



**NEW YORK STATE DEPARTMENT OF CIVIL SERVICE**

**REQUEST FOR PROPOSALS #2013MH-1**

**“MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM  
FOR THE EMPIRE PLAN, EXCELSIOR PLAN AND THE STUDENT  
EMPLOYEE HEALTH PLAN”**

**RELEASE DATE: February 15, 2013**

**PROPOSAL DUE DATE: April 16, 2013**

**IMPORTANT NOTICE:** A Restricted Period under the Procurement Lobbying Law is currently in effect for this Procurement and will remain in effect until State Comptroller approval of the resultant contract. During the Restricted Period for this Procurement ALL communications must be directed, in writing, solely to the Procurement Manager as listed below and shall be in compliance with the Procurement Lobbying Law and the NYS Department of Civil Service “*Rules Governing Conduct of Competitive Procurement Process*” (refer to RFP, Section II: Procurement Protocol and Process).

**Department of Civil Service Contact for  
Inquiries and Submissions for this Solicitation:**

**Procurement Manager  
Employee Benefits Division, Room 1106  
New York State Department of Civil Service  
Albany, New York 12239  
(518) 402-2096**

**E-mail: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us)**

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**Jerry Boone  
Commissioner  
New York State Department of Civil Service**

**Robert W. DuBois, CEBS  
Director  
New York State Department of Civil Service  
Employee Benefits Division**

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**SECTION I: INTRODUCTION****A. Purpose**

The purpose of this Request for Proposals (RFP or Procurement), entitled “Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan” is to secure the services of a qualified Offeror to administer The Empire Plan, Excelsior Plan and Student Employee Health Plan Mental Health and Substance Abuse Program (MHSA Program).

It is the Department of Civil Service’s (Department) intent to enter into a contract (Agreement) with one (1) Offeror selected as a result of this RFP. The Agreement will be for a term of five (5) years, commencing on January 1, 2014 through December 31, 2018, during which the selected Offeror shall be responsible for administering the MHSA Program in accordance with the terms and conditions of the Agreement.

The Offeror must agree to be bound by its Proposal which will be explicitly incorporated by reference into the executed Agreement. The Department will only contract with a single Offeror, which will be the sole contact with regard to all provisions of the Agreement. If the Offeror’s Proposal includes Key Subcontractors, the Offeror will be considered the Prime Contractor, and the Offeror shall assume full responsibility for the fulfillment of all of the Contractor responsibilities under the Agreement. This RFP and other relevant information may be reviewed at: [www.cs.ny.gov/MHSA2013RFP/index.cfm](http://www.cs.ny.gov/MHSA2013RFP/index.cfm)

**Note:** Refer to Section VIII: Glossary of Terms, for definitions of terms used throughout this RFP.

**B. Overview of the New York State Health Insurance Program**

The New York State Health Insurance Program (NYSHIP) was established by the New York State Legislature in 1957 to provide essential health insurance protection to New York State (NYS) employees, retirees, and their eligible dependents. Chapter 56 of the Laws of 2010 amended the law to allow the New York State Employee Health Insurance Plan the option to be self-funded. Specifically, the law states that the President of the Civil Service Commission

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“may provide health benefits directly to plan participants, in which case the president is hereby authorized to purchase a contract or contracts with one or more firms qualified to administer, on New York State health benefit plan’s behalf, the plan of benefits.” Public authorities, public benefit corporations, and other quasi-public entities, such as the NYS Thruway Authority and the Dormitory Authority may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). Article XI of the NYS Civil Service Law also allows local units of government such as school districts, special districts, and municipal corporations to participate in NYSHIP; those local government units which choose to participate in NYSHIP are called Participating Agencies (PAs). At present, there are approximately 461 NYS agencies, 94 PEs, and 802 PAs in NYSHIP. Under Article XI of the Civil Service Law, as amended, and 4 New York Code of Rules and Regulations (NYCRR) Part 73, as amended, the President of the New York State Civil Service Commission, who also serves as the Commissioner of the Department, through the Department’s Employee Benefits Division (EBD), is responsible for the ongoing administration of NYSHIP.

NYSHIP currently covers over 589,000 NYS, PA and PE employees and retirees. Eligible covered Dependents bring the total number of covered lives to approximately 1,223,000.

NYSHIP currently provides health insurance coverage through The Empire Plan, a Participating Provider Organization (PPO) with managed care components, and 10 Health Maintenance Organizations (HMOs). The Excelsior Plan is a lower cost version of The Empire Plan available to PAs. Additionally, the Student Employee Health Plan (SEHP) is insured and administered through The Empire Plan contracts. SEHP is a health insurance plan for graduate student employees of the New York State and New York City University systems. NYS and PE employees and retirees may elect to enroll in either The Empire Plan or in HMOs offered through NYSHIP. NYSHIP offers only The Empire Plan and the Excelsior Plan to PAs. PAs may, and frequently do, offer HMOs directly to their own employees and retirees as an alternative to Empire Plan coverage.

### **C. Overview of The Empire Plan, Excelsior Plan and Student Employee Health Plan**

The Empire Plan, Excelsior Plan, and SEHP (collectively referred to as the Program) are comprehensive health benefit programs for New York’s public employees and their families.

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The Program is sponsored by the Council on Employee Health Insurance (CEHI). The Council is composed of the President of the Civil Service Commission, the Director of the Governor's Office of Employee Relations (GOER), and the Director of the Division of the Budget (DOB). The Department holds the contracts with the Program carriers/third party administrators. Currently, all components of the Program are fully insured. However, effective January 1, 2014, the prescription drug component of the Program will be self-funded.

This RFP seeks to secure the services of a qualified Offeror under a self-funded Administrative Services Only (ASO) arrangement for the MHSA Program. The Employee Benefits Division (EBD) within the Department is responsible for the administration of the Program. The Empire Plan currently has over 529,000 Enrollees with approximately 1,098,000 covered lives. The Empire Plan benefit design has four (4) main parts including:

1. Hospital Program benefits that include coverage for hospital inpatient stays and emergency care that are primarily medical as opposed to psychiatric or substance abuse issues, as well as outpatient services. This program is currently insured and administered by Empire BlueCross BlueShield;
2. Medical Program benefits that include coverage for medical and surgical services under the Participating Provider and the Basic Medical Programs and includes several specialty programs. This program is currently insured and administered by UnitedHealthcare Insurance Company (UHC) of New York;
3. Prescription Drug Program benefits that include coverage for prescription drugs dispensed through retail network pharmacies, and through the Mail Service Pharmacy Process, through the Specialty Pharmacy Program, and through non-network pharmacies. This program is currently insured through UHC with Medco Health Solutions, Inc. (Medco) serving as pharmacy benefit manager. Effective January 1, 2014, this Program will convert to an ASO contract administered by CVS Caremark; and
4. Mental Health and Substance Abuse Program benefits that include coverage for network services through participating provider and non-network services. This program is

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currently insured by UHC with network administration, managed care services, and claims administration provided through OptumHealth, Inc. [Optum]).

The benefit design of The Empire Plan is the result of collective bargaining between NYS and the various unions representing its employees. Benefits are administratively extended to non-represented NYS employees, employees of PAs and PEs, and retirees. Therefore, the benefit design is subject to change from time to time as the result of those negotiations, and there are variations in The Empire Plan's benefit design among the bargaining units. The benefit design cannot deviate from that which has been collectively bargained. The majority of the active workforce is represented by various unions, and union participation in the design and oversight of NYSHIP is active and ongoing. The Excelsior Plan, available to NYS local governments who participate with NYSHIP, is a more affordable version of The Empire Plan. It offers many of the same features and benefits of The Empire Plan, with a higher degree of cost sharing by covered individuals. The collective bargaining units and the unions representing the collective bargaining units are identified in Exhibit II.A2 as well as the other groups that participate in the Program.

The Empire Plan also affords benefits to members of the SEHP through the various Empire Plan contracts with the Insurers and Administrators. The SEHP was established in 1994 through collective bargaining. The SEHP became part of NYSHIP in 2002 to provide basic health insurance protection to graduate student employees of the State University of New York and their eligible Dependents. This benefit was extended to the graduate student employees of the City University of New York (CUNY) on January 1, 2009. Like The Empire Plan, the SEHP includes hospital, medical, managed mental health and substance abuse benefits, and prescription drug benefits. In 2012, the SEHP had a combined hospital, medical, managed mental health and substance abuse, and prescription drug benefit annual limit of \$1,250,000. The benefit maximum will be increased to \$2,000,000 effective January 1, 2013 and no annual combined SEHP benefit limit is permitted for plan years beginning January 1, 2014. SEHP covers an average of 5,500 employees; their eligible covered Dependents bring the total number of average covered lives to approximately 6,700. As required under the Mental Health Parity and Addiction Equity Act (MHPAEA), effective January 1, 2012, annual deductibles and out-of-pocket coinsurance maximums are shared

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between the Program's medical, hospital and mental health and substance abuse (MHSA) carriers/third party administrators. The annual shared deductible and out-of-pocket coinsurance maximums vary by group. See **Exhibit II.B** for a summary of shared accumulators by group. Currently, the Program's medical carrier/third party administrator oversees administration of the shared accumulators through daily claims processing files. See **Exhibit II.F5** for the file layout of the shared accumulator claims files.

Also required under MHPAEA, the Program completed a review of the quantitative and non-quantitative treatment limits. As currently designed, the Program is fully parity compliant with regard to cost sharing, pre-certification requirements, concurrent review and utilization review for inpatient and outpatient services. The Program's MHSA and medical carrier/third party administrator interact on a regular basis to ensure that the Programs remain parity compliant.

Effective January 1, 2013, the MHSA Program is required to comply with the NYS Autism mandate to provide coverage for the screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD). This coverage must include assessments, evaluations or tests to diagnose ASD, medications, psychiatric and psychological care, and therapeutic care, including services provided by licensed speech therapists, occupational therapists, social workers and physical therapists. The Program's medical and MHSA carriers/third party administrators currently cover the vast majority of mandated benefits with the exception of Applied Behavioral Analysis (ABA). The MHSA Program will apply the \$45,000 per individual annual cap on ABA services as increased annually by the CPI escalator allowed by the legislation.

#### D. Overview of the Mental Health and Substance Abuse Program

Program coverage for mental health and substance abuse services has been part of the Empire Plan since its inception in 1986. In 1992, the Empire Plan was redesigned to provide coverage for MHSA services separate from hospital and medical benefits and, since that time, the MHSA benefit has been insured and administered as a separate program within the Empire Plan which provides both Network and out-of-network benefits.

A primary component of the Network benefit is a stable and adequate panel of behavioral health providers. The MHSA Program network is composed of a mix of licensed psychiatrists, psychologists, licensed and registered clinical social workers, psychiatric nurses and nurse practitioners, Certified Structured Outpatient Rehabilitation Programs, residential treatment centers, group homes, Partial Hospitalization Programs, hospitals and group practices. Effective January 1, 2013, it will also include licensed Certified Behavioral Analysts (CBA). To assure that there is the opportunity to supplement clinical care with community programs, the Network also includes alternative treatment programs such as half-way houses and treatment programs for dually diagnosed individuals and programs certified by the NYS Office of Alcoholism and Substance Abuse Services.

Since the MHSA Program guarantees access to the Network level of benefit, if an appropriate Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, the Contractor must make a Single Case Agreement with a Non-Network Provider for services at the Network level of benefits.

Recognizing the importance of providing individualized, appropriate treatment in the least restrictive option possible, the MHSA Program utilizes a Clinical Referral Line and care management. The Clinical Referral Line is staffed by licensed clinicians experienced in the assessment and treatment of mental health and substance use disorders, and is maintained by the Contractor as a Program-dedicated telephone line available twenty four hours a day, seven days a week from anywhere in the United States. Callers can reach the Clinical Referral Line through the NYSHIP toll-free number. The Clinical Referral Line gives callers a thorough clinical assessment which, in turn, helps the Contractor identify the most appropriate treatment setting and provider for referral. Once a referral is received, the caller is guaranteed that the provider is a Network Provider.

Clinical Management assesses the medical necessity of the proposed care so as to best meet the treatment needs of the Enrollee and evaluate whether appropriate care is rendered at the least restrictive level. Clinical Management is especially important where the case is complex and continuing review is necessary to determine if treatment goals are being met. Clinical

Managers coordinate care with the Enrollee's family, primary care provider, treating facility, and provider to follow the Enrollee through their treatment plan.

For inpatient services other than emergencies, including alternate levels of care such as halfway houses and residential treatment centers, Network care should be pre-certified to ensure the highest level of benefits. If the Enrollee is referred to inpatient treatment from the Clinical Referral Line, the Network Provider is responsible for contacting the Contractor to begin the pre-certification process. During this process, Clinical Managers apply the Contractor's clinical and medical necessity criteria as well as other tools standard to the industry to identify the diagnoses and assist in the development of appropriate treatment plans. Thereafter, the Clinical Manager discusses the proposed treatment with staff at the facility which includes either the facility attending provider or an internal utilization review nurse. The Clinical Manager determines medical necessity by reviewing the symptoms, diagnosis, history, treatment goals, and planned interventions against the Contractor's clinical criteria.

If the Clinical Manager cannot determine the medical necessity of an inpatient admission, the case is automatically reviewed by the Contractor's Peer Reviewers. Peer Reviewers must be either psychiatrists or Ph.D. psychologists, with a minimum of five years of clinical experience. Clinical Management also includes concurrent inpatient reviews that occur with variable frequency depending on the level of care and the complexity of the case. Clinical Managers closely monitor the Enrollee's transition from inpatient to outpatient care with appropriate discharge planning to make certain that appointments are kept and the Enrollee is compliant with medications.

The following services are covered under the MHSA Program, subject to applicable copayments, deductibles and coinsurance:

1. Outpatient Care
  - a. Emergency Care at a hospital for treatment of MHSA when there is no inpatient admission following the care;
  - b. Office Visits;
  - c. Psychiatric Second Opinion;



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- d. Substance Abuse-Structured Outpatient Rehabilitation Program;
  - e. Twenty (20) Family Sessions per year when Enrollee is in a Structured Outpatient Substance Abuse Rehabilitation Program and, if the Enrollee is not in active treatment and the family member is covered under the same Empire Plan enrollment, twenty Family Sessions per year;
  - f. Psychological Testing and Evaluations with prior approval from the Contractor;
  - g. Medically Necessary Ambulance Services for MHSA care;
  - h. Electro-Convulsive Therapy with prior approval from the Contractor;
  - i. Crisis Intervention (Copays waived for up to three (3) visits per crisis);
  - j. Home-Based Counseling (Network coverage only);
  - k. Registered Nurse Practitioners (Network coverage only); and
  - l. Telephone Counseling (Network coverage only).
  - m. Applied Behavioral Analysis for the treatment of Autism, subject to a \$45,000 annual cap - **effective 1/1/13**
  - n. Medication Management
2. Inpatient and Alternate Levels of Care
    - a. Hospital Services;
    - b. Residential Treatment Facilities; Halfway Houses and Group Homes. (Network coverage only for Empire Plan and limited network coverage only for SEHP);
    - c. Partial Hospitalization and other Hospital-Based Alternate Levels of Care such as Intensive Outpatient; Day Treatment 23 Hour Extended Bed and 72 Hour Crisis Bed;
    - d. Psychiatric Treatment or Consultation while you are a MHSA Inpatient
    - e. Psychiatric Consultations on a Medical Unit;
    - f. Prescription Drugs when dispensed by an approved facility, residential or day treatment program.

**Exhibit II.B2** of this RFP provides the applicable copayments by plan and employee group. Also, for informational purposes, the Department's current Empire Plan Certificate of Insurance, SEHP Summary Plan Description and the NYSHIP Benefit Plan Comparison are included as **Exhibits II.C, II.C2 and II.D** of this RFP.

The MHSA Program does not have an Employee Assistance Program (EAP) component. There is a Statewide EAP for New York State employees staffed by NYS employees who participate as volunteers; however, EAPs do not have a formal role in the MHSA Program. They are not permitted to make referrals, nor can the Contractor accept clinical information from the EAP unless the Enrollee is included in the conversation (i.e., either physically present or on a conference call). Some EAP volunteers have professional degrees in mental health fields, some are certified EAP counselors, and others have various levels of training. EAP volunteers have been provided the opportunity to receive training regarding the MHSA Program and are encouraged to assist employees in accessing MHSA services through the MHSA Program. Participating Employers and Participating Agencies may have no EAP, some have internal EAPs, and others have contracted, professional EAPs.

Finally, Enrollees use the Empire Plan identification card, the Excelsior identification card and the SEHP identification card to access MHSA Network services. The Offeror is not responsible for the production and distribution of identification cards, nor will a MHSA Program-specific identification card be accepted as part of the MHSA Program benefit design.

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**SECTION II: PROCUREMENT PROTOCOL AND PROCESS**
**A. Rules Governing Conduct of Competitive Procurement Process****1. Timeline/Key Events**

RFP Release Date	February 15, 2013
<b>Exhibit I.K</b> Procurement Lobbying Offeror's Affirmation of Understanding & Agreement Due Date	See below*
Request for Data Necessary to Submit a Proposal Suggested Date (See Section III.G of this RFP)	February 26, 2013
Pre-Proposal Conference	February 25, 2013
Questions Due Date	March 4, 2013, 5:00pm ET
<b>Amended February 26, 2013</b>	
<del>Optional Re Priced Claims Test File Suggested Date</del>	<del>March 11, 2013</del>
Release Date of Official Responses to Questions	March 11, 2013
<b>Exhibit I.J</b> Notice of Bidding Intention Due Date	March 25, 2013
Proposals Due Date	April 16, 2013, 3:00pm ET
Anticipated Contract Start Date	Upon OSC Approval of the Agreement to begin October 1, 2013

\* Prior to the Offeror's initial contact with the Department, the Offeror must complete and submit **Exhibit I.K** Procurement Lobbying Offeror's Affirmation of Understanding & Agreement to the MHSA Program Procurement Manager.

**2. Procurement Lobbying Limitations**

- a. Pursuant to State Finance Law sections 139-j and 139-k, this Procurement imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the Procurement's "Restricted Period" (from the issuance of the RFP until the date of the Contract's final approval by the OSC) to other than designated staff of the Department and the Executive Branch of New York State government, unless the contact falls within certain statutory exceptions ("permissible contacts"). For purposes of this Section II.A.2 of the RFP, "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids (i.e., Proposals) in response to the RFP. Staff is required to obtain certain information from Offerors and others whenever there is a contact about the Procurement during the Restricted Period, and is required to make a determination of the Offeror's responsibility that addresses the Offeror's

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compliance with the statutes' requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a proposal on, or be awarded a contract for four years from the date of the second non-responsibility finding. The Procuring Agencies' Policy and associated procedures are included as **Exhibit I.L, "Procurement Lobbying Policy: Restrictions on Contacts During the Procurement Process"** to this RFP. Further information about these requirements can be found at:

<http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html>

- b. In order to ensure public confidence and integrity in the procurement process, the Department will strictly control all communications between any Offeror and participants in the evaluation process, from the date the RFP is released until the Contract is approved by OSC. "Offeror" means any individual or entity, or any employee, agent, consultant, or person acting on behalf of such individual or entity, who contacts the Department or any other State governmental entity about a governmental procurement during that procurement's restricted period, whether or not the caller has a financial interest in the outcome of the governmental procurement; provided, however, that a governmental agency or its employees that communicates with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document. All contacts, inquires, questions, filings and submission of Proposals in regard to the RFP must be directed, in writing, by mail, facsimile or e-mail, as applicable, solely to the MHSA Program Procurement Manager. An Offeror's failure to comply with this requirement may result in the Offeror's disqualification from this Procurement.

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

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For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239  
Fax: 518-402-2835  
E-mail: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us)

Additionally, prospective Offerors and Offerors are strictly prohibited from making any contacts or inquiries concerning the Procurement with any member, officer or employee of any NYS governmental entity other than the Department from the date the RFP is released until the Contract is approved by OSC subject only to the specific exceptions listed below. Further, any Offeror shall not attempt to influence the Procurement in any manner that would result in a violation or an attempted violation of Public Officers Law sections 73(5) or 74.

- c. The following contacts are exempted from the provisions of paragraph 3 of section 139-j and as such do not need to be directed to the MHSA Program Procurement Manager pursuant to section 139-k:
- (1) the submission of written Proposals in response to the RFP;
  - (2) the submission of written questions by a method set forth in RFP when all written questions and responses are to be distributed to all Offerors who have expressed an interest in the Procurement;
  - (3) participation in a demonstration, conference or other means for exchange of information in a setting open to all potential bidders provided for in RFP;
  - (4) complaints by an Offeror regarding the failure of the MHSA Program Procurement Manager to respond to an Offeror's authorized contacts, when such complaints are made in writing to the Department's Office of the General Counsel, provided that any such written complaints shall become a part of the procurement record;

- (5) communications by a successful Offeror(s) who has been tentatively awarded a contract and is engaged in communications with the Department solely for the purpose of negotiating the terms of the Contract after having been notified of tentative award;
- (6) contact by an Offeror to request the review of a procurement award when done in accordance with the procedure specified in the solicitation document;
  - a. contacts by an Offeror in protests, appeals or other review proceedings (including the apparent successful Offeror and its representatives) before the Department seeking a final administrative determination, or in a subsequent judicial proceeding; or
  - b. complaints of alleged improper conduct in the Procurement when such complaints are made to the NYS Attorney General, Inspector General, District Attorney, or to a court of competent jurisdiction; or
  - c. written protests, appeals or complaints to the NYS Comptroller's office during the process of contract approval, where the NYS Comptroller's approval is required provided that the NYS Comptroller shall make a record of such communications and any response thereto which shall be entered into the procurement record pursuant to State Finance Law Section 163; or
  - d. complaints of alleged improper conduct in a governmental procurement conducted by a municipal agency or local legislative body to the NYS Comptroller's office; and
- (7) communications between Offerors and governmental entities that solely address the determination of responsibility by a governmental entity of an Offeror.

- d. It is ***mandatory*** that all prospective Offerors/offerors complete Part 1 of **Exhibit I.K**, “**Procurement Lobbying Offeror’s Affirmation of Understanding and Agreement**” affirming their understanding of, and agreement to, comply with the procurement lobbying requirements set forth in State Finance Law §139-k and §139-j. A completed **Exhibit I.K** must be submitted to the MHSA Program Procurement Manager **prior to a prospective Offeror making its initial contact with the Department** (e.g., attendance at the Pre-Proposal Conference, submission of a Notice of Bidding Intention Form (**Exhibit I.J**), submission of questions, etc. or concurrent with an Offeror’s submission of its Proposal, whichever shall occur first). Offerors are advised that whenever any of the Offeror’s officers, employees, agents or consultants contacts the Department, they should be prepared to provide their name, address, telephone number, place of principal employment, occupation, and whether they were retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement. To that end and to streamline the process, Offerors are requested to complete and submit Part 2 of **Exhibit I.K** entitled, “Designated Offeror Contact” for each officer, employee, agent or consultant authorized by the Offeror to appear before or contact the Department in regards to this Procurement before appearing or before or at the time such contact is initiated.

Additionally, at the time a Proposal is submitted to the Department, the Offeror is required to provide a completed “Offeror’s Certification of Compliance Pursuant to State Finance Law §139-k” form. This certification is included as **Exhibit I.P** of this RFP.

### 3. **Notice of Bidding Intention Form**

Filing of this notice is **not** mandatory; however, to assist the Department in better managing the procurement process, prospective Offerors, whether they intend to submit a Proposal in response to this RFP or not, are requested to complete a “**Notice of Bidding Intention Form**” (**Exhibit I.J**) and submit it to the MHSA Program Procurement Manager by the Notice of Bidding Intention Deadline as set forth in Section II.A.1. The completed form may be submitted either in hardcopy, at the address provided in Section II.A.2.b. or electronically at: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us).

On the Notice of Bidding Intention Form, New York State certified Minority and Women-Owned Businesses (M/WBE) may request that their firm's contact information be included on a list of M/WBE firms interested in serving as a subcontractor for this Procurement. The listing will be publicly posted on the Procurement webpage at:

[www.cs.ny.gov/MHSA2013RFP/index.cfm](http://www.cs.ny.gov/MHSA2013RFP/index.cfm) for reference by the bidding community. A firm requesting inclusion on this list should send a copy of its NYS M/WBE certification with its completed Notice of Bidding Intention Form. Nothing prohibits an M/WBE vendor from proposing as a prime contractor.

#### **4. Pre-Proposal Conference**

A Pre-Proposal Conference will be held on February 25, 2013 at 10:00 a.m. in the OGS Meeting Room 1 - Northeast Concourse Level of the Empire State Plaza, Albany, NY. Attendance is not mandatory, but is strongly encouraged for Offerors intending to submit a Proposal.

Each Offeror is requested to send no more than three (3) representatives to the Pre-Proposal Conference. If your organization plans to attend the Pre-Proposal Conference, please notify the MHSA Program Procurement Manager via facsimile or e-mail at the address noted in Section II.A.2.b. at least five (5) business days before the conference with the name and affiliation of each person attending. Information regarding directions to the Empire State Plaza, available parking and security requirements, may be found at: <http://ogs.ny.gov/ESP/CT/plaza.asp>. On the date of the conference, visitors may be required to present photo identification. Prospective Offerors are advised to allow sufficient time to go through security.

#### **5. Submission of Errors or Omissions in the RFP Document**

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, prospective Offerors agree to be bound by its terms, including, but not limited to, this process by which a prospective Offeror may submit errors or omissions for consideration. In the event that a prospective Offeror believes there is an



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error or omission in the RFP, the prospective Offeror may raise such issue according to the following provisions:

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

- (1) ***Time Frame:*** Assertions of errors or omissions in the procurement process which are or should have been apparent prior to the Proposal Due Date must be received by the Department, in writing, five (5) business days after the Release Date of Official Responses to Questions specified in Section II.A.1.
- (2) ***Content:*** The submission alleging the error or omission must clearly and fully state the legal and/or factual grounds for the assertion and must include all relevant documentation.
- (3) ***Format of Submission:*** All submissions asserting an error or omission must be in writing and submitted to the MHSA Program Procurement Manager at the following address:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239

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

**"Submission of Errors or Omissions for the  
Mental Health and Substance Abuse Program for the  
Empire Plan, Excelsior Plan and Student Employee Health Plan  
Request for Proposals # 2013MH-1"**

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

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

The Department shall conduct the review process for submission of errors or omissions. The Commissioner may appoint a designee who will review the submission and make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Department but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposals, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the prospective Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee, as the case may be, to support its submission. The prospective Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner or the Commissioner's designee.

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

The Department reserves the right to determine and to act in the best interests of the State in resolving any assertion of error or omission in the RFP document. As a consequence of reviewing the assertion, the Department may elect to extend the Proposal Due Date as may be appropriate. Notice of any such extension will be provided to all organizations who registered via mail, facsimile or e-mail. Notice of any extension will also be posted to: [www.cs.ny.gov/MHSA2013RFP/index.cfm](http://www.cs.ny.gov/MHSA2013RFP/index.cfm)

## 6. Submission of Questions

In the event a prospective Offeror has any substantive or procedural questions concerning the content of the RFP document, those questions can be submitted in the following manner to:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239  
Fax: 518-402-2835  
E-Mail: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us)

Prospective Offerors may submit questions to the MHSA Program Procurement Manager, in writing, via e-mail, facsimile or mail. The Department strongly urges prospective Offerors to submit the questions via e-mail. Each question should cite the particular RFP section, page number and paragraph number to which it refers. All responses will be considered unofficial until issued or confirmed in writing by the Department on the procurement website. Only those questions received prior to 5:00 p.m. Eastern Time (ET), on the Questions Due Date as shown in Section II.A.1. of this RFP, will be accepted.

To expedite its responses, the Department has provided a question template form which prospective Offerors are requested to use in submitting questions regarding the RFP (see RFP, [**Exhibit I.R**] "Question Template").

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After the Questions Due Date, the Department will provide to all organizations who have registered, e-mail notification of the posting of all questions received and the Department's Official Responses to said questions. The aforementioned information will be posted to: [www.cs.ny.gov/MHSA2013RFP/index.cfm](http://www.cs.ny.gov/MHSA2013RFP/index.cfm) and all registered potential Offerors will be notified of the posting to this site.

## 7. **Submission of Proposal**

### a. **Submission Requirements**

The Offeror's Proposal must be organized and separated into three (3) separate parts: Administrative Proposal, Technical Proposal, and Cost Proposal. To facilitate the evaluation process, Offerors must submit twelve (12) separately bound hard copies (two (2) ORIGINALS and ten (10) copies) and one (1) electronic copy (CD) **of each of the three (3) parts** of the Offeror's Proposal. Electronic submissions must be in Adobe Acrobat, as applicable. These thirty-six (36) documents and three (3) CDs are collectively hereafter referred to as "Submissions."

Each ORIGINAL hard copy of each part must be marked "ORIGINAL," contain original signatures of an official(s) authorization to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature and should be numbered sequentially, i.e. Original #1, Original #2,. The remaining ten (10) hard copies of each part may contain a copy of the official's signature and should be numbered sequentially (e.g. Copy #1, Copy #2, etc). Please note that for each of the three (3) parts, hard copies of each marked "Original #1" will be deemed controlling by the Department when viewing the Proposal.

Proposals should be placed and packaged together, by part, in sealed boxes/envelopes. Each sealed box/envelope should contain a label on the outside of the container which contains the information below.

**New York State Department of Civil Service  
Request for Proposals # 2013MH-1  
“Mental Health and Substance Abuse Program for the  
Empire Plan, Excelsior Plan and Student Employee Health Plan”**

**OFFEROR NAME  
OFFEROR ADDRESS**

Indicate content, as applicable

**ADMINISTRATIVE, TECHNICAL or COST PROPOSAL**

**There must be no cost information included in the Offeror’s Administrative Proposal or Technical Proposal.**

**All Proposals must be sent to the following:**

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239

For those Offerors who plan to have the Proposal hand delivered, arrangements for acceptance of the package must be made in accordance with procurement security procedures. **To make such arrangements, the Department requests that the Offeror notify the MHSA Program Procurement Manager forty-eight (48) hours prior to delivery. All Proposals must be received by 3:00 p.m. ET on the Proposal Due Date as set forth in Section II.A.1 of the RFP. No exceptions will be made for late submission or delays in delivery of the Proposal.** If the Proposal is

delivered by mail or courier, the Department recommends that it be sent "return receipt requested," so the Offeror obtains proof of timely delivery.

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

The Department will accept amendments and/or additions to an Offeror's Proposal if the request is received by the Department **prior** to 3:00 p.m. ET on the Proposal Due Date. All amendments to an Offeror's Proposal must be submitted in writing, in accordance with the format set forth in Section II.A.7. of this RFP, and will be included as part of the Offeror's Proposal, if accepted by the Department as provided above.

Offerors are cautioned to verify the content of their Proposal before submission. Except for material received from an Offeror in response to a request by the Department, the Department will not accept amendments or additions to a Proposal if such material is received after 3:00 p.m. ET on the Proposal Due Date. Offerors are encouraged to submit the Proposal Submission Checklist (**Exhibit I.A**) to facilitate verification of Proposal contents. An Offeror's request to withdraw a Proposal after the Proposal Due Date may be considered at the sole discretion of the Department.

**b. Formatting Requirements**

The Administrative Proposal, Technical Proposal, and Cost Proposal each should comply with the following formatting requirements (Failure to comply with the formatting requirements herein below may, but will not necessarily, result in the Proposal being deemed non-responsive and may, but will not necessarily, result in rejection of the Proposal):

- (1) ***Binding of Proposal:*** The Administrative, Technical, and Cost Proposals must be separately bound. The official name of the organization(s) and “Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan” must appear on the outside front cover of each copy of the Offeror's Administrative, Technical, and Cost Proposal. If the Proposals are submitted in loose-leaf binders, the official name(s) of the organization(s) and “Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan” also must appear on the spine of the binders;
- (2) ***Table of Contents:*** Each Proposal must include a table of contents;
- (3) ***Index Tabs:*** Each major Section of the Proposal and each Exhibit must be labeled with an index tab that completely identifies the title of the Section or Exhibit as named in the table of contents;
- (4) ***Pagination:*** Each page of the Proposal, including Exhibits, must be labeled on the upper right with the Section title and Section reference, page number, and date. Pages within each Section and Exhibit must be numbered consecutively;
- (5) ***Proposal Updates/Corrections:*** Each Offeror must submit its Proposal so that any update pages required by the Department can be easily incorporated into the Proposal. Should it be necessary for an Offeror to submit additional information in support of its Proposal, it must be submitted in accordance with the following: upon written notification by the Offeror and agreement by the Department, new or replacement pages may be placed in the Proposal. All new or replacement pages will show the date of the revision and indicate the portion of the page being changed. This latter requirement will be fulfilled by drawing vertical lines down both margins of all affected passages. All new/ replacement pages will be noted by the Department on the errata sheet to be placed at the front of the Proposal copy; and,

- (6) ***Required Content of Proposals:*** The Proposal shall consist of three parts: 1) the Administrative Proposal, which must respond to the requirements set forth in Section III of this RFP; 2) the Technical Proposal, which must respond to the requirements set forth in Section IV of this RFP; and 3) the Cost Proposal, which must respond to the requirements set forth in Section V of this RFP.

**c. Material Deviations**

New York State Law prohibits NYS from awarding a contract based upon material deviations from the specifications, terms, and conditions set forth in the RFP.

Consequently, each Offeror's Proposal must conform to the specifications, terms, and conditions set forth in this RFP and prospective Offerors are strongly advised to raise issues and/or concerns relating to this procurement during the question and answer phase rather than taking exceptions within their Proposals. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal non-responsive and may result in rejection of the Proposal.

In general, a material deviation is one that would (1) impair the interests of NYS, (ii) place the successful Offeror in a position of unfair economic advantage, (iii) place other Offerors at a competitive disadvantage, or (iv) which, if it had been included in the original RFP, could have formed a reasonable basis for an otherwise qualified Offeror to change its determination concerning the submission of a Proposal.

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



In order to be deemed responsive to this RFP, the Offeror shall submit a Proposal which independently satisfies all of the requirements set forth in this RFP, without substitution or modification (“stated requirements”). The Proposal will be evaluated against the requirements and specifications set forth in this RFP to determine the “best value” submission.

As stated above in part, New York State Law prohibits NYS from awarding a contract based upon material deviations from the specifications, terms, and conditions set forth in the RFP. Consequently, each Offeror’s Proposal must conform to the specifications, terms, and conditions set forth in this RFP. In addition to, but not in lieu of, its response to the RFP’s stated requirements, the Offeror may propose supplemental, “or equal”, additional or alternative terms (Extraneous Terms) to the stated requirements within the Proposal, provided that, in the State’s sole judgment, the Extraneous Term(s) does not constitute material deviations to the stated requirements. Proposed Extraneous Term(s) may only be considered by the State to the extent that such Extraneous Term(s) constitute non-material deviations from the requirements set forth in the RFP as determined in the Department’s sole discretion. Material deviations from the specifications, terms, and conditions set forth in the RFP may render the Proposal non-responsive and may result in rejection of the Proposal.

