UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

PAUL SHAFER AND JOSHUA HARDER, on behalf of themselves and all others similarly situated,

Plaintiffs,

- against -

RODERICK BREMBY, as Commissioner of the State of Connecticut Department of Social Services,

Defendant.

CIVIL ACTION NO. 3:12-cv-00039 (AWT)

March 28, 2014

STIPULATION AND ORDER OF SETTLEMENT

WHEREAS, the named Plaintiffs and all others similarly situated, as low-income Connecticut residents, commenced this action against Defendant Roderick Bremby, in his official capacity as Commissioner of the State of Connecticut Department of Social Services ("DSS"), for his alleged failure to process applications and provide Medicaid in a timely manner in violation of federal law, 42 U.S.C. § 1396a(a)(8) and implementing regulations thereunder; and

WHEREAS, the parties intend, through this Stipulation and Order of Settlement (hereinafter, "Settlement Agreement"), that Defendant shall obtain and maintain compliance with the requirements of federal law for the processing of applications and the provision of Medicaid services in a timely manner; and

WHEREAS, plaintiffs filed a Motion for Preliminary Injunctive Relief and a Motion for Class Certification at the time of the filing of this action; and

WHEREAS, the Court conducted a trial in May 2013 and heard evidence relating to such motions as well as relating to the merits of plaintiffs' claims; and

WHEREAS, the parties desire to settle this action on terms and conditions just and fair to all parties;

NOW, THEREFORE, IT IS HEREBY AGREED by and between the parties, as represented below, as follows:

I. General Recitals

1. The parties believe that resolving this matter through negotiation is in the best interests of both Defendant and the plaintiff class. Their agreement to settle the case, subject to the approval of the Court in accordance with Rule 23(e) of the Federal Rules of Civil Procedure, is the outcome of negotiations by the parties.

2. The parties enter into this Settlement Agreement solely in consideration of the mutual promises contained herein.

3. This Settlement Agreement shall become effective, final, and binding upon the parties, their successors and assigns, only at such time as it is finally approved by the Court pursuant to Rule 23(e) of the Federal Rules of Civil Procedure and any necessary state legislative approval has been obtained. Whether legislative approval of this agreement is required will be determined by the Attorney General of the State of Connecticut pursuant to the provisions of Conn. Gen. Stat. § 3-125a. The Defendant shall inform the Court of the Attorney General's determination and provide Plaintiffs with a copy of the letter transmitting the proposed settlement agreement to the Connecticut legislature for its review, which transmittal will include or incorporate justification for the conclusion that legislative review is required by state law. The Defendant shall also promptly inform the Court and plaintiffs of any actions taken by the

legislature, either by affirmative vote or by inaction by failing to vote within the requisite timeframe, which is deemed to be approval of the proposed settlement by operation of law pursuant to the terms of Conn. Gen. Stat. § 3-125a.

4. The parties herein execute this Settlement Agreement for the purposes of settlement of this action only. It does not reflect the positions of the parties in any other judicial or administrative action or proceeding, in any forum. This Settlement Agreement may not be raised affirmatively or defensively by either party in a future proceeding, if any, provided that any party herein may use this Settlement Agreement in connection with any subsequent proceeding brought to enforce the Settlement Agreement.

5. The parties intend this Settlement Agreement to be legally binding and enforceable by this Court. The parties understand and agree that until such time as the term of this Settlement Agreement, including any extensions thereof, expires, the Court's jurisdiction will continue for the purpose of enforcing, as necessary, the obligations of Defendant under this Settlement Agreement.

6. In reaching this settlement, Defendant Commissioner expressly does not admit liability, or violation of the law, as to any claims raised or which could have been raised by plaintiffs pertinent to events giving rise to this lawsuit, and plaintiffs do not concede that compliance with any or all of the terms herein, including specific percentages, constitutes full compliance with the governing requirements of federal Medicaid law.

