utilization Review (DUR) Program and Prior Authorization, and participates on the Pharmaceutical and Therapeutics Committee, which maintains the Medicaid Preferred Drug List (PDL). Pharmacy policy and regulations are also the responsibility of the Pharmacy staff.

d) The Medical and Clinical Services Team performs clinical and medical analysis, authorization for specified medical services, and contract monitoring of the Connecticut Peer Review Organization. The staff also performs medical case reviews for Employment Service Exemption requests in the Temporary Family Assistance Program. The Medical and Clinical Services Team reviews and authorizes non-citizen emergency assistance and determines nursing home level of care, as well as administers Connecticut's Katie Beckett model waiver.

3. Alternate Care Unit (ACU) - The Alternate Care Unit (ACU) develops, operates, and monitors the CHCPE. The CHCPE is a State and Federally funded comprehensive home care program. It is designed to enable elders at risk of institutionalization to receive the services they need to remain living in the community. CHCPE services include, but are not limited to, skilled nursing care, home health aide, homemaker services, emergency response system, home-delivered meals, and companion services. Currently, the CHCPE is piloting two new home care services offering subsidized assisted living services under the Medicaid Waiver and personal care assistant services.

   ACU staff are located both in Central Office and in five field offices throughout the State. ACU staff determine financial and functional eligibility and approve care plans. Staff monitor service utilization and care plan cost limits. Resultant contractor and subcontractor compliance with program policies and procedures are monitored by staff through required reports and onsite record and administrative reviews. Client satisfaction surveys are also conducted as part of ACU's quality assurance activities. Additionally, ACU staff educate the public and health care providers about program eligibility and services.

   ACU also administers and performs a portion of the pre-admission screening required by the Omnibus Budget Reconciliation Act (OBRA) Nursing Home Reform Act. Unit staff screen all individuals applying for admission to a Medicaid-certified nursing facility for mental illness and mental retardation. ACU also screens individuals sixty-five years and older, are Medicaid eligible, or whose Medicaid application is pending and are seeking nursing home placement for level of care and approval of nursing home placement.

4. Managed Care Division - The Managed Care Division has administrative and operational responsibilities for the Medicaid Managed Care Program (HUSKY A), the State Children's Health Insurance Program (SCHIP or HUSKY B), HUSKY Plus, Non-emergency Medical Transportation (NEMT), Dental Initiatives, and the

Connecticut Community Health Care Initiative (CCHI). Functions include program analysis, quality assurance, managed care capitation payments, FFS provider fee schedule updates, managed care enrollment, managed care regulations and policy development, reporting, and program and contract monitoring. The Managed Care Division has three teams:

a) The Program Analysis and Quality Assurance Team performs four major functions. It collects and analyzes data concerning utilization of services under the Medicaid Managed Care, SCHIP, and HUSKY Plus programs, as well as data analysis related to utilization of services under Medicaid FFS. Additional responsibilities include the updating of FFS provider fee schedules, oversight of quality assurance initiatives for the HUSKY programs and administration of NEMT services. The Program Analysis unit works closely with other state government departments, especially the Office of Policy and Management, the Department of Children and Families, the Department of Education, the Department of Mental Health and Addiction Services, and the Department of Public Health. The data and analyses gathered and prepared by Program Analysis staff are critical components of major statewide and Department of Social Services' programs.

b) The Managed Care Team administers the HUSKY A and HUSKY B programs and HUSKY Plus. HUSKY A provides Medicaid coverage and services to families and children through contracts with four Medicaid MCOs. HUSKY B provides health insurance to uninsured children who do not qualify for HUSKY A. HUSKY Plus provides supplemental coverage for children with special health care needs enrolled in the HUSKY B program. The Managed Care Team provides monitoring and oversight of the contracted HUSKY MCOs, HealthNet/Healthy Options, Blue Care Family Plan, FirstChoice/Preferred One of Connecticut, and Community Health Network of Connecticut. Responsibility for oversight of the HUSKY application and enrollment broker and HUSKY Plus contractors also rests with the Managed Care Team.

5. The Dental and CCHI Team oversees the CCHI. CCHI is made up of two components: HUSKY Outreach and the Healthy Start Program. The Healthy Start Program provides supportive services to low-income pregnant women. The Dental and CCHI Team is responsible for program management and contractor oversight of the fifteen organizations with whom the Department of Social Services contracts

to provide HUSKY Outreach and Healthy Start services. The Dental and CCHI Team also manages Dental services, both in managed care and FFS, and develops new initiatives that promote access to dental services.

## E. OVERVIEW OF THIRD PARTY LIABILITY

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

   a) Federal regulation specified at Title 42 CFR Subpart D, Third Party Liability

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

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

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

2. Third Party Liability Requirements - The Department of Social Services requests proposals from qualified bidders to perform the following third party liability and program integrity work requirements:

   a) Benefit Recovery of Medicaid Paid Claims

      (1) Benefit Recovery Methods When Third Parties Are Identified After the Department of Social Services Has Paid For the Cost of Care

      (2) Benefit Recovery Methods for Medicaid Paid Claims Not Cost Avoided When a Client Eligibility Record Contains Third Party Liability Information

      (3) New or Expanded Client Third Party Liability Information: Interrogation of the Client Eligibility Record and Medicaid Paid Claim Selection

   b) Third Party Liability Verification

   c) Third Party Liability Health Insurance Suspect Reporting

   d) Third Party Liability Information Form

   e) Third Party Liability Data Match and Identification

f) Trauma Recovery

g) Child Support Medical Insurance Identification

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

i) Integration of Related Proposal Requirements

j) New Third Party Liability Initiatives

3. Financial Liability - The resultant contractor shall be financially liable for any penalties imposed by CMS on the Department of Social Services for any of its third party liability functions performed under the requirements of this RFP, which was not adequately performed and adversely affects the state agency's compliance under Title 42 of the Code of Federal Regulations, Subpart D, Third Party Liability or other applicable Federal regulations or state laws.

4. Contractor Bank Lock-box Account - The resultant contractor shall establish and maintain a bank lock-box account for the deposit of all recovery checks. All deposits shall be made within twenty-four hours of receipt. The resultant contractors' fees will be deducted from lock-box balances as documented by invoices and confirmed by lock-box statements. The Department of Social Services will approve the format and timing of these statements. Adequate financial controls shall be established to ensure that all Department of Social Services recoveries are appropriately deposited to this account. Interest received on this account will revert to the Department of Social Services. A schedule will be established to transmit the funds to the Department of Social Services. Procedures will be developed to regulate how much money can remain in this account at any time.

## F. BIDDER QUALIFICATIONS

Qualified organizations must have a minimum of five years of demonstrated experience with third party liability and program integrity work. Bidders that propose the use of subcontractors must present the same information about the proposed subcontractors as for bidders. Use of subcontractors is subject to the approval of the Department of Social Services.

## SECTION II - OVERVIEW OF THE PROCUREMENT PROCESS

### A. ISSUING OFFICE AND CONTRACT ADMINISTRATION

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

Chandra Yvette Williams
Department of Social Services
Contract Administration
25 Sigourney Street
Hartford, CT 06106
Telephone: 860-424-5361
Fax: 860-424-4953
E-mail: Chandra.Willliams@ct.gov

All questions, comments, proposals, and other communications with the Issuing Office regarding this RFP must be submitted in writing directed to the Issuing Office and must be clearly identified as pertaining to the Third Party Liability RFP.

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

## B. PROCUREMENT SCHEDULE

The schedule for this procurement is as follows. The Department of Social Services reserves the right to adjust this schedule, as needed.

| Milestones | Expected End Date |
|---|---|
| RFP posting/release | June 2, 2008 |
| Deadline for mandatory Letter of Intent (no later than 3:00 p.m. eastern standard time) | June 17, 2008 |
| Deadline for the submission of written questions (no later than 3:00 p.m. eastern standard time) | June 17, 2008 |
| Posting/release of the Department of Social Services' official responses to questions (Questions/Answers Addendum) | June 23, 2008 |
| Proposals due (no later than 3:00 p.m. eastern standard time) | July 22, 2008 |
| Recommendations to Commissioners | To be determined |
| Announcement of awards for contract negotiation | To be determined |
| Contract negotiations end/contract execution | To be determined |
| Third Party Liability commences | October 1, 2008 |

The dates for review of proposals and recommendations to Commissioners, the announcement of awards for contract negotiation, and contract negotiations end/contract execution will be determined. Dates will be posted in an Addendum to this RFP on the State Procurement/Contracting Portal at http://www.das.state.ct.us/Purchase/Portal/Portal_Home.asp.

## C. MANDATORY LETTER OF INTENT (LOI)

Interested BIDDERS SHALL submit a mandatory nonbinding Letter of Intent (LOI) to the Issuing Office to advise the Department of Social Services of their intent to submit a proposal in response to this RFP. The LOI must be received by the Issuing Office no later than 3:00 p.m. eastern standard time on June 17, 2008.

Please choose one way to submit the LOI to the Issuing Office via e-mail, fax, or postal mail. Do not submit duplicate copies. The LOI must clearly identify the contact person including name, telephone number, fax number, and e-mail address. It is the bidder's responsibility to confirm the Issuing Office's receipt of an LOI.

Failure to submit an LOI in accordance with the requirements set forth herein shall disqualify a bidder from further consideration.

## D. BIDDER'S QUESTIONS

Interested bidders may submit questions regarding this RFP to the Issuing Office by fax or e-mail directed to the Issuing Office. To be considered, questions regarding this RFP must be received by the Issuing Office no later than 3:00 p.m. eastern standard time on June 17, 2008. The early submission of questions is encouraged. It is solely the bidder's responsibility to ensure and verify the Department of Social Services' receipt of questions.

The Issuing Office will respond only to those questions that meet the stated due date and time and criteria listed above. Official responses to all questions will be in a Questions/Answers Addendum to this RFP posted on the State Procurement/Contracting Portal at www.das.state.ct.us/Purchase/Portal/Portal_home.asp.

The expected posting/release date for the Questions/Answers Addendum is June 23, 2008. It is solely the bidder's responsibility to access the State Procurement/Contracting Portal to obtain any and all Addenda or official announcements pertaining to this RFP. To submit a responsive proposal, **THE BIDDER SHALL** provide a signed acknowledgment of the receipt of any and all Addenda posted to the State Procurement/Contracting Portal. The last page only of any and all Addenda must be signed (and company name provided) and submitted with the proposal.

In addition to the questions and answers, the Addendum will specify dates in the Procurement Schedule currently identified as To Be Determined.

## E. EVALUATION AND SELECTION

It is the Department of Social Services' intent to conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. Only proposals found to be responsive to this RFP will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFP including the general proposal requirements.

## F. CONTRACT EXECUTION

The resultant contract is subject to State contracting procedures. These procedures include approval of the State of Connecticut Attorney General's Office. Note that the resultant contract becomes executed upon the signature of the Attorney General. No financial commitments can be made until and unless the resultant contract has been approved by the Attorney General. The Attorney General reviews the resultant contract only after the parties have agreed to the provisions.

## G. BIDDER DEBRIEFING

The State will notify all bidders of any award issued by it as a result of this RFP. Unsuccessful bidders may, within thirty days of the signing of the resultant contract, request a meeting for debriefing and discussion of their proposal by writing the Issuing Office at the address provided above. Debriefing will not include any comparisons of proposals with other proposals.

## H. RIGHTS RESERVED

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

1. Cancellation - Cancel this procurement at any time before the contract award

2. Amendment of procurement - Amend this procurement at any time before contract award

3. Refusal to accept - Refuse to accept or return accepted proposals that do not comply with procurement requirements

4. Rejection of incomplete proposal - Reject any proposal in which any part of the proposal is incomplete or in which there are significant inconsistencies or inaccuracies (the State reserves the right to reject all proposals)

5. Prior contract default - Reject the proposal of any bidder in default of any prior contract or for the misrepresentation of material presented

6. Receipt of proposals after stated due date and time - Reject or refuse to evaluate any proposal that is received after the stated due date and time

7. Written clarification - Require bidders, at their own expense, to submit written clarification of proposals in a manner or format that the Department of Social Services may require

8. Oral clarification - Require bidders, at their own expense, to make oral presentations at a time selected and in a place provided by the Department of Social Services

   The Department of Social Services may invite bidders, but not necessarily all, to make an oral presentation to assist the Department

of Social Services in its determination of award. The Department of Social Services further reserves the right to limit the number of bidders invited to make such a presentation and the number of attendees per bidder.

9. Onsite visits - Make onsite visits to the operational facilities of bidders to further evaluate the bidder's capability to perform the duties required in this RFP

10. Allowance of proposal changes - Except as may be authorized by the Department of Social Services, allow no additions or changes to the original proposal after the stated due date and time

11. Property of the State - Own all proposals submitted in response to this procurement upon receipt by the Department of Social Services

12. Separate service negotiation - Negotiate separately any services in any manner needed to serve the best interest of the State

13. All or any portion - Contract for all or any portion of the Scope of Services or tasks contained in this RFP

14. One or more bidders - Contract with one or more bidders

15. Proposal most advantageous - Consider cost and all factors in determining the most advantageous proposal for the Department of Social Services when awarding a bidder the right to negotiate a contract with the Department of Social Services (while cost is a factor in determining the bidder to be awarded the right to negotiate a contract with the Department of Social Services, price alone shall not determine the successful bidders)

16. Technical defects - Waive technical defects, irregularities, and omissions, if in its judgment the best interest of the Department of Social Services will be served

17. Privileged and confidential information - Share the contents of any proposal with any of its designees for evaluating proposals to make an award (the contents of all meetings including the first, second, and any subsequent meetings and all communications in the course of negotiating and arriving at the resultant contract periods shall be privileged and confidential)

18. Best and Final Offers - Seek Best and Final Offers (BFO) on price from bidders upon review of the scored criteria (in addition, the Department

of Social Services reserves the right to set parameters on any BFOs it receives)

19. Unacceptable proposals - Reopen the bidding process if advantageous to the Department of Social Services

## I. PROPOSAL PRESENTATION EXPENSES

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

## J. PROPOSAL DUE DATE AND TIME

The Issuing Office must receive proposals no later than the due date and time specified in the Procurement Schedule. The Department of Social Services will not consider a postmark date as the basis for meeting the submission due date and time. Bidders must not interpret or otherwise construe receipt of a proposal after the stated due date and time as acceptance of the proposal, since the actual receipt of the document is a clerical function. The Department of Social Services suggests the bidder use certified or registered mail to deliver the proposal when the bidder is not able to deliver the proposal by courier or in person. Bidders that are hand-delivering proposals will not be granted access to the building without photo identification and shall allow extra time for security procedures. Bidders must address all RFP communications to the Issuing Office.

## K. ACCEPTANCE OF PROPOSAL CONTENTS

If acquisition action ensues, the contents of this RFP and the proposal of the successful bidder will form the basis of contractual obligations in the final contract. The resulting contract will be a Personal Services Agreement (PSA) contract (Appendix 1) between the successful bidder and the Department. The bidder's proposal must include a "Signatory Acceptance" (Appendix 2), without qualification, of all terms and conditions as stated within this RFP and the Terms and Conditions for a PSA contract. A successful bidder may suggest alternate language after having accepted without qualification the Terms and Conditions as specified in the PSA contract. The Department of Social Services may, after consultation with the State of Connecticut Attorney General's Office and the Office of Policy and Management (OPM), agree to incorporate the alternate language in any resultant contract; however, the Department of Social Services' decision is final. Any proposal that fails to comply in any way with this requirement may be disqualified as non-responsive. The Department of Social Services is solely responsible for

rendering decisions in matters of interpretation on all terms and conditions before and after contract execution.

## L. BIDDER ASSURANCES

1. Independent price determination - By submission of a proposal and through assurances given in its Transmittal Letter, the bidder certifies that in connection with this procurement the following requirements have been met:

   a) Costs - The costs proposed have been arrived at independently, without consultation, communication, or agreement, for restricting competition, as to any matter relating to such process with any other organization or with any competitor.

   b) Disclosure - Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the bidder on a prior basis directly or indirectly to any other organization or to any competitor.

   c) Competition - No attempt has been made or will be made by the bidder to induce any person or firm to submit or not submit a proposal for restricting competition.

   d) Prior knowledge - The bidder has no prior knowledge of RFP contents before actual receipt of this RFP and had no part in RFP development.

   e) Offer of gratuities - The bidder certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any resultant contract may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the resultant contractor, the resultant contractor's agent, or the resultant contractor's employees.

   f) Campaign contribution restrictions - The bidder certifies receipt of SEEC Form 11 (Appendix 10).

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

3. Press releases - The bidder agrees to obtain prior written consent and approval of the Department of Social Services for press releases that relate in any manner to this RFP or any resultant contract.

4. Restrictions on communications with Department of Social Services staff - The bidder agrees that from the RFP posting/release date until the Department of Social Services makes an award that it shall not communicate with the Department of Social Services' staff on matters relating to this RFP except as provided herein through the Issuing Office. Any other communication concerning this RFP with any of the Department of Social Services' staff may, at the decision of the Department of Social Services, result in disqualification of that bidder's proposal.

   A blanket assurance statement is acceptable.

## M. DECLARATION AND PROTECTION OF PROPRIETARY INFORMATION

Due regard will be given to the protection of proprietary information contained in all proposals received; however, bidders must be aware that all materials associated with this procurement are subject to the terms of the Freedom of Information Act (FOIA), the Privacy Act, and all rules, regulations, and interpretations resulting therefrom. The bidder must provide convincing explanation and rationale to justify each exception from release consistent with C.G.S. §1-210 to claim proprietary exemption.

It will not be adequate for bidders to merely state generally that the proposal is proprietary in nature and therefore not subject to release to third parties to claim an exemption. Price and cost alone do not meet exemption requirements. The particular pages or sections of the proposal that a bidder believes are proprietary must be specifically identified as such. The rationale and explanation must be stated in terms of the prospective harm to the bidder's competitive position that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above-cited statute. The Proprietary Declaration must be located immediately following the Table of Contents.

While bidders may claim proprietary exemptions, the final administrative authority to release or exempt any or all material so identified rests with the State.

## N. AFFIRMATIVE ACTION

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

1. The bidder's success in implementing an affirmative action plan

2. The bidder's success in developing an apprenticeship program complying with C.G.S. §46a-68-1 to 46a-68-17, inclusive

3. The bidder's promise to develop and implement a successful affirmative action plan

4. The bidder's submission of EEO-1 data indicating that the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area

5. The bidder's promise to set aside a portion of the resultant contract for legitimate small contractors and minority business enterprises (See C.G.S. 4a-60)

## O. RESULTANT CONTRACT PERIOD, FUNDING, AND NUMBER OF AWARDS

The Department of Social Services is requesting proposals for Third Party Liability functions for the resultant contract period of October 1, 2008 to September 30, 2012. The resultant contract will be for a four-year period with the option for two one-year extensions at the discretion of the Department of Social Services.

The resultant contract will be performance-based where the resultant contractor will reduce the Department of Social Services' recoveries by their fee, which in most cases, is a small percentage of the money they recover in a particular area.

The Department of Social Services expects to award one resultant contract.

Proposals do not require matching funds. The Department will not prioritize proposals that present matching funds over those that do not.

## SECTION III - GENERAL PROPOSAL REQUIREMENTS AND STRUCTURE

### A. GENERAL PROPOSAL REQUIREMENTS

Bidders must adhere to the Department of Social Services' rules as established in this RFP for proposal consideration, format, and content. The Department of Social Services requires each bidder, at a minimum, to clearly describe how the specifications in this RFP will be met. Proposals must provide evidence of successful experience or competence. The proposal structure requirements and the proposal content requirements are listed below. Bidders must respond to each content requirement that begins with **THE BIDDER SHALL**. Where indicated, the bidder shall supply separate information for each proposed service region. Proposals must provide evidence of successful experience or competence.

### B. INSTRUCTIONS FOR PROPOSAL STRUCTURE

1. Delivery Condition - An original (clearly marked) and six exact, legible copies of the proposal must be submitted in clearly identified ("Third Party Liability RFP") sealed envelopes or sealed boxes by the stated due date and time. In addition, one exact electronic copy (compact disk) of the entire proposal in a non-PDF format must be submitted with the original. Those required documents that cannot be converted into electronic format may be excluded from the electronic copy. All materials must be in Word or Excel except those items such as pictures or signatures that can be scanned into a Word document.

2. Proposal Structure - The Department of Social Services has structured the submission requirements into four distinct parts:

    a) Transmittal Communication, Forms, and Acceptances

    b) Organizational Capability and Structure

    c) Scope of Services

    d) Business Cost Section

3. Proposal Construction -

    a) Binding of Proposals - **THE BIDDER SHALL** submit a proposal in a format that will allow updated pages to be easily incorporated into the original proposal. An original (clearly marked) and six exact, legible copies of the proposal must be

submitted in loose leaf or spiral-bound notebooks with the bidder's official name appearing on the outside front cover of each binder and on each page of the proposal (location is at the bidder's discretion).

b) Tab Sheet Dividers - A tab sheet keyed to the Table of Contents (TOC) must separate each major part of the proposal. The title of each part must appear on the tab sheet.

c) Table of Contents (TOC) - Each proposal must incorporate a TOC. It is through this TOC that the Department of Social Services will evaluate conformance to uniform proposal content and format.

d) Cross-referencing RFP and Proposal - Each section of the proposal must cross-reference the appropriate section of this RFP that is being addressed. This will allow the Department of Social Services to determine uniform compliance with specific RFP requirements.

e) Page Numbers - Each page of the proposal must be numbered consecutively in Arabic numerals from the beginning of the proposal through all appended materials.

f) Page Format - The standard format to be used throughout the proposal is:

(1) Text shall be on 8½" x 11" paper, portrait orientation, single-spaced.

(2) Font shall be either Arial or Times New Roman and a minimum of twelve point.

(3) The binding edge margin of all pages shall be a minimum of 1½ inches; all other margins shall be one inch.

(4) Graphics may have a landscape orientation, bound along the top (11") side (if oversized, graphics may have a maximum of one fold).

(5) Graphics may have a smaller text spacing and font size.

## SECTION IV - PROPOSAL CONTENTS

### A. TRANSMITTAL COMMUNICATION, FORMS, AND ACCEPTANCES

Each proposal must include an original (clearly marked) and six exact copies clearly identified as "Third Party Liability RFP." One exact electronic copy (compact disk) must be submitted as well.

1. Transmittal Letter - To submit a responsive proposal, **THE BIDDER SHALL** submit the original proposal (clearly marked) and all copies with a Transmittal Letter limited to two pages, which addresses each of the assurances in Section II.L of this RFP. A blanket assurance statement is acceptable. The Transmittal Letter must include the bidder's Federal Employer Identification Number, if the bidder is an organization or the bidder's Social Security Number, if the bidder is an individual.

2. Table of Contents (TOC) - To submit a responsive proposal, **THE BIDDER SHALL** provide a TOC for the entire proposal beginning with the Executive Summary including all appendices.

3. Proprietary Declaration - To submit a responsive proposal, **THE BIDDER SHALL** identify any proprietary information, if applicable.

4. Executive Summary - To submit a responsive proposal, **THE BIDDER SHALL** provide a high-level summary limited to two pages that summarizes the content of the proposal. The Department of Social Services will not evaluate proposals from organizations that have no third party liability and program integrity work experience. The Executive Summary shall include the bidder's demonstrated experience of a minimum of five years providing third party liability and program integrity work.

5. Addendum Acknowledgement - To submit a responsive proposal, **THE BIDDER SHALL** provide the signed acknowledgement of its receipt of any and all Addenda issued for this RFP. The last page only of any and all Addenda must be signed (and company name provided) and submitted with the proposal.

6. Procurement and Contractual Agreements Signatory Acceptance (Appendix 2) - To submit a responsive proposal, **THE BIDDER SHALL** provide a signed Acceptance Statement, without qualification, of all Mandatory Terms and Conditions (Appendix 1).

7. Workforce Analysis Form (Appendix 3) - To submit a responsive proposal, **THE BIDDER SHALL** complete the Workforce Analysis Form. This form shall be completed by bidders with Connecticut worksites.

8. Notification to Bidders Form (Appendix 4 [signed]) - To submit a responsive proposal, **THE BIDDER SHALL** summarize the bidder's affirmative action plan and the bidder's affirmative action policy statement. Additionally, to submit a responsive proposal, **THE BIDDER SHALL** address in writing the following five factors, as appropriate, to the bidder's particular situation. These factors are:

    a) Affirmative Action Plan - The bidder's success in implementing an Affirmative Action Plan

    b) Development of Affirmative Action Plan - The bidder's promise to develop and implement a successful Affirmative Action Plan if no successful Affirmative Action Plan is in place

    c) Apprenticeship Program - The bidder's success in developing an apprenticeship program complying with C.G.S. §§46a-68-1 to 46a-68-17, inclusive

    d) EEO-1 Data - The bidder's submission of EEO-1 data indicating that the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area

    e) Set-aside for Minority Businesses - The bidder's promise to set-aside a portion of the resultant contract for legitimate minority business enterprises, and to provide the Department of Social Services Set-aside Reports in a format required by the Department of Social Services

9. Smoking Policy (Appendix 5 - signed Statement, if applicable) - If the bidder is an employer subject to the provisions of C.G.S. §31-40q, to submit a responsive proposal, **THE BIDDER SHALL** agree to provide the Department of Social Services with a copy of its written rules concerning smoking. The Department of Social Services must receive the rules or a statement that the bidder is not subject to the provisions of C.G.S. §31-40q before contract approval.

10. Certification Regarding Lobbying (Appendix 6) - To submit a responsive proposal, **THE BIDDER SHALL** provide a signed statement to the effect that no funds have been paid or will be paid to

any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any Federal contract, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

11. Contract Affidavits/Certifications - General Statutes of Connecticut (C.G.S.) §§4-250 through 4-252 require that State contracts with a value of $50,000 or more be accompanied by a Gift and Campaign Contribution Certification and a Consulting Agreement Affidavit. To submit a responsive proposal, **THE BIDDER SHALL** provide a completed Gift and Campaign Contribution Certification (Appendix 7) and a Consulting Agreement Affidavit (Appendix 8).

    If a bidder is exempt from the Contract Affidavit/Certification Requirements, the bidder must state this fact on the affidavits/certifications and return the forms with the proposal.

12. Affirmation of Receipt of State Ethics Laws Summary (Appendix 9) - Pursuant to C.G.S. §§1-101mm and 1-101qq, persons, resultant contractors, subcontractors, consultants, or the duly authorized representative thereof must affirm receipt of the summary of State ethics laws developed by the State Office of Ethics pursuant to C.G.S. §1-81b and that key employees of such person, resultant contractor, subcontractor, or consultant have read and understand the summary and agree to comply with its provisions. To submit a responsive proposal, **THE BIDDER SHALL** provide a completed and signed Affirmation of Receipt of State Ethics Laws Summary.

13. Notice to Executive Branch State Contractors and Prospective State Contractors of Campaign Contribution and Solicitation Ban (Appendix 10) - With regard to a State contract as defined in Public Act 07-1 having a value in a calendar year of $50,000 or more or a combination or series of such agreements or contracts having a value of $100,000 or more, the authorized signatory to this submission in response to the State's solicitation expressly acknowledges receipt of the State Elections Enforcement Commission's notice advising prospective State contractors of State campaign contribution and solicitation prohibitions, and will inform its principals of the contents of the notice.

## B. ORGANIZATIONAL CAPABILITY AND STRUCTURE **(MAXIMUM FIFTY PAGES)**

General - Responses to the requirements in this section must describe the bidder's background and experience and any proposed subcontractors. The responses must also address the details regarding the bidder's size and resources and any proposed subcontractors relevant to third party liability and program integrity work.

