AGREEMENT NO. C000XXX

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE
and
INSERT Contractor NAME

THIS Agreement is entered into by and between New York State Department of Civil Service ("Department" or "DCS"), having its principal office at Empire State Plaza, Agency Building #1, Albany, NY, 12239 and _____ ("Contractor"), a corporation authorized to do business in the State of New York with a principal place of business located at _____, and collectively referred to as "the Parties."

WITNESSETH

WHEREAS, Civil Service Law Article XI authorizes and directs the President of the State Civil Service Commission and New York State Department of Civil Service ("President") to establish a health benefit plan for the benefit of State Employees, Retirees, and their Dependents, and for the benefit of Participating Employers' Employees, Retirees, and their Dependents; and

WHEREAS, Civil Service Law Article XI authorizes and directs the President to purchase a contract or contracts to provide the benefits under the plan of health benefit; and

WHEREAS, The Empire Plan Mental Health and Substance Abuse Program ("Program") provides those mental health and substance abuse health benefits, purchased by the President, for the benefit of those stated above and shall be administered in accordance with New York State laws and regulations including the Civil Service Law, the State Finance Law Article XI, and their respective implementing regulations, including but not limited to the Regulations of the Department of Civil Service (President's Regulations); and

WHEREAS, on _____ , the Department of Civil Service issued a Request for Proposal (RFP) entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and

Student Health Plan" to secure the services of a qualified organization to provide Program Services as defined in the RFP; and

WHEREAS, after thorough review and evaluation by the State of Proposals received in response to the RFP, the Contractor's Proposal was selected as representing the best value to the State; and

WHEREAS, the Department, in reliance upon the expertise of the Contractor, desires to engage the Contractor to deliver the Program Services, pursuant to the terms and conditions set forth in this Agreement;

THEREFORE, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

1.1.0 **Administrative Fee** means the monthly fee that the Contractor charges the MHSA Program for all administrative services exclusive of the Shared Communication Expense as calculated on a per Enrollee per Month basis.

1.2.0 **Affiliate** means 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.

1.3.0 **Alternate Level of Care (ALOC)** means residential treatment centers, halfway houses, group homes, partial hospitalization programs or continuing day treatment programs which satisfy the requirements of an Approved Facility.

1.4.0 **Applied Behavioral Analysis (ABA)** means a behavioral health service for teaching children with Autism Spectrum Disorder through intensive skill training.

1.5.0 **Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations

for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by the Contractor. Residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by the Contractor.

1.6.0 **Business Day(s)** means every Monday through Friday, except for days designated as Business Holidays.

1.7.0 **Business Holiday(s)** means legal holidays observed by the State and any days designated by the Contractor as a holiday and approved as such by the State prior to January 1 of each Calendar Year.

1.8.0 **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.

1.9.0 **Call Center Hours** means 24 hours a Day, 365 Days a year.

1.10.0 **Certification or Certified** means a determination by the Contractor that mental health care or substance abuse care or proposed care is a Medically Necessary, Covered Service in accordance with the terms of the Contract.

1.11.0 **Child(ren)** means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a statement of dependence and documentation.

1.12.0 **Clinical Manager** means licensed Ph.D.; clinical psychologist, licensed professional registered nurse, or licensed master's level certified social worker with a minimum of three to five years of previous position-related clinical experience in mental health and/or substance abuse treatment or other licensed, qualified individual as approved by the Program.

1.13.0 Clinical Referral Line means the clinical resource and referral service called prior to receiving any Covered Services to obtain network referrals or benefit information. Available 24 hours a Day, 365 Days a year.

1.14.0 Coinsurance means, for Non-Network Approved Facility services, the difference between the billed charge and the percentage covered; and, for non-network Practitioner services, the difference between the Reasonable and Customary charge and the percentage covered. The Plan's coinsurance maximum is shared between Basic Medical, the Hospital Program and the Mental Health and Substance Abuse Program. Copayments paid to a Network Practitioner count toward meeting the Plan's Coinsurance Maximum.

1.15.0 Coinsurance Maximum means the sum of coinsurance costs incurred under the Basic Medical Program and Non -Network Coverage under the Hospital Program and Mental Health and Substance Abuse Program. After the combined annual Coinsurance Maximum is reached, benefits are paid at 100 percent of Reasonable and Customary charges for Covered Services.

1.16.0 Contractor means **(TBD)**, the successful Contractor selected as a result of the evaluation of Offerors' Proposals submitted in response to the RFP and who executes an Agreement with the Department to provide Program Services.

1.17.0 Copayment means the amount the Enrollee is required to pay per visit for Covered Services as specified by the benefit design of the Program.

1.18.0 Covered Services means Medically Necessary mental health and substance abuse care as defined under the terms of the Program, except to the extent that such care is otherwise limited or excluded under the Program.

1.19.0 Crisis Intervention Visits means an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

1.20.0 Day(s) means calendar days unless otherwise noted.

1.21.0 DCS or Department means the New York State Department of Civil Service.

1.22.0 Dedicated Call Center means a group of customer service representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the Program. The customer service representatives are dedicated to the Program and do not work on any other accounts.

1.23.0 Deductible means the amount paid by the Enrollee each Calendar Year for Covered Services under the non-network portion before a Plan payment is made. Plan deductibles are shared between the Medical Program and the Mental Health and Substance Abuse Program. The amount applied toward satisfaction of the deductible will be the lower of the following: the amount actually paid for a Medically Necessary service under the non-network portion of the Program; or for Practitioner services, the Reasonable and Customary charge; or for Approved Facility services, the billed amount for such service.

1.24.0 Dependent means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the New York State Health Insurance Program.

1.25.0 Dependent Survivor means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who was covered as a dependent of the deceased Enrollee at the time of the Enrollee's death and who elects to continue coverage under NYSHIP following the three (3) month extended benefits period.

1.26.0 Disabled Lives Benefit means the benefits provided to an Enrollee who is Totally Disabled on the date coverage ends. The benefits are provided on the same basis as if coverage had continued with no change until the day the Enrollee is no longer Totally Disabled or for ninety (90) days after the date the coverage ended, whichever is earlier.

1.27.0 **Emergency Care** means care received for an emergency condition. An emergency condition is a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such a person or others in serious jeopardy; serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person; or serious disfigurement of such person.

1.28.0 **Employee** means "Employee" as defined in 4 NYCRR Part 73, as amended, or as modified by collective bargaining agreement.

1.29.0 **Employer** means "Employer" as defined in 4 NYCRR Part 73, as amended.

1.30.0 **Enrollee** means an "Employee" or "Dependent" enrolled in the Program with mental health/ substance abuse benefits.

1.31.0 **ET** means prevailing Eastern Time.

1.32.0 **HIPAA** means Health Insurance Portability and Accountability Act of 1996

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1.33.0 **Inpatient Services** means those services rendered in an Approved Facility to an Enrollee who has been admitted for an overnight stay and is charged for room and board.

1.34.0 **Intensive Outpatient Program (IOP) is** a freestanding or hospital-based program that provides medically necessary services more than once weekly. Intensive outpatient programs are used as a step-up from routine outpatient services, or as a step-down from acute inpatient, residential care or a partial hospital program. Intensive outpatient programs can be used to treat mental health conditions or substance abuse disorders, or can specialize in the treatment of co-occurring mental health conditions and substance-use disorders.

1.35.0 **Key Subcontractor(s)** means those vendors with whom the Contractor subcontracts to provide Program Services and incorporates as a part of the Contractor's Program Team.

1.36.0 Medical Necessity/Medically Necessary means a Covered Service which the Contractor has certified to be: medically required; having a strong likelihood of improving the condition; and provided at the lowest appropriate level of care for the specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by the Contractor.

1.37.0 Mental Health Care means Medically Necessary care rendered by a covered Practitioner or Approved Facility and which, in the opinion of the Contractor, is directed predominately at treatable behavioral manifestations of a condition that the Contractor determines: is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and substantially or materially impairs a person's ability to function in one or more major life activities; and has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

1.38.0 MHSA Program/Plan means the New York State Health Insurance Program's Empire Plan Mental Health and Substance Abuse Program, the Excelsior Plan Mental Health and Substance Abuse Program and the Student Employee Health Plan Mental Health and Substance Abuse Program administered by the New York State Department of Civil Service.

1.39.0 Network Allowance means the amount Network Providers have agreed to accept as payment in full for services rendered, including applicable Copayment under the MHSA Program.

1.40.0 Network Coverage means the level of benefits provided by the Program for Medically Necessary services from a Network Provider or a Provider recommended by the Contractor.

1.41.0 Network Facility means an Approved Facility that has entered into a Network Provider agreement with the Contractor as an independent contractor. The records of the Contractor shall be conclusive as to whether a facility has a Network Provider agreement in effect on the date services are obtained. A non-network facility can be considered a network facility on a case-by-case basis when approved by the Contractor.

1.42.0 Network Practitioner means a Practitioner who has entered into an agreement with the Contractor as an independent contractor to provide Covered Services. The records of the Contractor shall be conclusive as to whether a person had a Network Provider agreement in

effect on the date services are obtained. A non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by the Contractor.

1.43.0 Network Provider means either a Network Practitioner or a Network Facility.

1.44.0 Non-Network Coverage means the level of reimbursement paid by the Program for Covered Services from a Non-Network Provider in compliance with the Program requirements outlined in the Agreement.

1.45.0 Non-Network Facility means an Approved Facility that has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services.

1.46.0 Non-Network Practitioner means a Practitioner who has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services. A Non-Network Practitioner can be considered a Network Practitioner on a case-by-case basis when approved by the Contractor.

1.47.0 Non-Network Provider means a Practitioner or Approved Facility that has not entered into an agreement with the Contractor to provide Covered Services.

1.48.0 NYS means New York State.

1.49.0 NYSHIP means the New York State Health Insurance Program.

1.50.0 Outpatient Services means those services rendered in a Practitioner's office or in the department of an Approved Facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.

1.51.0 Partial Hospitalization means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay.

1.52.0 Participating Agency (PA) means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the

President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.53.0 **Participating Employer (PE)** means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

1.54.0 **Pass-through Pricing** means the Program is charged the same mental health substance abuse services fee paid to the Network Provider.