II. Definitions

7. The following definitions apply to this Settlement Agreement:

a. **"Commissioner"** means the Commissioner of the Connecticut Department of Social Services, his successors and assigns, including any Acting Commissioner.

b. **"Defendant"** refers to the named defendant in this action, the Commissioner of the Connecticut Department of Social Services, his successors and assigns, including any Acting Commissioner.

c. **"DSS"** or **"the Department"** means the State of Connecticut Department of Social Services, or any successor agency, its officers, administrators, staff, and employees.

d. **"Plaintiffs"** refers to the named plaintiffs in this action and the certified plaintiff class, as set forth in plaintiffs' pending Motion for Class Certification.

e. **"Medicaid"** means medical assistance provided pursuant to 42 U.S.C. §1396, et seq.

f. **"Applicant"** means any person or household that applies, on or through any state-prescribed form, or any state-prescribed electronic or telephonic process, for Medicaid, including long-term care coverage.

g. **"Spend-Down Applicant"** means any individual who has been or will be found otherwise eligible for Medicaid but for excess income, and subject to a spend-down requirement.

h. **"Date of Application"** means the date the Medicaid application is first received by the Department, whether it is first received at a regional office, the Connecticut Health Insurance Exchange (also known as Access Health-CT), or the Department's scanning center (regardless of the date of scanning), or any other agency or contractor with the authority to accept applications on behalf of the Department, in whatever form and at whatever location DSS accepts applications, e.g., in-person, electronically, by mail, etc.

i. **"EMS Application Length Pending Report"** means the complete monthly EMS reports that are produced periodically by DSS showing, among other things, the numbers of

grants and denials (dispositions) of Medicaid applications and, of these dispositions, those made more than 45 days, or more than 90 days, after the date of the Medicaid application. It has the notation "DMF8030A-DMF80271" in the upper left corner. A month's data for purposes of this report is available approximately one week after the end of the reported month.

j. "**Intake Report**" means the monthly reports prepared by DSS showing the number of Medicaid applications pending at the end of the month, the number of such applications which are overdue, the number of such overdue applications which are excused by unusual circumstances as defined herein, and the percentage of the total pending Medicaid applications that are overdue, statewide and for each DSS office. A month's data is available approximately one week after the end of the reported month.

k. "**Medicaid Application Timeliness Report**" means the monthly reports prepared by DSS showing the number of applications received for the Medicaid program and for each specific Medicaid program, i.e., HUSKY A, HUSKY C (long-term care and non-long-term care) and HUSKY D in a given month and the number of those applications which were processed within the applicable standard of promptness, statewide and for each DSS office or regional processing center (to the extent processing is conducted on an office or regional basis). A month's timeliness data is available approximately three months and ten days after the end of the reported month. As approved by CMS, DSS uses the DSS/Access Health CT shared computer system to determine eligibility for MAGI Medicaid. The Plaintiffs maintain that eligibility is not determined until a granted application is entered into EMS. Notwithstanding, for purposes of the Medicaid Application Timeliness Report only, DSS will count (1) Medicaid application grants processed by the DSS/Access Health CT shared computer system as timely processed based on the date when information from the granted application is entered into EMS,

or another system that is capable of allowing Medicaid-enrolled providers to ascertain whether an individual is currently eligible for Medicaid; and (2) all Medicaid application denials processed by the DSS/Access Health CT shared computer system as timely processed, based on the date that the shared computer system issues a denial notice, with information about fair hearing rights.

l. "**Backlog Report**" means the monthly reports prepared by DSS that provide the following information:

1. For non-Long Term Care applications:
   a. The number of non-LTC applications filed with DSS in each of the three months preceding the reported month;
   b. The average monthly number of non-LTC applications filed with DSS based on the three months preceding the reported month;
   c. The number of pending, overdue non-LTC applications as of the end of the reporting month, regardless of whether the delay is "excused" or "unexcused" pursuant to Paragraph 7.n.; and
   d. The number of pending, overdue non-LTC applications as of the end of the reporting month as a percentage of the average monthly number of non-LTC applications filed with DSS in the three months preceding the reported month.