Therefore, in order for Extraneous Term(s) to be considered, the Extraneous Term must:

1. independently satisfy the applicable requirement(s) of the RFP on its own merits;
2. be clearly and separately identified as an “Extraneous Term” within the Administrative, Technical and/or Cost Proposals - Extraneous Terms Submission; and
3. be separately evaluated and scored in accordance with the bid evaluation criteria.

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If the Offeror proposes to include Extraneous Terms in its official Proposal, the Offeror must meet all of the following requirements:

- a. Each proposed Extraneous Term must be specifically enumerated in a separate section of the applicable Submission(s) (Administrative, Technical and/or Cost) labeled “Extraneous Terms Submission,” using the format as set forth in **Exhibit I.X** entitled, “Extraneous Terms Template.”
- b. The “Extraneous Terms” section must be in a writing prepared by Offeror and may not include any pre-printed literature or vendor forms;
- c. The writing must identify by part, section and title the particular RFP requirement (if any) which the Offeror proposes to supplement by inclusion of the Extraneous Term, with a brief description of the specific provision being modified by the Extraneous Term; and
- d. The Offeror shall enumerate the proposed additional or alternative term from the RFP requirement, and the reasons therefore.

Only those terms meeting the above requirements (a) through (d) shall be considered as having been submitted as part of the formal offer.

Extraneous Term(s) submitted on standard, pre-printed forms (including but not limited to: product literature, order forms, manufacturer’s license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Proposal, or that, in the State’s sole judgment, have not been submitted in compliance with the above requirements (a) through (d) above, will not be considered as having been submitted with or intended to be incorporated as part of the official offer contained in the Proposal, but rather will be deemed by the State to have been included by Offeror for informational or promotional purposes only.

Absent the State’s express written acceptance and incorporation of an

Extraneous Term, acceptance and/or processing of the Proposal shall not constitute the State's acceptance of Extraneous Term(s) or be deemed a waiver of the State's rights set forth herein.

**8. Notification of Award**

A proposed award notification letter will be sent to the selected Offeror indicating a conditional award subject to successful contract negotiations. The remaining Offerors will be notified of the conditional award and the possibility that failed negotiations could result in an alternative award. No public discussion or news releases relating to this RFP, the associated procurement process, including but not limited to the bid solicitation, proposal evaluation and award and contract negotiation processes or the Agreement shall be made by any Offeror or their agent without the prior written approval of the Department.

**9. Debriefing**

As stated in RFP, Section II.A.8 above, proposed award notification letters will be sent to the selected and non-selected Offerors. At that time, Offerors will be advised of the opportunity to request a Debriefing and the timeframe by which such requests must be made, dependent upon the nature of the Debriefing, i.e., pre-award or post-award. Debriefings are subject to the Department's Debriefing Guidelines which are set forth in **Exhibit I.H.** entitled, "NYS Department of Civil Service Debriefing Guidelines." An unsuccessful Offeror's written request for a debriefing shall be submitted to:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

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For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239  
Fax: 518-402-2835  
E-Mail: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us)

#### **10. Submission of Award Protests**

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, all Offerors agree to be bound by its terms including, but not limited to, the process by which an Offeror may submit protests of the selection award for consideration. In the event that an Offeror decides to protest the selection decision, the Offeror may raise such issue according to the following provisions.

##### **a. Process for Submitting Post Award Protests of the Selection Decision**

- (1) ***Time Frame:*** Any protest of the selection decision must be received no later than ten (10) business days after an Offeror's receipt of written notification by the Department of a conditional award.
- (2) ***Content:*** The submission of the protest must clearly and fully state the legal and/or factual grounds for the protest and must include all relevant documentation.
- (3) ***Format of Submission:*** All submissions of protest must be in writing and submitted to the MHSA Program Procurement Manager at the following address:

If using the U.S. Postal Service, please use the following address:

MHSA Program Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

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For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Program Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239

A protest of the selection decision must have the following statement clearly and prominently displayed on the envelope or package:

**“Submission of Selection Protest for the Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan”**

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

**b. Review of Submitted Protests**

The Department shall conduct the review process of submitted protests. The Department’s Commissioner may appoint a designee to review the submission and to make a recommendation to the Commissioner as to the disposition of the matter. The Commissioner's designee may be an employee of the Department but, in any event, shall be someone who has not participated in the preparation of this RFP, the evaluation of Proposals, or the selection decision. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or her designee, as the case may be, to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. Any and all issues concerning the manner in which the review process is conducted shall be determined solely by the Commissioner, or the Commissioner's designee. The Commissioner, or the Commissioner's designee, shall review the matter, and the Commissioner shall issue a written decision within twenty (20) business days after the close of the review process. If additional time for the issuance of the decision is necessary, the Offeror shall be advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be

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communicated to the party in writing and shall constitute the Department's final determination in the matter.

In the event that an Offeror protests the selection decision, the Department shall continue working with the selected Offeror pending the outcome of the protest. Any Offeror whose Proposal might become eligible for a conditional award in the event that the intended selection is disqualified may be asked to extend the time for which their Proposal shall remain valid.

The Department reserves the right to determine and to act in the best interests of the State in resolving any post award selection protest.

### **11. Department of Civil Service Reservation of Rights**

In addition to any rights articulated elsewhere in this RFP, the Department reserves the right to:

- a. Make or not make an award under the RFP, either in whole or in part.
- b. Prior to the bid opening, amend the RFP. If the Department elects to amend any part of the RFP, notification of the amendment will be provided to all organizations who submitted a Procurement Registration Form and/or a Procurement Lobbying Offeror's Affirmation of Understanding and Agreement (Exhibit I.K.) via e-mail, facsimile or mail. Any amendments will also be posted to:  
[www.cs.ny.gov/MHSA2013RFP/index.cfm](http://www.cs.ny.gov/MHSA2013RFP/index.cfm)
- c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent RFP amendments;
- d. Withdraw the RFP, at any time, in whole or in part, at the Department's sole discretion.
- e. Waive any requirements that are not material;
- f. Disqualify any Offeror whose conduct and/or Proposal fails to conform to any of the

- mandatory requirements of the RFP;
- g. Require clarification at any time during the Procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an Offeror's Proposal and/or to determine an Offeror's compliance with the requirements of this RFP;
  - h. Reject any or all Proposals received in response to this RFP, at its sole discretion;
  - i. Change any of the scheduled dates stated in this RFP;
  - j. Seek clarifications and revisions of Proposals;
  - k. Establish programmatic and legal requirements to meet the Department's needs, and to modify, correct, and/or clarify such requirements at any time during the Procurement, provided that any such modifications would not materially benefit or disadvantage any particular Offeror;
  - l. Eliminate any mandatory, non-material specifications that cannot be complied with by all of the Offerors;
  - m. For the purposes of ensuring completeness and comparability of the Proposals, analyze submissions and make adjustments or normalize submissions in the Proposal(s), including the Offeror's technical assumptions, and underlying calculations and assumptions used to support the Offeror's computation of costs, or to apply such other methods it deems necessary to make level comparisons across Proposals;
  - n. Use the Proposal, information obtained through any site visits, management interviews, and the Department's own investigation of an Offeror's qualifications, experience, ability or financial standing, and any other material or information submitted by the Offeror in response to the Department's request for clarifying information, if any, in the course of evaluation and selection under this RFP;

- o. Negotiate with the successful Offeror within the scope of the RFP in the best interests of the Department; and
- p. Utilize any and all ideas submitted in the Proposal(s) received.

### **12. Limitation of Liability**

The Department is not liable for any cost incurred by any Offeror prior to approval of the Agreement by OSC. Additionally, no cost will be incurred by the Department for any prospective Offeror or Offeror's participation in any procurement related activities.

The Department has taken care in preparing the data accompanying this RFP (hard copy Exhibits, website Exhibits, and sample document exhibits). However, the Department does not warrant the accuracy of the data; the numbers or statistics which appear in hardcopy Exhibits, website Exhibits, and sample document exhibits referenced throughout this RFP which are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation. Accordingly, prospective Offerors should rely upon and use such numbers or statistics in preparing their Proposals at their own discretion.

### **B. COMPLIANCE WITH APPLICABLE RULES, LAWS, REGULATIONS & EXECUTIVE ORDERS**

This Procurement is being conducted in accordance with, and is subject to, the competitive bidding laws of the State of New York (New York State Finance Law, Article 11) and it is governed by, at a minimum, the legal authorities referenced below. All Offerors must fully comply with the provisions and set forth in this Section II.B. of the RFP. The Department will consider for evaluation and selection purposes only those Offerors who agree to comply with these provisions whose Proposal contains the Statements, Formal Certifications, and Exhibits submissions required hereunder.



**1. Public Officers Law**

All Offerors and Offerors' employees and agents must be aware of and comply with the requirements of the New York State Public Officers Law ("POL"), particularly POL Sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establishing ethical standards for current and former NYS employees. In signing its Proposal, each Offeror guarantees knowledge and full compliance with such provisions for purposes of this RFP and any other activities including, but not limited to, contracts, bids, offers, and negotiations. Failure to comply with these provisions may result in disqualification from the procurement process, termination, suspension or cancellation of the Agreement and criminal proceedings as may be required by law. Per RFP Section III.C, Offerors must submit an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations, by submitting a completed **Exhibit I.M** in the Offeror's Administrative Proposal.

**2. Omnibus Procurement Act of 1994 and its 2000 Amendment**

Offerors are hereby notified that, if their principal place of business is located in a foreign or domestic jurisdiction that penalizes New York State vendors, and if the goods or services they offer would be produced or performed substantially outside New York State, the Omnibus Procurement Act of 1994 and its 2000 amendments require that they be denied contracts which they otherwise could obtain.

The list of jurisdictions subject to this provision is set forth in Article 21 of Appendix A.

**3. Contractor Requirements and Procedures for Business Participation Opportunities for NYS Certified Minority and Women-Owned Business Enterprises (MWBE) and Equal Employment Opportunities ("EEO") for Minority Group Members and Women**

**New York State Law:**

Pursuant to New York State Executive Law Article 15-A, the Department recognizes its obligation under the law to promote opportunities for the maximum feasible participation of certified minority and women-owned business enterprises and the employment of minority group members and women in the performance of the Department's contract. By submitting a Proposal in response to this procurement, the Offeror agrees to comply with the provisions of the RFP, including but not limited to Appendix D, entitled "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures" and the requirements set forth herein.

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (the "Disparity Study"). The Disparity Study can be accessed at: [http://www.esd.ny.gov/MWBE/Data/NERA\\_NYS\\_Disparity\\_Study\\_Final\\_NEW.pdf](http://www.esd.ny.gov/MWBE/Data/NERA_NYS_Disparity_Study_Final_NEW.pdf). The report found evidence of statistically significant disparities between the level of participation of minority and women-owned business enterprises in state procurement contracting versus the number of minority and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that the Department establish goals for maximum feasible participation of New York State Certified minority and women-owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

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**Business Participation Opportunities for MWBEs:**

For purposes of this Procurement, the Department hereby establishes an overall goal of 20% for MWBE participation as relates only to the administrative cost component of the overall cost of the Contract. The Contractor must document good faith efforts to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract and Contractor agrees that the Procuring Agencies may withhold payment pending receipt of the required MWBE documentation. The directory of New York State Certified MWBEs can be viewed at:

<https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp>

For guidance on how the Procuring Agencies will determine the Contractor's "good faith efforts," refer to 5 NYCRR §142.8.

In accordance with 5 NYCRR §142.13, Offeror/Contractor acknowledges that if it is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such finding constitutes a breach of Contract and the Department may withhold payment from the Contractor as liquidated damages.

Such liquidated damages shall be calculated as an amount equaling the difference between: (1) all sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and (2) all sums actually paid to MWBEs for work performed or materials supplied under the Contract.

By submitting a Proposal, the Offeror/Contractor agrees to submit the following documents and information as evidence of compliance with the foregoing:

- a. Offerors are required to submit a MWBE Utilization Plan - Form MWBE-100 (**Exhibit I.O.**) setting forth the Offeror's proposed plan to utilize MWBEs as subcontractors and suppliers under the Contract and a Certification of Good Faith Efforts - Form MWBE-104 (**Exhibit I.Q.**) with their Proposal. Any modifications or changes to the MWBE Utilization Plan after contract award and during the term of the Contract must be reported on a revised MWBE Utilization Plan and submitted to the Department.

- b. The Department will review the submitted MWBE Utilization Plan and advise the Offeror of the Department's acceptance or issue a notice of deficiency prior to contract award.
- c. If a notice of deficiency is issued, the Offeror agrees that it shall respond to the notice of deficiency within seven (7) business days of receipt by submitting to the MHS A Program Procurement Manager, a written remedy in response to the notice of deficiency. If the written remedy that is submitted is not timely or is found by the Department to be inadequate, the Department shall notify the Offeror and direct the Offeror to submit, within five (5) business days, a request for a partial or total waiver of MWBE participation goals on Form MWBE-101 entitled "Request for Waiver Form" available at: <http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm>. Failure to file the waiver form in a timely manner may be grounds for disqualification of the bid or proposal.
- d. The Department may disqualify an Offeror as being non-responsive under the following circumstances:
  - (1) If an Offeror fails to submit a MWBE Utilization Plan;
  - (2) If an Offeror fails to submit a written remedy to a notice of deficiency;
  - (3) If an Offeror fails to submit a request for waiver, if applicable; or
  - (4) If the Procuring Agencies determine that the Offeror has failed to document good faith efforts.

Contractors shall attempt to utilize, in good faith, any MBE or WBE identified within its MWBE Utilization Plan, during the performance of the Contract. Requests for a partial or total waiver of established goal requirements made subsequent to contract award may be made at any time during the term of the Contract to the Department, but must be made no later than prior to the submission of a request for final payment on the Contract.

Contractors are required to submit a Contractor's Quarterly M/WBE Contractor Compliance Reports - Form MWBE-103 to the Department's Contract Manager, at the address set forth in the Agreement, by the 10th day following each end of quarter over the

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term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract. Form MWBE-103 is available at:

<http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm>

**Equal Employment Opportunity Requirements:**

By submission of a Proposal in response to this procurement, the Offeror/Contractor agrees with all of the terms and conditions of Appendix A including Clause 12 - Equal Employment Opportunities for Minorities and Women. The Contractor is required to ensure that it and any subcontractors awarded a subcontract over \$25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor, shall undertake or continue programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability, or marital status. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation. This requirement does not apply to: (i) work, goods, or services unrelated to the Contract; or (ii) employment outside New York State.

Offeror/Contractor further agrees to submit with its Proposal an EEO Staffing Plan – Form EEO-100 (**Exhibit I.G**) identifying the anticipated work force to be utilized on the project and if awarded the contract, will, upon request, submit to DCS, a workforce utilization report identifying the workforce actually utilized on the Contract if known.

Further, pursuant to Article 15 of the Executive Law (the “Human Rights Law”), all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor and any subcontractors will not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital

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status, or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

**Please Note: Failure to comply with the foregoing requirements may result in a finding of non-responsiveness, non-responsibility and/or a breach of the Contract, leading to the withholding of funds, suspension or termination of the Contract or such other actions or enforcement proceedings as allowed by the Contract.**

Per RFP Section III.C, executed copies of:

**Exhibit I.G** entitled “EEO Staffing Plan (form EEO-100),”

**Exhibit I.Q** entitled, “Certification of Good Faith Efforts (form MWBE-104)”;

**Exhibit I.O** entitled, “MWBE Utilization Plan (form MWBE-100)” must be submitted as part of the Offeror’s Administrative Proposal.

**4. Americans with Disabilities Act**

The Contractor will be required to assure its compliance with the Americans with Disabilities Act (42 USC§12101 et. seq.), in that any services and programs provided during the course of performance of the Agreement shall be accessible under Title II of the Americans with Disabilities Act, and as otherwise may be required under the Americans with Disabilities Act by submitting a completed Compliance with Americans with Disabilities Act form (**Exhibit I.N**) in the Offeror’s Administrative Proposal.

**5. MacBride Fair Employment Principles Act & Non-Collusive Bidding Certification**

In accordance with Chapter 807 of the Laws of 1992, Offerors must certify whether they or any individual or legal entity in which the Offeror holds a ten percent (10%) or greater ownership interest, or any individual or legal entity that holds a ten percent (10%) or greater ownership in the Offeror have business operations in Northern Ireland. If an Offeror does have business operations in Northern Ireland, they must certify that they are taking lawful steps in good faith to conduct such business operations in accordance with the MacBride Fair Employment Opportunity Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern

Ireland, and shall permit independent monitoring of their compliance with such principles.

The Department also requires that Offerors certify that prices in their Proposal have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition with any other Offeror or competitor. In addition, that unless required by law, the prices quoted in the Offeror's Proposal have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly, indirectly, to any other Offeror or to any competitor. Offerors must also certify that no attempt has been made or will be made by the Offeror to induce any person, partnership or corporation to submit or not to submit a proposal for the purpose of restricting competition. An executed copy of the combined MacBride Act statement form and Non- Collusive Bidding Certification (**Exhibit I.D**) is required to be submitted in the Offeror's Administrative Proposal.

**6. Vendor Responsibility Requirements – State Finance Law §163**

New York State Finance Law §163 requires contracts for services and commodities be awarded on the basis of lowest price or best value “to a responsive and responsible Offeror.” Furthermore, §163(9)f requires the Procuring Agencies to make a determination of responsibility of the proposed contractor prior to making an award.

To assist the Department in evaluating the responsibility of Offerors, a completed “**New York State Standard Vendor Responsibility Questionnaire**” must be submitted in the Offeror's Administrative Proposal. A person legally authorized to represent the Offeror must execute the questionnaire. To the extent that the Contractor is proposing the use of Key Subcontractors (i.e., part of the Offeror's proposed Project Team), the Offeror must submit a completed “New York State Standard Vendor Responsibility Questionnaire” for each Key Subcontractor completed by a person legally authorized to represent the Key Subcontractor.

The Department recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System; however, vendors may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at:

[http://www.osc.state.ny.us/vendrep/vendor\\_index.htm](http://www.osc.state.ny.us/vendrep/vendor_index.htm) or go directly to the VendRep System online at: <https://portal.osc.state.ny.us>.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at:

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website [www.osc.state.ny.us/vendrep](http://www.osc.state.ny.us/vendrep) or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form. The paper form is also included in the RFP as **Exhibit I.I "New York State Standard Vendor Responsibility Questionnaire"**.

#### **7. Tax Law Section 5-a Certification Regarding Sales and Compensating Use Taxes**

Section 5-a of the New York Tax Law requires that any contract valued at more than \$100,000 entered into by a NYS agency shall not be valid, effective, or binding against the agency unless the Contractor certifies to the Tax Department that it is registered to collect New York State and local sales and compensating use taxes, if the Contractor made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000, measured over a specified period. In addition, the Contractor must certify to the Tax Department that each affiliate and Key Subcontractor of such Contractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. For the purpose of this requirement, "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. The Contractor also must certify to the procuring state entity that it filed the certification with the Tax Department and that the certification is correct and complete. Accordingly, in the event the value of the Agreement exceeds \$100,000, the Contractor must file a properly completed Form ST-220-CA (**Exhibit I.E**) with the Procuring Agencies and a properly completed Form ST-220-TD (**Exhibit I.F**) with the Department of Taxation & Finance before the Contract may take effect. In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Procuring Agencies if the Agreement's term is renewed. Further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

Submission of these forms (ST-220-CA and ST-220-TD) is not required at time of Proposal submission; however, the selected Offeror will be required to complete and submit these forms as a condition of contract award. These forms may also be found at:

[www.tax.ny.gov/forms/sales\\_cur\\_forms.htm](http://www.tax.ny.gov/forms/sales_cur_forms.htm)

**8. Disclosure of Proposal Contents – Freedom Of Information Law (“FOIL”)**

**NOTICE TO OFFEROR’S LEGAL COUNSEL**

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

To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding the New York State Freedom of Information Law (FOIL). If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret information and desires that such information not be disclosed if requested pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law, the Offeror must make that assertion by completing **Exhibit I.C “Freedom of Information Law – Request for Redaction Chart.”** The Offeror must complete the form specifically identifying by page number, line, or other appropriate designation, the specific information requested to be protected from FOIL disclosure and the specific reason why such information should not be disclosed. Page 2 of Exhibit I.C contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, summary allegations that material is proprietary or trade-secret are inadequate and will not result in protection from FOIL disclosure.

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

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

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**Requested Redactions (CD and Hard Copy):**

At the time of Proposal submission, the Offeror is required to identify the portions of its proposal that it is requesting to be redacted, in accordance with the instructions below, to be used in the event that its proposal is the subject of a Freedom of Information Law (FOIL) request received by the Department:

The Offeror must provide an electronic copy of the Administrative Proposal, the Cost Proposal and the Technical Proposal, each on a separate CD, which reflect the Offeror's requested redactions. Additionally, the Offer must provide a separately bound hardcopy of each of the three Proposal documents with redactions marked that are included on the CDs. The electronic documents must be prepared in PDF format using the Redaction Function in Adobe Acrobat Professional software, version 8 or higher. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using the Adobe **"Mark for Redaction" function; do not use the "Apply Redactions" function.** The resulting documents must show the Offeror's requested redactions as outlined, while the content remains visible. This will allow the Department to either apply or remove requested redactions when responding to FOIL requests. The documents included on the CD and in hard copy must be complete Proposals, including all Exhibits and Attachments. No section may be omitted from the CD or hard copy even if the entire section is requested to be redacted; such sections should be marked for redaction, not removed.

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

**9. Compliance with New York State Workers' Compensation Law**

Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Department shall not enter into any contract unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into a contract with the Department, the selected Offeror and Key Subcontractor(s), if any,

will be required to verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed in **Exhibit I.W** – Compliance with NYS Workers' Compensation Law. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers' Compensation Board, Bureau of Compliance at 518-486-6307. You may also find useful information at their website: <http://www.wcb.ny.gov>.

Failure to provide verification of either of these types of insurance coverage by the time the winning Offeror is selected and the Contract is ready to be executed will be grounds for disqualification of an otherwise successful Proposal.

Submission of the insurance verification information is **not** required at the time of submission; however, the Department would prefer the Offeror submit this insurance verification information with the Administrative Section, if possible.

To the extent that the Offeror is proposing the use of Key Subcontractors (i.e., part of the Offeror's proposed Project Team), the Offeror must verify for the Department, on forms authorized by the New York State Workers' Compensation Board, the fact that the Key Subcontractors" are properly insured or are otherwise in compliance with the insurance provisions of the WCL.

#### **10. Iran Divestment Act**

By submitting a proposal in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Offeror/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers 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 such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Offeror/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should the Department of Civil Service receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the Department of Civil Service 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 activity which is in violation of the Act within 90 days after the determination of such violation, then the Department of Civil Service 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 of Civil Service reserves the right to reject any proposal, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

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**SECTION III: ADMINISTRATIVE PROPOSAL REQUIREMENTS**

This Section of the RFP sets forth the requirements for the Offeror's Administrative Proposal submission, including the Minimum Mandatory Requirements that must be satisfied to qualify an Offeror to be considered for selection. The Department will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Proposals the Department determines to be in compliance with the requirements set forth in this Section III.

The Offeror's *Administrative Proposal* must respond to all of the following items as set forth below in the order and format specified and using the forms set forth in the RFP. Additional details pertaining to the required forms are found in Section II.B. Compliance With Applicable Rules, Laws, Regulations & Executive Orders, and Section III.

The *Administrative Proposal* must contain the following information, in the order enumerated below:

**A. Formal Offer Letter**

At this part of its Administrative Proposal, the Offeror must submit a formal offer in the form of the "**Formal Offer Letter**" as set forth in **Exhibit I.S**. The formal offer must be signed and executed by an individual with the capacity and legal authority to bind the Offeror in its offer to the State. Each of the two copies of the Offeror's Administrative Proposal marked "ORIGINAL" requires a letter with an original signature; the remaining copies of the Offeror's Administrative Proposal may contain photocopies of the signature. The Offeror must accept the terms and conditions as set forth in RFP, Section VII and Appendices A, B, C and D and agree to enter into a contractual agreement with the Department containing, at a minimum, the terms and conditions identified in the RFP section and appendices as cited herein (**Note:** Appendix A, "Standard Clauses for New York State Contracts" is basically a compilation of statutory requirements applicable to all persons and entities contracting with NYS and therefore has been deemed to be non-negotiable by the Offices of the Attorney General and the NYS Comptroller. Appendix B, "Standard Clauses for All Department Contracts," Appendix C, "Third Party Connection and Data Exchange Agreement," and Appendix D, "Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures" are

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compilations of standard clauses/requirements for the contracts and also are non-negotiable.) If an Offeror proposes to include the services of a Key Subcontractor(s), the Offeror shall be required to assume responsibility for those services as “Prime Contractor.” The Department will consider only the Prime Contractor in regard to contractual matters.

**B. Minimum Mandatory Requirements**

The Department will only accept Proposals from Offerors that attest and demonstrate through current valid documentation to the satisfaction of the Department that the Offeror meets the Proposal’s Minimum Mandatory Requirements set forth herein this Section III.B. At this part of its Administrative Proposal, the Offeror must submit a completed **Exhibit I.T “Offeror Attestations Form”** representing and warranting that:

1. the Offeror, as of the Proposal Due Date, possesses the legal capacity to enter into a contract with the Department
2. the Offeror, as of the Proposal Due Date, the Offeror provides behavioral management and associated claims adjudication services for a minimum of five million (5,000,000) lives as specified below. The Offeror must provide a list of client organizations with the number of lives served through each client to clearly demonstrate that the Offeror meets the minimum requirement of five million (5,000,000) lives. In determining lives, the Offeror should:
  - Include both at-risk and fee-for-service business;
  - Include Medicaid business;
  - Count all lives [e.g., an employee, a spouse and two (2) eligible dependents count as four (4)];
  - Exclude any non-behavioral health management business;
  - Exclude any employee assistance program business
3. as of the Proposal Due Date, the Offeror’s Empire Plan MHSA Provider Network, as proposed, meets or exceeds all of the following minimum

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Network access guarantees:

URBAN AREAS

- a. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Facility – Inpatient within five (5) miles; and,
  - one (1) Facility – ALOC within five (5) miles.
- b. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Psychiatrist within three (3) miles; and,
  - one (1) Psychologist within three (3) miles; and,
  - one (1) Licensed Clinical Social Worker (with R designation in NYS) within three (3) miles.

SUBURBAN AREAS

- c. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Facility – Inpatient within fifteen (15) miles; and,
  - one (1) Facility – ALOC within fifteen (15) miles.
- d. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Psychiatrist within fifteen (15) miles; and,
  - one (1) Psychologist within fifteen (15) miles; and,
  - one (1) Licensed Clinical Social Worker (with R designation in NYS) within fifteen (15) miles.

RURAL AREAS

- e. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Facility – Inpatient within forty (40) miles; and,
  - one (1) Facility – ALOC within forty (40) miles.
- f. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Psychiatrist within forty (40) miles; and,
  - one (1) Psychologist within forty (40) miles; and,



- one (1) Licensed Clinical Social Worker (with R designation in NYS) within forty (40) miles.

To demonstrate satisfaction of this requirement, the Offeror must submit all information required below based on the Geo-Coded Census file provided by the Department (**Exhibit III.A**). Based on these files the Offeror must submit with their Administrative Proposal the following:

- a. **Exhibit I.Y.2** – Offeror’s Proposed MHSA Provider Network File, following the instructions and file layout contained in **Exhibit I.Y.1**.
- b. **Exhibit I.Y.3** – Offeror’s MHSA Provider Network Access Prerequisite Worksheet;
- c. Offeror’s GeoAccess Report to Meet Minimum Mandatory Requirements (See **Exhibit III.A**– GeoAccess Reporting Format);
- d. **Attestation** – The Offeror must attest that, as of the Proposal Due Date, it holds executed contracts and has completed its credentialing of all Empire Plan MHSA Providers identified as “participating” in its proposed Empire Plan MHSA Provider Network File, **Exhibit I.Y.2**. Providers identified as “contingent” in the proposed Empire Plan MHSA Provider Network File for whom the Offeror has an executed Empire Plan specific provider contract contingent on award and/or for whom credentialing is not complete on the Proposal Due Date shall not be included in Exhibit I.Y.3, Offeror’s MHSA Provider Network Access Prerequisite Worksheet. . The Offeror must agree to provide documentation, including provider contracts, as required to demonstrate satisfaction of this requirement.

All Enrollees must be counted in calculating whether the Offeror meets the Empire Plan MHSA Provider Network access prerequisite. No Enrollee may be excluded even if there is no provider located within minimum mandatory access requirements.

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**Note: The Offeror’s proposed Empire Plan MHSA Provider network access standards will be scored as part of the evaluation of the Offeror’s Empire Plan MHSA Provider network and the Offeror’s Network Access Guarantees will be evaluated in accordance with the criteria specified in Section VI, entitled “Evaluation and Selection Criteria.”**

4. The Offeror understands and agrees to comply with all specific duties and responsibilities set forth in Section IV.B.3. of this RFP, entitled “Implementation,” including Section IV.B.3.b.(2) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.

**Note: The Offeror must propose a minimum Implementation and Start-Up Guarantee as a credit to the MHSA Program of at least 50% of the Administrative Fee for each day that all Implementation and Start-up requirements are not met for the period commencing January 1, 2014.**

5. The Offeror will maintain and make available as required by the Department a complete and accurate set of records related to the Agreement resulting from this RFP as required by Appendices A and B and the draft Agreement set forth in Section VII of this RFP. This includes, but is not limited to, provider contracts, detailed claim records, and any and all other financial records as deemed necessary by the Department to perform its fiduciary responsibilities to the Empire Plan MHSA Program’s participants and to ensure that public dollars are spent appropriately.
6. The Offeror has submitted as part of its Proposal, if so required by the RFP, or will submit all Transmittal letters, Statements, Formal Certifications and Exhibits as required in Section II of this RFP related to the Offeror’s compliance with all rules, laws, regulations and executive orders.
7. The Offeror will execute the duties and responsibilities set forth in Section IV of this RFP in strict conformance to the requirements described in that section of the RFP.

**Amended March 11, 2013**

8. The Offeror, **as of Proposal Due Date**, has current URAC-case management,

JCAHO, ACHC, NCQA or CARF full accreditation at the proposed primary worksite where case management will be performed for the Program services.

**Note: Any Offeror which fails to satisfy any of the above Minimum Mandatory Requirements shall be eliminated from further consideration.**

**C. Exhibits**

At this part of its Administrative Proposal, the Offeror must complete and submit the various Exhibits specified in Section II.B. and Section III of this RFP, in satisfaction of the regulatory requirements described therein. A listing of the required Exhibits is set forth below:

<b>Exhibit Name</b>	<b>Exhibit #</b>
Proposal Submission Requirement Checklist	<b>Exhibit I.A</b>
MacBride Statement and Non-Collusive Bidding Certification	<b>Exhibit I.D</b>
EEO Staffing Plan (form EEO-100)	<b>Exhibit I.G</b>
New York State Standard Vendor Responsibility Questionnaire	<b>Exhibit I.I</b>
Offeror's Affirmation of Understanding and Agreement	<b>Exhibit I.K</b>
Compliance with Public Officers Law Requirements	<b>Exhibit I.M</b>
Compliance with Americans with Disabilities Act	<b>Exhibit I.N</b>
MWBE Utilization Plan (form MWBE-100)	<b>Exhibit I.O</b>
Offeror's Certification of Compliance Pursuant to State Finance Law §139-k	<b>Exhibit I.P</b>
Certification of Good Faith Efforts (form MWBE-104)	<b>Exhibit I.Q</b>
Formal Offer Letter	<b>Exhibit I.S</b>
Offeror Attestations Form	<b>Exhibit I.T</b>
Key Subcontractors	<b>Exhibit I.U</b>
Program References	<b>Exhibit I.V</b>
Extraneous Terms Template	<b>Exhibit I.X</b>
Offeror's Proposed MHSA Participating Provider Network File	<b>Exhibit I.Y.2</b>
Offeror's MHSA Provider Network Access Prerequisite Worksheet	<b>Exhibit I.Y.3</b>
Confidentiality Agreement and Certificate of Non-Disclosure	<b>Exhibit I.Z</b>

**Note: If not already provided to the Department prior to Proposal submission, the Offeror must enclose a completed Exhibit I.K "Offeror's Affirmation of Understanding and Agreement."**

**D. Key Subcontractors**

At this part of its Administrative Proposal, the Offeror must provide a statement

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identifying all Key Subcontractors, if any, that the Offeror will be contracting with to provide MHSA Program services and must, for each such Key Subcontractor identify, complete and submit **Exhibit I.U** “Key Subcontractors”:

1. provide a brief description of the services to be provided by the Key Subcontractor; and
2. provide a description of any current relationships with such Key Subcontractor and the clients/projects that the Offeror and Key Subcontractor are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

The Offeror must indicate whether or not, as of the date of the Offeror’s Proposal, a subcontract has been executed between the Offeror and the Key Subcontractor for services to be provided by the Key Subcontractor relating to this RFP. If the Offeror will not be subcontracting with any Key Subcontractor(s) to provide MHSA Program services, the Offeror must provide a statement to that effect.

**E. Reference Checks**

At this part of its Administrative Proposal, for the purpose of reference checks, the Offeror must provide four (4) references of current clients and one (1) reference of a former client, for a total of 5 references, for whom the Offeror has supplied services similar to those described in this RFP. The number of covered lives covered by the Offeror for each referenced client must be at least 100,000. For each client reference provided, the Offeror must complete and submit **Exhibit I.V** “Program References.” The Offeror shall be solely responsible for providing contact names, e-mail addresses and phone numbers of client references who are readily available to be contacted by the State.

**F. Financial Statements**

At this part of its Administrative Proposal, the Offeror must provide a copy of the Offeror's last issued GAAP annual audited financial statement. A complete set of statements, not just excerpts, must be provided. Additionally, for each Key Subcontractor, if any, that

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provides any of the MHSA Program services; which are the subject matter of this RFP, provide the most recent GAAP annual audited statement. If the Offeror, or a Key Subcontractor, is a privately held business and is unwilling to provide copies of their GAAP annual audited financial statements as part of their Proposal, the Offeror/Key Subcontractor must make arrangements for the procurement evaluation team to review the financial statements. **Note:** If financial statements have not been prepared and/or audited, the Offeror /Key Subcontractor must provide the following as part of its Administrative Proposal: a letter from a bank reference attesting to the Offeror/Key Subcontractor's financial viability and creditworthiness. (Note: For purposes of this reference, the Offeror may not give as a reference, a parent or subsidiary company, a partner or an Affiliate organization.) The letter must include the bank's name, address, contact person name and telephone number and it must address, at a minimum, the following items:

1. a brief description of the business relationship between the parties (i.e., the Offeror/Key Subcontractor and the bank), including the duration of the relationship and the Offeror's current standing with the bank. For example: "*The (Offeror/Key Subcontractor's name) is currently and has been for "x" number of years a client in good standing*";
2. a description of any ownership/partner relationship that may exist between the parties, if any. (**Note:** One party cannot be the parent, partner or subsidiary of the other, nor can one party be an affiliate of the other); and,
3. any other facts or conclusions the bank may deem relevant to the State in regard to the bank's assessment of the Offeror /Key Subcontractor's financial viability and creditworthiness concerning the nature and scope of the Program Services, which are the subject matter of this RFP, and the Parties (i.e., Department, and the Offeror or the Offeror and Key Subcontractor) contractual obligations should the Offeror be awarded the resultant contract.