1. Organization -

   a) Governance - To submit a responsive proposal, **THE BIDDER SHALL** provide the following information for the bidder as the proposed prime contractor and each proposed subcontractor:

      (1) The name, work address, and percentage of time spent on the contract for each responsible director

      (2) The role of the Board of Directors in governance and policy-making

      (3) A current organizational chart defining levels of ownership, governance, and management

      (4) A complete description of any and all related-party relationships and transactions (Past exercise of influence or control need not be shown, only the potential or capability to directly or indirectly exercise influence or control. The bidder must fully disclose any expected payments to a related party. Such payments are unallowable unless the resultant contractor provides adequate data to satisfy the Department of Social Services that the costs are needed and reasonable.)

   b) Ownership Disclosure - To submit a responsive proposal, **THE BIDDER SHALL** provide the following information for the bidder as the proposed prime contractor and each proposed subcontractor:

      (1) A complete description of percent of ownership by the principals of the company or any other individual or organization that retains 5 percent or more including name and work address

(2) The relationship of the persons so identified to any other owner or governor as the individual's spouse, child, brother, sister, or parent

(3) The name of any person with an ownership or controlling interest of 5 percent or more in the bidder, who also has an ownership or controlling interest of 5 percent or more in any other related entity including proposed subcontracting entity or parent entity or wholly owned entity (the bidder provide include the name or names of the other entity)

(4) The name and address of any person with an ownership or controlling interest in the disclosing entity or an agent or employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act, since the inception of such programs

(5) Whether any person identified in the above subsections has been terminated, suspended, barred, or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, from any program under Titles XVIII, XIX, or XX of the Social Security Act, or has within the last five years been reinstated to participation in any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act, and before said reinstatement had been terminated, suspended, barred, or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in such programs

(6) A description of the relationship with other entities including:

(a) Whether the bidder is an independent entity or a subsidiary or division of another company (if the bidder is not an independent entity, the bidder shall describe the organizational linkages and the degree of integration/collaboration between the organizations including any roles of the organization's principals)

(b) A description of the relationship of any parent company when the bidder is an affiliate of another organization

The Ownership Disclosure section does not apply to a private nonprofit or a coalition. If the bidder is a private nonprofit or a coalition, to submit a responsive proposal, **THE BIDDER SHALL** indicate this as their response.

2. Key Personnel and Staff Resources - The resultant contractor shall certify that all personnel named in response to this requirement shall actually work on the resultant contract in the manner described in the proposal. No changes, substitutions, additions, or deletions shall be made unless approved in advance by the Contract Administrator. In addition, these individuals shall continue for the duration of the resultant contract, except in the event of resignation, incapacity, or death. In such event, the Contract Administrator shall approve the substitute personnel. Substitutions shall be made within thirty days of the resignation, incapacity, or death of a key person.

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

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

a) Corporate Project Unit - To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Provide an organizational chart detailing how the staffing for the proposed Third Party Liability functions fits within the bidder's organizational structure

(2) Describe how the proposed organizational structure will support the implementation of the Third Party Liability functions

(3) Provide the names or titles of proposed key personnel for the Third Party Liability functions and the hours and percentages of time dedicated to the Third Party Liability functions

(4) Justify its staffing resources to successfully meet its RFP response requirements in light of any other similar obligations for any other entity

b) Management Plan - To submit a responsive proposal, **THE BIDDER SHALL** describe a management plan for the Third Party Liability functions that includes, at a minimum:

(1) A description of the duties, authority, and responsibilities of each of the key personnel including the number and type of personnel under their direct supervision

(2) The names of key personnel who are not the bidder's full-time staff including a complete description of their employment status with the bidder

(3) The company's organizational structure indicating lines of authority

(4) A description of any other current or planned contractual obligations that might have an influence on the bidder's capability to perform the work under a resultant contract with the Department of Social Services

c) Program Manager - To submit a responsive proposal, **THE BIDDER SHALL** identify a Program Manager who will:

(1) Implement and manage the Third Party Liability function

(2) Monitor and ensure the performance of duties and obligations under a resultant contract

(3) Oversee the day-to-day functions of the Third Party Liability project

(4) Attend all Third Party Liability meetings at the request of the Department of Social Services

(5) Respond to the Department of Social Services' inquiries and other communications related to implementation, operations, and program management of the activities presented in this RFP

d) Job descriptions for proposed key positions and resumes for key personnel proposed to fill the key positions - To submit a responsive proposal, **THE BIDDER SHALL:**

(1) Provide job descriptions for proposed key positions and resumes for key personnel proposed to fill the key positions

(2) Describe the contract-related experience, credentials, education and training, and work experience required in job descriptions for proposed key positions and in the resumes for key personnel proposed to fill the key positions and include:

(a) Experience with bidder (or bidder's proposed subcontractor)

(b) Education, experience, and training relevant to third party liability and program integrity work

(c) Names, positions, titles, and telephone numbers of persons able to provide information concerning the persons' experience and competence

Resumes for key personnel proposed to fill the key positions are limited to two pages per resume. Resumes for key personnel proposed to fill the key positions and job descriptions for proposed key positions are not included in the page limitation of this section. Bidders must incorporate resumes and job descriptions into an appropriately tabbed section of the binder sequentially following the previous "bidder shall" item.

e) Job Personnel and Tasks - To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Describe the relationship between specific personnel for whom resumes have been submitted (or job descriptions for proposed key positions) and the specific tasks and assignments proposed to accomplish the Scope of Services and a justification of the individual's function based on the individual's competence including the bidder's:

(a) Procedures to secure and retain professional staff to meet the resultant contract requirements

(b) Method to evaluate personnel performance

3. Corporate Experience

a) Contracts - To submit a responsive proposal, **THE BIDDER SHALL** describe its experience and success related to the Scope of Services for the Third Party Liability functions including the following information concerning the bidder's experience with other contracts or projects for third party liability and program integrity work, whether ongoing or completed:

(1) Identify all state agencies and commercial vendors for which it has engaged in third party liability and program integrity work

(2) Describe its contracts or the work performed in the past five years for those state agencies or commercial vendors

(3) Provide a signed release allowing the Department of Social Services to access any evaluative information including, but not limited to, site reviews conducted by any state agency or commercial vendor for which it has performed work in the past five years (the signed release must be submitted as a separate sheet and is not included in the page limitation of this section.)

(4) Identify contacts for those projects including name of customer's project officer, title, address, telephone number, fax number, and e-mail address

(5) Identify the term for the contracts including the contract signing date, project initiation date, the initial scheduled completion date, and the actual completion date

(6) List all sanctions, fines, penalties, or letters of noncompliance issued against the bidder by any of the contracting entities listed above (the list shall describe the circumstance eliciting the sanction or letter of noncompliance and the corrective action or resolution to the sanction, fine, penalty, or letters of noncompliance; if no sanctions, fines, penalties, or letters of noncompliance were issued, a statement that attests that no sanction, penalty, or compliance action has been imposed on the bidder within the three years immediately preceding the RFP posting/release date must be submitted)

(7) Describe how the bidder contributed innovation and problem-solving expertise to a collaborative relationship with the governmental entity or commercial vendor for selected contracts listed above

b) Bidder References - To submit a responsive proposal, **THE BIDDER SHALL** provide three specific programmatic references for the bidder. References must be persons able to comment on the bidder's capability to perform the services specified in this RFP. The contact person must be an individual familiar with the organization and its day-to-day performance. If the bidder has been a State contractor within the last five years, the bidder must include a State of Connecticut reference. Bidders are strongly encouraged to call or write their references to ensure the accuracy of their contact information and their willingness and capability to be a reference. References must include the organization's name, address, current telephone number, and name of a specific contact person. The Department of Social Services expects to use these references in its evaluation process. References cannot be the bidder's current employees. If the bidder's proposal proposes the use of subcontractors for direct service provision, the bidder's proposal must also include three programmatic references for each proposed subcontractor.

4. Evidence of Qualified Entity - To submit a responsive proposal, **THE BIDDER SHALL** provide written assurance to the Department of Social Services from its legal counsel that it is qualified to conduct

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

5. Small, Minority, or Women's Business Enterprise - Section 32-9e of the General Statutes of Connecticut (C.G.S.) sets forth the requirements of each Executive Branch agency relative to the Connecticut Small Business Set-Aside program. Pursuant to that statute, 25 percent of the average total of all contracts let for each of the three previous fiscal years must be set aside. The Department of Social Services requires that the resultant contractor make a good-faith effort to set aside a portion of the resultant contract for a small, minority, or women's business enterprise as a proposed subcontractor. Such proposed subcontractors may supply goods or services. Prospective bidders may obtain a list of firms certified to participate in the Set-Aside program by contacting the State of Connecticut Department of Administrative Services at the DAS Web site at http://www.das.state.ct.us/Purchase/SetAside/SAP_Search_Vendors.asp or by calling 860-713-5236. During the evaluation process, special consideration will be given to those bidders who document their use of a certified small business or show the bidder's commitment to, whenever possible, use a certified small business. Businesses must be certified with the State of Connecticut. To submit a responsive proposal, **THE BIDDER SHALL** describe its effort to set aside a portion of the resultant contract for a small, minority, or women's business enterprise as a proposed subcontractor.

6. Department of Social Services Responsibilities - To submit a responsive proposal, **THE BIDDER SHALL** propose specific support the bidder requires from the Department of Social Services to perform the tasks in any resultant contract.

   Specific Department of Social Services responsibilities are:

   - Program Management - A Program Manager will be appointed by the Department of Social Services. This individual will monitor program progress and will have final authority to approve/disapprove program deliverables.

   - Staff Coordination - The Program Manager will coordinate all needed contacts between the resultant contractor and Department of Social Services staff.

- Approval of Deliverables - The Program Manager will review, evaluate, and approve all deliverables before the resultant contractor being released from further responsibility.

- Policy Decisions - The Department of Social Services retains final authority for making policy decisions affecting completion of the Third Party Liability function. In addition, the Department of Social Services shall:

    - Monitor the resultant contractor's performance and request updates, as appropriate

    - Respond to written requests for policy interpretations

    - Provide technical assistance to the resultant contractor, as needed

    - Allow access to the Department of Social Services' automated databases, as available and permitted

    - Allow access to management reports and case files, as appropriate

    - Provide a Program Manager

    - Hold regularly scheduled program meetings with the resultant contractor

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

    - Provide data as required by the resultant contractor to perform Third Party Liability functions

## C. SCOPE OF SERVICES **(MAXIMUM ONE HUNDRED PAGES)**

General - Responses for this section must describe the bidder's capability and competence to perform the requirements specified in this RFP.

No Rewrites - The Department of Social Services does not want a rewrite of the RFP requirements, since such a proposal would show a lack of understanding of the project and an inability to provide appropriate levels of support and guidance for the implementation of this type of project.

Most-favored Customer - The resultant contractor shall agree that if during the period of the resultant contract the resultant contractor shall enter into any contract with any other governmental customer or any nonaffiliated commercial customer by which it agrees to provide equivalent equipment or services at lower prices or additional services at comparable prices, the resultant contractor shall so notify the Department of Social Services and the resultant contract shall, at the Department of Social Services' option, be amended to accord equivalent advantage to the Department of Social Services.

1. Benefit Recovery of Medicaid Paid Claims

Introduction - The Department of Social Services is required to seek recovery of reimbursement up to the legal limit of liability if it learns of the existence of client third party liability after paying for client health care costs. The Department of Social Services' current benefit recovery process is predicated on identifying, verifying, and capturing third party health insurance and Medicare information on its Eligibility Management System (EMS). Currently, F&R receives unverified third party information from the Department of Social Services' regional offices, other State agencies, third party liability information referrals from the Medicaid provider community, and suspect third party liability information identified from Medicaid claims processing (a majority for commercial health insurance and to a lesser extent Medicare)[1]. F&R verifies the client health insurance coverage and enters this information on the EMS. This information is transmitted to the Department of Social Services' fiscal agent, EDS, weekly. A third party liability contractor identifies those clients with new or enhanced third party coverage monthly, interrogates those clients' Medicaid paid claims history, and from this examination selects the appropriate Medicaid paid claims for health insurance or Medicare recovery[2]. Health insurance claims are generated either electronically or on paper and billed directly to the third party. Medicare recoveries are performed through a provider recoupment process. No direct billing to a Medicare carrier or intermediary is performed. Instead, the Medicare-covered Medicaid paid claims are recouped from the Medicaid providers' real-

[1] The Department of Social Services receives most of its client Medicare information electronically from the Medicare Modernization Act (MMA) Return File provided by the Centers for Medicare and Medicaid Services (CMS) and the Beneficiary Data Exchange (BENDEX) file from the Social Security Administration, which are automatically loaded onto the EMS.

[2] In March 2008, a third party liability contractor began to exclusively perform this function. Previously, the Department of Social Services' fiscal agent, EDS, performed this function.

time Medicaid disbursements. The Medicaid provider bills Medicare for its services. The third party liability contractor maintains health insurance and Medicare benefit recovery claim selection and recovery information and produces detail and summary client, provider, and carrier third party data that tracks all aspects of the benefit recovery and claim selection activity.

The State of Connecticut implemented the third party liability provisions of the Deficit Reduction Act of 2005 (DRA) requiring health insurers to accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State Medicaid plan[3]. Historically, the Department of Social Services has always been subrogated to the right of recovery to Connecticut Medical Assistance clients' third party resources. Now, through implementing the DRA provisions, legally liable third parties conducting business in the State of Connecticut may not deny the state agency's claims for recovery or indemnification solely on the basis of the claim submission date, the type or format of the claim, or the failure to present proper documentation at the point of service that is the basis of the claim, if:

- The claim is submitted by the state within the three-year period beginning on the date the item or service was furnished

- Any action by the state to enforce its rights with respect to such claim is commenced within six years of the state's submission of the claim

The Department of Social Services has three State Agency Billing Agreements in place with TMA. TRICARE is the designation for the military health insurance plans available to members of the uniformed services and their dependents. TMA is the Federal agency that oversees the contractors administering the health insurance plans. These agreements provide for a billing procedure for the Department of Social Services to seek recovery of reimbursement for pharmacy and medical and mental health services for its dual and non-dual eligible clients who were also eligible for TRICARE benefits at the time the services were rendered. The Department of Social Services uses a third party liability contractor to submit Medicaid claims to the designated TRICARE fiscal intermediaries, managed care support, and pharmacy contractors.

[3] Connecticut General State Statute §17b-265. (formerly Sec. 17-134f). Department subrogated to right of recovery of applicant or recipient. Utilization of personal health insurance. Insurance coverage of medical assistance recipients. Limitations.

The Department of Social Services implemented a new MMIS in 2008 known as interChange. Although the Medicaid FFS cost avoidance function is performed in the interChange, the State agency's benefit recovery of Medicaid paid claims requirement is not supported in this system.

Medicaid Managed Care Administrative Service Organization (ASO) - Prepaid Inpatient Health Plan (PIHP) and At-risk Models - The Department of Social Services currently provides Medicaid benefits in a managed care environment to eligible individuals and families through an ASO-PIHP model. In this model, clients may choose to enroll in one of two ASO-PIHP Health Plans[4/5]. These health plans, working in concert with the client's primary care physician, perform case management, disease management, member services, and other functions. As part of the case management, clients access care through the ASO-PIHP member health care providers. The ASO-PIHPs are not at risk for the client's cost of care and as such do not directly reimburse health care providers for delivered client services. Instead, the providers submit claims to EDS and are reimbursed under the traditional Medicaid FFS program. In the future, during the duration of the resultant contractor's work to be performed under this RFP, Connecticut's Medicaid Managed Care model may change to health plans being at risk for the cost of care. This means that health plans will pay providers directly, rather than Medicaid FFS reimbursement being made.

Under Connecticut State Law, the Department of Social Services may recover from client third party liability both Medicaid FFS reimbursement and an MCO's incurred Medical costs (the actual payments made by the health plan to the provider). Similarly, the resultant contractor will also be afforded these same subrogation rights. EDS maintains Medicaid FFS claims experience. In the prospective at-risk model, health plans will provide the Department of Social Services with encounter claim experience reflecting the services for which it incurred costs.

The bidder should consider both FFS and at-risk models in responding to the Benefit Recovery of Medicaid Paid Claims requirement. A

[4] Anthem Blue Cross and Blue Shield of Connecticut and Community Health Network are ASO-PIHPs.

[5] Medicaid Managed Care-eligible individuals and families may choose not to receive their health benefits through the ASO-PIHP arrangement and instead become enrolled in the traditional Medicaid FFS program.

responsive proposal will address how this requirement will be performed in recovering either Medicaid FFS payments or health plan encounter claim incurred costs from legally liable third parties.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To recover Medicaid paid claims from client health insurance or Medicare when these third parties are identified after the Department of Social Services has paid for cost of care

- To recover from client health insurance or Medicare those Medicaid paid claims not cost avoided when a client's eligibility record contains third party liability information

- To identify new or expanded third party liability information on the client's eligibility record and then recover the client's Medicaid paid claims from health insurance or Medicare

- To perform electronic claims submission to legally liable third parties pursuant to Health Insurance Reform: Standards for Electronic Transmissions

- To provide financial accounting and report on its Medicaid paid claim benefit recovery projects

Supporting Regulations/Authority - This requirement falls under Title 42 CFR Part 433 Subpart D, Third Party Liability and Connecticut General State Statutes 17b-137 and 17b-265.

The resultant contractor shall build and implement an integrated Third Party Liability Benefit Recovery System, which captures all phases of the Department of Social Services' Medicaid FFS and Managed Care at-risk encounter claim recoveries from legally liable third parties. The resultant contractor's Third Party Liability Benefit Recovery System must be compatible with the Department of Social Services' EMS and interChange systems.

a) Benefit Recovery Methods When Third Parties are Identified After the Department of Social Services Has Paid for the Cost of Care -The Department of Social Services seeks proposals from qualified bidders to perform a Medicaid benefit recovery process. In response to this requirement, the bidder shall demonstrate that it has a strong understanding and experience with State Medicaid Agency benefit recovery practices by

describing its work for other state agencies. The bidder shall also describe its health insurance coordination of benefits and subrogation practices performed on behalf of health care providers, health plans, and/or other entities. The bidder's proposal and procedures to perform benefit recovery work under this requirement shall not duplicate, affect, or otherwise hinder similar or like work already being performed by the Department of Social Services. To submit a responsive proposal, **THE BIDDER SHALL**:

(1) List the State agencies, health care providers, health plans, and/or other entities for which it currently performs or has performed this function with the associated contract periods

(2) Describe the technology, logic, and methods used to select Medicaid and other types of health care claims

(3) Describe the type of media used to create and submit claims to legally liable third parties

(4) Describe the method used to affect the recovery (direct third party billing, provider recoupment, or other methods)

(5) Describe the benefit recovery success rate in recovering Medicaid dollars from liable third parties including:

(a) The annual Medicaid dollars recovered and a comparison of claim dollars billed versus claim dollars recovered

(b) The success rate in recovering health care dollars from liable third parties on behalf of other government agencies, health care providers, health plans, and/or other entities

(c) The health care dollars recovered and a comparison of health care dollars billed versus health care dollars recovered

(6) Propose methods that address its capability to select both Connecticut Medicaid FFS claims and Medicaid Managed Care at-risk encounter claims timely in accordance with State Medicaid Agency Federal

requirements specified at 42 CFR Part 433 Subpart D, Third Party Liability

(7) Explain how it will develop and perfect high-quality claims it will initially bill to legally liable third parties

(8) Provide two Performance Lists of all State Medicaid Agencies for which it performs benefit recovery for Medicaid FFS and/or Medicaid Managed Care at-risk encounter claims:

(a) Performance List 1 must include the name of the state agency, the last three SFYs in which it performed benefit recovery, for each SFY the aggregate total Medicaid dollars billed to third parties, and for each SFY the aggregate total Medicaid dollars recovered from third parties

(b) Performance List 2 must include the name of the state agency, the last three SFYs in which it performed benefit recovery, for each SFY the total Medicaid dollars billed to third parties for professional services, hospital services, skilled nursing facility services, prescription drug services, and Medicare coinsurance/deductible payments, and for each SFY the total Medicaid dollars recovered from third parties for professional services, hospital services, skilled nursing facility services, prescription drug services, and Medicare coinsurance/deductible payments (In addition, the bidder should specify the percentage of claim dollars billed and recovered by Medicaid FFS versus Medicaid Managed Care at-risk encounter claims.)

(9) Explain any difficulties, problems, or obstacles it has encountered in performing benefit recovery activity for State Medicaid Agencies or other entities, any solutions to those difficulties, problems, or obstacles, and the resulting financial benefit

(10) Describe its practices in recovering claims from all types of third party coverage available to the client including, but not limited to, Medicare coinsurance and deductible payments, inpatient care, outpatient care, professional

medical services, prescription drug services, behavioral services, home health care, nursing home care, pharmacy, durable medical equipment, and dental care

(11) Explain its experience following up on and pursuing denied benefit recovery claims and methods used to correct, perfect, and re-bill denied claims to legally liable third parties

(12) Describe proposed recovery methods that entail both a direct claim billing to a legally liable third party and/or Medicaid claim provider adjustment process[6] including, but not limited to:

(a) Claim type/service type selection

(b) Third party type (commercial and Federal insurance, health plans, MCPs, Medicare supplement plans, pharmacy benefit managers, and third party administrators)

(c) Frequency of performing direct billing and/or providing adjustment recovery

(d) Provider impact, resources, and costs

(13) Describe its experience in and propose methods to pursue Medicaid recovery from TRICARE including TRICARE's fiscal intermediaries, managed care support, pharmacy contractors for medical and mental health services and pharmacy for clients who were also eligible for TRICARE benefits at the time the Medicaid services were rendered

(14) Describe the frequency in which it will identify, select, and initiate recovery of claims (The bidder may propose to perform this task daily, weekly, or bimonthly but in no case shall identifying, selecting, and initiating recovery of claims be performed in a greater than thirty-day period.)

[6] A Medicaid claim provider adjustment, also known as a provider disallowance, means rather than a direct third party billing, the applicable Medicaid claims are deducted from the provider's current real-time Medicaid disbursements. The provider is responsible for pursuing payment from the third party to be made whole.

(15) Describe the methods it would use to eliminate or diminish any associated provider administrative work (The Department of Social Services is sensitive to the impact of a claim adjustment process on the Connecticut Medicaid provider. This requirement is for bidders proposing to use a provider adjustment process.)

(16) Explain how it has been successfully performing a provider disallowance process on behalf of a State Medicaid Agency or other entity

(17) Describe its capability to identify any recoveries that it receives that are not due to one of its projects and separately transfer those recoveries to the Department of Social Services

(18) Describe its capability to restrict the recovery on a particular claim to the Medicaid paid amount

(19) Describe how successful it has been in performing customer service when performing Medicaid benefit recovery through a provider disallowance process

(20) Describe its achievements in performing new and innovative benefit recovery methods and how this success is measured

b) Benefit Recovery Methods for Medicaid Paid Claims Not Cost Avoided When a Client Eligibility Record Contains Third Party Liability Information - The Department of Social Services seeks proposals from qualified bidders to perform Medicaid benefit recovery of claims not cost avoided for which client third party liability is available. The bidder shall propose methods that include recovery of claims not cost avoided for which client third party liability is available[7]. Connecticut Medicaid providers may submit claims to the Connecticut Medical Assistance Program using either electronic data interChange-electronic transaction processing or paper claims submission. Generally, the

[7] Cost avoidance is an MMIS claims processing function. It occurs either when a provider submits an electronic claim submission or paper claim or when a Medicare contractor transmits Medicare coinsurance/deductible claims. If client third party liability exists on the Department of Social Services' eligibility file and the provider did not show proof that the third party liability was used, the MMIS denies or cost avoids the claim. Medicare coinsurance/deductible claims will deny or cost avoid when the Department of Social Services knows that the client has third party resources.

Department of Social Services' MMIS cost avoids or denies a Medicaid claim and returns it back to the provider when it has not been demonstrated that client third party liability has been used. However, the Department of Social Services does not deny provider services indefinitely for third party liability reasons. Providers may submit a claim indicating that the client's health insurance or Medicare did not pay and receive Medicaid payment[8]. Providers submitting paper or electronic claims must indicate the appropriate health insurance or Medicare denial value on the respective media. Paper submissions require a copy of health insurance or Medicare denial attached to the claim[9]. For electronic claims, the provider must retain these denials in their files for audit purposes. In SFY 2007, providers submitted about thirty-two thousand electronic and paper claims, which were excluded from the Department of Social Services' cost avoidance edits due to the provider indicating that client health insurance benefits were either exhausted or not applicable. This represented about $6.6 million in Medicaid expenditures. For SFY 2008 (through April 11, 2008 provider payments), about nineteen thousand electronic and paper claims with a value of $4.1 million in Medicaid expenditures were also excluded from cost avoidance as a result of providers overriding the cost avoidance edits. See Attachment 1a and Attachment 1b.

Federal regulations provide certain conditions in adjudicating claims for prenatal care, postnatal care, and early and periodic screening, diagnosis, and treatment services (EPSDT) in which a State Medicaid Agency either must or has the option to avoid denying a claim when probable third party liability is known at the time the claim is filed. The Department of Social Services administers this requirement by not performing health insurance cost avoidance for Medicaid claims that meet the following conditions:

- For prenatal and postnatal services:
    - Services performed by a physician or nurse practitioner with the specialty of obstetrics and

[8] The Connecticut Medical Assistance Program Provider Manual (Chapter Five) defines Medicaid Provider Third Party Liability requirements and procedures.

[9] Paper claims with insurance denial attachments are filmed and kept on the Department of Social Services' CTMAP Retrieval System.

gynecology or services performed by a nurse midwife

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

- Procedure on the claim is in the list in Attachment 2

- Client gender is female

- For EPSDT services:

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

  - Procedure on the claim is in the list in Attachment 3

  - Client is less than twenty-one years of age

In SFY 2007, about two hundred fifty clients having health insurance resources received prenatal and postnatal services resulting in the adjudication of five hundred twenty-two Medicaid paid claims with a value of $165,000. In addition, about five hundred clients having third party liability received EPSDT services resulting in one thousand Medicaid paid claims with a value of about $50,000. The Department of Social Services' fiscal agent, EDS, would have billed these claims to health insurance companies. This experience reflects Medicaid FFS claims only and excludes Medicaid managed care experience.

The bidder should consider two conditions in responding to this requirement:

- Recovery of Medicaid claims associated with prenatal, postnatal care, and EPSDT the state agency does not cost avoid pursuant to 42 CFR §433.139

- Recovery of Medicaid paid claims in which the provider either by commission, omission, or error by-passed the Department of Social Services' third party liability

requirements and instead sought Medicaid reimbursement

The Department of Social Services is limited in knowing the extent of claims that correctly paid versus those claims in which the provider either by commission, omission, or error by-passed the Department of Social Services' third party liability requirements and instead sought Medicaid reimbursement. The bidder should consider this factor in responding to the following requirements. Bidders are encouraged to respond with innovative methods to identify and seek benefit recovery for those claims where the provider did not initially pursue client third party liability. To submit a responsive proposal, **THE BIDDER SHALL**:

(1) List the State agencies, health care providers, health plans, and/or other entities for which it currently performs or has performed this function with the associated contract periods

(2) Describe the technology, logic, and methods used to select Medicaid and other types of health care claims

(3) Describe the type of media used to create and submit claims to legally liable third parties

(4) Describe the method used to affect the recovery (direct third party billing, provider recoupment, or other methods)

(5) Describe the benefit recovery success rate in recovering Medicaid dollars from liable third parties including:

(a) The annual Medicaid dollars recovered and a comparison of claim dollars billed versus claim dollars recovered

(b) The success rate in recovering health care dollars from liable third parties on behalf of other government agencies, health care providers, health plans, and/or other entities

(c) The health care dollars recovered and a comparison of health care dollars billed versus health care dollars recovered

(6) Propose methods that address its capability to select both Connecticut Medicaid FFS claims and Medicaid Managed Care at-risk encounter claims timely in accordance with State Medicaid Agency Federal requirements specified at 42 CFR Part 433 Subpart D, Third Party Liability

(7) Explain how it will develop and perfect high-quality claims it will initially bill to legally liable third parties

(8) Provide two Performance Lists of all State Medicaid Agencies for which it performs benefit recovery for Medicaid FFS and/or Medicaid Managed Care at-risk encounter claims:

(a) Performance List 1 must include the name of the state agency, the last three SFY in which it performed benefit recovery, each SFY the aggregate, total Medicaid dollars billed to third parties, and for each SFY the aggregate, total Medicaid dollars recovered from third parties

(b) Performance List 2 must include the name of the state agency, the last three SFY in which it performed benefit recovery, for each SFY the total Medicaid dollars billed to third parties for professional services, hospital services, skilled nursing facility services, prescription drug services, and Medicare coinsurance/deductible payments, and for each SFY the total Medicaid dollars recovered from third parties for professional services, hospital services, skilled nursing facility services, prescription drug services, and Medicare coinsurance/deductible payments (In addition, the bidder should specify the percentage of claim dollars billed and recovered by Medicaid FFS versus Medicaid Managed Care at-risk encounter claims.)