2. For Long-Term Care applications (commencing with the report provided on May 15, 2014):

a. The number of LTC applications filed in each of the three months preceding the reported month;

b. The average monthly number of LTC applications filed with DSS based on the three months preceding the reported month;

c. The number of pending, overdue LTC applications as of the end of the reporting month, categorized as "excused" and "unexcused" pursuant to Paragraph 7.n. and, with respect to the report provided on May 15, 2014, Paragraph 18(c); and

d. The number of pending, unexcused and overdue LTC applications as of the end of the reporting month as a percentage of the average monthly number of LTC applications filed with DSS in the three months preceding the reported month.

A month's data is available approximately one week after the end of the reported month.

m. "**Long-Term Care**" or "**LTC**" means Medicaid funded (1) nursing facility care (not including hospital care) and (2) community-based services and supports provided under a Medicaid waiver.

n. "**Unusual Circumstances**" means a delay beyond the applicable standard of promptness (45 or 90 days) for Long-Term Care cases which will be considered "excused," and thus considered "unusual circumstances," only if:

(a) in the case of an applicant not currently receiving long-term care medical services, DSS (i) issued a W-1348 request for verification form, indicating the date of application and the date of issuance of the W-1348 form, within 10 days of the date of application, which request provided the applicant with 11 days to submit the requested documents, (ii) reviewed all documents subsequently submitted to it in support of the application within 10 days of receipt of such documents, which 10 day period commences on the date on which all requested verifications are received; and, within such 10 day period, issued any requests for additional documents determined to be needed; and (iii) in the case of a request to a third-party, has made such request within 10 days of the date that the need to request such verification first arose or within 10 days of the date that the applicant requested assistance in obtaining such information from the third-party, or

(b) in the case of an applicant who is currently receiving long-term care medical services, DSS (i) issued a W-1348 request for verification form, indicating the date of application and the date of issuance of the W-1348, within 15 days of the date the application was filed which provided the applicant with 11 days to submit the requested documents, (ii) reviewed all documents subsequently submitted to it in support of the application within 10 days of receipt of them, which ten day period commences on the date on which all requested verifications are received, and within such 10 day period issued any requests for additional documents determined to be needed, and (iii) in the case of a request to a third-party, has made such request within 10 days of the date the need to request such verification first arose or within 10 days of the date that the applicant requested assistance in obtaining such information from the third-party; and

(c) one of the following is also present:

i. The **Extension Granted (EX)** code is an excused delay code, used when

an applicant has not timely obtained verification of a factor of eligibility and the Department has granted the applicant an extension.

ii. The **Third Party Delay (TD)** code is an excused delay code used when the Department has requested verification from a third party, whether because the Department identified the need to obtain such verification or an applicant has requested the Department's assistance in obtaining such verification, and the department has not received verification.

iii. The **Insufficient Time (IT)** code is an excused delay code that can only be used for Medicaid applications and is used when the Department has had insufficient time to process verification. Insufficient time means less than 10 calendar days commencing on the date that the Department receives all requested verifications.

iv. The **More Verification (MV)** code is an excused delay code, used only when the Department has reviewed submitted verification and determined that the applicant needs to provide additional verification. A follow-up W-1348 must be sent before entering this code. The EMS notice will state: "You gave us information but we need more. Send us the rest of the information by the due date."

v. The **Emergency Event (EE)** code is an excused delay code, used when an administrative or other emergency beyond the Department's control causes a delay in processing an application. Workers are only to use this code when specifically instructed by DSS Central Office. The EMS notice will state "We will tell you soon if we need more information."

vi. "**Standard of Promptness**" means 45 days for all Medicaid applications except those where eligibility is based on disability, in which case it means 90 days.