**G. Request for Data Necessary to Submit a Proposal**

Offerors intending to submit a Proposal will require Empire Plan MHSA Program data.

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The Empire Plan MHSA Program data files can be obtained by sending a letter requesting the files and including a properly executed **Exhibit I.Z**, Confidentiality Agreement and Certificate of Non-Disclosure. The letter must be signed and executed by an individual with the capacity and legal authority to bind the prospective Offeror. The letter and properly executed Confidentiality Agreement and Certificate of Non-Disclosure form must be sent to:

If using the U.S. Postal Service, please use the following address:

MHSA Benefit Services Procurement Manager  
Employee Benefits Division, Room 1106  
NYS Department of Civil Service  
Albany, New York 12239

For all other carriers including couriers, UPS and FedEx please use the following address:

MHSA Benefit Services Procurement Manager  
NYS Department of Civil Service  
Employee Benefits Division  
Agency Building 1  
Empire State Plaza  
Albany NY 12239

The Empire Plan MHSA Program data files will only be sent to those prospective Offerors that request said files via submission of the pre-requisite letter referred to above, accompanied by properly executed **Exhibit I.Z**.

Upon receipt of said letter and form, the prospective Offerors will be sent a CD containing the following Empire Plan MHSA Program data files along with the accompanying record layout and instructions as further described in Exhibit III.A:

1. Market basket of Empire Plan MHSA Program 2011 claims for reference in preparing Exhibit V.A of the RFP;
2. Empire Plan Geocoded Census data file and GeoNetwork report file to be used to prepare Exhibit I.Y.3 of the RFP; and
3. Representative sample of MHSA Program providers to be used to complete Exhibit I.Y.4 of the RFP.

**Note:** Prospective Offerors are solely responsible for the delivery of the pre-requisite

letter and properly executed Exhibit I.Z.

The Department is not responsible for delays attributable to United States mail deliveries or any other means of transmittal, or for delays caused by the prospective Offeror due to their submission of incomplete, inaccurate or incorrect information.

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**SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS**

The Department is seeking to award the Agreement to a qualified Offeror to provide Mental Health and Substance Abuse Services for The Empire Plan, Excelsior Plan, and Student Employee Health Plan Mental Health and Substance Abuse Programs (collectively referred to as the Program). The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Successful Offeror selected in response to this RFP with whom the Department enters into the Agreement (“Contractor”) and to pose questions concerning those duties and responsibilities for response by the Offerors. The Offeror’s Technical Proposal must contain responses to all questions (i.e. Required Submissions) in the format requested. Each Offeror may submit only one Technical Proposal. The Technical Proposals will be evaluated based on the Offeror’s responses to the questions contained in this section. Therefore, it is critical that Offerors fully respond to each of the questions presented in this Section IV. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror’s Proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any supplemental material.

**Notes** Numbers, data, or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

**The Department will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.**

**Please note that Offerors may not include any cost information in the Technical Proposal including exhibits or attachments. This cost information pertains to the provider fees and Administrative Fees requested in the Cost Proposal. Performance guarantee amounts are to be included in the Technical Proposal. Specific savings estimates (dollars or percentages) should not be quoted in the Technical Proposal or in any exhibits or attachments submitted with the Technical Proposal.**



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**A. Program Administration****1. Executive Summary**

The Offeror must describe its capacity to administer the Department's Mental Health and Substance Abuse Program (also hereafter collectively referred to as the "MHSA Program").

**a. Required Submission**

The Offeror must submit an Executive Summary that describes its capacity to administer the Department's MHSA Program. The Executive Summary must include:

- (1) The name and address of the Offeror's main and branch offices and the name of the senior officer who will be responsible for this account;
- (2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Department in accomplishing its objectives;
- (3) A statement explaining previous experience managing the Mental Health and Substance Abuse Programs of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a self-funded Mental Health and Substance Abuse Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP; and
- (4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions;
  - (a) Account Team
  - (b) Premium Development Services
  - (c) Implementation
  - (d) Customer Service
  - (e) Enrollee Communication Support

- (f) Enrollment Management
- (g) Reporting
- (h) Consulting
- (i) Transition and Termination of Contract
- (j) Network Management
- (k) Claims Processing
- (l) Clinical Management/Utilization Review

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

2. **General Qualifications of the Offeror**

The MHSA Program covers over one million lives and incurs costs in excess of \$160 million annually. The Offeror/ Contractor must have the experience, reliability and integrity to ensure that each Enrollees' mental health and substance abuse care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the MHSA Program's duties and responsibilities set forth in the RFP, ensuring full compliance with the MHSA Program Services.

a. **Required Submission**

The Offeror must demonstrate that it has the wherewithal to administer the MHSA Program as required by this RFP. Please provide detailed responses to the following:

- (1) What experience does the Offeror have in managing/supervising a MHSA program similar to the MHSA Program described in this RFP?
- (2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational and clinical aspects of the MHSA Program?
- (3) What internal systems or procedures will the Offeror have in place to provide financial, legal, and audit oversight of its contract with the MHSA Program?

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**B. Proposed Empire Plan MHSA Program Services**

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the MHSA Program.

**1. Account Team**

The Department expects the Contractor to have a proactive, experienced account leader and team in place who are dedicated solely to the MHSA Program and who have the authority and expertise to coordinate the appropriate resources to implement and administer the MHSA Program.

**a. Duties and Responsibilities**

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

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regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department;

- (b) 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).
- (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.
- (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.

**b. Required Submission**

- (1) Provide an organizational chart and description illustrating how you propose to administer, manage, and oversee all aspects of the MHSA Program. Include the following:
  - (a) Reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within your organization. Describe how the account management team interfaces with senior management and ultimate decision makers within your organization;

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- (b) Names, qualifications, and job descriptions of those individuals selected to comprise the operational and clinical account and management team for the Offeror. Complete **Exhibit I.B** of this RFP, Biographical Sketch Form, for all key members of the proposed account and management team;
- (c) Where individuals are not named, include qualifications of the individuals that you would seek to fill the positions; and
- (d) Where will your account services, enrollment, claims processing, clinical management, clinical referral line and customer service staff be located and approximately how many staff members will work in each functional area?
- (2) Describe how the dedicated account team will have access to larger corporate resources as well as upper level management. What tools and resources are available to the account team to manage the MHSA Program? What tools will be available to the Department to work with the account team to manage the MHSA Program?

**Amended March 11, 2013**

- (3) List the national accreditations and levels (i.e. full, provisional, etc...) that your organization has achieved for the locations that will service the MHSA Program. ~~If none, indicate your corporate plan, if any, for seeking accreditation subsequent to MHSA Program award.~~
- (4) Confirm you will 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.

**2. Premium Development Services**

The Contractor must provide underwriting assistance and support to the Department in the development of premium rates chargeable to MHSA Program participants consistent with the interests and goals of the MHSA Program and the State. The Department intends to develop premium rates to be as realistic as possible, taking into account all significant

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elements that can affect MHSA Program costs including, but not limited to trend factors, changes in enrollment and enacted legislation. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the State, and to meet the budgetary needs of the State and local governments that participate in NYSHIP.

**a. Duties and Responsibilities**

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

- (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;
- (2) Developing 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
- (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.

**b. Required Submission**

- (1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the MHSA Program. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

- (2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.
- (3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

**Note:** The responses to the above three Required Submissions should be general descriptions of the financial methodology you intend to use for assisting and supporting the Department with the MHSAs Program. Responses may **NOT** include any specific cost information or values relative to the development of cost/rate projections and trends for the MHSAs Program; that information must be restricted to your Cost Proposal.

### **3. Implementation**

The Contractor must ensure that the MHSAs Program is fully functional by January 1, 2014. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities by December 31, 2013.

#### **a. Duties and Responsibilities**

- (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 IV.B.3.a.2a-2e. Such implementation activities must be completed no later than December 31, 2013 so that the MHSAs Program is fully operational on January 1, 2014.

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- (2) ***Implementation and Start-up Guarantee:*** The Contractor must guarantee 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;
- (a) A contracted Provider network (including Certified Behavior Analysts) that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP;
  - (b) A fully operational call center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP;
  - (c) A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section IV.B.11 of this RFP;
  - (d) 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
  - (e) 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 IV. B.4 of this RFP.

**b. Required Submission**

- (1) Provide an implementation plan (via a detailed narrative, diagram, and timeline) upon Agreement approval, on or around October 1, 2013 that results in the implementation of all MHSA Program services by the required date of December 31, 2013, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas



where complications may be expected. Include key activities such as member and Provider communications, training of call center and clinical staff, report generation, network development, transition benefits, customized website design, eligibility feeds and claims testing.

- (2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose the forfeiture of a percentage of the 2014 Administrative Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

*The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the MHSA Program are not met is a minimum of fifty percent (50%) of the 2014 Administrative Fee (prorated on a daily basis). However, Offerors may propose higher percentages.*

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is \_\_\_\_\_ percent (%) of the 2014 Administrative Fee (prorated on a daily basis).

#### **Amended February 20, 2013**

#### **4. Customer Service**

The MHSA Program requires that the Contractor provide quality customer service to Enrollees. The MHSA Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access representatives who respond to questions, complaints and inquiries regarding MHSA Program benefits, Network Providers, claim status etc., and, when a call involves a clinical matter, refer the caller to the Contractor's Clinical Referral Line. In 2011, the customer service line received 139,072 calls and the Clinical Referral Line received 112,758 calls for a total of 251,830 calls. For the first 6 months of 2012, the customer service line received 68,652 calls and the Clinical Referral Line received 54,419 calls for a total of 123,071 calls. The Offeror/Contractor is required to agree to customer service performance guarantees that reflect strong commitments to quality

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customer service. Exhibit II.I provides the number of members who have utilized the current DCS customized MHSA Program website from October 2011 through October 2012.

a. **Duties and Responsibilities**

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

- (1) 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;
- (2) 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 Offeror'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 RFP;
- (3) Maintaining a Dedicated Call Center for the MHSA Program located in the United States that:
  - (a) 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;

- (b) Provides access to fully trained customer service representatives and supervisors available between the hours of 8:00AM.to 5:00PM., Monday through Friday, except for legal holidays observed by the State;
  - (c) Meets the Contractor's proposed call center telephone guarantees set forth in Section IV.B.4b (8) of this RFP.
- (4) 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;
- (5) 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) 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;
- (7) 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 website must be provided. No other links are permitted without

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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; and

- (8) ***Call Center Telephone Guarantees:*** The Contractor must meet or exceed the following four (4) measures of service on the toll-free customer service telephone line;
- (a) ***Call Center Availability:*** 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;
- (b) ***Call Center Telephone Response Time:*** The MHSA Program's service level standard requires that, at the 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;
- (c) ***Telephone Abandonment Rate:*** 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

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exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated annually.

(d) **Telephone Blockage Rate:** 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.

**b. Required Submission**

- (1) Confirm that you will provide Enrollees access to the Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day 365 Days a year, as described above.
- (2) Confirm you will enter into a shared service agreement with the Empire Plan medical carrier/ third party administrator, or other party designated by the Department, and AT&T. Confirm you will provide 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.
- (3) Confirm you maintain a Dedicated Call Center for the MHSA Program located in the United States, employing a staff of Clinicians and a staff of fully trained customer service representatives (CSR's) and supervisors. Confirm that customer service representatives will be available, at a minimum, for the MHSA Program between the hours of 8:00AM to 5:00PM, Monday through Friday except for legal holidays observed by the State. If additional hours are proposed, please state. Confirm that access to Clinical Managers through the Clinical Referral Line will be 24 hours a Day, 365 Days a year.
- (4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries.  
Include:
  - (a) Whether any Interactive Voice Response (IVR) system is proposed;

- (b) A sample of the IVR script and a description of customizable options, if any, you propose for the MHSA Program;
  - (c) A description of the management reports and information available from the system including the key statistics you propose to report;
  - (d) A description of the capabilities of your phone system to track call types, reasons and resolutions;
- (5) Describe the training that is provided to CSR and Clinical Referral Line staff before they go “live” on the phone with Enrollees. Include:
- (a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;
  - (b) The first call resolution rate for the proposed call center;
  - (c) The turnover rate for customer service and Clinical Referral Line employees;
  - (d) Ratio of management and supervisory staff to customer service representatives; and
  - (e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels;
- (6) Describe the back-up systems for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how and in what order calls from Enrollees will be handled. Confirm that backup staff will have MHSA Program specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Center and that the backup call center would only be used in case of system failure or call overflow;

(7) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop a customize website for the MHSA Program. Also, confirm that the following information, at a minimum, will be available on the website: MHSA Program benefits, Network Provider locations, eligibility, Copayment information and claim status. Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website; and

(8) ***Call Center Telephone Guarantees:*** For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fees, for failure to meet the Offeror's proposed guarantee;

(a) ***Call Center Availability:***

*The Standard Credit Amount for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours, calculated on an annual basis, is \$100,000 per year. However, Offerors may propose higher or lesser amounts;*

The Offeror's 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 Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours calculated on an annual basis is \$\_\_\_ per year.

(b) ***Call Center Telephone Response Time:***

*The Standard Credit Amount for each .01 to 1.0% below the standard of at the least ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, is \$25,000 a year. However, Offerors may propose higher or lesser amounts.*

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The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror'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 \$\_\_\_\_\_ per year;

(c) **Telephone Abandonment Rate:**

*The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror'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%), is \$25,000 per year. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror'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 Offeror's proposed guarantee), calculated on an annual basis, is \$\_\_\_\_\_ per year; and

(d) **Telephone Blockage Rate:**

*The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of zero percent (0%), is \$25,000 per year. However, Offerors may propose higher or lesser amounts.*

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



**5. Enrollee Communication Support**

The Department regularly provides information regarding MHSa Program benefits to Enrollees through various publications, the Department's website and attendance at various meetings. The Contractor will be required to assist the Department with the creation, review and presentation of MHSa Program materials that will enhance an Enrollee's understanding of MHSa Program benefits. Please see Exhibit II.J for a summary of MHSa Program presentations that took place in the past 12 month period.

**a. Duties and Responsibilities**

- (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.
- (2) The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:
  - (a) 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;
  - (b) 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;
  - (c) Timely reviewing and commenting on proposed MHSa Program communication material developed by the Department;
  - (d) 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

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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; and

- (e) 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 Section VII of the RFP.
- (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 Offeror's Administrative Fee.**
- (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.

**b. Required Submission**

- (1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreement. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the MHSA Program communications you have developed for Enrollees. Confirm your understanding

that all MHSA Program communications developed by the Offeror are subject to the Department's final approval.

- (2) Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and your ability to provide input into such communications quickly.
- (3) Confirm that the Offeror will pay the allocated portion of Shared Communication Expenses covering the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees on a timely basis, and will bill the MHSA Program for reimbursement in accordance with Article XV of the Agreement.
- (4) Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.
- (5) Confirm your commitment to work with the Department to develop appropriate customized forms, letters and SBCs for the MHSA Program. Provide examples of how you have worked with other large clients to produce customized communications.
- (6) Confirm that upon Enrollee request, the Offeror will distribute SBCs to Enrollees in a timely manner.

## **6. Enrollment Management**

The MHSA Program requires the Contractor to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with the Program's eligibility rules. EBD utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A through II.A4.

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**Note:** The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names. This universal card is used by Enrollees and Dependents for all components of The Empire Plan. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.3. The Department will not accept an alternative approach to ID cards. It is the responsibility of the Offeror to ensure that the Provider Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll free number that providers may use to contact the MHSA Program if they need claim submission assistance. The Contractor should not expect any modification of the current identification card as part of implementation.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in Exhibit II.E.2.

**a. Duties and Responsibilities**

The selected 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:

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(1) ***Initial Testing:***

- (a) Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the MHP 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;
- (b) 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 MHP Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;
- (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 II.H. 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;
- (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;
  - (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;
  - (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) Maintaining a read only connection to the NYBEAS 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 through NYBEAS, Monday through Friday, from 8:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;
  - (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; and
  - (8) ***Enrollment Management Guarantee:*** The Contract must guarantee that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality

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standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by the Department.

**b. Required Submission**

- (1) Describe your testing plan to ensure that the initial enrollment loads for the MHSA Program are accurately updated to your system and that they interface correctly with your claims system.
  - (a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?
  - (b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?
- (2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by the Department as well as;
  - (a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?
  - (b) How your system handles retroactive changes and corrections to enrollment data;
  - (c) Detail how your enrollment system captures the information necessary to produce the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims" required in the Reporting Section of this RFP;
  - (d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department. Does your system have any special requirements to accommodate these three identification

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numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system;

- (3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.
- (4) Describe the backup system, process or policy that will be used to ensure that Enrollees receive Clinical Referral Line services in the event that enrollment information is not available.
- (5) Confirm you will cooperate 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) Confirm that you will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 8:00 AM. to 5:00 PM., with the exception of NYS holidays.
- (7) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.
- (8) ***Enrollment Management Guarantee:*** The MHSA Program 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 Offeror's enrollment system within twenty-four (24) hours of release by the Department. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the standard.

*The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA*



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*Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is \$5,000. However, Offerors may propose higher or lesser amounts.*

The Offeror'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 Offeror's enrollment system, is \$\_\_\_\_\_ .

## 7. **Reporting**

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with Network Providers and the terms of the Agreement. The Contractor may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

### **Amended March 29, 2013**

In order to fulfill its obligations to enrolled members and ensure contract compliance, the MHSA Program requires that the Contractor provide **accurate detailed** claims data **on a monthly basis, information on a claim processing cycle basis** as well as specific summary reports concerning the **administration of the MHSA Program and its administration in an accurate manner.**

All electronic files received by the Department are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

#### **a. Duties and Responsibilities**

The Contractor will be responsible for accurate reporting services including, but not limited to:

- (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;
- (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;
- (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;
- (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:
  - (a) Forecasting and trend analysis data
  - (b) Utilization data
  - (c) Utilization review savings
  - (d) Benefit design modeling analysis
  - (e) Reports to meet clinical program review needs
  - (f) Reports segregating claims experience for specific populations
  - (g) Reports to monitor Agreement compliance
- (5) Providing direct, secure access to the Contractor’s claims system and any online and web-based reporting tools to authorized Department representatives;
- (6) ***Management Reports and Claim File Guarantees:*** The Contractor must provide accurate management reports and claim files as specified in Section IV.B.7.a.(7)

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of this RFP will be delivered to the Department no later than their respective due dates inclusive of the date of receipt; and

**Amended March 29, 2013**

(7) *Supplying reports in paper format and/or in an electronic format* (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Quarterly and Monthly and Bi-weekly Reports and include the time frames for submittal to the Department:

**Annual Reports**

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

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;

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;

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;

### **Quarterly Reports**

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;

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;

Quarterly Utilization Report: The Contractor must submit quarterly the MHSA Program's Quarterly Utilization Report that details MHSA 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 the quarter;

Quarterly Network Access: The Contractor must submit a measurement of the Network access (using **Exhibit I.Y.3**) 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;

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;

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;

Quarterly Website Analytics Report: The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's

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customized MHSA Program website as set forth in Section IV.B.4.a.(7) of this RFP. 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**

Quarterly Provider Audit Report: The Contractor must submit a quarterly audit report to the Department that summarizes 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 quarters.

**Monthly Reports**

Monthly Report of Paid Claims by Month of Incurral: The Contractor must submit a monthly report that provides summarized paid claims by month of incurral. The Contractor must 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 month;

**Amended March 11, 2013**

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 reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Contractor; and

**Amended March 29, 2013****Monthly/Periodic Reports**

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 the 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.**

**b. Required Submission**

- (1) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the MHSA Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the MHSA Program.
- (2) Confirm that you will provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department;
- (3) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access;

**Amended March 11, 2013**

(4) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

(5) **Management Reports and Claim File Guarantees:** The MHSA Program's service level standard requires that accurate management reports and claims files will be delivered to the Department no later than their respective due dates. For the management reports and claim files listed in Section IV.B.7.a. (7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this standard.

*The Standard Credit Amount for each management report or claim file that is not received by its respective due date is \$1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.*

The Offeror'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 \$\_\_\_\_\_ 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.

**8. Consulting**

The Department requires the Contractor to be an expert in the MHSA industry, thus, the Department requires the Contractor to provide the Department with up-to-date developments in the MHSA industry and may be requested by the Department to provide advice and recommendations related to such developments. The Department expects the Contractor to proactively provide advice and recommendations that are related to the clinical quality and cost management of the MHSA Program. Such recommendations must, at a minimum include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design changes.

**a. Duties and Responsibilities**



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

- (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
- (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 Offeror request any change in compensation, any such change will be processed in accordance with Section V of this RFP.

**b. Required Submission**

- (1) What resources do you utilize to ensure the MHSA Program is kept abreast of the latest developments in the MHSA field? How do you propose to communicate trends, pending legislation and industry information to the MHSA Program?
- (2) Please confirm you will assist the Department with recommendations and evaluation of proposed benefit design changes and implement any changes

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necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State.

**9. Transition and Termination of Agreement**

The Contractor shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their MHSA benefits and associated customer services through the final termination of the Agreement . This includes, but is not limited to: ensuring Enrollees can continue to receive services from Network Provider, the processing of all claims; verification of enrollment; providing sufficient staffing to ensure members continue to receive good customer service and clinical management service even after the termination date of the Agreement; and developing a strategy for addressing the treatment needs of those members in treatment with Providers that are not in the successor contractor's network. It is also imperative that the MHSA Program continue to have dialogue with key personnel of the Contractor's dedicated account team, maintain access to online systems and receive data/reports and other information regarding the MHSA Program after the termination date of the Agreement. In addition, the Contractor and the successor contractor shall fully cooperate with the Department to create and establish a transition plan in a timely manner.

**a. Duties and Responsibilities**

- (1) 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;
- (2) The Contractor must, within one hundred twenty (120) Days prior to the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written transition plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

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- (a) Transition of MHSA 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 MHSA Program in the format acceptable to the Department. The transition or pre-certification/prior authorization files should include but not be limited to the following;
- (i) 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;
  - (ii) 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;
  - (iii) 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.
- (3) 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;
- (4) 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;

- (5) The Contractor shall be responsible for transitioning the MHSA Program in accordance with the approved Transition Plan;
- (6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Contractor must provide the following obligations and deliverables to the MHSA Program through the final financial settlement of the Agreement, including but not limited to:
- (a) 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 MHSA Program for Medicare claims, retaining NYBEAS access 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 MHSA 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;
  - (b) Complete all reports required in Section IV.B.7.a.(7) of this RFP;
  - (c) Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner;
  - (d) Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XXIII of the Agreement and Appendices A and B;

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- (e) 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 XXIII "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and
- (f) Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XXIII, "Audit Authority" and Article – "Payments/credits) to/from the Contractor" of Section VII, Contract Provisions and Appendices A and B.
- (7) The Contractor must receive and apply enrollment updates, keep dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjust phone scripts, and transfer calls to the successor contractor's lines during the transition period;
- (8) 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;
- (9) 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;
- (10) 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;
- (11) The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined on or before December 31, 2018 until the earlier of the step down of care or midnight on the 90<sup>th</sup> day subsequent to December 31, 2018; and
- (12) The Contractor must agree that, if the Contractor does not meet the Transition Plan requirements in the time frame stated above, the Contractor **will**

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**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.

**b. Required Submission**

- (1) Confirm that the Contractor will commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program.
- (2) Provide an outline of the key elements and tasks that would be included in your Transition Plan to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor. Include a brief explanation on how you would accomplish this with the successor contractor.
- (3) Please detail the level of customer service and clinical management that you will provide after the termination date of the Agreement resulting from this RFP.
- (4) Confirm the Contractor will, if the Contractor does not meet the Transition Plan requirements in the time frame stated above, **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.

**10. Network Management**

Empire Plan Enrollees reside throughout the United States and are guaranteed access to Network Providers under the design of the MHSA Program. The Contractor must have a comprehensive, nationwide Provider Network in place to allow adequate access for Enrollees to obtain all covered MHSA services through the Provider Network. Through this RFP, the Department MHSA Program is seeking a Provider Network that delivers cost-effective clinically appropriate MHSA services, while meeting the minimum guarantees for Network Provider access.

**Provider Network**

The current MHSA Program includes a nationwide Provider Network through which Enrollees can obtain all covered MHSA Program services. The Offeror must propose and the Contractor must provide a MHSA Provider Network that meets or exceeds the MHSA Program's minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the MHSA Program's Provider Network commencing on January 1, 2014. The Contractor may choose to enter into MHSA Program-specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's proposed provider Network File upon the submission date of their Proposal.

**a. Duties and Responsibilities**

- (1) The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the MHSA Program's minimum access standards throughout the term of the Agreement.
- (2) 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 IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Provider Network.
- (3) 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.
- (4) 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;

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- (5) **Network Composition Guarantee:** The Contractor must guarantee that throughout the five-year term of the Agreement, at the least, 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, Licensed Clinical Social Worker with “R” designation in NYS, Certified Behavior 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; and,
- (6) **Network Provider Access Guarantee:** The Contractor must guarantee that, throughout the term of the Agreement, the Contractor’s MHSA Provider Network meets or exceeds the Department’s minimum access guarantees as follows;



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- a) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles;
  - b) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;
  - c) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;
  - d) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;
  - e) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,
  - f) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

**Note:** In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no enrollee may be excluded even if a Provider is not located within the minimum access area.

Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two Provider types: Network Facility (Inpatient and ALOC) and Network Practitioner types (Psychiatrist; Psychologist; Licensed Clinical Social Worker) for a total of six separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home (zip code) to the nearest MHSA Provider Network Provider location.

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Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the guarantee must follow the same structure as the above minimum (i.e., access guarantees for each two Provider groups for each of the six

(6) Provider type/area combinations based on the entire MHSA Program population).

**b. Required Submission**

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding Certified Behavior Analysts, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists) that meet or exceed the minimum set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

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

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

(2) Propose access standards for Certified Behavior Analysts in the MHSA Program's Provider Network. The access standard must be provided in terms of actual distance from Enrollees' residences.

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

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- (3) Complete **Exhibit I.Y.4**, entitled “Comparison of MHSA Program Providers and the Offeror’s Proposed Provider Network.” Identify whether each of the MHSA Program’s Providers will or will not participate in the Offeror’s proposed Provider Network in accordance with the instructions provided in **Exhibit I.Y.4**. The file containing the MHSA Program’s Providers can be obtained by meeting the requirements specified in Section III.G of this RFP.
  - (4) Please confirm that if selected, you will provide an updated **Exhibits I.Y.2, I.Y.3** and **I.Y.4** on December 1, 2013 confirming that the Offeror’s proposed Provider Network will be implemented as required on January 1, 2014. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Provider Network along with a detailed explanation for all deviations.
  - (5) Describe the types of Providers, inpatient facilities and Alternative Levels Of Care (ALOC) included in your proposed Provider Network. Include a listing of programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) which are included in the Provider Network.
  - (6) Describe the approaches you would use to solicit additional Providers to enhance your proposed Provider Network for Facilities, OASAS Programs and Practitioners or to fulfill a request to add a specific Provider.
  - (7) Members may have successful therapy plans with current Network Providers that are not in the Offeror’s Network. For key Providers (i.e., those who provide services for a significant number of Members or who are in an underserved area), what criteria would be used to determine which to recruit?
  - (8) Describe your strategy for maintaining the MHSA Program’s Network throughout the term of the Agreement resulting from the RFP.
  - (9) How do you monitor whether Network Providers are accepting new patients into their practices? Do your proposed access standards take into account Provider availability? If yes, how?

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(10) **Network Composition Guarantee:** The MHSA Program's service level standard requires that at the least ninety percent (90%) 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, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior 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 throughout the five-year term of the Agreement. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

*The Standard Credit Amount for each .01 to 1.0% below the MHSA Program's service level standard requiring that at least ninety-percent (90%) 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, 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 is \$25,000 per year. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee is \$\_\_\_\_ for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror'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, 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 quarterly annual basis is \$\_\_\_\_\_. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

- (11) **Network Provider Access Guarantees:** You must guarantee that throughout the term of the Agreement resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Provider. The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the “Provider Network” Section of this RFP. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

*The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Network Facility Access for Urban Areas is not met by the Offeror, is \$6,000 per each quarter. However, Offerors may propose higher or lesser amounts.*

The Offeror’s quoted amount to be credited against the Administrative Fee is \$\_\_\_ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror’s proposed guarantee) for any quarter in which the Network Facility Access-for Urban Areas Guarantee, is not met by the Offeror.

*The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Facility Access for Suburban Areas is not met by the Offeror, is \$6,000 per each quarter. However, Offerors may propose higher or lesser amounts.*

The Offeror’s quoted amount to be credited against the Administrative Fee is \$\_\_\_ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror’s proposed guarantee) for any quarter in which the

Network Facility Access-for Suburban Areas Guarantee, is not met by the Offeror.

*The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Facility Access for Rural Areas is not met by the Offeror, is \$6,000 per each quarter. However, Offerors may propose higher or lesser amounts.*

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

*The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Network Practitioner Access for Urban Areas is not met by the Offeror, is \$6,000 per each quarter. However, Offerors may propose higher or lesser amounts.*

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

*The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner Access for Suburban Areas is not met by the Offeror, is \$6,000 per each quarter. However, Offerors may propose higher or lesser amounts.*

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

*The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner Access for Rural Areas is not met by the Offeror, is \$6,000 per each quarter. However, Offerors may propose higher or lesser amounts.*

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

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.

#### Provider Credentialing

The Contractor must ensure that MHSA Network Providers meet the licensing standards required by the state in which they operate. MHSA Network Providers are also required to meet the credentialing criteria established by the Contractor. These criteria should be designed to ensure quality MHSA care.

#### **a. Duties and Responsibilities**

- (1) The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.
- (2) 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.

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- (3) 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.
  - (4) The Contractor must maintain a Provider Relations staff presence within New York State.
  - (5) The Contractor must maintain credentialing records and make them available for review by the Department upon request.
  - (6) ***Provider Credentialing Guarantee:*** The Contractor must guarantee that within sixty (60) Days of receipt of a completed MHSA Provider application to join the Program's network, the review, including credentialing, will be completed and the Provider notified of the determination.

**b. Required Submission**

- (1) Confirm that you will utilize a credentialing verification organization or establish credentialing criteria for Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the 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.
- (2) Describe the Offeror's process to ensure that Network Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?
- (3) Describe your approach for credentialing Network Providers.
  - (a) Specify if you utilize an external credentialing verification organization. When was this process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?



- (b) What steps do you take between credentialing periods to ensure that Network Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Provider Network as soon as possible? What steps, if any, do you take to advise members when a Provider has been removed from the Provider network? Under what circumstance would you notify the Department of the removal of a Network Provider?
- (4) How does Provider Relations staff keep abreast of Provider practices, attitudes, and concerns in New York State and other areas? Do you have Provider Relations staff that is located in NYS? How do you support a strong information infrastructure for your Network Providers?
- (5) How do you help your Network Providers achieve patient-centered care? How do you help Network Providers improve their diagnosis and assessment abilities to ensure that the care they provide is based upon the best available scientific knowledge? How do you ensure that your Network Providers collaborate with other clinicians to ensure an appropriate exchange of Enrollee information and coordination of care?
- (6) Confirm that you will maintain credentialing records and make them available for review by the Department upon request.
- (7) ***Provider Credentialing Guarantee:*** The MHSAs Program's service level standard requires that at least within sixty (60) Days of receipt of a completed Provider application to join the MHSAs Program's Network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or Facility notified of the determination. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The Standard Credit Amount for each Provider application to join the MHSAs Program's Network where the review, including credentialing, and notification of*

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*the determination to the provider is not completed within sixty (60) Days is \$1,500. However, Offerors may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee is \$\_\_\_\_\_ for each Provider application to join the MHSA 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 Offeror's proposed guarantee).

### **Provider Contracting**

Contracts with Providers must be written to utilize the MHSA Program's market strength to obtain competitive reimbursement rates with high quality Providers while also ensuring MHSA Program access guarantees are met. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with Providers that reflect the best interests of the MHSA Program. The Contractor must ensure that all Network Providers contractually agree and comply with the MHSA Program's requirements and benefit design. Contracts must be consistent with and support proposed access guarantees to ensure long-term stability of the Provider network. The Contractor may choose to enter into MHSA Program specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's Proposed Provider Network File upon the submission date of its proposal.

#### **a. Duties and Responsibilities**

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

- (1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;
- (2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;

- (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;
- (4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Provider contracts utilized by the MHSA Program;
- (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) 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 guaranteed access issues; and
- (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.

**b. Required Submission**

- (1) Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.). Specify if Providers are reimbursed at varying levels of the Provider fee schedule for the same covered service.
- (2) Confirm that your agreements with Network Providers require their compliance with all the MHSA Program's requirements and benefit design specifications. Provide a copy of the Offeror's proposed Provider contract for both Facilities and Practitioners.

- (3) Confirm that 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.
- (4) Confirm that you will, without delay, notify the Department in writing of any substantial changes to the number, composition or terms of Provider contracts utilized by the MHSa Program.
- (5) Complete the following chart listing reasons for voluntary Provider Network terminations:

<b>Facilities/ALOCs/Practitioners</b>	<b>2012</b>	<b>2011</b>	<b>2010</b>
Voluntary Terminations:			
Dissatisfaction with fees			
Disagreement with clinical decision			
Dissatisfaction with administrative process or paperwork			
Dissatisfaction with contractual terms			
Other (describe)			
Total Voluntary terminations			
Number of Network Providers on December 31st			
Percent of Network			

- (6) Describe the circumstances under which the Offeror will negotiate a single case agreement with a Non-Network Provider. Estimate the frequency with which you would expect to authorize network level benefits for non-network inpatient and outpatient services received under the MHSa Program.
- (7) Describe the tiering criteria and incentives you propose for the MHSa Program.

### **Provider Audit and Quality Assurance**

The Contractor must support a high quality and cost-effective MHSa Program. The protection of MHSa Program assets must be a top priority of the Contractor. The

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Contractor must have a strong audit presence throughout its organization. The Contractor shall be responsible for the oversight and audit of Providers that provide MHSA services to MHSA Program Enrollees.

The Contractor must support and encourage quality MHSA care through the following audit and quality assurance duties and responsibilities:

**a. Duties and Responsibilities**

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

(a) 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 written prior approval by the State;

(b) 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/or 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;

- (c) Maintaining the capability and contractual right of the Contractor to effectively audit the MHSAs Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors;
  - (d) 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 X.V, "Payments/ (credits) to/from the Contractor," of the Agreement resulting from this RFP; and
  - (e) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees.
- (2) The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to:
- (a) Monitoring the quality of care provided by Network Providers;
  - (b) Monitoring technical competency and customer service skills of Network Provider staff;
  - (c) Network Provider profiling;
  - (d) Peer review procedures;
  - (e) Outcome and Quality Measurement analysis; and
  - (f) Maintaining an ongoing training and education program that will be offered to Network Providers.

