"Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

RELEASE DATE:

June 29, 2020

PROPOSAL DUE DATE:

July 27, 2020

IMPORTANT NOTICE: A Restricted Period under the Procurement Lobbying Law is currently in effect for this Procurement and it will remain in effect until State Comptroller approval of the resultant Contract. During the Restricted Period for this Procurement ALL communications must be directed, in writing, solely to the Designated Contact as listed in Section 2 of these Specifications and shall be in compliance with the Procurement Lobbying Law and the NYS Department of Civil Service "*Rules Governing Conduct of Competitive Procurement Process*" (refer to Specifications, Section 2: Procurement Protocol and Process).

All inquiries, questions, filings and submission of Proposals must be directed in writing to:

New York State Department of Civil Service
Attn: Office of Financial Administration, Floor 17
Agency Building 1, Empire State Plaza
Albany, New York 12239
DCSprocurement@cs.ny.gov

Lola Brabham
Acting Commissioner
NYS Department of Civil Service

James DeWan
Director
Employee Benefits Division

TABLE OF CONTENTS

SECTION 1: INTRODUCTION

1.1 Purpose

The New York State Department of Civil Service (Department or DCS) in consultation with the Joint Labor Management Committee (JLMC), has issued these Specifications to secure the services of qualified Health Maintenance Organizations (HMOs) for participation in the New York State Health Insurance Program (NYSHIP).

The Department expects to award Contracts to multiple qualified HMOs as a result of these Specifications.

These Specifications and other relevant information may be reviewed at https://www.cs.ny.gov/HMO2021/

1.2 Period of Performance

The initial Contract(s), issued as a result of this solicitation, will be for a term of five years beginning January 1, 2021 and ending December 31, 2025, subject to the approval of the New York State Attorney General's Office (AG) and the New York State Office of the State Comptroller (OSC).

For purposes of this Contract, the "Effective Date" is defined as January 1st of the initial year of the Contract.

1.3 Annual Periodic Recruitment of HMOs

The Department reserves the right, in consultation with the JLMC, to evaluate and award contracts to additional HMOs as described herein. Any Contract awarded after January 1, 2021, will commence on the 1st day of January in the subsequent year the contract is awarded or at any time deemed to be in the best interests of the State, and end on December 31, 2025. Such Contracts will be subject to the approval of the Contract by the AG and the OSC. HMOs interested in participating shall be required to submit a Proposal which shall be evaluated under the original Specification's requirements. An addendum containing additional applicable statutory requirements in effect at the time of the periodic recruitment period may be added to the original Specification's requirements.

1.4 Overview of the New York State Health Insurance Program

NYSHIP was established by the New York State Legislature in 1957 to provide essential health insurance protection to eligible New York State (NYS) employees, retirees, and their dependents. Public authorities, public benefit corporations, and other quasi-public

entities, such as the NYS Thruway Authority and the Dormitory Authority, may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). NYS Civil Service Law section 163 also allows local units of government such as school districts, municipal corporations, and special districts (examples include water districts, fire districts, and library districts) to participate in NYSHIP. Local government units which choose to participate in NYSHIP are called Participating Agencies (PAs).

NYSHIP is sponsored by the Council on Employee Health Insurance (Council). The Council is composed of the President of the Civil Service Commission, the Director of the Governor's Office of Employee Relations (GOER), and the Director of the Division of the Budget (DOB).

NYSHIP is currently comprised of the following health insurance plans:

1. The Empire Plan provides health insurance benefits for the employees, retirees and eligible dependents of New York State; and NYSHIP PAs and PEs. It pays for covered hospital services, physicians' bills, prescription drugs, and other covered medical expenses. The Empire Plan, which became fully self-funded as of January 1, 2014, has the highest level of enrollment with over a million covered lives of the approximate 1,241,000 NYSHIP enrollment. Presently, the Empire Plan benefit design consists of four (4) main components that are currently administered under separate Contracts:

    a. Hospital Program benefits, administered by Empire BlueCross, include coverage for hospital inpatient stays, hospice care, emergency care, skilled nursing facilities, and the Transplants Program.

    b. Medical Program benefits, administered by UnitedHealthcare Insurance Company of New York, include coverage for medical and surgical services under the Participating Provider and the Basic Medical Program. Coverage also includes specialty programs such as the Managed Physical Medicine Program and the Home Care Advocacy Program (HCAP).

    c. Mental Health and Substance Abuse Program benefits, administered by Beacon Health Options, include coverage for network and non-network services.

    d. Prescription Drug Program benefits, administered by CVS Caremark, include coverage for prescription drugs dispensed through retail network pharmacies, the Mail Service Pharmacy, and the Specialty Pharmacy Program.

2. The Excelsior Plan is a variation of the Empire Plan available to NYS local government units which choose to participate in NYSHIP. The Excelsior Plan offers many of the same features of the Empire Plan with a higher degree of cost-sharing between the employer and plan participants.

3. HMOs are offered as an alternative to coverage under the Empire Plan. The NYSHIP HMO options are available to State employees and Participating Employers (PEs). The Department requires that the HMO services offered be a community-based premium product, or a Center for Medicare and Medicaid Services (CMS)-approved Medicare Advantage Plan for Medicare-Primary Enrollees. The State currently offers 16 HMO options from 7 different insurers.

4. The Student Employee Health Plan (SEHP) is a health insurance plan for graduate student employees of the State University of New York system that provides benefits through the various Empire Plan insurance contracts. Like the Empire Plan, the SEHP includes hospital, medical, managed mental health and substance abuse benefits, and prescription drug benefits. SEHP is administered by the Department's Employee Benefits Division.

All plans are offered on a calendar year basis. Enrollees may elect either Individual or Family coverage; NYSHIP does not offer coverage based on the number of Dependents, (e.g. Enrollee plus one Dependent, Enrollee plus two Dependents, etc.), nor does NYSHIP permit Dependents to be enrolled in a different NYSHIP health plan than the Enrollee. NYSHIP enrollment in either the Empire Plan or an HMO is available at the time of initial employment in a benefits eligible position, subject to a waiting period, and thereafter, subject to a late enrollment waiting period. NYSHIP has an annual Option Transfer Period during which Enrollees may change their existing health benefit option for the next Plan Year. Retired employees may change their health benefit option once every twelve months without regard to the Option Transfer Period. Employer, Employee and Retiree premium contribution rates can be found in the *Employer Premium Contribution Rates* (Attachment 18). Further, Civil Service Law Article XI directs the President of the Civil Service Commission to purchase contracts for insurance to provide health benefits provided pursuant to that Article. Pursuant to this authority the Department contracts with HMOs to provide health benefits for participation in NYSHIP.

The number of NYSHIP Enrollees by county is presented in *NYSHIP Enrollment Statistics* (Attachment 17). HMOs may use these counts as an estimate of the number of Enrollees that may choose to enroll in an HMO during the Option Transfer Period. Currently, 16.16% of State and Participating Employers' NYSHIP Enrollees are enrolled in HMOs.

The JLMC is a committee consisting of representatives of the State's collective bargaining units, the Department, and GOER which is charged with the responsibility to cooperatively develop and oversee administration of health care programs for State-represented employees and to make mutually agreed upon changes to health plan benefits.

1.5 Offeror Eligibility

Offeror means any responsible and eligible entity submitting a responsive Proposal to these Specifications. It shall be understood that references in the Specifications to "Offeror" shall include an entity's proposed Subcontractor or Affiliates (as defined in Section 4.3 of these Specifications), if any. The Department and the JLMC request Proposals only from qualified Offerors, as specified below.

1. The Offeror must, at time of Proposal submission and throughout the term of the Contract, possesses the legal capacity to enter into a Contract with the Department.

2. The Offeror, at time of Proposal submission and throughout the term of the Contract, must:

    a. Be licensed as an insurer under Articles 42 or 43 of New York State Insurance Law or certified under Article 44 of New York State Public Health Law, in good standing, and in compliance with state solvency requirements; and

    b. If applicable, be certified/licensed in accordance with the certification and oversight jurisdiction imposed by another state.

3. The Offeror, at time of Proposal submission, must represent and warrant that it has been in operation as a going concern at least two (2) years prior to the Proposal Due Date set forth in Section 1.6 of these Specifications.

4. The Offeror, at time of Proposal submission and throughout the term of the Contract, must be accredited by the National Committee on Quality Assurance (NCQA) and/or Utilization Review Accreditation Committee (URAC).

5. The Offeror must provide a copy of their current Department of Health (DOH) Certificate of Authority to operate as an HMO under Articles 42 or 43 of New York State Insurance Law or Article 44 of New York State Public Health Law, for its requested Service Area, on or before the Tentative Contract Award date set forth in Section 1.6 of these Specifications.

6. The Offeror must agree to accept all determinations of eligibility as made by the Department and must provide a rider that provides identical coverage criteria to the NYSHIP eligibility criteria presented in the *2020 NYSHIP Dependent Eligibility Rider* (Attachment 19).

7. The Offeror must agree to use any enrollment data transmission protocol and encryption method stipulated by the Department. The current data transmission protocol must be Secure FTP, and the current encryption methodology must be PGP or as otherwise specified by the Department. Secure FTP must be compatible with the Open SSH implementation of Secure FTP. Further, the HMO must agree to comply with the Department's *Information Security*

Requirements (Appendix C) including any additional protocols required by the Department to ensure the security of its data transmissions.

8. The Offeror must provide coverage to both NYSHIP primary and Medicare primary enrollees and dependents that comply with the requirements of the Specifications throughout the term of the Contract. If the HMO has an approved Medicare Advantage Plan with Part D coverage in a Commercial Plan service area it MUST offer the Medicare Advantage Plan to Medicare primary enrollees. HMOs cannot offer a Plan that provides coverage to Medicare eligible enrollees only.

9. The Offeror must accept signed and valid *NYSHIP Authorization for Release of Protected Health Information* forms (Attachment 27), or any alternative form developed by the Department, for the purpose of the release of Protected Health Information to Enrollees' designees.

1.6 Timeline of Key Events

EVENT	DATE
Specifications Release Date	June 29, 2020
Deadline for Submission of Offeror Affirmation of Understanding	See below*
Deadline for Submission of Offeror Questions	July 9, 2020
Deadline to Submit Notice of Intent	July 9, 2020
Release Date of Official Responses to Offeror Questions	July 14, 2020
Proposal Due Date and Time	July 27, 2020 (3:00 p.m. ET)
Tentative Contract Award	August 14, 2020
Contract Start Date	January 1, 2021

*Prior to the Offeror's initial contact with the Department, the Offeror must complete and submit *Offeror Affirmation of Understanding and Agreement* (Attachment 1) to the Designated Contact identified in Section 2 of these Specifications.

SECTION 2: PROCUREMENT PROTOCOL AND PROCESS

2.1 Rules Governing Conduct of Competitive Procurement Process

All inquiries, questions, filings and submission of Proposals in regard to the Specifications must be directed, in writing to the contact information listed below. Proposals may not be submitted by e-mail or facsimile. Any inquiries, questions, filings or submission of Proposals that are submitted to any other contact or physical address shall not be considered as official, binding or as having been received by the Department.

1. Designated Contact

In accordance with State Finance Law § 139-j(2)(a) (Procurement Lobbying Law (PLL)), the following individual is the Designated Contact for this Solicitation. All questions relating to this Solicitation must be addressed to the following Designated Contact.

Brian Bopp
New York State Department of Civil Service
Attn: Office of Financial Administration, Floor 17
Agency Building 1, Empire State Plaza
Albany, New York 12239
DCSprocurement@cs.ny.gov

2. Restrictions on Contacts Between Offerors and State Staff During the Procurement Process

a. Pursuant to State Finance Law sections 139-j and 139-k, this Procurement imposes certain restrictions on communications between the Department and an Offeror during the procurement process. An Offeror is restricted from making contacts from the earliest posting, on the Department's website, in a newspaper of general circulation, or in the procurement opportunities newsletter in accordance with Article four-C of the Economic Development Law, of written notice, advertisement or solicitation of a request for Proposal, invitation for bids, or solicitation of proposals, or any other method provided for by law or regulation for soliciting a response from Offerors intending to result in a Contract with the Department through final award and approval of the Contract by the Department and, if applicable, the Office of the State Comptroller to other than the Designated Contact (unless it is a Contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a)). This time period is defined as the Restricted Period. The Designated Contact for this procurement is set forth in section 2.1(1) of these Specifications. Staff is required to obtain certain information from an Offeror whenever contacted about the procurement during the restricted period and is required to make

a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutory requirements. Certain findings of non-responsibility can result in rejection for Contract award and in the event of two findings within a 4-year period, the Offeror is debarred from obtaining governmental Procurement Contracts. The Department's policy and procedures can be found in the *Procurement Lobbying Policy* (Attachment 2). Further information about these requirements can be found at: https://www.ogs.ny.gov/ACPL/.

b. The Department strictly controls communications between any Offeror and participants in the procurement process. "Offeror" means the individual or entity, or any employee, agent or consultant or person acting on behalf of such individual or entity, who contacts the Department about a governmental procurement during the restricted period of such governmental procurement whether or not the caller has a financial interest in the outcome of the procurement; provided however, that a governmental agency or its employees that communicate with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document.

3. Submission of Errors or Omissions in this Specifications Document

By participating in activities related to these Specifications, and/or by submitting a Proposal in response to these Specifications, an Offeror agrees to be bound by its terms, including, but not limited to, this process by which an Offeror may submit errors or omissions for consideration. If an Offeror believes there is an error or omission in these Specifications, the Offeror may raise such issue as follows:

a. Process for Submitting Assertions of Errors or Omissions in RFP Document

i. *Time Frame:* Assertions of errors or omissions in the RFP process which are or should have been apparent prior to the Proposal Due Date must be received by the Department, in writing, five (5) Business Days after the Release Date of Official Responses to Questions specified in Section 1.6 of these Specifications. Business Day(s) means every Monday through Friday, from 9 a.m. to 5 p.m. ET, except for days designated as state holidays by the Department.

ii. *Content:* The submission alleging the error or omission must clearly and fully state the legal and/or factual grounds for the assertion and must include all relevant documentation.

iii. *Format of Submission:* All submissions asserting an error or omission must be in writing and submitted to the Designated Contact in hard copy at the address provided in Section 2 of these Specifications.

The envelope or package must clearly and prominently display the following statement:

"Submission of Errors or Omissions for the Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

Any assertion of an error or omission which does not conform to the requirements set forth in this section shall be deemed waived by the Offeror and the Offeror shall have no further recourse.

b. **The Review Process for Assertions of Errors or Omissions in RFP**

The Department shall conduct the review process for submission of errors or omissions. The Commissioner may appoint a designee who will review the submission and make a recommendation to the Commissioner as to the disposition of the matter. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner or designee.

The Commissioner or designee shall review the matter, and the Commissioner shall issue a written decision within twenty (20) Business Days after the close of the review process. If additional time for the issuance of the decision is necessary, the prospective Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the agency's final determination in the matter.