1.55.0 **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five (5) years of clinical experience who renders Medical Necessity decisions.

1.56.0 **Physician** means a Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.). He or she must be legally licensed to practice medicine, without limitations or restrictions.

1.57.0 **Plan Sponsor** means the Council on Employee Health Insurance, which is composed of the President of the Civil Service Commission, Director of the Governor's Office of Employee Relations, and the Director of the Division of Budget.

1.58.0 **Plan Year** means the period from January 1st to December 31st in each Plan Year covered by this Agreement, unless specified otherwise by the Program.

1.59.0 **PPACA** means Patient Protection and Affordable Care Act of 2010.

1.60.0 **Practitioner** means:

1.59.1 A psychiatrist; or

1.59.2 A psychologist; or

1.59.3 A licensed and registered clinical social worker with at least six (6) years of post-degree experience who is qualified by the New York State Board for Social Work. In New York State, this is determined by the "R" number given to qualified social workers. If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or

1.59.4 A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses who hold a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; or

1.59.5 A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat, and prescribe for a patient's condition that falls within their specialty area of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols; or

1.59.6 Applied behavioral analysis provider or Certified Behavioral Analyst (CBA) provider: A licensed provider who is certified as a behavior analyst pursuant to a behavioral analyst certification board. For ABA only, licensed provider means a psychiatrist, psychologist or licensed clinical social worker, or an individual licensed or otherwise authorized under education Law Title VIII to practice a profession for which ABA is within the scope of that profession; or

1.59.7 Applied behavioral analysis or ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a licensed provider and certified behavioral analyst. An ABA Agency may also employ ABA aides to deliver the treatment protocol of the ABA Provider.

1.61.0 **President** means the President of the Civil Service Commission who is also the Commissioner of the Department of Civil Service.

1.62.0 **Program Services** means all of the services to be provided by the Contractor as set forth in this Agreement.

1.63.0 **Program Team** means the Contractor and those Key Subcontractors, if any, utilized by the Contractor who collectively undertake and perform the Program Services which are the subject of the Agreement.

1.64.0 **Proposal** means the Contractor's Administrative Proposal, Technical Proposal, and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement, as follows **(TBD)**

1.65.0 **Provider** means a Practitioner or facility that supplies Covered Services under the MHSA Program.

1.66.0 **Provider Network** means the Contractor's credentialed and contracted network of Network Practitioners and Network Facilities.

1.67.0 **Reasonable and Customary** means the lowest of:

1.67.1 The actual charge for services; or

1.67.2 The usual charge for services by the Provider; or

1.67.3 The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

1.68.0 **Referral** means the process by which the Contractor's toll-free Clinical Referral Line refers an Enrollee to a Network Provider to obtain Covered Services.

1.69.0 **Regulations of the President of the New York State Civil Service Commission** means those regulations promulgated by the President of the Civil Service Commission under the authority of Civil Service Law Article XI, as amended, and including, but not limited to those regulations to be promulgated as 4 New York Code of Rules and Regulations (NYCRR) Part 73.

1.70.0 **Renewal Date** means January 1, 2015 and annually thereafter up to and including January 1, 2018.

1.71.0 **Retiree** means any person defined as a Retiree pursuant to the terms of 4 NYCRR Part 73, as amended.

1.72.0 **RFP or Procurement** means the Request for Proposals entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan, dated XXXX.".

1.73.0 **Shared Accumulator** means the Coinsurance and Deductible amounts shared between the MHSA, Medical and Hospital components of the Empire Plan, Student Employee Health Plan and Excelsior Plan.

1.74.0 **Shared Communication Expense** means the expense that the Contractor will be billed and must pay on a quarterly basis to contribute toward the cost of producing various Empire Plan and NYSHIP publications (i.e. provider directories, Choices Guides, At A Glance publications, etc)

1.75.0 **Single Case Agreement** means a unique agreement that the Contractor negotiates with a Network Provider to provide MHSA Program Network-level services for a specific Enrollee when there is sufficient access to a Network Provider within a certain geographic area or a Non-Network Provider possesses a unique specialty that is not currently possessed by a Network Provider within that geographic area.

1.76.0 **State** means New York State as a whole.

1.77.0 **Structured Outpatient Rehabilitation Program (SOP)** means a program that provides substance abuse care and is an operational component of an Approved Facility that is state licensed. If located in New York State, the program must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York. If the program is located outside New York State, it must be part of an Approved Facility accredited by the Joint Commission on Accreditation of Health Care Organizations as a hospital or as a health care organization that provides psychiatric and/or drug abuse or alcoholism services to adults and/or adolescents. The program must also meet all applicable federal, state and local laws and regulations. A Structured Outpatient Rehabilitation Program is a program, in which the patient participates, on an outpatient basis, in prescribed formalized treatment, including an aftercare component of weekly follow-up. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

1.78.0 **Substance Abuse Care** means Medically Necessary care provided by an eligible provider for the illness or condition that the Contractor has determined: is a clinically significant behavioral or psychological syndrome or pattern; and substantially or materially impairs a person's ability to function in one or more major life activities; and is a condition which has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this Program.

1.79.0 **Summary Plan Description(s) (SPD)** means the document(s) issued pursuant to and attached by reference to the Agreement. The SPD is issued to Enrollees and describes Program benefits. The SPD includes the initial SPD and amendments, if any.

1.80.0 **Total Disability and Totally Disabled** means that because of a mental health/substance abuse condition, the Enrollee, cannot perform his/her job or the Dependent cannot perform the normal activities of a person that age.

1.81.0 **Urgent Care** is care that does not meet the definition of emergency care but which should be provided early in the onset of symptoms in order to alleviate or prevent permanent disability, serious medical complications, loss of life or harm to the patient or others.

1.82.0 **Utilization Review** (UR) means a medical management program which reviews the Medical Necessity of mental health and substance abuse treatment. The review should be conducted by a team of licensed and/or certified psychiatric nurses, licensed clinical social workers ("R" status), board-certified or board-eligible psychiatrists and clinical psychologists, as appropriate, to determine whether proposed services are Medically Necessary for diagnosed condition(s). Utilization review includes pre-certification, prior authorization, concurrent review and discharge planning.

1.83.0 **Vestee** means a former Employee who is entitled to continue benefits under NYSHIP because he/she has met all the requirements for NYSHIP coverage as a Retiree, except for age eligibility for pension, at the time employment terminates.

ARTICLE II: AGREEMENT DURATION AND AMENDMENTS

2.1.0 This Agreement shall be subject to and effective upon the approval of the New York State Attorney General's Office ("AG") and the NYS Office of the State Comptroller ("OSC"). The term of the Agreement shall include an implementation period followed by five (5) years of Program Services. It is the Department's intent that this implementation period shall begin on or around October 1, 2013, upon OSC approval of the Agreement, with all other contractual responsibilities to begin on January 1, 2014, through and including December 31, 2018, and subject to the termination provisions contained herein.

2.2.0 The Agreement is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the AG and the OSC.

ARTICLE III: INTEGRATION

3.1.0 This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.

3.2.0 All statements made by the Department shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

4.1.0 The Agreement consists of:

4.1.1 The body of the Agreement (that portion preceding the signatures of the Parties in execution), and any amendments thereto;

4.1.2 Appendix A – Standard Clauses for All New York State Contracts;

4.1.3 Appendix B – Standard Clauses for All Department Contracts;

4.1.4 Appendix C – Third Party Connection and Data Sharing Agreement;

4.1.5 Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.6 The following Exhibits attached and incorporated by reference to the body of the Agreement:

4.1.6a Exhibit A: which includes: the MacBride Act Statement; and the Non-Collusive Bidding Certification;

4.1.6b Exhibit B: the Request for Proposals entitled “Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan,” dated ??and Exhibit B-1, the official Department response to questions raised concerning the RFP, dated **(TBD)**;

4.1.6c Exhibit C: the Contractor's Proposal; and

4.1.6d Exhibit D: the Summary Plan Descriptions.

4.1.7 In the event of any inconsistency in, or conflict among, the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:

4.1.7a First, Appendix A – Standard Clauses for All New York State Contracts;

4.1.7b Second, Appendix B – Standard Clauses for All Department of Civil Service Contracts;

4.1.7c Third, Appendix C –Third Party Data Connection and Data Exchange Agreement;

4.1.7d Fourth, Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;

4.1.7e Fifth, any Amendments to the body of the Agreement;

4.1.7f Sixth, the body of the Agreement;

4.1.7g Seventh, Exhibit B, the Request for Proposals entitled "Mental Health and Substance Abuse Benefit Services for The Empire Plan, Excelsior Plan and Student Employee Health Plan," and Exhibit B-1, the official Department response to questions raised concerning the RFP, dated **(TBD)**;

4.1.7h Eighth, Exhibit C: the Contractor's Proposal; and, Exhibit C-1: Written responses to the Management Interview and related materials clarifying the Contractor's Proposal; and

4.1.7i Ninth, Exhibit D, the Summary Plan Description and Benefit Summaries

4.2.0 The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

5.1.0 The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.

5.2.0 Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect, including but not limited to the requirements set forth in Chapter 56 of the Laws of 2010.

5.3.0 The Contractor shall provide the Department with immediate notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement.

ARTICLE VI: PROGRAM SERVICES

6.1.0 The Contractor shall provide all of the Program Services as set forth herein this Article VI of the Agreement for the entire term of the Agreement pursuant to the Summary Plan Description(s) incorporated into this Agreement as Exhibit D. All Program Services shall be provided in accordance with the New York State Civil Service Law and its implementing regulations, and other NYS and Federal Law as may be applicable. In addition, the Contractor shall deliver the Program Services in such a manner so as to comply with all provisions of this Agreement. The Contractor may provide certain services through Key Subcontracts with the prior review and approval of the Department. Each subcontract entered into with a corporate entity separate from the Contractor for the purpose of delivering Program Services must be maintained throughout the term of the Agreement unless such change is approved in writing by the Department. All Key Subcontracts shall expressly name the State of New York, through the Department, as the sole intended beneficiary of any such Key Subcontract. The Contractor must maintain significant financial, legal, and audit oversight of any of its Key Subcontractors. The Contractor remains fully responsible for all services and actions performed under this Agreement. The Contractor shall submit all Key Subcontracts to the Department for its approval. The Contractor shall submit all such Key Subcontracts with no redactions to the Department before execution for its review and approval.