**b. Required Submission**

- (1) Describe the Provider audit program you would conduct for the MHSAs Program including a description of the criteria you use to select Providers for audit and a description of the policy that you follow when a Provider audit detects possible fraudulent activity by the Provider or an Enrollee. Include all types of audits performed and offered by your organization.

- (2) Describe the corrective action and the monitoring that takes place when you find that a Provider is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your organization and its role in the Provider audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Provider?
- (3) Provide a copy of the audit language and fraud and abuse language that is contained in your standard contract(s) for Network Providers.
- (4) Confirm that the Offeror will remit 100% of Provider and Enrollee audit recoveries to the Department within thirty (30) Days of receipt consistent with the process specified in Section V, “Payments/ (credits) to/from the Contractor” and Appendix B of Section VII.
- (5) Describe the Offeror’s proposed auditing tools and performance measures for identifying fraud and abuse by Network Providers and/or Enrollees.

### **11. Claims Processing**

The Contractor must process all claims submitted under the MHSA Program according to the benefit design, including Network Provider claims and manual submit claims including but not limited to Medicaid, out-of-network claims, foreign claims, in-network manual claims and COB including Medicare primary claims. The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the benefit design MHSA Program provisions and negotiated, agreements with Providers. All MHSA Program provisions for benefit design and other utilization or clinical management programs must be adhered to for all claims.

Enrollee Submitted Claims are required to be submitted to the Contractor no later than one hundred twenty (120) Days after the end of the Calendar Year in which the MHSA service was rendered, or one hundred twenty (120) Days after another plan processes the

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claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The MHSa Program count of claims can be found in Exhibit II.G3 of this RFP.

**a. Duties and Responsibilities**

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

- (a) Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;
- (b) 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;
- (c) 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, annual maximums and coinsurance maximums, at the time the claim was incurred as specified to the Contractor by the Department;

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- (d) 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;
- (e) 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;
- (f) Maintaining the security of the claim files and ensuring HIPAA compliance;



- (g) Adjusting all attributes of claim records processed in error crediting the MHSa Program for the amount of the claim processed in error;
- (h) 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;
- (i) 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;
- (j) 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;
- (k) 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;
- (l) Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports shared Deductible and Coinsurance Maximums;
- (m) 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 that have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health

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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;

- (n) 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;
- (o) 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;
- (p) Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours;
- (q) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims

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processed under the Disabled Lives Benefit in accordance with Section V.C of this RFP; and

(r) Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

(2) ***Financial Accuracy Guarantee:*** The Offeror must meet or exceed the following 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%);

(3) ***Non-Financial Accuracy Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the 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%);

**Amended March 11, 2013**

~~(4) *Turnaround Time for Network Claims Adjudication Guarantee:* The Offeror must meet or exceed the following performance guarantee. The MHSA Program's service level standard requires that, at the least, ninety nine and five tenths percent (99.5%) of Provider submitted claims that are received electronically, or in the Offeror'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 Offeror'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; and~~

**Amended March 11, 2013**

(5) *Turnaround Time for Non-Network Claims Adjudication Guarantee:* The Offeror must meet or exceed the following performance guarantee. The MHSA Program's service level standard requires that, at the least, ninety-nine and five-tenths percent (99.5%) of enrollee-submitted claims that are received in the Offeror'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 Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent.

**b. Required Submission**

- (1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating Non-Network and Network claims. Provide a description of the comprehensive edits you propose to ensure proper claim adjudication.
- (2) Describe your claims processing system platform including any backup system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure.

- (3) Confirm that all aspects of claims processing are located only in the United States staffed by fully trained claims processors and supervisors.
- (4) Describe the capabilities of your claims processing system to integrate each of the following required MHSA Program components:
  - (a) Prior authorization for inpatient services, psychological testing and electroconvulsive treatment and concurrent review of outpatient services;
  - (b) Eligibility verification;
  - (c) Customized edits for variations in benefits required various employee groups;
  - (d) Historic look up capability for claims and clinical information; and
  - (e) Multi-level cost sharing (Deductibles, Co-insurance, Co-payments).
- (5) Confirm that you will develop and securely route a daily claims file of shared accumulator amounts to the Empire Plan medical carrier/third party administrator and hospital carrier.
- (6) Confirm that you will timely load the daily claims files of shared accumulator amounts received from the Empire Plan medical carrier/third party administrator and hospital carrier.
- (7) Describe how any changes to the benefit design would be monitored, verified and tested for the MHSA Program, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the MHSA Program.
- (8) Confirm that you participate in Medicare Crossover and provide details of your experience with Medicare Crossover.

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- (9) Describe your procedures for the collection, storage and investigation of COB information other than Medicare.
  - (10) Explain how your claims processing system collects overpayments from your Provider network.

**Amended March 29, 2013**

- (11) Describe how your adjudication system feeds the reporting ~~and billing~~ systems, ~~and any claim update data delays~~ including how claims backlogs are captured and reported.
- (12) Confirm the Offeror will adjust all attributes of claim records processed in error and credit the MHSA Program for all costs associated with the claim processed in error.
- (13) Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the MHSA Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged an Administrative Fee only for Final Paid Claims. Confirm the Offeror 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 Offeror error. In cases of overpayments resulting from errors only found to be the responsibility of the Department and for fraud and abuse, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Program upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.
- (14) Confirm that the Offeror will update the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

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- (15) ***Financial Accuracy Guarantee:*** The MHSA Program's service level standard requires that the MHSA Program's financial accuracy be achieved for a minimum of ninety-nine percent (99%) of all claims processed and paid each 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%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) the Offeror's financial accuracy rate of all claims processed and paid each year is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror's proposed guarantee) that the MHSA Program's financial accuracy isn't achieved as calculated on an annual basis is \$\_\_\_\_\_.

- (16) ***Non-Financial Accuracy Guarantee:*** The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-five percent (95 %) of all claims processed and paid during the first year of the Agreement. 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. 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%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety-five percent (95 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during the first contract year is \$10,000 per year and for each .01 to 1.0% below ninety-seven percent (97 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during years two through five of the Agreement is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Offeror's proposed guarantee) in years two through five of the Agreement) that the MHSa Program's non-financial accuracy isn't achieved, as calculated on an annual basis is \$\_\_\_\_\_.

#### **Amended March 11, 2013**

~~(17) **Turnaround Time for Network Claims Adjudication Guarantee:** The MHSa Program's service level standard requires that a minimum of ninety-nine and five-tenths percent (99.5%) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.~~

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



*the date the Explanation of Benefits is received by the mailing agent is \$6,000 per each quarter. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror's proposed guarantee) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days from the date the claim is received in the Offeror'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 \$\_\_\_\_\_.

**(187) Turnaround Time for Non-Network Claims Adjudication Guarantee:** The MHP Program's service level standard requires that a minimum of ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days **or twenty-four (24) Days** from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days **or twenty-four (24) Days** from the date the claim is received electronically or in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent is \$6,000 per each quarter. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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

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(99.5%) (or the Offeror's proposed guarantee) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror'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 \$\_\_\_\_\_.

## **12. Clinical Management**

Quality Clinical Management techniques help to control costs and ensure that Enrollees are receiving safe, effective treatment in the least restrictive setting. The Department requires the Contractor to provide clinical management that is MHSA parity compliant through three Utilization Review (UR) methods that are currently used for the medical component of the Empire Plan: Pre-certification, Concurrent review and Retrospective review. The Contractor must, at a minimum, provide UR as described further in this Section; however, Offerors are not prevented from offering other value oriented UR methods, provided that they are parity compliant and implementation is at the sole discretion of the Department.

Both inpatient hospital and MHSA admissions are subject to pre-certification, except in Emergencies, concurrent review and retrospective review. Recurring outpatient therapy visits under the medical program, such as physical therapy, occupational therapy and chiropractic care, are certified based on clinical assessment of the member by the provider. The determination occurs after there has been a clinical assessment by the provider and the clinical assessment can occur after one or more visits. Services rendered by "tier 1" in-network providers for physical therapy, occupational therapy and chiropractic services do not need to be certified. The following are the options related to when a Provider is expected to seek authorization for these services:

1. No contact at all
2. Prior to the first contact
3. After the first contact
4. After the tenth visit

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Under the MHSA Program, recurring outpatient therapy visits may be reviewed prior to the 11<sup>th</sup> visit, but services may not be denied prior to the 11<sup>th</sup> visit.

For the period January 1, 2011 through December 31, 2011 clinical management of the MHSA Program resulted in authorization of approximately 1,117,000 outpatient visits and the certification of nearly 4,300 inpatient and alternate level of care admissions.

### Pre-Certification of Care

The MHSA Program is designed to strongly encourage members to seek clinical referral prior to receiving MHSA services. This is accomplished through the use of a Clinical Referral Line (CRL). The CRL is staffed by clinicians who determine the medical appropriateness of MHSA care and direct members to the most appropriate Network Provider and level of care. Also, the pre-certification process includes procedures to determine medical necessity in advance of non-emergent inpatient admissions and for out-patient benefits for “recurrent therapy visits”. “Recurrent Therapy Visits” are defined as treatment modalities or services that are dependent on the provider and patient interaction during the patient encounter as the major form of treatment, reoccur on a regular basis, and the total number of which are determined by a specific treatment plan based on the patient’s clinical presentation. The current Contractor requires pre-certification for ECT, psychological testing and Applied Behavioral Analysis (effective January 1, 2013).

#### **a. Duties and Responsibilities**

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:

- (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

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provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;

- (2) Use of alternate procedures to precertify care when the Enrollee fails to call the CRL, as follows:
  - (a) 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 authorizations 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;
  - (b) 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; and
  - (c) 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.
- (3) 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;
- (4) 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;

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- (5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;
- (6) Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program carrier/third party administrator and managing the Enrollee's care if transferred to rehab;
- (7) 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 implementation date, once acceptable files are received; and
- (8) Clinical Referral Line Guarantees: The Contractor must meet or exceed the following three (3) performance guarantees as follows:
- (a) ***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 MHSA Non-Network Provider or program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases.
- (b) ***Emergency Care CRL Guarantee:*** The Program's service level standard requires one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within (thirty) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non life-threatening emergency care shall be contacted by a Network Provider or recontacted by the CRL clinician within thirty (30) minutes of the Enrollee's call to the CRL.
- Amended March 11, 2013**
- (c) ***Urgent Care CRL Guarantee:*** The Program's service level standard requires that, at the least, ninety-nine percent (99%) of Enrollees in need of urgent care be contacted by ~~the Network Provider~~ Contractor to ensure that the Network

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**Provider contacted the Enrollee** within forty-eight (48) hours of the Enrollee's call to the CRL.

**b. Required Submission**

- (1) Describe in detail how you propose to precertify services including:
  - (a) An overview of your Clinical Referral Line (CRL) and proposed precertification process as well as the criteria you use to identify the services that the Program should consider for pre-certification or prior authorization.
  - (b) Your proposed Clinical Referral Line staffing and qualifications of each level of clinician rendering authorizations and denials of care. Will clinical management staff be dedicated to the Program or will they service other customers as well?
  - (c) For the calendar year 2012, the percentage of Enrollees who called the CRL and who received a referral at a different level of care from the one initially requested.
  - (d) A description of your proposed precertification program including the type of services subject to precertification, staffing levels, the timeline for completion, clinical information requested, and the number of cases reviewed, approved and declined for a client similar to the Program (for the most recent calendar year). Provide a sample of any pre-certification forms used by the Offeror.
  - (e) A description of the steps that will be taken to meet the needs of Enrollees who require a Provider with subspecialties, especially those who require pediatric, adolescent or geriatric mental health services. How will you meet the ongoing therapy needs of those Enrollees whose first language is not English; who are hearing impaired; or who request a Provider with a particular ethnic background?

- (f) An explanation of how urgent and emergency cases will be identified. Who on the Clinical Management team will be responsible for making such determinations? Describe the procedures that will be followed for ensuring that Enrollees receive appropriate care in urgent and emergency situations.
  - (g) An explanation of the procedures followed in cases where a Network Provider is contacted directly by an Enrollees seeking treatment.
  - (h) A description of the steps you will take to encourage the use of the toll-free number for the Clinical Referral Line to minimize self-referrals to Providers, as well as steps you will take to encourage the use of Network Providers; (i) Specify the location where Clinical Referral Line and other clinical management services for the Program will be provided. How will you ensure that CRL and clinical management staff are aware of MHSA community resources?
  - (i) The methods you use to measure the effectiveness of the Clinical Referral Line and pre-certification services (*Do not include any reference to specific monetary savings*).
  - (j) How you will transition Enrollees with existing precertifications with a Network Provider into your system. Confirm you will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.
- (2) Confirm that you will prepare and send approved communications to notify Enrollees and/or their Providers of the outcome of their pre-certification and/or prior authorization request.
- (3) Confirm that you will promptly load into the clinical management and/or claims processing system approved pre-certification and prior authorizations determined by the Offeror.

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- (4) Describe the steps the Contractor will take to pre-certify inpatient hospital admissions for alcohol detox and manage the patient's care if transferred to rehab.
- (5) Confirm the Contractor will load into the 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 implementation date, once acceptable files are received.
- (6) ***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 cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror'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, is \$\_\_\_\_\_.

- (7) ***Emergency CRL Guarantee:*** The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety.



Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below one hundred percent (100%) of Enrollees who call the CRL in need of emergency care will be contacted by either the Network Provider or the clinicians within 30 minutes of the Enrollee's call to the Clinical Referral Line, is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 is \$\_\_\_\_\_.

**Amended March 11, 2013**

(8) **Urgent Care CRL Guarantee:** The MHSA Program's service level standard requires that at least ninety-nine percent (99%) of Enrollees who call the CRL in need of urgent care will be contacted by ~~the Network Provider~~ Contractor to ensure that the Network Provider contacted the Enrollee within 48 hours of the call to the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) of cases when an Enrollee calls the CRL and 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, is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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

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Offeror'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, is \$\_\_\_\_\_.

### Concurrent Review

The Program's concurrent utilization review process assists the Provider in identifying MHSA care that is medically necessary and cost effective, without compromise to the quality of care.

#### **a. Duties and Responsibilities**

- (1) To safeguard Enrollee health and ensure adherence 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:
  - (a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;
  - (b) 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;
  - (c) is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;
  - (d) 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;

- (e) For inpatient admissions, the Contractor must recognize when to utilize more appropriate and less restrictive levels of care when medically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers;
  - (f) 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;
  - (g) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment; and
  - (h) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions.
- (2) 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;
- (3) 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:
- (a) 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

- (b) 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.
- (4) 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;
- (5) The Contractor must use care managers or Peer Advisors to manage the care of members;
- (6) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA care and MHSA Program costs;
- (7) ***Outpatient Treatment UR Guarantee:*** The Offeror must guarantee that, at the least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider notified within twelve (12) Business Days of receipt of the report as calculated on an annual basis; and
- (8) ***Inpatient Treatment UR Guarantee:*** The Offeror must guarantee that, at least, ninety percent (90%) of requests for authorization of inpatient care be reviewed 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.

**b. Required Submission**

- (1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the Program, including:
  - (a) The qualifications of the staff responsible for oversight of your concurrent UR program;
  - (b) Review of outpatient care;
  - (c) Review of inpatient care;
  - (d) Discharge planning and follow-care; and
  - (e) Case management of high risk cases.
- (2) Describe the software you will utilize to administer the concurrent UR program and any other technologies that will be used to apply UR.
- (3) Completely describe the criteria used to establish medical necessity as defined by the Program and how medical necessity is determined.
- (4) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.
- (5) Describe the methods you utilize to measure Program effectiveness (*Do not include any reference to specific monetary savings*).
- (6) ***Outpatient Treatment UR 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 Day of receipt of the report, calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

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*The standard credit amount for each .01 to 1.0% below ninety percent (90%) of outpatient treatment plans that the Offeror reviews and does not notify the Provider within twelve (12) Business Day of receipt of the report is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror's proposed guarantee) of outpatient treatment plans not reviewed and the Provider notified within twelve (12) Business Day of receipt of the report, is \$\_\_\_\_\_.

- (7) ***Inpatient Treatment UR 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. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety percent (90%) of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror'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 the Enrollee or Provider notified within one (1) Business Day of the determination, is \$\_\_\_\_\_.

#### Disabled Dependent Determinations

During the term of the Contract, the Contractor shall be responsible for making Disabled Dependent Determinations for dependents with a disability that is Mental Health and Substance Abuse related. Disabled dependents of NYSHIP enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those dependents are incapable of self support. For The Empire Plan, the medical component contractor determines disability status for those with physical disabilities and the mental health Contractor determines disabled status for mental health and substance abuse related disabilities. An Application for Coverage for your Disabled Dependent Child For Medical, Dental and/or Vision Coverage (form PS-451) is completed by the Enrollee, the Dependent's Physician, the Enrollee's employer and then evaluated by the Contractor to determine if the Dependent is disabled. All determinations are subject to review by the Contractors on a periodic basis. The following guidelines are used for all disabled dependent reviews:

If improvement of the dependent's condition is:

- "Expected," the case will be normally reviewed within six to eight months, unless the Contractor determines a need for a more frequent review.
- Possible," the case will be normally reviewed no sooner than three years, unless the Contractor determines a need for a more frequent review.
- "Not expected," the case will normally be reviewed no sooner than seven years, unless the Contractor determines a need for a more frequent review.

**a. Duties and Responsibilities**

(1) 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.

**Amended March 11, 2013**

(2) The Contractor must send a determination letter, approved in advance by the Program, to the Enrollee and to the Department advising of the determination within 3 Business Days of receipt of a complete form the determination

**b. Required Submission**

- (1) Provide a description of your process when determining disabled dependent status. Confirm that the Offeror will review the PS-451 form and all additional medical information required to make a clinical determination within 10 Business Days.
- (2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within 3 Business Days of the determination.

**Appeal Process**

When UR results in a decision to deny authorization or reduce the level of services authorized, and the denial is based on medically necessary, experimental or investigational treatment, members may appeal to the Contractor any utilization review decisions. The appeals committee shall make a determination within 10 Business Days of the receipt of the necessary medical records. The Contractor will comply with the utilization review process requirements and **external appeal** process found in Article 49 of NYS Insurance Law, as amended.

**a. Duties and Responsibilities**

The Contractor must:

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



- (b) Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and
  - (c) Integrating the appeal decisions into the clinical management and claims processing systems.
- (3) Establish two levels of internal clinical appeals as follows:
- (a) A level 1 clinical appeal must be performed by an independent Peer Advisor; and
  - (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.
  - (c) Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:
    - (i) For a second level clinical appeal of a post-service claim, within 30 days of the member's request;
    - (ii) For a second level clinical appeal of a pre-service request for benefits, within 15 days of the member's request; and
    - (iii) For clinical appeals involving urgent situations, in no more than seventy-two hours following receipt of the appeal.
- (4) 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 the "Reporting" section of this RFP;

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- (5) 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) ***Inpatient Appeal Guarantee:*** The Contractor must guarantee that at least ninety-five percent (95%) of level one appeals for inpatient care shall 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; and
- (7) ***Outpatient and Alternate Level of Care Appeal Guarantee:*** The Contractor must guarantee that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals shall 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.

**b. Required Submission**

- (1) Confirm the Contractor will 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.

- (2) Confirm the Contractor will 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.
- (3) Describe in detail how you would administer the required appeal processes for the Program, including:
- (a) Turnaround time;
  - (b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;
  - (c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;
  - (d) Do you currently administer an appeals process as described above for MHSA? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent calendar year); and
  - (e) How is the Enrollee's care handled during the appeal process?
- (4) Confirm that you will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.
- (5) ***Inpatient Appeal Guarantee:*** The MHSA Program's service level standard requires that, at the 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 Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to

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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. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

*The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of level one appeals for inpatient care that are not reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror'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 \$\_\_\_\_\_.

- (6) ***Outpatient and ALOC Appeal Guarantee:*** The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of 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 Offeror having made and documented three (3) aggressive 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.

*The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) 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*

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*Days of the receipt of the appeal is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror'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 Offeror'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 \$\_\_\_\_\_.

### **13. Other Clinical Management Programs**

#### **a. Duties and Responsibilities**

- (1) 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 programs must include:
  - (a) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail;
  - (b) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;
  - (c) accepting referrals to Network Providers;
  - (d) telephonic support, coordination with treating providers and referrals to community services; and
  - (e) 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.

- (2) The Offeror 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.

**b. Required Submission**

- (1) Describe the depression management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.
- (2) Describe the eating disorder management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.
- (3) Describe the ADHD management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.
- (4) Please describe any other voluntary clinical management or utilization review programs that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees.

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**SECTION V: COST PROPOSAL REQUIREMENTS****A. Introduction**

As described in this RFP, the Mental Health and Substance Abuse Program provides health benefits to covered members on a self-funded basis. The costs associated with the MHSA Program include Network Claims Costs, Non-Network Claim Costs, Administrative Fees, Shared Communication Expenses and Assessments made through State or federal legislation. Section V presents the Cost Proposal submission requirements as well as the requirements concerning the financial transactions and other cost/transparency related questions.

**B. Cost Proposal components**

The following present the Cost Proposal components, associated duties and responsibilities and the Cost Proposal submission requirements.

**1. Network Claims****a. Duties and Responsibilities**

- 1) In accordance with Section IV of the RFP, 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.
  
- 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.

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- 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 fee 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.
  - 4) Claim Payments are to be made based on the requirements contained in Articles 6.11.0 and 12.1.0 of the Agreement resulting from this RFP, including but not limited to each group's Copayment, Co-insurance, Deductible as reflected in Exhibit II.B; and Exhibit II.B2 as well as the annual maximum for ABA services as reflected in the most current Plan Communication materials.

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 solely determined by the Department. During each Plan year, the Contractor must report any proposed Provider Network 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:

<u>Report Due</u>	<u>Base Year</u>	<u>Current Year</u>
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.

**b. Required Submission**

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.1a.above, Section IV of the RFP and Section VII, Articles 6.10.0 and 12.1.0 of the RFP.
- 2) The Offeror must complete Exhibit V.A, Quoted Average Network Fees by CPT, HCPCS and Revenue Code, in accordance with the instructions contained in Exhibit V.A.1 of the RFP.

- 3) The Offeror must complete Exhibit V.B, Network Fees - Applied Behavioral Analysis Benefits, in accordance with the instructions contained therein.

## **2. Non-Network Claims**

### **a. Duties and Responsibilities**

- 1) The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee in a timely manner.
- 2) The Contractor will process Non-Network claims using Reasonable and Customary charges based on the 90<sup>th</sup> 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.
- 3) The claim payments are to be made based on the requirements contained in Section IV of the RFP, including but not limited to each group's Co-insurance and Deductible as reflected in Exhibit II.B; and Exhibit II.B2 as well as the annual maximum for ABA services.
- 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 in-network.
- 5) The Contractor will update its database with Fair Health's Reasonable and Customary amounts in a timely manner, at a minimum of twice a year.

**b. Required Submission**

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.2.a. above, Section IV of the RFP and Section VII, Article 12.2.0 of the RFP.

**3. Administrative Fee**

The Administrative Fee is the fee quoted by the Contractor representing the charge to the MHSA Program to cover all of the administrative services provided by the Contractor, with the exception of Shared Communication Expenses.

**a. Duties and Responsibilities**

The Contractor is required to:

- 1) Be bound by its quoted Administrative Fee, as proposed in the Contractor's Cost Proposal for the entire term of the Agreement, unless amended in writing;
- 2) Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;
- 3) 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;
- 4) Implement all benefit designs as required by the Department with or without final resolution of any request for an Administrative Fee adjustment. Refusal to implement benefit design changes will constitute a material breach of the Agreement and the Department will seek compensation for all damages resulting;
- 5) 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.

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The determination of what constitutes a material change will be at the sole discretion of the Department;

- 6) 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 verify that the request for an increase to the Administrative Fee is warranted. 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 amendment to the Agreement by the New York State Attorney General and New York State Office of State Comptroller;
- 7) Agree that the Administrative Fee shall be payable only for the number of covered Enrollees each month and that the number of covered Enrollees for a given month shall be determined by the Department based upon monthly MHSA Program enrollment data contained in NYBEAS; and
- 8) Claims incurred during the period January 1, 2014 through December 31, 2018 but processed/paid after December 31, 2018, as well as applicable Disabled Lives claims incurred after December 31, 2018 will be administered by the Contractor selected in response to this RFP. An Administrative Fee will not be payable beyond December 31, 2018; therefore, Offerors should take this into consideration in developing their proposed Administrative Fee.

**b. Required Submission**

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.3.a. above.

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- 2) The Offeror is required to provide the Offeror's Administrative Fee quote in Exhibit V.C

#### **4. Assessments**

In accordance with the Health Care Reform Act of 1996, two assessments/surcharges are chargeable to applicable health plans, including the Empire Plan: 1) Graduate Medical Expense (GME) and 2) Bad Debt and Charity (BDC) Assessment. The GME component of the Empire Plan is assessed on the Hospital component of the Empire Plan and therefore not chargeable under the MHSA Program. The BDC is applicable to the MHSA Program.

In addition, other fees and assessments as stipulated by State or federal law may be applicable over the term of the contract. Such amounts shall be paid by the MHSA Program either through the Contractor or directly to the authorized agency after a determination is made by the Department regarding the applicability of each fee/assessment to the MHSA Program.

##### **a. Duties and Responsibilities**

- 1) The Contractor shall calculate the applicable BDC each month from the applicable paid claims and may charge the MHSA Program at the time this assessment is paid to the regulatory agency/intermediary by the Contractor.
- 2) The Contractor shall advise the Department of any new applicable assessments in a timely manner.
- 3) The Contractor shall bill the MHSA Program for any new assessments within 30 days after the amounts are paid to the regulating entity.

##### **b. Required Submission**

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.4.a. above.

- 2) Disclose other applicable assessments, if any, including the amount and basis of the assessment, made by other states/federal government that are applicable to the MHSA Program. Advise whether these assessments can be paid by the Offeror on behalf of the MHSA Program or if they would be directly paid by the Department.

## **5. Shared Communication Expense**

### **a. Duties and Responsibilities**

- 1) The Contractor will pay the medical carrier/third party administrator on a quarterly basis an amount billed for Shared Communication Expenses. The Contractor will be notified prior to the beginning of each Plan Year the amount of Shared Communication Expenses that will be billed.
- 2) The Contractor shall seek reimbursement of the Shared Communications Expense from the Department by including the amount with the voucher for the payment of the next Administrative Fee to be paid.

### **b. Required Submission**

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.5.a. above.

## **C. Payments/ (Credits) to/ from the Contractor**

This Section presents information regarding the financial structure and timing of financial transactions related to the Agreement and the specific items Offerors must submit with their Cost Proposal and questions related to those requirements.

The following information is presented for use by Offerors in developing their Cost Proposal. As of October 2012, there were 231,297 individual contracts and 290,800 family contracts with Empire Plan Mental Health and Substance Abuse coverage. In addition to the Empire Plan contracts, there are 126 individual contracts and 110 family contracts with the Excelsior Plan and 4,737 individual contracts and 767 family contracts

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with the Student Employee Health Plan (SEHP) benefits. The enrollment mix and benefit characteristics are presented in Exhibit II.A through Exhibit II.A4; Exhibit II.C; Exhibit II.C2; and Exhibit II.D. of this RFP. However, the Department cannot guarantee that, during the term of the Agreement, the same enrollment mix and benefit characteristics as those set forth in Exhibit II.A through Exhibit II.A4; Exhibit II.C; Exhibit II.C2; and Exhibit II.D will exist.

**a. Duties and Responsibilities**

- (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.
- (2) The Plan will pay an 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 on 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.
- (3) The Contractor will be billed the MHSA Program's portion of the Shared Communications Expense by the medical carrier/third party administrator in 2014 and each Plan Year thereafter in four (4) equal installments. The Contractor will pay the medical carrier/third party administrator the amount billed and may seek reimbursement from the MHSA Program. Subsequent years' amounts will be calculated by the Department and communicated to the Contractor during the annual rate renewal process. Upon receipt of each Shared Communications

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Expense bill, the Contractor may bill and the Plan will pay the Contractor an identical amount within thirty (30) Days.

- (4) 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.
- (5) The Contractor shall analyze and monitor claim submissions to promptly identify errors, fraud and/or abuse and report 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 made by the Contractor 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. 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 Program within 30 Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.
- (6) Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.
- (7) The Contract resulting from this RFP is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that MHSA 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 dates as set forth in Article XV of the Agreement. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice, as set forth in Article XV of the Agreement, 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.

**b. Required Submission**

- 1) The Offeror is required to confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.C.a above.
- 2) Describe, in detail, the Offeror's proposed invoicing process, if any, including the timing for invoice preparation and supporting detail claims files at the end of each payment period, required payment timeframes and whether this structure is in effect for any other self-funded customers.

**D. Cost/Transparency Related Questions**

1. Network Provider Questions

- a. Describe fully the nature of your reimbursement arrangements with Network Facilities. Distinguish between per diems, case rates, percent of charges versus other types of reimbursement arrangements. Also distinguish between how your reimbursement arrangements are structured in NYS versus states other than NYS with a high concentration of Empire Plan members, such as New Jersey and Florida.
- b. Is there an escalator clause in your contracts with Network Facilities to increase fees or do increases have to be negotiated? What is your contracting cycle with Facilities? When were the Network Facility fees last increased?
- c. What is your current average Network Facility reimbursement as a percentage of covered charges for your book of business in New York State?
- d. Is there an escalator clause in your Network Practitioner contracts for fee increases or are increases negotiated on a case by case basis? What is your contracting cycle with Network Practitioners? When did you last increase these fees?

- e. What does the current average Network Practitioner reimbursement represent as: 1) a percentage of covered charges for your book of business in NYS; and 2) a percentage of the reasonable and customary charges?
- f. Some Offerors negotiate global reimbursement arrangements with Network Facilities to cover certain services such as professional inpatient visits that are normally billed by Practitioners. With respect to global reimbursement, please respond to the following:
  - 1) Do you reimburse Network Facilities globally for any Practitioners' services?
  - 2) If yes, describe completely the types of services that are globally reimbursed and the prevalence of such reimbursement both within and outside NYS. What percent of your Network Facility claim dollars do you estimate are attributable to global reimbursement?
- g. Confirm your willingness to provide the Department with information pertaining to specific fee arrangements made with Providers, if requested.
- h. Is the Offeror's Proposed Network a standard Network or has it been specifically contracted to administer the Empire Plan MHSA Program?
- i. Does the Offeror have a single standard contract with Network Providers with consistent terms applied to all of the Offeror's clients? If no, please describe the basis and reasons for the differences.
- j. In addition to negotiating agreements with Network Providers on behalf of clients, does the Offeror or any of its Affiliates or any sub-contractor's Affiliates have other business arrangements with Network Providers from which the Offeror or any of its Affiliates or any sub-contractor's Affiliates have derived revenues? If the Offeror and/or any of its Affiliates or any sub-contractor's Affiliates derive revenue or obtain other consideration or compensation from agreements with Network Providers, please identify the recipient(s) of such Network Provider revenue and explain the business

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relationship from which the revenue is derived. Please detail how the Offeror's business model ensures that these relationships do not create a real or perceived conflict with the clinical and financial interests of the MHSA Program.

- k. Are the Offeror's Network fee schedules incorporated in formally adopted corporate policies and procedures? Please explain.
- l. Does the Offeror maintain more than one Network fee schedule for purposes of reimbursing Network Providers? Or, does the Offeror have multiple reimbursement agreements with individual Network Providers that are assigned and utilized based on client?

2. Transparency of Financial Interests - Post Contract Award Requirements

The Contractor must agree to be open and forthright in all matters related to the clinical management and cost management of the MHSA Program. The State has strict standard audit provisions, subject to confidentiality requirements. Disclosure obligations include, but are not limited to:

- a. Providing full access to all sub-contractor and Network Provider agreements related to the MHSA Program under strict confidentiality provisions;
- b. Agreeing to the standard audit provisions set forth in Contract Provisions, Section VII of this RFP (see Article XXIII entitled "Audit Authority"), and Appendices A and B; and
- c. Agreement that the Contractor will disclose all agreements related to the provision, servicing and administration of MHSA Program services in effect during the term of the Agreement resulting from this RFP. This includes all relationships between or among the Contractor, and relevant third parties including but not limited to the Contractor, Providers and any other entity from which the Contractor or the subcontractor receives any form of compensation or any other consideration as a consequence of managing and reimbursing for services under the MHSA Program.

3. Transparency During the Procurement Process. Contractor must provide all information the Department deems necessary to support their Cost Proposal. This includes but is not limited to adequate information to support the Offeror's Proposal relative to assuring alignment with the financial interests of the MHSA Program and other information as the Department determines is necessary to address any perceived or actual conflicts between the Contractor's business model and the financial interests of the MHSA Program. Please confirm.
4. Explain the contractual and financial relationships among or between the Contractor, subcontractor, if any, and key Network Providers. Please describe how the Offeror's proposed business model eliminates any real or potential conflicts with the clinical and financial interests of the MHSA Program.
5. The Department recognizes that the Offerors' business model may present potential conflicts between the financial interests of the MHSA Program and the Offeror. Please describe any protections or processes the Offeror proposes to mitigate any conflicts of interest.

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**SECTION VI: EVALUATION AND SELECTION CRITERIA**

Proposals determined by the Department to satisfy the submission requirements set forth in Section II and the Minimum Mandatory Requirements set forth in Section III of this RFP will be evaluated by an evaluation team composed of staff of the Department, the Governor's Office of Employee Relations (GOER) and the Division of the Budget (DOB), assisted by any person(s), other than one associated with a competing Offeror, designated by the Department. Proposals will be made available to representatives of NYS employee unions for review and comment. An Offeror's Proposal shall be removed from the evaluation process and not be considered for award should it be determined that the Offeror did not satisfy the Minimum Mandatory Requirements as specified in Section III, despite any attestation made regarding the Minimum Mandatory Requirements.

During the evaluation process, the Department may require clarifying information from an Offeror(s) for the purpose of assuring a full understanding of the Offeror's responsiveness to the RFP requirements and the duties and responsibilities set forth therein. This clarifying information must be submitted in writing in accordance with the formats set forth in Section II of this RFP and, if accepted, shall be included as a formal part of the Offeror's Proposal. Failure to provide the required information by the due date set forth in the Department's request for clarification may result in rejection of the Offeror's Proposal. Nothing in the foregoing shall mean or imply that the Department is obligated to seek or allow clarifications provided for herein. The Department may, at its discretion, elect to perform site visits of Offerors' facilities and have Offerors provide oral presentations pertaining to their Technical Proposal and Cost Proposal. If scheduled, representatives of NYS employee unions may also participate in site visits, Offeror oral presentations, and such other activities applicable to the evaluation of Proposals. The Procurement Manager will coordinate the necessary scheduling arrangements with the Offeror(s).

The Department will consider for evaluation and selection purposes only those Proposals 1) determined to have met the Minimum Mandatory Requirements specified in Section III of this RFP, and 2) determined to be responsive to the duties and responsibilities set forth in the RFP. The Department's desire is to select a single Offeror to administer the MHSA Program (i.e., The

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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). To this end, the Department intends to select that responsive and responsible Offeror whose Proposal offers the “Best Value” to the Department as specified in the following evaluation criteria for the purpose of entering into negotiations for a contract.