(9) Explain any difficulties, problems, or obstacles it has encountered in performing benefit recovery activity for State Medicaid Agencies or other entities, any solutions to those difficulties, problems, or obstacles, and the resulting financial benefit

(10) Describe its practices in recovering claims from all types of third party coverage available to the client including, but not limited to, Medicare coinsurance and deductible payments, inpatient care, outpatient care, professional medical services, prescription drug services, behavioral services, home health care, nursing home care, pharmacy, durable medical equipment, and dental care

(11) Explain its experience following up on and pursuing denied benefit recovery claims and methods used to correct, perfect, and re-bill denied claims to legally liable third parties

(12) Describe proposed recovery methods that entail both a direct claim billing to a legally liable third party and/or Medicaid claim provider adjustment process[10] including, but not limited to:

(a) Claim type/service type selection

(b) Third party type (commercial and Federal insurance, health plans, MCPs, Medicare supplement plans, pharmacy benefit managers, and third party administrators)

(c) Frequency of performing direct billing and/or providing adjustment recovery

(d) Provider impact, resources, and costs

(13) Describe its experience in and propose methods to pursue Medicaid recovery from TRICARE including TRICARE's fiscal intermediaries, managed care support, pharmacy contractors for medical and mental health services and pharmacy for clients who were also eligible for TRICARE benefits at the time the Medicaid services were rendered

(14) Describe the frequency in which it will identify, select, and initiate recovery of claims (The bidder may propose to

[10] A Medicaid claim provider adjustment, also known as a provider disallowance, means rather than a direct third party billing, the applicable Medicaid claims are deducted from the provider's current real-time Medicaid disbursements. The provider is responsible for pursuing payment from the third party to be made whole.

perform this task daily, weekly, or bimonthly but in no case shall identifying, selecting, and initiating recovery of claims be performed in greater than a thirty-day period.)

(15) Describe the methods it would use to eliminate or diminish any associated provider administrative work (The Department of Social Services is sensitive to the impact of a claim adjustment process on the Connecticut Medicaid provider. This requirement is for bidders proposing to use a provider adjustment process.)

(16) Explain how it has been successfully performing a provider disallowance process on behalf of a State Medicaid Agency or other entity

(17) Describe its capability to identify any recoveries that it receives that are not due to one of its projects and separately transfer those recoveries to the Department of Social Services

(18) Describe its capability to restrict the recovery on a particular claim to the Medicaid paid amount

(19) Describe how successful it has been in performing customer service when performing Medicaid benefit recovery through a provider disallowance process

(20) Describe its achievements in performing new and innovative benefit recovery methods and how this success is measured

c) New or Expanded Client Third Party Liability Information: Interrogation of the Client Eligibility Record and Medicaid Claim Selection - Attachment 4 contains listings of health insurance codes used to systematically capture client third party liability types of coverage in the client third party liability record. Attachment 5 contains the current (interChange) Client Eligibility and Recipient Third Party Liability Vendor extract file layouts. The resultant contractor shall use this information with any of its own third party liability information for creating quality benefit recovery of Medicaid paid claims. The bidder's capability to identify the type of Medicaid claims to be selected is fundamental to this requirement. F&R has developed selection logic that technically accounts for all possible Medicaid paid claims for which recovery from third parties should be sought.

This logic is to ensure that state agency third party liability requirements are met when new or expanded client Medicare or health insurance is entered into the Department of Social Services' eligibility file. Attachment 6a identifies Medicaid paid claims that should be selected for benefit recovery contingent on a client's health insurance or Medicare type of coverage and a specific medical service. Attachment 6b explains Reference Codes. The Department of Social Services has no approval from CMS to waive Medicaid claim benefit recovery based on threshold claim dollars or other criteria. The bidder's response should not propose any recovery methods that pertain to any threshold or claim dollar limitation. To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Propose a method to identify Medicaid paid claims for those clients that have new or expanded third party liability coverage entered on the EMS

(2) Describe how it will use the Department of Social Services' and its own data and any other processes to generate Medicaid paid claims for submission to third parties

(3) Describe how it will interrogate the Department of Social Services' client eligibility data on a frequency to be determined by the state agency but not greater than a thirty-calendar-day period to identify new and/or expanded client health insurance and/or Medicare information

(4) Demonstrate its knowledge, capability, expertise, and technical experience to perform this requirement by describing similar work performed on behalf of State Medicaid Agencies, health plans, health care providers, or other entities

(5) Describe any projects for which it has performed similar work on behalf of State Medicaid Agencies, health plans, or other entities

(6) Detail the methods it would use to identify claims that should be selected for benefit recovery either by a direct claim billing or provider adjustment

(7) Describe the methods it will use to correct and perfect a claim that will diminish the likelihood of rejection by the liable third party

(8) Describe the methods it will use to follow up on, correct, and perfect claims billed to and denied by a third party

(9) Describe the methods it will use to follow up on aged and outstanding claims billed to third parties

(10) Describe the methods it will use to select and bill claim to liable third parties and/or perform a Medicaid claim provider adjustment process in a frequency to be determined by the state agency but not greater than sixty days after the end of the month in which the triggering third party information was entered on the Department of Social Services' eligibility file

(11) Describe its capability to select and then generate claims either in paper or electronic format, whichever is acceptable to the liable third party

d) Health Insurance Reform: Standards for Electronic Transactions - Pursuant to HIPAA compliance specified at 45 CFR Part 162, Health Insurance Reform: Standards for Electronic Transactions, the resultant contractor shall generate HIPAA-compliant health care claims or equivalent encounter information using the following standards:

- For Professional Health Care Claims: the ASC XI2N 837 - Health Care Claim: Professional, Volumes 1 and 2, Version 4010, May 2000, Washington Publishing Company, 004010X098 (incorporated by reference in §162.920)

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

- For Retail Pharmacy Drug Claims: the National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Implementation Guide, Version 5, Release 1, September 1999, and equivalent

NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 0, February 1, 1996 (incorporated by reference in §162.920)

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

HIPAA standards for electronic transmissions do not specifically address State Medicaid Agencies transmitting claims to health insurance companies. The resultant contractor shall be required to submit HIPAA standard electronic transmissions to legally liable third parties to recover Medicaid payments. To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Demonstrate its capability to meet the HIPAA claim submission requirements by describing the work performed on behalf of other State Medicaid Agencies, health care providers, health care plans, or other entities

(2) Describe its success and failure experience in submitting on behalf of State Medicaid Agencies HIPAA-compliant claims to legally liable third parties

(3) Describe its capability to modify its systems and billing practices to accommodate changes and/or new requirements to the HIPAA Health Insurance Reform: Standards for Electronic Transactions

e) Benefit Recovery Accounting and Reporting - The bidder must consider the following objectives in responding to this requirement:

- To develop and establish financial controls that account for all third party liability cash recoveries, denied Medicaid claims, and provider recoupment/disallowed claims

- To generate reporting that encompasses all benefit recovery of Medicaid claims activity

The resultant contractor shall:

- Meet all Department of Social Services benefit recovery accounting and reporting requirements
- Report recoveries in a format, frequency, and manner that will support the Department of Social Services' required CMS reporting
- Establish financial controls for transmitting to the Department of Social Services recovered third party liability dollars or claims information necessary to affect a recovery through provider disallowance
- Report its Medicaid paid claim benefit recovery experience in media and frequency specified by the Department of Social Services
- Report detail and summary information for the results of its benefit recovery process
- Report at least annually financial information regarding its current and outstanding recoveries for all projects which it performs under this RFP (for the Department of Social Services' GAAP reporting requirements)

(1) To submit a responsive proposal, **THE BIDDER SHALL**:

(a) Describe its experience in supporting State Medicaid Agency Generally Accepted Accounting Principles (GAAP) regarding benefit recovery of Medicaid paid claims

(b) Describe previous reporting experience of Medicaid or other benefit recovery type of work

(c) Propose a method of transmitting provider adjustment Medicaid paid claim information to the Department of Social Services

(d) Describe and provide examples of how it will report Medicaid benefit recovery activity including, but not limited to:

(i) Summary and detail level reporting of claims selected and billed to health insurance carriers

(ii) Summary and detail level reporting of claims selected for recoupment from providers

(iii) Summary of claims recouped from provider

(iv) Summary and detail level reporting of claims excluded from benefit recovery

(v) Summary and detail level reporting of outstanding claims

(vi) Summary and detail level reporting of denied claims

(vii) Summary and detail level reporting of health insurance recoveries

2. Third Party Liability Verification

Introduction - The Department of Social Services is required to identify third party liability information during a client's initial application and subsequent re-determinations for Connecticut Medical Assistance eligibility. This eligibility process, performed at one of twelve Department of Social Services Regional Offices located throughout the State acts as a main focal point for clients to provide third party liability information to the state agency. As a result, the Regional Offices forward this unverified third party liability information to a centralized location at F&R. F&R also receives other types of health insurance referrals.

Under Federal regulation, F&R is required to follow up on this information within sixty days to identify legally liable third party resources and incorporate the third party liability data into the Department of Social Services' client eligibility case file so that the state agency may process claims under its third party liability payment and recovery procedures. Regional Office workers submit a W-1685

"Medical Insurance Information" form with the insurance information and a copy of the front and back of the insurance card, if possible. The W-1685 form can contain new and/or changed insurance information. In SFY 2007, F&R received about fourteen thousand health insurance referrals. Based on SFY 2008 year-to-date experience (through April 30, 2008), nearly sixteen thousand referrals are expected. Attachment 7 lists these referrals with the number received from each source. This includes about three thousand referrals originating from Medicaid providers (which are separately addressed later in this RFP).

Because third party liability information is used for cost avoiding medical claims in the Department of Social Services' coordination of benefits effort and for benefit recovery of Medicaid paid claims, it is imperative that the third party liability information on the system is accurate. To ensure accuracy, the Department of Social Services requires that the third party liability information be verified before entering on the EMS.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To develop and implement an enhanced third party liability verification program that leverages manual and Web-based health insurance interrogation, data match, electronic commerce, and other verification processes (The Department of Social Services believes that this synergy will result in a high-quality health insurance validation process.)

- To perform a high-quality health insurance validation process that results in accurate and genuine health insurance information of the highest integrity, which would be suitable for performing Medicaid paid claim benefit recovery and cost avoidance of both Medicaid FFS and Medicaid Managed Care encounter claims

- To transmit verified health insurance information electronically for automatic updating the EMS in a manner, format, and frequency to be specified by the Department of Social Services

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

Supporting Regulations/Authority - This requirement falls under Title 42 CFR Part 433 Subpart D, Third Party Liability.

The resultant contractor shall:

- Build and implement a Third Party Liability Verification System based on receiving third party liability referrals from a variety of sources, which succeeds the Department of Social Services' current verification processes

- Be responsible for the costs associated with obtaining referral information from the Department of Social Services

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

- Verify health insurance coverage for all Connecticut Medical Assistance clients covered under a Department of Social Services' Medical Assistance Unit[11] (This means that if it were to receive a referral to verify third party liability on one client it would be required to identify any other family members eligible for medical assistance and also perform third party verification on these additional individuals.)

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

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

- From the date of receipt of a referral, perform the third party liability verification and update the Department of Social Services' eligibility file in a timeframe to be determined by the Department of Social Services but not greater than thirty business days

[11] A Medical Assistance Unit consists of one or more individuals who apply for or receive assistance together under one of the Department of Social Services' programs.

- Report to the Department of Social Services any referrals that are not updated to the Department of Social Services' eligibility file within the required period

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

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

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

- Report to the Department of Social Services summary and detail information on its completed referrals by referral type, as required

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

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

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

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

    - Whether or not pre-authorization is required

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

    - Whether or not there is a lifetime maximum

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Describe how robust its approach and capabilities are to perform a high-quality third party verification process (Factoring in electronic, manual, or other methods it will use to verify third party liability and the problems associated with obtaining information from third parties, the bidder shall describe how many client verifications it will complete daily, weekly, and monthly. The bidder shall document this performance by providing examples of its experience from similar third party verification work with other entities.)

(2) Describe how it will verify client commercial health insurance third party liability including, but not limited to, electronic data match, Web-based verification, and/or manual verification (the bidder's proposal shall not rely solely on a data match as the means of verifying a third party liability)

(3) Describe any formal arrangements or technology it currently has in place to obtain information from various sources of third party liability

(4) Describe how it has performed similar third party verification on behalf of other State Medicaid Agencies, health care providers, health plans, and/or other entities

(5) Describe its processes that ensure its verified third party information is accurate and of high quality

(6) Propose a method to review and determine if any changes, corrections, or deletions to a client's existing third party liability record need to be performed subsequent to its verification of new client health insurance information

(7) Describe its capability of verifying hospital inpatient and outpatient coverage, doctor/professional service coverage, dental, vision, drug, and long-term care/skilled nursing coverage and tracking this verified coverage

(8) Describe how in its verification process it will differentiate between a client's eligibility in a Medicaid Managed Care Plan versus separate and unique commercial health

insurance coverage (Medicaid Managed Care information should not be transmitted to the Department of Social Services as third party liability information.)

(9) Describe how in its verification process it will differentiate between a client's eligibility in a Medicare Advantage Plan versus separate and unique commercial health insurance coverage (Information on a Medicare Advantage Plan should not be transmitted to the Department of Social Services as information.)

3. Third Party Liability Health Insurance Suspect Reporting

Introduction - The MMIS claims processing system edits claims to identify clients that might have health insurance third party liability, which is not captured on the EMS. During July 2007 through January 2008, about two thousand clients were identified through MMIS claims processing as having potential health insurance third party liability.

The MMIS interChange claims processing system identifies through Medicaid claim adjudication potential health insurance client third party liability in the following way:

- A provider submits a claim for reimbursement of the balance of its usual and customary charge not paid for by a client's health insurance. The claim contains the previously billed health insurance carrier (by a three-digit carrier code) and the prior insurance payment. During claim adjudication, the MMIS determines that the health insurance carrier for which the provider previously billed (as determined by the three-digit carrier code) is not also contained on the client's eligibility record. This information is generated to the Potential Third Party Liability for Follow-Up Report.

The Potential Third Party Liability for Follow-Up Report definition and layout are found in Attachment 8. Beginning in March 2008, a third party liability contractor works the two reports verifying the suspect client third party liability and forwarding new information to the Department of Social Services for inclusion in its eligibility file.

Objective - The bidder must consider the following objectives in responding to this requirement: to develop a working process of analyzing the Department of Social Services' interChange health insurance suspect report to identify and determine if a client has or had third party liability coverage.

Supporting Regulations/Authority - This requirement falls under Title 42 CFR Part 433 Subpart D, Third Party Liability.

The resultant contractor shall:

- Build and implement a suspect third party liability health insurance verification and reporting program that succeeds the Department of Social Services' current process
- Correct its previously reported health insurance information, which is subsequently determined to be erroneous
- Manually update the client third party liability information on the EMS, as needed
- Ensure that its third party liability verification system is compatible with the EMS and MMIS, as needed
- Provide a file of any changes, corrections, or deletions needed to be performed on a client's existing third party liability record subsequent to its verification of new client health insurance information in a manner, frequency, and format to be specified by the Department of Social Services
- Provide the verified third party liability information to the Department of Social Services in a personal computer-based software, if the Department of Social Services so requests
- Report to the Department of Social Services summary and detail information on its completed referrals by referral type, as required
- Actively assist the Department of Social Services in correcting any discrepancies or errors in its transmitted data including working with the Department of Social Services to identify modifications and enhancements to the Department of Social Services' process of updating the EMS
- Provide output reports to the Department of Social Services that identify and track the clients for which health insurance coverage was verified as not applicable and reported to the Department of Social Services for deletion from the EMS

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

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

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

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

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

    - Whether or not pre-authorization is required

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

    - Whether or not there is a lifetime maximum

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Propose a process to verify if the clients that are reported on the Potential Third Party Liability for Follow-Up Report have valid health insurance coverage

(2) Describe how robust its approach and capabilities are to perform a high-quality third party verification process (Factoring in electronic, manual, or other methods it will use to verify third party liability and the problems associated with obtaining information from third parties, the bidder shall describe how many client verifications it will complete daily, weekly, and monthly. The bidder shall document this performance by providing examples of its experience from similar third party verification work with other entities.)

(3) Describe how it will verify client commercial health insurance third party liability including, but not limited to,

electronic data match, Web-based verification, and/or manual verification (the bidder's proposal shall not rely solely on a data match as the means of verifying a third party liability)

(4) Describe any formal arrangements or technology it currently has in place to obtain information from various sources of third party liability

(5) Describe how it has performed similar third party verification on behalf of other State Medicaid Agencies, health care providers, health plans, and/or other entities

(6) Describe its processes that ensure its verified third party information is accurate and of high quality

(7) Propose a method to review and determine if any changes, corrections, or deletions to a client's existing third party liability record need to be performed subsequent to its verification of new client health insurance information

(8) Describe its capability of verifying hospital inpatient and outpatient coverage, doctor/professional service coverage, dental, vision, drug, and long-term care/skilled nursing coverage and tracking this verified coverage

(9) Describe how in its verification process it will differentiate between a client's eligibility in a Medicaid Managed Care Plan versus separate and unique commercial health insurance coverage (Medicaid Managed Care information should not be transmitted to the Department of Social Services as third party liability information.)

(10) Describe how in its verification process it will differentiate between a client's eligibility in a Medicare Advantage Plan versus separate and unique commercial health insurance coverage (Information on a Medicare Advantage Plan should not be transmitted to the Department of Social Services as information.)

4. Third Party Liability Information Form

Introduction - Connecticut Medicaid providers can communicate to the Department of Social Services that a client's third party liability

information needs to be corrected or updated. This is performed using the Provider Third Party Liability Information Form. From July 2006 through January 2008, Connecticut Medicaid providers used the Third Party Liability Information Form about five thousand times. Based on this standard, about two hundred and sixty forms are processed monthly. An example of the Third Party Liability Information Form is found in Attachment 9. Detailed instructions and use may be found at the Department of Social Services/EDS Web site at www.ctdssmap.com under Information - Publications - Provider Manuals - Chapter 5 - §5.4, Client Third Party Liability Update Procedures. Beginning in March 2008, providers began sending completed forms to the Department's third party liability contractor[12]. The third party liability contractor researches the client third party liability information and forwards to the Department of Social Services any needed changes (either new insurance, closed/terminated insurance, or incorrect insurance data) to be updated to or removed from the client's eligibility file. In addition, the third party liability contractor notifies the provider of the results of its verification work.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To develop a working process of receiving Third Party Liability Information Form referrals from the Connecticut Medicaid Program Provider Community

- To verify if the Third Party Liability Information Form referral pertains to either previously unknown third party liability or to changes, corrections, or deletions of health insurance information that needs to be made to the Department of Social Services' Third Party Liability database

- To report the results of the Third Party Liability Information Form referral to the Department of Social Services so that it may update its Third Party Liability database with accurate information and to the referring Medicaid provider so that it may efficiently coordinate benefits between Medicaid and client third party liability

Supporting Regulations/Authority - This requirement falls under Title 42 CFR Part 433 Subpart D, Third Party Liability.

[12] Providers may send Third Party Liability Information Forms to the third party liability contractor by mail, facsimile, or encrypted secure email.

The resultant contractor shall:

- Build and implement a Third Party Liability Information Form - provider reporting process that succeeds the Department of Social Services' current effort

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

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

- Report to the Department of Social Services summary and detail information on its completed referrals by referral type, as required

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

- Transmit necessary commercial health insurance information to the Department of Social Services for inclusion on the EMS

- Provide customer service to the Medicaid provider in communicating the status and result of the Third Party Liability Information Form

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

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

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

    - Whether or not pre-authorization is required

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

- Whether or not there is a lifetime maximum

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Propose a method of implementing a Third Party Liability Information Form - provider reporting process

(2) Describe how robust its approach and capabilities are to perform a high-quality third party verification process (Factoring in electronic, manual, or other methods it will use to verify third party liability and the problems associated with obtaining information from third parties, the bidder shall describe how many client verifications it will complete daily, weekly, and monthly. The bidder shall document this performance by providing examples of its experience from similar third party verification work with other entities.)

(3) Describe how it will verify client commercial health insurance third party liability including, but not limited to, electronic data match, Web-based verification, and/or manual verification (the bidder's proposal shall not rely solely on a data match as the means of verifying a third party liability)

(4) Describe any formal arrangements or technology it currently has in place to obtain information from various sources of third party liability

(5) Describe how it has performed similar third party verification on behalf of other State Medicaid Agencies, health care providers, health plans, and/or other entities

(6) Describe its processes that ensure its verified third party information is accurate and of high quality

(7) Propose a method to review and determine if any changes, corrections, or deletions to a client's existing third party liability record need to be performed subsequent to its verification of new client health insurance information

(8) Describe its capability of verifying hospital inpatient and outpatient coverage, doctor/professional service coverage, dental, vision, drug, and long-term care/skilled nursing coverage and tracking this verified coverage

(9) Describe how in its verification process it will differentiate between a client's eligibility in a Medicaid Managed Care Plan versus separate and unique commercial health insurance coverage (Medicaid Managed Care information should not be transmitted to the Department of Social Services as third party liability information.)

(10) Describe how in its verification process it will differentiate between a client's eligibility in a Medicare Advantage Plan versus separate and unique commercial health insurance coverage (Information on a Medicare Advantage Plan should not be transmitted to the Department of Social Services as information.)

(11) Describe how it will handle Third Party Liability Forms daily from the Medicaid provider community

(12) Propose methods to verify commercial health insurance information as indicated on the Third Party Liability Information Form

5. Third Party Liability Data Match and Identification

Introduction - The Department of Social Services is required to secure agreements to obtain from:

- The State Workers' Compensation or Industrial Accident Commission files information that identifies Medicaid recipients and absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses

- State Motor Vehicle accident report files information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists

- The State wage information collection agency and Social Security Administration wage and earnings files data information that identifies Medicaid recipients that are employed and their employers, employed absent or custodial parents of recipients,

and their employers to determine the legal liability of third parties

In addition, for identifying client third party liability, the Department of Social Services or its agents may secure agreements with any health insurer including a self-insured plan, group health plan, as defined in §607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, and which may or may not be financially at risk for the cost of a health care item or service.

The State of Connecticut implemented the third party liability provisions of the Deficit Reduction Act of 2005 requiring health insurers to provide the Department of Social Services with eligibility and coverage information that will enable the state agency to determine the existence of third party coverage for its Connecticut Medical Assistance clients[13]. Connecticut state law requires third parties defined as any health insurer including a self-insured plan, group health plan, as defined in §607(1) of the Employee Retirement Income Security Act of 1974, service benefit plan, managed care organization, health care center, pharmacy benefit manager, dental benefit manager or other party that is, by statute, contract or agreement, legally responsible for payment of a claim for a health care item or service, which may or may not be financially at risk for the cost of a health care item or service, to cooperate with the Department of Social Services in performing data matches.

As part of the Department of Social Services' previously mentioned State Agency Billing Agreements with TMA, the state agency is required to participate in an annual DEERS data match to identify Connecticut Medicaid clients with TRICARE benefits. A third party liability contractor performs this function.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To establish and perform a broad scope data match operation encompassing commercial health insurance, Federal health

[13] Connecticut General Statutes Sec. 17b-137. (Formerly Sec. 17-303). Disclosure of property of recipients of state aid, care, or child support enforcement services. Disclosure of property of persons liable to support recipients or subject to IV-D support case investigation. Access to records. Automated data match system. High-volume automated administrative enforcement.

insurance, and certain government agencies for identifying Connecticut Medical Assistance Client third party liability

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

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

- To transmit electronically to the Department of Social Services verified health insurance information for automatic updating the EMS

Supporting Regulations/Authority - This requirement falls under Title 42 CFR Part 433 Subpart D, Third Party Liability and Connecticut General Statutes §17b-137.

The resultant contractor shall:

- Conduct on behalf of the Department of Social Services, the state agency's government agency required and commercial health insurance data matches (The resultant contractor shall coordinate this data match activity with the benefit recovery and third party liability verification work it will perform in response to RFP requirements.)

- Jointly identify recovery opportunities with the Department of Social Services and conduct data exchanges and recoveries for agreed upon health plans

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

to the resultant contractor will be borne by the resultant contractor.)

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

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

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

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

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

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

- Report to the Department of Social Services summary and detail information on its completed referrals by referral type, as required

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

- Provide the Department of Social Services with matched third party information in a format acceptable for electronic submission on the EMS and/or manually update the EMS

- Provide the Department of Social Services with timely third party liability information consistent with a Department of Social Services defined schedule of data transmission

- Correct, quantify, and clarify any third party liability information that did not get captured on the EMS due to a discrepancy between the third party liability information provided by the resultant contractor and the third party liability information already captured on the EMS, or by other interface problems that result in matched third party liability information not getting captured on the EMS

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

- Establish and maintain the necessary data exchange agreements with health plans, carriers, or administrators (Copies of such agreements will be provided to the Department of Social Services. Any expenses charged by the carriers or health plans for supplying eligibility information or other files to the resultant contractor shall be borne by the resultant contractor.)

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

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

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

    - Whether or not pre-authorization is required

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

    - Whether or not there is a lifetime maximum

a) <u>To submit a responsive proposal, **THE BIDDER SHALL**</u>:

(1) Describe its experience in performing data matches with State Workers' Compensation or Industrial Accident

Commission files, State Motor Vehicle accident report files, or State Wage Information Collection Agencies (SWICA) (The bidder may propose a data match process with an alternate source of information, which it believes furnishes information as timely, complete, and useful as the SWICA and SSA Wage and earnings files. The bidder shall explain why its use of alternative information meets this criterion)

(2) Propose a method of identifying clients with work-related injury or illnesses and pursuing Medicaid recovery from the client's Worker Compensation carrier

(3) Propose a method of identifying clients involved in motor vehicle accidents as either drivers, passengers, or pedestrians and pursuing Medicaid recovery from automobile liability insurance and/or coordinating recovery efforts through the Connecticut Department of Administrative Services

(4) Describe the relationship between its automated data match technology and recovering Medicaid payments from the identified legally liable third parties

(5) Describe the accuracy and integrity of its data match logic and the processes it will use to determine the validity and quality of a match between client demographic information and a legally liable third party's subscriber/member information

(6) Describe the frequency in which it plans to perform government agency and commercial health insurance data matches

(7) List all its existing data exchange agreements in force and agreements in negotiation with health insurance companies[14], CMS Fiscal Intermediaries and Carriers, and/or other state or Federal agencies (The bidder's list should include those third parties in which it does not necessarily have an agreement in force, but instead works as an agent in performing the data match on behalf of the party holding the agreement. The bidder's

[14] Health insurance companies include health insurers, self-insured plans, group health plans (as defined in §607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, health care centers, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, which may or may not be financially at risk for the cost of a health care item or service.

list should include the effective or expected effective dates of the agreements, the frequency in which it performs (or is expected to perform) the matches, weekly, monthly, quarterly, bi-annually, annually, or other frequency, and the method in which data will be exchanged and used between the bidder and third party, does the bidder receive the third party's eligibility information and perform the match process or does the bidder provide a Medicaid eligibility file to the third party and it performs the match process.)

(8) Describe any problems it has had in establishing data match agreements and what it conducted to remedy the problem

(9) Describe how robust its approach and capabilities are to perform a high-quality third party verification process (Factoring in electronic, manual, or other methods it will use to verify third party liability and the problems associated with obtaining information from third parties, the bidder shall describe how many client verifications it will complete daily, weekly, and monthly. The bidder shall document this performance by providing examples of its experience from similar third party verification work with other entities.)

(10) Describe how it will verify client commercial health insurance third party liability including, but not limited to, electronic data match, Web-based verification, and/or manual verification (the bidder's proposal shall not rely solely on a data match as the means of verifying a third party liability)

(11) Describe any formal arrangements or technology it currently has in place to obtain information from various sources of third party liability

(12) Describe how it has performed similar third party verification on behalf of other State Medicaid Agencies, health care providers, health plans, and/or other entities

(13) Describe its processes that ensure its verified third party information is accurate and of high quality

(14) Propose a method to review and determine if any changes, corrections, or deletions to a client's existing third party liability record need to be performed subsequent to its verification of new client health insurance information

(15) Describe its capability of verifying hospital inpatient and outpatient coverage, doctor/professional service coverage, dental, vision, drug, and long-term care/skilled nursing coverage and tracking this verified coverage

(16) Describe how in its verification process it will differentiate between a client's eligibility in a Medicaid Managed Care Plan versus separate and unique commercial health insurance coverage (Medicaid Managed Care information should not be transmitted to the Department of Social Services as third party liability information.)

(17) Describe how in its verification process it will differentiate between a client's eligibility in a Medicare Advantage Plan versus separate and unique commercial health insurance coverage (Information on a Medicare Advantage Plan should not be transmitted to the Department of Social Services as information.)