III. Processing of Medicaid Applications

8. To the extent required by Paragraphs 15-19, Defendant shall determine and provide notice of an Applicant's eligibility for Medicaid within forty-five (45) days of the Date of Application, as required by 42 C.F.R. §435.912, implementing 42 U.S.C. §1396a(a)(8), except in circumstances where the applicant claims to be eligible for Medicaid because of a disability, in which case the application shall be processed within ninety (90) days of the Date of Application, as required by 42 C.F.R. §435.912, implementing 42 U.S.C. § 1396a(a)(8), or in the event of "unusual circumstances" as defined above in Paragraph 7.n.

9. Defendant acknowledges that, in order to ensure timely and accurate processing, applicants must be informed by DSS of any need to provide documentation to verify the eligibility requirements for the particular Medicaid program for which they are applying and for which they may be eligible. For this reason, Defendant shall make a good faith effort to insure that such verification requests (currently referred to as Form "W-1348") and requests to third parties are sent to, or on behalf of, all LTC and non-LTC (i.e., HUSKY A, HUSKY D, non-Long Term Care HUSKY C) applicants in a reasonably timely manner. Before issuing the W-1348, the DSS eligibility worker shall review the file and determine what verifications are required based upon a reasonably competent review of that file. The worker's determination of what verifications are required and requested in the W-1348 shall be based on the information contained in the case file at the time of the worker's review, and the worker shall only seek

documentation of matters relevant and material to the particular Medicaid program or programs for which the applicant is applying and for which the applicant may be eligible. All W-1348 verification requests sent out shall include, on the face of such request, the date that the application was filed, and the date that the verification request was issued.

10. All W-1348 verification requests to applicants shall be issued manually or through the ConneCT system (and not via EMS) and shall be mailed out no later than one business day from the date of issuance stated on the face of the W-1348 verification form.

11. All W-1348 verification requests shall allow the applicant no less than eleven (11) days from the date of issuance to return the documents requested in said W-1348 to the Department.

12. **Emergency Expedited Processing**. To facilitate the expedited processing of emergency Medicaid applications, Defendant will include information about the availability of expedited processing in a Medicaid Provider Bulletin that is issued to participating providers at least annually during the term of this Settlement Agreement, with the initial mailing occurring no later than thirty days after court approval of the Interim Agreement.

13. **Processing of Spend-Down Medical Bills**. In order to ensure prompt provision of medical assistance to individuals otherwise eligible for Medicaid but for excess income based on spend-down, Defendant has contracted with a third party vendor to process spend-down medical bills. DSS and this vendor have agreed that the vendor must act on medical bills submitted for spend-down purposes within five (5) business days or three (3) business days in the case of emergency processing of medical bills. DSS and this vendor have further agreed that the vendor has an additional three (3) business days to act if medical bills are submitted to a DSS regional office rather than directly to the vendor. Defendant will continue the contract with this

vendor, or another vendor, to process spend-down medical bills on the same terms in place with the third party vendor as of October; 2013 at all times for the duration of this Settlement Agreement. Alternatively, if DSS elects to process spend-down medical bills in-house utilizing DSS staff, DSS' processing of medical bills shall be subject to the same time standards, namely five (5) business days or three (3) business days in the case of emergency processing of medical bills. In addition, DSS would be entitled to an additional three (3) business days to process medical bills if the bills are submitted to a location other than the location designated by DSS to process medical bills.

14. To facilitate the processing of medical bills submitted by the members of the spend-down subclass by its contractor, Defendant shall prominently post notices on DSS websites and at all regional office drop boxes and reception desks advising that medical bills for spend-down purposes are not to be placed in such drop boxes and instead are to be mailed directly to the contractor for processing, and shall readily provide pre-paid envelopes for applicants to send medical bills directly to the contractor, at all regional offices and at the time any spend-down amount notice is provided to a spend down client.

IV. <u>Compliance</u>

15. Defendant shall be in full compliance with all federal requirements to promptly determine eligibility for Medicaid of each applicant for a Medicaid program, and to provide assistance to any such eligible applicant, as set forth in Paragraph 8, above, and Paragraphs 16 and 17 and 18.a., below, by the benchmark month of April, 2015; provided that Defendant shall be in full compliance with all obligations with respect to the number of pending overdue, unexcused LTC applications by the benchmark month of July, 2015 as specified in Paragraphs 17, 18.c., and 19 below.