The Technical Proposal and Cost Proposal components of the evaluation process shall be based on 1,000 available points; with 700 points available to the Technical Proposal and 300 points available to the Cost Proposal (i.e., 70% allocated to the Technical Proposal and 30% allocated to the Cost Proposal).

The Technical Proposal and Cost Proposal will be evaluated separately as described below.

**A. Technical Evaluation**

Each Offeror’s ability and willingness to deliver the MHSA Program Services described in this RFP will be evaluated and scored based on a weighted point system. The evaluation of the Offeror’s Technical Proposal will be based on that Offeror’s written Technical Proposal; responses to clarifying questions, if any; information obtained through reference checks, including specific reference checks made with the Directors’ of Employee Benefits at the Department and GOER for any Offeror, including any proposed Key Subcontractor(s) who performed services under a contract with the Department and, as deemed necessary by the Department, oral presentation(s) and/or site visits conducted to amplify and/or clarify that Offeror’s proposed Technical Proposal.

**1. Technical Score Ratings**

Each Offeror’s Technical Proposals will be evaluated based on the following rating scale and criteria as applied to each Required Submission response as required in Section IV of the RFP. A rating of “excellent” equates to a score of 5 for each evaluated Required Submission response. Each reduction in the ratings results in a one point reduction in the score such that a rating of “poor” equates to a score of 1.

**a. Excellent (5)**

The Offeror far exceeds the criteria. The services described indicate that the Offeror will provide very high quality services and is very pro-active and innovative.

**b. Good (4)**

The Offeror exceeds the criteria. The services described indicate that the Offeror will exceed the MHSA Program's needs. The Offeror demonstrates some innovative features not shown in typical proposals.

**c. Meets Criteria (3)**

The Offeror meets but does not exceed the criteria. The services described indicate that the Offeror will meet the MHSA Program's needs.

**d. Fair (2)**

The Offeror's answer is minimal; or the answer is very general and does not fully address the question; or the Offeror meets only some of the criteria.

**e. Poor (1)**

The Offeror misinterpreted or misunderstood the question; or the Offeror does not answer the question/criteria in a clear manner or the Offeror does not answer the question; or the Offeror does not meet the criteria.

The Offeror's commitment to meet the levels of standards it outlines in its proposal will be verified by reviewing responses to related performance guarantee questions and reviewing the Offeror's proposed credit to the administrative fee (credit amount) for its failure to meet each of its proposed performance guarantees.

**2. Performance Guarantee Ratings**

A rating of "excellent" equates to a score of 5 for each evaluated service level standard. Each reduction in the ratings results in a one point reduction in the score such that a

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rating of “poor” equates to a score of 1. Offerors may propose performance guarantees that exceed the MHSA Program’s service level standards presented in this RFP.

Proposed performance guarantees are contained within the respective technical areas and will be evaluated using the following criteria:

**a. Excellent (5)**

- (1) The Offeror’s proposed performance guarantee exceeds the MHSA Program’s service level standard contained within this RFP; and
- (2) The Offeror’s proposed credit amount is one hundred and twenty-five percent (125%) or more of the standard credit amount stated within this RFP.

**b. Good (4)**

- (1) The Offeror’s proposed performance guarantee equals the MHSA Program’s service level standard contained within this RFP, and the Offeror’s proposed credit amount is one hundred and twenty-five percent (125%) or more of the standard credit amount stated within this RFP; or
- (2) The Offeror’s proposed performance guarantee exceeds the MHSA Program’s service level standard contained within this RFP; and the Offeror’s proposed credit amount is greater than one hundred percent (100%) but less than one hundred and twenty-five percent (125%) of the standard credit amount stated within this RFP.

**c. Meets Criteria (3)**

- (1) The Offeror’s proposed performance guarantee equals or exceeds the MHSA Program’s service level standard contained within this RFP; and
- (2) The Offeror’s proposed credit amount equals the standard credit amount stated within this RFP.



**d. Fair (2)**

- (1) The Offeror's proposed performance guarantee equals or exceeds the MHSA Program's service level standard contained within this RFP; and
- (2) The Offeror's proposed credit amount is greater than fifty percent (50%) but less than one hundred percent (100%) of the standard credit amount stated within this RFP.

**e. Poor (1)**

- (1) The Offeror's proposed performance guarantee is below the MHSA Program's service level standard contained within this RFP regardless of the credit amount proposed by the Offeror; or
- (2) The Offeror's proposed credit amount is fifty percent (50%) or less of the standard credit amount stated within this RFP regardless of the level of performance the Offeror pledges.

**3. Performance Guarantee Standard Credit Amounts**

The MHSA Program's standard credit amount for each Offeror's proposed performance guarantee is as follows:

- a. Implementation and Start-Up (Section IV.B.3.b.(2)): Fifty percent (50%) of the Administrative Fee(s) (minimum mandatory requirement);
- b. Call Center Availability (Section IV.B.4.b (8.a)): \$100,000 per year;
- c. Telephone Response Time (Section IV.B.4.b (8.b)): \$25,000 per year;
- d. Telephone Abandonment Rate (Section IV.B.4.b.(8.c)): \$25,000 per year;
- e. Telephone Blockage Rate (Section IV.B.4.b.(8.d)) : \$25,000 per year;

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- f. Enrollment Management (Section IV.B.6.b(8)): \$5,000 for each 24 hour period beyond 24 hours from the release of the MHSA Program enrollment records;
  - g. Reporting (Section IV.B.7.b.(6)): \$1,000 per report per Business Day between the due date and the date the report is received by the Department inclusive of the day the report is received;
  - h. Network Composition (Section IV.B.10.b.(10) under the subheading “Provider Network”): \$25,000 per year;
  - i. Network Provider Access (Section IV.B.10.b.(11) under the subheading “Provider Network”): \$6,000 per each quarter for each performance guarantee in each of the two (2) Provider types in each of the three (3) areas in which the performance guarantee is not met;
  - j. Provider Credentialing (Section IV.B.10.b.(7)), under the subheading “Provider Credentialing: \$1,500 per instance;
  - k. Financial Accuracy (Section IV.B.11.b.(14)): \$10,000 per year;
  - l. Non-Financial Accuracy (Section IV.B.11.b (15)): \$10,000 per year;
  - Amended March 11, 2013**
  - m. ~~Turnaround Time for Network Claims (Section IV.B.11.b.(16)): \$6,000 per each quarter;~~
  - n. Turnaround Time for Non-Network Claims (Section IV.B.11.b.(17)): \$6,000 per each quarter;
  - o. Non-Network Referrals (Section IV.B.12.b.(6)): \$10,000 per year;
  - p. Emergency Care Follow-up (Section IV.B.12.b.(7)): \$10,000 per year;
  - q. Urgent Care Follow-up (Section IV.B.12.b.(8)): \$10,000 per year;

- r. Precertification of Care - Outpatient (Section IV.B.12.b. (6)), under subheading “Concurrent Review”: \$10,000 per year;
- s. Precertification of Care - Inpatient (Section IV.B.12.b.(7)), under subheading “Concurrent Review”: \$10,000 per year;
- t. Inpatient Appeals (Section IV.B.12.b.(7)), under subheading “Concurrent Review”: \$10,000 per year; and
- u. Outpatient Appeals (Section IV.B.12.b.(6)), under subheading “Concurrent Review”: \$10,000 per year.

#### **4. Technical Scoring**

Qualifying Proposals will be evaluated independently by multiple evaluators based on pre-established Evaluation Criteria. The average score for each evaluated response shall be applied to the points associated with each question such that an average score of “Excellent” for each evaluated response will result in a maximum available score of 1,000. All Offerors whose Technical Proposal is evaluated will receive a score in this manner. The technical score will then be converted to points for each Offeror such that the Offeror with the highest technical score will receive 700 points. As calculated by the Procurement Manager, all other Offerors are awarded points at a reduced level with 0.01 points being the lowest possible point value that may be assigned. The awarded points are calculated to the hundredth decimal place. The reduction in points shall be calculated in accordance with a pre-determined formula.

#### **B. Cost Evaluation Component**

The Cost Proposal of any Offeror that meets the Minimum Mandatory Requirements will be evaluated by the Department, and others deemed appropriate by the Department. The Department reserves the right to conduct Cost Proposal oral interviews and/or seek written responses from Offerors to clarify any aspect of the Offeror’s cost Proposal. The Department will then calculate a Cost Score for each Offeror.

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**1. Cost Evaluation**

The following components will be utilized to determine the Evaluated Projected MHSAs Program Cost:

**a. Claim Costs:**

- i. Projected Cost of Network Claims: The projected cost of Network claims identified by the Offeror shall be those amounts reflected in Exhibit V.A. as submitted by the Offeror; plus,
- ii. Projected Cost of Non-Network Claims: The projected cost of Non-Network claims as calculated and normalized by the Department; plus,
- iii. Projected Cost of Applied Behavioral Analysis Claims: The projected cost of Applied Behavioral Analysis claims shall be the Offeror's quoted amounts submitted in Exhibit V.B multiplied by fixed utilization counts; plus,
- iv. Projected Bad Debt and Charity (BDC) Assessment: The projected BDC assessment shall be calculated by multiplying a fixed BDC percentage by the Network and Non-Network claim amounts calculated in i and ii above.

The sum of paragraphs i, ii iii and iv shall represent the evaluated claims cost.

- b. **Administrative Fee(s):** The Department shall multiply the Administrative Fee quoted in Exhibit V.C of this RFP by the number of covered Enrollees, multiplied by twelve (12 months).
- c. **The Department reserves the right to Analyze and/or Normalize:** The Department reserves the right to make other cost calculation adjustments as necessary to determine the evaluated cost of the Offeror's Proposal. Any such adjustments shall be made with the intent to evaluate Offeror's Proposals on a fair and consistent basis, without prejudice. These normalization adjustments may include but are not limited to unforeseen circumstances whereby the normalization of specific factors among

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Offerors shall result in a more accurate and fair comparison of the Offerors' Cost Proposals as applied to the normalized claim base.

- d. The Department shall then calculate each Offeror's Evaluated MHPA Program cost as the sum of paragraphs VI.B.1a and b, above.

## **2. Cost Score**

The Offeror's Proposal with the lowest calculated cost will be awarded three hundred (300) points. The points awarded to all other Offerors shall be based on a scale representing a 1 point reduction for each \$50,000 the Offeror's calculated cost is higher than the calculated cost of the lowest Cost Proposal. The point value calculated and assigned shall be proportional within each \$50,000 increment and calculated to the hundredth decimal place.

## **C. Total Combined Score of Technical and Cost**

The Total Combined Score assigned for each Offeror shall be calculated by adding the Offeror's Technical Score and Cost Score.

## **D. Best Value Determination**

It is the Department's desire and intent, if deemed in the best interest of the Department, to select, and enter into negotiations for the purpose of executing a contract, that Offeror that has accumulated the highest Total Combined Score ultimately determined by the Department to be responsible. (Note: If an Offeror's Total Combined Score is equal to or less than 1 point below the highest Total Combined Score, the Offeror's Proposal will be determined to be substantially equivalent to the Offeror holding the highest score. Among any Offeror's Proposals deemed substantially equivalent, the Department shall select the Offeror that has the highest Cost Score calculated pursuant to Section VI.B.1 of this RFP). Contract award shall be deemed made when notice of proposed contingent award is issued by the Department to the selected Offeror.

By submitting a Proposal in response to this RFP, the Offeror agrees that, if selected, the Offeror will enter into a contract that substantially includes the terms set forth in Section VII of this RFP, Contract Provisions, and Appendices A,B,C and D.

Please note that the terms in Appendix A, “Standard Clauses for All New York State Contracts”; Appendix B, “Standard Clauses for all Department Contracts”; Appendix C, “Third Party Connection and Data Exchange Agreement”; and Appendix D, “Participation by Minority Group Members and Women with Respect to State contracts: Requirements and Procedures,” are not subject to negotiation.

If the Department determines that contract negotiations between the Department and the selected Offeror are unsuccessful because of material differences in key provision(s) as determined by the Department, the contract award shall be withdrawn. The Department may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing a contract. Scores will not be recalculated for any remaining Offerors, should contract negotiations between the Department and the selected Offeror be unsuccessful, except in a case where the reason for such failure is based on a determination, made subsequent to contract award, that the Offeror is non-responsive or non-responsible.

If an Offeror is eliminated any time prior to contract award, and that Offeror had the highest Technical score and/or Cost score, the Department shall recalculate the applicable Cost and/or Technical Scores for each remaining Offeror in accordance with the methodologies set forth herein.

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

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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



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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.

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- 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.

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- 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.

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- 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
- 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.

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- 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

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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

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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 1<sup>st</sup> to December 31<sup>st</sup> 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)**



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- 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.

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**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.

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**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**

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- 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**



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- 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;

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- 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

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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 Enrollee Communication Support:**

- 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 Enrollment Management:**

**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

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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

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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;

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- 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:

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

<b>% of Enrollees with Access to Network Practitioners</b>	<b>Enrollee Location</b>	<b>Access Guarantee – 1 Network Practitioner at least within</b>
___%	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:

<b>% of Enrollees with Access to Certified Behavior Analysts</b>	<b>Enrollee Location</b>	<b>1 Certified Behavior Analyst at least within</b>
___%	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**

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- 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 Provider Audit and Quality Assurance**

**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

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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;

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- 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

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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 authorizations 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;

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- 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 adherence 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;

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- 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

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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.

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- 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

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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:



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- 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-

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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

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(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 to 1.0% 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.

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**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 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 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 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 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 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 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

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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

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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%

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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

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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:

<u>Report Due</u>	<u>Base Year</u>	<u>Current Year</u>
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 90<sup>th</sup> 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.

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- 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

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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 MHSAs Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSAs 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 Quarterly Reports**

**16.2.1 *Quarterly Financial Summary Reports:*** The Contractor must submit quarterly financial reports which present the MHSAs 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 MHSAs 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

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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,

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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;

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- 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 90<sup>th</sup> 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

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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

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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



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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.

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**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.

**20.13.0 *Miscellaneous:***

**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

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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.

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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:

Approved:

ERIC SCHNEIDERMAN  
ATTORNEY GENERAL

THOMAS P. DINAPOLI  
COMPTROLLER

By: \_\_\_\_\_ By: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

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**Administrative Fee** means the 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.

**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.

**Agreement** means the contract that results from this RFP between the Department and the Contractor.

**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.

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

**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.

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

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**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.

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

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

**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.

**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.

**Clinical Manager** means licensed PhD, 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.

**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.

**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

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Mental Health and Substance Abuse Program. Copayments paid to a Network Practitioner count toward meeting the Plan's Coinsurance Maximum.

**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 by a person or persons covered under the plan during the course of a calendar year. After the Coinsurance Maximum is reached, benefits are paid at one hundred percent (100%) percent of Reasonable and Customary charges for Covered Services.

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

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

**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.

**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.

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

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

**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

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customer service representatives are dedicated to the Program and do not work on any other accounts.

**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.

**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.

**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.

**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.

**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

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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.

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

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

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

**ET** means prevailing Eastern Time.

**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.

**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.

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

**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.

**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

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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.

**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.

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

**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.

**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.

**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.

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



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**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 resulting from this RFP.

**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.

**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.

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

**NYS** means New York State.

**NYSHIP** means the New York State Health Insurance Program.

**Offeror** means a person or entity that submits a Proposal in response to this RFP.

**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.

**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.

**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.

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**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.

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

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

**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.

**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.

**Plan Year** means the period from January 1<sup>st</sup> to December 31<sup>st</sup> in each Plan Year covered by the Agreement resulting from this RFP, unless specified otherwise by the Program.

**Practitioner** means:

1. A psychiatrist; or
2. A psychologist; or
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
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

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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
  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
  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.

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

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

**Program Team** means, for purposes of the Agreement, 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. Program Team means, for purposes of the RFP, an Offeror and those Key Subcontractors, if any, the Offeror proposes to utilize to collectively undertake and perform the Program Services which are the subject matter of the RFP.

**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.

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**Provider** means a Practitioner or facility that supplies Covered Services under the Mental Health and Substance Abuse Program.

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

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

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

**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.

**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.

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

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

**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 February 15, 2013.

**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.

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**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).

**Single Case Agreement** means a unique agreement that the Contractor negotiates with a Non-Network Provider to provide MHSA Program Network-level services for a specific Enrollee when there is insufficient 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.

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

**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.

**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.

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

**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.

**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.

**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.

**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.

**APPENDIX A**

**STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS**

**PLEASE RETAIN THIS DOCUMENT  
FOR FUTURE REFERENCE.**

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## STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licenser, licensee, lessor, lessee or any other party):

**1. EXECUTORY CLAUSE.** In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

**2. NON-ASSIGNMENT CLAUSE.** In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

**3. COMPTROLLER'S APPROVAL.** In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6-a). However, such pre-approval shall not be required for any contract established as a centralized contract through the Office of General Services or for a purchase order or other transaction issued under such centralized contract.

**4. WORKERS' COMPENSATION BENEFITS.** In accordance with Section 142 of the State Finance Law, this

contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

**5. NON-DISCRIMINATION REQUIREMENTS.** To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

**6. WAGE AND HOURS PROVISIONS.** If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of

any State approved sums due and owing for work done upon the project.

**7. NON-COLLUSIVE BIDDING CERTIFICATION.** In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

**8. INTERNATIONAL BOYCOTT PROHIBITION.** In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

**9. SET-OFF RIGHTS.** The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

**10. RECORDS.** The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this

contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely affect, the State's right to discovery in any pending or future litigation.

**11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION.**

(a) Identification Number(s). Every invoice or New York State Claim for Payment submitted to a New York State agency by a payee, for payment for the sale of goods or services or for transactions (e.g., leases, easements, licenses, etc.) related to real or personal property must include the payee's identification number. The number is any or all of the following: (i) the payee's Federal employer identification number, (ii) the payee's Federal social security number, and/or (iii) the payee's Vendor Identification Number assigned by the Statewide Financial System. Failure to include such number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or Claim for Payment, must give the reason or reasons why the payee does not have such number or numbers.

(b) Privacy Notification. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in the Statewide Financial System by the Vendor Management Unit within the Bureau of State Expenditures, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

**12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN.**

In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00,

whereby a contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment

opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

**13. CONFLICTING TERMS.** In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

**14. GOVERNING LAW.** This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

**15. LATE PAYMENT.** Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

**16. NO ARBITRATION.** Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

**17. SERVICE OF PROCESS.** In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

**18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS.** The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

**19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES.**

In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

**20. OMNIBUS PROCUREMENT ACT OF 1992.** It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development  
Division for Small Business  
Albany, New York 12245  
Telephone: 518-292-5100  
Fax: 518-292-5884  
email: [opa@esd.ny.gov](mailto:opa@esd.ny.gov)

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development  
Division of Minority and Women's Business Development  
633 Third Avenue  
New York, NY 10017  
212-803-2414  
email: [mwbecertification@esd.ny.gov](mailto:mwbecertification@esd.ny.gov)  
<http://esd.ny.gov/MWBE/directorySearch.html>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

(a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;

(b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;

(c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

(d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

**21. RECIPROCITY AND SANCTIONS PROVISIONS.**

Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

**22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT.**

Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

**23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW.**

If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded

the contract, the Department of Civil Service and the State Comptroller.

**24. PROCUREMENT LOBBYING.** To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

**25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.**

To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

**APPENDIX B**  
**STANDARD CLAUSES FOR ALL DEPARTMENT CONTRACTS**

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**1. INTEGRATION**

The contract executed between the Department and the Contractor (or Purchase Order issued by the Department) is hereinafter referred to as the Agreement. The Agreement, including all Exhibits and Appendices, including this Appendix B, copies of which are attached thereto, and incorporated therein by reference, constitutes the entire agreement between the Parties for the purpose of the fulfillment of Program Services or Project Services. All prior agreements, representations, statements, negotiations and undertakings are superseded hereby.

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

**2. EXECUTORY PROVISION**

Section 112 of the State Finance Law requires that any contract made by a State department which exceeds fifty thousand dollars (\$50,000) in amount be first approved by the Comptroller of the State of New York before becoming effective. The Parties recognize that, if the Agreement is for fifty thousand dollars or more, it is wholly executory until and unless approved by the Comptroller of the State of New York.

**3. CHOICE OF LAW**

The Parties agree that the Agreement shall be interpreted according to the laws of the State of New York, except where the federal supremacy clause requires otherwise. The Contractor shall be required to bring any legal proceeding against the Department arising from the Agreement in New York State courts located in Albany County.

**4. DISPUTE RESOLUTION**

Except as otherwise provided in the Agreement, any dispute raised by the Contractor concerning any question of fact or law arising under the Agreement which is not disposed of by mutual agreement of the Parties shall be decided initially by the designee of the President of the Civil Service Commission (President). A copy of the written decision shall be furnished to the Contractor. The Parties shall proceed diligently with the performance of the Agreement and shall comply with the provisions of such decision and continue to comply pending further resolution of any such dispute as provided herein. The decision of the designee of the President shall be final and conclusive unless, within ten (10) Days from the receipt of such decision, the Contractor furnishes the President a written appeal. In the event of an appeal, the President shall promptly review the initial decision, and confirm, annul, or modify it. The decision of the President shall be final and conclusive unless, as determined by a court of competent jurisdiction, it violates one of the provisions of section 7803 of the Civil Practice Law and Rules. Pending final decision of any Article 78 proceeding hereunder, both Parties shall proceed diligently with the performance of the Agreement in accordance with the President's decision.

**5. WAIVER OF BREACH**

No term or provision of the Agreement shall be deemed waived and no breach excused, unless such waiver or consent shall be in writing and signed by the Party claimed to have waived or consented. No consent by a Party to, or waiver of, a breach under the Agreement shall constitute a consent to, a waiver of, or excuse for any other, different or subsequent breach.

**6. NEW YORK STATE REQUIREMENTS**

The Contractor acknowledges that it is bound by the terms of Appendix A, Standard Clauses For All New York State Contracts, which is attached and incorporated by reference to the Agreement.

**7. OUTSIDE OF SCOPE**

The Contractor agrees that any and all work performed outside the scope of the Agreement shall be deemed to be gratuitous and not subject to any charge, cost or payment of any kind.

**8. NON-ASSIGNABILITY**

Neither the rights nor the obligations of the Contractor under the Agreement may be conveyed, assigned, delegated, or otherwise transferred in any manner whatsoever by the Contractor, either in whole or in part, without the prior written approval of the Department.

**9. NOTIFICATION**

All notices permitted or required by the Agreement to be given by one Party to the other shall be in writing and shall be transmitted either (1) via certified or registered mail, return receipt requested; (2) by facsimile transmission; (3) by personal delivery; (4) by expedited delivery service; or (5) by e-mail.

**10. INDEMNIFICATION**

The Contractor agrees to indemnify, defend and save harmless the Department, the State, its officers, agents and employees, for any claims or losses the Department, the State or any individuals may suffer when such claims or losses result from the claims of any person or organization for any and all injuries or damages caused by the negligent acts or omissions of the Contractor, its officers, employees, agents, consultants and/or sub-contractors in performance of the Agreement. Furthermore, the Contractor agrees to indemnify, defend and save harmless the Department and the State, its officers, agents, and employees from any and all claims or losses caused by the acts or omissions of any and all contractors, sub-contractors, consultants and any other persons, firms, or corporations furnishing or supplying work, services, materials, or supplies in connection with the performance of the Agreement and from all claims and losses accruing or resulting to any person, firm or corporation who may be injured or damaged by the Contractor in the performance of the Agreement, and against any loss, damages or actions, including, but not limited to, costs and expenses, for violation of proprietary rights, copyrights, patents, or rights of privacy, arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any material, information or data furnished under the Agreement, or based on any libelous or otherwise unlawful matter contained in such material, information or data, except as otherwise provided in the Article entitled "Patent Copyright or Proprietary Rights Infringement" of this Appendix B.

The Contractor also shall provide indemnification against all losses, and/or cost expenses (including reasonable counsel fees) that may be incurred by reason of the Contractor's breach of any term, provision, covenant, warranty, or representation contained herein and/or in connection with the enforcement of the Agreement or any provision hereof.

The Department does not agree to any indemnification provisions in any documents attached hereto that require the Department or the State of New York to indemnify or save harmless the Contractor or third parties.

Notwithstanding anything to the contrary in the Agreement, neither the Department nor the Contractor shall be liable to the other for any special, consequential, or punitive damages, or loss of profits or revenues, whether such damages are alleged as a result of tort (including strict liability), contract, warranty, or otherwise, arising out of or relating to either Party's acts or omissions under the Agreement.



## **11. PATENT, COPYRIGHT OR PROPRIETARY RIGHTS INFRINGEMENT**

The Contractor, solely at its expense, shall defend any claim or suit which may be brought against the Department or the State for the infringement of United States patents, copyrights or proprietary rights arising from the Contractor's or the Department's use of any software, equipment, data, materials and/or information of any kind prepared, developed or furnished by the Contractor in connection with performance of the Agreement and, in any such suit, shall satisfy any final judgment for such infringement. The Department shall give the Contractor written notice for such claim or suit and full right and opportunity to conduct the defense thereof, together with full information and all reasonable cooperation.

If principles of governmental or public law are involved, the State of New York may participate in the defense of any action identified under this Article, but no costs or expenses shall be incurred upon the account of the Contractor without the Contractor's written consent.

If, in the Contractor's opinion, any software, equipment, data, materials and/or information prepared, developed or furnished by the Contractor is likely to or does become the subject of a claim of infringement of a United States patent, copyright or proprietary right, then, without diminishing the Contractor's obligation to satisfy any final award, the Contractor may, with the Department's prior written approval, substitute other equally suitable software, equipment, materials, data and/or information. In the event that an action at law or in equity is commenced against the Department arising out of a claim that the Department's use of any software, equipment, materials and/or information under the Agreement infringes on any patent, copyright, or proprietary right, such action shall be forwarded by the Department to the Contractor for defense and indemnification under this Article and to the Office of the Attorney General of the State of New York together with a copy of the Agreement. If upon receipt of such request for defense, or at any time thereafter, the Contractor is of the opinion that the allegations in such action, in whole or in part, are not covered by the defense and indemnification set forth herein, the Contractor shall immediately notify the Department and the Office of the Attorney General of the State of New York, in writing, and shall specify to what extent the Contractor believes it is and is not obligated to defend and indemnify under the terms and conditions of the Agreement. The Contractor shall in such event protect the interests of the State of New York and shall take the steps necessary to secure a continuance to permit the State of New York to appear and defend its interest in cooperation with the Contractor, as is appropriate, including any jurisdictional defenses which the State shall have.

## **12. DATE/TIME WARRANTY**

The Contractor warrants that products furnished pursuant to the Agreement shall be able to accurately process, date/time data (including, but not limited to, calculating, comparing, and sequencing) transitions, including leap year calculations. Where a Contractor proposes or an acquisition requires that specific products and/or services must perform as a package or system, this warranty shall apply to the products and/or services as a system.

Where the Contractor is providing ongoing services, including but not limited to: i) consulting, integration, code or data conversion, ii) maintenance or support services, iii) data entry or processing, or iv) contract administration services (e.g. billing, invoicing, claim processing), the Contractor warrants that services shall be provided in an accurate and timely manner without interruption, failure, or error due to the inaccuracy of the Contractor's business operations in processing date/time data (including, but not limited to, calculating, comparing, and sequencing) various date/time transitions, including leap year calculations. The Contractor shall be responsible for damages resulting from any delays, errors, or untimely performance resulting there from, including but not limited to the failure or untimely performance of such services.

This Date/Time Warranty shall survive beyond termination or expiration of the Agreement through a) ninety (90) days or b) the Contractor's or product manufacturer/developer's stated date/time warranty term, whichever is longer. Nothing in this warranty statement shall be construed to limit any rights or remedies otherwise available under the Agreement for breach of warranty.

**13. VIRUS WARRANTY**

Product contains no viruses, either known to the Contractor or which reasonably should have been known to the Contractor exercising due diligence. The Contractor is not responsible for viruses introduced at the Department's site.

**14. TITLE AND OWNERSHIP WARRANTY**

The Contractor warrants, represents and conveys (i) full ownership, clear title free of all liens, or (ii) the right to transfer or deliver perpetual license rights to any Product(s) transferred to the Department under the Agreement. The Contractor shall be solely liable for any costs of acquisition associated therewith. The Department may require the Contractor to furnish appropriate written documentation establishing the above rights and interests as a condition of payment. The Department's request or failure to request such documentation shall not relieve the Contractor of liability under this warranty.

**15. USE RESTRICTIONS AND INTELLECTUAL PROPERTY**

The Parties agree that all work by the Contractor for the Department is intended as work for hire. The Parties agree that the Contractor's work is specifically ordered and commissioned for use as contributions to a collective work, or is other such work as specified by section 101(2) of the U.S. Copyright Act [17 U.S.C. 101(2)], and is intended to be a work for hire that is made for the use and ownership of the State of New York and the Department. Furthermore, the Department and the Contractor agree that the State of New York and the Department are the owners of all copyrights regarding the work. The Contractor warrants to the State of New York and the Department that the Contractor, and all of its subcontractors and their employees, who have been, or may be used in regard to the Agreement, forfeits all past or future claims of title or ownership to the work produced.

Materials such as forms and publications used by the Contractor in the course of its performance under the Agreement which have been agreed upon by the Parties as generic materials are specifically excluded from this provision.

**16. OWNERSHIP/TITLE TO PRODUCT DELIVERABLES**

For purposes of this Article, the term "Department" is understood to mean the Department acting on behalf of the State.

**(A) Definitions**

1. Product(s):

A deliverable furnished under the Agreement by or through the Contractor, including existing and custom Product(s), including, but not limited to: a) components of the hardware environment; b) printed materials (including but not limited to training manuals, system and user documentation, reports, drawings); c) third party software; d) modifications, customizations, custom programs, program listings, programming tools, data, modules, components; and e) any properties embodied therein, whether in tangible or intangible form (including but not limited to utilities, interfaces, templates, subroutines, algorithms, formulas, source code, object code).

2. Existing Product(s):

Tangible Product(s) and intangible licensed Product(s) which exist prior to the commencement of work under the Agreement. The Contractor retains the burden of proving that a particular product existed before commencement of the Agreement.

3. Custom Product(s):

Product(s), preliminary, final or otherwise, which are created or developed by the Contractor, or its subcontractors, partners, employees, or agents under the Agreement for the benefit of the Department.

**(B) Title to Project Deliverables**

The Contractor acknowledges that it is commissioned by the Department to perform services detailed in the Agreement. Unless otherwise specified in writing in the Agreement, the Department shall have ownership and/or license rights as follows:

1. Existing Product(s):

a) Hardware - Title and ownership of Existing Hardware Product shall pass to Department upon acceptance.

b) Software - Title and ownership to Existing Software Product(s) delivered by the Contractor under the Agreement which is normally commercially distributed on a license basis by the Contractor or other independent software vendor/proprietary owner ("Existing Licensed Product"), whether or not embedded in, delivered or operating in conjunction with hardware or Custom Products, shall remain with the Contractor or other independent software vendor/proprietary owner ("ISV"). Effective upon acceptance, such Product shall be licensed to the Department in accordance with the Contractor or ISV owner's standard license agreement, provided, however, that such standard license, must, at a minimum: (a) grant the Department a non-exclusive, perpetual license to use, execute, reproduce, display, perform, adapt (unless the Contractor advises the Department as part of the Contractor's bid proposal that adaptation will violate existing agreements or statutes and the Contractor demonstrates such to the Department's satisfaction) and distribute Existing Licensed Product to the Department up to the license capacity stated in the work order with all license rights necessary to fully effect the general business purpose(s) stated in the Agreement and (b) recognize the State of New York as the licensee. Where these rights are not otherwise covered by the ISV's standard license agreement, the Contractor shall be responsible for obtaining these rights at its sole cost and expense. The Department shall reproduce all copyright notices and any other legend of ownership on any copies authorized under this paragraph.

2. Custom Product(s):

Effective upon creation of Custom Product(s), the Contractor hereby conveys, assigns and transfers to State the sole and exclusive rights, title and interest in Custom Product(s), whether preliminary, final or otherwise, including all trademark and copyrights. The Contractor hereby agrees to take all necessary and appropriate steps to ensure that the Custom Product(s) are protected against unauthorized copying, reproduction and marketing by or through the Contractor, its agents, employees, or subcontractors. Nothing herein shall preclude the Contractor from otherwise using the related or underlying general knowledge, skills, ideas, concepts, techniques and experience developed under the Agreement in the course of the Contractor's business.

Where payment for Custom Product does not involve Certificates of Participation (COPS) pursuant to Article 5-A of the State Finance Law or other third party

financing, the Department may, by providing written notice thereof to the Contractor, elect in the alternative to take a non-exclusive perpetual license to Custom Products in lieu of State taking exclusive ownership and title to such Products. In such case, the Department shall be granted a non-exclusive perpetual license to use, execute, reproduce, display, perform, adapt and distribute Custom Product as necessary to fully effect the general business purpose(s) as stated herein.

In the event that the Contractor wishes to obtain ownership rights to Custom Product(s), the sale or other transfer shall be at fair market value as determined by the Parties at the time of such sale or other transfer, and must be pursuant to a separate written agreement in a form acceptable to the State which complies with the terms of this paragraph.

3. Documentation, Data & Reports

The Department shall own title to all documentation, drawings, (e.g., engineering drawings, system diagrams, logic/schematics, plans, reports, training, maintenance or operating manuals), including network design, equipment configurations and other documentation prepared or developed pursuant to the Agreement, whether preliminary, final or otherwise. The Contractor shall deliver to the possession of the Department all work-in-progress documentation as it becomes available, but in no case longer than thirty (30) days after creation.

**17. FORCE MAJEURE**

Neither Party to the Agreement shall be liable or deemed to be in default for any delay or failure in performance under the Agreement resulting directly or indirectly from acts of God, civil or military authority, acts of public enemy, wars, riots, civil disturbances, insurrections, accident, fire, explosions, earthquakes, floods, the elements, acts or omissions of public utilities or strikes, work stoppages, slowdowns or other labor interruptions due to labor/management disputes involving entities other than the Parties to the Agreement, or any other causes not reasonably foreseeable or beyond the control of a Party. The Parties are required to use best efforts to eliminate or minimize the effect of such events during performance of the Agreement and to resume performance of the Agreement upon termination or cessation of such events.

**18. TIME OF THE ESSENCE**

The Department and the Contractor acknowledge and agree that time is of the essence for the Contractor's performance under the Agreement.

**19. RIGHTS AND REMEDIES**

The rights, duties and remedies set forth in the Agreement shall be in addition to, and not in limitation of, rights and obligations otherwise available at law.

**20. FEDERAL AND STATE COMPLIANCE**

The Contractor shall ensure that its employment practices comply with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended.

The Contractor shall ensure compliance with the Americans With Disabilities Act (42 USC §2101 et. seq.) such that programs and services provided during the course of performance of the Agreement shall be accessible under Title II of the Americans With Disabilities Act and as otherwise applicable under the Americans With Disabilities Act.

**21. TAXES**

It shall be understood that the Department, as an agency of the State of New York, is not liable for the payment of any sales, use, excise, or other form of tax however designated, levied or imposed, and shall agree to reimburse the Contractor for same only if taxes would have been incurred through the Department's normal business operations.