The Department reserves the right to determine and to act in the best interests of the State in resolving any assertion of error or omission in these Specifications document. The Department may elect to extend the Proposal Due Date as may be appropriate. Notice of any such extension will be provided to all organizations who provided an email address on the submitted *Offeror Affirmation of Understanding and Agreement* form (Attachment 1). Notice of any extension will also be posted to: https://www.cs.ny.gov/HMO2021/

4. Submission of Questions

Using the *Questions Template* (Attachment 4), a prospective Offeror may submit questions concerning the content of these Specifications via email to the Designated Contact's address specified in Section 2 of these Specifications. Only those questions received prior to the Questions Due Date specified in Section 1 of these Specifications, will be accepted. After the Questions Due Date, the Department will provide an email notification of the posting of all questions and the Department's official answers to all those individuals who provided an email address on the submitted *Offeror Affirmation of Understanding and Agreement* form (Attachment 1), the *Questions Template* (Attachment 4), the *Notice of Intent* (Attachment 28) and those individuals who register to attend the pre-proposal conference (if any). The questions and answers will also be posted to: https://www.cs.ny.gov/HMO2021/.

5. Submission of Proposal

a. The Offeror's Proposal must be organized and separated into (2) separate sections: Administrative Proposal; and Technical Proposal. To facilitate the evaluation process, an Offeror must follow the submission requirements described below:

   i. One ORIGINAL hard copy and thirteen (13) hard copy versions of each of the two (2) sections of the Specifications, separated into Administrative, and Technical sections.

   ii. Each ORIGINAL hard copy of each section must be marked "ORIGINAL," contain original signatures of an official(s) authorized to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature. The remaining hard copies of each section may contain a copy of the official's signature on all forms submitted that require the Offeror's signature and should be numbered sequentially (i.e., Copy #1, Copy #2).

   iii. A master electronic submission containing all of the ORIGINAL hard copy sections of the proposal must be provided on searchable Adobe Portable Document Format (PDF) electronic media. Electronic media shall be included on unprotected Microsoft Windows formatted USB 2.0 or higher storage drive and must be clearly labeled by proposal section and identified as the master electronic submission. In situations where proposal content differs between the ORIGINAL bound hard copies and the master electronic submission, the master electronic submission is deemed controlling.

iv. The Offeror must submit sixteen (16) additional USB drives, which each contain an electronic copy of the Administrative and Technical Proposal ONLY. The USB drives must conform to the technical specifications outlined in Section 2 of these Specifications. Each of the sixteen electronic copies should be labeled by section and uniquely designated with a number (e.g. "TECHNICAL & ADMINISTRATIVE COPY 1", "TECHNICAL & ADMINISTRATIVE COPY 2, etc."). The sixteen (16) USB drives should be packaged in the sealed box/envelope labeled Administrative Proposal.

v. Each Proposal must include a table of contents.

vi. Each major section of the Proposal, including attachments, must be labeled with an index tab that completely identifies the title of the section, subsection or attachment as named in the table of contents.

vii. Each page of the Proposal, including attachments, must be labeled on the upper right with the Offeror name, applicable Section reference, page number and date. Pages must be numbered consecutively.

viii. Each Proposal must be submitted in binders so that any new/replacement pages required by the Department can be easily incorporated into the binders. The Offeror name, the Proposal Due Date, and "2021 HMO Submission" must appear on the outside cover and on the spine of each binder.

ix. Each electronic Attachment must be a separate searchable PDF document. Each Certificate or Rider must be a separate searchable PDF document. Each electronic document must be clearly named with the specific corresponding file title.

b. Proposals should be placed and packaged together, by section, in sealed boxes/envelopes (i.e., all Administrative Proposals in one box, all and Technical Proposals in a second box). Each sealed box/envelope should contain a label on the outside which contains the information below.

New York State Department of Civil Service
"Health Maintenance Organizations
Specifications for the New York State Health Insurance Program"
OFFEROR NAME
OFFEROR ADDRESS

Indicate content, as applicable

c. All Proposals must be mailed or hand-delivered to the address provided in Section 2.1(1) of these Specifications. To make arrangements for hand-delivery, the Offeror must notify the Designated Contact twenty-four (24) hours prior to delivery. All Proposals must be received by 3:00 p.m. ET on the Proposal Due Date as set forth in Section 1.6 of the Specifications.

d. Any proposal received after 3:00 p.m. ET on the Proposal Due Date, as specified in Section 1.6, shall not be accepted by the Department and may be returned to the submitting entity at the Department's discretion. All Proposals submitted become the property of the Department.

e. The Department will accept amendments and/or additions to an Offeror's Proposal if the amendment and/or addition is received by the Proposal Due Date. All amendments to an Offeror's Proposal must be submitted in accordance with the format set forth in Section 2.1(5) of these Specifications and will be included as part of the Offeror's Proposal. All such amendments must reference the page number(s) from the original Proposal that are being replaced, show the date of the revision and indicate the portion of the page being changed. The PDF version of the replacement pages must be named in the same manner described in Section 2.1(5)(a)(vii).

f. An Offeror is solely responsible for timely delivery of the Proposal to the Department prior to the Proposal Due Date stated in Section 1.6 of these Specifications. Delays in United States mail deliveries or any other carrier, including couriers or agents of New York State, shall not excuse late bid submissions. If the Proposal is delivered by mail or courier, the Department recommends that it be sent "Returned Receipt Requested", so the Offeror obtains proof of timely delivery. No phone, facsimile or e-mail submission of Proposals will be accepted for these Specifications. In addition, it is the sole responsibility of the Offeror to verify that all elements of the Proposal submission are complete, correct and without error.

g. After the Bid Opening, the Department will promptly provide copies of all Proposals to the *JLMC Contact Members* (Attachment 13).

6. Bid Deviations

a. The Department will not entertain bid deviations to *Standard Clauses for New York State Contracts* (Appendix A). The Department will also not entertain material and substantive bid deviations to the solicitation to *Standard Clauses for All Department Contracts* (Appendix B) and *Information Security Requirements* (Appendix C). NYS law precludes awarding a Contract based on material deviation(s) from the

specifications, terms, and/or conditions set forth in the solicitation. Therefore, Proposals containing a bid deviation (including additional, inconsistent, conflicting or alternative terms) that are a material and substantive change from the specifications, terms, and conditions set forth in the solicitation may render the Proposal non-responsive and may result in rejection of the Proposal.

b. If Offeror has an issue or concern regarding provisions in the solicitation and is considering submission of a proposal containing a bid deviation, Offeror is strongly advised to raise such issues and/or concerns during the question and answer period so that the Department may give due consideration to the issue prior to the submission of Proposals. Failure to use the question and answer period and instead submitting a Proposal containing a bid deviation could render the entire Proposal non-responsive and rejected in its entirety.

c. In general, a material and substantive bid deviation is one that would (i) impair the interests of New York State, (ii) place the successful Offeror in a position of unfair economic advantage, (iii) place other Offerors at a competitive disadvantage, or (iv) which, if it had been included in the original solicitation, could have formed a reasonable basis for an otherwise qualified Offeror to change its determination concerning the submission of a Proposal. For example, a deviation that would substantially shift liability (risk) or financial responsibility from the Offeror to New York State would be considered material.

d. An Offeror is further advised that its standard, pre-printed material (including but not limited to product literature, order forms, manufacturer's license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Offeror's Proposal, unless specifically required by the solicitation to be submitted as part of the Offeror's Proposal, are not considered as having been submitted with or intended to be incorporated as part of the official offer contained in the Proposal. Rather, such material shall be deemed by the Department to have been included by Offeror for informational or promotional purposes only.

e. To submit a non-material bid deviation, an Offeror must complete and submit the proposed deviation(s) using the *Non-Material Deviations Template* (Attachment 8), as part of the Administrative Proposal. If a non-material bid deviation does not meet these requirements, it shall not be considered by the State and shall be rejected.

f. An Offeror who does not submit the *Non-Material Deviations Template* (Attachment 8), as part of the Administrative Proposal is presumed to have no bid deviations.

7. Notification of Tentative Contract Award

A tentative award letter will be sent to the selected Offerors indicating a tentative award subject to successful Contract negotiations and approval by OSC.

8. Debriefing

Unsuccessful Offerors will be advised of the opportunity to request a Debriefing and the timeframe by which such requests must be made. Debriefings are subject to the *NYS Department of Civil Service Debriefing Guidelines* (Attachment 5). An unsuccessful Offeror's written request for a debriefing shall be submitted to the address provided in Section 2 of these Specifications.

9. Submission of a Protest

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to these Specifications, an Offeror agrees to be bound by its terms including, but not limited to, the process by which an Offeror may submit a protest of a non-responsive determination or the selection award for consideration. In the event the Offeror elects to submit a protest of a non-responsive determination, the Offeror agrees it shall not be permitted to also submit a protest on the selection decision. In the event that an Offeror decides to submit a protest, the Offeror may raise such issue according to the following provisions.

a. Process for Submitting a Protest of a Non-Responsive Determination or a Selection Decision

i. Time Frame*:* Any protest must be received no later than ten (10) Business Days after an Offeror's receipt of written notification by the Department of a non-responsive determination or tentative award.

ii. Content: The protest must fully state the legal and factual grounds for the protest and must include all relevant documentation.

iii. Format of Submission: The protest must be in writing and submitted to the Designated Contact at the address provided in Section 2 of these Specifications.

iv. A protest of either a non-responsive determination or a selection decision must have one of the following statements clearly and prominently displayed on the envelope or package:

"Submission of Non-Responsive Determination Protest for Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

OR

"Submission of Tentative Award Protest for Health Maintenance Organizations Specifications for the New York State Health Insurance Program"

v. Any assertion of protest which does not conform to the requirements set forth in this section shall be deemed waived by the Offeror, and the Offeror shall have no further recourse.

b. **Review of Submitted Protests**

i. The Department shall conduct the review process of submitted protests. The Department's Commissioner may appoint a designee to review the submission and to make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Department but, in any event, shall be someone who has not participated in the preparation of these Specifications, the evaluation of Proposal, the determination of non-responsiveness, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee, to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. The Department shall be represented by counsel at such meeting. Any issues concerning the way the review process is conducted shall be determined solely by the Commissioner, or the Commissioner's designee.

ii. The Commissioner, or the Commissioner's designee, shall review the matter, and shall issue a written decision within twenty (20) Business Days after the close of the review process. If additional time is necessary for the issuance of the decision, the Offeror shall be advised of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the Department's final determination in the matter.

iii. If an Offeror protests the selection decision or a non-responsive

determination, the Department shall continue Contract negotiations regarding the terms and conditions of the Contract with the selected Offeror.

10. Department of Civil Service Reservation of Rights

In addition to any rights articulated elsewhere in these Specifications, the Department and the JLMC reserve the right to:

a. Make or not make an award under the Specifications, either in whole or in part;

b. Prior to the bid opening, amend the Specifications. If the Department elects to amend any part of these Specifications, such amendments will also be posted to: https://www.cs.ny.gov/HMO2021/;

c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent Specifications amendments;

d. Withdraw these Specifications, at any time, in whole or in part, prior to OSC approval of award of the Contract;

e. Waive any requirements that are not material;

f. Disqualify any Offeror whose conduct and/or Proposal fails to conform to any of the mandatory requirements of these Specifications;

g. Require clarification at any time during the Procurement process and/or require correction of apparent errors for the purpose of assuring a full and complete understanding of an Offeror's Proposal and/or to determine an Offeror's compliance with the requirements of these Specifications;

h. Reject any or all Proposals received in response to these Specifications;

i. Change any of the scheduled dates stated in these Specifications;

j. Seek clarifications and revisions of Proposals;

k. Establish programmatic and legal requirements to meet the Department's needs, and to modify, correct, and/or clarify such requirements at any time during the Procurement, provided that any such modifications would not materially benefit or disadvantage any particular Offeror;

l. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the Offerors;

m. For the purposes of ensuring completeness and comparability of the Proposals, analyze submissions and make adjustments or normalize submissions in the Proposal(s), including the Offeror's technical assumptions, and underlying calculations and assumptions used to support the Offeror's computation of costs, or to apply such other methods it deems necessary to make level comparisons across Proposals;

n. Use the Proposal, information obtained through any site visits, and the Department's own investigation of an Offeror's qualifications, experience, ability or financial standing, and any other material or information submitted by the Offeror in response to the Department's request for clarifying information, if any, in the course of evaluation and selection under these Specifications;

o. Negotiate with the successful Offeror within the scope of these Specifications in the best interests of the Department;

p. Utilize any and all ideas submitted in the Proposal(s) received;

q. Unless otherwise specified in these Specifications, every offer is firm and not revocable for a minimum period of three hundred sixty- five (365) days from the Proposal Due Date as set forth in the Specifications; and

r. Any Offeror whose Proposal might become eligible for a tentative award may be asked to extend the time for which its Proposal shall remain valid.

s. The Department reserves the right to hold a Technical Management Interview with any Offeror, at any time, prior to the Tentative Contract Award. Any Technical Management Interview will be scheduled and conducted, in consultation with the JLMC, with the purpose of obtaining clarifying information regarding the Offeror's proposal submission.

11. Disclaimer

The Department is not liable for any cost incurred by any Offeror prior to approval of the Contract by OSC. Additionally, no cost will be incurred by the Department for any prospective Offeror or Offeror's participation in any Procurement-related activities. The Department has taken care in preparing the data accompanying these Specifications (hard copy attachments, website attachments, and sample document attachments). However, the Department does not warrant the accuracy of the data. The numbers or statistics which appear in hardcopy attachments, website attachments, and sample document attachments referenced throughout these Specifications are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or

participation. Accordingly, prospective Offerors should rely upon and use such numbers or statistics in preparing their Proposal at their own discretion.

2.2 Compliance with Applicable Laws, Rules and Regulations, and Executive Orders

This Procurement is subject to the New York State competitive bidding laws and also governed by, at a minimum, the legal authorities referenced below. An Offeror must fully comply with the provisions set forth in this section of the Specifications, as well as the provisions of the *Standard Clauses for New York State Contracts* (Appendix A) and the *Standard Clauses for All Department Contracts* (Appendix B) and *Information Security Requirements* (Appendix C), which will become a part of the resulting Contract. The Department will consider for evaluation and selection purposes only those Offerors who agree to comply with these provisions and whose proposal contains the submission required hereunder.

1. Disclosure of Proposal Contents – Freedom of Information Law (FOIL)

a. NOTICE TO OFFEROR AND ITS LEGAL COUNSEL

All materials submitted by an Offeror in response to these Specifications shall become the property of the Department and may be returned to the Offeror at the sole discretion of the Department. Proposals may be reviewed or evaluated by any person, other than one associated with a competing Offeror, designated by the Department. Offerors may anticipate that Proposals will be evaluated by staff and consultants retained by the Department; Members of the JLMC; and may also be evaluated by staff of other New York State agencies interested in the provision of the subject services including, but not limited to, GOER and DOB, unless otherwise expressly indicated in these Specifications. The Department has the right to adopt, modify, or reject any or all ideas presented in any material submitted in response to these Specifications.