(Note: Costs/Fees for all services required under this Agreement shall be included in the Contractor's Administrative Fee).

6.2.0 **Account Team**

6.2.1 The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the MHSA Program during implementation and operation.

6.2.1a The account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the MHSA Program in an efficient manner;

6.2.1b The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all MHSA Program requirements and to address any issues that may arise during the performance of the Agreement.

6.2.2 The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

6.2.2a provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council on Employee Health Insurance or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department;

6.2.2b immediately notify the Department in writing of actual or anticipated events impacting MHSA Program costs and/or delivery of services to Enrollees such as but not limited to legislation, class action settlements, and operational issues.

6.2.3 The Contractor's dedicated account team must ensure that the MHSA Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor must work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or MHSA Program material.

6.2.4 The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.

6.3.0 **Premium Development Services:** The Contractor will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

6.3.1 Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the MHSA Program and the State;

6.3.2 Developing of projected aggregate claim, trend and Administrative Fee amounts for each MHSA Program Year. Analysis of all MHSA Program components impacting the MHSA Program cost shall be performed including, but not limited to claims, trend factors, Administrative Fees and changes in enrollment; and

6.3.3 Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

6.4.0 **Implementation**

6.4.1 The Contractor must commence an implementation period beginning on or around October 1, 2013 following approval of the Agreement by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section 7.2.0 of this Agreement. Such implementation activities must be completed no later than December 31, 2013 so that the MHSA Program is fully operational on January 1, 2014.

6.5.0 **Customer Service**

6.5.1 The Contractor will be responsible for all customer support and services including, but not limited to:

6.5.1a Providing Enrollees access to information on all MHSA benefits and services related to the MHSA Program through the Empire Plan consolidated toll-free number twenty-four (24) hours a Day, 365 Days a year;

6.5.1b The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Contractor's line at their call center service site. The Contractor must sign a shared service agreement with the Empire Plan's medical carrier/third party administrator (currently UnitedHealthcare) and AT&T. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to call center service as required by this Section of the Agreement;

6.5.1c Maintaining a Dedicated Call Center for the MHSA Program located in the United States that:

6.5.1d Provides direct access to trained Clinicians who direct members to appropriate Network Providers, provide clinical MHSA information and if requested by the caller, assist in scheduling appointments on behalf of the member twenty-four (24) hours a Day, 365 Days a year;

6.5.1e Provides access to fully trained customer service representatives and supervisors available between the hours of 8:00a.m.to 5:00p.m. Monday through Friday, except for legal holidays observed by the State;

6.5.1f Meets the Contractor's proposed call center telephone guarantees set forth in Section 7.3.0 through 7.6.0 of this Agreement.

6.5.2 Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions;

6.5.3 Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to: MHSA Program benefits levels, status of pre-certification requests, eligibility and claim status and be able to identify calls requiring transfer to a Clinician;

6.5.4 Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the dedicated customer service center is unable to meet the Contractor's proposed customer service performance guarantees. This back-up system would also be utilized in the event the primary customer service center becomes unavailable;

6.5.5 Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding: MHSA Program benefits, Network Provider locations, eligibility, Copayment information, pre-authorization information, claim status and clinically-based educational material. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department's website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department

initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal;

6.6.0 <u>Enrollee Communication Support</u>:

6.6.1 All Enrollee communications developed by the Contractor are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their MHSA Providers in connection with covered benefits or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department, in its sole discretion, reserves the right to require any change it deems necessary.

6.6.2 The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

6.6.2a Developing language describing the MHSA Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;

6.6.2b Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing MHSA Program benefit features and/or highlighting trends in MHSA utilization;

6.6.2c Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department;

6.6.2d Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period.

6.6.2e Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XV of the Agreement resulting from this RFP.

6.6.3 Upon request, subject to the approval of the Department, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. The Contractor agrees that the costs associated with these services are included in the Contractor's Administrative Fee.

6.6.4 The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Programs, including but not limited to Enrollee claim forms and certification letters. All such communications must be approved by the Department, in writing, prior to distribution.

6.7.0 <u>Enrollment Management</u>:

6.7.1 The Contractor will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files. The Contractor must provide enrollment management services including but not limited to:

6.7.1a ***Initial Testing:*** Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or

834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department;

6.7.1b Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSA Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department.

6.7.2 Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit B of the Agreement. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

6.7.3 Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data

contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

6.7.4 Providing a back-up system or have a process in place where, if enrollment information is unavailable, Enrollees can obtain Clinical Referral Line services without interruption;

6.7.5 Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement;

6.7.6 Maintaining a read only connection to the enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information Monday through Friday, from 8:00 am to 5:00 pm EST, with the exception of NYS holidays as indicated on the Department's website;

6.7.7 Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO;

6.8.0 **Reporting:** The Contractor is responsible for accurate reporting services including, but not limited to:

6.8.1 Ensuring that all financial reports including claim reports are generated from amounts billed to the MHSA Program, and reconcile to amounts reported in the quarterly and annual financial experience reports;

6.8.2 Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the MHSA Program. These reports must tie to the amounts billed to the MHSA Program. The final format of reports is subject to the Department review and approval;

6.8.3 Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The reports include, but are not limited to, reports and data files listed in Article XVI "Reports and Claim Files" section of this Agreement;

6.8.4 Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing:

6.8.4a Forecasting and trend analysis data
6.8.4b Utilization data
6.8.4c Utilization review savings
6.8.4d Benefit design modeling analysis
6.8.4e Reports to meet clinical program review needs
6.8.4f Reports segregating claims experience for specific populations
6.8.4g Reports to monitor Agreement compliance; and

6.8.5 Providing direct, secure access to the Contractor's claims system and any online and web based reporting tools to authorized Department representatives.

6.9.0 **Consulting:** The Contractor will be responsible for providing advice and recommendations regarding the MHSA Program. Such responsibility shall include, but not be limited to:

6.9.1 Informing the Department in a timely manner concerning such matters as cost containment strategies, technological improvements, Provider best practices and State/Federal legislation (e.g., Federal parity legislation, etc.) that may affect the MHSA Program. The Contractor must also make available to the Department one or more

members of the clinical or account management team to discuss the implications of new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

6.9.2 Assisting the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed MHSA Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and should the Contractor requests any change in compensation, any such change will be processed in accordance with Article VIII, Modification of Program Services.

6.10.0 Network Management

6.10.1 Provider Network

6.10.1a The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the Contractor's proposed access standards throughout the term of the Agreement. The access standards must be provided in terms of actual distance from Enrollees' residences, as follows:

% of Enrollees with Access to Network Facilities	Enrollee Location	Access Guarantee – 1 Network Facility at least within
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles

% of Enrollees with Access to Network Practitioners	Enrollee Location	Access Guarantee – 1 Network Practitioner at least within
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles

6.10.1b The Contractor must meet or exceed the Contractor's proposed access standards for, credentialed and contracted Certified Behavior Analysts in the MHSA Program's Provider Network throughout the term of the Agreement. The access standards must be provided in terms of actual distance from Enrollees' residences, as follows:

% of Enrollees with Access to Certified Behavior Analysts	Enrollee Location	1 Certified Behavior Analyst at least within
___%	Urban	___miles
___%	Suburban	___miles
___%	Rural	___miles

6.10.1c The MHSA Program requires that the Contractor have available to Enrollees on January 1, 2014 its proposed MHSA Provider Network in accordance with the requirements set forth in Section 6.4.0 of this Agreement guaranteeing effective implementation of their proposed MHSA Provider Network.

6.10.1d The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria upon the Department's request where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.

6.10.1e In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed and registered Clinical Social Workers (CSW) (in NYS social workers must have an "R" number issued by the State Education Department), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs

including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied;

6.10.2 Provider Credentialing

6.10.2a The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

6.10.2b The Contractor must establish credentialing criteria for Network Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the MHSA Provider Network, including, but not limited to, years of experience, level of education/certification, Licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments;

6.10.2c The Contractor must credential MHSA Network Providers in a timely manner and shall have an effective process by which to confirm MHSA Network Providers continuing compliance with credentialing standards.

6.10.2d The Contractor must maintain a Provider Relations staff presence within New York State.

6.10.2e The Contractor must maintain credentialing records and make them available for review by the Department upon request.

6.10.3 Provider Contracting

6.10.3a The Contractor will be responsible for providing Provider contracting services including but not limited to:

6.10.3a(1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;

6.10.3a(2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;

6.10.3a(3) Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program Copayments;

6.10.3a(4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Network Provider contracts utilized by the MHSA Program;

6.10.3a(5) Negotiating Single Case Agreements with Non-Network Providers on a case- by-case basis when the Contractor determines that it is clinically appropriate or to address guaranteed access issues;

6.10.3a(6) Negotiating agreements on a case-by-case basis, with prior approval from the Department, with Licensed Marriage and Family Therapists (LMFTs) and Licensed Mental Health Counselors (LMHCs) when an LMFT or LMHC possess a particular subspecialty that is clinically appropriate or to address access issues;

6.10.3a(7) Establishing a tiered MHSA Provider Network and incentives including but not limited to financial, administrative and continuing professional education to enhance Provider performance and clinical outcomes.

6.10.4 <u>Provider Audit and Quality Assurance</u>

6.10.4a The Contractor must have a staffed and trained audit unit employing a comprehensive Provider audit program that includes but is not limited to:

6.10.4a(1) Conducting routine and targeted on-site audits of Network Providers. Providers that deviate significantly from normal patterns in terms of cost, CPT coding or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department and/or OSC, or when information is received by the Contractor that indicates a pattern of conduct by a Provider that is not consistent with the MHSA Program's design and objectives. Any modifications to the proposed audit program must receive prior written approval from the State;

6.10.4a(2) Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of receipt of such allegations or identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the MHSA Program upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State;

6.10.4a(3) Maintaining the capability and contractual right to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

6.10.4a(4) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt

consistent with the process specified in Section XV, "Payments/ (credits) to/from the Contractor" of this Agreement;

6.10.4a(5) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees; and,

6.10.4b The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to:

6.10.4b(1) Monitoring the quality of care provided by Network Providers;
6.10.4b(2) Monitoring technical competency and customer service skills of Network Provider staff;
6.10.4b(3) Network Provider profiling;
6.10.4b(4) Peer review procedures;
6.10.4b(5) Outcome and Quality Measurement analysis; and
6.10.4b(6) Maintaining an ongoing training and education program that will be offered to Network Providers.