**22. INDEPENDENT CONTRACTOR**

The Parties agree that the Contractor is an independent contractor, and the Contractor, its officers, employees, agents, consultants and/or sub-contractors in the performance of the Agreement shall act in an independent capacity and not as agents, officers or employees of the State or the Department. Neither the Contractor nor any sub-contractor shall thereby be deemed an agent, officer, or employee of the State. The Contractor agrees, during the term of the Agreement, to maintain at the Contractor's expense those benefits to which its employees would otherwise be entitled by law, including health benefits, and all necessary insurance for its employees, including worker's compensation, disability and unemployment insurance, and to provide the Department with certification of such insurance upon request. The Contractor remains responsible for all applicable federal, State, and local taxes, and all FICA contributions.

**23. NO THIRD PARTY BENEFICIARIES**

Nothing contained in the Agreement, expressed or implied, is intended to confer upon any person, corporation, other than the Parties hereto and their successors in interest and assigns, any rights or remedies under or by reason of the Agreement.

**24. HEADINGS OR CAPTIONS**

The headings or captions contained within the Agreement are intended solely for convenience and reference purposes and shall in no way be deemed to define, limit or describe the scope or intent of the Agreement or any provisions thereof.

**25. PARTIAL INVALIDITY**

Each Party agrees that it shall perform its obligations under the Agreement in accordance with all applicable federal and State laws, rules, and regulations, policies and/or guidelines now or hereafter in effect. If any term or provision of the Agreement shall be found to be illegal or unenforceable, then, notwithstanding such term or provision, the Agreement shall remain in full force and effect, and such term or provision shall be deemed stricken.

**26. CONFLICT OF INTEREST**

The Contractor shall ensure that its officers, employees, agents, consultants and/or sub-contractors comply with the requirements of the New York State Public Officers Law ("POL"), as amended, including but not limited to sections 73 and 74, as amended, with regard to ethical standards applicable to State employees, and particularly POL sections 73(8)(a)(i) and (ii) regarding post-employment restrictions affecting former State employees. Additionally, the Contractor shall ensure that no violation of these provisions will occur by reason of the Contractor's proposal for or negotiation and execution of the Agreement or in its delivery of services pursuant to the Agreement. If, during the term of the Agreement, the Contractor becomes aware of a relationship, actual or potential, which may be considered a violation of the POL or which may otherwise be considered a conflict of interest, the Contractor shall notify the Department in writing immediately. Should the Department thereafter determine that such employment is inconsistent with State law; the Department shall so advise the Contractor in writing, specifying its basis for so determining, and may require that the contractual or employment relationship be canceled. Failure to comply with these provisions may result in suspension or cancellation of the Agreement and criminal proceedings as may be required by law.

The Contractor is required to make full disclosure of any circumstances that could affect its ability to perform in complete compliance with the POL. Any questions as to the applicability of these provisions should be addressed by the Contractor to the New York State Ethics Commission, 540 Broadway, Albany, NY 12207 (518) 408-3976.

**27. AUDIT AUTHORITY**

The Contractor acknowledges that the Department and the Office of the State Comptroller have the authority to conduct financial and performance audits of the Contractor's delivery of Program Services (or Project Services) in accordance with the Agreement and any applicable State and federal statutory and regulatory authorities. Such audit activity may include, but not necessarily be limited to, the review of documentary evidence to determine the accuracy and fairness of all items on the Contractor's submission of claims for payment under the Agreement, and the review of any and all activities relating to the Contractor's performance and administration of the Agreement.

The Contractor shall make available documentary evidence necessary to perform such reviews. Documentation 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 and pertinent contracts and correspondence.

The audit provisions contained herein shall in no way be construed to limit the audit authority or audit scope of the Office of the State Comptroller as set forth in Appendix A of the Agreement - Standards Clauses for All New York State Contracts.

**28. CONFIDENTIALITY**

All records maintained by the Contractor and relating to the Agreement are confidential and shall be used by the Contractor and its officers, employees, and subcontractors or agents solely for the purpose of carrying out its obligations under the Agreement. Except as directed by a court of competent jurisdiction or as may be permitted or required by applicable New York State or federal law or regulations, no such records may be otherwise used or released to any person by the Contractor, its employees, subcontractors or agents, 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.

The Contractor shall promptly advise the Department of all requests made to the Contractor for information regarding the performance of services under the Agreement, including any information provided by the Department, except as required by subcontractors or agents solely for the purpose of carrying out obligations under the Agreement or as required by law.

The Contractor shall be responsible for assuring that any agreement between the Contractor and any of its officers, agents and employees or applicable subcontractors contains a provision that conforms strictly to the provisions of this Article.

**29. INFORMATION SECURITY REQUIREMENTS**

In accordance with the Information Security Breach and Notification Act (ISBNA) (General Business Law §889-aa, State Technology Law §208), Contractor shall be responsible for complying with provisions of the ISBNA and the following terms contained herein with respect to any private information (as defined in ISBNA) received by Contractor under the Agreement (Private Information) that is within the control of the Contractor either on the Department's information security systems or the Contractor's information security system (System). In the event of a breach of the security of the System (as defined by ISBNA),

Contractor shall immediately commence an investigation, in cooperation with the Department, to determine the scope of the breach and restore security of the System to prevent any further breaches. Contractor shall also notify the Department of any breach of the security of the System immediately following discovery of such breach.

Except as otherwise instructed by the Department, Contractor shall, to the fullest extent possible, first consult with and receive authorization from the Department prior to notifying any individuals, the State Office of Cyber Security and Critical Infrastructure Coordination (CSCIC), the State Consumer Protection Board and the Office of the Attorney General (OAG) or any consumer reporting agencies of a breach of the security of the System or concerning any determination to delay notification due to law enforcement investigations. Contractor shall be responsible for providing the notice to all such required recipients and for all the costs associated with providing such notice. Contractor shall be liable for any other costs associated with noncompliance of ISBNA if caused by the Contractor or Contractor's agents, officers, employees, or subcontractors. Nothing herein shall in any way impair the authority of the OAG to bring an action against the Contractor to enforce the provisions of ISBNA or limit Contractor's liability for any violation of the ISBNA. Additional information relative to the law and the notification process is available at:

<http://www.cscic.state.ny.us/security/securitybreach>

Contemporaneous with the execution of the Agreement, the Contractor and its designees shall execute the Department's Third Party Connection and Data Exchange Agreement and any other protocol required by the Department, and shall ensure its employees, agents and designees complete the related Third Party Acceptable Use Policy and Agreement if applicable, to ensure the security of data transmissions and other information related to the administration of the Agreement. This request may be waived by the Department in its sole discretion.

### **30. NONDISCLOSURE OF CONFIDENTIAL INFORMATION**

Except as may be required by applicable law or a court of competent jurisdiction, the Contractor, its officers, agents, employees, and subcontractors shall maintain strict confidence with respect to any Confidential Information to which the Contractor, its officers, agents, employees, and subcontractors have access in the course of the Contractor's performance under the Agreement. For purposes of the Agreement, all State information of which the Contractor, its officers, agents, employees and subcontractors becomes aware during the course of performing services for the Department shall be deemed to be Confidential Information (oral, visual or written). Notwithstanding the foregoing, information that falls into any of the following categories shall not be considered Confidential Information:

- (a) information that is previously rightfully known to the receiving party without restriction on disclosure;
- (b) information that becomes, from no act or failure to act on the part of the receiving party, generally known in the relevant industry or is in the public domain; and
- (c) information that is independently developed by the Contractor without use of confidential information of the State.

The Contractor shall hold the State and the Department harmless from any loss or damage to the State or the Department resulting from the disclosure by the Contractor, its officers, agents, employees, and subcontractors of such Confidential Information.

The Contractor shall provide for its officers, agents, employees, and subcontractors to acknowledge and execute a nondisclosure agreement containing substantially the terms described in this Article, if requested to do so by the Department or the State.

This representation shall survive termination of the Agreement.

### **31. FREEDOM OF INFORMATION LAW**

Disclosure of information and material provided to the Department by the Contractor in the course of the Contractor's performance under the Agreement shall be permitted consistent with the laws of the State of New York, and specifically the Freedom of Information Law (FOIL), Article 6 of the Public Officers Law. The Department shall take reasonable steps to protect from public disclosure any of the records relating to the Contractor's performance under the Agreement that otherwise are exempt from disclosure under FOIL.

If the Contractor believes that any information or material provided to the Department constitutes trade secret information that should be exempted from FOIL disclosure, the Contractor must, at the time of the materials' submission, request the exemption in writing, specifically identifying the material by page number, line, or other appropriate designation, and provide a particularized explanation as to why the material constitutes trade secret information and how the disclosure of the identified information would cause substantial injury to the Contractor's competitive position. The material sought to be protected from disclosure must be clearly marked in yellow highlighter, on a duplicate copy of the submission and may be provided in hardcopy or on a CD. Generically marking all material as "Confidential" will not be considered adequate for the purpose of this Article.

The Department's receipt of the Contractor's submission of material and the Contractor's request for protection of the material from FOIL disclosure does not constitute a determination that the information is exempt from disclosure under FOIL. In the event any information or material is requested pursuant to FOIL, the Department will address each party's interests fully in accordance with the procedures required by Article 6 of the Public Officers Law.

### **32. TERMINATION OF AGREEMENT**

In addition to any termination provisions specified elsewhere in the Agreement, the following provisions also shall apply:

The Agreement may be terminated by mutual written agreement of the Parties.

The Agreement may be terminated by the Department for cause upon the failure of the Contractor to comply with the terms and conditions of the Agreement, including any exhibits incorporated herein, provided that the Department shall give the Contractor written notice via registered or certified mail, return receipt requested, or hand delivery, such written notice to specify the Contractor's failure and the termination of the Agreement. Termination shall be effective ten (10) Business Days after receipt of such notice unless the Contractor, in the opinion of the Department, has cured such failure. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination. Upon termination for cause, the Department shall have the right to award a new contract to another contractor. Termination for cause shall create a liability upon the Contractor for actual damages incurred and for all reasonable additional costs incurred in reassigning the Agreement.

The Agreement may be terminated if the Department deems that termination would be in the best interest of the State provided that the Department shall give written notice to the Contractor not less than thirty (30) Days prior to the date upon which termination shall become effective, such notice to be made via registered or certified mail, return receipt requested or hand delivered. The date of such notice shall be deemed to be the date of postmark in the case of mail or the date of hand delivery.



The Agreement may be terminated immediately in the event the Department determines that funds are unavailable. The Department agrees to provide notice to the Contractor as soon as it becomes aware that funds are unavailable in the event of termination under this paragraph. If the initial notice is via oral notification, the Department shall provide written notice immediately thereafter. The Department shall be obligated to pay the Contractor only for the expenditures made and obligations incurred by the Contractor until such time as notice of termination or received either orally or in writing by the Contractor from the Department.

In the event of termination for any reason, the Contractor shall not incur new obligations for the terminated portion. The Contractor agrees, after consultation with the Department, to cancel such outstanding obligations as the Contractor deems appropriate in the exercise of sound business judgment.

Upon termination of the Agreement each Party shall, if applicable, return to the other all papers, materials, and other properties of the other Party held by each for purposes of performance under the Agreement. In addition, each Party shall assist the other Party in orderly termination of the Agreement and the transfer of all aspects hereof, tangible, and intangible, as may be necessary to ensure the orderly administration of the State program.

### **33. CONTRACTOR PERSONNEL**

The Contractor shall designate an Account Executive, who shall be the contact person for all matters arising under the Agreement.

The Contractor agrees to be solely responsible for the recruitment, hiring, provision of employment benefits, payment of salaries, and management of its personnel. These functions shall be carried out by the Contractor in accordance with the provisions of the Agreement and with all applicable federal and State laws and regulations.

The Contractor is required to commit key personnel for the administration of all aspects of the Agreement. In the event that any of the key personnel will be or are unavailable for the performance of their duties, the Contractor will designate and propose to the Department an equally qualified alternate with full authority to act for the unavailable key person.

The Contractor shall notify the Department in writing of any changes in the key personnel designated for performance of the Agreement. This shall include any changes in the personnel designated to bind the Contractor.

The Department reserves the right to demand the reassignment or cancellation of assignment to duties under the Agreement of any Contractor personnel so assigned. The Department shall not exercise the authority unreasonably. The Contractor agrees to replace any employees so reassigned or canceled with an employee of equal or better qualifications. If the Department exercises its right under this provision, it agrees to provide written notice to the Contractor setting forth its reasons with specificity.

### **34. OPERATIONAL CONTACTS**

The Contractor shall maintain appropriate corporate and/or legal authority, which shall include, but not be limited to, the maintenance of an organization capable of delivering 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 Program Services are to be delivered pursuant to the Agreement. The Contractor also shall maintain operations, financial and legal staff that shall be directly available to the Department's operations, financial and legal staff, respectively. For purposes of the Agreement, maintenance of such staff and staff availability by the Contractor shall in no way create any agency relationship between the Department and the Contractor.

The Contractor acknowledges and agrees that no aspect of the Contractor's performance under the Agreement is contingent upon Department personnel or the availability of Department resources, with the exception of all proposed actions of the Contractor specifically identified in the Agreement as requiring the Department approval. With respect to such approval, the Department shall act promptly and in good faith.

The Contractor must cooperate fully with any other contractors who may be engaged by the Department relative to the the Agreement.

The Contractor must ensure that all contacts by the Contractor personnel with other New York State agencies, external organizations (Federal Agencies, Unions, etc.) which result in any charge, cost or payment of any kind, must receive prior written authorization from the Department's Contract Manager.

### **35. SUBCONTRACTING**

If allowed in the solicitation instrument (e.g., Request for Proposal, Invitation for Bids, etc.) that results in the Agreement, the Contractor may arrange for specified portion(s) of its responsibilities under the Agreement to be subcontracted to a Key Subcontractor(s). A "Key Subcontractor" means that vendor(s) with whom the Contractor subcontracts to provide any portion of Program Services. If the Contractor determines to subcontract a portion(s) of Program Services, the Key Subcontractors must be clearly identified and the nature and extent of its involvement in and/or proposed performance under the Agreement must be fully explained by the Contractor to the Department. The Contractor retains ultimate responsibility for all Program Services performed under the Agreement.

All subcontracts shall be in writing and shall contain provisions, which are functionally identical to, and consistent with, the provisions of the Agreement including, but not be limited to, the body of the Agreement, Appendix A - Standard Clauses For All New York State Contracts, Appendix B - Standard Clauses for All Department Contracts and if applicable as determined by the Department, Appendix C - Third Party Connection and Data Exchange Agreement. Unless waived in writing by the Department, all subcontracts between the Contractor and a Key Subcontractor shall expressly name the State of New York, through the Department, as the sole intended third party beneficiary of such subcontract. The Department reserves the right to review and approve or reject any subcontract with a Key Subcontractor, as well as any amendments to said subcontract(s), and this right shall not make the Department or the State of New York a party to any subcontract or create any right, claim, or interest in the Key Subcontractor or proposed Key Subcontractor against the Department.

The Department reserves the right, at any time during the term of the Agreement, to verify that the written subcontract between the Contractor and Key Subcontractor(s) is in compliance with all of the provision of this Article and any subcontract provisions contained in the Agreement. In addition to other remedies allowed by law, the Department reserves the right to terminate the Agreement for cause if an executed subcontract does not contain all of the provisions/statements stipulated above. If during the term of the Agreement, any executed subcontract between the Contractor and a Key Subcontractor is amended, the Contractor shall, within 30 calendar days of such amendment, provide a copy to the Department.

The Contractor shall give the Department immediate notice in writing of the initiation of any legal action or suit which relates in any way to a subcontract with a Key Subcontractor or which may affect the performance of the Contractor's duties under the Agreement. Any subcontract shall not relieve the Contractor in any way of any responsibility, duty and/or obligation of the Agreement.

**36. PUBLICITY AND COMMUNICATIONS**

The Contractor shall ensure that all requests for the Contractor's participation in events where the Contractor will be participating on behalf of the Department receive prior written authorization from the Department.

No public discussion or news releases relating to the Agreement shall be made or authorized by the Contractor or the Contractor's agent without the prior written approval of the Department, which written approval shall not be unreasonably withheld or delayed provided, however, that Contractor shall be authorized to provide copies of the Agreement and answer any questions relating thereto to any State or federal regulators or, in connection with its financial activities, to financial institutions for any private or public offering.

**37. CONSULTANT DISCLOSURE REQUIREMENTS**

Unless directed otherwise by the Department, the Contractor shall demonstrate its compliance with Chapter 10 of the Laws of 2006 throughout the term of the Agreement by submitting to the Department and to the Office of the State Comptroller a "State Consultant Services - Contractor's Annual Employment Report" for each State Fiscal Year. Such report shall be due no later than May 15<sup>th</sup> of each year following the end of the State Fiscal Year being reported. Such report shall be required of any contract that includes services for analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health and mental health services, accounting, auditing, paralegal, legal, or similar services. Such report shall conform with Bulletin No. G-226 – Form B as issued by the Office of the State Comptroller. The report must be submitted to the Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11<sup>th</sup> floor, Albany, NY 12236, ATTN: Consultant Reporting; and to the Department's Contract Manager.

**38. PROCUREMENT LOBBYING RESTRICTIONS UNDER STATE FINANCE LAW SECTIONS 139-j AND 139-k**

The Contractor certifies that all information that it has provided or will provide to the Department pursuant to State Finance Law sections 139-j and 139-k is complete, true, and accurate, including but not limited to information regarding prior determinations of non-responsibility within the past four years based upon (i) impermissible contacts of other violations of SFL section 139-j, or (ii) the intentional provision of false or incomplete information to a governmental entity.

The Department reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with SFL sections 139-j or 139-k was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its right to terminate the Agreement by providing written notification to the Contractor in accordance with Article 9 of this Appendix B.

**39. VENDOR RESPONSIBILITY**

The Contractor is required to provide the Department with an updated Vendor Responsibility Questionnaire when requested to do so by the Department throughout the term of the Agreement. Regardless, the Contractor is required to report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

**40. TAX LAW SECTION 5-A - CERTIFICATION REGARDING SALES AND COMPENSATING USE TAXES**

In the event the value of the Agreement exceeds \$100,000, the Contractor must file a properly completed Form ST-220-CA with the Department and a properly completed Form ST-220-TD with the Department of Taxation & Finance before the Agreement may take effect.

In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Department if the Agreement's term is renewed; further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

**41. CONTRACT PAYMENT**

Contractor shall provide complete and accurate billing invoices to the Department in order to receive payment. Billing invoices submitted to the Department must contain all information and supporting documentation required by the Agreement, the Department and the State Comptroller. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at [www.osc.state.ny.us/epay/index.htm](http://www.osc.state.ny.us/epay/index.htm), by e-mail at [epunit@osc.state.ny.us](mailto:epunit@osc.state.ny.us), or by telephone at 518-474-4032. Contractor acknowledges that it will not receive payment on any invoices submitted under the Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

*May 2011*



**THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT**

**THIS AGREEMENT** (the “Agreement”) by and between the NYS Department of Civil Service (“DCS”), with principal offices in Albany, NY 12239, and


with principal offices at


(hereinafter “Third Party”), is entered into as of the date last written below (“the Effective Date”).

This Agreement consists of this signature page and the following attachments incorporated by reference:

- 1. Attachment 1: Third Party Connection and Data Exchange Agreement Terms and Conditions
- 2. Attachment 2: Third Party Connection and Data Exchange Request Requirements Document
- 3. Attachment 3: Third Party Acceptable Use Policy and Agreement
- 4. Attachment 4: DCS Equipment Loan Agreement (Applicable: Yes No )

This Agreement may only be modified by a written document executed by the parties hereto. Any disputes arising out of or in connection with this Agreement shall be governed by New York State law without regard to choice of law provisions.

**IN WITNESS WHEREOF**, the parties hereto have caused this Agreement to be duly executed. Each party warrants and represents that its respective signatories whose signatures appear below have been and are on the date of signature duly authorized to execute this Agreement.

<i>Third Party Name:</i>	<i>NYS Department of Civil Service (DCS)</i>
Authorized Signature	Authorized Signature
Name ( <i>Print</i> )	Name ( <i>Print</i> )
Date	Date



## THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

### ATTACHMENT 1 – SECURITY REQUIREMENTS

#### 1. *Right to Use Connection*

Third Party may only use the connection and the information obtained from DCS for business purposes as outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2).

#### 2. *Data Exchange*

2.1 Third Party may only use the data obtained for purposes outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2) and the contract or Memoranda of Understanding, if any, that exists between DCS and Third Party for the provision of goods or services or governing conduct between DCS and Third Party with respect to the access to and use of DCS data.

2.2 Data exchange may be conducted only by methods and/or services outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2). Third Party should expect that access to information and services may be limited, as determined or required by DCS.

#### 3. *Network Security*

3.1 Third Party will allow only its own employees approved in advance by DCS (“Third Party Users”) to access the Network Connection or any DCS-owned equipment. Third Party shall be solely responsible for ensuring that Third Party Users are not security risks, and upon DCS’ request, Third Party will provide DCS with any information reasonably necessary for DCS to evaluate security issues relating to any Third Party User.

3.2 Third Party will promptly notify DCS whenever any Third Party User leaves Third Party’s employ or no longer requires access to the connection or DCS-owned Equipment.

3.3 Each Party will be solely responsible for the selection, implementation, and maintenance of security procedures and policies that are sufficient to ensure that (a) such party’s use of the connection (and Third Party’s use of DCS-owned Equipment) is secure and is used only for authorized purposes, and (b) such Party’s business records and data are protected against improper access, use, loss alteration or destruction.

3.4 The preferred connectivity method is via the Internet to a DCS-approved or DCS-provided Virtual Private Network (VPN) device. If the device is DCS-provided, DCS will loan the Third Party, in accordance with the DCS Equipment Loan Agreement, the required client software for establishing VPN connections with DCS. Normal DCS perimeter security measures will control access to the internal network.

3.5 Extranet – Designated routers are used in combination with firewall rules to allow access to be managed. A second authentication may be required.



**Appendix C**  
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- 3.6 Remote Access - Using the DCS-provided remote access software, Third Party will connect via an Internet browser. The account may be disabled until usage is required and controls are placed and managed by DCS. Third Party will be required to follow procedures to enable the account for each use.
- 3.7 Third Party Connections will be audited. All remote access user accounts for Third Parties will be given an expiration time. Renewals must be requested by Third Party and approved by the Department Sponsor. Obsolete Third Party connections will be terminated.
- 3.8 Software versions on all Third Party computers that connect to the DCS network must be versions that are currently supported by the software manufacturer, and all available security updates and hot fixes for that software must be applied in a timely fashion. Software and firmware for all Third Party networking equipment that is part of the connection to the DCS network must be kept up to date, especially with patches that fix security vulnerabilities.
- 3.9 Anti-virus software and firewalls must be installed and enabled at all times on DCS-owned computers and on Third Party computers that connect to the DCS network. Additionally, virus definition files must be kept up to date.
- 3.10 In no case may a Third Party Connection to DCS be used as an Internet Connection for Third Party or for a Third Party User.

**4. Notifications**

- 4.1 Third Party shall notify DCS in writing promptly of any change in its Users for the work performed over the Network Connection or whenever Third Party believes a change in the connection and/or functional requirements of the connection is necessary.
- 4.2 Any notices required by this Agreement shall be given in hand, sent by first class mail, or via facsimile to the applicable address set forth below.

Third Party Name:	NYS Department of Civil Service Albany, New York 12239
Address:	
Attention:	Attention:



**5. *Citizen Notifications***

If Third Party maintains "identifying personal information" on behalf of the Department and such information is compromised, Third Party shall notify the Department immediately that the information has been compromised, the circumstances under which the information was compromised, and the measures undertaken by Third Party to address those circumstances and to otherwise mitigate the effects of the compromise. If encrypted data is compromised along with the corresponding encryption key and encryption software, the data shall be considered unencrypted and the information will be considered compromised through unauthorized access. If the Department requests Third Party to do so, Third Party shall notify the persons whose identifying information was compromised. Such notification shall be communicated via postal service or email, as directed by the Department, and shall otherwise be executed in accordance with the Department's direction. Notification shall be delayed if a law enforcement agency determines that such notification may impede a criminal investigation. For the purpose of this section, "identifying personal information" shall be any information concerning an individual which, because of name, number, symbol, mark or other identifier in combination with any of the following, is unencrypted: (1) Social Security Number; or (2) driver's license number; or (3) financial account number, credit or debit card number, in combination with any required security code, access code, or password which would permit access to an individual's financial account; or (4) password which would permit access to the individual's account.

**6. *Payment of Costs***

Each Party will be responsible for all costs incurred by that Party under this Agreement, including, without limitation, costs for phone charges, telecommunications equipment and personnel for maintaining the connection.

**7. *Confidentiality***

7.1 Information exchanged for the business purposes outlined in Attachment 2 will be held confidential by the Parties to the maximum extent permitted by law. Each Party may internally use the information received from the other Party hereunder in connection with and as specifically necessary to accomplish the Business Purpose set forth in Attachment 2 and for no other purposes. Each Party may otherwise share such information with other third parties (e.g. consultants, subcontractors, control agencies) as required or permitted by law in order to effect the business purposes outlined in Attachment 2 and for no other purposes, provided that such third parties agree to the confidentiality restrictions set forth herein and as may be required otherwise by State and federal law.

7.2 Third Party must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the sensitive information that it creates, receives, maintains, or transmits on behalf of DCS.

7.3 Unencrypted DCS information must not be transmitted over email.

7.4 Third Party must ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it and report to the DCS Help Desk any security incident of which it becomes aware.





**8. *Third Party Users***

- 8.1 Third Party must require that each Third Party User executes a Third Party Acceptable Use Policy and Agreement (Attachment 3). Third Party must ensure that DCS is notified by fax or mail when the user base changes, following the specifications in the Third Party Connection & Data Exchange Agreement.
- 8.2 All aspects of Third Party connections within DCS control may be monitored by the appropriate DCS support group and/or the DCS Information Security Officer. Any unauthorized use or change to devices will be investigated immediately.
- 8.3 All Third Party Connections will be reviewed on a regular basis and information regarding specific Third Party connection will be updated as necessary. Obsolete Third Party connections will be terminated.

**9. *DCS-owned Equipment***

- 9.1 DCS may, in DCS' sole discretion, loan to Third Party certain equipment and/or software for use on Third Party premises (the DCS-owned Equipment) under the terms of the DCS Equipment Loan Agreement set forth in Attachment 4. DCS-owned equipment will only be configured for TCP/IP, and will be used solely by Third Party on Third Party's premises or other locations authorized by DCS for the purposes set forth in this Agreement. DCS is responsible for ensuring that it has the right under applicable software licenses to permit third party use.
- 9.2 Third Party may modify the configuration of the DCS-owned equipment only after notification and approval in writing by authorized DCS personnel.
- 9.3 Third Party will not change or delete any passwords set on DCS-owned equipment without prior approval by authorized DCS personnel. Promptly upon any such change, Third Party shall provide DCS with such changed password.

**10. *Term, Termination and Survival***

- 10.1 This Agreement will remain in effect until terminated by either Party, but in no event prior to the termination or expiration of any contract or agreement between the Parties for the purchase of goods or services that provides the business purpose for the exchange of data between the Parties, unless both Parties mutually agree to so terminate this Agreement.
- 10.2 Upon termination, Third Party shall return all tangible DCS data to DCS within a timeframe specified by DCS for that purpose, and further shall certify in writing to DCS that all other DCS data in whatever form has been destroyed. Additionally, any DCS-owned equipment and/or software shall be promptly returned to DCS at Third Party's expense.
- 10.3 Notwithstanding the above, the Parties' obligations to safeguard the confidentiality of the data subject to this Agreement shall survive the termination of this Agreement, and shall bind the Parties' employees, subcontractors, agents, heirs, successors and assigns.



**11. Severability**

If for any reason a court of competent jurisdiction finds any provision or portion of this Agreement to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the Parties, and the remainder of this Agreement will continue in full force and effect.

**12. Waiver**

The failure of any Party to enforce any of the provisions of this Agreement will not be construed to be a waiver of the right of such Party thereafter to enforce such provisions.

**13. Assignment**

Third Party may not assign this Agreement, in whole or in part, without the prior written consent from DCS. Any attempt to assign this Agreement, without such consent, will be null and of no effect. Subject to the foregoing, this Agreement is for the benefit of and will be binding upon the parties' respective successors and permitted assigns.

**14. Force Majeure**

Neither Party will be liable for any failure to perform its obligations if such failure results from any act of God or other cause beyond such Party's reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any data.

**15. Partial Invalidity**

If this Agreement is entered into as a consequence of Third Party's provision of goods or services to DCS pursuant to a contract or other written agreement, that Agreement supersedes this Agreement to the extent the agreements' provisions may be inconsistent.



**THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT**

**ATTACHMENT 2 – REQUEST REQUIREMENTS**

In accordance with the DCS *Third Party Connection and Data Exchange Policy*, all requests for Third Party connections and data exchanges must be accompanied by this completed requirements document. This document should be completed by the DCS person or group requesting the Third Party connection and/or data exchange. The DCS Department Sponsor must be the Director of the Division whose business requires the Third Party connection and/or data exchange. DCS Divisions are encouraged to work with their IRM Liaison to complete the information in this document.

***Part 1 – Business Justification***

**A. DCS Sponsor** (*Division Director*)

Name: \_\_\_\_\_ Division: \_\_\_\_\_  
Office Location: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

***Back-up Point of Contact: (Data Custodian)***

Name: \_\_\_\_\_ Division: \_\_\_\_\_  
Office Location: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

**B. Business Reason for Connection** (*To be completed by Sponsor*)

State the purpose of establishing the connection and the purpose of the data transmission. Specify the business needs of the proposed connection. Use additional sheets of paper if needed.

**C. Specify the details of the work to be accomplished via the connection. What applications will be used? What information will be used? What transactions will be accomplished?**



**D. Specify the Third Party Controls to be Implemented for Safeguarding DCS Data:**

Access Controls:

Audit Controls:

Working procedures or practices for handling printed material and verbal exchanges:

Method of Disposal of media and paper:

User Account Management, including review of accounts:

Physical Security:

Other:

**E. Estimated number of hours of use each week?**

1 – 20

21 – 40

More than 40 hours per week

**F. Anticipated normal hours of use?**

M – F, 8:00 – 5:00 pm Eastern time

Other (specify):

**G. What is the requested installation date? (Minimum lead-time is 30 days)**

**H. Approximately how long will the connection be needed?**

Up to 6 months

6 – 12 months

More than 12 months

Specific time period:

**Note: If a connection is needed for more than a year, the Connection Agreement must be renewed annually.**



**I. Other useful information**

**J. Third Party Information**

Name of Third Party:

Main Phone Number:

Main Office Address:

*Management Contact*

Name:

Department:

Address:

Email Address:

Phone Number:

Manager's Name:

Manager's Phone:

*Backup Contact*

Name:

Department:

Address:

Email Address:

Phone Number:

Manager's Name:

Manager's Phone:

*Technical Contact*

Name:

Department:

Address:

Email Address:

Phone Number:

Manager's Name:

Manager's Phone:

Technical Support Hours:

Escalation List:

Domain name(s):

Host name(s):



**Appendix C**  
**Page 10 of 16**

**User Names and Contact Information.** (*List all employees of the Third Party who will use this access.*)

User 1 (*name, phone, email*):

User 2 (*name, phone, email*):

User 3 (*name, phone, email*):

User 4 (*name, phone, email*):

User 5 (*name, phone, email*):

User 6 (*name, phone, email*):

User 7 (*name, phone, email*):

User 8 (*name, phone, email*):

User 9 (*name, phone, email*):

User 10 (*name, phone, email*):

**K. Other information**



**THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT**

**ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT**

This Policy and Agreement applies to all forms of computer and networking use, including local access at the Department of Civil Service (DCS) premises, remote access via public or private networks, access using DCS equipment, access using individual or group accounts, and access via other methods.

A signed paper copy of this form must be submitted by any individual (1) for whom authorization of a new user account is requested, (2) who will use a shared third party account, and/or (3) who is requesting reauthorization of an existing use. Modifications to the terms and conditions of this agreement will not be accepted by DCS management.

Indicate here if this is a notification that the User named below no longer requires access:

User's Name ( <i>print</i> ):			
Organization:			
Telephone Number:	Area code	Number	Extension
Office Address:			

<i>The undersigned acknowledges that he or she has read, understands, and agrees to comply with this Third Party Acceptable Use Policy and Agreement governing the use of DCS computing resources.</i>	
User Signature:	Date:

**You must sign this signature page and send it to DCS. Retain a copy of the signature page and the attached Policy for your records. This form must be delivered either by fax or mail to:**

**MAIL:** NYS Department of Civil Service, Albany, NY 12239  
 Attention: Help Desk  
**FAX:** 518-485-5588



## THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

### ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

#### I. *Protection of DCS Information*

All records and information maintained in DCS systems accessed by the User are confidential and shall be used by the User solely for the purpose of carrying out the User's official duties. Users may not use any such records and information for any other purpose. No such records or information may otherwise be used or released to any person by the User or by the User's employer or agent, except as may be required by applicable State or federal law or by a court of competent jurisdiction. All accounts and connections will be regularly reviewed.

#### II. *DCS Log-on Banner*

All users will follow the guidelines of the DCS Log-on Banner as stated below.

NOTICE \* The contents of this banner have been recommended to all State agencies by the Office for Technology in the NYS Preferred Standards and Procedures for Information Security. \* This electronic system, which includes hardware, software and network components and all data contained therein (the "system"), is the property of the New York State Department of Civil Service (DCS). \* Unauthorized use or attempted unauthorized use of this system is not permitted and may constitute a federal or state crime. Such use may subject you to appropriate disciplinary and/or criminal action. Use of this system is only permitted to the extent authorized by DCS. \* Use is limited to conducting official business of DCS. Under the Electronic Communications Privacy Act of 1986 (18 U.S.C. 2510, et seq.), notice is hereby given that there are NO facilities provided by this system for sending or receiving private confidential electronic communication. Any use, whether authorized or not, may be monitored, intercepted, recorded, read, copied, accessed or captured in any manner, and used or disclosed in any manner, by authorized DCS personnel without additional prior notice to users. In this regard, users have no legitimate expectation of privacy during any use of this system or in any data on this system. \* Use, whether authorized or unauthorized, constitutes expressed consent for DCS to monitor, intercept, record, read, copy, access or capture and use or disclose such information. \* DCS policy regarding this matter can be reviewed on the DCS internal website. Copies can also be obtained from the Office of Human Resources Management. Such policies are subject to revision. This notice is consistent with the Acceptable Use Policy issued to DCS employees regarding acceptable use, June 15, 2005. I have read and understand this notification and department policy.

#### III. *Passwords*

The User is not permitted to share his/her password with anyone. Passwords must never be written down. The User must not use the same password for multiple applications. The User must use passwords that are not easily guessed and must not use their email address as their password.





**IV. *Shared Accounts***

All use of shared accounts must be authorized by DCS. Users of shared accounts must be identified to DCS via the completion and signing of this policy/agreement. Third Parties are responsible for notification to DCS when the user base changes. Passwords for shared accounts must not be provided to individuals who have not been identified by Third Party to DCS and who have not completed and signed this policy/agreement.