The Department shall take reasonable steps to protect from public disclosure any records or portions thereof relating to this solicitation that are exempt from disclosure under the New York State Freedom of Information Law (FOIL). Information constituting trade secrets or critical infrastructure information for purposes of FOIL must be clearly marked and identified as such by the Offeror upon submission. To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding FOIL. If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret or critical infrastructure information and desires that such information not be disclosed pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law, the Offeror must make that assertion by completing a *Freedom of Information*

Law Request for Redaction Chart (Attachment 11). The Offeror must complete the form specifically identifying by page number, line, or other appropriate designation, the specific information requested to be protected from FOIL disclosure and the specific reason why such information should not be disclosed. Page 2 of Attachment 11 contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, or summary assertions that material is proprietary or trade-secret are inadequate and will not result in protection from FOIL disclosure.

The completed Attachment 11 must be submitted to the Department at the time of its Proposal submission; it should be included with the Requested Redactions (USB storage drive and Hard Copy), described below. It should not be included in the Offeror's Proposal. If the Offeror chooses not to assert that any Proposal material and/or supplemental submission should be protected from FOIL disclosure, the Offeror should so advise the Department by checking the applicable box on Attachment 11 and submitting it to the Department at the time of its Proposal submission, but separately from its Proposal. If a completed Attachment 11 form is not submitted, the Department will assume that the Offeror chooses not to assert that any proposal material or supplemental submission, as applicable should be protected from FOIL disclosure.

The FOIL-related materials described herein are not considered part of the Offeror's Proposal and shall not be reviewed as a part of the Procurement's evaluation process.

Acceptance of the identified information by the Department does not constitute a determination that the information is exempt from disclosure under FOIL. Determinations as to whether the materials or information may be withheld from disclosure will be made in accordance with FOIL at the time a request for such information is received by the Department.

b. Requested Redactions (USB Storage Drive and Hard Copy):

At the time of Proposal submission, the Offeror is required to identify the portions of its Proposal that it is requesting to be redacted in the event that its Proposal is the subject of a FOIL request as follows.

The Offeror must provide an electronic copy of the Administrative Proposal and the Technical Proposal on a separate USB storage drive of the type outlined in Specifications Section 2, which reflect the Offeror's requested redactions. Additionally, the Offeror must provide a separately bound hardcopy of each of the two (2) Proposal documents with redactions marked, but not applied, that are included on the USB storage drives. The electronic documents must be prepared in PDF format using the Redaction Function in Adobe Acrobat Professional software, version 8

or higher. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using the Adobe "Mark for Redaction" function; do not use the "Apply Redactions" function. The resulting documents must show the Offeror's requested redactions as outlined, while the content remains visible. This will allow the Department to either apply or remove requested redactions when responding to FOIL requests. The documents included on the USB storage drives and in hard copy must be complete Proposals, including all Attachments. No section may be omitted from the USB storage drive or hard copy even if the entire section is requested to be redacted; such sections should be marked for redaction, not removed. For forms, attachments, and charts, please mark for redaction only those cells/fields/entries that meet the criteria for protection from FOIL, not the entire page. Do not request redaction of Department-supplied materials or information.

During the Proposal evaluation process, the Department, in consultation with the JLMC, may request additional information through clarifying letters. Any requested redactions for additional written material provided by the Offeror in response to the Department's requests also must be submitted following the instructions, above.

2. Public Officers Law

All Offerors and Offerors' employees and agents must be aware of and comply with the requirements of the New York State Public Officers Law (POL), particularly POL sections 73 and 74, as well as all other provisions of NYS law, rules and regulations, and policy establishing ethical standards for current and former State employees. Failure to comply with these provisions may result in disqualification from the Procurement process, termination, suspension or cancelation of the Contract and criminal proceedings as may be required by law. An Offeror must submit an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed Contracts, engagements, or affiliations, by submitting a completed *New York State Required Certifications* (Attachment 7), in the Offeror's Administrative Proposal.

3. New York State Required Certifications

An Offeror is required to submit the signed *New York State Required Certifications* (Attachment 7) with its Administrative Proposal. This attachment sets forth the Offeror's required statements on the MacBride Fair Employment Principles and Non-Collusive Bidding Certification. It also sets forth the certifications regarding compliance with the Federal Americans with Disabilities Act, compliance with the NYS Public Officers Law, certification required under NYS Procurement Lobbying Law, certification required under Executive Order

No. 177 and certification required by New York State Finance Law section 139-l regarding written sexual harassment policies.

4. New York Subcontractors and Suppliers

An Offeror is required to complete *New York State Subcontractors and Suppliers* (Attachment 12). New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the State and the nation. In recognition of their economic activity and leadership in doing business in NYS, An Offeror for this Contract is strongly encouraged and expected to consider NYS businesses in the fulfillment of the requirements of the Contract. Such partnering may be as subcontractors, suppliers, protégés, or other supporting roles.

5. Not for Profit Organizations

Article 7-a of the Executive Law requires, with certain exemptions, that charitable organizations shall register with the Office of the Attorney General. In addition, the Estates, Powers and Trusts Law (EPTL) Section 8-1.4(s) requires that a charitable organization "shall not be qualified to make application for funds or grants or to receive such funds from any department or agency of the state without certifying compliance with" all applicable registration and filing requirements.

Section 172-a of the Executive Law and Section 8.14 of the EPTL enumerate certain entities which are exempt from the registration requirements. These entities are listed on the Office of the Attorney General's Request for Registration Exemption (Schedule E).

SECTION 3: PROJECT SERVICES

The Department seeks qualified Offerors to provide the following Project Services as an HMO within the NYSHIP. For the purpose of submitting a Proposal, an Offeror must meet the Offeror Eligibility requirements specified in section 1.5 and provide the following Project Services during the Contract term:

3.1 Account Management Team

The Department expects the HMO's Account Management Team to have a proactive, experienced account leader and team in place who have the authority and expertise to coordinate the appropriate resources.

1. Duties and Responsibilities

The Offeror must:

a. Ensure that there is a process in place to gain immediate access to appropriate corporate resources and senior management necessary to meet all HMO Program requirements and to address any issues that may arise during the performance of the Contract;

b. Be accessible and sufficiently staffed to provide timely responses (within 1 to 2 Business Days) to concerns and inquiries posed by the Department, or other staff on behalf of the JLMC regarding Member-specific claims issues for the duration of the Contract to the satisfaction of the Department; and

c. Immediately notify the Department in writing of actual or anticipated events impacting the HMO Program requirements and/or delivery of services to Members such as but not limited to, change from not-for-profit status to for-profit status, applications by another party to acquire control of the HMO, legislation, class action settlements, and operational issues.

3.2 NYSHIP Eligibility Requirements

HMOs that are selected must accept all individuals determined by the Department to be eligible for services under the Contract that results from these requirements and may not enroll any individuals who have not been determined to be eligible by the Department. The Department will send the HMO information about eligible Enrollees and Dependents on an enrollment file on a scheduled basis as determined by the Department. An HMO may not independently add a Dependent who has not been determined by the Department to be eligible. The only time an HMO may disenroll an individual without first receiving a determination by the Department is when CMS tells an HMO to disenroll the individual due to other coverage. In this situation, the HMO must notify the Department within one (1) Business Day of notification by CMS.

To facilitate accurate enrollment records, HMOs that are selected must work with the State including the New York State Office of Information Technology Services (ITS) to develop an automated process for Medicare enrollment reconciliations, at no additional cost to the State.

Individuals who may enroll in an HMO through NYSHIP include Employees and Retirees of the State of New York and PEs who live or work in the HMO's NYSHIP approved Service Area, as well as their Dependents. Persons who have primary coverage with Medicare, who reside in the HMO's Medicare Advantage Plan NYSHIP approved Service Area are also eligible Enrollees under the NYSHIP. Dependent eligibility is subject to the collective bargaining process and may change as a result of labor/management negotiations or changes to State and/or Federal law.

The HMO must agree to accept all determinations of eligibility as made by the Department and must provide an insurance rider that includes all NYSHIP Dependent eligibility provisions. A draft *2020 NYSHIP Eligibility Rider* (Attachment 19) provides the NYSHIP Dependent eligibility requirements.

NYSHIP's dependent eligibility provisions include, but are not limited to:

A. An Enrollee's Spouse, including a legally separated spouse. If an Enrollee is divorced or the marriage has been annulled, the former spouse is not eligible as of the divorce or annulment effective date, even if a court orders the Enrollee to maintain coverage.

B. An Enrollee's Domestic Partner. The Enrollee may cover a same or opposite sex domestic partner as a dependent under NYSHIP. A domestic partnership, for eligibility under NYSHIP, is one in which the Enrollee and a partner are 18 years of age or older, unmarried and not related in a way that would bar marriage; living together; involved in an exclusive mutually committed relationship; and financially interdependent. To enroll a Domestic Partner, the Enrollee must have been in the partnership for six months and be able to provide proof of 6 months of cohabitation and 6 months of financial interdependence. There is a one year waiting period from the termination date of the Enrollee's previous partner's coverage before the Enrollee may again enroll a domestic partner.

C. An Enrollee's Children under 26 years of age. This includes the Enrollee's natural children, legally adopted children, children in a waiting period prior to finalization of adoption, stepchildren and children of the Enrollee's domestic partner who are covered without regard to financial dependence, residency with the Enrollee, student status or employment. Other children who reside permanently in the Enrollee's household, who are chiefly dependent on the Enrollee and for whom the Enrollee has assumed legal responsibility, in place of the parent, are also eligible. The Enrollee must verify eligibility by submitting a completed *PS-457 Statement of Dependence* form (Attachment 29) in addition to providing documentation to the Enrollee's employer upon enrollment and every two years thereafter. For "other

children," legal responsibility by the Enrollee must have commenced before the child reached age 19.

D. An Enrollee's Child with Military Service. For purposes of eligibility for health insurance coverage as a child, up to four years for service in a branch of the U.S. Military between the age of 19 and 25 may be deducted from the Dependent child's age provided that the dependent child returns to school on a full-time basis, is unmarried and is otherwise not eligible for employer group coverage. The Enrollee must be able to provide written documentation from the U.S. Military. Proof of full-time student status at an accredited secondary or preparatory school, college or other educational institution will be required by the HMO for verification.

E. An Enrollee's unmarried Dependent child 26 or over who is incapable of self-sustaining employment by reason of mental disability, as defined in the mental hygiene law, or physical disability, who became incapacitated prior to attainment of the age at which Dependent coverage would otherwise be terminated, are eligible.

F. An Enrollee's unmarried children, including adopted children and stepchildren through age 29 ("Young Adult"), who live, work, or reside in New York State or the Service Area of the HMO's network-based NYSHIP policy are eligible to enroll for coverage under the Young Adult Option if these Young Adults:

    I. Are not insured by or eligible for coverage through the Young Adult's own employer-sponsored health plan, whether insured or self-funded, provided that the health plan includes both hospital and medical benefits, and

    II. Are not covered under Medicare.

    In addition:

    III. the Young Adult need not live with the parent, be financially dependent upon the parent, or be a student;

    IV. the Young Adult's eligibility for health insurance coverage through a former employer under federal COBRA or State continuation coverage does not disqualify the Young Adult from electing the young adult option under NYSHIP;

    V. the Young Adult's children are not eligible for coverage under the Young Adult Option, but may be eligible for health insurance coverage under other programs, such as the Child Health Plus program;

    VI. the parent need not have family coverage for the young adult to enroll in the Young Adult Option; and

VII. the Young Adult need not have been previously covered under the parent's NYSHIP coverage.

For additional information related to the Young Adult Option, please refer to Attachment 19.

G. Dependent(s) of a deceased Enrollee may be eligible to continue coverage as a dependent survivor. The Enrollee must have completed at least 10 years of benefits eligible service, and the dependent must have been covered as the Enrollee's dependent under NYSHIP at the time of the Enrollee's death. The 10-year service requirement is waived if the Enrollee's death was the result of a work-related injury. Additionally, a dependent spouse, or domestic partner, is ineligible for survivor benefits if they remarry or acquired a new domestic partner. Dependent children must also meet all relevant eligibility criteria as a child dependent.

H. An Enrollee who is eligible for Vestee coverage may also cover their eligible dependent(s). The dependent(s) must meet the relevant eligibility criteria. A Vestee is a former benefits eligible employee who has met the service requirement to continue coverage as a retiree, and the relevant pension system service requirement, but has not met the age requirement to collect a pension. The eligible Enrollees may continue Vestee coverage until they qualify for retirement, so long as they are not canceled for non-payment of premium.

1. <u>Duties and Responsibilities</u>

a. The HMO is required to use an identification number other than Social Security Number on identification cards and other documents, forms or correspondence provided to users external to the HMO for its Members enrolled through NYSHIP.

b. The HMO must maintain accurate, complete, and up-to-date enrollment files, based on information provided by the Department. These enrollment files shall be used by the Offeror to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files.

c. The Department will send the HMO an eligible Enrollees and Dependents enrollment file on a scheduled basis. An HMO may not independently add an Enrollee or Dependent who has not been determined by the Department to be eligible.

d. The only time an HMO may disenroll an individual without first receiving a determination by the Department is when CMS tells an HMO to disenroll the individual due to other coverage. In this situation, the HMO must notify the Department within ~~five~~<u>one</u> (~~5~~<u>1</u>) Business Day~~s~~ of notification by CMS.

e. A participating HMO must comply with the *Information Security Requirements* (Appendix C) and ensure the confidentiality, integrity and security of all enrollment information.

f. Use of the enrollment data transmission protocol and encryption method as stipulated by the Department. The current data transmission protocol must be Secure FTP, and the current encryption methodology must be PGP or as otherwise specified by the Department. Secure FTP must be compatible with the OpenSSH implementation of Secure FTP.

3.3 Disabled Dependent Determinations

The HMO will be responsible for making clinical Disabled Dependent Determinations for Dependent children with a disability who are enrolled in the HMO. Disabled Dependents of NYSHIP Enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those Dependents are incapable of self-sustaining employment. As part of the Disabled Dependent Determination, a *Statement of Disability Dependent 19 Years of Age or Older Form PS-451* (Attachment 22) is completed by the Enrollee, the Dependent's physician and the Enrollee's Employer, and then evaluated by the HMO to determine if the Dependent is disabled. All determinations are subject to review by the HMO on a periodic basis. The following guidelines must be used for all Disabled Dependent Determinations:

If improvement of the Dependent's condition is:

A. "Expected," the case will be normally reviewed within six to eight months, unless the HMO determines a need for a more frequent review.

B. "Possible," the case will be normally reviewed no sooner than three years, unless the HMO determines a need for a more frequent review.

C. "Not expected," the case will normally be reviewed no sooner than seven years, unless the HMO determines a need for a more frequent review.

1. Duties and Responsibilities

a. Once the HMO makes the disability determination, the PS-451 must be sent to the Department to confirm eligibility. If the disabled Dependent is eligible, the HMO will receive confirmation of eligibility through the weekly enrollment transaction file.

b. The HMO must accept determinations of total disability under the above standards that were made by other NYSHIP plans provided that there has not been a break in coverage between plans.