6. Trauma Recovery

Introduction - The Department of Social Services is required to identify Medicaid clients that have been involved in an accident or trauma to determine if any legally liable third parties may be responsible for paying the cost of health care. The Department of Social Services' MMIS interChange system performs this requirement through a diagnosis and trauma codes edit process. The interChange system produces a Third Party Liability Accident Trauma Report. The report identifies by client Medicaid paid claims that:

- Have an accident indicator, or
- Where the claim diagnosis codes are within the range defined for accident/trauma (800.00-999.9), or
- Where the claim diagnosis codes are within the range defined as the supplementary classification of external causes of injury and poisoning found in diagnosis code range E800-E999, inclusive

A client and Medicaid claim experience report is generated when the cumulative accident/trauma claim paid amounts for the client exceed $500. Once a client is reported, they are not reported again for one hundred fifty days to preclude redundancy. For each of these reported clients, EDS produces an Accident Trauma questionnaire to facilitate research and follow up. The questionnaires are sent to the billing provider to request additional information for any claims that have been the result of an accident or trauma. As EDS receives responses back from the providers, information is reviewed, and if it appears that the Medicaid paid services were the result of an accident, all documentation is sent to the Department of Social Services for ongoing handling and follow up.

In the State of Connecticut, DAS is the agency that recovers from lawsuit settlements and causes of action on behalf of the Department of Social Services. DAS performs a match to identify potential recoveries from insurance claims. DAS also matches/searches court information to search for clients who have potential lawsuit settlements against which the State can make a claim under State and Federal law. DAS liens the potential settlements and makes Medicaid recoveries.

Concurrently, the Department of Social Services' third party liability vendor performs a process of identifying clients not initially determined by DAS as being involved in an accident or trauma. The third party liability vendor may identify if a client has an attorney or has otherwise initiated a cause of action. The third party liability vendor may uncover potential accident or trauma third party liability and forward this information to DAS for follow up.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To perform the State agency's required diagnosis and trauma code editing of Medicaid FFS and Managed Care at-risk encounter claim experience

- To develop the accident trauma case information including, but not limited to, establishing the existence of an attorney, a cause of action, and/or a legally liable third party

- To coordinate its accident trauma work with and refer to DAS to avoid duplication of effort and for DAS to follow up on and complete the recovery

Supporting Regulations/Authority - This requirement falls under Title 42 CFR, Part 433 Subpart D, Third Party Liability and Connecticut General Statutes 17b 93.

The resultant contractor shall:

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

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

- Refer its developed case to DAS who will then follow up on the recovery

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Describe its experience in identifying Medicaid clients that have been involved in an accident or trauma and recovering client Medicaid expenditures from accident insurance, liability insurance, automobile liability insurance, State Workers' Compensation insurance, client indemnity insurance, or any other legally liable third party

(2) Describe its experience in identifying Medicaid clients that have been involved in an accident or trauma and in recovering client Medicaid expenditures from Causes of Action/Torts including the average amount of time it takes to settle a case, the average Medicaid recovery amount from Causes of Action/Torts and percentage recovered versus Medicaid claim amount, and any role the bidder

has played in expediting the settlement to the benefit of a State Medicaid Program

(3) Describe how it will develop an accident trauma case to learn the existence of an attorney, a cause of action, and/or a legally liable third party

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

(5) Describe the relationship between its proposed accident trauma project and work it will perform in data matching with the State Workers' Compensation or Industrial Accident Commission files and State Motor Vehicle accident report file

7. Child Support Medical Insurance Identification

Introduction - In Connecticut, the Support Enforcement Services (SES) and the Bureau of Child Support Enforcement (BCSE) enforce child support orders including the medical support component. If medical insurance is available through employment, the noncustodial parent is required to enroll his/her children in this medical insurance unless certain exceptions apply. An overview of the current internal process follows:

- The Department of Social Services provides the current contractor with a file containing all dependents that have a medical support order but no medical insurance on file, along with noncustodial parent information. This includes dependents that may or may not be Medicaid clients.

- The contractor discovers and verifies existing insurance for the dependent or potential insurance because the noncustodial parent has insurance through an employer then submits a file

containing the insurance information to the Department of Social Services.

- SES follows up on potential insurance, enters medical insurance information on the Connecticut Child Support Enforcement System (CCSES), the automated system used by BCSE and its cooperating agencies to collect and distribute child support and maintain related records.

- The Child Support Program notifies F&R, which verifies the insurance and enters it on the EMS.

- Medical insurance is sent to the MMIS via a full file replacement for cost avoidance and paid claim recovery purposes.

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

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To discover existing medical insurance for dependents that have a child support medical order, whether or not these dependents are on Medicaid, and regardless of who the policyholder is

- To discover potential medical insurance for children covered under a medical support order (This is performed by identifying insurance for the noncustodial parent. If a parent is enrolled in an employer-sponsored health insurance plan, it is likely that the opportunity to enroll his/her dependents exists.)

- To verify the medical insurance and employer

Supporting Regulations/Authority - This requirement falls under:

- Deficit Reduction Act of 2005, §7307

- 42 USC 666(a)(19)(A)

- 42 USC 652(f)
- 29 USC 1169
- 42 USC 652(f)
- 45 CFR §§301.1
- 42 CFR §§433.136
- 45 CFR §§303.30

The resultant contractor shall:

- Correct its previously reported health insurance information, which is subsequently determined to be erroneous
- Manually update the client third party liability information on the EMS, as needed
- Ensure that its third party liability verification system is compatible with the EMS and MMIS, as needed
- Jointly identify recovery opportunities with the Department of Social Services and conduct data exchanges and recoveries for agreed upon health plans
- Establish and maintain the necessary data exchange agreements with health plans, third party benefit managers, or administrators (Copies of such agreements will be provided to the Department of Social Services, when requested. Any expenses charged by health plans, third party benefit managers or administrators for supplying eligibility information or other files to the resultant contractor will be borne by the resultant contractor.)
- Contact organizations and arrange for the data matches (The resultant contractor shall be responsible for payment of any and all costs incurred in securing necessary files from the Department of Social Services and the Department of Social Services' MMIS contractor, performing the data matches, ensuring the third party liability billings do not duplicate those generated by the MMIS contractor, and returning the output of

data matches to the Department of Social Services for input on the EMS.)

- Provide the Department of Social Services with matched third party information in a format acceptable for electronic submission on the EMS and/or manually update the EMS

- Provide the Department of Social Services with timely third party liability information consistent with a Department of Social Services defined schedule of data transmission

- Correct, quantify, and clarify any third party liability information that did not get captured on the EMS due to a discrepancy between the third party liability information provided by the resultant contractor and the third party liability information already captured on the EMS, or by other interface problems that result in matched third party liability information not getting captured on the EMS

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

- Compare its insurance eligibility database to the noncustodial parent data available from the Department of Social Services to locate insurance coverage for noncustodial parents

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

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

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

- Electronically provide a file containing the verified third party liability information in the frequency, format, and manner requested by the Department of Social Services for update to the EMS including providing the Department of Social Services with coverage type codes identified in Attachment 4

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

- At a minimum, report the date of the deliverable, the number of records where the resultant contractor identified and verified insurance, and the number of unique policies identified

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

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

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

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

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

    - Whether or not pre-authorization is required

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

    - Whether or not there is a lifetime maximum

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Describe how robust its approach and capabilities are to perform a high-quality third party verification process (Factoring in electronic, manual, or other methods it will use to verify third party liability and the problems associated with obtaining information from third parties, the bidder shall describe how many client verifications it will complete daily, weekly, and monthly. The bidder shall document this performance by providing examples of its experience from similar third party verification work with other entities.)

(2) Describe how it will verify client commercial health insurance third party liability including, but not limited to, electronic data match, Web-based verification, and/or manual verification (the bidder's proposal shall not rely solely on a data match as the means of verifying a third party liability)

(3) Describe any formal arrangements or technology it currently has in place to obtain information from various sources of third party liability

(4) Describe how it has performed similar third party verification on behalf of other State Medicaid Agencies, health care providers, health plans, and/or other entities

(5) Describe its processes that ensure its verified third party information is accurate and of high quality

(6) If the individual is a Medicaid client, describe its capability of verifying hospital inpatient and outpatient coverage, doctor/professional service coverage, dental, vision, drug, and long-term care/skilled nursing coverage and tracking this verified coverage

(7) Describe how in its verification process it will differentiate between a client's eligibility in a Medicaid Managed Care Plan versus separate and unique commercial health insurance coverage (Medicaid Managed Care information should not be transmitted to the Department of Social Services as third party liability information.)

(8) Describe how in its verification process it will differentiate between a client's eligibility in a Medicare Advantage Plan versus separate and unique commercial health insurance coverage (Information on a Medicare Advantage Plan should not be transmitted to the Department of Social Services as information.)

(9) Describe the accuracy and integrity of its data match logic and the processes it will use to determine the validity and quality of a match between client demographic information and a legally liable third party's subscriber/member information

(10) List all its existing data exchange agreements in force and agreements in negotiation with health insurance companies[15], CMS Fiscal Intermediaries, and Carriers, and/or other state or Federal agencies (The bidder's list should include those third parties in which it does not necessarily have an agreement in force, but instead works as an agent in performing the data match on behalf of the party holding the agreement. The bidder's list should include the effective or expected effective dates of the agreements, the frequency in which it performs (or is expected to perform) the matches, weekly, monthly, quarterly, bi-annually, annually, or other frequency, and the method in which data will be exchanged and used between the bidder and third party, does the bidder receive the third party's eligibility information and perform the match process or does the bidder provide a Medicaid eligibility file to the third party and it performs the match process.)

(11) Describe any problems it has had in establishing data match agreements and what it conducted to remedy the problem

(12) Propose a process for issuing the NMSN and following up with the employer to ensure response and that as many children as possible covered under a medical support order actually obtain medical insurance as required by law

[15] Health insurance companies include health insurers, self-insured plans, group health plans (as defined in §607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, health care centers, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, which may or may not be financially at risk for the cost of a health care item or service.

(13) Describe its capability to verify employment for the cases where the noncustodial parent is found to have health insurance for him/herself and not the dependents

(14) Describe its capability to prepare a file of verified insurance and submit that file to the Department of Social Services via a HIPAA-approved secure method

(15) Describe its capability to return a file containing the fields on the original child support file with the verified health insurance information appended for each record in the format requested by the Department of Social Services

(16) Describe its capability to successfully cross match the verified insurance found via the match to the Department of Social Services' client eligibility file and provide the verified insurance for update to the EMS, electronically or manually, for individuals who are Medicaid recipients

(17) Describe its capability to accept a file from the Department of Social Services' Division of Child Support containing dependents covered under a medical support order and their noncustodial parents

8. Acute Care Hospital and Skilled Nursing Facility Credit Balance/Overpayment Audits, Applied Income Project, and Maintenance of Online Credit Balance Reporting System for Long-term Care Facilities

Introduction - Erroneous payments made by State Medicaid Agencies to long-term care facilities and hospitals represent a significant portion of third party liability recoveries owed to the State. In many cases, these overpayments are recorded on the books of the facilities as credit balances.

Credit balances arise, in part, because of the complexity involved in managing the coordination of benefits process. For various reasons, providers receive revenue from multiple sources and often have trouble in reconciling accounts. Additionally, the speed at which providers seek payment for services further impedes the third party payment process by causing errors in documentation. Payments by third party payers that create refunds due State Medicaid Agencies often go unresolved because provider efforts to refund overpayments are minimal and secondary to their priority financial activities: collecting the receivable and reducing bad debt.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- Perform credit balance/overpayment audits of skilled nursing facilities and acute care hospitals
- Process Applied Income Disposition Project (AIDP) claims
- Maintain a provider overpayment self-reporting program

Supporting Regulations/Authority - N/A

The resultant contractor shall:

- Develop and implement an audit program that identifies inappropriate/erroneous payments and credit balances owed to the Department of Social Services by long-term care facilities and hospitals (There are about two hundred fifty skilled nursing facilities and thirty hospitals that will be subject to these audits.)
- Process AIDP claims not processed by the Department of Social Services and also develop and maintain a self-reporting program which allows long-term care providers to self report provider identified Medicaid overpayments directly to the resultant contractor
- Identify potential overpayments through retrospective onsite audits of paid claims data (All potential overpayments identified shall be thoroughly researched and presented to the appropriate provider representative for review and concurrence.)
- Meet with providers for exit conferences and to discuss audit results, as necessary
- Conduct an onsite overpayment compliance audit of financial records of all Medicaid Long-term Care providers every two years to identify and recover Medicaid overpayments not reported by providers through the program
- Process AIDP claims identified and not processed by the Department of Social Services' Applied Income Overpayments identified through provider audits where there is no record of a W-9 Medicare Clearance Form will continue to be recovered through the Provider Audit project as described herein

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

- Ensure that all long-term care providers are accurate, complete, and timely when reporting Medicaid overpayments to the Department of Social Services by establishing a provider self-reporting program to allow long-term care providers to self report provider identified Medicaid overpayments directly to the resultant contractor

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

- Perform the above requirements on a supplemental basis and not duplicate any efforts performed by the Department of Social Services

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

- Detail the recoveries by claims payments and applied income payments

- Provide the Department of Social Services with audit schedules and audit procedures

- Provide individual provider and recipient reports detailing overpaid claims as requested by the Department of Social Services

- Be available by telephone and site visits to provide the Department of Social Services with an oral status report on request

- Update the EMS directly as needed for changes

- Process identified overpayments directly through EDS for recoveries when requested by the Department of Social Services.

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Describe its experience in performing credit balance/overpayment audits of long-term care facilities and acute care hospitals

(2) Describe its audit approach that ensures proper identification, reporting, and recovery of credit balance/overpayments

(3) Identify and recover inappropriate Medicaid payments made by the Department of Social Services' long-term care facilities in Connecticut

9. Integration of Related Proposal Requirements

Introduction - This RFP contains diverse proposal requirements that entail the discovery and verification of third party liability information and the subsequent benefit recovery of Medicaid claims. A responsive proposal shall demonstrate the bidder's understanding of the interrelationship between the third party liability verification and Medicaid claim recovery. For each proposal requirement in which the bidder explains how it will identify and confirm third party liability, it must be able to also demonstrate the equivalent Medicaid recovery from the legally liable third party. Ultimately, the bidder needs to demonstrate how these two related processes are performed in the most cost-effective manner while maintaining quality.

Objective - The bidder must consider the following objective in responding to this requirement: to perform concurrent third party liability identification/verification and Medicaid recovery.

Supporting Regulations/Authority - N/A

The resultant contractor shall provide the Department of Social Services with an integrated third party liability - coordination of benefits product.

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Describe how well it integrates its Third Party Liability Verification and Data Match processes with the Benefit Recovery of Medicaid Paid Claims to ensure that all possible Medicaid FFS and Medicaid Managed Care at-risk claims are pursued for recovery

(2) Describe how it will prevent duplication of client third party liability verification based on referrals received from different sources (for example, data match, Third Party Liability Information Form, Child Support Medical Insurance Identification)

10. New Third Party Liability Initiatives - This requirement is not optional.

Introduction - The Department of Social Services will consider any additional third party liability initiatives or projects that the bidder proposes. The bidder shall propose new cost avoidance and benefit recovery projects or enhancements to the Department of Social Services' current third party liability functions.

Objectives - The bidder must consider the following objectives in responding to this requirement:

- To learn about new Third Party Liability ideas and technologies that could be implemented to enhance and improve the Department of Social Services' Medicaid coordination of benefits efforts

- To develop new third party liability programs, which would assist the Connecticut Medicaid provider community in coordinating benefits between Medicaid and legally liable third parties in a cost-effective manner

Supporting Regulations/Authority - N/A

a) To submit a responsive proposal, **THE BIDDER SHALL**:

(1) Propose any new third party liability or other related cost containment initiatives not addressed in this RFP

(2) Provide the name of the state agency or entity and the annual time periods in which it performed this work

(3) Describe its success rate in performing this work including the annual dollars recovered or saved for each enterprise

(4) Provide the projected Department of Social Services' annual recoveries or savings as a result of developing and implementing each new initiative

## D. BUSINESS COST SECTION

Performance-based contracting - The resultant contract will be performance-based where the resultant contractor will reduce the Department of Social Services' recoveries by their fee, which in most cases, is a small percentage of the money they recover in a particular area.

No cost information or other financial information may be included in any other portion of the proposal. Any proposal that fails to adhere to this requirement may be disqualified as non-responsive. Each proposal must include cost information and other financial information in the following order:

1. Audited Financial Statements - To submit a responsive proposal, **THE BIDDER SHALL** provide audited financial statements for each of the last two fiscal years. If audited financial statements for each of the last two fiscal years are not available, the bidder shall provide comparable statements that will document the bidder's financial stability and include an explanation of the submission of documents other than audited financial statements. Audited Financial Statements do not count toward the total page limit of the proposal.

2. Business Cost Section - To submit a responsive proposal, **THE BIDDER SHALL** use the Budget Form in Attachment 10 to propose costs for each deliverable specified in this RFP. Bidders must complete the Budget Form (Excel spreadsheet) designed by the Department. Bidders shall only provide a percentage (for contingency) or a dollar amount (for per verification) in Column D. Formulas for subtotals and totals have been provided in the Excel worksheets. Do not delete or revise formulas and other figures provided. The Department of Social Services has provided estimated volumes for RFP comparison purposes only in Column F. The spreadsheet is available by emailing Chandra Yvette Williams at Chandra.Williams@ct.gov.

## SECTION V - PROPOSAL EVALUATION

### A. OVERVIEW OF THE EVALUATION OF PROPOSALS

The Department of Social Services will conduct a comprehensive, fair, and impartial evaluation of proposals received in response to this RFP. An Evaluation Team will be established to assist the Department of Social Services in selection of the resultant contractor. The Department of Social Services reserves the right to alter the composition of the Evaluation Team. The Evaluation Team will submit recommendations to the Commissioners. The Commissioner of Social Services will notify the selected bidders that the selected bidders have been awarded the right to negotiate a contract with the Department of Social Services for the Third Party Liability function.

The evaluation will be conducted in five phases:

- Phase One - Evaluation of General Proposal Requirements and Structure
- Phase Two - Evaluation of the Organizational Capability and Structure
- Phase Three - Evaluation of the Scope of Services
- Phase Four - Evaluation of the Business Cost Section
- Phase Five - Ranking of the Proposals

### B. PHASE ONE - EVALUATION OF GENERAL PROPOSAL REQUIREMENTS AND STRUCTURE

The purpose of this phase is to determine whether each proposal is adequately responsive to the General Proposal Requirements to permit a complete evaluation of the proposal. Proposals must comply with the instructions to bidders contained throughout. Failure to comply with the instructions may deem the proposal non-responsive and subject to rejection without further consideration. The Department of Social Services reserves the right to waive minor irregularities. The General Proposal Requirements are identified above.

## C. PHASE TWO - EVALUATION OF THE ORGANIZATIONAL CAPABILITY AND STRUCTURE

Only those proposals passing the General Proposal Requirements review will be considered in Phase Two. The Department of Social Services reserves the right to reject any and all proposals.

The quality of the work plan and the program management will be evaluated including the organization, completeness, and logic of the proposed plan. The evaluation will consider how comprehensive and knowledgeable the bidder is in responding to the functional and technical requirements outlined in this RFP.

The Department of Social Services will evaluate the experience of proposed key personnel, agency and individual resources, and bidder's qualifications and affirmative action achievement (as shown on the Workforce Analysis Form) and any proposed subcontractors. The Department of Social Services will determine to what extent the organization and its key personnel have the capability to work effectively with the Department of Social Services to successfully develop and implement a Third Party Liability function. The Department of Social Services will also assess the bidder's capability to take on the additional workload that would be generated by the resultant contract and the bidder's financial capability to undertake the resultant contract. References will be checked. The Organizational Capability and Structure section of the proposal will be worth 25 percent of the available points for the entire proposal.

## D. PHASE THREE - EVALUATION OF THE SCOPE OF SERVICES

The proposed Scope of Services will be evaluated for its responsiveness to the requirements of this RFP including its organization, appropriateness, completeness, and logic. The evaluation will consider how creative and innovative the bidder is in responding to the functional and technical requirements outlined in this RFP. The Scope of Services section of the proposal will be worth 65 percent of the available points for the entire proposal.

## E. PHASE FOUR - EVALUATION OF THE BUSINESS COST SECTION

The Business Cost Section will be evaluated only for bidders who achieve a minimum of 75 percent of the total available points in Phase Two and Phase Three. The Business Cost Section will be worth 10 percent of the available points for the entire proposal. It will be scored for:

1. Cost comparison (determined by comparing bid price information)

2. Cost reasonableness (determined by examining the Business Narrative and the relationship between the costs, personnel, and the work plan outlined in the proposal)

## F. PHASE FIVE - RANKING OF THE PROPOSALS

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

# SECTION VI - APPENDICES

## APPENDIX 1 - MANDATORY TERMS AND CONDITIONS

Section 1 - General RFP Provisions:

1.1 Preparation Expense

The State of Connecticut assumes no liability for payment of expenses incurred by respondents in preparing and providing submissions in response to this procurement.

1.2 Insurance

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

1.3 Suspension or Debarment

By provision of a submission, the bidder certifies the bidder or any person (including subcontractors) involved in the administration of Federal or State funds:

a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental department or agency (local, state or Federal)

b. Has not within a three-year period preceding the application submission been convicted or had a civil judgment rendered against him/her for commission of fraud or criminal offense in connection with obtaining, attempting to obtain, or performing a public (local, state or Federal) transaction or contract under a public transaction, violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property

c. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses

d. Has not within a three-year period preceding the application submission had one or more public transactions terminated for cause or fault.

Any change in the above status shall be immediately reported to the Department.

1.4. Procurement and Contractual Agreements

The terms and conditions contained in this section constitute a basis for any resultant contract to this RFP and are mandatory for any resultant contracts. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions. As used in these mandatory terms and conditions, the term, “contract,” refers to any resultant contract to this RFP, although the term, “contract,” as used in these terms and conditions does not suggest, warrant, nor guarantee that the Department will enter into a contract as a result of this RFP. Also, as used in these mandatory terms and conditions, the term, “contractor,” refers to any resultant contractor to this RFP, although the term, “contractor,” does not suggest, warrant nor guarantee that the Department will enter into a contract as a result of this RFP.

Section 2 - General Contract Provisions:

The Contractor agrees to comply with the following mandatory terms and conditions.

A. Contract Term

1. The contract term shall be subject to contract negotiations between the Department and the resultant contractor.

2. Notices

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

In case of notice to the contractor:

To be determined

In case of notice to the Department:

To be Determined
Department of Social Services
25 Sigourney Street
Hartford, CT 06106

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

B. Contractor Obligations

1. Credits and Rights in Data

(a) Unless expressly waived in writing by the Department, all documents, reports, and other publications for public distribution during or resulting from the performances of this Contract shall include a statement acknowledging the financial support of the state and the Department and, where applicable, the Federal government. All such publications shall be released in conformance with applicable Federal and state law and all regulations regarding confidentiality. Any liability arising from such a release by the Contractor shall be the sole responsibility of the Contractor and the Contractor shall indemnify the Department, unless the Department or its agents co-authored said publication and said release is done with the prior written approval of the Commissioner of the Department. Any publication shall contain the following statement: “This publication does not express the views of the Department or the State of Connecticut. The views and opinions expressed are those of the authors.” The Contractor or any of its agents shall not copyright data and information obtained under the terms and conditions of this contract, unless expressly authorized in writing by the Department. The Department shall have the right to publish, duplicate, use, and disclose all such data in any manner, and may authorize others to do so. The Department may copyright any data without prior notice to the Contractor. The Contractor does not assume any responsibility for the use, publication, or disclosure solely by the Department of such data.

(b) “Data” shall mean all results, technical information and materials developed and/or obtained in the performance of the services

hereunder including, but not limited to, all reports, surveys, plans, charts, recordings (video and/or sound), pictures, curricula, public awareness or prevention campaign materials, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda, and documents, whether finished or unfinished, which result from or are prepared in connection with the services performed hereunder.

2. Organizational Information, Conflict of Interest, IRS Form 990

Annually during the term of the contract, the Contractor shall submit to the Department the following:

(a) A copy of its most recent IRS Form 990 submitted to the Federal Internal Revenue Service

(b) Its most recent Annual Report as filed with the Office of the Secretary of the State or such other information that the Department deems appropriate with respect to the organization and affiliation of the Contractor and related entities.

3. Federal Funds

The Contractor shall comply with requirements relating to the receipt or use of Federal funds. The Department shall specify all such requirements in Part I of this contract.

4. Audit Requirements

The Contractor shall provide for an annual financial audit acceptable to the Department for any expenditure of state-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The State Auditors of Public Accounts shall have access to all records and accounts for the fiscal years in which the award was made. The Contractor will comply with Federal and state single audit standards as applicable.

5. Prohibited Interest

The Contractor warrants that no state appropriated funds have been paid or will be paid by or on behalf of the Contractor to contract with or retain any company or person, other than bona fide employees working solely for the Contractor, to influence or attempt to influence an officer or employee of any state agency in connection with the

awarding, extension, continuation, renewal, amendment, or modification of this agreement, or to pay or agree to pay any company or person, other than bona fide employees working solely for the Contractor, any fee, commission, percentage, brokerage fee, gift or any other consideration contingent upon or resulting from the award or making of this Agreement.

6. Offer of Gratuities

By its agreement to the terms of this contract, the Contractor certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this contract. The Department may terminate this contract if it is determined that gratuities of any kind were either offered or received by any of the aforementioned officials or employees from the Contractor or its agents or employees.

7. Related Party Transactions

The Contractor shall report all related party transactions, as defined in this clause, to the Department 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, its employees, Board members or members of the Contractor’s governing body, and a related party include, but are not limited to:

(a) Real estate sales or leases

(b) Leases for equipment, vehicles or household furnishings

(c) Mortgages, loans and working capital loans

(d) Contracts for management, consultant, and professional services as well as for materials, supplies and other services purchased by the Contractor

8. Lobbying

The Contractor agrees to abide by state and Federal lobbying laws, and further specifically agrees not to include in any claim for reimbursement any expenditures associated with activities to influence,

directly or indirectly, legislation pending before Congress, or the Connecticut General Assembly or any administrative or regulatory body unless otherwise required by this contract.

9. Suspension or Debarment

(a) Signature on Contract certifies the Contractor or any person (including subcontractors) involved in the administration of Federal or State funds:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental department or agency (Federal, State or local)

(2) Within a three-year period preceding this Contract, has not been convicted or had a civil judgment rendered against him/her for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (Federal, State or local) transaction or Contract under a public transaction, violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property

(3) Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the above offenses

(4) Has not within a three-year period preceding this agreement had one or more public transactions terminated for cause or fault.

(b) Any change in the above status shall be immediately reported to the Department.

10. Liaison

Each party shall designate a liaison to facilitate a cooperative working relationship between the Contractor and the Department in the performance and administration of this contract.

11. Subcontracts

None of the services to be provided by the contractor shall be subcontracted or delegated to any other organization, subdivision, association, individual, corporation, partnership or group of individuals or other such entity without the prior written consent of the Department. Any subcontract to which the State has consented in writing shall be in writing attached to the contract and made a part thereof and shall in no way alter the contract terms and conditions. Said subcontract shall contain the access to the books, document, and records, provided for in paragraph 2.11 infra. No subcontract or delegation shall relieve or discharge the contractor from any obligation, provision, or liability thereunder.

The contractor agrees to make a good faith effort to award a reasonable proportion of subcontracts to small, minority, and women's businesses in accordance with C.G.S. §4a-60.

12. Independent Capacity of Contractor

The Contractor, its officers, employees, subcontractors, or any other agent of the Contractor in the performance of this contract will act in an independent capacity and not as officers or employees of the State of Connecticut or of the Department.

13. 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

(2) Liabilities, damages, losses, costs and expenses including, but not limited to, attorneys' and other professionals' fees, arising, directly or indirectly, in connection with Claims, Acts or the contract (The Contractor shall use counsel reasonably acceptable to the State in carrying out its obligations under this 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 the bid or any records, and intellectual property rights, other propriety rights of any person or entity, copyrighted or un-copyrighted 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 provisions survive the term of the contract, sufficient general liability insurance to satisfy its obligations under this contract. The Contractor shall name the State as an additional insured on the policy and shall provide a copy of the policy to the Agency prior to the effective date of the contract. The Contractor shall not begin performance until the delivery of the policy to the Agency.

(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.

14. Choice of Law and Choice of Forum, Settlement of Disputes, Office of the Claims Commission

(a) The Contractor agrees to be bound by the laws of the State of Connecticut and the Federal government where applicable, and agrees that this contract shall be construed and interpreted in

accordance with Connecticut law and Federal law where applicable.