16. Full Compliance for non-LTC Medicaid applications (i.e. HUSKY A, HUSKY D, non-Long Term Care HUSKY C) is defined, for purposes of this settlement agreement only, as occurring when (a) 92% of all applications filed in a given calendar month are processed within the applicable standard of promptness required by federal law, as measured by the Timeliness Reports, regardless of whether any untimely processed applications are deemed excused due to unusual circumstances or not; (b) the number of overdue applications pending at the end of the calendar month is not greater than 12% of the average number of applications submitted in a month based upon the three month period immediately preceding such month as measured by the Backlog Report; and (c) the percentage of applications timely processed does not differ between and among non-LTC eligibility programs (i.e. HUSKY A, HUSKY D, and non-LTC HUSKY C) by more than 5%.

17. Full Compliance for Medicaid LTC applications is defined, for purposes of this settlement agreement only, as occurring when (a) 92% of all LTC applications filed in a given calendar month are timely processed, as measured by the Timeliness Reports, unless excused by reason of unusual circumstances, as defined in Paragraph 7.n., above; and (b) the number of overdue, unexcused applications pending at the end of the calendar month is not greater than 16% of the average number of applications for the LTC program submitted in a month based upon the three months immediately preceding such month as measured by the Backlog Report, unless such percentage is modified pursuant to Paragraph 19.

18. **Interim Compliance:**

a. **Timeliness**: For each Benchmark Month listed below, DSS shall timely complete the processing of the designated percentage of filed applications as it works towards

achieving full compliance with the applicable standard of promptness. Specifically, with respect to the table set forth below, for data reported on DSS's monthly Timeliness Report for each Benchmark Month, DSS shall have achieved the stated percentage of Medicaid applications processed within the applicable standard of promptness, provided that, with respect to applicants for LTC, cases that were not timely processed by reason of unusual circumstances as defined in Paragraph 7.n. above shall count towards meeting the following benchmarks. Unusual circumstances will not be considered in determining compliance for non-LTC applications.

Non-LTC		LTC		Data Available
Benchmark Month	%	Benchmark Month	%	
Apr 2014	87	Apr 2014	60	August 15, 2014
Jul 2014	88	Jul 2014	75	November 15, 2014
Oct 2014	90	Oct 2014	80	February 15, 2015
Jan 2015	91	Jan 2015	88	May 15, 2015
Apr 2015 Benchmark Month - deadline for full compliance	92	Apr 2015 Benchmark Month – deadline for full compliance	92	August 15, 2015

b. **Overdue Non-LTC Cases**. For each Benchmark Month as stated in the table set forth below, the number of overdue non-LTC Medicaid applications pending as of the

end of the Benchmark Month (as set forth in DSS' monthly Backlog Report) shall not exceed the stated percentage as calculated by taking the number of overdue non-LTC Medicaid applications divided by the average number of applications filed per month within the three months preceding the Benchmark Month (as set forth in DSS' Backlog Report):

Benchmark Month	%	Data Available
Apr 2014	16	May 15, 2014
July 2014	15	August 15, 2014
Oct 2014	14	November 15, 2014
Jan 2015	14	February 15, 2015
April 2015 Benchmark month for full compliance deadline	12	May 15, 2015

c. **Overdue LTC cases**. By May 15, 2014, Defendant will provide Plaintiffs with the numbers of overdue LTC applications pending as of April 30, 2014, broken down by (a) the number of overdue pending LTC cases that DSS has not classified as being overdue by reason of unusual circumstances as defined in Paragraph 7.n. (i.e. "unexcused delays"); (b) the number of overdue pending LTC cases which DSS has classified as being excused by reason of unusual circumstances (i.e. "excused delays"); for purposes of this sub-paragraph, all LTC