3.4 Plan Requirements

The Offeror must provide coverage to both NYSHIP primary and Medicare primary Enrollees and dependents that comply with the requirements of the Specifications throughout the term of the Contract. If the HMO has an approved Medicare Advantage Plan with Part D coverage in a Commercial Plan service area it must offer the Medicare Advantage Plan to Medicare primary enrollees. The Offeror cannot offer a Plan that provides coverage to Medicare eligible enrollees only.

Persons who have primary coverage with Medicare, who reside in the HMO's Medicare Advantage Plan NYSHIP approved Service Area are also eligible Enrollees under the NYSHIP.

HMOs must provide at least the minimum benefits as described in the sections below.

1. Duties and Responsibilities

a. Commercial Plan Benefit Requirements

i. Must be fully Patient Protection and Affordable Care Act (PPACA) compliant.

ii. An HMO may specify copayments or coinsurance as part of their benefit package; however, copayments or coinsurance for inpatient hospital care and annual deductibles will not be permitted.

iii. Starting with the 2022 plan year, and for each subsequent year of the resulting Contract, an HMO may not utilize coinsurance as a cost sharing mechanism for air ambulance services in their proposed benefit package.

iv. Coverage must comply with all services required by Federal and State laws and/or regulations in addition to the following enhanced coverage:

1) Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and ostomy supplies. Replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement must be covered when

functionally necessary;

2) Medically necessary Durable Medical Equipment (DME) that can withstand repeated use and is primarily used to serve a medical purpose must be covered. Examples of DME include but are not limited to wheelchairs, walkers, respiratory equipment, and oxygen supplies. Replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

3) Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement must be covered when functionally necessary;

4) Medically necessary federal legend and state restricted drugs, compounded medications and injectable and self-injectable medications, contraceptive drugs and devices, fertility drugs and enteral formulas must be covered. (The copayment for self-injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs, except drugs limited to 30-day supply at dispensing.) No annual or lifetime maximum permitted; and

5) Coverage for diagnosis and treatment of Gender Dysphoria.

v. Benefits for services not listed as minimum benefit requirements pursuant to Section 3.4 of these Specifications, such as routine/preventive dental services and/or the provision of eyeglasses for routine vision correction may be included in the HMO's standard package. However, riders that include an additional charge for such benefits will not be accepted. As such, such riders and costs should not be included in HMO Rate Submission Template (Attachment 31). Exclusions and other limiting language are subject to modification by the Department in consultation with the JLMC.

vi. HMOs may propose to meet the minimum benefit requirements

set forth in these requirements using a standard contract, or through a combination of a standard contract and riders. Proposals that do not meet the minimum benefits will be rejected by the Department in consultation with the JLMC. HMOs may provide benefits in excess of the minimum benefits required by these specifications. The standard contract must be approved for offering by the appropriate regulatory authority. Riders shall be accepted by the Department in consultation with the JLMC only if such rider is necessary to bring the standard contract proposed by the HMO into conformity with the minimum benefit requirements. It is not the intent of the Department to purchase from HMOs riders that increase the benefit package to a level above the minimum requirements set forth in the Specifications. Riders that provide benefits not required by the minimum benefit requirements at an additional cost, or which provide benefits in excess of the minimum benefit requirements at an additional cost, may be rejected by the Department in consultation with the JLMC.

b. Medicare Advantage Plan Benefit Requirements

i. The HMO's Medicare Advantage Plan must follow the regulations and requirements set forth in the CMS Medicare Managed Care Manual (MMCM). The Department is obligated to follow the rules and regulations in the MMCM as applicable to the employer group.

ii. The benefit levels provided must meet or exceed the minimum benefits as set forth in Section 3.4 of these Specifications; and other benefits above the minimum benefits must be comparable to those provided to non-Medicare primary Enrollees. Instances where Federal Law and/or regulation preclude an HMO from complying with this requirement must be clearly identified in the HMO's Proposal.

iii. If an HMO is submitting a Medicare Advantage Plan with Prescription Drug coverage, the Plan must be CMS approved for all counties in the proposed Service Area.

iv. Starting with the 2022 plan year, and for each subsequent year of the resulting Contract, an HMO's proposed Medicare Advantage Plan may not utilize coinsurance as a cost sharing mechanism for either Part B medications or air ambulance services.

v. An HMO may submit only one product for Medicare primary

Enrollees. It may submit either (a) the Commercial Plan which coordinates with Medicare and includes prescription drug coverage equal to, or better than, Medicare Part D or (b) a Medicare Advantage with Prescription Drug Plan. An HMO must provide Part D coverage at an equal level to the Commercial Plan in the coverage gap.

vi. An HMO whose CMS Star quality rating falls below 3 stars and whose enrollment is frozen by CMS would be permitted to keep an Enrollee that otherwise would have aged-into the Medicare Advantage Plan in the Commercial Plan until CMS lifts the enrollment freeze.

vii. The HMO must agree to cooperate with the Department to enroll individuals into the HMO's Medicare Advantage Plan as they become Medicare eligible in accordance with this process. The Department will follow the process required of the employer group for providing information to each eligible Employee / Retiree in the timeframes defined in the MMCM, as follows:

1) The Department shall provide advance notice to eligible Enrollees and/or their eligible Dependents that Department intends to enroll them in Medicare Advantage Prescription Drug Plan (MAPD) Plan;

2) The Department shall provide eligible Enrollees and/or their eligible Dependents notice that they may affirmatively opt-out of such enrollment; explain the process to opt-out; and any consequences to their benefits opting out would bring. This notice shall be provided to Enrollees and/or their eligible dependents not less than 21 calendar days prior to the effective date of coverage in the MAPD Plan;

3) The Department shall provide eligible Enrollees and/or their eligible Dependents a summary of benefits offered under the MAPD, an explanation of how to get more information about the MAPD, and an explanation on how to contact Medicare for information on other Medicare health plan options that might be available; and

4) The Department shall provide eligible Enrollees and/or their eligible Dependents the information contained in the MMCM Chapter 2 Exhibit 2 Model Employer/Union Group Health Plan Enrollment Request Form under the heading "Please Read & Sign Below."

viii. The HMO must follow the procedures set forth in Chapter 2 of the MMCM, Optional Mechanism for MA Group-sponsored Plan Enrollment, which allows an employer to enroll its retirees using an enrollment process that does not require submission of a signed application by the retiree. The HMO must agree to work in cooperation with the Department to enroll individuals into the HMO's Medicare Advantage Plan as they become Medicare eligible in accordance with this process. Enrollments into the HMO's Medicare Advantage Plan may not occur unless received by the HMO through the Department's enrollment files.

ix. HMOs must obtain any additional Member information not included on the Department enrollment files required for the HMO to submit an enrollment request to CMS, as set forth in the MMCM. The HMO must advise the Department in writing of any changes to the required enrollment data at least 60 days prior to implementation. If the HMO receives notification of change from CMS less than 60 days in advance of implementation, the HMO must advise the Department within 2 Business Days from receipt of such notification from CMS.

x. The HMO shall furnish MAPD identification cards and Evidence of Coverage (EOC) documents, which describe in detail the prescription drug benefits covered by the plan, to each MAPD Member enrolled for MAPD Plan benefits.

xi. The HMO shall agree to follow the procedures set forth in Chapter 2 of the MMCM, Optional Employer/Union MA Disenrollment Request Mechanism, which allows MA Plans to accept voluntary disenrollment elections directly from the employer or union without obtaining a MA disenrollment form from each individual and Group Disenrollment for Employer/Union Sponsored Plans, which allows an employer to group disenroll its MAPD Members using a group disenrollment process that does not require submission of a signed disenrollment form. The HMO must agree to work in cooperation with the Department to disenroll individuals out of the HMO's Medicare Advantage Plan. The Department shall agree to follow the process and timelines required for group disenrollment as stated in the MMCM including notification of the group's intention to disenroll the MAPD Members and transmit the information required for the HMO to submit a disenrollment request to CMS. For individual voluntary disenrollment requests, the Department shall agree to submit disenrollment information which accurately reflects the

Department's record of the disenrollment made by each MAPD Member according to the processes the Department has in place.

xii. An HMO that offers a Medicare Advantage Plan through NYSHIP shall agree to notify the Department on a ~~monthly~~weekly basis in a specified format when CMS regulations impact the enrollment of a NYSHIP Enrollee or Dependent in the Medicare Advantage Plan. These events include but are not limited to the following:

1) CMS generated disenrollments that remove a NYSHIP Enrollee or Dependent from the Medicare Advantage employer group plan;

2) Disenrollments prompted by MAPD Member correspondence where CMS regulations require the HMO to act on the MAPD Member's request prior to the Department's notification through the Optional Employer/Union MA Disenrollment Request Mechanism or Group Disenrollment for Employer/Union Sponsored Plans;

3) Enrollments received from the Department through the Group Enrollment for Employer/Union Sponsored Plans that cannot be processed with CMS. These situations include but are not limited to cases where the NYSHIP Enrollee or Dependent is not enrolled in Medicare Part A or Part B, already enrolled in another Medicare Advantage Plan, has an invalid or missing Medicare Beneficiary Identifier (MBI) or does not reside in service area; and

4) Other situations not described above.

xiii. The HMO shall agree that the commencement of coverage for Enrollees and their eligible Dependents will begin as of the requested effective date, in accordance with CMS regulations, for any eligible NYSHIP who makes a timely application for enrollment.

xiv. Termination of coverage for a MAPD Member who is determined by the Department to be ineligible for benefits shall be reported to the HMO in the enrollment files transmitted on the scheduled basis. Upon the Department's notification to the HMO, the coverage of such MAPD Member shall terminate after providing notice to such MAPD Member in accordance with the Department's policy and

CMS regulations. The Department is responsible for providing NYSHIP required notice; the HMO is responsible for providing CMS required notice. Retroactive disenrollment shall not be permitted except in specific situations approved by CMS.

xv. An HMO that offers a Medicare Advantage Plan through NYSHIP must within forty-five (45) business days from the date the HMO receives the Low-Income Subsidy (LIS) payment from CMS, send the LIS beneficiary the low-income premium subsidy payment.

xvi. The Department acknowledges that a Medicare Part D Late Enrollment Penalty (LEP) may be assessed to a MAPD Member when the Member has a break in Creditable Coverage. To determine the existence of Creditable Coverage, the HMO shall review the MAPD coverage history by viewing the MAPD NYSHIP enrollment record in the New York Benefits Eligibility & Accounting System (NYBEAS). For those MAPD Members whose NYBEAS record does not confirm continuous Creditable Coverage, the HMO shall send a Creditable Coverage attestation form to the MAPD Members in accordance with CMS regulations. The HMO shall bill the MAPD Member directly for any LEP assessed by CMS.

3.5 Service Requirements

The Department, in consultation with the JLMC, will only consider submissions from HMOs that agree to provide coverage to both NYSHIP primary and Medicare primary Enrollees and Dependents. An HMO may either submit a Commercial Plan offering that is available to both such groups or an offering that is a combination of a Commercial Plan and a Medicare Advantage Plan that includes the CMS-approved Part D coverage. If the HMO has an approved Medicare Advantage Plan with Part D coverage in the same Service Area as the Commercial Plan offering, the HMO must offer the Medicare Advantage Plan to Medicare Primary Enrollees. The Department and JLMC will consider participation requests from HMOs that include their entire Service Area or an HMO that limits its proposal to include only certain counties in the Service Area. The Department may, at its discretion and in conjunction with the JLMC, select an HMO's entire proposed Service Area or may select specific counties within the proposed Service Area for participation in NYSHIP.

An HMO must ensure that comprehensive health care services are available to covered individuals. Title 10 of New York State Code, Rules, and Regulations (Part 98) defines Comprehensive Health Care Services as all those health services which an enrolled population might require in order to be maintained in good health, and shall include, but shall not be limited to:

A. Physician and other provider services (including consultant and referral services);

B. Inpatient and outpatient hospital services;

C. Diagnostic laboratory and therapeutic and diagnostic radiologic services; and

D. Emergency and preventive health services, including providing HIV counseling and recommending voluntary HIV testing to pregnant women.

1. **Duties and Responsibilities**

a. An HMO must comply with New York State Laws and/or regulations; provide coverage to Members, either directly or through their Primary Care Physician (PCP), twenty-four (24) hours a day, 365 days a year; and instruct their Members on what to do to obtain services after regular business hours.

b. An HMO must also abide by the following appointment standards:

i. Emergency medical or mental health and substance abuse problems, immediately;

ii. Urgent medical or mental health and substance abuse problems, within 24 hours of request;

iii. Non-urgent “sick visits,” within 48 to 72 hours, as clinically indicated;

iv. In-Plan, non-urgent mental health and substance abuse visits, within two (2) weeks;

v. Adult baseline and routine physicals and non-urgent or preventive care visits, within twelve (12) weeks;

vi. Initial prenatal visits, within three (3) weeks during the first trimester and two (2) weeks thereafter; and

vii. Initial visit for newborns to their PCP, within two (2) weeks of hospital discharge.

3.6 Communications Material Requirements

The Department and the JLMC place a high priority on ensuring that NYSHIP Members are able to make informed choices when selecting a health plan during the annual Option Transfer Period. The Department requires that the benefits offered by an HMO be fully described to the HMO’s Members.

To assist NYSHIP Members in choosing a health insurance plan during the annual Option Transfer Period, the Department will develop a Health Insurance Choices guide. This guide will contain uniformly formatted pages for each plan offering (Commercial and Medicare Advantage, if offered) so that Members may easily compare the benefits offered. The information to be included in these Choices pages is outlined in *CHOICES Guide* (Attachment 34). Please note that the Department reserves the right to add, remove or change any of the Choices page requirements for each plan year of the Contract.