6.11.0 Claims Processing

6.11.1 The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

6.11.1a Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;
6.11.1b Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

6.11.1c Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance and Coinsurance Maximums, at the time the claim was incurred as specified to the Contractor by the Department;

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6.11.1d Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed by the Contractor and ~~utilized~~ approved by the Department. The Contractor's system must ensure that payments are made only for authorized services;

6.11.1e Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for the balance of the calendar year in which they were made and for six (6) additional years thereafter, per Appendix A, with procedures to easily retrieve and load claim records;

6.11.1f Maintaining the security of the claim files and ensuring HIPAA compliance;

6.11.1g Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error;

6.11.1h Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department;

6.11.1i Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

6.11.1j Maintaining a claims processing system capable of integrating and enforcing the various clinical management and utilization review components of the MHSA Program; including pre-certification, prior authorization, concurrent review and benefit maximums;

6.11.1k Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been applied to the shared Deductible and Coinsurance Maximums between the Empire Plan Hospital Program, Medical Program and MHSA Program;

6.11.1l Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports shared Deductible and Coinsurance Maximums;

6.11.1m Participating in Medicare Crossover by entering into an agreement with the Empire Plan medical carrier/third party administrator to accept electronic claims data record files from the medical carrier/third party administrator for Empire Plan Enrollees who have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health and substance abuse outpatient claims which also involve Medicare coverage. The claims information sent from the medical carrier/third party administrator will include claims filed with the Center for Medicare and Medicaid Services (CMS) that should be considered by the Contractor for secondary coverage. The Empire Plan medical carrier/third party administrator will sort out any claims for benefits that are for mental health or substance abuse services and electronically forward the claim to the Contractor for consideration;

6.11.1n Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing edits and pursuing collection of any money due the MHSA Program from other payers or Enrollees who have primary MHSA coverage through another carrier;

6.11.1o Analyzing and monitoring claim submissions to promptly identify errors, fraud and/or abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error, without additional administrative charge to the MHSA Program. The Contractor shall report fraud

and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Programs upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered;

6.11.1p Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours;

6.11.1q Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Article XV Payments/(Credits) to/from the Contractor.

6.12.0 Clinical Management

6.12.1 Pre-Certification of Care

6.12.1a To ensure that the resources available to the MHSA Program are utilized for appropriate, medically necessary care, the Contractor is required to perform pre-certification of care which includes, at a minimum:

6.12.1a(1) Use of a voluntary Clinical Referral Line (CRL) located in the United States to evaluate Enrollees MHSA care needs and direct Enrollees to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate Clinicians' assessment of the caller's MHSA treatment needs and to provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;

6.12.1a(2) Use of alternate procedures to precertify care when the Enrollee fails to call the CRL, as follows:

6.12.1a(3) When an Enrollee contacts a Network Provider directly for treatment without calling the CRL, the Contractor is ultimately responsible for ensuring that Enrollees receive the Network level of benefits and obtaining all necessary aurthorizations for treatments for Network outpatient services for "Recurrent Therapy Visits" and Network inpatient care, when an Enrollee contacts a Network Provider directly for treatment without calling the CRL;

6.12.1a(4) When an Enrollee contacts a Network Provider directly and the Network Provider is not the appropriate Provider to treat that Enrollee, the Contractor is responsible for ensuring that its Network Providers take responsibility for assisting the member in obtaining an appropriate referral;

6.12.1a(5) When an Enrollee contacts a Non-Network Facility for treatment and the Contractor is notified in advance of the admission, the Contractor must provide the Enrollee or other HIPAA authorized representative of the Enrollee, with a written determination of medical necessity of care in advance of the inpatient admission, where feasible;

6.12.1a(6) Timely written notification to the Enrollee, or other HIPAA authorized representative of the Enrollee, of the potential financial consequence of remaining in a Non-Network Facility when the initial determination of medical necessity occurs;

6.12.1a(7) Preparing and sending communications to notify Enrollees and/or their Providers of the outcome of their pre-certification or prior authorization request and notifying them in writing of the date through which MHSA Program services are approved;

6.12.1a(8) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;

6.**12.1a(9)** Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program vendor and managing the patient's care if transferred to rehab: and

6.12.1a(10) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014, during the implementation period, once acceptable files are received.

6.12.2 Concurrent Review

6.12.2a To safeguard Enrollee health and ensure adherance with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:

6.12.2a(1) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;

6.12.2a(2) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services. The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;

6.12.2a(3) is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;

6.12.2a(4) The Contractor must perform concurrent review of outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

6.12.2a(5) The Contractor must maintain a process for identifying cases where a less restrictive or higher level of care is clinically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers;

6.12.2a(6) Establishes maximum time frames for inpatient review based upon the level of care provided, and a time frame that allows for discharge planning where the continued stay is not certified;

6.12.2a(7) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment;

6.12.2a(8) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions;

6.12.2a(9) For Enrollees admitted to non-network facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if the facility was in the network, including negotiating discounts with the facility;

6.12.2a(10) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must

include continual review of the progress of aftercare treatment with the Provider by a care manager, as follows:

6.12.2a(10)i Care managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and

6.12.2a(10)ii Care managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.

6.12.2a(11) The Contractor must provide case management on a voluntary basis for complex cases or cases requiring long-term treatment. The Contractor must cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases of medical/mental health multiple diagnoses in accordance with guidelines established by the Department. Under those guidelines, in cases where there is both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan;

6.12.2a(12) The Contractor must use care managers or Peer Advisors to manage the care of members; and

6.12.2a(13) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA Program costs and care.

6.12.3 Disabled Dependent Determinations

6.12.3a The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse-related dependent disabilities. The review must be completed in the United States and clinical determination must be completed within 10 Business Days of receipt of a complete form.

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6.12.3b The Contractor must send a determination letter, approved in advance by the MHSA Program, to the Enrollee and to the Department advising of the determination within 3 Business Days ~~of receipt~~ of ~~a complete form~~ the determination.

6.12.4 Appeal Process

6.12.4a The Contractor must:

6.12.4a(1) Perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer.

6.12.4a(2) Administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment, including:

6.12.4a(2)a Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment;

6.12.4a(2)b Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals and;

6.12.4a(2)c Integrating the appeal decisions into the clinical management and claims processing systems.

6.12.4a(3) Establish two levels of internal clinical appeals as follows:

6.12.4a(3)a A level 1 clinical appeal must be performed by an independent Peer Advisor; and,

6.12.4a(3)b A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case.

6.12.4a(3)c Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:

6.12.4a(3)c(1) For a second level clinical appeal of a post-service claim, within 30 days of the member's request;

6.12.4a(3)c(2) For a second level clinical appeal of a pre-service request for benefits, within 15 days of the member's request;

6.12.4a(3)c(3) For appeals involving urgent situations, in no more than seventy-two hours following receipt of the appeal.

6.12.4a(4) Interface with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

6.12.4a(5) Oversee and enforce the MHSA Program's appeal processes including reporting the results of the administrative, clinical and external appeal processes for the MHSA Program to the Department in the format and frequency required in Article XVI: Reports and Claim Files section of this Agreement.

6.12.5 Other Clinical Management Programs

6.12.5a The Contractor must provide voluntary opt-in programs for Depression Management, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD). The cost of the Depression Management, Eating Disorder and ADHD Programs shall be included in the Administrative Fee. The voluntary opt-in programs must minimally include:

6.12.5a(1) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail;

6.12.5a(2) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;

6.12.5a(3) accepting referrals to Network Providers;

6.12.5a(4) telephonic support, coordination with treating providers and referrals to community services; and

6.12.5a(5) a method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of depression, eating disorders and

ADHD in order to educate medical Providers about the availability of the depression, eating disorder and ADHD programs.

6.12.5b The Contractor may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to not participate in any program offered and the right to opt out of any program at any time.

ARTICLE VII: PERFORMANCE GUARANTEES

7.1.0 The Parties agree that the following guarantees and the corresponding credit amounts for failure to meet the Contractor Performance Guarantees shall be implemented effective January 1, 2014. The Contractor acknowledges and agrees that failure to perform the Program Services features in such a manner which either meets or exceeds any, and/or all of the Contractor Performance Guarantee(s) as set forth in this Article VII, and/or fails to make any payment(s) of any such credit amounts for such failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties, and obligations as otherwise set forth in the Agreement. Credit amounts are cumulative. Amounts due from the Contractor to the Department for failure to perform and audit credit amounts, as determined pursuant to Article XV of this Agreement, shall be made in such amounts as determined by the Department to be final. Upon such determination, the Department shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the Administrative Fee in accordance with Article XV of this Agreement within thirty (30) Days of receiving such notification by the Department. These amounts must also be applied as a credit against the Administrative Fee and reported in the Annual Financial Report.

7.2.0 Implementation and Start-up Guarantee and Credit Amount:

7.2.1 ***Guarantee:*** The Contractor guarantees that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the MHSA Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational:

7.2.1a A contracted Provider network (including a Certified Behavior Analyst Provider Network) that meets the access standards set forth in Section 6.10.1 of this Agreement;

7.2.1b A fully operational call center, including a clinical referral line, providing all aspects of customer support and clinical services as set forth in Section 6.5.0 of this Agreement;

7.2.1c A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section 6.11.0 of this Agreement;

7.2.1d A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSA Program benefit design and contractual obligations; and

7.2.1e A fully functioning customized MHSA Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section 6.5.5 of this Agreement.

7.2.2 Credit Amount: The Contractor's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is **(TBD)** percent (%) of the 2014 Administrative Fee (prorated on a daily basis).

7.3.0 Call Center Availability Guarantee and Credit Amount

7.3.1 ***Guarantee:*** The MHSA Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents and providers at least ninety-nine and five-tenths percent *(*99.5%) of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated annually.

7.3.2 ***Credit*** *Amount:* The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to .50% below the standard of ninety-nine and five-

tenths percent (99.5%) (or the Contractor's proposed guarantee) that the Contractor's telephone line is not operational and available to Enrollees, Dependents and Providers during the Contractor's Call Center Hours calculated on an annual basis is $**(TBD)**___ per year.