applications filed before January 1, 2014 that are still pending as of April 30, 2014 shall be considered overdue, unexcused; and (c) the number of pending, unexcused and overdue LTC applications as of the end of April, 2014 as a percentage of the average monthly number of LTC applications filed with DSS in the three months preceding such month. The unexcused delay percentage identified in (c) will serve as a baseline measurement of unexcused, overdue pending LTC applications. No later than June 15, 2014, the parties will agree on quarterly benchmark goals by which to measure progress in bringing down the number of unexcused, overdue pending LTC applications that are overdue at the end of the months of July 2014, October 2014, January 2015, April, 2015, and July, 2015. Specifically, for each such Benchmark Month, the parties will agree to reduce the backlog of unexcused, overdue LTC applications pending as of the end of the Benchmark Month, to a designated percentage. Unless the parties otherwise agree, such reductions will be in roughly equal percentages with the goal that, as of the end of Benchmark Month July 2015, DSS will have achieved full compliance with respect to the percentage of pending unexcused, overdue LTC applications.

<u>Overdue, Unexcused LTC Applications Pending At End Of Calendar Month</u>

Benchmark Month	Goal	Data Available
July 2014	*	August 15, 2014
October 2014	*	November 15, 2014
January 2015	*	February 15, 2015
April 2015	*	May 15, 2015
July 2015 (Benchmark Month for Full Compliance Deadline)	16%**	August 15, 2015

*Interim compliance goals shall be negotiated by the parties following the receipt of data in accordance with the provisions of paragraph 18.c.

**The full compliance goal of overdue, unexcused LTC applications pending at the end of a calendar month, stated as a percentage of the average number of LTC applications filed per month in the three prior months, may be subject to negotiation pursuant to Paragraph 19, below.

19. **Potential Modification of LTC Backlog Full Compliance Goal**

At any time after January 1, 2015, but prior to October 1, 2015, Defendant may move the Court for a modification of the full compliance goal for the number of overdue, unexcused LTC applications that are pending at the end of the month, stated as a percentage of the average number of LTC applications filed in a month based on an average of the number of LTC applications filed in the three prior months. The Defendant may only file such motion if the Defendant is in compliance with the LTC timely application processing goal for the Benchmark Month immediately preceding the date of such motion to modify, as established pursuant to paragraphs 17 and 18.a; provided that, if Defendant does not meet the full compliance timeliness goal for the Benchmark Month of April 2015, but meets that full compliance goal for applications filed in the month of May 2015, Defendant may file the motion based on such compliance. At least two weeks before Defendant files any such motion, the parties will confer and attempt to reach agreement on whether modification of the full compliance LTC backlog goal is appropriate. If the parties cannot reach agreement and such a motion is filed, the Defendant shall have the burden of demonstrating, by the preponderance of the evidence, that modification is appropriate for good cause shown.

20. The Defendant shall make reasonable efforts to ensure that, for each Benchmark Month listed above and thereafter:

(a) the percentage of applications timely processed does not significantly deviate without substantial justification between or among offices or regional processing centers, if the Department is not processing applications through a central system. Plaintiffs have the right to seek relief in the event that there is a significant deviation in the number of applications timely processed at one or more offices or regional centers that is without substantial justification; and

(b) the percentage of applications timely processed shall not differ between and among non-LTC programs (i.e. HUSKY A, HUSKY D, and non-LTC HUSKY C) by more than 5%.

V. **Enforcement**.

21. Subject to the requirements of Paragraphs 3 and 32 related to approval by the Connecticut legislature, if necessary, and upon approval of this Agreement by the Court, this Agreement shall be entered as an Order of the Court and the parties contemplate that the Court shall have jurisdiction to enforce its terms for the duration of the Agreement and any extension.

22. Nothing herein shall preclude Plaintiffs from moving for contempt, enforcement or modification of this Settlement Agreement based upon a showing of substantial non-compliance with the requirements of this Settlement Agreement. In the event that Plaintiffs move for contempt, enforcement, or modification of this Settlement Agreement, it shall not be a defense to Defendant's noncompliance with any percentage requirements with respect to non-LTC applications that any or all of the untimely processed applications are or were excused by "unusual circumstances".