(b) Any dispute concerning the interpretation or application of this contract shall be decided by the Commissioner of the Department or his/her designee whose decision shall be final subject to any rights the Contractor may have pursuant to state law. In appealing a dispute to the commissioner pursuant to this provision, the Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. Pending final resolution of a dispute, the Contractor and the Department shall proceed diligently with the performance of the contract.

(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 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.

15. Compliance with Law and Policy

Contractor shall comply with all pertinent provisions of local, state, and Federal laws and regulations as well as Departmental policies and procedures applicable to Contractor's programs as specified in this contract. The Department shall notify the Contractor of any applicable new or revised laws, regulations, policies, or procedures, which the Department has responsibility to promulgate or enforce.

16. Facility Standards and Licensing Compliance

The Contractor will comply with all applicable local, state and Federal licensing, zoning, building, health, fire and safety regulations or ordinances, as well as standards and criteria of pertinent state and Federal authorities. Unless otherwise provided by law, the Contractor is not relieved of compliance while formally contesting the authority to require such standards, regulations, statutes, ordinance, or criteria.

17. Reports

The Contractor shall provide the Department with such statistical, financial, and programmatic information necessary to monitor and evaluate compliance with the contract. All requests for such information shall comply with all applicable state and Federal

confidentiality laws. The Contractor agrees to provide the Department with such reports as the Department requests.

18. Delinquent Reports

The Contractor will submit required reports by the designated due dates as identified in this agreement. After notice to the Contractor and an opportunity for a meeting with a Department representative, the Department reserves the right to withhold payments for services performed under this Contract if the Department has not received acceptable progress reports, expenditure reports, refunds, and/or audits as required by this agreement or previous agreements for similar or equivalent services the Contractor has entered into with the Department.

19. 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 years after the completion and submission to the state of the Contractor's annual financial audit.

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 provide written notice to the Department of any litigation that relates to the services directly or indirectly financed under this contract or that has the potential to impair the ability of the Contractor to fulfill the terms and conditions of this contract including, but not limited to, financial, legal or any other situation which may prevent the Contractor from meeting its obligations under the contract.

(b) The Contractor shall provide written notice to the Department of any final decision by any tribunal or state or Federal agency or

court which is adverse to the Contractor or which results in a settlement, compromise or claim or agreement of any kind for any action or proceeding brought against the Contractor or its employee or agent under the Americans with Disabilities Act of 1990, Executive Orders Nos. 3 & 17 of Governor Thomas J. Meskill and any other provisions of Federal or state law concerning equal employment opportunities or nondiscriminatory practices.

C. Alterations, Cancellation, and Termination

1. Contract Revisions and Amendments

(a) The Contractor shall submit to the Department in writing any proposed revision to the contract and the Department shall notify the Contractor of receipt of the proposed revision.

(b) Contract amendments must be in writing and shall not be effective until executed by both parties to the contract, and, where applicable, approved by the Attorney General.

(c) No amendments may be made to a lapsed contract.

2. Contract Reduction

(a) The Department reserves the right to reduce the Contracted amount of compensation at any time in the event that:

(1) The Governor or the Connecticut General Assembly rescinds, reallocates, or in any way reduces the total amount budgeted for the operation of the Department during the fiscal year for which such funds are withheld

(2) Federal funding reductions result in reallocation of funds within the Department.

(b) The Contractor and the Department agree to negotiate on the implementation of the reduction within thirty days of receipt of formal notification of intent to reduce the contracted amount of compensation from the Department. If agreement on the implementation of the reduction is not reached within 30 calendar days of such formal notification and a contract amendment has not been executed, the Department may terminate the contract sixty days from receipt of such formal

notification. The Department will formally notify the Contractor of the termination date.

3. Default by the Contractor

(a) If the Contractor defaults as to, or otherwise fails to comply with, any of the conditions of this contract the Department may:

(1) Withhold payments until the default is resolved to the satisfaction of the Department

(2) Temporarily or permanently discontinue services under the contract

(3) Require that unexpended funds be returned to the Department

(4) Assign appropriate state personnel to execute the contract until such time as the contractual defaults have been corrected to the satisfaction of the Department

(5) Require that contract funding be used to enter into a subcontract arrangement with a person or persons designated by the Department to bring the program into contractual compliance

(6) Terminate this contract

(7) Take such other actions of any nature whatsoever as may be deemed appropriate for the best interests of the state or the programs provided under this contract or both

(8) Any combination of the above actions

(b) In addition to the rights and remedies granted to the Department by this contract, the Department shall have all other rights and remedies granted to it by law in the event of breach of or default by the Contractor under the terms of this contract.

(c) Prior to invoking any of the remedies for default specified in this paragraph except when the Department deems the health or welfare of service recipients is endangered as specified in of this contract or has not met requirements as specified in this contract, the Department shall notify the Contractor in writing of

the specific facts and circumstances constituting default or failure to comply with the conditions of this contract and proposed remedies. Within five business days of receipt of this notice, the Contractor shall correct any contractual defaults specified in the notice and submit written documentation of correction to the satisfaction of the Department or request in writing a meeting with the commissioner of the Department or his/her designee. Any such meeting shall be held within five business days of the written request. At the meeting, the Contractor shall be given an opportunity to respond to the Department's notice of default and to present a plan of correction with applicable timeframes. Within five business days of such meeting, the commissioner of the Department shall notify the Contractor in writing of his/her response to the information provided including acceptance of the plan of correction and, if the commissioner finds continued contractual default for which a satisfactory plan of corrective action has not been presented, the specific remedy for default the Department intends to invoke. This action of the Commissioner shall be considered final.

(d) If at any step in this process the Contractor fails to comply with the procedure and, as applicable, the agreed upon plan of correction, the Department may proceed with default remedies.

4. Non-enforcement Not to Constitute Waiver

The failure of either party to insist upon strict performance of any terms or conditions of this agreement shall not be deemed a waiver of the term or condition or any remedy that each party has with respect to that term or condition nor shall it preclude a subsequent default by reason of the failure to perform.

5. Cancellation and Recoupment

(a) This agreement shall remain in full force and effect for the entire term of the contract period, above, unless either party provides written notice ninety days or more from the date of termination, except that no cancellation by the Contractor may be effective for failure to provide services for the agreed price or rate and cancellation by the Department shall not be effective against services already rendered, so long as the services were rendered in compliance with the contract during the term of the contract.

(b) In the event the health or welfare of the service recipients is endangered, the Department may cancel the contract and take any immediate action without notice it deems appropriate to protect the health and welfare of service recipients. The Department shall notify the Contractor of the specific reasons for taking such action in writing within five business days of cancellation. Within five business days of receipt of this notice, the Contractor may request in writing a meeting with the commissioner of the Department or his/her designee. Any such meeting shall be held within five business days of the written request. At the meeting, the Contractor shall be given an opportunity to present information on why the Department's actions should be reversed or modified. Within five business days of such meeting, the Commissioner of the Department shall notify the Contractor in writing of his/her decision upholding, reversing, or modifying the action of the Department. This action of the Commissioner shall be considered final.

(c) The Department reserves the right to cancel the contract without prior notice when the funding for the contract is no longer available.

(d) The Department reserves the right to recoup any deposits, prior payment, advance payment, or down payment made if the contract is terminated by either party. Allowable costs incurred to date of termination for operation or transition of programs under this contract shall not be subject to recoupment. The Contractor agrees to return to the Department any funds not expended in accordance with the terms and conditions of the contract and, if the Contractor fails to do so upon demand, the Department may recoup said funds from any future payments owing under this contract or any other contract between the State and the Contractor.

6. Equipment

In the event this Contract is terminated or not renewed, the Department reserves the right to recoup any equipment, deposits or down payments made or purchased with start-up funds or other funds specifically designated for such purpose under this Contract. For purposes of this provision, equipment means tangible personal property with a normal useful life of at least one year and a value of at least $5,000. Equipment shall be considered purchased from Contractor funds and not from Department funds if the equipment is

purchased for a program that has other sources of income equal to or greater than the equipment purchase price.

7. Transition after Termination or Expiration of Contract

In the event that this contract is terminated for any reason except where the health and welfare of service recipients is endangered or if the Department does not offer the Contractor a new contract for the same or similar service at the contract's expiration, the Contractor will assist in the orderly transfer of clients served under this contract as required by the Department and will assist in the orderly cessation of operations under this contract. Prior to incurring expenses related to the orderly transfer or continuation of services to service recipients beyond the terms of the contract, the Department and the Contractor agree to negotiate a termination amendment to the existing agreement to address current program components and expenses, anticipated expenses necessary for the orderly transfer of service recipients and changes to the current program to address service recipient needs. The Contractual agreement may be amended as necessary to assure transition requirements are met during the term of this contract. If the transition cannot be concluded during this term, the Department and the Contractor may negotiate an amendment to extend the term of the current contract until the transition may be concluded.

8. Program Cancellation

Where applicable, the cancellation or termination of any individual program or services under this Contract will not, in and of itself, in any way affect the status of any other program or service in effect under this Contract.

9. Mergers and Acquisitions

a) Contracts in whole or in part are not transferable or assignable without the prior written agreement of the Department

(b) At least ninety days prior to the effective date of any fundamental changes in corporate status including merger, acquisition, transfer of assets, and any change in fiduciary responsibility, the Contractor shall provide the Department with written notice of such changes.

(c) The Contractor shall comply with requests for documentation deemed necessary by the Department to determine whether the Department will provide prior written agreement. The

Department shall notify the Contractor of such determination not later than forty-five business days from the date the Department receives such requested documentation.

D. Statutory and Regulatory Compliance

1. Health Insurance Portability Act of 1996 (“HIPAA”)

(a) If the Contactor is a Business Associate under the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Contractor must comply with all terms and conditions of this Section of the Contract. If the Contractor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contractor for this Contract.

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

(c) The State of Connecticut Department named on page 1 of this Contract (hereinafter “Department”) is a “covered entity” as that term is defined in 45 CFR §160.103; *and*

(d) The Contractor, on behalf of the Department, performs functions that involve the use or disclosure of “individually identifiable health information,” as that term is defined in 45 CFR §160.103; *and*

(e) The Contractor is a “business associate” of the Department, as that term is defined in 45 CFR §160.103; *and*

(f) The Contractor and the Department agree to the following to secure compliance with the HIPAA, more specifically with the Privacy and Security Rules at 45 CFR Part 160 and Part 164, subparts A, C, and E.

(g) Definitions

(1) “Business Associate” shall mean the Contractor.

(2) “Covered Entity” shall mean the Department of the State of Connecticut named on page 1 of this Contract.

(3) “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 CFR §164.501.

(4) “Individual” shall have the same meaning as the term “individual”’ in 45 CFR §160.103 and shall include a person who qualifies as a personal representative as defined in 45 CFR §164.502(g).

(5) “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Parts 164, subparts A and E.

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

(7) “Required by Law”’ shall have the same meaning as the term “required by law” in 45 CFR §164.103.

(8) “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.

(9) “More stringent” shall have the same meaning as the term “more stringent” in 45 CFR §160.202.

(10) “This Section of the Contract” refers to the HIPAA Provisions stated herein, in their entirety.

(11) “Security Incident” shall have the same meaning as the term “security incident” in 45 CFR §164.304.

(12) “Security Rule” shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and parts 164, subpart A and C.

(h) Obligations and Activities of Business Associates

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

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

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

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

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

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

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

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

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

(10) Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.

(11) Business Associate agrees to provide to Covered Entity, in a time and manner agreed to by the parties, information collected in accordance with paragraph I of this Section of the Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528.

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

(i) Permitted Uses and Disclosure by Business Associate

(1) General Use and Disclosure Provisions - Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(2) Specific Use and Disclosure Provisions

(A) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

(B) Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(C) Except as otherwise limited in this Section of the Contract, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR §164.504(e)(2)(i)(B).

(j) Obligations of Covered Entity

(1) Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 CFR §164.520, or to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

(2) Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

(3) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

(k) Permissible Requests by Covered Entity

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

(l) Term and Termination

(1) Term - The Term of this Section of the Contract shall be effective as of the date the Contract is effective and shall terminate when all 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

(B) Immediately terminate the Contract if Business Associate has breached a material term of this Section of the Contract and cure is not possible.

(C) If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

3) Effect of Termination

(A) Except as provided in (l)(2) above, upon termination of his Contract, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

(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 of destruction of PHI is infeasible, Business Associate shall

extend the protections of this Section of the Contract to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or Federal law that the Business Associate maintains or preserves the PHI or copies thereof.

(m) Miscellaneous Provisions

(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, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, Contractors or agents, or any third party to whom Business Associate has disclosed PHI pursuant to this Contract. Business Associate is solely responsible for all decisions made, and actions taken, by Business Associate regarding the

safeguarding, use and disclosure of PHI within its possession, custody, or control.

(7) Indemnification - The Business Associate shall indemnify and hold the Covered Entity harmless from and against all claims, liabilities, judgments, fines, assessments, penalties, awards, or other expenses, of any kind or nature whatsoever including, without limitation, attorney's fees, expert witness fees, and costs of investigation, litigation or dispute resolution, relating to or arising out of any violation by the Business Associate and its agents including subcontractors, of any obligation of Business Associate and its agents including subcontractors, under this Section of the Contract.

2. Americans with Disabilities Act of 1990 - This clause applies to those Contractors which are or will come to be responsible for compliance with the terms of the Americans with Disabilities Act of 1990 (42 USC §§12101-12189 and §§12201-12213) (Supp. 1993), 47 USCS §§225, 611 (Supp. 1993). During the term of the Contract, the Contractor represents that it is familiar with the terms of this Act and that it is in compliance with the law. The Contractor warrants that it will hold the state harmless from any liability, which may be imposed upon the state as a result of any failure of the Contractor to be in compliance with this Act. As applicable, the Contractor agrees to abide by provisions of §504 of the Federal Rehabilitation Act of 1973, as amended, 29 USC §794 (Supp. 1993), regarding access to programs and facilities by individuals with disabilities.

3. Utilization of Minority Business Enterprises - It is the policy of the state that minority business enterprises should have the maximum opportunity to participate in the performance of government Contracts. The Contractor agrees to use best efforts consistent with 45 CFR §§74.160 et seq. (1992) and paragraph 9 of Appendix G thereto for the administration of programs or activities using HHS funds, and §§13a-95a, 4a-60 to 4a-62, 4b-95(b), and 4a-60q of the Connecticut General Statutes 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 use its best efforts to ensure that it gives priority to hiring welfare recipients who are subject to time-limited welfare and must find employment. The Contractor and the Department will work cooperatively to determine the number and types of positions to which this paragraph shall apply. The Department of Social Services regional office staff or staff of Department of Social Service Contractors will undertake to counsel

and screen an adequate number of appropriate candidates for positions targeted by the Contractor as suitable for individuals in the time limited welfare program. The success of the Contractor's efforts will be considered when awarding and evaluating Contracts.

5. Non-discrimination Regarding Sexual Orientation - Unless otherwise provided by C.G.S. §46a-81p, the Contractor agrees to the following provisions required pursuant to §4a-60a of the Connecticut General Statutes:

(a)

(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 U.S. or of 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 representatives of workers with which such Contractor has a collective bargaining agreement or other Contract or understanding and each vendor with which such Contractor has a Contract or understanding a notice to be provided by the commission on human rights and opportunities advising the labor union or workers' representative of the Contractor's commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment.

(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 §46a-56 of the Connecticut General Statutes.

(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 provisions of this section and §46a-56 of the Connecticut General Statutes.

(b) The Contractor shall include the provisions of subsection (a) of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a Contract with the state and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the commission. The Contractor shall take 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 §46a-56 of the Connecticut General Statutes 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. Nondiscrimination and Affirmative Action Provisions in Contracts of the State and Political Subdivisions Other Than Municipalities - The Contractor agrees to comply with provisions of §4a-60 of the Connecticut General Statutes:

(a) Every Contract to which the state or any political subdivision of the state other that a municipality is a party shall contain the following provisions:

(1) The Contractor agrees and warrants that in the performance of the Contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation or physical disability including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the U.S. or of the state of Connecticut. The Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation, or physical disability including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved.

(2) The Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that is an “affirmative action-equal opportunity employer” in accordance with regulations adopted by the commission.

(3) The Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining agreement or other Contract or understanding and each vendor with which such Contractor has a Contract or understanding, a notice to be provided by the commission advising the labor union or workers’ representative of the Contractor’s commitments under this section, and to post copies of the notice in conspicuous places available to employees and applicants for employment.

(4) The Contractor agrees to comply with each provision of this section and C.G.S. §§46a-68e and 46a-68f and with each regulation or relevant order issued by said commission pursuant to C.G.S. §§46a-56, 46a-68e and 46a-68f.

(5) The Contractor agrees to provide the commission of human rights and opportunities with such information requested by the commission, and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this section and C.G.S. §46a-56. If the Contract is a public works Contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works project.

(b) For the purposes of this section, “minority business enterprise” means any small Contractor or supplier of materials fifty-one per cent or more of capital stock, if any, or assets of which is owned by a person or persons:

(1) Who are active in the daily affairs of the enterprise

(2) Who have the power to direct the management and policies of the enterprise

(3) Who are members of a minority, as such term is defined in subsection (a) of C.G.S. §49-60g.

(c) For the purposes of this section, “good faith” means that degree of diligence, which a reasonable person would exercise in the performance of legal duties and obligations. “Good faith efforts” shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements. Determinations of the Contractor’s good faith efforts shall include but shall not be limited to the following factors: The Contractor’s employment and subcontracting policies, patterns and practices, affirmative action advertising, recruitment and training, technical assistance activities and such other reasonable activities or efforts as the commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

(d) The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the commission, of its good faith efforts.

(e) Contractor shall include the provisions of subsection (a) of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a Contract with the state and such provision shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with C.G.S. §46a-56, provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the commission, the Contractor may request the state of Connecticut to enter into such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

7. Performance of Governmental Functions - Pursuant to §1-218 of the State of Connecticut General Statutes, each contract in excess of two million five hundred thousand dollars between a public agency and a person for the performance of a governmental function requires the

inclusion of language indicating that the records and files associated with the performance of the governmental function are subject to the Freedom of Information Act and may be disclosed by the public agency pursuant to the Freedom of Information Act.

Section 1-200(11) of the State of Connecticut General Statutes defines "Governmental Function" as the administration or management of a program of a public agency, which program has been authorized by law to be administered or managed by a person, where (A) the person receives funding from the public agency for administering or managing the program, (B) the public agency is involved in or regulates to a significant extent such person's administration or management of the program, whether or not such involvement or regulation is direct, pervasive, continuous or day-to-day, and (C) the person participates in the formulation of governmental policies or decisions in connection with the administration or management of the program and such policies or decisions bind the agency. The Department and the Contractor agree that the Contractor does not make governmental policy decisions that are binding on the Department. Therefore the Contractor's performance under the terms of this Contract do not equate to the performance of a governmental function.

8. Whistleblowing - This Agreement is subject to the provisions of §4-61dd of the Connecticut General Statutes. In accordance with this statute, if an officer, employee or appointing authority of the Contractor takes or threatens to take any personnel action against any employee of the Contractor in retaliation for such employee's disclosure of information to any employee of the Contracting state or quasi-public agency or the Auditors of Public Accounts or the Attorney General under the provisions of subsection (a) of such statute, the Contractor shall be liable for a civil penalty of not more than five thousand dollars for each offense, up to a maximum of twenty per cent of the value of this Agreement. Each violation shall be a separate and distinct offense and in the case of a continuing violation, each calendar day's continuance of the violation shall be deemed to be a separate and distinct offense. The State may request that the Attorney General bring a civil action in the Superior Court for the Judicial District of Hartford to seek imposition and recovery of such civil penalty. In accordance with subsection (f) of such statute, each large state Contractor, as defined in the statute, shall post a notice of the provisions of the statute relating to large state Contractors in a conspicuous place, which is readily available for viewing by the employees of the Contractor.

9. Campaign Contribution Restrictions - On February 8, 2007, Governor Rell signed into law Public Act 07-1, An Act Concerning the State

Contractor Contribution Ban and Gifts to State and Quasi-Public Agencies.

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

10. Non-smoking - If the Contractor is an employer subject to the provisions of §31-40q of the Connecticut General Statutes, the Contractor agrees to provide upon request the Department with a copy of its written rules concerning smoking. Evidence of compliance with the provisions of §31-40q of the Connecticut General Statutes must be received prior to Contract approval by the Department.

11. Executive Orders

    (a) Executive Order No. 3: Nondiscrimination - This Contract is subject to the provisions of Executive Order No. Three of Governor Thomas J. Meskill promulgated June 16, 1971, and, as such, this Contract may be canceled, terminated, or suspended by the State Labor Commissioner for violation of or noncompliance with said Executive Order No. 3 or any state or Federal law concerning nondiscrimination, notwithstanding that the Labor Commissioner is not a party to this Contract. The parties to this Contract, as part of the consideration hereof, agree that said Executive Order No. 3 is incorporated herein by reference and made a part hereof. The parties agree to abide by said Executive Order and agree that the State Labor Commissioner shall have continuing jurisdiction in respect to Contract performance in regard to nondiscrimination, until the Contract is completed or terminated prior to completion. The Contractor agrees, as part consideration hereof, that this Contract is subject to the Guidelines and Rules issued by the State Labor Commissioner to implement Executive Order No. 3 and that the Contractor will not discriminate in employment practices or policies, will file all reports as required, and will fully cooperate with the State of Connecticut and the State Labor Commissioner.

(b) Executive Order No. 16: Violence in the Workplace Prevention Policy. This Contract is subject to provisions of Executive Order No. 16 of Governor John J. Rowland promulgated August 4, 1999, and, as such, this Contract may be cancelled, terminated or suspended by the contracting agency or the State for violation of or noncompliance with said Executive Order No. 16. The parties to this Contract, as part of the consideration hereof, agree that:

(1) Contractor shall prohibit employees from bringing into the state work site, except as may be required as a condition of employment, any weapon/dangerous instrument defined in Section 2 to follow

(2) Weapon means any firearm including a BB gun, whether loaded or unloaded, any knife (excluding a small pen or pocket knife) including a switchblade or other knife having an automatic spring release device, a stiletto, any police baton or nightstick or any martial arts weapon or electronic defense weapon. Dangerous instrument means any instrument, article or substance that, under the circumstances, is capable of causing death or serious physical injury

(3) Contractor shall prohibit employees from attempting to use, or threaten to use, any such weapon or dangerous instrument in the state work site and employees shall be prohibited from causing, or threatening to cause, physical injury or death to any individual in the state work site

(4) Contractor shall adopt the above prohibitions as work rules, violation of which shall subject the employee to disciplinary action up to and including discharge. The Contractor shall require that all employees are aware of such work rules

(5) Contractor agrees that any subcontract it enters into in the furtherance of the work to be performed hereunder shall contain the provisions 1 through 4, above.

(c) Executive Order No. 17: Connecticut State Employment Service Listings. This Contract is subject to provisions of Executive Order No. 17 of Governor Thomas J. Meskill promulgated February 15, 1973, and, as such, this Contract may be canceled, terminated or suspended by the contracting agency or

the State Labor Commissioner for violation of or noncompliance with said Executive Order Number 17, notwithstanding that the Labor Commissioner may not be a party to this Contract. The parties to this Contract, as part of the consideration hereof, agree that Executive Order No. 17 is incorporated herein by reference and made a part hereof. The parties agree to abide by said Executive Order and agree that the contracting agency and the State Labor Commissioner shall have joint and several continuing jurisdiction in respect to Contract performance in regard to listing all employment openings with the Connecticut State Employment Service.

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

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

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

termination of a Contract for the sale or purchase of a fee simple interest in real property following transfer of title.

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

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

12. Change order process

The Department may, at any time, with written notice to the contractor, make changes within the general scope of the contract. Such changes may include activities required by new or amended Federal or State laws or regulations or quality related projects that are identified following the execution of the contract. The Department may reimburse the contractor for any activities required by new or amended State or Federal laws or regulations not mentioned in the Scope of Work or for any other changes outside the Scope of Work defined in the contract, which the Department deems necessary.

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

As soon as possible after receipt of a written Change Order request, but in no event more than five business days thereafter, the contractor

shall provide the Department with a written statement that the change has a cost neutral effect on the Department, or that there is a cost impact, in which case the statement shall include a description of the cost involved in implementing the change.

Significant Change Order work may require authorization from the State of Connecticut Office of Policy and Management in order to amend the contract to allocate additional funds to this project.

APPENDIX 2 - PROCUREMENT AND CONTRACTUAL AGREEMENTS
SIGNATORY ACCEPTANCE

Statement of Acceptance

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

Acceptance Statement

On behalf of _____ I, _____ agree to accept the Mandatory Terms and Conditions as set forth in the Department of Social Services' Third Party Liability Request for Proposals.

Signature

_____ _____

Title Date

## APPENDIX 3 - WORKFORCE ANALYSIS FORM

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

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

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

Workforce Analysis Form (continued)

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

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

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

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

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

_____ _____

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

## APPENDIX 4 - NOTIFICATION TO BIDDERS FORM

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

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

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

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

---

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

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

_____ _____

Signature Date

On Behalf of: _____

_____

Organization Name

_____

Address

## APPENDIX 5 - SMOKING POLICY

General Statutes of Connecticut

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

a) As used in this section:

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

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

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

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

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

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

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

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

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

Cited. 24C. 666,672-674.

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

## APPENDIX 6 - CERTIFICATION REGARDING LOBBYING

Contractor:_____

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

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

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

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

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

_____ _____

Signature Typed Name and Title

_____ _____

Firm/Organization Date

APPENDIX 7 - GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

# STATE OF CONNECTICUT
## GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

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

**INSTRUCTIONS:**

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

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

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

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

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

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

**CAMPAIGN CONTRIBUTION CERTIFICATION:**

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

# STATE OF CONNECTICUT
## GIFT AND CAMPAIGN CONTRIBUTION CERTIFICATION

**Lawful Campaign Contributions to Candidates for Statewide Public Office:**

| Contribution Date | Name of Contributor | Recipient | Value | Description |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Lawful Campaign Contributions to Candidates for the General Assembly:**

| Contribution Date | Name of Contributor | Recipient | Value | Description |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

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

_____ _____

Printed Contractor Name **Signature of Authorized Official**

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

_____

**Commissioner of the Superior Court (or Notary Public)**

**For State Agency Use Only**

_____ _____

Awarding State Agency Planning Start Date

_____

Contract Number or Description

APPENDIX 8 - CONSULTING AGREEMENT AFFIDAVIT

# STATE OF CONNECTICUT
## CONSULTING AGREEMENT AFFIDAVIT

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

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

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

This affidavit must be amended if the contractor enters into any new consulting agreements during the term of the State contract.

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

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

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

_____ _____ _____
Start Date End Date Cost

Description of Services Provided: _____

_____

_____

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

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

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

_____ _____
Printed Name (of above) Awarding State Agency

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

_____
**Commissioner of the Superior Court**
**or Notary Public**

APPENDIX 9 - AFFIRMATION OF RECEIPT OF STATE ETHICS LAWS SUMMARY

# STATE OF CONNECTICUT
## AFFIRMATION OF RECEIPT OF STATE ETHICS LAWS SUMMARY

*Affirmation to accompany a large State construction or procurement contract, having a cost of more than $500,000, pursuant to General Statutes of Connecticut §§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.

**IMPORTANT NOTE:**

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 General Statutes of Connecticut §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 at http://www.ct.gov/ethics/lib/ethics/contractors_guide_final2.pdf.

_____ _____
Signature Date

_____ _____
Printed Name Title

_____
Firm or Corporation (if applicable)

_____ _____ ____ _____
Street Address City State Zip

_____
Awarding State Agency

## APPENDIX 10 - NOTICE TO EXECUTIVE BRANCH STATE CONTRACTORS AND PROSPECTIVE STATE CONTRACTORS OF CAMPAIGN CONTRIBUTION AND SOLICITATION BAN

SEEC FORM 11

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

Campaign Contribution and Solicitation Ban

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

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

Duty to Inform

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

Penalties for Violations

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

Civil penalties

$2,000 or twice the amount of the prohibited contribution, whichever is greater, against a principal or a contractor. Any state contractor or prospective state contractor, which fails to make reasonable efforts to comply with the provisions requiring notice to its principals of these prohibitions and the possible consequences

of their violations, may also be subject to civil penalties of $2,000 or twice the amount of the prohibited contributions made by their principals.