1. **Duties and Responsibilities**

    a. All Member communication material must be pre-approved by the Department prior to distribution to Members. For purposes of Section 3.6 and the resultant Contract, "Member communication material" is defined as any electronic or hardcopy communications directly or indirectly distributed to NYSHIP Members. Distribution means delivery through any media electronic or otherwise directly or indirectly targeting NYSHIP Members. This includes both annual benefit plan communications and updated Member communication material distributed by the HMO throughout the year.

    b. Upon approval by the Department and JLMC, the HMO must distribute the Cover Letter, Schedule of Benefits, and the applicable Side-by-Side Comparison of Benefit Changes to Members in hard copy, in one envelope and in one mailing. Final versions of these mailings must be sent to all *JLMC Contact Members* (Attachment 13) at least one (1) week prior to mailing to NYSHIP Members.

    c. All Member communication material must present a clear, factually correct, complete and easily understood description of the benefits available through the HMO. Any incorrect or incomplete Member communication material sent by the HMO to NYSHIP Members related to Member communication materials must be corrected and re-sent at the HMO's expense. Benefits offered and/or received through incorrect or incomplete Member communication material sent by the HMO must be covered until the Member(s) receive the corrected Member communication material or, at the discretion of the Department, in consultation with the JLMC, for the balance of the Plan Year.

    d. Member communication materials may promote the HMO but must not make general or specific comparisons to any other NYSHIP option. HMOs will not be permitted to refer to the Empire Plan or plan specific comparisons to other HMOs. For example, an HMO may not state that they "serve more NYSHIP Members than any other HMO that participates in NYSHIP."

e. Member communication materials may not discriminate on the basis of a potential Member's health status, prior use of health service, or need for future health services.

f. HMOs may not distribute Member communication materials that mislead or confuse NYSHIP Members by promoting or misstating benefits for which the NYSHIP Member is not covered.

g. The premium cost or rate information of all NYSHIP health plan options will be communicated to Enrollees by the Department's Employee Benefits Division and shall not be included in any communication materials distributed by any HMO, with the exception of rate filing notifications required by the New York State Department of Financial Services (DFS). HMOs may, however, direct NYSHIP Enrollees to rate information provided by the Department. Rate information is provided on the Department's web site at www.cs.ny.gov.

h. Visual presentations of Members in the HMO Member communication material must represent a diverse New York State workforce.

i. All HMOs must include the following statement in the Cover Letter for the Member communication materials mailing to HMO NYSHIP Members: "Your Eligibility Guidelines may be different from those guidelines listed in the Certificate of Coverage. Please refer to your NYSHIP General Information Book for these guidelines or visit the New York State Department of Civil Service's web site at www.cs.ny.gov."

j. The HMO must comply with PPACA to produce, revise, distribute and, upon request, translate a Summary of Benefits and Coverage (SBC) that accurately describes the NYSHIP group benefits and coverage to all HMO NYSHIP Members. The SBC must be provided to the Department in an Adobe PDF electronic format document no later than 30 days before the beginning of each Plan Year for posting to the Department website. The HMO must distribute a SBC to any eligible Employee or Retiree contacting the HMO or the Department requesting a hard copy in accordance with PPACA requirements for timely distribution. Annually, at plan renewal or upon material modification of the SBC, the HMO must provide notice to all current Enrollees via a postcard, plan materials, or other Federally compliant means of notification, of how to view or obtain a copy of the SBC from the HMO.

k. The Schedule of Benefits must include, but not be limited to, applicable copayments and/or coinsurance levels. The Schedule of Benefits must also include a comprehensive description of limitations and exclusions. A separate Schedule of Benefits is required for the Commercial HMO Plan

and the Medicare Advantage Plan (if offered) in the HMO's Submission. See *SAMPLE Schedule of Benefits* (Attachment 24).

l. HMOs that participate in NYSHIP in 2020 are required to submit a Side by Side Comparison of Benefits that lists changes in the benefits offered to Enrollees from 2020 to 2021. Such changes include but are not limited to copayments; new benefits; number of days of a prescription supply; delivery of services; and provider networks. In the event there are no changes in the benefits offered, the HMO will be required to mail to Members an affirmative statement that states that there are no changes in either the benefits offered or delivery of services from the previous year. The Side by Side Comparison of Benefits must be provided to the Department in an electronic format as a PDF document no later than 30 days before the beginning of each plan year for posting to the Department website. See *SAMPLE Side-by-Side Comparison* (Attachment 25).

m. In addition to the required Member communication material, HMOs may develop and distribute other marketing materials to current NYSHIP Enrollees who live or work in the HMO's NYSHIP service area. All Member communication materials distributed to NYSHIP Members must present the NYSHIP HMO's benefits. The Department will not provide any information to HMOs regarding the identification of eligible NYSHIP Enrollees or their mailing addresses. Any Member communication materials distributed by the HMO to NYSHIP Enrollees must be pre-approved by the Department, in consultation with the JLMC, prior to distribution.

n. HMOs shall not provide NYSHIP Members with gift(s) as an inducement to enroll in the HMO. Generally, a gift is something that has a fair market value of $15.00 or more (i.e. nominal value).

o. HMOs are not permitted to conduct NYSHIP related marketing activities including distribution of NYSHIP related material, at any worksite event without prior approval of the Department. HMOs may only distribute Department approved materials that provide specific information regarding the NYSHIP HMO or relate to general health care issues at such events. Worksite events include, but are not limited to, health benefit fairs and information booths.

p. Distributed promotional items (e.g. pens, shirts, mugs, phone holder etc.) or advertising or promotional material (e.g. billboards, brochures, flyers, postcards, business cards, posters, menus, sales sheets, etc.) shall not contain the NYSHIP logo or the term NYSHIP or any language that would infer the State promotes or supports the particular HMO.

q. If an HMO's benefit changes are expected to reduce premium costs, a notation may be included in the HMO communication materials that certain benefit changes are expected to result in decreased premiums or to help limit premium increases; however, the language may not state how much premiums will decrease or how much savings may be realized.

r. All Member communication materials must be submitted to all JLMC Members for approval before the submission deadline specified in the *Timeline of Key Events for Plan Year 2021* (Attachment 26). JLMC Contact Members may approve optional marketing materials submitted late, but also reserve the right to disapprove any material that does not meet the specified deadline. The HMO shall adhere to the Department's decision on any and all optional marketing materials, regardless of format or timing of deployment. For purposes of this section "optional marketing materials" refer to any communication or promotional materials, electronic or otherwise, made visible and relevant to NYSHIP Members or used to promote enrollment by the HMO that are outside of the required Member communications materials.

s. The HMO is required to advise all *JLMC Contact Members* (Attachment 13) of the potential withdrawal of any hospital or hospital group and of any significant provider group from the HMO's provider network as soon as the potential withdrawal is identified but no later than thirty (30) days prior to the group's potential withdrawal date.

t. For the initial year of this Contract term, the HMO is required to list its current five largest employer groups, in descending order, by number of contracts for the organization's HMO business (i.e., large group HMO product) in which NYSHIP is included and indicate where NYSHIP enrollment would rank in the standings. On an ongoing basis during the term of the Contract, an HMO must advise the Department and JLMC Contact Members in writing of any change to NYSHIP's position in the standings.

u. Notification of proposed changes in the configuration of Service Area counties, including a shift in Service Area counties within rating regions or the establishment of a new rating region(s), must be provided to the Department at the same time the request is submitted to the regulatory agency and noted as pending. The Department must be notified of the determination by the regulatory agency and upon approval, be provided all pertinent information including, but not limited to, the effective date of the change. The HMO must also provide the Department and all *JLMC Contact Members* (Attachment 13) with copies of all notification materials for Members impacted by the region switch prior to distribution to the Members.

3.7 Reporting

The Offeror must provide the Department with regular, periodic reports that are designed to document that Member, network, and account management service levels are being maintained and that claims are being paid in accordance with the Contract. The Offeror may on occasion be requested to provide ad-hoc reporting and analysis within 24 hours.

In order to fulfill its obligations to enrolled Plan Members and ensure Contract compliance, the Offeror must provide accurate claims data information on a claim processing cycle basis as well as summary reports concerning the Plan and its administration.

All electronic files must be in a format acceptable to the Department. The Department will review and approve the proposed format, but this format may be adjusted during the term of the Contract. Upon receipt by the Department, all electronic files are first validated for compliance with the agreed-upon file structure. Files that fail to adhere to this structure are rejected in their entirety and must be re-submitted.

The Department reserves the right to seek information immediately from an HMO pursuant to investigation of a particular Member or provider complaint.

1. Duties and Responsibilities

a. An HMO must maintain records of all complaints that have been unresolved for more than forty-five days (45) days. Such records shall include the actual complaint, all correspondence related to the complaint, and an explanation of the disposition of the complaint. The HMO must make these records available to the Department and *JLMC Contact Members* (Attachment 13) in searchable format upon request. All Member identifying information must be redacted.

b. The Department requires an HMO to maintain a report summarizing the number of grievances filed for the most recent Plan Year, sorted by procedure type. The report must include the total number of grievances, the number of grievances upheld, overturned, modified or withdrawn. The HMO must make these records available to the Department or JLMC *Contact Members* (Attachment 13) upon request.

c. The Department requires an HMO to maintain a report summarizing the number of external appeals filed for the most recent Plan Year, sorted by procedure type. The report must include the total number of external appeals, the number of appeals upheld, overturned, modified or withdrawn. The HMO must make these records available to the Department or *JLMC Contact Members* (Attachment 13) upon request.

d. The HMO must provide all JLMC Contact Members (Attachment 13) with

notification of changes in Subcontractors within thirty (30) days of such changes becoming final.

e. Whenever an HMO conducts a Member satisfaction survey that includes NYSHIP Enrollees, the HMO must provide a copy of the survey and survey results electronically in searchable format within 30 days upon request from any *JLMC Contact Members* (Attachment 13).

f. The HMO must notify the Department on a weekly basis of any Members no longer eligible to be enrolled in the Medicare Advantage Plan for reasons identified by the HMO or CMS; including but not limited to, missing Medicare Beneficiary Identifier (MBI), no Medicare Parts A and/or B, or enrollment in another Medicare Advantage Plan or Medicare Part D plan. The Department must also be notified if an Enrollee moved out of the HMOs Service Area or is deceased. The HMO must notify the Department using the format provided in the *Medicare Enrollment Report Format and Frequency* (Attachment 21).

g. The HMO must file its Medical Loss Ratio (MLR) with the federal government by July 1st of each calendar year. The HMO must provide its filed MLR to the Department no later than September 1st of each calendar year. In those instances where the HMO fails to meet the required MLR threshold for community rated large group contracts during the preceding calendar year, rebates must be paid to NYSHIP by September 30th of that calendar year as required under the PPACA. In addition, notification must be provided to both Enrollees and the employer group in instances where the MLR threshold has not been met.

h. The HMO must submit a Low-Income Subsidy (LIS) report to the Department no later than fifteen (15) Business Days from the date the HMO receives the subsidy payment from CMS. The report must include the following information regarding payments made by the HMO to LIS Enrollees:

    i. Payment Date

    ii. Carrier ID

    iii. Benefit Plan

    iv. Benefit Program

    v. Last Name, First Name

    vi. Date of Birth

vii. MBI

viii. Member ID

ix. Social Security Number

x. Number of Payments

xi. Payment Start Date

xii. Payment End Date

xiii. ADJ (Adjustment) Reason Code

xiv. ADJ (Adjustment) Reason Code Description

xv. LIS Premium Subsidy Amount.

i. Consistent with State and Federal regulations, Healthcare Effectiveness Data and Information Set (HEDIS) Reports need to be completed on a timely basis.

3.8 Submission of Premium Rates

Those HMOs selected by the Department and the JLMC for participation in the NYSHIP in 2021 shall be required to submit premium rates to the Department by the date specified in this Section 3.8 of these Specifications and in accordance with *HMO Rate Submission Template* (Attachment 31). In order to prepare for the annual health insurance Option Transfer Period, NYSHIP premium rate submissions are due by September 1st of each Calendar Year. The premium rates shall be accompanied by the HMO's most recent available year-to-date loss ratio for the community pool in which NYSHIP Members are included. The premiums submitted to the Department shall be guaranteed rates under DFS regulation 11 NYCRR 52.42(b). The premium rates guaranteed shall be the presently prevailing approved or filed premiums. The premium rates for those Members who reside out of state must be the same as NYS premium rates filed with the NYS DFS.

Many HMOs submit for a rate adjustment to DFS with an effective date of January 1st. Such rate adjustments are only applicable until another rate request is made and approved by DFS. For administrative purposes, an HMO may guarantee the payment of the implemented rate for one year. To ensure the timely review and implementation of annual NYSHIP HMO premium rate changes by the Department, the HMO's selected for participation in NYSHIP must submit rate adjustments to DFS by June 1st of each calendar year.

1. Duties and Responsibilities

The HMO must provide the following detailed information to support the quoted premium rates.

a. The Offeror must provide a complete copy of the DFS's "Prior Approval Rate Change" application along with the printout of the System for Electronic Rate and Form Filing (SERFF) disposition notice indicating DFS approval of the rates submitted must be submitted to the Department by September 1st of each Calendar Year. The SERFF, administered by the National Association of Insurance Commissioners (NAIC), is a web-based system that facilitates the submission of electronic rate and form filing and facilitates electronic storage, management analysis, and communication regarding filings and their disposition.

b. If the Offeror has a rate request pending DFS's approval with an effective date no later than January 1st, the Offeror must submit a complete copy of the DFS "Prior Approval Rate Change" application and the SERFF application notice indicating submission of the application by September 1st of each Calendar Year. The receipt confirmation from the DFS must be sent to the Department upon receipt from DFS.

c. NYSHIP rates are comprised of: (1) the HMO's Community Rates associated with the JLMC approved benefits for the following Plan Year, as submitted to and approved by DFS; and (2) Medicare Rate Adjustments (if applicable):

    i. The HMO's Community Rates (basic contract rates and required benefit rider rates) for Plan Year for the specific Commercial Plan approved by the Department in consultation with the JLMC which have either been approved or are pending approval by DFS.

    ii. Medicare Rate Adjustments for each Medicare Plan. The premium rates for the Medicare Plan approved by the JLMC will vary from the Commercial Plan rates; they are typically less than those for the Commercial Plan. The variances between the Commercial Plan rates and the Medicare Rates are recognized in the NYSHIP rate development calculation by means of adjustments to the Community Rates (see *HMO Rate Submission Template* (Attachment 31).

3.9 Website Access

The HMO must provide the Department and JLMC Contact Members responsible for administrative oversight of NYSHIP HMOs during the term of the Contract access to

website applications that are available only to Members. The HMO must also provide the address of its main website and provide a dummy ID and password so that the Department may view the capabilities and user friendliness of the HMO's website.

3.10 Medicare Coordination and Secondary Payment

The Department requires that the Offeror coordinate and comply with the requirements of the Centers for Medicare and Medicaid Services (CMS); this includes complying with Medicare Crossover and all Medicare Secondary Payor Mandatory Reporting and data matching established and required by CMS. Medicare Crossover is the process by which Medicare, as a primary insurance carrier for some Plan Members, automatically forwards Medicare Part B claims to the Offeror for processing. The Department also receives demand summary notices from Medicare for claims that Medicare believes were paid in error. In 2019, the Department received 295 demand summaries totaling over $4.5 million, and in 2018, the Department received 217 notices totaling over $104.7 million.

The Offeror shall also be required to provide the appropriate benefit level to Members diagnosed with end-stage renal disease (ESRD) and adjudicate claims as per Medicare Secondary Payor Rules and regulations.