7.4.0 Call Center Telephone Response Time Guarantee and Credit Amount

7.4.1 ***Guarantee:*** The MHSA Program's service level standard requires that at least ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported monthly and calculated annually.

7.4.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is $**(TBD)** per year.

7.5.0 Telephone Abandonment Rate Guarantee and Credit Amount

7.5.1 ***Guarantee:*** The MHSA Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative or Clinical Manager, if after hours will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated annually.

7.5.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent

(3%) (or the Contractor's proposed guarantee), calculated on an annual basis, is $**(TBD)** per year.

7.6.0 Telephone Blockage Rate and Credit Amount:

7.6.1 ***Guarantee:*** The MHSA Program's service level standard requires that the Contractor guarantee that not more than zero percent (0%) of incoming calls to the customer service telephone line be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated annually.

7.6.2 ***Credit Amount*****:** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%) (or the Contractor's proposed guarantee), calculated on an annual basis, is $**(TBD)** per year.

7.7.0 Enrollment Management Guarantee and Credit Amount

7.7.1 ***Guarantee:*** The MHSA Program's service level standard requires that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by the Department.

7.7.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each twenty-four (24) hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Contractor's enrollment system is $**(TBD).**

7.8.0 Management Reports and Claim File Guarantee and Credit Amount

7.8.1 ***Guarantee:*** The MHSA Program's service level standard requires that accurate management reports and claim files as specified in Section 16.1.0 through 16.4.1 of this Agreement will be delivered to the Department no later than their respective due dates inclusive of the date of receipt.

7.8.2 ***Credit Amount*:** The Contractor's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not received by its respective due date, is $**(TBD)** per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt.

7.9.0 Network Composition Guarantee and Credit Amount

7.9.1 ***Guarantee:*** The Contractor must propose a Network Composition performance guarantee. The MHSA Program's service level standard requires, that at least at a minimum, that throughout the five-year term of the Agreement, ninety percent (90%) of the Providers ~~counts~~ in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, and Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2 will be maintained. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee. This standard shall be measured annually.

7.9.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee is $___ for each .01 to1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) of the ~~total~~ Providers ~~counts~~ in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, and Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on **Exhibit I.Y.2** as calculated on an annual ~~quarterly~~ basis is $**_(TBD)**. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

7.10.0 Network Provider Access Guarantee and Credit Amount:

7.10.1 ***Guarantee:*** The Contractor guarantees that effective January 1, 2014 and throughout the term of the Agreement:

7.10.1a Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles;

7.10.1b Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;

7.10.1c Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;

7.10.1d Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;

7.10.1e Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,

7.10.1f Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

7.10.2 ***Credit Amounts***:

7.10.2a The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)** for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility Access-for Urban Areas Guarantee, is not met by the Contractor.

7.10.2b The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)** for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility Access-for Suburban Areas Guarantee, is not met by the Contractor.

7.10.2c The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)** for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility Access-for Rural Areas Guarantee, is not met by the Contractor.

7.10.2d The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD)**for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner Access-for Urban Areas Guarantee, is not met by the Contractor.

7.10.2e The Contractor's quoted amount to be credited against the Administrative Fee is $**(TBD**)for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner Access-for Suburban Areas Guarantee is not met by the Contractor.

7.10.2f The Contractor's quoted amount to be credited against the Administrative Fee is $(TBD)___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner Access-for Rural Areas Guarantee, is not met by the Contractor.

7.10.3 Measurement of compliance with each access guarantee will be based on a "snapshot" of the Provider Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in Exhibit I.Y.3. The report is due thirty (30) Days after the end of the quarter.

7.11.0 Provider Credentialing Guarantee and Credit Amount

7.11.1 ***Guarantee:*** The Contractor must propose a Provider Credentialing performance guarantee. The MHSA Program's service level standard requires that at least within sixty (60) Days of receipt of a completed Provider application to join the MHSA

Program's network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or facility notified of the determination.

7.11.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee, on a quarterly basis is $(TBD) for each Provider application to join the Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days (or the Contractor's proposed guarantee).

7.12.0 Financial Accuracy Guarantee and Credit Amount

7.12.1 ***Guarantee:*** The Contractor must propose a financial accuracy performance guarantee. The Program's service level standard requires that the MHSA Program's financial accuracy be maintained for a minimum of ninety-nine percent (99%) of all claims processed and paid each Plan Year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). This standard shall be measured on an annual basis;

7.12.2 ***Credit Amount*****:** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Contractor's proposed guarantee) that the MHSA Program's financial accuracy isn't achieved as calculated on an annual basis is $(TBD).

7.13.0 Non-Financial Accuracy Guarantee and Credit Amount

7.13.1 ***Guarantee:*** The Contractor must propose a non-financial accuracy performance guarantee. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by

the total number of claims reviewed. Non-financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code, as well as incorrect application of Deductibles and/or Coinsurance amounts to the shared accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

7.13.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (of the Contractor's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Contractor's proposed guarantee) in years two through five of the Agreement) that the MHSA Program's non-financial accuracy rate isn't achieved, as calculated on an annual basis is $(TBD).

Amended March 11, 2013

~~**7.13.3** ***Turnaround Time for Network Claims Adjudication Guarantee:*** The Contractor must propose a turnaround time for Network claims adjudication performance guarantee. The MHSA Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Provider-submitted claims that are received electronically, or in the Contractor's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days of receipt. Turnaround time is measured from the date the Provider-submitted claim is received electronically or received in the Contractor's designated post office box to the date the Explanation of Benefits is received by the U.S. Post office or Contractor's mailing agent;~~

~~**7.13.4** ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five tenths percent (99.5%) (or the Contractor's proposed guarantee) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within eighteen (18) Business Days from the date the claim is received in the Contractor's designated post office box to the~~

~~date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is $(TBD).~~

7.14.0 Turnaround Time for Non-Network Claims Adjudication Guarantee

Amended March 11, 2013

7.14.1 ***Guarantee*:** The Contractor must propose a turnaround time for non-network claims adjudication performance guarantee. The MHSA Program's service level standard requires that at least ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that are received in the Contractor's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Contractor's designated post office box to the date the Explanation of Benefits is received by the U.S. Post Office or Contractor's mailing agent.

Amended March 11, 2013

7.14.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Contractor's proposed guarantee) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Contractor and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Contractor's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is $(TBD).

7.15.0 Clinical Referral Line Guarantees and Credit Amounts

7.15.1 ***Non-Network CRL Guarantee:*** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of the cases as calculated annually.

7.15.2 ***Emergency Care CRL Guarantee:*** The MHSA Program's service level standard requires that one hundred percent (100%) of Enrollees who call the CRL in need of emergency care be contacted by either the Network Provider or the Contractor's clinicians within thirty (30) minutes of the Enrollees call to the CRL to assure their safety.

Amended March 11, 2013

7.15.3 ***Urgent Care CRL Guarantee:*** The MHSA Program's service level standard requires at least ninety-nine percent (99%) of Enrollees in need of urgent care be contacted by the ~~Network Provider~~ Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.

7.15.4 ***Non-Network CRL Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Contractor's proposed guarantee) when an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, as calculated annually, is $(TBD).

7.15.5 ***Emergency Care CRL Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care, contact will be made by either the Network Provider or the Contractor's Clinicians within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line, as calculated annually, is $(TBD)

Amended March 11, 2013

7.15.6 ***Urgent Care CRL Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Contractor's proposed guarantee) when an Enrollee requires urgent care, contact will be made by the ~~Network Provider~~ Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, as calculated annually, is $(TBD).

7.16.0 Utilization Review Guarantees and Credit Amounts

7.16.1 Outpatient Treatment Utilization Review Guarantee and Credit Amount

7.16.1a ***Guarantee:*** The Contractor must propose an outpatient treatment utilization review performance guarantee. The MHSA Program's service level standard requires that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Days of receipt of the report as calculated on an annual basis.

7.16.1b ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) of outpatient treatment plans not reviewed and the Provider notified within twelve (12) Business Day of receipt of the report, is $(TBD).

7.17.0 Inpatient Treatment Utilization Review Guarantee and Credit Amount

7.17.1 ***Guarantee:*** The Contractor must propose an inpatient treatment utilization review performance guarantee. The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis.

7.17.2 ***Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider notified within one (1) Business Day of the determination, is $(TBD).

7.18.0 Appeal Guarantees and Credit Amounts

7.18.1 Inpatient Appeal Guarantee and Credit Amount

7.18.1a ***Inpatient Appeal Guarantee:*** The Contractor must propose a performance guarantee. The MHSA Program's service level standard requires that at least

ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis;

7.18.1b ***Outpatient and ALOC Appeal Guarantee:*** The Contractor must propose a performance guarantee. The MHSA Program's service level standard requires that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

7.18.1c ***Inpatient Appeal Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Contractor's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal, is $(TBD).

7.18.1d ***Outpatient and ALOC Appeal Credit Amount:*** The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0%

below the standard of ninety-five percent (95%) (or the Contractor's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal, is $(TBD).

ARTICLE VIII: MODIFICATION OF PROGRAM SERVICES

8.1.0 In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Agreement in such a manner that the Department determines that any design elements or requirements of the Agreement must be revised, the Department shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.

8.2.0 In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the Department shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes.

8.3.0 To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the MHSA Program as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, either Party may submit a written request to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that a modification of the fees or guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The Contractor will agree to modify the fee (s) to the extent necessary to relieve the DCS of the obligation to pay for Program services that are no longer required. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect MHSA Program modifications. Should the Parties agree to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by

OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

ARTICLE IX: DEVELOPMENT OF SUMMARY PLAN DESCRIPTIONS AND BENEFIT SUMMARIES

9.1.0 The Contractor shall present to the Department its recommendations for the development of the necessary Summary Plan Descriptions and Benefit Summaries for the Empire Plan, Excelsior Plan and SEHP Mental Health and Substance Abuse Programs. The Department shall review the Contractor's recommendations and shall make the final determination regarding the manner in which the Summary Plan Descriptions and Benefit Summaries shall be developed and issued by the Contractor.