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

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

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

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

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

## ATTACHMENTS

| | |
|---|---|
| Attachment 1a: | State Fiscal Year 2007 Paid Claims: Health Insurance Not Applicable or Exhausted |
| Attachment 1b: | State Fiscal Year 2008 Paid Claims: Health Insurance Not Applicable or Exhausted |
| Attachment 2: | Prenatal and Postnatal Procedure Codes |
| Attachment 3: | Early and Periodic Screening, Diagnosis, and Treatment EPSDT Procedure Codes |
| Attachment 4: | Department of Social Services Eligibility Management System Commercial Insurance Coverage Codes |
| Attachment 5: | Client Eligibility and Recipient Third Party Liability Vendor Extract File Layouts |
| Attachment 6a: | Claim Selection Logic |
| Attachment 6b: | Reference Codes |
| Attachment 7: | Fraud and Recoveries Health Insurance Referrals - State Fiscal Years 2007 and 2008 |
| Attachment 8: | Potential Third Party Liability for Follow-Up Report and Third Party Liability Information Form Definition and Layout |
| Attachment 9: | Third Party Liability Information Form |
| Attachment 10: | Budget Form |

# ATTACHMENT 1a
## State Fiscal Year 2007
## Paid Claims: Health Insurance Not Applicable or Exhausted

| Provider Type Description | TPL Override Reason | Unduplicated Claim Count Paper Claims | Medicaid Paid Amount Paper Claims | Unduplicated Claim Count Electronic Claims | Medicaid Paid Amount Electronic Claims | Total Claims | Total Claims % of Total | Total Paid Amount | Total Paid Amount % of Total |
|---|---|---|---|---|---|---|---|---|---|
| General Hospital | other insurance is not applicable | 1,032 | $1,643,025 | | | 1,032 | 3.22% | $1,643,025 | 24.79% |
| General Hospital | other insurance is exhausted | 113 | $42,085 | | | 113 | 0.35% | $42,085 | 0.63% |
| School-Based Child Health | other insurance is not applicable | | | 1 | $275 | 1 | 0% | $275 | 0% |
| Special Services | other insurance is not applicable | 31 | $57,720 | | | 31 | 0.10% | $57,720 | 0.87% |
| Special Services | other insurance is exhausted | 1 | $14,464 | | | 1 | 0.00% | $14,464 | 0.22% |
| Nurse Midwife Group | other insurance is not applicable | 4 | $159 | | | 4 | 0.01% | $159 | 0% |
| Nurse Midwife Group | other insurance is exhausted | 1 | $5 | | | 1 | 0% | $5 | 0% |
| CT Home Care Program | other insurance is not applicable | | | 1 | $62 | 1 | 0% | $62 | 0% |
| Physician, MD | other insurance is not applicable | 139 | $11,228 | | | 139 | 0.43% | $11,228 | 0.17% |
| Physician, MD | other insurance is exhausted | 3 | $211 | | | 3 | 0.01% | $211 | 0.00% |
| Physician, MD - Group | other insurance is not applicable | 1,654 | $156,952 | | | 1,654 | 5.16% | $156,952 | 2.37% |
| Physician, MD - Group | other insurance is exhausted | 106 | $10,184 | | | 106 | 0.33% | $10,184 | 0.15% |
| Nurse Practitioner | other insurance is not applicable | 1 | $215 | | | 1 | 0% | $215 | 0% |
| Nurse Practitioner | other insurance is exhausted | 1 | $139 | | | 1 | 0% | $139 | 0% |
| Nurse Practitioner - Group | other insurance is not applicable | 65 | $2,847 | | | 65 | 0.20% | $2,847 | 0.04% |
| Optometrist | other insurance is not applicable | 15 | $1,074 | | | 15 | 0.05% | $1,074 | 0.02% |
| Optician | other insurance is not applicable | 5 | $385 | | | 5 | 0.02% | $385 | 0.01% |
| Optometrist - Group | other insurance is not applicable | 36 | $1,115 | | | 36 | 0.11% | $1,115 | 0.02% |
| Dentist | other insurance is not applicable | 8 | $1,100 | | | 8 | 0.02% | $1,100 | 0.02% |
| Dentist | other insurance is exhausted | 1 | $57 | | | 1 | 0% | $57 | 0% |
| Dentist - Group | other insurance is not applicable | 4 | $726 | | | 4 | 0.01% | $726 | 0.01% |
| Community Clinic | other insurance is not applicable | 3,045 | $424,123 | 1 | $121 | 3,046 | 9.51% | $424,244 | 6.40% |
| Community Clinic | other insurance is exhausted | 92 | $15,624 | | | 92 | 0.29% | $15,624 | 0.24% |
| Home Health Agency | other insurance is not applicable | 527 | $582,654 | | | 527 | 1.65% | $582,654 | 8.79% |

# ATTACHMENT 1a
## State Fiscal Year 2007
## Paid Claims: Health Insurance Not Applicable or Exhausted

| Provider Type Description | TPL Override Reason | Unduplicated Claim Count Paper Claims | Medicaid Paid Amount Paper Claims | Unduplicated Claim Count Electronic Claims | Medicaid Paid Amount Electronic Claims | Total Claims | Total Claims % of Total | Total Paid Amount | Total Paid Amount % of Total |
|---|---|---|---|---|---|---|---|---|---|
| Home Health Agency | other insurance is exhausted | 51 | $22,179 | | | 51 | 0.16% | $22,179 | 0.33% |
| Pharmacy - Rx only | other insurance is not applicable | | | 15,115 | $2,485,684 | 15,115 | 47.18% | $2,485,684 | 37.50% |
| Pharmacy - Rx only | other insurance is exhausted | | | 7,575 | $769,903 | 7,575 | 23.65% | $769,903 | 11.61% |
| Medical Equipment Supplier | other insurance is not applicable | 1,922 | $334,631 | | | 1,922 | 6.00% | $334,631 | 5.05% |
| Medical Equipment Supplier | other insurance is exhausted | 2 | $963 | | | 2 | 0.01% | $963 | 0.01% |
| Independent Laboratory | other insurance is not applicable | 122 | $4,439 | | | 122 | 0.38% | $4,439 | 0.07% |
| Independent Laboratory | other insurance is exhausted | 6 | $137 | | | 6 | 0.02% | $137 | 0% |
| Independent Radiology | other insurance is not applicable | 5 | $116 | | | 5 | 0.02% | $116 | 0% |
| Medical Transportation | other insurance is not applicable | 70 | $17,195 | | | 70 | 0.22% | $17,195 | 0.26% |
| Medical Transportation | other insurance is exhausted | 6 | $1,126 | | | 6 | 0.02% | $1,126 | 0.02% |
| Behavioral Health Clinician | other insurance is not applicable | 23 | $3,966 | | | 23 | 0.07% | $3,966 | 0.06% |
| Psychologist | other insurance is not applicable | 12 | $2,783 | | | 12 | 0.04% | $2,783 | 0.04% |
| Psychologist | other insurance is exhausted | 1 | $381 | | | 1 | 0% | $381 | 0.01% |
| Therapist | other insurance is not applicable | 85 | $4,932 | | | 85 | 0.27% | $4,932 | 0.07% |
| Behavioral Health Clinician Group | other insurance is not applicable | 29 | $2,788 | | | 29 | 0.09% | $2,788 | 0.04% |
| Psychologist - Group | other insurance is not applicable | 2 | $288 | | | 2 | 0.01% | $288 | 0% |
| Therapist - Group | other insurance is not applicable | 122 | $10,696 | | | 122 | 0.38% | $10,696 | 0.16% |
| TOTAL | | 9,342 | $3,372,708 | 22,693 | $3,256,044 | 32,035 | 100% | $6,628,753 | 100% |

# ATTACHMENT 1b
## State Fiscal Year 2008*
## Paid Claims: Health Insurance Not Applicable or Exhausted

| Provider Type Description | TPL Override Reason | Unduplicated Claim Count Paper Claims | Medicaid Paid Amount Paper Claims | Unduplicated Claim Count Electronic Claims | Medicaid Paid Amount Electronic Claims | Total Claims | Total Claims % of Total | Total Paid Amount | Total Paid Amount % of Total |
|---|---|---|---|---|---|---|---|---|---|
| General Hospital | other insurance is not applicable | 691 | $1,116,371 | | | 691 | 3.71% | $1,116,371 | 27.15% |
| General Hospital | other insurance is exhausted | 46 | $20,999 | | | 46 | 0.25% | $20,999 | 0.51% |
| Special Services | other insurance is not applicable | 60 | $144,468 | | | 60 | 0.32% | $144,468 | 3.51% |
| Nurse Midwife Group | other insurance is not applicable | 4 | $194 | | | 4 | 0.02% | $194 | 0% |
| Nurse Midwife Group | other insurance is exhausted | 2 | $129 | | | 2 | 0.01% | $129 | 0% |
| CT Home Care Program | other insurance is not applicable | | | 1 | $274 | 1 | 0.01% | $274 | 0.01% |
| Physician, MD | other insurance is not applicable | 74 | $4,057 | | | 74 | 0.40% | $4,057 | 0.10% |
| Physician, MD | other insurance is exhausted | 1 | $47 | | | 1 | 0.01% | $47 | 0.00% |
| Physician, MD - Group | other insurance is not applicable | 764 | $52,220 | | | 764 | 4.10% | $52,220 | 1.27% |
| Physician, MD - Group | other insurance is exhausted | 24 | $1,768 | | | 24 | 0.13% | $1,768 | 0.04% |
| Nurse Practitioner | other insurance is not applicable | 1 | $105 | | | 1 | 0.01% | $105 | 0% |
| Nurse Practitioner - Group | other insurance is not applicable | 55 | $1,889 | | | 55 | 0.30% | $1,889 | 0.05% |
| Nurse Practitioner - Group | other insurance is exhausted | 1 | $86 | | | 1 | 0.01% | $86 | 0.00% |
| Optometrist | other insurance is not applicable | 8 | $598 | | | 8 | 0.04% | $598 | 0.01% |
| Optician | other insurance is not applicable | 5 | $332 | | | 5 | 0.03% | $332 | 0.01% |
| Optometrist - Group | other insurance is not applicable | 35 | $1,123 | | | 35 | 0.19% | $1,123 | 0.03% |
| Dentist | other insurance is not applicable | 1 | $174 | | | 1 | 0.01% | $174 | 0% |
| Dentist | other insurance is exhausted | 1 | $31 | | | 1 | 0.01% | $31 | 0% |
| Dentist - Group | other insurance is not applicable | 3 | $633 | | | 3 | 0.02% | $633 | 0.02% |
| Dentist - Group | other insurance is exhausted | 1 | $23 | | | 1 | 0.01% | $23 | 0.00% |
| Community Clinic | other insurance is not applicable | 2,530 | $451,410 | 8 | $908 | 2,538 | 13.62% | $452,318 | 11.00% |
| Community Clinic | other insurance is exhausted | 33 | $4,878 | | | 33 | 0.18% | $4,878 | 0.12% |
| Alcohol and Drug Abuse Center | other insurance is not applicable | 1 | $1,597 | | | 1 | 0.01% | $1,597 | 0.04% |
| Home Health Agency | other insurance is not applicable | 261 | $162,899 | 14 | $4,338 | 275 | 1.48% | $167,237 | 4.07% |

* Through April 11, 2008 provider payments

# ATTACHMENT 1b
## State Fiscal Year 2008*
## Paid Claims: Health Insurance Not Applicable or Exhausted

| Provider Type Description | TPL Override Reason | Unduplicated Claim Count Paper Claims | Medicaid Paid Amount Paper Claims | Unduplicated Claim Count Electronic Claims | Medicaid Paid Amount Electronic Claims | Total Claims | Total Claims % of Total | Total Paid Amount | Total Paid Amount % of Total |
|---|---|---|---|---|---|---|---|---|---|
| Home Health Agency | other insurance is exhausted | 21 | $18,648 | 50 | $57,076 | 71 | 0.38% | $75,725 | 1.84% |
| Pharmacy - Rx only | other insurance is not applicable | | | 7,403 | $1,317,087 | 7,403 | 39.73% | $1,317,087 | 32.03% |
| Pharmacy - Rx only | other insurance is exhausted | | | 5,153 | $536,323 | 5,153 | 27.65% | $536,323 | 13.04% |
| Medical Equipment Supplier | other insurance is not applicable | 901 | $168,999 | | | 901 | 4.83% | $168,999 | 4.11% |
| Medical Equipment Supplier | other insurance is exhausted | 2 | $157 | 8 | $2,819 | 10 | 0.05% | $2,976 | 0.07% |
| Independent Laboratory | other insurance is not applicable | 124 | $6,907 | | | 124 | 0.67% | $6,907 | 0.17% |
| Independent Laboratory | other insurance is exhausted | 6 | $199 | | | 6 | 0.03% | $199 | 0% |
| Independent Radiology | other insurance is not applicable | 3 | $122 | | | 3 | 0.02% | $122 | 0% |
| Medical Transportation | other insurance is not applicable | 45 | $8,515 | | | 45 | 0.24% | $8,515 | 0.21% |
| Behavioral Health Clinician | other insurance is not applicable | 39 | $4,093 | | | 39 | 0.21% | $4,093 | 0.10% |
| Psychologist | other insurance is not applicable | 14 | $2,228 | | | 14 | 0.08% | $2,228 | 0.05% |
| Therapist | other insurance is not applicable | 101 | $5,568 | | | 101 | 0.54% | $5,568 | 0.14% |
| Behavioral Health Clinician Group | other insurance is not applicable | 36 | $4,106 | | | 36 | 0.19% | $4,106 | 0.10% |
| Psychologist - Group | other insurance is not applicable | 1 | $117 | | | 1 | 0.01% | $117 | 0.00% |
| Therapist - Group | other insurance is not applicable | 103 | $7,083 | | | 103 | 0.55% | $7,083 | 0.17% |
| TOTAL | | 5,998 | $2,192,771 | 12,637 | $1,918,825 | 18,635 | 100% | $4,111,595 | 100% |

* Through April 11, 2008 provider payments

ATTACHMENT 2
Prenatal and Postnatal Procedure Codes

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

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | OB_GYN | 59514 | CESAREAN DELIVERY ONLY |
| 1/1/2008 | OB_GYN | 59515 | CESAREAN DELIVERY ONLY; INCLUDING POSTPARTUM CARE |
| 1/1/2008 | OB_GYN | 59525 | SUBTOTAL OR TOTAL HYSTERECTOMY AFTER CESAREAN DELIVERY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE) |
| 1/1/2008 | OB_GYN | 59812 | TREATMENT OF INCOMPLETE ABORTION, ANY TRIMESTER, COMPLETED SURGICALLY |
| 1/1/2008 | OB_GYN | 59820 | TREATMENT OF MISSED ABORTION, COMPLETED SURGICALLY; FIRST TRIMESTER |
| 1/1/2008 | OB_GYN | 59830 | TREATMENT OF SEPTIC ABORTION, COMPLETED SURGICALLY |
| 1/1/2008 | OB_GYN | 59897 | UNLISTED FETAL INVASIVE PROCEDURE, INCLUDING ULTRASOUND GUIDANCE M.P. |
| 1/1/2008 | OB_GYN | 76801 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION |
| 1/1/2008 | OB_GYN | 76802 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, FIRST TRIMESTER (14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; EACH ADDITIONAL GESTATION (LIS |
| 1/1/2008 | OB_GYN | 76805 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (> OR = 14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; SINGLE OR FIRST |
| 1/1/2008 | OB_GYN | 76810 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION, AFTER FIRST TRIMESTER (> OR = 14 WEEKS 0 DAYS), TRANSABDOMINAL APPROACH; EACH ADDITIONAL |
| 1/1/2008 | OB_GYN | 76811 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION PLUS DETAILED FETAL ANATOMIC EXAMINATION, TRANSABDOMINAL APPROACH; SINGLE OR FIRST GESTATION |
| 1/1/2008 | OB_GYN | 76812 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, FETAL AND MATERNAL EVALUATION PLUS DETAILED FETAL ANATOMIC EXAMINATION, TRANSABDOMINAL APPROACH; EACH ADDITIONAL GESTATION (LIS |
| 1/1/2008 | OB_GYN | 76815 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, LIMITED (EG, FETAL HEART BEAT, PLACENTAL LOCATION, FETAL POSITION AND/OR QUALITATIVE AMNIOTIC FLUID VOLUME), ONE OR MORE FETU |
| 1/1/2008 | OB_GYN | 76817 | ULTRASOUND, PREGNANT UTERUS, REAL TIME WITH IMAGE DOCUMENTATION, TRANSVAGINAL |
| 1/1/2008 | OB_GYN | 76818 | FETAL BIOPHYSICAL PROFILE; WITH NON-STRESS TESTING |
| 1/1/2008 | OB_GYN | 93975 | DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; COMPLETE STUDY |

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | OB_GYN | 93976 | DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; LIMITED STUDY |
| 1/1/2008 | OB_GYN | 99201 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAI |
| 1/1/2008 | OB_GYN | 99202 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXA |
| 1/1/2008 | OB_GYN | 99203 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISI |
| 1/1/2008 | OB_GYN | 99204 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL D |
| 1/1/2008 | OB_GYN | 99205 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL D |
| 1/1/2008 | OB_GYN | 99211 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY, THE PRESENTING PROBLEM(S) ARE MINIMAL. T |
| 1/1/2008 | OB_GYN | 99212 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOC |
| 1/1/2008 | OB_GYN | 99213 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN |
| 1/1/2008 | OB_GYN | 99214 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATI |
| 1/1/2008 | OB_GYN | 99215 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE |
| 1/1/2008 | OB_GYN | 99383 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | OB_GYN | 99384 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99385 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99386 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99387 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99393 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99394 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99395 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORYGUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99396 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORYGUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99397 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION, COUNSELING/ANTICIPATORYGUIDANCE/RISK FA |
| 1/1/2008 | OB_GYN | 99401 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES |
| 1/1/2008 | OB_GYN | 99402 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES |
| 1/1/2008 | OB_GYN | 99403 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 45 MINUTES |
| 1/1/2008 | OB_GYN | 99404 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES |

ATTACHMENT 2
Prenatal and Postnatal Procedure Codes

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | OB_GYN | 99411 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES |
| 1/1/2008 | OB_GYN | 99412 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES |
| 1/1/2008 | OB_GYN | S0190 | MIFEPRISTONE, ORAL, 200 MG |
| 1/1/2008 | OB_GYN | S0191 | MISOPROSTOL, ORAL, 200 MCG |
| 1/1/2008 | OB_GYN | S0199 | MEDICALLY INDUCED ABORTION BY ORAL INGESTION OF MEDICATION INCLUDING ALL M.P. ASSOCIATED SERVICES AND SUPPLIES (E.G., PATIENT COUNSELING, OFFICE VISITS, CONFIRMATION OF PREGNANCY BY HCG, ULTRAS |

# ATTACHMENT 3
# EPSDT Procedure Codes

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

# ATTACHMENT 3
# EPSDT Procedure Codes

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | MEDICAL | 90647 | HEMOPHILUS INFLUENZA B VACCINE (HIB), PRP-OMP CONJUGATE (3 DOSE SCHEDULE),FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90649 | HUMAN PAPILLOMA VIRUS (HPV) VACCINE, TYPES 6, 11, 16, 18 (QUADRIVALENT), 3DOSE SCHEDULE, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90655 | INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR CHILDREN 6-35 MONTHS OFAGE, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90656 | INFLUENZA VIRUS VACCINE, SPLIT VIRUS, PRESERVATIVE FREE, FOR USE IN INDIVIDUALS 3YEARS AND ABOVE, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90657 | INFLUENZA VIRUS VACCINE, SPLIT VIRUS, WHEN ADMINISTERED TO CHILDREN 6 - 35 MONTHSOF AGE, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90658 | INFLUENZA VIRUS VACCINE, SPLIT VIRUS FOR USE IN INDIVIDUALS 3 YEARS OF AGE ANDABOVE, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90660 | INFLUENZA VIRUS VACCINE, LIVE, FOR INTRANASAL USE. |
| 1/1/2008 | MEDICAL | 90669 | PNEUMOCOCCAL CONJUGATE VACCINE, POLYVALENT, FOR CHILDREN UNDER 5 YEARS, FORINTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90680 | ROTAVIRUS VACCINE, PENTAVALENT, 3 DOSE SCHEDULE, LIVE, FOR ORAL USE. |
| 1/1/2008 | MEDICAL | 90700 | DIPHTHERIA, TETANUS TOXOIDS, AND ACELLULAR PERTUSSIS VACCINE (DTAP), FOR USE ININDIVIDUALS YOUNGER THAN 7 YEARS, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | PEDIATRIC | 90702 | DIPHTHERIA AND TETANUS TOXOIDS (DT) ADSORBED WHEN ADMINISTERED TO YOUNGER THAN 7YEARS, FOR INTRAMUSCULAR USE |
| 1/1/2008 | PEDIATRIC | 90704 | MUMPS VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS OR JET INJECTION USE |
| 1/1/2008 | PEDIATRIC | 90705 | MEASLES VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS OR JET INJECTION USE |
| 1/1/2008 | PEDIATRIC | 90706 | RUBELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS OR JET INJECTION USE |
| 1/1/2008 | MEDICAL | 90707 | MEASLES, MUMPS AND RUBELLA VIRUS VACCINE (MMR), LIVE FOR SUBCUTANEOUS USE. |
| 1/1/2008 | MEDICAL | 90710 | MEASLES, MUMPS, RUBELLA AND VARICELLA VACCINE (MMRV), LIVE, FOR SUBCUTANEOUSUSE. |
| 1/1/2008 | MEDICAL | 90713 | POLIOVIRUS VACCINE, INACTIVATED, (IPV), FOR SUBCUTANEOUS USE. |
| 1/1/2008 | MEDICAL | 90714 | TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHENADMINISTERED TO 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90715 | TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), FOR USE ININDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90716 | VARICELLA VIRUS VACCINE, LIVE, FOR SUBCUTANEOUS USE. |
| 1/1/2008 | MEDICAL | 90723 | DIPHTHERIA, TETANUS TOXOIDS, ACELLULAR PERTUSSIS VACCINE, HEPATITIS B, ANDPOLIOVIRUS VACCINE, INACTIVATED (DTAP-HEPBIPV), FOR INTRAMUSCULAR USE. |

# ATTACHMENT 3
# EPSDT Procedure Codes

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | MEDICAL | 90734 | MENINGOCOCCAL CONJUGATE VACCINE, SEROGROUPS A, C, Y AND W-1 35(TETRAVALENT), FOR INTRAMUSCULAR USE. |
| 1/1/2008 | MEDICAL | 90744 | HEPATITIS B VACCINE, PEDIATRIC/ADOLESCENT DOSAGE (3 DOSE SCHEDULE), FOR INTRAMUSCULAR USE. |
| 1/1/2008 | PEDIATRIC | 99201 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; APROBLEM FOCUSED EXAMINATION; AND STRAI |
| 1/1/2008 | PEDIATRIC | 99202 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSEDHISTORY; AN EXPANDED PROBLEM FOCUSED EXA |
| 1/1/2008 | PEDIATRIC | 99203 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; ADETAILED EXAMINATION; AND MEDICAL DECISI |
| 1/1/2008 | PEDIATRIC | 99204 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; ACOMPREHENSIVE EXAMINATION; AND MEDICAL D |
| 1/1/2008 | PEDIATRIC | 99205 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF A NEW PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; ACOMPREHENSIVE EXAMINATION; AND MEDICAL D |
| 1/1/2008 | PEDIATRIC | 99211 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, THAT MAY NOT REQUIRE THE PRESENCE OF A PHYSICIAN. USUALLY,THE PRESENTING PROBLEM(S) ARE MINIMAL. T |
| 1/1/2008 | PEDIATRIC | 99212 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:A PROBLEM FOCUSED HISTORY; A PROBLEM FOC |
| 1/1/2008 | PEDIATRIC | 99213 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:AN EXPANDED PROBLEM FOCUSED HISTORY; AN |
| 1/1/2008 | PEDIATRIC | 99214 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:A DETAILED HISTORY; A DETAILED EXAMINATI |

# ATTACHMENT 3
# EPSDT Procedure Codes

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | PEDIATRIC | 99215 | OFFICE OR OTHER OUTPATIENT VISIT FOR THE EVALUATION AND MANAGEMENT OF AN ESTABLISHED PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS:A COMPREHENSIVE HISTORY; A COMPREHENSIVE |
| 1/1/2008 | PEDIATRIC | 99231 | SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A PROBLEM FOCUSEDINTERVAL HISTORY; A PROBLEM FOCU |
| 1/1/2008 | PEDIATRIC | 99232 | SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEMFOCUSED INTERVAL HISTORY; AN EXP |
| 1/1/2008 | PEDIATRIC | 99233 | SUBSEQUENT HOSPITAL CARE, PER DAY, FOR THE EVALUATION AND MANAGEMENT OF A PATIENT, WHICH REQUIRES AT LEAST TWO OF THESE THREE KEY COMPONENTS: A DETAILED INTERVALHISTORY; A DETAILED EXAMINATION |
| 1/1/2008 | PEDIATRIC | 99381 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99382 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99383 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99384 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99385 | INITIAL COMPREHENSIVE PREVENTIVE MEDICINE EVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99391 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99392 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |

# ATTACHMENT 3
# EPSDT Procedure Codes

| FEE SCHEDULE DATE | CODE TYPE | CODE | CODE DESCRIPTION |
|---|---|---|---|
| 1/1/2008 | PEDIATRIC | 99393 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99394 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99395 | PERIODIC COMPREHENSIVE PREVENTIVE MEDICINE REEVALUATION AND MANAGEMENT OF AN INDIVIDUAL INCLUDING AN AGE AND GENDER APPROPRIATE HISTORY, EXAMINATION,COUNSELING/ANTICIPATORY GUIDANCE/RISK FA |
| 1/1/2008 | PEDIATRIC | 99401 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 15 MINUTES |
| 1/1/2008 | PEDIATRIC | 99402 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 30 MINUTES |
| 1/1/2008 | PEDIATRIC | 99403 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 45 MINUTES |
| 1/1/2008 | PEDIATRIC | 99404 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO AN INDIVIDUAL (SEPARATE PROCEDURE); APPROXIMATELY 60 MINUTES |
| 1/1/2008 | PEDIATRIC | 99411 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 30MINUTES |
| 1/1/2008 | PEDIATRIC | 99412 | PREVENTIVE MEDICINE COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION(S) PROVIDED TO INDIVIDUALS IN A GROUP SETTING (SEPARATE PROCEDURE); APPROXIMATELY 60MINUTES |
| 1/1/2008 | PEDIATRIC | 99433 | SUBSEQUENT HOSPITAL CARE, FOR THE EVALUATION AND MANAGEMENT OF A NORMAL NEWBORN, PER DAY |

ATTACHMENT 4

Department of Social Services Eligibility Management System
Commercial Insurance Coverage Codes

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

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

Recipient TPL Vendor Extract Layout

LRECL = 200

Base Record

| Field Name<br>Base Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| RECORD_CODE | CHAR(01) | Indicates the record type. | N/A | N/A | 'B' – For Base Information |
| ID_MEDICAID | CHAR(12) | Client's identification number. | T_RE_BASE | ID_MEDICAID | |
| BASE NAM_LAST | CHAR(20) | Client's last name. | T_RE_BASE | NAM_LAST | |
| BASE NAM_FIRST | CHAR(15) | Client's first name. | T_RE_BASE | NAM_FIRST | |
| BASE NAM_MID_INIT | CHAR(1) | Client's middle initial. | T_RE_BASE | NAM_MID_INIT | |
| ADR_STREET_1 | CHAR(30) | The first line of the client's street address. | T_RE_BASE | ADR_STREET_1 | |
| ADR_STREET_2 | CHAR(30) | The second line of the client's street address. | T_RE_BASE | ADR_STREET_2 | |
| ADR_CITY | CHAR(30) | The city where the recipient resides. | T_RE_BASE | ADR_CITY | |
| ADR_STATE | CHAR(2) | The state where the recipient resides. | T_RE_BASE | ADR_STATE | |
| ADR_ZIP_CODE | CHAR(5) | The five character zip code for the recipient. | T_RE_BASE | ADR_ZIP_CODE | |
| ADR_ZIP_CODE_4 | CHAR(4) | The zip plus four of the recipient. | T_RE_BASE | ADR_ZIP_CODE_4 | |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>Base Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| NUM_SSN | CHAR(9) | The social security number for a recipient. | T_RE_BASE | NUM_SSN | |
| DTE_BIRTH | CHAR(8) | The date of birth for the recipient. | T_RE_BASE | DTE_BIRTH | |
| DTE_DEATH | CHAR(8) | The date of death for the recipient. | T_RE_BASE | DTE_DEATH | |
| CDE_SEX | CHAR(1) | Indicates the sex of the recipient. | T_RE_BASE | CDE_SEX | |
| CDE_RACE | CHAR(1) | Code that will map to a specific race or combination of races. | T_RE_BASE | CDE_RACE | |
| CDE_TOWN | CHAR(4) | Numeric code for the Town Codes. | T_RE_BASE | CDE_TOWN | |
| CDE_DISTRICT | CHAR(3) | Numeric code that represents each District Office. | T_CDE_DISTRICT | CDE_DISTRICT | Select t_town.cde_district from t_re_base, t_town where t_re_base.cde_town = t_town.cde_town. |
| ID_MEDICARE | CHAR(12) | Current Medicare ID | T_RE_HIB` | ID_MEDICARE | |
| IND_ACTIVE | CHAR (1) | Indicates if the client Medicaid ID is active. Valid values are ‘A’ for active, ‘N’ for non-active. | T_RE_BASE | IND_ACTIVE | |
| Filler | CHAR(63) | Filler | | | SPACES |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