1. **Duties and Responsibilities**

   The HMO shall agree to follow the procedures set forth below in handling Medicare Secondary Payer (MSP) claims for any NYSHIP Enrollees and Dependents:

   a. The HMO shall immediately remit to the Department a copy of any MSP notice received that pertains to a NYSHIP Member. The HMO shall provide status updates on each MSP case through and including final payment resolution.

   b. Upon receipt of a demand letter directly from CMS or indirectly from the Department for the payment of a claim that was paid primary by Medicare and for which CMS asserts NYSHIP coverage should have been primary, the HMO shall make its best effort to resolve the claim within the timeframe specified by CMS. This shall include working with the Department to determine the claimant's employment status at the time the claim was incurred, the amount of liability for such claim on the part of the HMO and the payment of any liability owed by the HMO to CMS;

   c. In the event an MSP claim is not settled with CMS within the timeframe specified in the demand letter, the Department reserves the right to have CMS reimburse the full amount of the claim by another NYSHIP plan administrator for the purpose of avoiding any interest charges and/or the offset of other Federal funds payable to the State. The HMO agrees that if

it is determined that there was liability for payment of all or part of such claim including accrued interest, the HMO shall, upon the direction of the Department, repay to the NYSHIP insurer/third party administrator amounts paid on behalf of the HMO for MSP claims by the NYSHIP insurer/third party administrator;

d. The HMO agrees to periodically report to the Department the status of any unresolved MSP claims, including both claims received directly from CMS or indirectly received from the Department. The timing and information to be included in such reports shall be specified by the Department. In addition, the HMO shall provide to the Department copies of any correspondence it sends to CMS regarding NYSHIP MSP claims; and

e. In the event there is an offset of Federal funds payable to a New York State agency by the U.S. Treasury because of an unresolved MSP claim attributable to the HMO, the Department shall reimburse the agency for the offset and shall reduce the next premium payment to the HMO by the amount of such offset.

3.11 Annual Recertification

HMOs selected for participation in the NYSHIP for 2021 may continue participation in NYSHIP in 2022 through and including 2025, at the discretion of the Department, in consultation with the JLMC. Acceptance by the Department and JLMC for participation in 2021 is not a guarantee that the Department will approve an HMO's continued participation in NYSHIP in 2022 or beyond. Upon acceptance for participation in NYSHIP in 2021, an HMO must, on an annual basis submit documentation, referred to as the "Required Annual Submission," to the JLMC for the Committee's review and approval. The Offeror's continued participation in NYSHIP for each year subsequent to the initial year of the Contract term is contingent upon the Department and the JLMC's review and approval of the Required Annual Submission. Failure of the HMO to submit the Required Annual Submission documents to the Department by the established annual deadline (as identified in an annual call letter by the Department to the HMO) may result in rejection of an HMO's Submission, suspension of that HMOs participation in NYSHIP for the default year, or other consequence such as the Department's freezing of enrollment in that HMO. A suspended HMO may apply for participation in subsequent years by adhering to the Required Annual Submission Requirements. The deadline for this annual certification is addressed through an annual call letter to the HMOs. The Department, in consultation with the JLMC, may also hold periodic annual submission meetings with the HMOs to discuss HMO performance or annual submission materials.

An HMO's continued participation in NYSHIP for each year subsequent to 2021 is contingent upon review and approval of the following documents by the Department and

the JLMC. The Required Annual Submission documents will include, but are not limited to:

1. A current DOH Certificate of Authority for an HMO to operate within an approved Service Area and the ability to provide comprehensive hospital, medical and prescription drug benefits for covered Enrollees.

2. Current HMO status based on the National Committee on Quality Assurance (NCQA) or Utilization Review Accreditation Committee (URAC).

3. Subcontractors listing.

4. Service Area expansion requests.

5. Submission to offer or discontinue a Medicare Advantage product.

6. Most recent annual filing of Schedule M (Complaints).

7. Coverage and benefit documents, including but not limited to:

    a. Enrollee Certificate of Coverage

    b. MAP Evidence of Coverage

    c. Choices - HMO e-page

    d. Schedule of Benefits

    e. Side by Side comparison of changes in benefits from 20XX (current year) to 20XX (upcoming year)

    f. Coverage Riders and Addendums

    g. Annual communication materials to Enrollees

    h. Summary of Benefits and Coverage

    i. Other Required Submission Material

At the discretion of the Department and the JLMC, the Required Annual Submission documents may be amended. The Department will notify the HMO in writing of such changes no later than thirty (30) days prior to the requested due date of the Required Annual Submission.

SECTION 4: ADMINISTRATIVE PROPOSAL

This section of the Specifications sets forth the requirements for the Offeror's Administrative Proposal. The Department will consider for evaluation and selection purposes only those Proposals the Department determines to be in compliance with the requirements set forth in this section of the Specifications. Any Offeror which fails to satisfy any of these requirements shall be eliminated from further consideration.

The Offeror's *Administrative Proposal* must respond to all of the following items as set forth below in the order and format specified and using the forms set forth in these Specifications. Additional details pertaining to the required forms are found in Section 2 of these Specifications.

4.1 Formal Offer Letter

The Offeror must submit a formal offer in the form of the *Formal Offer Letter* (Attachment 3). The formal offer must be signed and executed by an individual with the capacity and legal authority to bind the Offeror in its offer to the State. The copy of the Offeror's Administrative Proposal marked "ORIGINAL" requires a letter with an original signature; the remaining copies of the Offeror's Administrative Proposal may contain photocopies of the signature. Except as otherwise permitted under Section 2.1(6), Bid Deviations, the Offeror must accept the terms and conditions as set forth in these Specifications, and Appendices A, B, and C, and agree to enter into a Contract with the Department containing, at a minimum, the terms and conditions identified in these Specifications and appendices as cited herein. If an Offeror proposes to include the services of a Subcontractor(s) or Affiliate(s), the Offeror must be required to assume responsibility for those services as "Prime Contractor." The Department will consider the Prime Contractor solely responsible for contractual matters.

4.2 Offeror Attestation Form

The Offeror must complete and submit an executed copy of the *Offeror Attestations Form* (Attachment 6) attesting that it meets or exceeds the criteria for eligibility to bid as set forth in Section 1 of these Specifications. A person legally authorized to represent the Offeror must execute this certification.

4.3 Subcontractors or Affiliates

The Offeror must complete the *Subcontractors or Affiliates* form (Attachment 9) to identify all Subcontractors or Affiliates**.** Subcontractors or Affiliates is defined as those contractors with whom the Offeror subcontracts to provide Project Services and incorporates as part of the Offeror's Project Management Team. For purposes of reporting in the *Subcontractors or Affiliates* form (Attachment 9), Subcontractors include all vendors who will provide $100,000 or more in Project Services over the term of the

Contract that results from these Specifications, as well as any vendor who will provide Project Services in an amount lower than the $100,000 threshold, and who is a part of the Offeror's Project Management Team. For each Subcontractor identified, the Offeror must complete and submit the *Subcontractors or Affiliates* form (Attachment 9) and indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Subcontractor for services to be provided by such subcontractor relating to the Specifications. For the purpose of these Specifications, Affiliate is defined as a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent. On the *Subcontractors or Affiliates* form (Attachment 9), the Offeror must:

1. Mark the applicable box in Attachment 9 if the Offeror will not be subcontracting with any Subcontractor(s) or Affiliate(s) to provide Project Services.

2. Indicate whether or not, as of the date of the Offeror's Proposal, a subcontract (or shared services Contract) has been executed between the Offeror and the Subcontractor or Affiliate for services to be provided by the Subcontractor or Affiliate relating to these Specifications.

3. Provide a brief description of the services to be provided by the Subcontractor or Affiliate.

4. Provide a description of any current relationships with such Subcontractor or Affiliate and the clients/projects that the Offeror and Subcontractor or Affiliate are currently servicing under a formal legal Contract or arrangement, the date when such services began and the status of the Project.

5. The HMO must provide all *JLMC Contact Members* (Attachment 13) with notification of changes in Subcontractors within thirty (30) days of such changes becoming final.

4.4 New York State Standard Vendor Responsibility Questionnaire

The Offeror must complete and submit an executed copy of the New York State Vendor Responsibility Questionnaire. A person legally authorized to represent the Offeror must execute the questionnaire. The questionnaire must be completed by all Subcontractors as defined above.

The Department recommends each Offeror file the required Questionnaire online via the New York State VendRep System. To use the VendRep System, please refer to https://www.osc.state.ny.us./vendors/index.htm.

By submitting a Proposal, the Offeror agrees to fully and accurately complete the Questionnaire. The Offeror acknowledges that the State's execution of the Contract will be contingent upon the State's determination that the Offeror is responsible, and that the State will be relying upon the Offeror's responses to the Questionnaire when making its responsibility determination. The Offeror agrees that if it is found by the State that the Offeror's responses to the Questionnaire were intentionally false or intentionally incomplete, on such finding, the Department may terminate the Contract. In no case shall such termination of the Contract by the State be deemed a breach thereof, nor shall the State be liable for any damages for lost profits or otherwise, which may be sustained by the Contractor as a result of such termination.

4.5 New York State Tax Law Section 5-a

Tax Law § 5-a requires certain Offerors awarded state Contracts for commodities, services and technology valued at more than $100,000 to certify to New York State Department of Taxation and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to Contracts where the total amount of such Offerors' sales delivered into New York State is in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any Affiliates and subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

An Offeror is required to file the completed and notarized Form ST-220-CA with the Department certifying that the Offeror filed the ST-220-TD with DTF. The Offeror should complete and return the certification forms within five (5) Business Days from the date of request (if the forms are not completed and returned with bid submission). Failure to make either of these filings may render an Offeror non-responsive and non-responsible. The Offeror must take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

Website links to the Offeror certification forms and instructions are provided below.

1. Form ST-220-TD must be filed with and returned directly to DTF and can be found at http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the Offeror, its Affiliate(s), or its subcontractor(s), a new Form ST-220-TD must be filed with DTF.

1. Form ST-220-CA must be submitted to the Department. This form provides the required certification that the Offeror filed the ST-220-TD with DTF. This form can be found at http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf

4.6 Compliance with New York State Workers' Compensation Law

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any Contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a Contract with the Department, the selected Offeror and Subcontractor(s) or Affiliates, with more than $100,000 in expected expenses over the life of the Contract, if any, will be required to verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed in *Compliance with NYS Workers' Compensation Law* (Attachment 10). Any questions relating to either workers' compensation or disability benefits coverage should be directed to the New York State Workers' Compensation Board, Bureau of Compliance at 518-486-6307. Useful information may also be found on their website: http://www.wcb.ny.gov.

Submission of the proof of workers' compensation and disability benefits insurance coverage is required at the time of Proposal submission. Failure to provide verification of either of these types of insurance coverage with the Offeror's Administrative Proposal may be grounds for disqualification of an otherwise successful Proposal.

To the extent that the Offeror is proposing the use of Subcontractors or Affiliates, the Offeror must verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that the Subcontractors or Affiliates are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

4.7 Insurance Requirements

Prior to the start of work the Offeror shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of any Contract resulting from these Specifications, policies of insurance as required by this section, written by companies that have an A.M. Best Company rating of "A-," Class "VII" or better. In addition, companies writing insurance intended to comply with the requirements of this Contract should be licensed or authorized by the New York State Department of Financial Services to issue insurance in the State of New York. The Department may, in its sole discretion, accept policies of insurance written by a non-authorized carrier or carriers when certificates and/or other policy documents are accompanied by a completed Excess Lines Association of New York (ELANY) affidavit or other documents demonstrating the company's strong financial rating. If, during the term of a policy, the carrier's A.M. Best rating falls below "A-," Class "VII," the insurance must be replaced, on or before the renewal date of the policy, with insurance that meets the requirements above. These policies must be written in accordance with the requirements of the paragraphs below, as applicable.

An Offeror shall deliver to the Department evidence of the insurance required by these Specifications and any Contract resulting from these Specifications in a form satisfactory to the Department. Policies must be written in accordance with the requirements of the paragraphs below, as applicable. While acceptance of insurance documentation shall not be unreasonably withheld, conditioned or delayed, acceptance and/or approval by the Department does not, and shall not be construed to, relieve an Offeror of any obligations, responsibilities or liabilities under these Specifications or any Contract resulting from these Specifications.

The Offeror shall not take any action or omit to take any action that would suspend or invalidate any of the required coverages during the term of any Contract resulting from these Specifications.

1. General Conditions

a. All policies of insurance required by this Solicitation or any Contract resulting from these Specifications shall comply with the following requirements:

i. Coverage Types and Policy Limits. The types of coverage and policy limits required from the selected Offeror are specified in paragraph 12. Specific Coverages and Limits below.

ii. Policy Forms. Except as may be otherwise specifically provided herein or agreed to in any Contract resulting from these Specifications, all policies of insurance shall be written on an occurrence basis.

iii. Certificates of Insurance/Notices. The selected Offeror shall provide the Department with a Certificate or Certificates of Insurance, in a form satisfactory to the Department, as detailed below, and pursuant to the timelines set forth in Section 11 below. Certificates should reference the Solicitation or award number and shall name the New York State Department of Civil Service, Agency Building 1, Empire State Plaza, Albany, NY 12239, as the certificate holder.

b. Certificates of Insurance shall:

i. Be in the form acceptable to the Department and in accordance with the New York State Insurance Law (e.g., an ACORD certificate);

ii. Disclose any deductible, self-insured retention, aggregate limit or any exclusion to the policy that materially changes the

coverage required by this Solicitation or any Contract resulting from this Solicitation;

iii. Be signed by an authorized representative of the insurance carrier of the referenced insurance carriers; and

iv. Contain the following language in the Description of Operations / Locations / Vehicles section of the Certificate or on a submitted endorsement: Additional insured protection afforded is on a primary and non-contributory basis. A waiver of subrogation is granted in favor of the additional insureds.

c. Only original documents (Certificates of Insurance and any endorsements and other attachments) or electronic versions of the same that can be directly traced back to the insurer, agent or broker via e-mail distribution or similar means will be accepted.

The Department generally requires an Offeror to submit only certificates of insurance and additional insured endorsements, although the Department reserves the right to request other proof of insurance. An Offeror should refrain from submitting entire insurance policies, unless specifically requested by the Department. If an entire insurance policy is submitted but not requested, the Department shall not be obligated to review and shall not be chargeable with knowledge of its contents. In addition, submission of an entire insurance policy not requested by The Department does not constitute proof of compliance with the insurance requirements and does not discharge an Offeror from submitting the requested insurance documentation.

2. Primary Coverage

All liability insurance policies shall provide that the required coverage shall be primary and non-contributory to other insurance available to the Department and their officers, agents, and employees. Any other insurance maintained by the Department and their officers, agents, and employees shall be excess of and shall not contribute with the Offeror's insurance. Insurance policies that remove or restrict blanket contractual liability located in the "insured contract" definition (as stated in Section V, Number 9, Item f in the Insurance Services Offices (ISO) Commercial General Liability (CGL) policy) so as to limit coverage against Claims that arise out of the work, or that remove or modify the "insured contract" exception to the employers liability exclusion, or that do not cover the Additional Insured for Claims involving injury to employees of the Named Insured or subcontractors, are not acceptable.

3. Breach for Lack of Proof of Coverage

The failure to comply with the insurance requirements at any time during the term of any Contract resulting from this Solicitation shall be considered a breach of the terms of any Contract resulting from this Solicitation and shall allow the Department and their officers, agents, and employees to avail themselves of all remedies available under any Contract resulting from this Solicitation, at law or in equity.