23. Prior to moving for contempt, enforcement, or modification of this Settlement Agreement, Plaintiffs shall first provide thirty (30) days' written notice to Defendant specifically detailing the factual basis for the claimed non-compliance. Plaintiffs shall meet with Defendant to discuss and to attempt to resolve in good faith any claimed non-compliance no fewer than 20 days after the provision of the written notice required by this paragraph before filing any such motion for contempt, enforcement or modification of this Settlement Agreement.

VI. Monitoring

24. **Reporting to be provided**. By the 15th day of each calendar month and for each month during the term of this Settlement Agreement, Defendant shall provide Plaintiffs' counsel or their designated representatives with the following reports:

a. Timeliness Reports, as defined in Paragraph 7.k., including both timeliness data for all Connecticut Medicaid programs and data for each Medicaid program with HUSKY C also broken down by LTC and non-LTC HUSKY C cases. All LTC case data will also be broken down by individual DSS offices or regional processing centers to the extent such offices or regional centers are used by DSS to process applications, as will data for any other Medicaid programs should they be processed on an office or regional processing center basis.

b. Intake Reports, as defined in Paragraph 7.j.

c. EMS Application Length Pending Reports, as defined in Paragraph 7.i.

d. Backlog Reports, as defined in Paragraph 7.l.

25. **Monitoring of Unusual Circumstances/Excused Delay Codes for Long-Term Care Applications**.

a. DSS shall periodically monitor the accuracy of its LTC "unusual circumstances/excused delay" determinations using its own Quality Assurance staff as reviewers. Case reviews shall be based upon a sampling of LTC cases where delay was determined to be excused by "unusual circumstances" and shall include determinations of whether the case was properly classified as "excused" based on the criteria established in Paragraph 7.n.. Such reviews shall be conducted quarterly commencing in August, 2014, when timeliness data is available for the first interim timeliness benchmark month of April 2014 and "backlog" data is available for the first interim LTC backlog benchmark month of July 2014. Reports of such quarterly monitoring reviews shall be issued to Plaintiffs' counsel commencing on the fifteenth day of October, 2014, and shall be provided to Plaintiffs' counsel by the 15th day of every third month thereafter.

b. For good cause shown, Plaintiffs may petition the Court for one or more outside audits of the accuracy of the Department's LTC "unusual circumstances/excused delay" determinations (including whether the case was properly classified as "excused"), at the Department's expense, including sampling and review of individual case files by a third party pursuant to appropriate confidentiality agreements, under a methodology to be agreed to by the parties or, if agreement cannot be reached, to be Ordered by the Court.

VII. <u>Termination of Settlement Agreement</u>

26. (a) This Settlement Agreement shall remain in full force and effect until July 1, 2017.

(b) Notwithstanding Paragraph 26(a) of this Settlement Agreement, Defendant shall be entitled to move, no earlier than March 1, 2016, to terminate the Settlement Agreement and dismiss the action earlier than July 1, 2017 if he can demonstrate that DSS has achieved full

compliance for eight (8) of any twelve (12) consecutive months after full compliance has been achieved for at least three (3) consecutive months and is in substantial compliance with all other provisions of this Settlement Agreement.

(c) Notwithstanding Paragraphs 26(a) or 26(b) of this Settlement Agreement, Plaintiffs shall be entitled to move, between May 15, 2017 and June 15, 2017, to extend the terms of this Agreement for a specified time period if Defendant has not substantially complied with the requirements of this Agreement. Nothing in this paragraph shall be construed to be any limitation on the ability of the parties to negotiate changes to the provisions of this Settlement Agreement during the term of this Settlement Agreement.

VIII. Attorneys' Fees and Costs

27. The parties herein agree that Defendant shall pay Plaintiffs' counsel the amount of three hundred and twenty thousand dollars ($320,000) which represents the sum total of attorneys' fees and costs that Plaintiffs seek in this action, except that Plaintiffs may, in the absence of any separate agreement among the parties addressing such fees, petition the Court for an award of attorneys' fees incurred from the date of the signing of this Settlement Agreement until the date the agreement is approved by the Court and any necessary legislative approvals have been obtained.