ARTICLE X: ENROLLMENT INFORMATION AND RECORDS

10.1.0 The Contractor shall maintain records in the United States from which may be determined at all times the names of all Enrollees insured hereunder, and their Dependents, and the benefits in force for each such Enrollee, together with the date when any coverage became effective and the effective date of any change in or termination of benefits.

10.2.0 The Department shall transmit enrollment information provided by the Enrollee to the Contractor for the Department Program in an electronic format consistent with Section 6.7.0 of this Agreement. The eligibility rules and the enrollment reports generated as a result of these eligibility rules shall be the sole means of determining valid enrollment for benefits under the Department Program.

10.3.0 The Department and the Enrollees/Dependents shall furnish to the Contractor all information that the Contractor may reasonably require with regard to any matters pertaining to the enrollment of Enrollees/Dependents under this Agreement. A person will not be entitled to or deprived of benefits under the Agreement due to clerical errors.

10.4.0 The Department agrees to provide the Contractor with reasonable access to records of the Department which may have a bearing on the benefits provided by the Contractor or calculation of the Contractor’s Administrative Fee as set forth under Article XIV of this Agreement.

ARTICLE XI: DATA SHARING AND OWNERSHIP

11.1.0 All claims and other data related to the Department Program is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other NYSHIP carriers Department consultants and the Department's Decision Support System contractor and Department of Health's all payer claims database.

11.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, the Contractor shall not share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department.

ARTICLE XII: DCS PROGRAM CLAIMS REIMBURSEMENT

12.1.0 Provider Network Claims

12.1.1 The Contractor must contract with Network Providers. The amount charged to the MHSA Program shall be the contracted Network Provider fee, less any applicable Copayment and coordination of benefits when the claim is processed as secondary coverage.

12.1.2 The Contractor agrees that the weighted average of the actual Network Provider fees to be charged to the MHSA Program for each CPT, HCPCS and Revenue Code implemented on January 1, 2014, shall not exceed the amounts quoted in Exhibit V.A. During implementation, the Contractor shall submit an analysis confirming that the weighted average contracted 2014 Provider Network fees are less than or equal to the fees quoted in Exhibit V.A, subject to the review and written approval of the Department. No increases to the Network Provider fees, charged to the MHSA Program, will be permitted for the 2014 Plan year.

12.1.3 For each Plan year after 2014**,** the Contractor must manage the Network Provider fee charged to the Department such that the annualized aggregate impact on MHSA Program costs of any proposed modification to the Network Provider fees is capped by

the annual increase in CPI-W for medical care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year.

12.1.4. Claim Payments are to be made based on the requirements contained in Article 6.11.0 of the Agreement, including but not limited to each group's Copayment, Co-insurance, Deductible as well as the annual maximum for ABA services as reflected in the most current Plan communication materials.

12.1.5 ***Network Pricing Guarantee:*** The Contractor is responsible for managing modifications, if any, to the fees paid to Network Providers in Plan years two through five of the Agreement to the extent such modifications in the Provider Network fees are in the best financial interest of the MHSA Program and the Department, as determined solely by the Department. During each Plan year, the Contractor must report any proposed Network Provider fee schedule modifications, if any, and the estimated financial impact to the MHSA Program to the Department prior to any such changes. The MHSA Program allows for Network Provider fee increases every Plan year after 2014; however, the annualized aggregate impact on MHSA Program costs of any modification to the Network Provider fees shall be reviewed and shall be capped by the annual increase in CPI-W for medical care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year. This annual review of any modification to the Network Provider fees shall be completed by the Contractor, in writing, for final review and written approval by the Department. The annual review provided by the Contractor shall include a calculation of the aggregate impact of the modification of Network Provider fees, for that Plan year, as compared to the Network Provider fees paid in the base year, based on the actual utilization of each Network Provider and service in the base year. The following presents the current and base years for each annual review covered by the Agreement:

Report Due	Base Year	Current Year
6/30/16	2014	2015
6/30/17	2015	2016
6/30/18	2016	2017
6/30/19	2017	2018

The calculated aggregate impact of the Network Provider fee modification for that Plan year, normalized for any change in enrollment, will be compared to the maximum allowable CPI increase to determine the Contractor's compliance with the Network Provider pricing guarantee. At the conclusion of each annual review, the Contractor shall forfeit a specific dollar amount of the Administrative Fee for failure to meet this guarantee, as follows:

For each annual review, the Contractor's amount to be credited against the Administrative Fee for each .01 to 1.0% increase in the aggregate MHSA Program Network costs in excess of the annual increase in the CPI-W for medical care as reported by the Bureau of Labor Statistics for the month of July is $250,000.

The Offeror's amount to be credited against the Administrative Fee for each .01 to 1.0% increase in the aggregate MHSA Program Network costs in excess of the annual increase in the CPI-W for medical care as reported by the Bureau of Labor Statistics for the month of July is $250,000.

12.2.0 Non-Network Claims

12.2.1 The cost to the MHSA Program for Covered Services for which Enrollees submit direct claims for reimbursement shall be charged to the MHSA Program at the actual amounts reimbursed by the Contractor.

12.2.2 Payments are to be made based on the requirements contained in Section IV of Exhibit B (RFP) including but not limited to each group's Copayments, Co-insurance, Shared Accumulators and benefit maximums based on the member's benefit program assignment as reflected in Exhibit D of the Agreement

12.2.3 The Contractor will process Non-Network claims using Reasonable and Customary charges based on the 90th percentile of charges for each service performed. Reasonable and Customary means the lowest of:

1. The actual charge for services; or

2. The usual charge for services by the Provider for the same or similar service; or
3. The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

12.2.4 Where a Network Provider is not available because of clinical or access considerations, the Contractor must negotiate a Single Case Agreement with a Non-Network Provider in a manner consistent with what is typically allowed for a Network Provider in the same discipline for the same service. The Contractor must pay the claim and charge the MHSA Program as if the services were incurred by a Network Provider.

12.2.5 The Contractor will process Non-Network Provider claims and make payments directly to the Enrollee.

12.2.6 The Contractor will update its claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts at a minimum of twice a year.

ARTICLE XIV: ADMINISTRATIVE FEE

14.1.0 The Administrative Fee is the fee that the Contractor charges the MHSA Program for all administrative services provided by the Contractor. This includes the administration of the Empire Plan, SEHP, and the Excelsior Plan. The Contractor shall:

14.1.1 Agree that the following non-exclusive costs are not allowable and shall not be charged to the MHSA Plan as either a direct or formula expense: commissions, non-Plan advertising costs, capital expenditures for improvement or acquisition of facilities, entertainment costs, including social activities or cost of alcoholic beverages, costs of fund raising, costs for political activities, costs for attendance at conferences or meetings of professional organizations unless attendance is necessary in connection with the MHSA Plan and the Contractor received prior written approval by the Department and any costs related to or associated with the preparation and submission of a competitive proposal, including but not limited to the Contractor's Proposal, Exhibit C.

14.1.2 The Department shall calculate the total Administrative Fee payable to the Contractor for each month by multiplying the per Administrative Fees of $(TBD), by the number of Enrollees in force each month as reported by the New York State Benefit Eligibility and Accounting System on the first Thursday of each month. The Department shall furnish to the Contractor a written statement for each month showing the number of Plan contacts then in force.

14.1.3 Be bound by its Administrative Fee, as proposed in the Contractor's Proposal, Exhibit C, for the entire term of the Agreement unless amended in writing by the Parties;

14.1.4 Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor's Proposal, Exhibit C;

14.1.5 Implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice.

14.1.6 Agree not to request a higher Administrative Fee, and the Department will not consider any increase to the Administrative Fee, that is not based on a material change to the MHSA Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Department.

14.1.7 Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Administrative Fee resulting from a material change in the benefit structure of the MHSA Program. The Department reserves the right to request and the Contractor agrees to provide any additional information and documentation the Department deems necessary to make its determination whether a the Contractor's request for an increase to the Administrative Fee is approved. The Department's decision to modify the Administrative Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal written amendment to the Agreement, signed by the Parties, and approved by the New York State Attorney General and New York State Office of State Comptroller;

14.1.8 Implement all benefit designs as required by the Department with or without final resolution of any request by the Contractor for a higher Administrative Fee. Refusal to implement benefit design changes will constitute a material breach of this Agreement and the Department shall take any action as may be appropriate and provided for by law, rule or in this Agreement, including, but not limited to, seeking compliance and recovering damages..

ARTICLE XV: Payments/(Credits) to/from the Contractor

15.1.0 The Contractor agrees to manage such financial transactions in accordance with the following:

15.1.1 The Department will set up an imprest bank account from which the Contractor may issue claim payments by check or wire transfer. The claim amounts charged to the imprest account will occur when checks to Providers and Enrollees are presented for payment and cleared, or when wire transfers to Providers are completed.

15.1.2 Any credit amounts due from the Contractor to the Department for failure of the Contractor to meet the performance guarantees set forth in this Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program in the first invoice issued by the Contractor subsequent to the Department's written approval of the performance guarantee calculation. Alternatively, the Department may request and receive payment of any performance guarantee amount directly from the Contractor, as opposed to a credit against the Administrative Fee payable to the Contractor.

15.2.0 Upon final audit determination by the Department, any audit liability amount assessed by the Department shall be paid/credited to the MHSA Programs within thirty (30) Days of the date of the Department's final determination, or within thirty (30) Days of receipt of recoveries related to fraud or abuse or Department errors.

15.3.0 Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.

15.4.0 The MHSA Plan will pay the Administrative Fee on a monthly basis thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the Department for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program.

15.5.0 This Agreement is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due date as set forth in this Article XV. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice and claims data file, as set forth in this Article XV, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.

15.6.0 The Contractor will be billed by the Empire Plan medical carrier for the MHSA Program's portion of the Shared Communications Expense in 2014 and each Plan year thereafter in four (4) equal installments. Subsequent years' amounts will be calculated by the Department and communicated to the Contractor during the annual premium renewal process. Upon receipt of each Shared Communications Expense bill, the Contractor may bill and the Plan will pay the Contractor an identical amount within thirty (30) Days.

ARTICLE XVI: REPORTS AND CLAIM FILES

16.1.0 Annual Reports

16.1.1 ***Annual Financial Report*:** The Contractor must submit an annual experience report of the Program's charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. These statements must detail, at minimum, claims paid during the year, projected incurred claims not yet paid, administration costs, performance credits, etc.. Such detail must include all charges by the Contractor to the Program.