4. Self-Insured Retention/Deductibles

Certificates of Insurance must indicate the applicable deductibles/self-insured retentions for each listed policy. Deductibles or self-insured retentions above $100,000.00 are subject to approval from the Department. Such approval shall not be unreasonably withheld, conditioned or delayed. An Offeror shall be solely responsible for all claim expenses and loss payments within the deductibles or self-insured retentions. If the Offeror is providing the required insurance through self-insurance, evidence of the financial capacity to support the self-insurance program along with a description of that program, including, but not limited to, information regarding the use of a third-party administrator shall be provided upon request.

5. Subcontractors

Prior to the commencement of any work by a Subcontractor, the Offeror shall require such Subcontractor to procure policies of insurance as required by this section and maintain the same in force during the term of any work performed by that Subcontractor. An Additional Insured Endorsement (ISO coverage form CG 20 38 04 13), or the equivalent, evidencing such coverage shall be provided to the Offeror prior to the commencement of any work by a subcontractor and pursuant to the timelines set forth in Section 4.7(11), as applicable, and shall be provided to the Department upon request. For subcontractors that are self-insured, the subcontractor shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the subcontractor would have been required to pursuant to this section had the subcontractor obtained such insurance policies.

6. Waiver of Subrogation

For all liability policies, the Offeror shall cause to be included in its policies insuring against loss, damage or destruction by fire or other insured casualty a waiver of the insurer's right of subrogation against the Department and their officers, agents, and employees, or, if such waiver is unobtainable (i) an express Contract that such policy shall not be invalidated if the Offeror waives or has waived before the casualty, the right of recovery against the Department and their officers, agents, and employees or (ii) any other form of permission for the release of the Department any entity authorized by law or

regulation to use any Contract resulting from this Solicitation and their officers, agents, and employees. A Waiver of Subrogation Endorsement shall be provided upon request. A blanket Waiver of Subrogation Endorsement evidencing such coverage is also acceptable.

7. Additional Insured

The Offeror shall cause to be included in each of the liability policies required below coverage for on-going and completed operations naming as additional insureds (via ISO coverage forms CG 20 10 04 13 or 20 38 04 13 and CG 20 37 04 13 and form CA 20 48 10 13, or a form or forms that provide equivalent coverage): the Department and their officers, agents, and employees. An Additional Insured Endorsement evidencing such coverage shall be provided to the Department pursuant to the timelines set forth in Section 11 below. A blanket Additional Insured Endorsement evidencing such coverage is also acceptable. For Offerors who are self-insured, the Offeror shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the Offeror would have been required to pursuant to this Attachment had the Contractor obtained such insurance policies.

8. Excess/Umbrella Liability Policies

Required insurance coverage limits may be provided through a combination of primary and excess/umbrella liability policies. If coverage limits are provided through excess/umbrella liability policies, then a Schedule of underlying insurance listing policy information for all underlying insurance policies (insurer, policy number, policy term, coverage and limits of insurance), including proof that the excess/umbrella insurance follows form must be provided upon request.

9. Notice of Cancellation or Non-Renewal

Policies shall be written so as to include the requirements for notice of cancellation or non-renewal in accordance with the New York State Insurance Law. Within five (5) business days of receipt of any notice of cancellation or non-renewal of insurance, the Offeror shall provide the Department with a copy of any such notice received from an insurer together with proof of replacement coverage that complies with the insurance requirements of this Solicitation and any Contract resulting from this Solicitation.

10. Policy Renewal/Expiration

Upon policy renewal/expiration, evidence of renewal or replacement of coverage that complies with the insurance requirements set forth in this Solicitation and any Contract resulting from this Solicitation shall be delivered

to the Department. If, at any time during the term of any Contract resulting from this Solicitation, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Solicitation or any Solicitation and any Contract resulting from this Solicitation, or proof thereof is not provided to the Department, the Offeror shall immediately cease work. The Offeror shall not resume work until authorized to do so by the Department.

11. <u>Deadlines for Providing Insurance Documents after Renewal or Upon Request</u>

As set forth herein, certain insurance documents must be provided to the Department contact identified in the Contract Award Notice after renewal or upon request. This requirement means that the Offeror shall provide the applicable insurance document to the Department as soon as possible but in no event later than the following time periods:

a. For certificates of insurance: 5 business days from request or renewal, whichever is later;

b. For information on self-insurance or self-retention programs: 15 calendar days from request or renewal, whichever is later;

c. For other requested documentation evidencing coverage: 15 calendar days from request or renewal, whichever is later;

d. For additional insured and waiver of subrogation endorsements: 30 calendar days from request or renewal, whichever is later; and

e. For notice of cancellation or non-renewal and proof of replacement coverage that complies with the requirements of this section: 5 business days from request or renewal, whichever is later.

Notwithstanding the foregoing, if the Offeror shall have promptly requested the insurance documents from its broker or insurer and shall have thereafter diligently taken all steps necessary to obtain such documents from its insurer and submit them to the Department, the Department shall extend the time period for a reasonable period under the circumstances, but in no event shall the extension exceed 30 calendar days.

12. <u>Specific Coverage and Limits</u>

a. Commercial General Liability

Commercial General Liability Insurance, (CGL) shall be written on the current edition of ISO occurrence form CG 00 01, or a substitute form

providing equivalent coverage and shall cover liability arising from premises operations, independent contractors, products-completed operations, broad form property damage, personal & advertising injury, cross liability coverage, and liability assumed in a contract (including the tort liability of another assumed in a contract). Policy shall include bodily injury, property damage, and broad form contractual liability coverage. The limits under such policy shall not be less than the following:

i. Each Occurrence – $2,000,000

ii. General Aggregate – $2,000,000

iii. Products/Completed Operations – $2,000,000

iv. Personal Advertising Injury – $1,000,000

v. Medical Expense – $5,000

Coverage shall include, but not be limited to, the following:

i. Premises liability;

ii. Independent contractors/subcontractors;

iii. Blanket contractual liability, including tort liability of another assumed in a contract;

iv. Defense and/or indemnification obligations, including obligations assumed under any Contract resulting from this Solicitation;

v. Cross liability for additional insureds; and

vi. Products/completed operations for a term of no less than 1 year, commencing upon acceptance of the work, as required by the Contract.

The CGL policy, and any umbrella/excess policies used to meet the “Each Occurrence” limits specified above, must be endorsed to be primary with respect to the coverage afforded the Additional Insureds, and such policy(ies) shall be primary to, and non-contributing with, any other insurance maintained by the Department. Any other insurance maintained by the Department shall be excess of and shall not contribute with the Contractor’s or Subcontractor’s insurance, regardless of the “Other Insurance” clause contained in either party’s policy(ies) of insurance, if applicable.

b. Business Automobile Liability Insurance

The Offeror shall maintain Business Automobile Liability Insurance in the amount of at least $2,000,000 each occurrence, covering liability arising out of any automobile used in connection with performance under any Contract resulting from these Specifications, including owned, leased, hired and non-owned automobiles bearing or, under the circumstances under which they are being used, required by the Motor Vehicles Laws of the State of New York to bear, license plates.

c. Professional Errors and Omissions Insurance

The Offeror shall maintain Professional Errors and Omissions (Professional Liability) in the amount of at least $1,000,000 each occurrence, for claims arising out of but not limited to delay or failure in diagnosing a disease or condition and alleged wrongful acts, including breach of Contract, bad faith and negligence. Such insurance shall apply to professional errors, acts, or omissions arising out of the scope of services.

i. Such insurance shall include coverage of all professionals and technical personnel whose actions could be considered “professional services” arising out of the scope of services as additional named insureds.

ii. If coverage is written on a claims-made policy, the Offeror warrants that any applicable retroactive date precedes the start of work; and that continuous coverage will be maintained, or an extended discovery period exercised, throughout the performance of the services and for a period of not less than three years from the time work under any Contract resulting from this Solicitation is completed. Written proof of this extended reporting period must be provided to the Department upon request.

iii. The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of any Contract resulting from this Solicitation.

d. Technology Errors & Omissions Insurance

The Offeror shall maintain, during the term of any Contract, Technology Errors and Omissions Insurance in the amount of at least $10,000,000 each occurrence, for claims for damages arising from computer related services including, but not limited to, the following: consulting, data processing, programming, system integration, hardware or software

development, installation, distribution or maintenance, systems analysis or design, training, staffing or other support services, any electronic equipment, computer software developed, manufactured, distributed, licensed, marketed or sold. The policy shall include coverage for third party fidelity including cyber theft if coverage is not met in a Data Breach and Privacy/Cyber Liability policy.

If the policy is written on a claims made basis, the Offeror must provide to the Department proof that the policy provides the option to purchase an Extended Reporting Period ("tail coverage") providing coverage for no less than one (1) year after work is completed in the event that coverage is cancelled or not renewed. This requirement applies to both primary and excess liability policies, as applicable.

e. Data Breach/Cyber Liability Insurance

An Offeror is required to maintain during the term of any Contract and as otherwise required herein, Data Breach and Privacy/Cyber Liability Insurance in the amount of at least $10,000,000 each occurrence, including coverage for failure to protect confidential information and failure of the security of the Offeror's computer systems or the Department systems due to the actions of the Offeror which results in unauthorized access to the Department or their data.

Said insurance shall provide coverage for damages arising from, but not limited to the following:

i. Breach of duty to protect the security and confidentiality of nonpublic proprietary corporate information;

ii. Personally identifiable nonpublic information (e.g., medical, financial, or personal in nature in electronic or non-electronic form);

iii. Privacy notification costs;

iv. Regulatory defense and penalties;

v. Website media liability; and

vi. Cyber theft of customer's property, including but not limited to money and securities.

SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

The purpose of Section 5 of the Specifications is to set forth the submissions required of the Offeror. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of these Specifications.

5.1 Plan Requirements

The Offeror must provide a copy of their current DOH Certificate of Authority to operate an HMO.

In addition, the Offeror must:

1. Submit a copy of the draft NYSHIP Dependent Eligibility Rider that the organization will file with the DFS. A draft *2020 NYSHIP Dependent Eligibility Rider* (Attachment 19) provides the NYSHIP dependent eligibility requirements. The HMO must include this Rider, approved by the DFS, as part of its proposed benefit package.

2. Indicate whether or not the HMO will be proposing a Medicare Advantage offering.

3. Provide a list of Counties and associated rating region configuration for the HMO's proposed 2021 NYSHIP Service Area. Counties must be contiguous and listed for both Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP. The Medicare Advantage Plan Service Area must be identical to the Commercial Plan and all counties must be CMS approved. However, additional participation in underserved counties is permissible during the term of the Contract. As of January 1, 2020, the Department, in consultation with the JLMC, considers Chemung, Schuyler, Rockland, Bronx, New York, Richmond, Queens, Kings, Nassau, and Suffolk counties in New York State to be underserved. The Department, in consultation with the JLMC currently defines an "underserved county" as a county in which, in addition to the Empire Plan, only one (1) NYSHIP HMO is offered. The definition of an "underserved county" is subject to change for any given plan year by the Department in consultation with the JLMC.

4. Provide a copy of your organization's most recent annual filing of Schedule M (Complaints).

5. Describe the method that the Offeror uses to determine that all Members have reasonable access to Network Providers. For example, access to primary care physicians (PCP) should be within a 5-mile radius in an urban setting and 15 miles in a rural area. Provide the minimum standards that the Offeror uses to

measure access. Submit a measurement of network access based on a "snapshot" of the network taken on March 31, 2020.

6. Describe how the Offeror monitors if Network Providers are accepting new patients into their practices. Indicate whether the Offeror's proposed access standards take into account Provider availability. If yes, describe how.

7. Describe the Offeror's approach for credentialing Network Providers; specify if the Offeror utilizes an external credentialing verification organization. When was this process last completed? What is the Offeror's process for confirming continuing compliance with credentialing standards? How often does the Offeror conduct a complete review? Include a description of how the Offeror monitors disciplinary actions by licensing agencies.

8. Explain the Offeror's approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements that the Offeror has with each type of Provider (e.g., per diems, case rates, hourly rates, all-inclusive per diems covering Facility and Practitioner fees, etc.).

9. Indicate whether the Offeror ever incorporates pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers. If yes, describe.

10. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

11. Provide an electronic copy of the most recent Health Plan Network (HPN) report submitted to the DOH indicating the HMO provider network in place at the time of submission. This electronic report must be provided for both the Commercial Plan and Medicare Advantage Plan, if offered through NYSHIP.

12. Describe the utilization review procedures used when determining if care is medically necessary.

13. If the Offeror previously participated in NYSHIP, provide the total appeals filed by, or on behalf of NYSHIP Members for the previous plan year. Please provide the number of upheld, denied, and modified internal and external appeals. For internal appeals, HMOs must provide a breakdown of appeals by administrative and clinical categories.

14. State if the Offeror requires referrals to network specialists. If referrals are required, describe the procedure enrollees must follow for referrals to network specialists. This information should be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

15. Describe the procedure Enrollees must follow for referrals to non-network providers. This information must be provided for both the Commercial Plan and Medicare Advantage Plan, if one is proposed to be offered through NYSHIP.

16. For HMOs proposing to offer both a Commercial Plan and a Medicare Advantage Plan (MAP) through NYSHIP, state if the provider networks for both plans are identical. If there are differences in the networks, describe any differences among the networks relative to provider type. For example, 95% of the primary care physicians in the Commercial Plan also participate in the Medicare Advantage Plan and 40% of the Specialty providers (HMO must define "Specialty providers") in the Commercial Plan also participate in the Medicare Advantage Plan.

17. For HMOs proposing to offer a Medicare Advantage Plan through NYSHIP, provide the last three (3) years of CMS Star Ratings for the Medicare Advantage Plan that will be offered through NYSHIP. Indicate whether CMS has frozen enrollment any time during the last three (3) years.

18. Describe the Offeror's Medicare Enrollment reporting process. This description must include how changes to Medicare eligibility and enrollment/ disenrollment is identified and the proposed frequency and method these enrollment changes will be provided to the Department. Additionally, an Offeror is encouraged to suggest/identify a methodology of preference that will facilitate the most accurate and frequent sharing of information.

19. Describe the Offeror's process for Enrolling Members into their Medicare Advantage that conforms to the requirements set forth in Chapter 2 of the MMCM.

20. Provide current status of the NCQA or URAC rating. Please provide the 5-point NCQA rating scale or the applicable URAC rating. The JLMC encourages an HMO to seek accreditation by nationally recognized organizations such as NCQA or URAC. If not currently accredited by NCQA or URAC, provide a detailed explanation why accreditation was not obtained.

21. HMOs (charitable organizations) that are not for profit entities must provide a statement that the organization is exempt pursuant to one of the categories indicated on the Office of Attorney General's Request for Registration Exemption (Schedule E). The statement must identify the specific category under which the charitable organization is exempt.

22. Outline what, if any, coverage is available to both Commercial and Medicare Members travelling outside of the United States. Please provide an overview for both Commercial and Medicare coverage as well as emergent, non-emergent and prescription drug services.

23. Provide an overview of the current telemedicine/telehealth program available to NYSHIP Members in the HMO. Explain if there is an out-of-pocket cost to Members for these services and what the cost would be. Indicate if the program is administered in house or if the HMO uses a subcontractor. Describe when Members have access to telemedicine/telehealth services.