**V. *Virus Protection***

Anti-virus software must be installed and enabled at all times on DCS-owned computers and on third party computers used to conduct DCS business. Virus definition files must be kept up to date. DCS Information Resource Management (IRM) provides anti-virus software and maintains the configuration of that software for all DCS-owned computers.

**VI. *Acceptable Use***

DCS computers, computing systems and their associated communication systems are provided to support the official business of DCS. All uses inconsistent with DCS' business activities and administrative objectives are considered to be inappropriate use.

Examples of unacceptable behavior include, but are not limited to the following.

- Any illegal activities that could result in legal actions against and/or financial damage to DCS.
- Computer usage that reasonably harasses or offends other employees, users, or outsiders, or results in public embarrassment to DCS.
- Computer usage that is not specifically approved and which consumes significant amounts of computer resources not commensurate with its benefit to DCS' mission or which interferes with the performance of a worker's assigned job responsibilities.
- Use in connection with compensated outside work or unauthorized not-for-profit business activities.
- Use of sniffers, spyware, ad-ware or other related technology.

**VII. *Software Protection***

The User is responsible for complying with copyright, licensing, trademark protection, and fair use restrictions.

**VIII. *Reporting Incidents***

Users are required to report incidents of system errors, data discrepancies, application performance problems, to the DCS Help Desk, at 518-457-5406 phone; 518-485-5588 fax.



**IX. *DCS Rights***

Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq.), notice is hereby given that there are no facilities provided by this system for sending or receiving private or confidential electronic communications. DCS has access to all access attempts, messages created and received, and information created or stored using DCS resources, and will monitor use as necessary to assure efficient performance and appropriate use. Information relating to or in support of illegal activities will be reported to the appropriate authorities.

DCS reserves the right to log and monitor use. DCS reserves the right to remove a user account from the network. DCS assumes no responsibility or liability for files or information deleted.

The DCS will not be responsible for any damages. This includes the loss of data resulting from delays, non-deliveries, or service interruptions caused by negligence, errors or omissions, or caused by the way the user chooses to use DCS computing facilities.

DCS reserves the right to change its policies and rules at any time.

**X. *Penalties***

The User shall hold the State and DCS harmless from any loss or damage to the State and/or DCS resulting from the User's inappropriate disclosure of information covered by this User Agreement. Further, the User's non-compliance with this Agreement may result in the revocation of system privileges, termination of employment or contract with DCS, and/or criminal and/or civil penalties.



Name And Address Of Borrower	DCS Business Unit (Loaning Organization)	
	Point Of Contact	
	Work Location	Telephone
Shipping Address ( <i>If different from borrower's</i> )	Manager's Name	
	Date To Be Loaned	
	Date To Be Returned	
<b>Equipment To Be Loaned</b>		
Quantity	Description	Value
Purpose Of Loan		
<b>CONDITIONS OF LOAN</b>		
<ol style="list-style-type: none"> <li>1. The Borrower of the above equipment agrees to return same in like condition as received from DCS, normal wear and tear excepted, on or before the above return date, unless the loan period is formally extended.</li> <li>2. Upon termination of this Agreement, Borrower shall uninstall all DCS software included in this Agreement from Borrower's computer and/or network equipment.</li> <li>3. The Borrower shall not make <b>any</b> copies of DCS software included in this Agreement.</li> <li>4. In case of loss or damage beyond repair, DCS shall be reimbursed by Borrower at the current price of replacement.</li> <li>5. The equipment shall not be loaned or transferred to a third party without the written consent of DCS.</li> <li>6. The right is reserved to cancel the loan or recall the equipment upon ____ days notice.</li> <li>7. The Borrower shall assume all shipping and/or transportation costs involved.</li> <li>8. Other conditions:</li> </ol>		



State of New York  
 Department of Civil Service  
 The State Campus  
 Albany, New York 12239

**ADMINISTRATIVE SERVICES DIVISION**  
**Third Party Connection and Data Exchange Agreement**  
**Attachment 4 –Equipment Loan Agreement**  
 ADM-125 (4/06)

**Appendix C**  
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<b>Agreed (Borrower)</b>	<b>Approved (DCS)</b>
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date
<b>RECEIPT OF EQUIPMENT</b>	
<b>Borrower</b> ( <i>Upon initial receipt</i> )	<b>DCS Lender</b> ( <i>Upon termination of Agreement</i> )
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

## **APPENDIX D - Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures**

### **CONTRACTOR REQUIREMENTS AND OBLIGATIONS UNDER NEW YORK STATE EXECUTIVE LAW, ARTICLE 15-A (PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS)**

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#### **I. General Provisions**

- A. The Department is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 (“MWBE Regulations”) for all “State contracts” as defined therein, with a value (1) in excess of \$25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of \$100,000 for real property renovations and construction.
- B. Contractor agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State Department (the “Department”), to fully comply and cooperate with the Department in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women (“EEO”) and contracting opportunities for certified minority and women-owned business enterprises (“MWBEs”). Contractor’s demonstration of “good faith efforts” pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the “Human Rights Law”) or other applicable federal, state or local laws.
- C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to section VII of this Appendix or enforcement proceedings as allowed by the Contract.

#### **II. Contract Goals**

- A. For purposes of the Contract, the Department established an overall goal of 20% for Minority and Women-Owned Business Enterprises (“MWBE”) participation as subcontractors and suppliers, as relates only to the administrative cost component of the overall cost of the Contract.
- B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in section II-A above, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address:  
<http://www.nylovesmwbe.ny.gov/cf/search.cfm>

Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on this Contract.

- C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document “good faith efforts” to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the Department for liquidated or other appropriate damages, as set forth herein.

#### **III. Equal Employment Opportunity (EEO)**

- A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.
- B. Contractor shall comply with the following provisions of Article 15-A:
1. Contractor and subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
  2. The Contractor shall submit an EEO policy statement to the Department within seventy two (72) hours after the date of the notice by Department of proposed award of the Contract to the Contractor.
  3. If Contractor or subcontractor does not have an existing EEO policy statement, the Department may provide the Contractor or subcontractor a model statement (see Form EEO-102 entitled "Minority and Women-Owned Business Enterprises M/WBE - Equal Employment Opportunity (EEO) Policy Statement).
  4. The Contractor's EEO policy statement shall include the following language:
    - a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
    - b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.
    - c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
    - d. The Contractor will include the provisions of sections (a) through (c) of this subsection 4 and paragraph "E" of this section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.
- C. Form EEO-100 – EEO Staffing Plan  
To ensure compliance with this section III, the Contractor shall submit an EEO Staffing Plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. The Contractor shall complete the EEO Staffing Plan form and submit it as part of its Proposal or within a reasonable time, but no later than the time of proposed award of the Contract.
- D. Form EEO-101 - Workforce Utilization/Compliance Report ("Workforce Report")

1. Once proposed contract award has been made and during the term of Contract, Contractor is responsible for updating and providing notice to the Department of any changes to the previously submitted EEO Staffing Plan. This information is to be submitted on a quarterly basis during the term of the Contract to report the actual workforce utilized in the performance of the Contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
  2. Separate forms shall be completed by Contractor and any subcontractor performing work on the Contract.
  3. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the Contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Workforce Report and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the Contract.
- E. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

**IV. MWBE Utilization Plan Form (MWBE-100) and Certification of Good Faith Efforts (Form MWBE-104)**

- A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan (form MWBE-100) either prior to, or at the time of, the execution of the Contract for Department consideration and acceptance. The Contractor shall ensure that enterprises have been identified within the MWBE Utilization Plan, and the Contractor shall attempt, in good faith, to utilize such enterprise(s) at least to the extent indicated in the Contractor's MWBE Utilization Plan as accepted by the Department. The Contractor must document "good faith efforts" to provide meaningful participation by New York State Certified MWBE subcontractors or suppliers in the performance of the Contract. In support of such efforts, the Contractor will include with its MWBE Utilization Plan submission a Certification of Good Faith Efforts statement (Form MWBE-104).
- B. Contractor agrees to use such MWBE Utilization Plan, as accepted by the Department, for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in section III-A of this Appendix D.
- C. Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, Department shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

**V. Waiver Requests (MWBE-101)**

- A. For Waiver Requests Contractor should use Form MWBE-101 – Request for Waiver Form.

- B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver Form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the Waiver Request is complete, the Department shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.
- C. If the Department, upon review of the MWBE Utilization Plan and updated Quarterly M/WBE Contractor Compliance Reports determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the Department may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

**VI. Quarterly M/WBE Contractor Compliance Report (Form MWBE-103)**

Contractor is required to submit a Quarterly M/WBE Contractor Compliance Report (Form MWBE-103) to the Department by the 10th day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract.

**VII. Liquidated Damages - MWBE Participation**

- A. Where Department determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, Contractor shall be obligated to pay to the Department liquidated damages.
- B. Such liquidated damages shall be calculated as an amount equaling the difference between:
  - 1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
  - 2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.
- C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the Department, Contractor shall pay such liquidated damages to the Department within sixty (60) days after they are assessed by the Department unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development pursuant to subdivision 8 of section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the Department.

**VII. Further Information:**

General questions concerning New York's MWBE program should be directed to:

New York State Department of Economic Development  
633 Third Avenue  
New York, NY 10017  
Telephone: (212) 803-2414

New York State Department of Economic Development  
Division of Minority and Women's Business Development  
30 South Pearl Street  
Albany, NY 12245  
Telephone: (518) 292-5150



All of the EEO and M/WBE forms referenced herein this Appendix D are available for download at the Department's website at: <http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm>). These forms are to be submitted without change to the goals specified by Department in the Contract.

## Exhibit I.A - Proposal Submission Requirement Checklist

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Please indicate by checkmark that your Proposal meets **each** of the following submission requirements:

- 1. TIMELY SUBMISSION:** Proposal submitted to assure receipt by the Department no later than 3:00 p.m. ET on the Proposal Due Date as indicated in RFP Section II.A.1.
- 2. FORMATTING REQUIREMENTS:** The Offeror's Proposal must be organized in three parts: Administrative Proposal; Technical Proposal and Cost Proposal and each part must each comply with the formatting requirements stated in Section II.A.7.a and II.A.7.b of this RFP.
- a. Twelve (12) separately bound hardcopies – **two (2) Originals each of the Administrative Proposal, Technical Proposal and Cost Proposal** containing original documents (i.e., original signatures, no photocopies) and marked and numbered (i.e., "ORIGINAL #1" and "ORIGINAL #2."), **ten (10) copies of each Administrative Proposal, Technical Proposal and Cost Proposal** marked and numbered (i.e., "COPY #1," "COPY #2," etc.) and a separate CD for the Administrative, Technical and Cost Proposal.
  - b. Proposals must be prepared in Adobe Acrobat, with the exception of certain cost and provider network exhibits that have specific formatting instructions.
  - c. Each Administrative, Technical and Cost Proposal must be separately bound and externally labeled with "Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan" and Offeror's name(s). (No cost information [i.e., \$ quotes] can be referenced in the Administrative or Technical Proposal.
  - d. Table of Contents
  - e. Index Tabs
  - f. Pagination
  - g. Updates/Corrections
  - h. Required Content of Proposals - The Proposal shall consist of three parts: the Administrative Proposal must contain the documentation required in Section III of this RFP. The Technical Proposal must be responsive to the programmatic duties and responsibilities set forth in Section IV of this RFP. The Cost Proposal must demonstrate a commitment to perform all programmatic duties and responsibilities in accordance with Section V of this RFP.
- 3. REQUIRED CONTENT OF THE ADMINISTRATIVE PROPOSAL:** The Administrative Proposal must contain the following information, in the order enumerated below:
- A. **Formal Offeror Letter:** The Offeror must submit a formal offer in the form of the "Formal Offer Letter" as set forth in RFP, Exhibit I.S in accordance with the requirements set forth in RFP, Section III.A
  - B. **Minimum Mandatory Requirements:** The Offeror must submit a completed Exhibit I.T "Offeror Attestations Form" containing the representations and warranties set forth therein.
  - C. **Exhibits:** The Offeror must complete and submit the Exhibits specified in Section III.C as follows:
    - Exhibit I.A Proposal Submission Requirement Checklist
    - Exhibit I.D MacBride Statement and Non-Collusive Bidding Certification
    - Exhibit I.G EEO Staffing Plan (form EEO-100)
    - Exhibit I.I New York State Standard Vendor Responsibility Questionnaire
    - Exhibit I.K Offeror's Affirmation of Understanding & Agreement

## Exhibit I.A - Proposal Submission Requirement Checklist

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### C. **Exhibits** Continued

- \_\_\_ Exhibit I.M Compliance with Public Officers Law Requirements
- \_\_\_ Exhibit I.N Compliance with Americans with Disabilities Act
- \_\_\_ Exhibit I.O MWBE Utilization Plan (form MWBE-100)
- \_\_\_ Exhibit I.P Offeror's Certification of Compliance Pursuant to State Finance Law §139-k
- \_\_\_ Exhibit I.Q Certification of Good Faith Efforts (form MWBE-104)
- \_\_\_ Exhibit I.S Formal Offer Letter
- \_\_\_ Exhibit I.T Offeror Attestations Form
- \_\_\_ Exhibit I.U Key Subcontractors
- \_\_\_ Exhibit I.V Program References
- \_\_\_ Exhibit I.X Extraneous Terms
- \_\_\_ Exhibit I.Y.2 Offeror's Proposed MHSA Network
- \_\_\_ Exhibit I.Y.3 Offeror's MHSA Network Pre-requisite Worksheet
- \_\_\_ Exhibit I.Y.4 Comparison of Current Program Providers to Offeror's MHSA Network
- \_\_\_ Exhibit I.Z Confidentiality Agreement and Certificate of Non-Disclosure

- \_\_\_ D. **Key Subcontractors:** The Offeror must provide a statement identifying all Key Subcontractors, if any, that the Offeror will be contracting with to provide program services and must, for each such Key Subcontractor identified, complete and submit **Exhibit I.U "Key Subcontractors"**:
1. provide a brief description of the services to be provided by the Key Subcontractor; and
  2. provide a description of any current relationships with such Key Subcontractor and the clients/projects that the Offeror and Key Subcontractor are currently servicing under a formal legal agreement or arrangement, the date when such services began and the status of the project.

The Offeror must indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Key Subcontractor for services to be provided by the Key Subcontractor relating to this RFP. If the Offeror will not be subcontracting with any Key Subcontractor(s) to provide program services, the Offeror must provide a statement to that effect.

- \_\_\_ E. **Reference Checks:** The Offeror must provide four (4) references of current clients and one reference of a former client(s) for a total of Five (5) references, for whom the Offeror has supplied services similar to those describe in this RFP. The number of covered lives covered by the Offeror for each referenced client must be at least 100,000. For each client reference provided, the Offeror must complete and submit **Exhibit I.V "Program References."** The Offeror shall be solely responsible for providing contact names, e-mail addresses and phone numbers of client references who are readily available to be contacted by the State.

- \_\_\_ F. **Financial Statements:** The Offeror must provide a copy of the Offeror's last issued GAAP annual audited financial statement. A complete set of statements, not just excerpts, must be provided. Additionally, for each Key Subcontractor, if any, that provides any of the program services; provide the most recent GAAP annual audited statement. If the Offeror, or a Key Subcontractor, is a privately held business and is unwilling to provide copies of their GAAP annual audited financial statements as part

## Exhibit I.A - Proposal Submission Requirement Checklist

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of their Proposal, the Offeror/Key Subcontractor must make arrangements for the procurement evaluation team to review the financial statements

**NOTE:** If financial statements have not been prepared and/or audited, the Offeror must provide the following as part of its Administrative Proposal a letter from a bank reference attesting to the Offeror's financial viability and creditworthiness. (Note: for purposes of this reference, the Offeror may not give as a reference, a parent or subsidiary company, a partner or an affiliate organization. For the purpose of this requirement, "affiliate" means an organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another organization, is controlled by another organization, or is, along with another organization, under the control of a common parent.) The letter must include the bank's name, address, contact person name and telephone number and it must address, at a minimum, the following items:

1. a brief description of the business relationship between the parties (i.e., the Offeror and the bank), including the duration of the relationship and the Offeror's current standing with the bank. For example: "*The Offeror is currently and has been for "x" number of years a client in good standing.*";
2. a description of any ownership/partner relationship that may exist between the parties, if any. (Note: One party cannot be the parent, partner or subsidiary of the other, nor can one party be an affiliate of the other.); and,
3. any other facts or conclusions the bank may deem relevant to the State in regard to the bank's assessment of the Offeror's financial viability and creditworthiness concerning the nature and scope of the Project Services, which are the subject matter of this RFP, and the parties (i.e., DCS and the Offeror) contractual obligations should it be awarded the resultant contract(s).

\_\_\_ **4. REQUIRED CONTENT OF THE TECHNICAL PROPOSAL:** The Technical Proposal must be responsive to the duties and responsibilities and submission requirements set forth in Section IV of this RFP and it must contain the following information, in accordance with the submissions associated requirements, and in the order enumerated below:

\_\_\_ **A. Program Administration**

- \_\_\_ 1. Executive Summary
- \_\_\_ 2. General Qualifications of the Offeror

\_\_\_ **B. Proposed Empire Plan MHPA Program Services**

- \_\_\_ 1. Account Team
- \_\_\_ 2. Premium Development Services
- \_\_\_ 3. Implementation
- \_\_\_ 4. Customer Service
- \_\_\_ 5. Enrollee Communication Support
- \_\_\_ 6. Enrollment Management
- \_\_\_ 7. Reporting
- \_\_\_ 8. Consulting
- \_\_\_ 9. Transition and Termination of Agreement
- \_\_\_ 10. Network Management
- \_\_\_ 11. Claims Processing
- \_\_\_ 12. Clinical Management
- \_\_\_ 13. Other Clinical Management Programs

## **Exhibit I.A - Proposal Submission Requirement Checklist**

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\_\_\_ **5. REQUIRED CONTENT OF THE COST PROPOSAL:** The Offeror's Cost Proposal must demonstrate that it will execute the duties and responsibilities set forth in Section V of this RFP and it must contain the following cost exhibits in strict accordance with the directions set forth in this RFP:

\_\_\_ Exhibit V.A Claims Analysis

\_\_\_ Exhibit V.B Applied Behavioral Analysis Fee Quote

\_\_\_ Exhibit V.C Administrative Fee Evaluation

\_\_\_ **6. REQUESTED REDACTIONS CD and HARD COPY:** The FOIL-related materials described herein which the Offeror is requested to provide per RFP, Section II.B.8 will not be considered part of the Offeror's Proposal and will not be reviewed as a part of the Procurement's evaluation process. Notwithstanding this they have been identified in this Checklist as a reminder to Offerors of the need to provide the requested items.

At the time of Proposal submission the Offeror is requested to submit:

\_\_\_ A. Exhibit I.C Freedom of Information Law – Request for Redaction Chart

\_\_\_ B. Separately bound hardcopy of the Administrative Proposal, Technical Proposal, and Cost Proposal with each specific item requested to be protected from FOIL disclosure by highlighting in yellow.

\_\_\_ C. Electronic copy (on CD in Adobe Acrobat Professional software, version 8 or higher) of the complete Proposal noting each the specific item requested to be protected from FOIL which contains no more than three pdf files; one for each part of the Proposal (Administrative Proposal, Technical Proposal, and Cost Proposal).

**Exhibit I.B - BIOGRAPHICAL SKETCH FORM**

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**INSTRUCTION:** Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

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**Name:** \_\_\_\_\_

**Job Title:** \_\_\_\_\_

**Relationship to Project:** \_\_\_\_\_

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**EDUCATION**

<u>Institution &amp; Location</u>	<u>Degree</u>	<u>Year Conferred</u>	<u>Discipline</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**PROFESSIONAL EMPLOYMENT** (Start with most recent.)

<u>Dates From - To</u>	<u>Employer</u>	<u>Title</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PROFESSIONAL EXPERIENCE** (Significant experience/education relevant to program)

_____
_____
_____
_____

**Exhibit I.C - Freedom of Information Law – Request for Redaction Chart**

\_\_\_\_\_ (Name of Company)

Proposal Dated \_\_\_\_\_

In Response to the Procuring Agencies Request for Proposals entitled **Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, and Student Employee Health Plan**

- Offeror asserts that the information noted in the table below constitutes proprietary and/or trade secret information and desires that such information not be disclosed if requested pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law.
  
- Offeror makes NO assertion that any information in its Proposal, in whole or in part, should be protected from FOIL disclosure.

<b>Administrative Proposal:</b>		
<b>Requested Redaction Page #'s and Proposal Sections or Exhibit/Attachment #</b>	<b>Description</b>	<b>Offeror Rationale for Proposed Redaction</b>
<i>Insert rows above as necessary</i>		
<b>Technical Proposal:</b>		
<b>Requested Redaction Page #'s and Proposal Sections or Exhibit/Attachment #</b>	<b>Description</b>	<b>Offeror Rationale for Proposed Redaction</b>
<i>Insert rows above as necessary</i>		
<b>Cost Proposal:</b>		
<b>Requested Redaction Page #'s and Proposal Sections or Exhibit/Attachment #</b>	<b>Description</b>	<b>Offeror Rationale for Proposed Redaction</b>
<i>Insert rows above as necessary</i>		

**REDACTION CHART**

Please provide specific justification for each item for which you seek protection from FOIL disclosure. An appropriate justification may any one or more of the following considerations by which to demonstrate reasonably whether the item for which you seek protection may be excepted from disclosure:

- a) the confidential nature of the specific item, including a description of the nature and extent of the injury to the Offeror's competitive position, such as unfair economic or competitive damage, which would be incurred were the information/record to be disclosed;
- b) whether the specific information/record is treated as confidential by the Offeror, including whether it ever has been made available to any person or entity;
- c) whether any patent, copyright, or similar legal protection exists for the specific item of information;
- d) whether the public disclosure of the information/record is otherwise restricted by law, and the specific source and content of such restriction;
- e) the date upon which the information/record no longer will need to be kept confidential, if applicable;
- f) whether the item of information is known by anyone outside the Offeror's business or organization;
- g) the extent to which the information is known by Offeror's employees and others involved in the Offeror's business;
- h) the value of the specific information/record to the Offeror and to its competitors;
- i) the amount of effort or money expended by the Offeror in developing the information/record; and
- j) the ease or difficulty with which the information could be properly acquired or duplicated (not merely copied) for use by others.



**Exhibit I.D – MacBride and Non-Collusive Bidding Certification**

**NON-DISCRIMINATION IN EMPLOYMENT IN NORTHERN IRELAND**  
**MACBRIDE FAIR EMPLOYMENT PRINCIPLES**

In accordance with Chapter 807 of the Laws of 1992 the Offeror, by submission of this bid, certifies that it or any individual or legal entity in which the Offeror holds a 10% or greater ownership interest, or any individual or legal entity that holds a 10% or greater ownership interest in the Offeror, either (answer "yes" or "no" to one or both of the following, as applicable):

Have business operations in Northern Ireland. Yes \_\_\_\_\_ or No \_\_\_\_\_

If yes:

Shall take lawful steps in good faith to conduct any business operations they have in Northern Ireland in accordance with the MacBride Fair Employment Principles relating to nondiscrimination in employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such Principles. Yes \_\_\_\_\_ or No \_\_\_\_\_

**NON-COLLUSIVE BIDDING CERTIFICATION**

By submission of this bid, each Offeror and each person signing on behalf of any Offeror certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of his knowledge and belief:

1. The prices in this bid have been arrived at independently without collusion, consultation, communication or agreement for the purpose of restricting competition, as to any matter relating to such prices with any other Offeror or with any competitor;
2. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the Offeror and will not knowingly be disclosed by the Offeror prior to opening, directly or indirectly, to any other Offeror or to any competitor; and
3. No attempt has been made or will be made by the Offeror to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature*

**PRINT:**

**SIGNATORY'S NAME** \_\_\_\_\_ **TITLE** \_\_\_\_\_

**INDIVIDUAL, CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT**

STATE OF \_\_\_\_\_ }  
  :    **SS.:**  
COUNTY OF \_\_\_\_\_ }

On the \_\_\_\_ day of \_\_\_\_\_ in the year 20\_\_\_\_, before me personally appeared:

\_\_\_\_\_, known to me to be the person who executed the foregoing

instrument, who, being duly sworn by me did depose and say that \_he resides at \_\_\_\_\_, Town of

\_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_; and

further that, if applicable:

**[Check One, If Applicable]**

( \_\_\_ **If a corporation**): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, \_he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

( \_\_\_ **If a partnership**): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the partnership described in said instrument; that, by the terms of said partnership, \_he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

\_\_\_\_\_  
**Notary Public**



New York State Department of Taxation and Finance

**Contractor Certification to Covered Agency**  
 (Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

**ST-220-CA**  
 (6/06)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help? on back*).

Contractor name		For covered agency use only Contract number or description
Contractor's principal place of business	City State ZIP code	
Contractor's mailing address (if different than above)		Estimated contract value over the full term of contract (but not including renewals)
Contractor's federal employer identification number (EIN)	Contractor's sales tax ID number (if different from contractor's EIN)	
Contractor's telephone number	Covered agency name	\$
Covered agency address		Covered agency telephone number

I, \_\_\_\_\_, hereby affirm, under penalty of perjury, that I am \_\_\_\_\_

(name)

(title)

of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an X in only one box)

- The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.
- The contractor has previously filed Form ST-220-TD with the Tax Department in connection with \_\_\_\_\_  
 (insert contract number or description)  
 and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this \_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_

\_\_\_\_\_  
 (sign before a notary public)

\_\_\_\_\_  
 (title)

**Instructions**

**General information**

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency*, with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. This publication is available on our Web site, by fax, or by mail. (See *Need help?* for more information on how to obtain this publication.) In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

If you have questions, please call our information center at 1 800 698-2931.

**Note:** Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

**When to complete this form**

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

- i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);
- ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and
- iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of \$100,000 and (b) is a contract for *commodities or services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned on or after April 26, 2006 (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the \_\_\_ day of \_\_\_\_\_ in the year 20\_\_\_, before me personally appeared \_\_\_\_\_,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
\_he resides at \_\_\_\_\_,
Town of \_\_\_\_\_,
County of \_\_\_\_\_,
State of \_\_\_\_\_; and further that:

[Mark an X in the appropriate box and complete the accompanying statement.]

- (If an individual): \_he executed the foregoing instrument in his/her name and on his/her own behalf.
(If a corporation): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, \_he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.
(If a partnership): \_he is a \_\_\_\_\_ of \_\_\_\_\_, the partnership described in said instrument; that, by the terms of said partnership, \_he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.
(If a limited liability company): \_he is a duly authorized member of \_\_\_\_\_, LLC, the limited liability company described in said instrument; that \_he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public
Registration No.

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).
This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.
Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.
Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.
This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?
Internet access: www.nystax.gov (for information, forms, and publications)
Fax-on-demand forms: 1 800 748-3676
Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday. 1 800 698-2931
To order forms and publications: 1 800 462-8100
From areas outside the U.S. and outside Canada: (518) 485-6800
Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110
Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.



**Contractor Certification**

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a (see Need help? below)*.

Contractor name				
Contractor's principal place of business		City	State	ZIP code
Contractor's mailing address (if different than above)				
Contractor's federal employer identification number (EIN)		Contractor's sales tax ID number (if different from contractor's EIN)		Contractor's telephone number ( )
Covered agency or state agency	Contract number or description		Estimated contract value over the full term of contract (but not including renewals) \$	
Covered agency address			Covered agency telephone number	

**General information**

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded certain state contracts valued at more than \$100,000 to certify to the Tax Department that they are registered to collect New York State and local sales and compensating use taxes, if they made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000, measured over a specified period. In addition, contractors must certify to the Tax Department that each affiliate and subcontractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. Contractors must also file a Form ST-220-CA, certifying to the procuring state entity that they filed Form ST-220-TD with the Tax Department and that the information contained on Form ST-220-TD is correct and complete as of the date they file Form ST-220-CA.

All sections must be completed including all fields on the top of this page, all sections on page 2, Schedule A on page 3, if applicable, and Individual, Corporation, Partnership, or LLC Acknowledgement on page 4. If you do not complete these areas, the form will be returned to you for completion.

For more detailed information regarding this form and section 5-a of the Tax Law, see Publication 223, *Questions and Answers Concerning Tax Law Section 5-a, (as amended, effective April 26, 2006)*, available at [www.nystax.gov](http://www.nystax.gov). Information is also available by calling the Tax Department's Contractor Information Center at 1 800 698-2931.

**Note:** Form ST-220-TD must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 4 of this form must be completed before a notary public.

Mail completed form to:

**NYS TAX DEPARTMENT  
DATA ENTRY SECTION  
W A HARRIMAN CAMPUS  
ALBANY NY 12227**

**Privacy notification**

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).





This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227.

**Need help?**

	<b>Internet access:</b> <a href="http://www.nystax.gov">www.nystax.gov</a> (for information, forms, and publications)	
	<b>Fax-on-demand forms:</b>	1 800 748-3676
	<b>Telephone assistance</b> is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.	
	To order forms and publications:	1 800 462-8100
	<b>Sales Tax</b> Information Center:	1 800 698-2909
	From areas outside the U.S. and outside Canada:	(518) 485-6800
	<b>Hearing and speech impaired</b> (telecommunications device for the deaf (TDD) callers only):	1 800 634-2110
	<b>Persons with disabilities:</b> In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.	

I, \_\_\_\_\_, hereby affirm, under penalty of perjury, that I am \_\_\_\_\_  
*(name)* *(title)*  
of the above-named contractor, and that I am authorized to make this certification on behalf of such contractor.

**Complete Sections 1, 2, and 3 below. Make only one entry in each section.**

**Section 1 — Contractor registration status**

- The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made. The contractor is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law, and is listed on Schedule A of this certification.
- The contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

**Section 2 — Affiliate registration status**

- The contractor does not have any affiliates.
- To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each affiliate exceeding the \$300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each affiliate exceeding the \$300,000 cumulative sales threshold during such quarters on Schedule A of this certification.
- To the best of the contractor's knowledge, the contractor has one or more affiliates, and each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

**Section 3 — Subcontractor registration status**

- The contractor does not have any subcontractors.
- To the best of the contractor's knowledge, the contractor has one or more subcontractors having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each subcontractor exceeding the \$300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each subcontractor exceeding the \$300,000 cumulative sales threshold during such quarters on Schedule A of this certification.
- To the best of the contractor's knowledge, the contractor has one or more subcontractors, and each subcontractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Sworn to this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_

\_\_\_\_\_  
*(sign before a notary public)*

\_\_\_\_\_  
*(title)*

**Schedule A — Listing of each entity (contractor, affiliate, or subcontractor) exceeding \$300,000 cumulative sales threshold**

List the contractor, or affiliate, or subcontractor in Schedule A only if such entity exceeded the \$300,000 cumulative sales threshold during the specified sales tax quarters. See directions below. For more information, see Publication 223.

A Relationship to Contractor	B Name	C Address	D Federal ID Number	E Sales Tax ID Number	F Registration in progress

Column A – Enter **C** in column A if the contractor; **A** if an affiliate of the contractor; or **S** if a subcontractor.

Column B – Name - If the entity is a corporation or limited liability company, enter the exact legal name as registered with the NY Department of State, if applicable. If the entity is a partnership or sole proprietor, enter the name of the partnership and each partner's given name, or the given name(s) of the owner(s), as applicable. If the entity has a different DBA (doing business as) name, enter that name as well.

Column C – Address - Enter the street address of the entity's principal place of business. Do not enter a PO box.

Column D – ID number - Enter the federal employer identification number (EIN) assigned to the entity. If the entity is an individual, enter the social security number of that person.

Column E – Sales tax ID number - Enter only if different from federal EIN in column D.

Column F – If applicable, enter an X if the entity has submitted Form DTF-17 to the Tax Department but has not received its certificate of authority as of the date of this certification.

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the \_\_\_ day of \_\_\_\_\_ in the year 20\_\_\_, before me personally appeared \_\_\_\_\_,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
\_he resides at \_\_\_\_\_,
Town of \_\_\_\_\_,
County of \_\_\_\_\_,
State of \_\_\_\_\_; and further that:

[Mark an X in the appropriate box and complete the accompanying statement.]

- (If an individual): \_he executed the foregoing instrument in his/her name and on his/her own behalf.
(If a corporation): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, \_he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.
(If a partnership): \_he is a \_\_\_\_\_ of \_\_\_\_\_, the partnership described in said instrument; that, by the terms of said partnership, \_he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.
(If a limited liability company): \_he is a duly authorized member of \_\_\_\_\_ LLC, the limited liability company described in said instrument; that \_he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public
Registration No. \_\_\_\_\_



State of New York  
 Department of Civil Service  
 Alfred E. Smith State Office Building  
 Albany, NY 12239

**EQUAL EMPLOYMENT OPPORTUNITY STAFFING PLAN**

OFFICE OF FINANCIAL ADMINISTRATION

EEO-100 (9/2011)

Solicitation No.:	Reporting Entity: <input type="checkbox"/> Contractor <input type="checkbox"/> Subcontractor	Report includes: <input type="checkbox"/> Contractor's work force to be utilized on this contract <input type="checkbox"/> Contractor's total work force <input type="checkbox"/> Subcontractor's work force to be utilized on this contract <input type="checkbox"/> Subcontractor's total work force
Contractor/Subcontractor's Name:		
Contractor/Subcontractor's Address:		
FEIN:		

**Enter the total number of employees in each classification in each of the EEO-Job Categories identified.**

EEO Job Categories	Total Work Force	Work force by Gender		Work force by Race/Ethnic Identification								Disabled Individual		Veteran				
		Total Male (M)	Total Female (F)	White (M) (F)		Black (M) (F)		Hispanic (M) (F)		Asian (M) (F)		American Indian or Alaskan Native (M) (F)		(M)	(F)	(M)	(F)	
Executive/Senior level Officials & Managers																		
First/Mid level officials & Managers																		
Professionals																		
Technicians																		
Sales Workers																		
Administrative Support Workers																		
Craft Workers																		
Operatives																		
Laborers and Helpers																		
Service Workers																		
Totals																		

<b>PREPARED BY (Signature):</b>	<b>TELEPHONE NO.:</b>	<b>DATE:</b>
	<b>EMAIL ADDRESS:</b>	
<b>NAME AND TITLE OF PREPARER (Print or Type):</b>		





State of New York  
Department of Civil Service  
Alfred E. Smith State Office Building  
Albany, NY 12239

## EQUAL EMPLOYMENT OPPORTUNITY STAFFING PLAN

OFFICE OF FINANCIAL ADMINISTRATION

EEO-100 (9/2011)

Page 2 of 2

**General Instructions:** All Offerors must complete an EEO Staffing Plan (EEO 100) and submit it as part of the bid or proposal package. Where the work force to be utilized in the performance of the State contract can be separated out from the contractor's total work force, the Offeror shall complete this form only for the anticipated work force to be utilized on the State contract. Where the work force to be utilized in the performance of the State contract cannot be separated out from the contractor's total work force, the Offeror shall complete this form for the contractor's total work force. Subcontractors awarded a subcontract over \$25,000 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor must complete this form upon request of the Department.