16.1.2 ***Annual Premium Renewal Report:*** The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all

assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must included, but not be limited to: paid claim amounts, projected incurred claims, trend, Administrative Fees and changes in enrollment.

16.1.3 ***Annual Summary Reporting*****:** The Contractor must prepare and present to the Department, GOER, Division of Budget and NYS employee unions an annual report that details MHSA Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSA Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues are to be comprehensively addressed. The annual presentation and report is due each May after the end of each complete Calendar Year.

16.1.4 ***Annual Report of Claims and Credits Paid by Agency*****:** The Contractor must submit a report with summary level claims and credits paid by agency. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due thirty (30) Days after the end of the Calendar Year.

16.2.0 <u>Quarterly Reports</u>

16.2.1 ***Quarterly Financial Summary Reports*****:** The Contractor must submit quarterly financial reports which present the MHSA Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of:

- annual financial performance;
- assessment of MHSA Program costs;
- incurred claim triangles;
- audit recoveries;
- settlement and litigation recoveries;
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

16.2.2 ***Quarterly Performance Guarantee Report:*** The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation, customer service (telephone availability, telephone response time, abandonment rate and blockage rate); enrollment management, reporting, network composition, provider access, provider credentialing, financial and non financial accuracy, turnaround time for processing network and non-network claims, non-network Clinical Referral Line, emergency care Clinical Referral Line, urgent care Clinical Referral Line outpatient and inpatient Utilization Review; and inpatient and outpatient appeals. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F.. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

16.2.3 ***Quarterly Utilization Report:*** The Contractor must submit quarterly the MHSA Program's Quarterly Utilization Report that details the MHSA Program's care utilization by type of service for both network and non-network authorizations, by type of treatment (inpatient, outpatient, ALOC) Applied Behavioral Analysis, collective bargaining unit, age of the member, type of Dependent, and any other category as requested by the Department. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due forty-five (45) Days after the end of each quarter;

16.2.4 ***Quarterly Network Access*****:** The Contractor must submit a measurement of the Network access using Exhibit C of the Agreement based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

16.2.5 ***Quarterly Coordination of Benefit Report:*** The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans

including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;

16.2.6 ***Quarterly Participating Agency Claims:*** The Contractor must submit a quarterly report that presents summary level claim information by Participating Agency. The Contractor shall submit this report using the data elements specified by the Department in Exhibit II.F, unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter; and

16.2.7 ***Quarterly Website Analytics Report:*** The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section 6.5.5 of this Agreement. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter.

Amended March 11, 2013

16.2.8 ***Quarterly Provider Audit Report***: The Contractor must securely submit a provider audit report to the Department summarizing audits planned, initiated, in progress and completed, as well as audit findings, recoveries and any other enforcement action by the Contractor. The report is due thirty (30) Days after the end of the quarter.

16.3.0 Monthly Reports

16.3.1 ***Monthly Report of Paid Claims by the Month Incurred:*** The Contractor must submit a monthly report that provides summarized paid claims by the month incurred. The Contractor must submit this report using data elements acceptable to the Department. The report is due thirty (30) Days after the end of the month; and,

Amended March 11, 2013

16.3.2 MHSA *Program Customer Service Monthly Reports:* Each month the Contractor must submit a customer service report that measures the Contractor's customer service performance including ~~customer service~~ call center availability, ~~customer service~~ call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The customer service report is due fifteen (15) Days after the end of the month. For the first two months of the Agreement, this report will be due on a weekly basis. After two months, the Department will re-examine the required frequency of this report and establish due dates with the Contractor.

Amended March 29, 2013

16.4.0 Monthly Periodic Claim File

16.4.1 *Detailed Claim File Data:* The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records using data elements acceptable to the Department to support all claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each ~~claims processing cycle~~ month and submit a summarized report by ~~claims processing cycle~~ month utilizing a format acceptable to the Department ~~including a narrative presenting any important programmatic information, trends or abnormalities observed by the Contractor.~~

ARTICLE XVII: TRANSITION AND TERMINATION OF CONTRACT

17.1.0 The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program.

17.1.1 The Contractor must, one hundred twenty (120) Days prior to the end of this Agreement, or within forty-five (45) Days of notification of termination, if this

Agreement is terminated prior to the end of its term, provide the Department with a detailed written plan for transition, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

17.1.1a Transition of Program data, including but not limited to a minimum of one year of historical Enrollee claim data including providers' telephone numbers, names, addresses, zip codes and tax identification numbers, detailed COB data, report formats, pre-certification/prior authorization, approved - through dates, disability determination approved-through dates, any exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Department approves during implementation of the Program by the successor contractor in the format acceptable to the Department. The transition or pre-certification/prior authorization files should include but not be limited to the following:

17.1.1a(1) Providing a test file to the successor contractor in advance of the implementation date to allow the successor contractor to address any potential formatting issues;

17.1.1a(2) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains pre-certification/prior authorization approved - through dates and one year of claims history as specified by the Department working in conjunction with the successor contractor;

17.1.1a(3) Providing a second production file to the successor Contractor by the close of business January 2nd (or 2 days after the Agreement terminates) that contains all pre-certification/prior authorization approved – through dates specified by the Department working in conjunction with the successor contractor.

17.1.2 Within fifteen (15) Business Days from receipt of the Contractor's proposed Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor,

in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department.

17.1.3 Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department.

17.1.4 The Contractor shall be responsible for transitioning the MHSA Plan in accordance with the approved Transition Plan.

17.1.5 To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA Plan benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Contractor is required to provide Contractor-related obligations and deliverables to the Program through the final financial settlement of the Agreement, including but not limited to:

17.1.5a Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, manual submit claims including but not limited to: Medicaid, out-of-network claims, foreign claims, in-network claims, COB claims, and Medicare, reimbursing late filed claims if warranted, repaying or recovering monies on behalf of the Program for Medicare claims, and continuing to provide updates on pending litigation and settlements that the Contractor or the NYS Attorney General's Office has/may file on behalf of the Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

17.1.5b Complete all reports required in Article XVI of this Agreement;

17.1.5c Provide the MHSA Plan with sufficient staffing in order to address State audit requests and reports in a timely manner;

17.1.5d Agree to fully cooperate with all Department or Office of State Comptroller (OSC) audits consistent with the requirements of Article XVIII of the Agreement and Appendices A and B;

17.1.5e Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XVIII "Audit Authority" of the Agreement and Appendices A and B; and

17.1.5f Remit reimbursement due the Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XVIII, "Audit Authority" and Article XV "Payments/credits) to/from the Contractor" of the Agreement and Appendices A and B.

17.1.6 The Contractor is required to reach agreement with the Department on receiving and applying enrollment updates, keeping dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjusting phone scripts, and transferring calls to the successor contractor's lines.

17.1.7 The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;

17.1.8 The Contractor must prepare, on a case by case basis, a plan to extend and manage the care of high risk Enrollees who are nearing the end of a course of treatment beyond the transition period;

17.1.9 The Contractor must continue to clinically manage and pay for Covered Services for Enrollees determined to be Totally Disabled on the last day of the Contract, for ninety (90) Days or until the disability ends, whichever occurs first.

17.1.10 The Contractor must continue to manage and pay for Covered Services for Enrollees who are confined on or before December 31, 2018 until the earlier of the step down of care or midnight of the 90th day subsequent to December 31, 2018.

17.1.11 If the Contractor does not meet the Transition Plan requirements in the time frame stated above, the Contractor **will permanently forfeit 100%** of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

ARTICLE XVIII: AUDIT AUTHORITY

In addition to the Audit Authority requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

18.1.0 The Contractor acknowledges that the Department has the authority to conduct financial and performance audits of the Contractor's delivery of Program services in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities;

18.2.0 Such audit activity may include, but not necessarily be limited to, the following activities:

18.2.1 Review of the Contractor's activities and records relating to the documentation of its performance under this Agreement in areas such as determination of Enrollee or Dependent eligibility and application of various Department program administrative features (e.g., dependent survivor benefits, reasonable adjudication of disabled dependent status);

18.2.2 Comparison of the information in the Contractor's enrollment file to that on the enrollment reports issued to the Contractor by the Department; and

18.2.3 Assessment of the Contractor's information, utilization and demographic systems to the extent necessary to verify accuracy of data on the reports provided to the Department in accordance with Article XVI "Reports and Claim Files" of this Agreement.

18.3.0 The Contractor shall maintain and make available documentary evidence necessary to perform the reviews. Documentation maintained and made available by the Contractor may include, but is not limited to, source documents, books of account, subsidiary records and supporting work papers, claim documentation, pertinent contracts, key subcontracts, provider agreements, and correspondence;

18.4.0 The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at the Department's discretion, be submitted to the Department in machine-readable format, or the data may be extracted by the Department, or by the Contractor under the direction of the Department;

18.5.0 The Contractor shall support audits conducted by the Department, Office of the State Comptroller or any designee of these agencies, as follows, including but not limited to:

18.5.1 Providing ample audit resources including access to the Contractor's online system to the Department and OSC at their respective offices through the date of the final financial settlement of the Agreement;

18.5.2 The capability and contractual right of the State to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors; and

18.5.3 Providing full cooperation with all Department and/or OSC audits consistent with the requirements of Appendices A and B and as set forth in this Agreement including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Contractor must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department or the OSC's audit unit in accordance with the requirements of Article XVIII "Audit Authority" in this Agreement. Such audits may include, but are not limited to both electronically submitted and paper claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The Contractor shall facilitate audits of Network Providers, including on-site audits, as requested by the Department and/or OSC;

18.6.0 The Contractor shall, at the Department's request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such

documentary evidence as they require. The Contractor shall make sufficient resources available for the efficient performance of audit procedures;

18.7.0 The Contractor shall comment on the contents of any audit report prepared by the Department and transmit such comments in writing to the Department within 30 days of receiving any audit report. The response will specifically address each audit recommendation. If the Contractor agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Contractor disagrees with an audit recommendation, the response will give all details and reasons for such disagreement. Resolution of any disagreement as to the resolution of an audit recommendation shall be subject to the Dispute Resolution provision set forth in Appendix B of this Agreement;

18.8.0 If the Contractor has an independent audit performed of the records relating to this Agreement, a certified copy of the audit report shall be provided to the Department within ten (10) Days after receipt of such audit report by the Contractor and;

18.9.0 The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the OSC as set forth in either Appendix A of this Agreement, Standard Clauses for All New York State Contracts, or Appendix B, Standard Clauses for All Department Contracts.