24. Provide confirmation that the HMO will cover the diagnosis and treatment of Gender Dysphoria. Please also provide any Member cost-sharing or prior authorizations that may apply.

25. Complete the charts and answer the narrative questions as they appear on the *Prescription Drug Benefit Form* (Attachment 14).

26. Certificate of Coverage (for Commercial Plan) and coverage riders. The proposed standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Certificate of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Certificate and separate out the prescription drug coverage provisions.

27. Evidence of Coverage (for Medicare Advantage Plans) and coverage riders, if offering a Medicare Advantage Plan. The proposed Medicare standard contract and riders should be available with prescription drug coverage and without prescription drug coverage. If the Evidence of Coverage is the same but for the prescription drug coverage, please submit only one copy of the Evidence of Coverage and separate out the prescription drug coverage provisions.

28. A completed *Commercial Benefits Chart* (Attachment 35) and *Medicare Benefits Chart* (Attachment 36) for both Commercial and Medicare Advantage Plans, as applicable, citing where each of the named benefits proposed for 2021 can be found in Contract or rider language. All Contracts and/or riders relating to the 2021 benefit offering must be listed. If there is no additional cost, indicate N/C in Projected Monthly Premium column. List the cost of the standard contract and riders for each rating region once, reference the citation in all other appropriate areas.

5.2 Member Communication Material Requirements

The Offeror must:

1. Submit drafts of the Cover Letter for the Member communications materials mailing to HMO Members, federally mandated Summary of Benefits and Coverage (SBC) and Schedule of Benefits, in both hard copies and PDF with their Proposals. In addition, those HMOs that participated in NYSHIP in 2020 are required to submit drafts of the Side by Side Comparison of Benefits in both hard copies and PDF with their Proposals. HMOs that did not participate in NYSHIP in 2020 will not be required to furnish the Side by Side Comparison with their

Proposals.

2. The Offeror must provide a list of wellness programs/activities held or scheduled for 2020 and a summary of planned activities for 2021 using the Wellness Programs/Activities chart (Attachment 15).

3. The Offeror must provide a list of its current five largest employer groups in descending order by number of contracts using the *Current Five Largest Employer Groups* chart (Attachment 16).

4. Federally required Summary of Benefits and Coverage (SBC) for the proposed benefit package offered through NYSHIP. If the final 2021 SBC is not available for inclusion with this submission, please submit a draft version and advise when it is expected to be finalized. A finalized SBC must be submitted as soon as it is available, but no later than October 1, 2020.

5. Additional Member Communication Materials to Members for 2021 – Cover Letters, Marketing Materials. Refer to Section 3.6 of these Specifications for specific details. To ensure all Members have plan information prior to the NYSHIP Option Transfer Period, HMOs must submit confirmation to the Department that all Required Communications Materials have been mailed to Members by October 21, 2020.

6. Choices Page, for both Commercial and Medicare Advantage Plans, as applicable. HMOs will have ten business days to complete their HMO e-page(s), after which time, access will be denied. All HMOs submitting Proposals will be required to access a Department online data interface (HMO ePage) through which plan benefit details will be electronically submitted to the Department. Additionally, HMOs are required to print a hard copy of their Choices page information from the database and submit it with their Proposal. This process will enable the Department to implement their online health benefit plan comparison tool. [**Note:** HMOs will ONLY be granted access to the Department's online data interface with their ePage if they have completed and submitted an affirmative *Notice of Intent* (Attachment 28) to participate in the 2021 NYSHIP plan year. The *Notice of Intent* will only be considered valid if it is sent to both the Department and the *JLMC Contact Members* (Attachment 13).]

   HMOs that participate in NYSHIP during 2020 will be able to edit selected fields of their 2021 Choices page content in the electronic templates to accurately describe plan benefits for the 2021 Plan Year. HMOs that did not participate in NYSHIP during 2020 will access blank electronic templates to electronically submit their Choices page information.

   The Department's Communications Unit will use the electronic information submitted by each HMO to format a version of their pages for the Choices guide. HMOs will receive copies of their final Choices pages for sign off for accuracy via

e-mail from the Communications Unit. Benefits described on an HMO's Choices pages will be binding upon such HMO, even in the event of erroneous oversight during such review.

7. Schedule of Benefits required for Commercial Plan and Medicare Advantage Plan enrollees, if applicable. [**Note**: If this is part of the Offeror's Certificate of Coverage and/or Evidence of Coverage, indicate page numbers where this information can be found].

8. Side by Side Comparison of Benefit Changes 2020 to 2021 (document must be titled as such) identifying changes from 2020 (current year) to 2021 (upcoming year) for Commercial Plan and Medicare Advantage Plan Enrollees, if applicable. In the event there are no changes in the benefits offered, the HMO is required to mail an affirmative statement to Members confirming that there are no changes from the previous year; a copy of the statement of "no change" should be included in this submission, if applicable. This requirement is only for HMOs that participated in NYSHIP in 2020. See *SAMPLE Side-by-Side Comparison* (Attachment 25).

9. Listing of Certificate/Group Contract, Riders and/or Amendments (see *SAMPLE Contract and Rider* Summary (Attachment 30)). Include both Commercial HMO and Medicare Advantage Plan documents.

5.3 Website Access

1. In accordance with Section 3.9 of these Specifications, the Offeror must provide the following:

    a. The website address to the online prescription drug formulary that the Offeror proposes for the NYSHIP plan;

    b. The process by which JLMC Members obtain the user IDs and passwords necessary to access the HMO website to view applications available to Members other than protected health information.

    c. For the Provider search, provide a copy of the message that would be returned if a Member entered a zip code outside of the HMOs approved NYSHIP service area.

SECTION 6: FINANCIAL PROPOSAL

An Offeror is not required to include a Financial Proposal in their submission for these Specifications.

SECTION 7: EVALUATION AND SELECTION CRITERIA

The Department intends to award Contracts to each Offeror whose Proposal meets the Minimum Mandatory Requirements outlined in Section 1.5 of these Specifications.

7.1 Administrative Proposal Evaluation

Proposals determined by the Department to satisfy the submission requirements set forth in Section 4 of these Specifications will be reviewed by an evaluation team composed of staff from the Department. An Offeror's Proposal shall not be considered for award until the Offeror submits a *Formal Offer Letter* (Attachment 3) and an *Offeror Attestations Form* (Attachment 6).

7.2 Technical Proposal Evaluation

The Department, in coordination with the JLMC will verify that an Offeror has a Certificate of Authority issued by the DOH. If the Offeror's proposal meets this requirement, it will be considered for an award.

7.3 Method of Award

The Department, in coordination with the JLMC, intends to award Contracts to all Offerors whose Proposals meet the Administrative and Technical Proposal Requirements.

SECTION 8: LEGAL TERMS AND CONDITIONS

The Offeror that is determined to provide the best value to the Department shall be notified of its conditional award of a Contract subject to the successful development of a Contract. The resulting Contract shall incorporate the requirements set forth in the Specifications. Additional terms and conditions not already addressed in the Specifications are set forth below.

1. The Department shall establish the premium rates to be paid to the Offeror during the term of Contract resulting from these Specifications. The premium payments made by the Department to the Offeror based on the established rates, shall be the sole and exclusive payment for all Project Services required by the Contract.

2. The Department shall make premium payments to the Contractor on a monthly basis, starting with the Effective Date of the Contract resulting from these Specifications. The amount of premium payment for each monthly period shall be calculated by multiplying the number of Enrollees enrolled in the Plan by the premium rate in effect for the respective types of coverage.

3. Use and Disclosure of Protected Health Information

    a. The Offeror acknowledges that the Offeror is a "Business Associate" as that term is defined in the HIPAA implementing regulations at 45 CFR 160.103. of the Department as a consequence of the Offeror's provision of Project Services on behalf of the Department within the context of the Offeror's performance under the resulting Contract and that the Offeror's provision of Project Services will involve the disclosure to the Offeror of individually identifiable health information from the Department or other service providers on behalf of the Department, as well as the Offeror's disclosure to the Department of individually identifiable health information as a consequence of the Project Services performed under the resulting Contract. As such, the Offeror, as a Business Associate, will be required to comply with the provisions of this Section.

    b. For purposes of this Section, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within the context of the resulting Contract, PHI may be received by the Offeror from the Department or may be created or received by the Offeror on behalf of the Department in the Offeror's capacity as a Business Associate. All PHI

received or created by the Offeror in the Offeror's capacity as a Business Associate and as a consequence of its performance under the resulting Contract is referred to herein collectively as "Department's PHI."

c. The Offeror acknowledges that the Department administers on behalf of New York State several group health plans as that term is defined in HIPAA's implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a "covered entity" under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these "covered entities" under HIPAA. The Offeror further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Offeror further acknowledges that (i) the Offeror is a HIPAA "Business Associate" of the group health plans identified herein as "covered entities" as a consequence of the Offeror's provision of certain services to and/or on behalf of the Department as administrator of the "covered entities" within the context of the Offeror's performance under the resulting Contract, and that the Offeror's provision of such services may involve the disclosure to the Offeror of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Offeror's disclosure to the Department of individually identifiable health information as a consequence of the services performed under the resulting Contract; and (ii) Contactor is a "covered entity" under HIPAA in connection with its provision of certain services under the resulting Contract. To the extent Offeror acts as a HIPAA "Business Associate" of the group health plans identified as "covered entities", the Offeror shall adhere to the requirements as set forth herein. All consents and/or authorizations, if any, required for Offeror to perform the services hereunder and for the use and disclosure of information, including the Department's PHI, as permitted under the resulting Contract have or will be obtained from Enrollees and or Members.

d. Permitted Uses and Disclosures of the Department's PHI: The Offeror may create, receive, maintain, access, transmit, use and/or disclose the Department's PHI solely in accordance with the terms of the resulting Contract. In addition, the Offeror may use and/or disclose the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Offeror may use and disclose the Department's PHI for the proper management and administration of the Offeror if such use is necessary for the Offeror's proper management and administration or to carry out the Offeror's legal responsibilities, or if such disclosure is required by law or the Offeror obtains reasonable assurances from the person to whom the information

is disclosed that it shall be held confidentially 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 the Offeror of any instances of which it is aware in which the confidentiality of the information has been breached. Additionally, the Offeror may use and/or disclose the Department's PHI, as appropriate: (i) for treatment, payment and health care operations as described in 45 CFR Section 164.506(c)(2), (3) or (4); and (ii) to de-identify the information or create a limited data set in accordance with 45 CFR §164.514, which de-identified information or limited data set may, consistent with Section 8(3)(e), below, be used and disclosed by Offeror only as agreed to in writing by the Department and permitted by law.

e. Nondisclosure of the Department's PHI: The Offeror shall not create, receive, maintain, access, transmit, use or further disclose the Department's PHI otherwise than as permitted or required by the resulting Contract or as otherwise required by law. The Offeror shall limit its uses and disclosures of PHI when practicable to the information comprising a Limited Data Set, and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

f. Safeguards: The Offeror shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for in the resulting Contract. The Offeror shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards that satisfy the standards set forth in the HIPPA Security Rule at 45 C.F.R §§164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 C.F.R. § 164.316, appropriate to the size and complexity of the Offeror's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, accesses, or that it transmits on behalf of the Department pursuant to the resulting Contract to the same extent that such electronic PHI would have to be safeguarded if created, received, maintained, accessed or transmitted by a group health plan identified herein.

g. Breach Notification:

In addition to the Disclosure of Breach requirements specified in Appendix B, the following provisions shall apply:

i. Reporting: The Offeror shall report to the Department any breach of unsecured PHI, including any use or disclosure of the Department's PHI otherwise than as provided for by the resulting Contract, of which the Offeror becomes aware. An acquisition,

access, transmission, use or disclosure of the Department's PHI that is unsecured in a manner not permitted by HIPAA or the resulting Contract is presumed to be a breach unless the Offeror demonstrates that there is a low probability that Department's PHI has been compromised based on the Offeror's risk assessment of at least the following factors: (i) the nature and extent of Department's PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used Department's PHI or to whom the disclosure was made; (iii) whether Department's PHI was actually acquired or viewed; and (iv) the extent to which the risk to Department's PHI has been mitigated.

ii. Required Information: In addition to the information required in Appendix B, Disclosure of Breach, the Offeror shall provide the following information to the Department within in the time period identified in Appendix B, Disclosure of Breach, except when, despite all reasonable efforts by the Offeror to obtain the information required, circumstances beyond the control of the Offeror necessitate additional time. Under such circumstances, the Offeror shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

1) the date of the breach incident;

2) the date of the discovery of the breach;

3) a brief description of what happened;

4) a description of the types of unsecured PHI that were involved;

5) identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

6) a brief description of what the Offeror is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

7) any other details necessary to complete an assessment of the risk of harm to the individual.

iii. The Offeror will be responsible to provide notification to individuals whose unsecured PHI has been or is reasonably

believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary of the United States Department of Health and Human Services and the media, as required by 45 CFR Part 164.

iv. The Offeror shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

v. The Offeror shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Offeror not permitted by the resulting Contract.

h. Associate's Agents: The Offeror shall require all of its agents or Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Offeror on behalf of the Department, to agree, by way of written Contract or other written arrangement, to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Offeror with respect to the Department's PHI under the resulting Contract.

i. Availability of Information to the Department: The Offeror shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Offeror to fulfill the Department's obligations to provide access to, provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Offeror shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department. The Offeror must provide the Department with access to the Department's PHI in the form and format requested, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by the Parties, provided, however, that if the Department's PHI that is the subject of the request for access is maintained in one or more designated record sets electronically and if requested by the Department, the Offeror must provide the Department with access to the requested PHI in a readable electronic form and format.

j. Amendment of the Department's PHI: The Offeror shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Offeror shall, as directed by the Department, incorporate any amendments to the

Department PHI into copies of such Department PHI maintained by the Offeror.

k. Internal Practices: The Offeror shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Offeror on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

l. Termination

    i. This Contract may be terminated by the Department at the Department's discretion if the Department determines that the Offeror, as a Business Associate, has violated a material term of this Section. Data return and destruction upon Contract termination is governed by Information Security Requirements, Appendix C.

m. Indemnification: Notwithstanding the provisions in Appendix B, the Offeror agrees to indemnify, defend and hold harmless the State and the Department and its respective employees, officers, agents or other Members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Contract or from any acts or omissions related to this Contract by the Offeror or its employees, officers, subcontractors, agents or other Members of its workforce, without limitations. Accordingly, the Offeror shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Offeror's acts or omissions hereunder. The Offeror's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Contract. This section is not subject to the limitation of liability provisions of the Contract.

n. Miscellaneous:

    i. Survival: The respective rights and obligations of Business Associate and the "covered entities" identified herein under HIPAA and as set forth in this Section, USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION, shall survive termination of the resulting Contract.

ii. Regulatory References: Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified, as of their respective compliance dates.

iii. Interpretation: Any ambiguity in the resulting Contract shall be resolved to permit covered entities to comply with HIPAA.