Third Party Liability Record

LRECL = 200

| Field Name<br>TPL Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| RECORD_CODE | CHAR(01) | Indicates the record type. | N/A | N/A | 'T' – Third Party Liability |
| ID_MEDICAID | CHAR(12) | Client's identification number. | T_RE_BASE | ID_MEDICAID | |
| CDE_CARRIER | CHAR(7) | This is a unique, user-defined carrier ID which is used on all screens and reports to identify the TPL carrier. | T_TPL_CARRIER | CDE_CARRIER | Select t_tpl_carrier.cde_carrier from t_tpl_carrier, t_tpl_resource, t_re_base where t_tpl_carrier.sak_carrier = t_tpl_resource.sak_carrier and t_tpl_resource.sak_recip = t_re_base.sak_recip |
| NUM_TPL_POLICY | CHAR(16) | Policy number for this TPL policy. | T_TPL_RESOURCE | NUM_TPL_POLICY | Select t_tpl_resource .num_tpl_policy from t_tpl_carrier, t_tpl_resource, t_re_base where t_tpl_carrier.sak_carrier = t_tpl_resource.sak_carrier and t_tpl_resource.sak_recip = t_re_base.sak_recip |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>TPL Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| NUM_GROUP | CHAR(16) | Policy group number. If present, gives the group number of the policy. | T_TPL_RESOURCE | NUM_GROUP | Select t_tpl_resource .num_tpl_policy from t_tpl_carrier, t_tpl_resource, t_re_base where t_tpl_carrier.sak_carrier = t_tpl_resource.sak_carrier and t_tpl_resource.sak_recip = t_re_base.sak_recip |
| CDE_POLICY_TYPE | CHAR(1) | This code identifies whether the recipient's resource is private pay insurance or state paid insurance. | T_TPL_RESOURCE | CDE_POLICY_TYPE | Select t_tpl_resource .cde_policy_type from t_tpl_resource, t_re_base where t_tpl_resource.sak_recip = t_re_base.sak_recip |
| CDE_RELATION | CHAR (2) | This code identifies the relationship of the policyholder to the recipient covered by a TPL policy. | T_TPL_RESOURCE | CDE_RELATION | Select t_tpl_resource .cde_relation from t_tpl_resource, t_re_base where t_tpl_resource.sak_recip = t_re_base.sak_recip |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>TPL Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| POLICY HOLDER NAM_LAST | CHAR(30) | This is the last name of the policyholder. It is used to send correspondence to the policyholder. | T_POLICY_HOLDER | NAM_LAST | Select t_policy_holder.nam_last from t_policy_holder, t_tpl_resouce, t_re_base where t_policy_holder.sak_pol_hold = t_tpl_resource.sak_policy_ownr and t_tpl_resource.sak_recip = t_re_base.sak_recip |
| POLICY HOLDER NAM_FIRST | CHAR(13) | This is the first name of the policyholder. It is used to send correspondence to the policyholder. | T_POLICY_HOLDER | NAM_FIRST | Select t_policy_holder.nam_first from t_policy_holder, t_tpl_resouce, t_re_base where t_policy_holder.sak_pol_hold = t_tpl_resource.sak_policy_ownr and t_tpl_resource.sak_recip = t_re_base.sak_recip |
| POLICY HOLDER NAM_MID_INIT | CHAR(1) | This is the middle initial of the policyholder. It is used to send correspondence to the policyholder. | T_POLICY_HOLDER | NAM_MID_INIT | Select t_policy_holder.nam_mid_init from t_policy_holder, t_tpl_resouce, t_re_base where t_policy_holder.sak_pol_hold = t_tpl_resource.sak_policy_ownr and t_tpl_resource.sak_recip = t_re_base.sak_recip |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>TPL Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| POLICY HOLDER NUM_SSN | CHAR(9) | This is the social security number of the policyholder. | T_POLICY_HOLDER | NUM_SSN | Select t_policy_holder.num_ssn from t_policy_holder, t_tpl_resouce, t_re_base where t_policy_holder.sak_pol_hold = t_tpl_resource.sak_policy_ownr and t_tpl_resource.sak_recip = t_re_base.sak_recip |
| NAM_BUS | CHAR(39) | This is the business name of an employer. | T_TPL_EMPLOYER | NAM_BUS | Select t_tpl_employer.nam_bus from t_tpl_employer, t_tpl_resouce, t_re_base where t_tpl_employer.sak_emp = t_tpl_resource.sak_emp and t_tpl_resource.sak_recip = t_re_base.sak_recip |
| ABSENT PARENT NAM_LAST | CHAR(15) | This is the last name of the recipient's absent or custodial parent. | T_TPL_AC_PARENT | NAM_LAST | Select t_tpl_ac_parent.nam_last from t_tpl_ac_parent, t_tpl_ac_parent_recip_xref, t_re_base where t_tpl_ac_parent.sak_ac_parent = t_tpl_ac_parent_recip_xref.sak_ac_parent and t_tpl_ac_parent_recip_xref.sak_recip = t_re_base.sak_recip |
| ABSENT PARENT NAM_FIRST | CHAR (13) | This is the first name of the recipient's absent or custodial parent. | T_TPL_AC_PARENT | NAM_FIRST | Select t_tpl_ac_parent.nam_first from t_tpl_ac_parent, t_tpl_ac_parent_recip_xref, t_re_base where t_tpl_ac_parent.sak_ac_parent = t_tpl_ac_parent_recip_xref.sak_ac_parent and t_tpl_ac_parent_recip_xref.sak_recip = t_re_base.sak_recip |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>TPL Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| ABSENT PARENT NAM_MID_INIT | CHAR(1) | This is the middle initial of the recipient's absent or custodial parent. | T_TPL_AC_PARENT | NAM_MID_INIT | Select t_tpl_ac_parent.nam_mid_init from t_tpl_ac_parent, t_tpl_ac_parent_recip_xref, t_re_base where t_tpl_ac_parent.sak_ac_parent = t_tpl_ac_parent_recip_xref.sak_ac_parent and t_tpl_ac_parent_recip_xref.sak_recip = t_re_base.sak_recip |
| ABSENT PARENT NUM_SSN | CHAR(9) | This is the parent's social security number. | T_TPL_AC_PARENT | NUM_SSN | Select t_tpl_ac_parent.num_ssn from t_tpl_ac_parent, t_tpl_ac_parent_recip_xref, t_re_base where t_tpl_ac_parent.sak_ac_parent = t_tpl_ac_parent_recip_xref.sak_ac_parent and t_tpl_ac_parent_recip_xref.sak_recip = t_re_base.sak_recip |
| FILLER | CHAR (15) | Filler | N/A | N/A | Spaces |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

Coverage Code Record

LRECL = 200

| Field Name<br>Coverage Code Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| RECORD_CODE | CHAR(01) | Indicates the record type. | N/A | N/A | 'C' – Coverage Code Record |
| ID_MEDICAID | CHAR(12) | Client's identification number. | T_RE_BASE | ID_MEDICAID | |
| NUM_TPL_POLICY | CHAR(16) | Policy number for this TPL policy. | T_TPL_RESOURCE | NUM_TPL_POLICY | Select t_tpl_resource .num_tpl_policy from t_tpl_carrier, t_tpl_resource, t_re_base where t_tpl_carrier.sak_carrier = t_tpl_resource.sak_carrier and t_tpl_resource.sak_recip = t_re_base.sak_recip |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>Coverage Code Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| CDE_COVERAGE | CHAR(2) | This code identifies the type of coverage that a TPL policy provides. | T_COVERAGE_XREF | CDE_COVERAGE | Valid Values:<br>1 - Hospitalization Inpatient<br>2 - Hospital Outpatient<br>3 - Dr-Major Medical<br>4 - Dr-Surgical<br>5 - Dr-Physician<br>6 - Dr-Diagnosis X-Ray and Laboratory<br>7 - Dr-Anesthesia<br>8 – Dental<br>9 – Vision<br>A – Drug<br>L – Long Term Care |
| DTE_EFFECTIVE | CHAR(8) | The effective begin date of this coverage code. | T_COVERAGE_XREF | DTE_EFFECTIVE | |
| DTE_END | CHAR(8) | The effective ending date of this coverage code. | T_COVERAGE_XREF | DTE_END | |

| Field Name<br>Coverage Code Record | Data Type<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| IND_EXHAUST | CHAR(1) | This is the Exhaustion indicator used to indicate if a recipient TPL has been exhausted. | T_COVERAGE_XREF | IND_EXHAUST | Valid Values:<br>Y – Yes<br>N - No |
| FILLER | CHAR (152) | Filler | N/A | N/A | Spaces |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

Medicare Record

LRECL = 200

o 5 Occurrences of the Medicare Start and Stop dates.

| Field Name<br>Header Record | Data Type/<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| RECORD_CODE | CHAR(01) | Indicates the record type. | N/A | N/A | 'M' – Medicare |
| ID_MEDICAID | CHAR(12) | Client's identification number. | T_RE_BASE | ID_MEDICAID | |
| FILLER | CHAR(105) | FILLER | N/A | N/A | |
| MED-IND | CHAR(01) | Indicates if the record is Medicare A, B or D. | N/A | N/A | Value 'A', 'B', or 'D' |
| NO-OCCURS | CHAR(01) | The number of Medicare segments. Occurs 5 Times. | N/A | N/A | The number will start with '1' and increase by '1' for every segment written. |
| MED-START | CHAR(08) | Medicare start date | T_RE_MEDICARE_A<br>T_RE_MEDICARE_B<br>T_RE_MEDICARE_D | DTE_EFFECTIVE | |
| MED-STOP | CHAR(08) | Medicare stop date | T_RE_MEDICARE_A<br>T_RE_MEDICARE_B<br>T_RE_MEDICARE_D | DTE_END | |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

Client Eligibility Extract

LRECL - 34

The following extract will contain Benefit Plan data where the following qualifications will be applied:

1. A 5 year qualifier parameter will determine the benefit plan data provided

   Extract run date – 5 years
2. Where either or both the benefit plan effective and end dates fall within the 5 year timeframe
3. There will be no filters placed on the benefit plan type
4. The CDE_TYPE_PLAN will be Benefit plan only (BNFT)

| Field Name<br>Header Record | Data Type/<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| RECORD_CODE | CHAR(01) | Indicates the record type. | N/A | N/A | 'E' – Eligibility |
| ID_MEDICAID | CHAR(12) | Client's identification number. | T_RE_BASE | ID_MEDICAID | |
| CDE_PGM_HEALTH | CHAR(5) | Identifies the medical assistance program that is supported in the system. | T_PUB_HLTH_PGM | CDE_PGM_HEALTH | Valid Values:<br>See the CDE_PGM_HEALTH table below. |
| DTE_EFFECTIVE | CHAR(8) | The date that the recipient becomes eligible for the corresponding Medical Assistance program. | T_RE_ELIG | DTE_EFFECTIVE | |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

| Field Name<br>Header Record | Data Type/<br>(Length) | Field Description | Source Table | Source Field | Other Derivation Logic |
|---|---|---|---|---|---|
| DTE_END | CHAR(8) | The date that the recipient is no longer eligible for the corresponding Medical Assistance program. | T_RE_ELIG | DTE_END | |

# ATTACHMENT 5

## Client Eligibility and Recipient TPL Vendor Extract File Layouts

CDE_PGM_HEALTH Valid Values

| | |
|---|---|
| ABI | Acquired Brain Injury Waiver |
| ALL | All Benefit Plans |
| ASMTS | Assessment CHC Waiver-1 Limited or 2 Intermed |
| ASMTF | Assessment Only CHC FFS Waiver |
| ALF | Assisted Living FFS Waiver |
| ALS | Assisted Living Waiver-1 Limited or 2 Intermediate |
| BHP D | Behavioral Health Partnership D05 |
| BHP A | Behavioral Health Partnership Husky A FFS |
| BHP B | Behavioral Health Partnership Husky B FFS |
| CBCMF | Community Based Case Managed FFS Waiver |
| CBCMS | Community Based Case Managed State Waiver |
| CP | ConnPACE |
| CADAP | Connecticut Aids Drug Assistance Program |
| FFS | Fee For Service (Medicaid) |
| GA | General Assistance |
| KB | Katie Becket Program |
| PCA | Personal Care Assistant Waiver |
| QI1 | Qualified Individual – 1 |
| QMB | Qualified Medicare Beneficiary |
| SDIRF | Self Directed CHC FFS Waiver |
| SDIRS | Self Directed CHC State Waiver |
| SLMB | Specified Low Income Medicare Beneficiary |
| SAGA | State Administered General Assistance Program |

# ATTACHMENT 5

Client Eligibility and Recipient TPL Vendor Extract File Layouts

Benefit Plan Codes

| CODE | DESCRIPTION |
|---|---|
| ABI | Acquired Brain Injury Waiver |
| ABIA | Acquired Brain Injury Assignment Plan |
| ALA | Assisted Living Assignment Plan |
| ALF | Assisted Living FFS Waiver |
| ALL | All Benefit Plans |
| ALS | Assisted Living Waiver-1 Limited or 2 Intermediate |
| ANEST | Anesthesia coverage |
| ASMTF | Assessment Only CHC FFS Waiver |
| ASMTS | Assessment CHC Waiver-1 Limited or 2 Intermed |
| ASSA | Assessment Only Assignment Plan |
| BHP A | Behavioral Health Partnership Husky A FFS |
| BHP B | Behavioral Health Partnership Husky B FFS |
| BHP D | Behavioral Health Partnership D05 |
| CADAP | Connecticut Aids Drug Assistance Program |
| CBCMA | Community Based/Case Managed Assignment Plan |

# ATTACHMENT 5

Client Eligibility and Recipient TPL Vendor Extract File Layouts

| CODE | DESCRIPTION |
|---|---|
| CBCMF | Community Based Case Managed FFS Waiver |
| CBCMS | Community Based Case Managed State Waiver |
| CP | ConnPACE |
| DENTL | Dental insurance plan |
| DRUG | Drug insurance coverage |
| FFS | Fee For Service (Medicaid) |
| GA | General Assistance |
| HOSPS | Hospice |
| INPAT | Inpatient hospital coverage |
| KB | Katie Becket Program |
| LABXR | Diagnostic lab & radiology coverage |
| LOCKN | Pharmacy Lockin |
| LTC | Long term care coverage |
| MAJME | Major medical coverage |
| MCO | Title 19 Managed Care |
| MCOB | HUSKY B MCO Lockin |
| MEDA | Medicare A coverage |
| MEDB | Medicare B coverage |

# ATTACHMENT 5

Client Eligibility and Recipient TPL Vendor Extract File Layouts

| CODE | DESCRIPTION |
|---|---|
| MEDD | Medicare D coverages |
| NHOME | Nursing Home Facility |
| OUTPT | Outpatient hospital coverage |
| PCA | Personal Care Assistant Waiver |
| PCAA | Personal Care Assistant Assignment Plan |
| PHYLC | Physician Lockin |
| PHYS | Physician coverage |
| QI1 | Qualified Individual - 1 |
| QMB | Qualified Medicare Beneficiary |
| SAGA | State Administered General Assistance Program |
| SDIRF | Self Directed CHC FFS Waiver |
| SDIRS | Self Directed CHC State Waiver |
| SLMB | Specified Low Income Medicare Beneficiary |
| SURG | Surgery coverage |
| TEST2 | Benefit Plan Testing |
| VISN | Vision coverage |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 01 | Hospital | 002 | Psychiatric/Inpatient Under 21 | I | 1 and/or 2 | | MDA | |
| 01 | Hospital | 002 | Psychiatric/Inpatient Under 21 | A | 1 and/or 2 | | None | |
| 01 | Hospital | 003 | Psychiatric/Inpatient 21-64 (Crossovers) | I | 1 and/or 2 | | MDA | |
| 01 | Hospital | 003 | Psychiatric/Inpatient 21-64 (Crossovers) | A | 1 and/or 2 | | None | |
| 01 | Hospital | 004 | Psychiatric/Inpatient 65+ | I | 1 and/or 2 | | MDA | |
| 01 | Hospital | 004 | Psychiatric/Inpatient 65+ | A | 1 and/or 2 | | None | |
| 01 | Hospital | 008 | Psychiatric - Outpatient | O | 1 and/or 2 | | MDB | |
| 01 | Hospital | 008 | Psychiatric - Outpatient | C | 1 and/or 2 | | None | |
| 01 | Hospital | 086 | Dental Clinic | D | 1 and/or 2, and 8 | | MDB | |
| 01 | Hospital | 086 | Dental Clinic | B | 1 and/or 2, and 8 | | None | |
| 01 | Hospital | 001 | Inpatient | I | 1 and/or 2 | | MDA | |
| 01 | Hospital | 001 | Inpatient | A | 1 and/or 2 | | None | |
| 01 | Hospital | 007 | Outpatient | O | 1 and/or 2 | | MDA and MDB | |
| 01 | Hospital | 007 | Outpatient | C | 1 and/or 2 | | None | |
| 90 | State Institution | 002 | Psychiatric/Inpatient Under 21 | I | 1 and/or 2 | | MDA | |
| 90 | State Institution | 002 | Psychiatric/Inpatient Under 21 | A | 1 and/or 2 | | None | |
| 90 | State Institution | 003 | Psychiatric/Inpatient 21-64 (Crossovers) | I | 1 and/or 2 | | MDA | |
| 90 | State Institution | 003 | Psychiatric/Inpatient 21-64 (Crossovers) | A | 1 and/or 2 | | None | |
| 90 | State Institution | 004 | Psychiatric/Inpatient 65+ | I | 1 and/or 2 | | MDA | |
| 90 | State Institution | 004 | Psychiatric/Inpatient 65+ | A | 1 and/or 2 | | None | |
| 90 | State Institution | 005 | Chronic - Inpatient | I | L | | MDA | |
| 90 | State Institution | 005 | Chronic - Inpatient | A | L | | None | |
| 90 | State Institution | 038 | ICF/MR (Non Bed Count Specific) | L | Exclude All TOC | | Exclude All Medicare | |
| 90 | State Institution | 038 | ICF/MR (Non Bed Count Specific) | L | Exclude All TOC | | Exclude All Medicare | |
| 90 | State Institution | 008 | Psychiatric - Outpatient | O | 1 and/or 2 | | MDB | |
| 90 | State Institution | 008 | Psychiatric - Outpatient | C | 1 and/or 2 | | None | |
| 90 | State Institution | 111 | Community Mental Health Center (CMHC) | O | 3,4,5,6, and/or 7 | | MDB | |
| 90 | State Institution | 111 | Community Mental Health Center (CMHC) | C | 3,4,5,6, and/or 7 | | None | |
| 90 | State Institution | 040 | Rehabilitation Facility | M | 3,4,5,6, and/or 7 | | MDB | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 90 | State Institution | 040 | Rehabilitation Facility | C | 3,4,5,6, and/or 7 | | None | |
| 90 | State Institution | 006 | Alcohol and Drug Abuse Inpatient | I | 1 and/or 2 | | MDA | |
| 90 | State Institution | 006 | Alcohol and Drug Abuse Inpatient | A | 1 and/or 2 | | None | |
| 90 | State Institution | 009 | Alcohol and Drug Abuse Outpatient | O | 1 and/or 2 | | MDB | |
| 90 | State Institution | 009 | Alcohol and Drug Abuse Outpatient | C | 1 and/or 2 | | None | |
| 90 | State Institution | 001 | Inpatient | I | 1 and/or 2 | | MDA | |
| 90 | State Institution | 001 | Inpatient | A | 1 and/or 2 | | None | |
| 90 | State Institution | 017 | Chronic - Outpatient | O | 1 and/or 2 | | MDB | |
| 90 | State Institution | 017 | Chronic - Outpatient | C | 1 and/or 2 | | None | |
| 03 | Extended Care Facility | 005 | Chronic - Inpatient | L | L | | MDA | |
| 03 | Extended Care Facility | 005 | Chronic - Inpatient | A | 1 and/or 2 | | None | |
| 03 | Extended Care Facility | 038 | ICF/MR (Non Bed Count Specific) | L | Exclude All TOC | 1 | Exclude All Medicare | 1 |
| 03 | Extended Care Facility | 038 | ICF/MR (Non Bed Count Specific) | A | Exclude All TOC | 1 | None | |
| 03 | Extended Care Facility | 035 | Skilled Nursing Facility | L | L | | Exclude MDA and MDB | 22 |
| 03 | Extended Care Facility | 035 | Skilled Nursing Facility | A | 1 and/or 2 | | None | |
| 03 | Extended Care Facility | 030 | Nursing Facility | L | L | | Exclude MDA and MDB | 22 |
| 03 | Extended Care Facility | 030 | Nursing Facility | A | 1 and/or 2 | | None | |
| 03 | Extended Care Facility | 039 | ICF-2 | L | L | | Exclude MDA and MDB | 22 |
| 03 | Extended Care Facility | 039 | ICF-2 | A | 1 and/or 2 | | None | |
| 03 | Extended Care Facility | 041 | Super Skilled Nursing Facility | L | L | | Exclude MDA and MDB | 22 |
| 03 | Extended Care Facility | 041 | Super Skilled Nursing Facility | A | 1 and/or 2 | | None | |
| 12 | Special Services | 586 | SBCH - Nurses | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 587 | SBCH - Social Workers | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 588 | SBCH - Guidance Counselor | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 589 | SBCH - Psychologist | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 120 | School Corporation | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 582 | SBCH School District/Performing Provider | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 583 | Regional Family Service Coordination Center (RFSCC) | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 584 | Birth to Three Performing Provider | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 581 | Private Non-Medical Institution Performing provider | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 580 | Private Non-Medical Institution Billing Provider | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 12 | Special Services | 033 | Psy Res Treatment Facility | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 585 | Community Services | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 12 | Special Services | 511 | Mental Health Group Home | M | Exclude All TOC | 2 | Exclude All MDA and MDB | 2 |
| 71 | Nurse Midwife Group | 095 | Certified Nurse Midwife | M | 3,4,5,6, and/or 7 | | MDB | |
| 71 | Nurse Midwife Group | 095 | Certified Nurse Midwife | B | 3,4,5,6, and/or 7 | | None | |
| 32 | Nurse Midwife | 095 | Certified Nurse Midwife | M | 3,4,5,6, and/or 7 | | MDB | |
| 32 | Nurse Midwife | 095 | Certified Nurse Midwife | B | 3,4,5,6, and/or 7 | | None | |
| 57 | CT Home Care Program | 541 | CT Home Care Access Agency | M | 3,4,5,6, and/or 7 | 3 | None | 3 |
| 57 | CT Home Care Program | 542 | Assisted Living | M | Exclude All TOC | 4 | None | 4 |
| 58 | CT Home Care Program Performing Provider | 540 | CT Home Care Program Performing Provider | M | Exclude All TOC | 2 | Exclude All Medicare | 2 |
| 53 | DMR Waiver | 530 | DMR Waiver | M | Exclude All TOC | 2 | Exclude All Medicare | 2 |
| 54 | DMR Waiver Performing Provider | 533 | DMR Waiver Performing Provider - State | M | Exclude All TOC | 2 | Exclude All Medicare | 2 |
| 31 | Physician | 318 | General Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 318 | General Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 319 | General Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 319 | General Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 310 | Allergy | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 310 | Allergy | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 332 | Otology, Laryngology, Rhinology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 332 | Otology, Laryngology, Rhinology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 311 | Anesthesiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 311 | Anesthesiology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 312 | Cardiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 312 | Cardiology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 314 | Dermatology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 314 | Dermatology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 316 | Family Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 316 | Family Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 31 | Physician | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 326 | Neurology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 326 | Neurology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 328 | Obstetrics/Gynecology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 328 | Obstetrics/Gynecology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 330 | Ophthalmology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 330 | Ophthalmology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 272 | Oral Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 272 | Oral Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 331 | Orthopedic Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 331 | Orthopedic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 333 | Pathology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 333 | Pathology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 337 | Plastic Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 337 | Plastic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 336 | Physical Medicine and Rehabilitation Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 336 | Physical Medicine and Rehabilitation Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 339 | Psychiatry | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 339 | Psychiatry | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 338 | Proctology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 338 | Proctology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 341 | Radiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 341 | Radiology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 342 | Thoracic Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 342 | Thoracic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 343 | Urology | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 343 | Urology | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 353 | Homeopath | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 353 | Homeopath | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 320 | Geriatric Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 320 | Geriatric Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 31 | Physician | 352 | Osteopath | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 352 | Osteopath | B | 3,4,5,6, and/or 7 | | None | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 31 | Physician | 345 | General Pediatrician | M | 3,4,5,6, and/or 7 | | MDB | |
| 31 | Physician | 345 | General Pediatrician | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 318 | General Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 318 | General Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 319 | General Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 319 | General Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 310 | Allergy | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 310 | Allergy | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 332 | Otology, Laryngology, Rhinology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 332 | Otology, Laryngology, Rhinology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 311 | Anesthesiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 311 | Anesthesiology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 312 | Cardiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 312 | Cardiology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 314 | Dermatology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 314 | Dermatology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 316 | Family Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 316 | Family Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 326 | Neurology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 326 | Neurology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 328 | Obstetrics/Gynecology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 328 | Obstetrics/Gynecology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 330 | Ophthalmology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 330 | Ophthalmology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 272 | Oral Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 272 | Oral Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 331 | Orthopedic Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 331 | Orthopedic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 333 | Pathology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 333 | Pathology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 337 | Plastic Surgery | M | 3,4,5,6, and/or 7 | | MDB | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 72 | Physician Group | 337 | Plastic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 336 | Physical Medicine and Rehabilitation Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 336 | Physical Medicine and Rehabilitation Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 339 | Psychiatry | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 339 | Psychiatry | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 338 | Proctology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 338 | Proctology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 341 | Radiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 341 | Radiology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 342 | Thoracic Surgery | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 342 | Thoracic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 343 | Urology | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 343 | Urology | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 353 | Homeopath | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 353 | Homeopath | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 320 | Geriatric Practitioner | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 320 | Geriatric Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 352 | Osteopath | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 352 | Osteopath | B | 3,4,5,6, and/or 7 | | None | |
| 72 | Physician Group | 345 | General Pediatrician | M | 3,4,5,6, and/or 7 | | MDB | |
| 72 | Physician Group | 345 | General Pediatrician | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 093 | Nurse Practitioner (Other) | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 093 | Nurse Practitioner (Other) | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 319 | General Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 319 | General Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 310 | Allergy | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 310 | Allergy | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 332 | Otology, Laryngology, Rhinology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 332 | Otology, Laryngology, Rhinology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 094 | Certified Registered Nurse Anesthetist (CRNA) | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 094 | Certified Registered Nurse Anesthetist (CRNA) | B | 3,4,5,6, and/or 7 | | None | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 09 | Advance Practice Nurse | 312 | Cardiology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 312 | Cardiology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 314 | Dermatology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 314 | Dermatology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 092 | Family Nurse Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 092 | Family Nurse Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 326 | Neurology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 326 | Neurology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 091 | Obstetric Nurse Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 091 | Obstetric Nurse Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 330 | Ophthalmology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 330 | Ophthalmology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 272 | Oral Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 272 | Oral Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 331 | Orthopedic Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 331 | Orthopedic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 333 | Pathology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 333 | Pathology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 337 | Plastic Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 337 | Plastic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 336 | Physical Medicine and Rehabilitation Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 336 | Physical Medicine and Rehabilitation Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 339 | Psychiatry | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 339 | Psychiatry | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 338 | Proctology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 338 | Proctology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 347 | Radiation Therapy | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 347 | Radiation Therapy | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 342 | Thoracic Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 09 | Advance Practice Nurse | 342 | Thoracic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 343 | Urology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 343 | Urology | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 353 | Homeopath | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 353 | Homeopath | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 320 | Geriatric Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 320 | Geriatric Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 352 | Osteopath | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 352 | Osteopath | B | 3,4,5,6, and/or 7 | | None | |
| 09 | Advance Practice Nurse | 090 | Pediatric Nurse Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 09 | Advance Practice Nurse | 090 | Pediatric Nurse Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 093 | Nurse Practitioner (Other) | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 093 | Nurse Practitioner (Other) | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 319 | General Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 319 | General Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 310 | Allergy | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 310 | Allergy | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 332 | Otology, Laryngology, Rhinology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 332 | Otology, Laryngology, Rhinology | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 094 | Certified Registered Nurse Anesthetist (CRNA) | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 094 | Certified Registered Nurse Anesthetist (CRNA) | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 312 | Cardiology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 312 | Cardiology | B | 3,4,5,6, and/or 7 | | None | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 70 | Advance Practice Nurse Group | 314 | Dermatology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 314 | Dermatology | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 092 | Family Nurse Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 092 | Family Nurse Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 322 | Internal Medicine | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 322 | Internal Medicine | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 326 | Neurology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 326 | Neurology | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 091 | Obstetric Nurse Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 091 | Obstetric Nurse Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 330 | Ophthalmology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 330 | Ophthalmology | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 272 | Oral Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 272 | Oral Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 331 | Orthopedic Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 70 | Advance Practice Nurse Group | 331 | Orthopedic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 333 | Pathology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 333 | Pathology | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 337 | Plastic Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 337 | Plastic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 336 | Physical Medicine and Rehabilitation Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 336 | Physical Medicine and Rehabilitation Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 339 | Psychiatry | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 339 | Psychiatry | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 338 | Proctology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 338 | Proctology | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 347 | Radiation Therapy | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 347 | Radiation Therapy | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 342 | Thoracic Surgery | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 342 | Thoracic Surgery | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 343 | Urology | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 343 | Urology | B | 3,4,5,6, and/or 7 | | None | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 70 | Advance Practice Nurse Group | 353 | Homeopath | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 353 | Homeopath | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 320 | Geriatric Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 320 | Geriatric Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 352 | Osteopath | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 352 | Osteopath | B | 3,4,5,6, and/or 7 | | None | |
| 70 | Advance Practice Nurse Group | 090 | Pediatric Nurse Practitioner | M | 3,4,5,6, and/or 7 | | MDB | 7 |
| 70 | Advance Practice Nurse Group | 090 | Pediatric Nurse Practitioner | B | 3,4,5,6, and/or 7 | | None | |
| 36 | Personal Care Services | 361 | Personal Care - Agency | M | Exclude All TOC | | Exclude | |
| 14 | Podiatrist | 140 | Podiatrist | M | 3,4,5,6, and/or 7 | | MDB | 8 |
| 14 | Podiatrist | 140 | Podiatrist | B | 3,4,5,6, and/or 7 | | None | |
| 18 | Optometrist | 180 | Optometry | M | 9 | | MDB | 6 |
| 18 | Optometrist | 180 | Optometry | B | 3,4,5,6, and/or 7 | | None | |
| 19 | Optician | 190 | Optician | M | 9 | | MDB | 6 |
| 19 | Optician | 190 | Optician | B | 3,4,5,6, and/or 7 | | None | |
| 73 | Podiatrist Group | 140 | Podiatrist | M | 3,4,5,6, and/or 7 | | MDB | 8 |
| 73 | Podiatrist Group | 140 | Podiatrist | B | 3,4,5,6, and/or 7 | | None | |
| 74 | Optometrist Group | 180 | Optometry | M | 9 | | MDB | 6 |
| 74 | Optometrist Group | 180 | Optometry | B | 3,4,5,6, and/or 7 | | None | |
| 75 | Optician Group | 190 | Optician | M | 9 | | MDB | 6 |
| 75 | Optician Group | 190 | Optician | B | 3,4,5,6, and/or 7 | | None | |
| 27 | Dentist | 272 | Oral Surgery | D | 8 | | None | |
| 27 | Dentist | 273 | Orthodontist | D | 8 | | None | |
| 27 | Dentist | 278 | Dental Hygienist | D | 8 | | None | |
| 27 | Dentist | 271 | General Dentistry Practitioner | D | 8 | | None | |
| 76 | Dentist Group | 272 | Oral Surgery | D | 8 | | None | |
| 76 | Dentist Group | 273 | Orthodontist | D | 8 | | None | |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 76 | Dentist Group | 278 | Dental Hygienist | D | 8 | | None | |
| 76 | Dentist Group | 271 | General Dentistry Practitioner | D | 8 | | None | |
| 08 | Clinic | 300 | Free-standing Renal Dialysis Clinic | M | 3,4,5,6, and/or 7 | | MDB | 9 |
| 08 | Clinic | 300 | Free-standing Renal Dialysis Clinic | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 096 | Methadone Clinic | M | 3,4,5,6, and/or 7 | | MDB | 10 |
| 08 | Clinic | 096 | Methadone Clinic | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 020 | Ambulatory Surgical Center (ASC) | M | 3,4,5,6, and/or 7 | | MDB | 11 |
| 08 | Clinic | 020 | Ambulatory Surgical Center (ASC) | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 525 | Mental Health Clinic | M | 3,4,5,6, and/or 7 | | MDB | 12 |
| 08 | Clinic | 525 | Mental Health Clinic | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 083 | Family Planning Clinic | M | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 083 | Family Planning Clinic | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 523 | Medical Clinic | M | 3,4,5,6, and/or 7 | | MDB | 13 |
| 08 | Clinic | 523 | Medical Clinic | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 081 | Rural Health Clinic (RHC) | M | 3,4,5,6, and/or 7 | | MDB | 13 |
| 08 | Clinic | 081 | Rural Health Clinic (RHC) | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 040 | Rehabilitation Facility | M | 3,4,5,6, and/or 7 | | MDB | 14 |
| 08 | Clinic | 040 | Rehabilitation Facility | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 524 | Dental Clinic | M | 8 | | None | |
| 08 | Clinic | 524 | Dental Clinic | B | 8 | | None | |
| 08 | Clinic | 088 | Pediatric Clinic | | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 088 | Pediatric Clinic | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 520 | Dental FQHC | | 8 | | None | |
| 08 | Clinic | 520 | Dental FQHC | B | 8 | | None | |
| 08 | Clinic | 521 | Medical FQHC | | 3,4,5,6, and/or 7 | | MDB | 13 |
| 08 | Clinic | 521 | Medical FQHC | B | 3,4,5,6, and/or 7 | | None | |
| 08 | Clinic | 522 | Mental Health FQHC | | 3,4,5,6, and/or 7 | | MDB | |
| 08 | Clinic | 522 | Mental Health FQHC | B | 3,4,5,6, and/or 7 | | None | |
| 63 | Drug and Alcohol Abuse Center | 001 | Inpatient | M | 1 and/or 2 | | | |
| 63 | Drug and Alcohol Abuse Center | 001 | Inpatient | B | Exclude | | None | |
| 63 | Drug and Alcohol Abuse Center | 007 | Outpatient | M | 3,4,5,6, and/or 7 | | MDB | 10 |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 63 | Drug and Alcohol Abuse Center | 007 | Outpatient | B | 3,4,5,6, and/or 7 | | None | |
| 63 | Drug and Alcohol Abuse Center | 550 | Halfway House - Reserved for Future Use | Not Yet Available | Exclude | | Exclude MDA and MDB | |
| 63 | Drug and Alcohol Abuse Center | 551 | Long Term Care - Reserved for Future Use | Not Yet Available | Exclude | | Exclude MDA and MDB | 22 |
| 05 | Home Health Agency | 050 | Home Health Agency | H | 3,4,5,6, and/or 7 | 5 | Exclude MDA and MDB | 22 |
| 05 | Home Health Agency | 050 | Home Health Agency | C | 3,4,5,6, and/or 7 | | None | |
| 24 | Pharmacy | 240 | Pharmacy | P | A | | MDB | 15 |
| 24 | Pharmacy | 240 | Pharmacy | Q | A | | MDB | 15 |
| 25 | DME/Medical Supply Dealer | 248 | Medical and Surgical Supplies | M | 3,4,5,6, and/or 7 | | MDB | |
| 25 | DME/Medical Supply Dealer | 248 | Medical and Surgical Supplies | B | 3,4,5,6, and/or 7 | | None | |
| 25 | DME/Medical Supply Dealer | 249 | Durable Medical Goods | M | 3,4,5,6, and/or 7 | | MDB | |
| 25 | DME/Medical Supply Dealer | 249 | Durable Medical Goods | B | 3,4,5,6, and/or 7 | | None | |
| 25 | DME/Medical Supply Dealer | 277 | Orthotic And Prosthetic Devices | M | 3,4,5,6, and/or 7 | | MDB | |
| 25 | DME/Medical Supply Dealer | 220 | Hearing Aid Dealer | M | 3,4,5,6, and/or 7 | | MDB | |
| 25 | DME/Medical Supply Dealer | 220 | Hearing Aid Dealer | B | 3,4,5,6, and/or 7 | | None | |
| 25 | DME/Medical Supply Dealer | 277 | Orthotic And Prosthetic Devices | B | 3,4,5,6, and/or 7 | | None | |
| 25 | DME/Medical Supply Dealer | 250 | DME/Medical Supply Dealer | M | 3,4,5,6, and/or 7 | | MDB | |
| 25 | DME/Medical Supply Dealer | 250 | DME/Medical Supply Dealer | B | 3,4,5,6, and/or 7 | | None | |
| 62 | Naturopath | 355 | Naturopath | M | 3,4,5,6, and/or 7 | | None | |
| 65 | Naturopath Group | 355 | Naturopath | M | 3,4,5,6, and/or 7 | | None | |
| 15 | Chiropractor | 150 | Chiropractor | M | 3,4,5,6, and/or 7 | | MDB | 16 |
| 15 | Chiropractor | 150 | Chiropractor | B | 3,4,5,6, and/or 7 | | None | |
| 68 | Chiropractor Group | 150 | Chiropractor | M | 3,4,5,6, and/or 7 | | MDB | 16 |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 68 | Chiropractor Group | 150 | Chiropractor | B | 3,4,5,6, and/or 7 | | None | |
| 28 | Laboratory | 280 | Independent Lab | M | 3,4,5,6, and/or 7 | | MDB | |
| 28 | Laboratory | 280 | Independent Lab | B | 3,4,5,6, and/or 7 | | None | |
| 29 | Radiology | 291 | Portable Radiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 29 | Radiology | 291 | Portable Radiology | B | 3,4,5,6, and/or 7 | | None | |
| 29 | Radiology | 290 | Non-Portable Radiology | M | 3,4,5,6, and/or 7 | | MDB | |
| 29 | Radiology | 290 | Non-Portable Radiology | B | 3,4,5,6, and/or 7 | | None | |
| 26 | Transportation Provider | 260 | Ambulance | M | 3,4,5,6, and/or 7 | | MDB | |
| 26 | Transportation Provider | 260 | Ambulance | X | 3,4,5,6, and/or 7 | | None | |
| 26 | Transportation Provider | 264 | Common Carrier (Ambulatory) | M | Exclude All TOC | | None | |
| 26 | Transportation Provider | 264 | Common Carrier (Ambulatory) | X | Exclude All TOC | | None | |
| 26 | Transportation Provider | 263 | Taxi | M | Exclude All TOC | | None | |
| 26 | Transportation Provider | 263 | Taxi | X | Exclude All TOC | | None | |
| 26 | Transportation Provider | 265 | Common Carrier (Non-ambulatory) | M | 3,4,5,6, and/or 7 | | MDB | |
| 26 | Transportation Provider | 265 | Common Carrier (Non-ambulatory) | X | 3,4,5,6, and/or 7 | | None | |
| 26 | Transportation Provider | 262 | Critical Care Helicopter | M | 3,4,5,6, and/or 7 | | MDB | |
| 26 | Transportation Provider | 262 | Critical Care Helicopter | X | 3,4,5,6, and/or 7 | | None | |
| 26 | Transportation Provider | 261 | Air Ambulance | M | 3,4,5,6, and/or 7 | | MDB | |
| 26 | Transportation Provider | 261 | Air Ambulance | X | 3,4,5,6, and/or 7 | | None | |
| 26 | Transportation Provider | 560 | Travel Agent | M | Exclude All TOC | | None | |
| 26 | Transportation Provider | 560 | Travel Agent | X | Exclude All TOC | | None | |
| 33 | Behavioral Health Clinician | 112 | Psychology | M | 3,4,5,6, and/or 7 | | MDB | 17,18 |
| 33 | Behavioral Health Clinician | 115 | Clinical Social Worker | M | 3,4,5,6, and/or 7 | | MDB | 17,18 |
| 33 | Behavioral Health Clinician | 119 | Marital and Family Therapist | M | 3,4,5,6, and/or 7 | 19 | None | |
| 33 | Behavioral Health Clinician | 118 | Alcohol & Drug Counselor | M | 3,4,5,6, and/or 7 | 19 | None | |
| 33 | Behavioral Health Clinician | 121 | Professional Counselor | M | 3,4,5,6, and/or 7 | 19 | None | |
| 86 | Behavioral Health Clinician Groups | 112 | Psychology | M | 3,4,5,6, and/or 7 | | MDB | 17,18 |
| 86 | Behavioral Health Clinician Groups | 115 | Clinical Social Worker | M | 3,4,5,6, and/or 7 | | MDB | 17,18 |