28. After this Settlement Agreement is finally approved by both this Court and the Connecticut state legislature pursuant to Conn. Gen. Stat. § 3-125a, Plaintiffs' counsel shall not be entitled to any additional fees for monitoring Defendant's compliance with the requirements of this Agreement, and shall only be entitled to additional fees if they file a motion alleging substantial non-compliance seeking additional relief or an extension of the terms of this Agreement and substantially prevail on said motion by judicial adjudication or by a negotiated

agreement of the parties, enforcing, modifying or extending the terms of this Settlement Agreement.

IX. Approval of Agreement

29. Upon execution of this Agreement, the parties shall promptly notify the District Court of such execution and request the Court to enter an order certifying a class, for purposes of the above-captioned litigation, consisting of all current and future applicants for Medicaid and all individuals eligible for Medicaid but subject to a spend-down, in Connecticut, as defined in Plaintiffs' pending Motion for Class Certification.

30. All of the parties' obligations under this Settlement Agreement are conditioned upon the Court's certification of a plaintiff class that is broad enough to include, at a minimum, all such applicants and all such eligible individuals.

31. Within 30 days of execution of this Agreement, the parties shall file this Settlement Agreement with the District Court and request that the Court enter an order:

a. preliminarily approving the proposed settlement as fair, reasonable, and adequate;

b. scheduling a final hearing to determine the fairness, reasonableness, and adequacy of the proposed settlement and whether the Court should approve the Settlement Agreement; and

c. approving a class action notice containing a summary of the settlement terms, the date of the final hearing, and information regarding the right to comment or object, which notice shall be posted, in English and Spanish, on the homepages of the websites for the Department of Social Services www.ct.gov/dss and New Haven Legal Assistance Association, www.nhlegal.org, and in DSS's regional offices, and such other places as agreed by the parties

and approved by the Court, or as ordered by the Court in the absence of agreement between the parties.

d. Between the signing of this Settlement Agreement and the fairness hearing, DSS shall direct all inquiries regarding the Settlement Agreement from class members to Plaintiffs' counsel.

32. If the Attorney General determines that legislative approval of the proposed settlement is required pursuant to Conn. Gen. Stat. § 3-125a, any final approval of the proposed settlement shall be conditional, subject to the approval by the Connecticut state legislature, if such approval had not yet been obtained. Any approval by the Court will be of no force or effect unless and until the requisite legislative approval is obtained.

33. Nothing in this action or this Settlement Agreement concerns the timeliness of processing of Medicaid redeterminations. In the event Plaintiffs bring a separate action against the Department for any claims related to the processing of Medicaid redeterminations, nothing herein shall serve as a res judicata, collateral estoppel or other bar to obtaining relief in such separate action.

Plaintiffs, by Undersigned, Authorized
Counsel of Record

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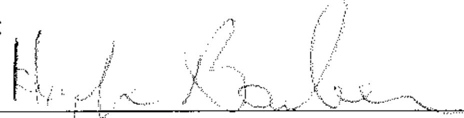
Counsel of Record

BY:



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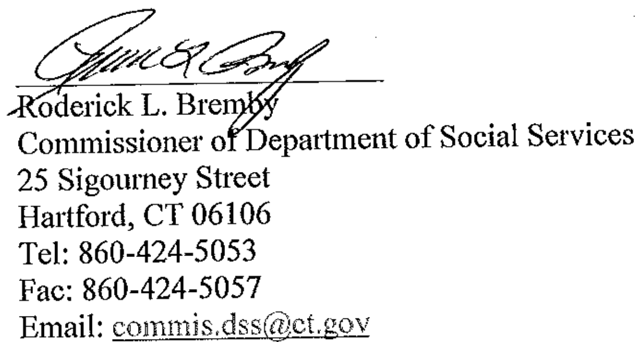

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