ARTICLE XIX: CONFIDENTIALITY

In addition to the Confidentiality requirements specified in Appendices A and B to this Agreement, the following provisions shall apply:

19.1.0 All claims and enrollment records relating to the Agreement are confidential and shall be used by the Contractor solely for the purpose of carrying out its obligations under the Agreement, for measuring the performance of the Contractor in accordance with the performance guarantees set forth in Section VII of this Agreement, and for providing the Department with material and information as may be specified elsewhere in this Agreement;

19.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the

Enrollee/Dependent, no records may be otherwise used or released to any party other than the Department by the Contractor, its officers, employees, agents, consultants or Key Subcontractors either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement;

19.3.0 The Contractor, its officers, employees, agents, consultants and/or any Key Subcontractors agree to comply, during the performance of the Agreement, with all applicable Federal and State privacy, security and confidentiality statutes, including but not limited to the Personal Privacy Protection Law (New York Public Officer's Law Article 6-A, as amended), and its implementing regulations, policies and requirements, for all material and information obtained by the Contractor through its performance under the Agreement, with particular emphasis on such information relating to Enrollees and Dependents;

19.4.0 The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, employees, agents, consultants and/or Key Subcontractors contains a provision that strictly conforms to the various confidentiality provisions of this Agreement; and

19.5.0 The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under this Agreement, including, but not limited to, requests for any material and information provided by the Department, except as required by Key Subcontractors solely for the purpose of fulfilling the Contractor's obligations under this Agreement or as required by law.

ARTICLE XX: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

20.1.0 For purposes of this Agreement, 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 this Agreement, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department. All PHI received or

created by the Contractor as a consequence of its performance under this Agreement is referred to herein collectively as "Department's PHI."

20.2.0 The Contractor 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 Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that the Contractor is a HIPAA "business associate" of the Department as a consequence of the Contractor's provision of services to and/or on behalf of the Department within the context of the Contractor's performance under this Agreement, and that the Contractor's provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor's disclosure to the Department of individually identifiable health information as a consequence of the services performed under this Agreement.

20.3.0 ***Permitted Uses and Disclosures of the Department's PHI*:** The Contractor may use and/or disclose the Department's PHI solely in accordance with the terms of this Agreement. In addition, the Contractor may use the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Contractor may use and disclose the Department's PHI for the proper management and administration of the Contract if such use is necessary for the Contractor's proper management and administration or to carry out the Contractor's legal responsibilities, or if such disclosure is required by law or the Contractor 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 Contractor of any instances of which it is aware in which the confidentiality of the PHI has been breached.

20.4.0 ***Nondisclosure of the Department's PHI:*** The Contractor shall not use or further disclose the Department's PHI other than as permitted or required by this Agreement or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practical 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.

20.5.0 ***Safeguards:*** The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor'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, or that it transmits on behalf of the Department pursuant to this Agreement.

20.6.0 ***Breach Notification:***

20.6.1 ***Reporting:*** The Contractor shall report to the Department any breach of unsecured PHI, even if the breach is not reportable under HIPAA, including any use or disclosure of the Department's PHI otherwise than as provided for by this Agreement, of which the Contractor becomes aware. Further, the Contractor shall report to the Department any security incident of which it becomes aware. "Security incident" shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in an information system. The Contractor shall notify the Department within five (5) Business Days of the date the Contractor becomes aware of the event.

20.6.2 ***Required Information:*** The Contractor shall provide the following information to the Department within ten (10) Business Days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor 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:

20.6.2a the date of the breach incident;

20.6.2b the date of the discovery of the breach;

20.6.2c a brief description of what happened;

20.6.2d a description of the types of unsecured PHI that were involved;

20.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

20.6.2f A brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

20.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

20.6.3 The Department will be responsible for providing 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 and the media, as required by 45 CFR Part 164.

20.6.4 The Contractor 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.

20.6.5 For purposes of this Agreement, "Unsuccessful Security Incidents" include activity such as pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

20.6.6 The Contractor shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Contractor not permitted by this Agreement.

20.7.0 ***Associate's Agents:*** The Contractor shall require all of its agents or Key Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, agree to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Contractor with respect to the Department's PHI under this Agreement.

20.8.0 ***Availability of Information to the Department:*** The Contractor shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Contractor to fulfill the Department's obligations to provide access to, to provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Contractor shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department.

20.9.0 ***Amendment of the Department's PHI:*** The Contractor 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 Contractor shall, as directed by the Department, incorporate any amendments to the Department's PHI into copies of the Department's PHI as maintained by the Contractor.

20.10.0*Internal Practices*: The Contractor 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 Contractor 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.

20.11.0*Termination*:

20.11.1 This Agreement may be terminated by the Department at the Department's discretion if the Department determines that the Contractor, as a business associate, has violated a material term of this Article or of the Agreement with respect to the Contractor's obligations under this Article.

20.11.2 ***Disposition of the Department's PHI:*** At the time this Agreement is terminated, the Contractor shall, if feasible, return or destroy all of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, that the Contractor still maintains in any form and retain no copies of such information. Alternatively, if such return or destruction is not feasible, the Contractor shall extend indefinitely the protections of this Agreement to the information and shall limit further uses and disclosures to those purposes that make the return or destruction of the Department's PHI infeasible.

20.12.0*Indemnification:* The Contractor agrees to indemnify, defend and hold harmless the State, the Department and Department's 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 Article or from any acts or omissions related to this Article by the Contractor or its employees, officers, Key Subcontractors, agents or other members of its workforce. Accordingly, the Contractor 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 Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party under this Article shall survive the expiration or termination of this Agreement.

20.13.0Miscellaneous:

20.13.1 ***Amendments*:** This Article may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The Parties agree to take such action as is necessary to amend this Article

from time to time as is necessary to achieve and maintain compliance with the requirements of 45 CFR Parts 160-164.

20.13.2 ***Survival*****:** The respective rights and obligations of the Business Associate (Contractor), and Covered Entity under HIPAA as set forth in this Article shall survive termination of this Agreement.

20.13.3 ***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.

20.13.4 ***Interpretation*****:** Any ambiguity in this Article shall be resolved to permit covered entities to comply with HIPAA.

ARTICLE XXI: NOTICES

21.1.0 All notices permitted or required hereunder shall be in writing and shall be transmitted either:

21.1.1 via certified or registered United States mail, return receipt requested;

21.1.2 by facsimile transmission;

21.1.3 by personal delivery;

21.1.4 by expedited delivery service; or

21.1.5 by e-mail.

Such notices shall be addressed as follows or to such different addresses as the Parties may from time-to-time designate:

State of New York [Agency Name]

Name: Robert W. DuBois
Title: Director, Employee Benefits Division
Address:
Telephone Number: 518-473-1977
Facsimile Number: 518-473-3292
E-Mail Address: Robert.DuBois@cs.state.ny.us

[Contractor Name]

Name: (TBD)
Title: (TBD)
Address: (TBD)
Telephone Number: (TBD)
Facsimile Number: (TBD)
E-Mail Address: (TBD)

21.2.0 Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

21.3.0 The Parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this Agreement by giving fifteen (15) days written notice to the other Party sent in accordance herewith. The Parties agree to mutually designate individuals as their respective representatives for the purposes of receiving notices under this Agreement. Additional individuals may be designated in writing by the Parties for purposes of implementation and administration/billing, resolving issues and problems and/or for dispute resolution.

ARTICLE XXII: IRAN DIVESTMENT ACT

22.1.0 As a result of the Iran Divestment Act of 2012 (Act), Chapter 1 of the 2012 Laws of New York, a new provision has been added to the State Finance Law (SFL), § 165-a, effective April 12, 2012. Under the Act, the Commissioner of the Office of General Services (OGS) was charged with the responsibility to develop a list (Prohibited Entities List) of "persons" who are engaged in "investment activities in Iran" (both are defined terms in the law). Pursuant to SFL § 165-a(3)(b), the initial list was posted to the OGS website on August 10, 2012.

22.2.0 By entering into this Contract, Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerors Pursuant to The New York State Iran Divestment Act of 2012" list (Prohibited Entities List) posted on the OGS website at http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf and further certifies that it will not utilize on the Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that after should it seek to renew or extend the Contract, it must provide the

same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of the Contract will be required to certify that it is not on the Prohibited Entities List before the Department may approve a request for Assignment of the Contract.

22.3.0 During the term of the Contract, should the Department receive information that a person (as defined in State Finance Law 165-a) is in violation of the above-referenced certification, the Department will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment which is in violation of the Act within ninety (90) days after the determination of such violation, then the Department shall take such action as may be appropriate and provided for by law, rule or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default.

The Department reserves the right to reject any request for renewal, extension, or assignment for an entity that appears on the Prohibited Entities List prior to the renewal, extension or assignment of the Contract, and pursue a responsibility review with Contractor should it appear on the Prohibited Entities List hereafter.

(The remainder of this page was intentionally left blank)

Contractor: __(TBD)_____

Contract Number: (TBD)_____

IN WITNESS WHEREOF, the Parties hereto have hereunto signed this Agreement on the day and year appearing opposite their respective signatures.

Agency Certification: "In addition to the acceptance of this Agreement, I also certify that original copies of this signature page shall be attached to all other exact copies of this Agreement."

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: _____ By: _____

Name: _____

Title:_____

CONTRACTOR

Date: _____ By:_____

Name: _____

Title:_____

STATE OF) ss:

COUNTY OF

On the _____ day of _____, _____, before me personally came _____, to me known, and known to me to be the person who executed the above instrument, who, being duly sworn by me, did for her/himself depose and say that (s)he is the _____ of _____ the corporation or organization described in and which executed the above instrument; and that (s)he signed his/her name thereto.

My commission expires: _____ _____
NOTARY PUBLIC

Approved as to Form:
ERIC SCHNEIDERMAN
ATTORNEY GENERAL

By:_____
Date:_____

Approved:
THOMAS P. DINAPOLI
COMPTROLLER

By:_____
Date:_____