ATTACHMENT 6a
Claim Selection Logic

| interChange Provider Type | interChange Provider Type Description | interChange Proivder Speciality | interChange Provider Speciality Desctiption | interChange Type of Claim | Claims Selection For Other Insutance: EMS Type of Coverage | O.I. Ref. | Claims Selection For Medicare: EMS Carrier Code: "MDA" and "MDB" | MDA MDB Ref. |
|---|---|---|---|---|---|---|---|---|
| 86 | Behavioral Health Clinician Groups | 119 | Marital and Family Therapist | M | 3,4,5,6, and/or 7 | 19 | None | |
| 86 | Behavioral Health Clinician Groups | 118 | Alcohol & Drug Counselor | M | 3,4,5,6, and/or 7 | 19 | None | |
| 86 | Behavioral Health Clinician Groups | 121 | Professional Counselor | M | 3,4,5,6, and/or 7 | 19 | None | |
| 10 | Mid-Level Practitioner | 108 | Physician Assistant | TBD | TBD | TBD | TBD | TBD |
| 17 | Therapist | 173 | Audiologist Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 17 | Therapist | 173 | Audiologist Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 17 | Therapist | 176 | Speech Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 17 | Therapist | 176 | Speech Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 17 | Therapist | 170 | Physical Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 17 | Therapist | 170 | Physical Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 17 | Therapist | 171 | Occupational Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 17 | Therapist | 171 | Occupational Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 87 | Therapist Group | 176 | Speech Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 87 | Therapist Group | 176 | Speech Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 87 | Therapist Group | 170 | Physical Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 87 | Therapist Group | 170 | Physical Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 87 | Therapist Group | 171 | Occupational Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 87 | Therapist Group | 171 | Occupational Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 87 | Therapist Group | 173 | Audiologist Therapist | M | 3,4,5,6, and/or 7 | | MDB | |
| 87 | Therapist Group | 173 | Audiologist Therapist | B | 3,4,5,6, and/or 7 | | None | |
| 52 | Acquired Brain Injury | 029 | Acquired Brain Injury Fiduciary | | Exclude All TOC | 4 | Exclude | 4 |

ATTACHMENT 6b
Reference Codes

| REFERENCE CODE | EXPLANATION |
|---|---|
| 1 | Claims excluded. Third Party Liability does not pay for Intermediate Care Facilities for the Mentally Retarded. |
| 2 | Claims excluded. Procedures are bundled and cannot identify medical services that Third Parties would cover. |
| 3 | Claims should be selected that contain only the following paid procedure codes : * For dates of service prior to 8/01/03 procedure codes: 1267Z, 1268Z, 1269Z, 1270Z, 1271Z, 1272Z, 1273Z, 1274Z, 1276Z, 1278Z, 1277Z,1275Z, 1279Z, 1280Z, 1282Z, 1284Z; * For dates of service on or after 8/01/03 procedure codes: S9123, S9124, S9128, S9129, S9131, T1001, T1002, T1003, T1004, 97001,97003, 92506 |
| 4 | Claims excluded. Majority of ABI procedures are for non-medical home and community based services that commercial Health Insurance and Medicare do not reimburse. The procedure 1548P - Cognitive Behavioral Programs could contain medically-orientated bundled services and the specific clinical modality cannot be discerned. |
| 5 | Claims should be selected that contain only the following paid home health procedure or revenue center codes: * For D.O.S Prior to 7/01/03 procedure codes: 1800Z, 1912Z, 1961Z, 1962Z, 1963Z, 1964Z, 1965Z, 1966Z, 1807Z, 1806Z, 1805Z, 1910Z, 1918Z, 1830Z, 1921Z, 1960Z, 1840Z, 1850Z; * For D.O.S on or after 7/01/03 procedure codes: S9123, T1002, S9124, T1003, T1502, T1001, T1004; * For D.O.S on or after 7/01/03 revenue center codes: 421, 424, 434, 431, 444, 441 |
| 6 | Claims should be selected for eye exams, preventative tests and screenings, eye glasses/contact lenses, glaucoma screenings, treatment of macular degeneration, for a client diagnosis of cataract surgery, macular degeneration, glaucoma, diabetes or other high risk groups. |
| 7 | Medicare Part B covered service under Non-Physician Health Care Provider Services |
| 8 | Medicare Part B covered service for medically necessary treatment of injuries or diseases of the foot |
| 9 | Medicare Part B coverage for outpatient maintenance dialysis treatments |
| 10 | Medicare Part B coverage for substance abuse treatment in an outpatient treatment center |
| 11 | Medicare Part B coverage for services given in an Ambulatory Surgical Center for a covered surgical procedure. |
| 12 | Medicare Part coverage for mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department. |

ATTACHMENT 6b
Reference Codes

| REFERENCE CODE | EXPLANATION |
|---|---|
| 13 | Medicare Part B coverage for physician and specially qualified non-physician practitioners such as clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, for medically necessary services. |
| 14 | Medicare Part B coverage for medically necessary outpatient physical and occupational therapy and speech-language pathology services |
| 15 | Medicare Part B coverage for antigens, injectible osteoporosis drugs for women, injection of erythropoietin (Epogen®) or epoetin alpha for end-stage renal disease (permanent kidney failure) for treating anemia, injection of hemophilia clotting factors, injectable drugs administered by a licensed medical practitioner, immunosuppressive drugs for transplant patients, and the following oral Cancer Drugs: Capecitabine (brand name Xeloda®), Cyclophosphamide (brand name Cytoxan®), Methhotrexate, Temozolomide (brand name Temodar®), Busulfan (brand name Myleran®), Etoposide (brand name VePesid®), and Melphalan (brand name Alkeran®), related oral anti-nausea drugs, and drugs used in infusion pumps and nebulizers if considered reasonable and necessary. |
| 16 | Medicare Part B coverage for medically necessary manipulation of spine to correct a subluxation. |
| 17 | Medicare Part B coverage for the services of specially qualified non-physician practitioners: clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists, speech-language pathologists, and certified nurse midwives, as allowed by state and local law for medically necessary services. |
| 18 | Medicare Part B coverage for mental health services on an outpatient basis by either a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, or physician assistant in an office setting, clinic, or hospital outpatient department. |
| 19 | Exclude procedure code T1016 Case Management - Coordination of health care services |
| 20 | Medicare Part B coverage not available for services given by a speech pathologist in private practice. |
| 21 | Medicare Part B coverage for medically necessary outpatient physical and occupational therapy provided in a private practice; subject to an an annual financial limitation cap of $1780. |
| 22 | Selecting claims for Medicare would conflict with other CTDSS TPL Programs |

ATTACHMENT 7

Fraud and Recoveries Health Insurance Referrals - State Fiscal Years 2007 and 2008

| Accretion Referral Type | Number of Referrals | |
|---|---|---|
| | SFY 2007 | SFY 2008[1] |
| CT DSS Regional Office | 8,229 | 7,608 |
| Adhoc Referrals | 596 | 1,373 |
| Connecticut AIDS Drug Assistance Program (CADAP) | 280 | 240 |
| CHAMPUS/TRICARE | 90 | 738 |
| EDS and TPL Contractor - Provider TPL Information Cards | 3,344 | 2,968[2] |
| IV-D Child Support Enforcement | 1,023 | 989 |
| DCF Subsidized Adoption Referrals | 442 | 288 |
| DCF Other Referrals | 85 | 77 |
| Katie Beckett | 17 | 9 |
| Total | 14,106 | 14,290 |

Notes

1 = SFY 2008 experience is based upon referrals received through April 30, 2008.

2 = The TPL Contractor began processing TPL Information Cards in March 2008. The 2,968 referral count pertains to 1,868 EDS processed cards and approximately 1100 cards handled by the TPL Contractor.

Potential TPL for Follow-Up Report (TPL-0023-R): The Potential TPL for Follow-up is a system generated cycle report. This report identifies all unduplicated claims paid or denied with an amount greater than zero in the TPL payment field and the client has no insurance information on the TPL tables. Once a client reports, they are flagged and will not report again for 60 days. The sort order for this report will be by provider ID and then clients' by provider ID listed.

## Potential TPL for Follow-Up Report Layout (TPL-0023-R)

```
Report  : TPL-0023-R                              interChange MMIS                                  Run Date: MM/DD/CCYY
Process : TPLJW002                    MEDICAID MANAGEMENT INFORMATION SYSTEM                    Run Time:   HH:MM:SS
Location: TPL0023W                          POTENTIAL TPL FOR FOLLOW-UP                             Page:       9999
                                          PERIOD: MM/DD/CCYY - MM/DD/CCYY


          PROVIDER ID:  9999999999999999999   PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                      FROM DATE     TO DATE                                          MEDICAID
          CLIENT ID.       ICN      OF SERVICE    OF SERVICE      TOTAL CHARGE     TPL AMOUNT        PAYMENT

          XXXXXXXXXXXX     9999999999999   MM/DD/CCYY    MM/DD/CCYY      $999,999.99      $999,999.99      $999,999.99
          XXXXXXXXXXXX     9999999999999   MM/DD/CCYY    MM/DD/CCYY      $999,999.99      $999,999.99      $999,999.99

          PROVIDER ID:  9999999999999999999   PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                      FROM DATE     TO DATE                                          MEDICAID
          CLIENT ID.       ICN      OF SERVICE    OF SERVICE      TOTAL CHARGE     TPL AMOUNT        PAYMENT

          XXXXXXXXXXXX     9999999999999   MM/DD/CCYY    MM/DD/CCYY      $999,999.99      $999,999.99      $999,999.99
          XXXXXXXXXXXX     9999999999999   MM/DD/CCYY    MM/DD/CCYY      $999,999.99      $999,999.99      $999,999.99


          PROVIDER ID:  9999999999999999999   PROVIDER NAME: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

                                      FROM DATE     TO DATE                                          MEDICAID
          CLIENT ID.       ICN      OF SERVICE    OF SERVICE      TOTAL CHARGE     TPL AMOUNT        PAYMENT

          XXXXXXXXXXXX     9999999999999   MM/DD/CCYY    MM/DD/CCYY      $999,999.99      $999,999.99      $999,999.99
          XXXXXXXXXXXX     9999999999999   MM/DD/CCYY    MM/DD/CCYY      $999,999.99      $999,999.99      $999,999.99


                                              *** END OF REPORT ***
```

Field Descriptions for Potential TPL for Follow-Up Report

| Field | Description | Data Type | Length |
|---|---|---|---|
| Client ID | The client's Connecticut Medical Assistance Program Identification Number. | Character | 12 |
| From Date of Service | First date of service on the claim. | Date (MM/DD/CCYY) | 10 |
| ICN | Internal Control Number (claim number). | Number | 13 |
| Medicaid Payment | Medicaid payment amount. | Number | 11 |
| Period | This field displays the period the data was collected for the report. | Date (MM/DD/CCYY) | 23 |
| Provider ID | Medicaid Provider identification number that uniquely identifies the provider preceded by the type of provider ID being displayed (NPI=National Provider ID, MCD=Medicaid and BSE=Base ID). | Number | 19 |
| Provider Name | The provider name that is reported. | Character | 44 |
| TPL Amount | Third party payment amount on claim. | Number | 11 |
| To Date Of Service | Last date of service on claim. | Date (MM/DD/CCYY) | 10 |
| Total Charge | Total amount provider charged on the claim. | Number | 11 |

Today's Date:

ATTACHMENT 9
DEPARTMENT OF SOCIAL SERVICES
Connecticut Medical Assistance Program
TPL Information Form

This form is used to communicate to the Department of Social Services that a client's health insurance information needs to be added or corrected. This applies to situations where either you believe the Department client health insurance or Medicare information is incorrect or needs a termination date, or you know of client third party information that does not appear to be on the Department's records. It is essential that you notify the Department of these changes in order to avoid having your Medicaid claims unnecessarily denied for health insurance or Medicare reasons.

Please complete as much of the following information as possible.

**1**_____
Client's Name

**2**_____
Client ID (9 characters)

**3**_____
Insurance Carrier Name

**4**_____
Client Date of Birth

**5**_____ __
Policyholder First & Last Name

**6**_____
Policyholder Social Security Number

**7** _____
Policyholder Date of Birth

**8** Client's Relationship to the Insured (select one):

☐ Self ☐ Child ☐ Spouse ☐ Other_____

**9**_____
Group Number

**10**_____
Policy Number (for client)

**11**_____/_____/_____
Policy Effective Date

**12**_____/_____/_____
Policy Term Date (if applicable)

**13** Medicare Coverage (select all that apply): ☐ Part A ☐ Part B

**14**_____
Medicare Policy Number

**15**_____/_____/_____
Medicare Effective Date

**16**_____/_____/_____
Medicare Term Date

**17** Was this insurance information obtained via AEVS? ☐ Yes ☐ No

**18** Please explain any discrepancy: _____

_____

**19**_____
Provider Name

**20** _____
NPI/Non- Medical Provider Identifier

**21**_____
Contact Name

**22**(_____)_____-_____
Contact Telephone Number

**23**(_____)_____-_____
Contact Fax Number

**24** _____@_____
Contact Email

The information on this form will be verified by Health Management Systems, Inc. (HMS). HMS will transmit to the Department of Social Services any necessary additions, corrections or deletions, which will be made to this client's third party liability record. To insure that HMS contacts you directly within forty five (45) days of receipt of this Form with the results of your referral, your provider information in boxes 18-23 above must be completed. You may also go to AEVS to check the status of this client's third party liability information.

Fax completed forms to: 214-560-3932 OR Mail completed forms to:

HMS
Attn: CT Insurance and Verification Unit
5615 High Point Dr, Suite 100
Irving, TX 75038

ATTACHMENT 10
Third Party Liability Request for Proposals Budget Form

| A | B | C | D | E | F | G | H |
|---|---|---|---|---|---|---|---|
| | | | Your Proposed Cost for This Deliverable | | Estimate of Volume for RFP Comparison Purposes Only | | Estimated Cost to Department of Social Services for RFP Comparison Purposes |
| Complete only Column D. | | | | | | | |
| 1 | Benefit Recovery of Medicaid Paid Claims | | | | | | |
| | a) Benefit Recovery Methods When Third Parties Are Identified After the Department of Social Services Has Paid for the Cost of Care | Contingency | 0.00% | X | $9,800,000 | = | $0 |
| | b) Benefit Recovery Methods for Medicaid Paid Claims Not Cost Avoided When a Client Eligibility Record Contains Third Party Liability Information | Contingency | 0.00% | X | $200,000 | = | $0 |
| | c) New or Expanded Client Third Party Liability Information: Interrogation of the Client Eligibility Record and Medicaid Paid Claim Selection | Contingency | 0.00% | X | $4,300,000 | = | $0 |
| 2 | Third Party Liability Verification | Per Verification | $0.00 | X | 12,500 | = | $0 |
| 3 | Third Party Liability Health Insurance Suspect Reporting | Per Verification | $0.00 | X | 2,000 | = | $0 |
| 4 | Third Party Liability Information Form | Per Verification | $0.00 | X | 4,000 | = | $0 |
| 5 | Third Party Liability Data Match and Identification | Per Verification | $0.00 | X | 16,000 | = | $0 |
| 6 | Trauma Recovery | Contingency | 0.00% | X | $100,000 | = | $0 |
| 7 | Child Support Medical Insurance Identification | Per Verification | $0.00 | X | 3,600 | = | $0 |
| 8 | Acute Care Hospital and Skilled Nursing Facility Credit Balance/Overpayment Audits, Applied Income Project, and Maintenance of Online Credit Balance Reporting System for Long-term Care Facilities | Contingency | 0.00% | X | $18,000,000 | = | $0 |
| 9 | Integration of Related Proposal Requirements | N/A | N/A | | N/A | | N/A |
| | Total: | | | | | | $0 |