### Instructions for completing:

1. Enter the Solicitation Number that this report applies to along with the name and address of the Offeror (contractor).
2. Check off the appropriate box to indicate if the report is the contractor or a subcontractor.
3. Check off the appropriate box to indicate if the contractor's/subcontractor's work force being reported is just for the contract or the total work force.
4. Enter the total work force by EEO job category.
5. Break down the total work force by gender and enter under the heading "Work force by Gender."
6. Break down the total work force by race/ethnic background and enter under the heading "Work force by Race/Ethnic Identification."
7. Enter information on any disabled or veteran employees included in the work force under the appropriate heading.
8. Enter the name, title, phone number and email address for the person completing the form. Sign and date the form in the designated boxes.

### RACE/ETHNIC IDENTIFICATION

Race/ethnic designations as used by the Equal Employment Opportunity Commission do not denote scientific definitions of anthropological origins. For the purposes of this report, an employee may be included in the group to which he or she appears to belong, identifies with, or is regarded in the community as belonging. However, no person should be counted in more than one race/ethnic group. The race/ethnic categories for this survey are:

**WHITE:** (Not of Hispanic origin) All persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

**BLACK:** A person, not of Hispanic origin, who has origins in any of the black racial groups of the original peoples of Africa.

**HISPANIC:** A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.

**ASIAN & PACIFIC ISLANDER:** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent or the Pacific Islands.

**AMERICAN INDIAN OR ALASKAN NATIVE (Not of Hispanic Origin):** A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

**DISABLED INDIVIDUAL** - any person who:

- has a physical or mental impairment that substantially limits one or more major life activity
- has a record of such an impairment; or
- is regarded as having such an impairment.

**VIETNAM ERA VETERAN:** A veteran who served at any time between and including January 1, 1963 and May 7, 1975.

## **Exhibit I.H - NYS Department of Civil Service Debriefing Guidelines**

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NYS State Finance Law §163(9)(c), as amended by Section 3 of Chapter 137 of the Laws of 2008, requires that:

*“A state agency shall, upon request, provide a debriefing to any unsuccessful offerer<sup>1</sup> that responded to a request for proposal or an invitation for bids, regarding the reasons that the proposal or bid submitted by the unsuccessful offerer was not selected for an award. The opportunity for an unsuccessful offerer to seek a debriefing shall be stated in the solicitation, which shall provide a reasonable time for requesting a debriefing.”*

The Procurement Council Guidelines define “Debriefing” as:

*The practice whereby, upon the request of a bidder, the state agency advises such bidder of the reasons why its bid was not selected for an award. It is viewed as a learning process for the bidder to be better prepared to participate in future procurements.*

In accordance with the law, the Department shall make a Debriefing available to any entity that submitted a proposal or bid in response to a given solicitation (“Offeror”), including the selected Offeror after notice award is made by the Department. All Offerors shall be given written notice of award, via email with hardcopy to follow.

### **Timeframes associated with requesting/conducting Debriefings:**

Debriefing must be requested by Offerors in writing to the designated individual or email address as set forth in the notice of award.

- **Pre-Award Debriefings:**

Any Offeror, upon request, will be afforded an opportunity for a pre-award Debriefing at least five business days prior to the date by which any protest must be filed. An Offeror’s failure to timely request a pre-award Debriefing shall not cause an extension of the time period within which a protest must be filed. In those cases where the Offeror fails to make a timely request for a pre-award Debriefing, the Department will schedule the Debriefing as soon after the time the request is made as it deems practicable.

- **Post-Award Debriefings:**

In the case of requests made by an Offeror(s) for a post-award Debriefing, the request must be received by the Department not more than twenty calendar days after final approval of the contract is received or the date the award is posted on OSC’ website at the address set forth below and the Department will schedule the Debriefing as soon after the time the request is made as it deems practicable.

<http://wwe1.osc.state.ny.us/transparency/contracts/contractsearch.cfm>

### **How Debriefings shall be conducted by the Department:**

A Debriefing may be requested by any unsuccessful Offeror after a contract award is made regarding the reasons that the proposal or bid submitted by the unsuccessful Offeror was not selected for award. While a Debriefing is typically conducted in person, it may be conducted

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<sup>1</sup> For purposes of this policy, the terms Offeror, Offerer and Bidder are understood to have same meaning.

## **Exhibit I.H - NYS Department of Civil Service Debriefing Guidelines**

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by video conference, over the phone, or through written summaries, if agreed to by the Offeror.

Since Debriefings are intended to make the procurement process open and transparent and to help the vendor community become more viable competitors for New York State goods and services, when conducting a Debriefing, the Department will, at a minimum, discuss the strengths and weaknesses of the Offeror's proposal and provide information as to the relative rating of the Offeror's proposal in each of the major evaluation categories as provided for in the solicitation document. Typically such a debriefing will include information as to the rating of the Offeror's proposal in both the technical and cost components of the evaluation and an identification of any areas in the proposal deemed deficient. The Department will not provide any documents/materials at a Debriefing as their release is subject to NYS FOIL laws.

During a pre-award Debriefing, the Department:

- will limit the discussion to the reasons why the Offeror's proposal/bid was unsuccessful;
- will not provide information concerning any other Offerors' proposals, including the winning proposal; will not discuss any other aspects of the Procurement Record, including but not limited to the detailed scoring and evaluation criteria as such information is subject to NYS FOIL laws; and
- may, but is not required to, offer general advice and guidance to the Offeror for the Offeror's consideration as regards future bidding opportunities.

During a post-award Debriefing, the Department:

- will provide information as to the reasons why the Offeror's proposal/bid was unsuccessful;
- will provide information concerning the other Offerors' proposals, including the winning proposal, but only in the context of the bid evaluation scoring;
- will not discuss specific details of other Offerors' proposals, including their individual strengths and weakness as such information is subject to NYS FOIL laws
- will not discuss any other aspects of the Procurement Record, including but not limited to the detailed scoring and evaluation criteria as such information is subject to NYS FOIL laws and
- may offer advice and guidance to the Offeror for the Offeror's consideration as regards future bidding opportunities, including those services which were the subject matter of the procurement.

General:

- ✓ The Department will schedule the same amount of time for each Offeror who requests a debriefing.
- ✓ Debriefing will not be scheduled for more than one hour.
- ✓ Debriefings will be held individually with a requesting Offeror.
- ✓ The Department's Designated Agency Contact (i.e., the Procurement Manager) is the sole person authorized to schedule a Debriefing.
- ✓ The Offeror must provide a list of intended attendees prior to the Debriefing, including their titles or relationship to the Offeror and notify the Department if the Offeror is intending to bring legal counsel, so that the Department can notify agency legal counsel.
- ✓ At a minimum at least two agency employees must be present at each Debriefing.

## **Exhibit I.H - NYS Department of Civil Service Debriefing Guidelines**

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- ✓ Debriefings will not be taped or transcribed by the Department, and Offerors are prohibited from taping the Debriefing.
- ✓ Any discussion of a proposal's strengths and weaknesses will relate to scoring of that bid submission against the RFP requirements, not against a competitor's proposal. The Department will not discuss the relative merits of one Offeror's submission against its competitors as that is not how proposals are evaluated and scored.
- ✓ Requests for copies of documents made by an Offeror at the Debriefing must be handled in accordance with the Department's FOIL procedures.

April 2011

## NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE FOR-PROFIT BUSINESS ENTITY

You have selected the For-Profit Non-Construction questionnaire which may be printed and completed in this format or, for your convenience, may be completed online using the New York State VendRep System.

### COMPLETION & CERTIFICATION

The person(s) completing the questionnaire must be knowledgeable about the vendor's business and operations. An owner or officer must certify the questionnaire and the signature must be notarized.

### DEFINITIONS

All underlined terms are defined in the "New York State Vendor Responsibility Definitions List," found at <http://www.osc.state.ny.us/vendrep/documents/definitions.pdf>. These terms may not have their ordinary, common or traditional meanings. Each vendor is strongly encouraged to read the respective definitions for any and all underlined terms. By submitting this questionnaire, the vendor agrees to be bound by the terms as defined in the "New York State Vendor Responsibility Definitions List" existing at the time of certification.

### RESPONSES

Every question must be answered. Each response must provide all relevant information which can be obtained within the limits of the law. However, information regarding a determination or finding made in error which was subsequently corrected is not required. Individuals and Sole Proprietors may use a Social Security Number but are encouraged to obtain and use a federal Employer Identification Number (EIN).

### REPORTING ENTITY

Each vendor must indicate if the questionnaire is filed on behalf of the entire Legal Business Entity or an Organizational Unit within or operating under the authority of the Legal Business Entity and having the same EIN. Generally, the Organizational Unit option may be appropriate for a vendor that meets the definition of "Reporting Entity" but due to the size and complexity of the Legal Business Entity, is best able to provide the required information for the Organizational Unit, while providing more limited information for other parts of the Legal Business Entity and Associated Entities.

### ASSOCIATED ENTITY

An Associated Entity is one that owns or controls the Reporting Entity or any entity owned or controlled by the Reporting Entity. However, the term Associated Entity does **not** include "sibling organizations" (i.e., entities owned or controlled by a parent company that owns or controls the Reporting Entity), unless such sibling entity has a direct relationship with or impact on the Reporting Entity.

### STRUCTURE OF THE QUESTIONNAIRE

The questionnaire is organized into eleven sections. Section I is to be completed for the Legal Business Entity. Section II requires the vendor to specify the Reporting Entity for the questionnaire. Section III refers to the individuals of the Reporting Entity, while Sections IV-VIII require information about the Reporting Entity. Section IX pertains to any Associated Entities, with one question about their Officials/Owners. Section X relates to disclosure under the Freedom of Information Law (FOIL). Section XI requires an authorized contact for the questionnaire information.

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

I. LEGAL BUSINESS ENTITY INFORMATION			
<u>Legal Business Entity Name</u> *		<u>EIN</u> (Enter 9 digits, without hyphen)	
Address of the <u>Principal Place of Business</u> (street, city, state, zip code)		Telephone ext.	Fax
E-mail		Website	
Additional <u>Legal Business Entity Identities</u> : If applicable, list any other <u>DBA</u> , <u>Trade Name</u> , <u>Former Name</u> , Other Identity, or <u>EIN</u> used in the last five (5) years and the status (active or inactive).			
Type	Name	EIN	Status
1.0 <u>Legal Business Entity Type</u> – Check appropriate box and provide additional information:			
<input type="checkbox"/> <u>Corporation</u> (including <u>PC</u> )		Date of Incorporation	
<input type="checkbox"/> <u>Limited Liability Company</u> ( <u>LLC</u> or <u>PLLC</u> )		Date of Organization	
<input type="checkbox"/> <u>Partnership</u> (including <u>LLP</u> , <u>LP</u> or <u>General</u> )		Date of Registration or Establishment	
<input type="checkbox"/> <u>Sole Proprietor</u>		How many years in business?	
<input type="checkbox"/> Other		Date Established	
If Other, explain:			
1.1 Was the <u>Legal Business Entity</u> formed or incorporated in New York State?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'No,' indicate jurisdiction where <u>Legal Business Entity</u> was formed or incorporated and attach a <u>Certificate of Good Standing</u> from the applicable jurisdiction or provide an explanation if a <u>Certificate of Good Standing</u> is not available.			
<input type="checkbox"/> United States    State    _____			
<input type="checkbox"/> Other            Country    _____			
Explain, if not available:			
1.2 Is the <u>Legal Business Entity</u> publicly traded?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide <u>CIK Code</u> or Ticker Symbol			
1.3 Does the <u>Legal Business Entity</u> have a <u>DUNS Number</u> ?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," Enter <u>DUNS Number</u>			
1.4 If the <u>Legal Business Entity's Principal Place of Business</u> is not in New York State, does the <u>Legal Business Entity</u> maintain an office in New York State?			<input type="checkbox"/> Yes <input type="checkbox"/> No
(Select "N/A," if <u>Principal Place of Business</u> is in New York State.)			<input type="checkbox"/> N/A

\*All underlined terms are defined in the "New York State Vendor Responsibility Definitions List," which can be found at <http://www.osc.state.ny.us/vendrep/documents/definitions.pdf>.

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

**I. LEGAL BUSINESS ENTITY INFORMATION**

If "Yes," provide the address and telephone number for one office located in New York State.

<p>1.5 Is the <u>Legal Business Entity</u> a New York State certified <u>Minority-Owned Business Enterprise</u> (MBE), <u>Women-Owned Business Enterprise</u> (WBE), <u>New York State Small Business</u> (SB) or a federally certified <u>Disadvantaged Business Enterprise</u> (DBE)?</p> <p>If "Yes," check all that apply:</p> <p><input type="checkbox"/> New York State certified <u>Minority-Owned Business Enterprise</u> (MBE)</p> <p><input type="checkbox"/> New York State certified <u>Women-Owned Business Enterprise</u> (WBE)</p> <p><input type="checkbox"/> <u>New York State Small Business</u> (SB)</p> <p><input type="checkbox"/> Federally certified <u>Disadvantaged Business Enterprise</u> (DBE)</p>	<p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
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1.6 Identify Officials and Principal Owners, if applicable. For each person, include name, title and percentage of ownership. Attach additional pages if necessary. If applicable, reference to relevant SEC filing(s) containing the required information is optional.

Name	Title	Percentage Ownership ( <i>Enter 0% if not applicable</i> )

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

**II. REPORTING ENTITY INFORMATION**

The Reporting Entity for this questionnaire is:

Note: Select only one.

Legal Business Entity  
*Note: If selecting this option, “Reporting Entity” refers to the entire Legal Business Entity for the remainder of the questionnaire. (SKIP THE REMAINDER OF SECTION II AND PROCEED WITH SECTION III.)*

Organizational Unit within and operating under the authority of the Legal Business Entity  
 SEE DEFINITIONS OF “REPORTING ENTITY” AND “ORGANIZATIONAL UNIT” FOR ADDITIONAL INFORMATION ON CRITERIA TO QUALIFY FOR THIS SELECTION.  
*Note: If selecting this option, “Reporting Entity” refers to the Organizational Unit within the Legal Business Entity for the remainder of the questionnaire. (COMPLETE THE REMAINDER OF SECTION II AND ALL REMAINING SECTIONS OF THIS QUESTIONNAIRE.)*

**IDENTIFYING INFORMATION**

a) Reporting Entity Name

Address of the <u>Primary Place of Business</u> (street, city, state, zip code)	Telephone  ext.
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b) Describe the relationship of the Reporting Entity to the Legal Business Entity

c) Attach an organizational chart

d) Does the Reporting Entity have a DUNS Number?  Yes  No

If “Yes,” enter DUNS Number

e) Identify the designated manager(s) responsible for the business of the Reporting Entity. *For each person, include name and title. Attach additional pages if necessary.*

Name	Title



## NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE FOR-PROFIT BUSINESS ENTITY

### INSTRUCTIONS FOR SECTIONS III THROUGH VII

For each "Yes," provide an explanation of the issue(s), relevant dates, the government entity involved, any remedial or corrective action(s) taken and the current status of the issue(s). For each "Other," provide an explanation which provides the basis for not definitively responding "Yes" or "No." Provide the explanation at the end of the section or attach additional sheets with numbered responses, including the Reporting Entity name at the top of any attached pages.

#### III. LEADERSHIP INTEGRITY

**WITHIN THE PAST FIVE (5) YEARS, HAS ANY CURRENT OR FORMER REPORTING ENTITY OFFICIAL OR ANY INDIVIDUAL CURRENTLY OR FORMERLY HAVING THE AUTHORITY TO SIGN, EXECUTE OR APPROVE BIDS, PROPOSALS, CONTRACTS OR SUPPORTING DOCUMENTATION ON BEHALF OF THE REPORTING ENTITY**

- |  |   |
|--|---|
| 3.0 <u>Sanctioned</u> relative to any business or professional permit and/or license?  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other |
| 3.1 <u>Suspended, debarred, or disqualified</u> from any <u>government contracting process</u> ?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other |
| 3.2 The subject of an <u>investigation</u> , whether open or closed, by any <u>government entity</u> for a civil or criminal violation for any business-related conduct?   | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other |
| 3.3 Charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime or subject to a <u>judgment</u> for:<br>a) Any business-related activity; or<br>b) Any crime, whether or not business-related, the underlying conduct of which was related to truthfulness? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other |

For each "Yes" or "Other" explain:

#### IV. INTEGRITY – CONTRACT BIDDING

**WITHIN THE PAST FIVE (5) YEARS, HAS THE REPORTING ENTITY:**

- |   |  |
|---|--|
| 4.0 Been <u>suspended</u> or <u>debarred</u> from any <u>government contracting process</u> or been <u>disqualified</u> on any government procurement, permit, license, concession, franchise or lease, including, but not limited to, <u>debarment</u> for a violation of New York State Workers' Compensation or Prevailing Wage laws or New York State Procurement Lobbying Law? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.1 Been subject to a denial or revocation of a government prequalification?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.2 Been denied a contract award or had a bid rejected based upon a <u>non-responsibility finding</u> by a <u>government entity</u> ?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.3 Had a low bid rejected on a <u>government contract</u> for failure to <u>make good faith efforts</u> on any <u>Minority-Owned Business Enterprise, Women-Owned Business Enterprise or Disadvantaged Business Enterprise</u> goal or <u>statutory affirmative action requirements</u> on a previously held contract?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.4 Agreed to a voluntary exclusion from bidding/contracting with a <u>government entity</u> ?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.5 Initiated a request to withdraw a bid submitted to a <u>government entity</u> in lieu of responding to an information request or subsequent to a formal request to appear before the <u>government entity</u> ?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

For each "Yes," explain:

#### V. INTEGRITY – CONTRACT AWARD

**WITHIN THE PAST FIVE (5) YEARS, HAS THE REPORTING ENTITY:**

- |   |  |
|---|--|
| 5.0 Been <u>suspended</u> , cancelled or <u>terminated for cause</u> on any <u>government contract</u> including, but not limited to, a <u>non-responsibility finding</u> ? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

5.1 Been subject to an <u>administrative proceeding</u> or civil action seeking specific performance or restitution in connection with any <u>government contract</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.2 Entered into a formal monitoring agreement as a condition of a contract award from a <u>government entity</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes," explain:	

**VI. CERTIFICATIONS/LICENSES  
WITHIN THE PAST FIVE (5) YEARS, HAS THE REPORTING ENTITY:**

6.0 Had a revocation, <u>suspension</u> or <u>disbarment</u> of any business or professional permit and/or license?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6.1 Had a denial, decertification, revocation or forfeiture of New York State certification of <u>Minority-Owned Business Enterprise</u> , <u>Women-Owned Business Enterprise</u> or federal certification of <u>Disadvantaged Business Enterprise</u> status for other than a change of ownership?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes," explain:	

**VII. LEGAL PROCEEDINGS  
WITHIN THE PAST FIVE (5) YEARS, HAS THE REPORTING ENTITY:**

7.0 Been the subject of an <u>investigation</u> , whether open or closed, by any <u>government entity</u> for a civil or criminal violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.1 Been the subject of an indictment, grant of immunity, <u>judgment</u> or conviction (including entering into a plea bargain) for conduct constituting a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.2 Received any OSHA citation and Notification of Penalty containing a violation classified as <u>serious or willful</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.3 Had a <u>government entity</u> find a willful prevailing wage or supplemental payment violation or any other willful violation of New York State Labor Law?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.4 Entered into a consent order with the New York State Department of Environmental Conservation, or received an enforcement determination by any <u>government entity</u> involving a violation of federal, state or local environmental laws?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.5 Other than previously disclosed: a) Been subject to fines or penalties imposed by <u>government entities</u> which in the aggregate total \$25,000 or more; or b) Been convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any <u>government entity</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes," explain:	

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

VIII. FINANCIAL AND ORGANIZATIONAL CAPACITY	
8.0 Within the past five (5) years, has the <u>Reporting Entity</u> received any <u>formal unsatisfactory performance assessment(s)</u> from any <u>government entity</u> on any contract?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide an explanation of the issue(s), relevant dates, the <u>government entity</u> involved, any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
8.1 Within the past five (5) years, has the <u>Reporting Entity</u> had any <u>liquidated damages</u> assessed over \$25,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide an explanation of the issue(s), relevant dates, contracting party involved, the amount assessed and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
8.2 Within the past five (5) years, have any <u>liens</u> or <u>judgments</u> (not including UCC filings) over \$25,000 been filed against the <u>Reporting Entity</u> which remain undischarged?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide an explanation of the issue(s), relevant dates, the Lien holder or Claimant's name(s), the amount of the <u>lien(s)</u> and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
8.3 In the last seven (7) years, has the <u>Reporting Entity</u> initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide the bankruptcy chapter number, the court name and the docket number. Indicate the current status of the proceedings as "Initiated," "Pending" or "Closed." Provide answer below or attach additional sheets with numbered responses.	
8.4 During the past three (3) years, has the <u>Reporting Entity</u> failed to file or pay any tax returns required by <u>federal, state or local tax laws</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide the taxing jurisdiction, the type of tax, the liability year(s), the tax liability amount the <u>Reporting Entity</u> failed to file/pay and the current status of the tax liability. Provide answer below or attach additional sheets with numbered responses.	
8.5 During the past three (3) years, has the <u>Reporting Entity</u> failed to file or pay any New York State unemployment insurance returns?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide the years the <u>Reporting Entity</u> failed to file/pay the insurance, explain the situation and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
8.6 During the past three (3) years, has the <u>Reporting Entity</u> had any <u>government audit(s)</u> completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) If "Yes," did any audit of the <u>Reporting Entity</u> identify any reported significant deficiencies in internal control, fraud, illegal acts, significant violations of provisions of contract or grant agreements, significant abuse or any <u>material disallowance</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes" to 8.6 a), provide an explanation of the issue(s), relevant dates, the <u>government entity</u> involved, any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

<b>IX. ASSOCIATED ENTITIES</b> <b>THIS SECTION PERTAINS TO ANY ENTITY(IES) THAT EITHER CONTROLS OR IS CONTROLLED BY THE REPORTING ENTITY.</b> <b>(SEE DEFINITION OF "ASSOCIATED ENTITY" FOR ADDITIONAL INFORMATION TO COMPLETE THIS</b>	
9.0 Does the <u>Reporting Entity</u> have any <u>Associated Entities</u> ?  Note: All questions in this section must be answered if the <u>Reporting Entity</u> is either: – An <u>Organizational Unit</u> ; or – The entire <u>Legal Business Entity</u> which controls, or is controlled by, any other entity(ies). If "No," SKIP THE REMAINDER OF SECTION IX AND PROCEED WITH SECTION X.	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.1 Within the past five (5) years, has any <u>Associated Entity Official</u> or <u>Principal Owner</u> been charged with a misdemeanor or felony, indicted, granted immunity, convicted of a crime or subject to a <u>judgment</u> for: a) Any business-related activity; or b) Any crime, whether or not business-related, the underlying conduct of which was related to truthfulness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide an explanation of the issue(s), the individual involved, his/her title and role in the <u>Associated Entity</u> , his/her relationship to the <u>Reporting Entity</u> , relevant dates, the <u>government entity</u> involved, any remedial or corrective action(s) taken and the current status of the issue(s).	
9.2 Does any <u>Associated Entity</u> have any currently undischarged <u>federal</u> , New York State, New York City or New York local government <u>liens</u> or <u>judgments</u> (not including UCC filings) over \$50,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes," provide an explanation of the issue(s), identify the <u>Associated Entity</u> 's name(s), <u>EIN</u> (s), primary business activity, relationship to the <u>Reporting Entity</u> , relevant dates, the Lien holder or Claimant's name(s), the amount of the <u>lien</u> (s) and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	
9.3 Within the past five (5) years, has any <u>Associated Entity</u> :	
a) Been <u>disqualified</u> , <u>suspended</u> or <u>debarred</u> from any <u>federal</u> , New York State, New York City or other New York local <u>government contracting process</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Been denied a contract award or had a bid rejected based upon a <u>non-responsibility finding</u> by any <u>federal</u> , New York State, New York City, or New York local <u>government entity</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Been <u>suspended</u> , <u>cancelled</u> or <u>terminated for cause</u> (including for <u>non-responsibility</u> ) on any <u>federal</u> , New York State, New York City or New York local <u>government contract</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Been the subject of an <u>investigation</u> , whether open or closed, by any <u>federal</u> , New York State, New York City, or New York local <u>government entity</u> for a civil or criminal violation with a penalty in excess of \$500,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Been the subject of an indictment, grant of immunity, <u>judgment</u> , or conviction (including entering into a plea bargain) for conduct constituting a crime?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Been convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any <u>federal</u> , New York State, New York City, or New York local <u>government entity</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Initiated or been the subject of any bankruptcy proceedings, whether or not closed, or is any bankruptcy proceeding pending?	<input type="checkbox"/> Yes <input type="checkbox"/> No
For each "Yes," provide an explanation of the issue(s), identify the <u>Associated Entity</u> 's name(s), <u>EIN</u> (s), primary business activity, relationship to the <u>Reporting Entity</u> , relevant dates, the <u>government entity</u> involved, any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses.	

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

**X. FREEDOM OF INFORMATION LAW (FOIL)**

<p>10. Indicate whether any information supplied herein is believed to be exempt from disclosure under the Freedom of Information Law (FOIL). Note: A determination of whether such information is exempt from FOIL will be made at the time of any request for disclosure under FOIL.</p>	<p><input type="checkbox"/> Yes   <input type="checkbox"/> No</p>
<p>Indicate the question number(s) and explain the basis for the claim.</p>	

**XI. AUTHORIZED CONTACT FOR THIS QUESTIONNAIRE**

Name	Telephone ext.	Fax
Title	Email	

**NEW YORK STATE VENDOR RESPONSIBILITY QUESTIONNAIRE  
FOR-PROFIT BUSINESS ENTITY**

**Certification**

The undersigned: (1) recognizes that this questionnaire is submitted for the express purpose of assisting New York State contracting entities in making responsibility determinations regarding an award of a contract or approval of a subcontract; (2) recognizes that the Office of the State Comptroller (OSC) will rely on information disclosed in the questionnaire in making responsibility determinations and in approving a contract or subcontract; (3) acknowledges that the New York State contracting entities and OSC may, in their discretion, by means which they may choose, verify the truth and accuracy of all statements made herein; and (4) acknowledges that intentional submission of false or misleading information may constitute a misdemeanor or felony under New York State Penal Law, may be punishable by a fine and/or imprisonment under Federal Law, and may result in a finding of non-responsibility, contract suspension or contract termination.

**The undersigned certifies that he/she:**

- is knowledgeable about the Reporting Entity's business and operations;
- has read and understands all of the questions contained in the questionnaire;
- has not altered the content of the questionnaire in any manner;
- has reviewed and/or supplied full and complete responses to each question;
- to the best of his/her knowledge, information and belief, confirms that the Reporting Entity's responses are true, accurate and complete, including all attachments, if applicable;
- understands that New York State will rely on the information disclosed in the questionnaire when entering into a contract with the Reporting Entity; and
- is under obligation to update the information provided herein to include any material changes to the Reporting Entity's responses at the time of bid/proposal submission through the contract award notification, and may be required to update the information at the request of the New York State contracting entities or OSC prior to the award and/or approval of a contract, or during the term of the contract.

Signature of Owner/Officer \_\_\_\_\_

Printed Name of Signatory \_\_\_\_\_

Title \_\_\_\_\_

Reporting Entity Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_ ;

\_\_\_\_\_ Notary Public

**Exhibit I.J – Notice of Bidding Intention Form**

**NYS Department of Civil Service  
RFP No. 2013MH-1  
entitled  
“Mental Health and Substance Abuse Program for the  
Empire Plan, Excelsior Plan, Student Employee Health Plan”**

**Notice of Bidding Intention Form**

\_\_\_\_\_

(Please PRINT Firm’s Name Above)

With regard to this RFP, (check one of the following boxes applicable):

- We **ARE INTERESTED & MAY** submit a bid response.
- We **ARE NOT INTERESTED & WILL NOT** be submitting a bid response because:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INTEREST IN M/WBE SUBCONTRACTING POSTING:**

(Check box if applicable)

- Our firm is a NYS certified M/WBE interested in a subcontracting opportunity. Please add our firm’s contact information, indicated at the top of this Form, to the list of certified M/WBE subcontractors that have expressed interest in this Procurement. The list will be posted on Department’s web page for this Procurement. The NYS M/WBE certification documentation for our firm is attached

\_\_\_\_\_  
Name of Contact at Firm

\_\_\_\_\_  
Title

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Complete the tables above and submit it to the MHSA Program Procurement Manager specified in RFP, Section II.A.2.b. The completed table may be emailed, faxed and/or mailed (see addresses provided in RFP, Section II.A.2.b.).

## **Exhibit I.K – Offeror’s Affirmation of Understanding and Agreement**

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Part 1 of this Exhibit I.K, as contained on the following page, should be completed by the Offeror and emailed, faxed and/or mailed to the MHSA Program Procurement Manager as set forth in RFP, Section II.A.2.b.

Part 2 of this Exhibit I.K should, prior to initiating any contact with the Department, be completed for each Offeror officer, employee, agent or consultant retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement and submit it to the MHSA Program Procurement Manager specified in RFP, Section II.A.2.b.



**Part 1**

**Offeror’s Affirmation of Understanding and Agreement**

**Instructions:**

Pursuant to State Finance Law §§139-j and 139-k, this solicitation imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the procurement’s “Restricted Period” (from the earliest written notice, advertisement or solicitation of a request for proposal, invitation for bids, or solicitation of proposals, or any other method for soliciting a response from Offerors intending to result in a procurement contract with a governmental entity and ending with the final contract award and approval by the governmental entity and, where applicable, approval by the State Comptroller) to other than designated staff, unless the contact falls within certain statutory exceptions (“permissible contacts”). the Department’s employees are required to obtain certain information from Offerors and others whenever there is a contact about the procurement during the Restricted Period, and are required to make a determination of the Offeror’s responsibility that addresses the Offeror’s compliance with the statutes’ requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a proposal on or be awarded a contract for four years from the date of the second non-responsibility finding.

Further information about these requirements can be found at:

<http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html>.

As a prerequisite for participating in this procurement, an Offeror must provide the following Affirmation of Understanding and Agreement to comply with these procurement lobbying restrictions in accordance with State Finance Law §§139-j and 139-k.

**Offeror Affirmation and Agreement**

The Offeror affirms that it understands the procurement lobbying requirements set forth in State Finance Law §§139-j and 139-k, and agrees to comply with the Department’s procedures regarding permissible contacts as required thereby.

Name of Offeror:


By:

(Signature)

Name:

Title:

Address:

Date:


**Exhibit I.K – Offeror’s Affirmation of Understanding and Agreement**

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**Part 2**

<b>Offeror Designated Contact</b>	
<b>First Name</b>	
<b>Last Name</b>	
<b>Company Name</b>	
<b>Company Address:</b>	
<b>Street Address</b>	
<b>City</b>	
<b>State</b>	
<b>Zip</b>	
<b>Individual's Business Telephone # (xxx) xxx-xxxx</b>	
<b>Principal Place of Business (1)</b>	
<b>Individual's Occupation</b>	

*(1) Enter the location of the individual's Principal Place of Business (e.g. Albany, NY)*

Complete the table above for each Offeror officer, employee, agent or consultant retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement, prior to the individual initiating any contact with the Department, and submit it to the MHSA Program Procurement Manager specified in Section II.A.2.b. of the RFP.



State of New York  
Department of Civil Service  
Albany, NY 12239

**ADMINISTRATION DIVISION**

**Procurement Lobbying Policy: Restrictions  
on Contacts During the Procurement Process**

**Policy on Restrictions on Contacts During the Procurement Process  
Procurement Lobbying, Ch.4, L. 2010 State Finance Law (SFL)  
Sections 139-j and 139-k**

**I. Definitions**

For the purpose of this policy as it regards RFP#2013-MH1, the following definitions apply:

"Article of procurement" means a commodity, service, technology, public work, construction, revenue contract, the purchase, sale or lease of real property or an acquisition or granting of other interest in real property, that is the subject of a Department governmental procurement.

"Contacts" means any oral, written, or electronic communication with DCS or any other State governmental entity under circumstances where a reasonable person would infer that the communication was intended to influence the governmental entity's conduct or decision regarding the governmental procurement. However, any communications received by the Department from members of the State legislature or legislative staff, when acting in his or her official capacity, shall not be considered to be a "contact" and shall not be recorded by the Department's staff pursuant to this policy.

"Procurement Contract" means any contract or other agreement, including an amendment, extension, renewal, or change order to an existing contract (other than amendments, extensions, renewals, or change orders that are authorized and payable under the terms of the contract as it was finally awarded or approved by the comptroller, as applicable), for an article of procurement involving an estimated annualized expenditure in excess of \$15,000. Grants, contracts entered into under SFL Article 11-B, and intergovernmental agreements shall not be deemed "procurement contracts" for the purpose of this policy.

"Governmental entity" means: (1) any department, board, bureau, commission, division, office, council, committee or officer of the state, whether permanent or temporary, including the Department; (2) each house of the state legislature; (3) the unified court system; (4) any public authority, public benefit corporation or commission created by or existing pursuant to the public authorities law; (5) any public authority or public benefit corporation, at least one of whose members is appointed by the governor or who serves as a member by virtue of holding a civil office of the state; (6) a municipal agency, as that term is defined in paragraph (ii) of subdivision (s) of section one-c of the legislative law; (7) a subsidiary or affiliate of such a public authority.

## Exhibit I.L – Procurement Lobbying Policy

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

"Proposal" means any bid, quotation, offer or response to the Department's solicitation of submissions relating to procurement.

"Governmental procurement" means:

- a) the public announcement, public notice, or public communication to any potential vendor of a determination of need for a procurement, which shall include, but not be limited to, the public notification of the specifications, , bid documents, request for proposals or evaluation criteria for a procurement contract;
- b) the solicitation for a procurement contract;
- c) the evaluation of a procurement contract;
- d) the award, approval, denial, or disapproval of a procurement contract; or
- e) the approval or denial of an assignment, amendment (other than amendments that are authorized and payable under the terms of the procurement contract as it was finally awarded or approved by the State Comptroller, as applicable), renewal or extension of a procurement contract, or any other material change in the procurement contract resulting in a financial benefit to the Offeror/Contractor.

"Restricted period" means the period of time commencing with the earliest written notice, advertisement or solicitation of a request for proposal, or invitation for bids, or solicitation of proposals, or any other method for soliciting a response from Offerors intending to result in a procurement contract, and ending with the final contract award and approval of the Department and, where applicable, the State Comptroller.

"Revenue contract" means any written agreement between the Department and an Offeror whereby the Department gives or grants a concession or a franchise.

**II. Designated Contacts**

For each governmental procurement, the Department shall at the same time that a restricted period is imposed, designate, with regard to each governmental procurement, a person or person(s) who are knowledgeable about the procurement and who may be contacted by Offerors relating to the governmental procurement. Each Offeror who contacts the Department during procurement's restricted period is permitted to make permissible contacts only the person(s) designated by the Department for that purpose (i.e., Designated Contact). Such contacts must comply with the requirements established by SFL sections 139-j and 139-k, and with the requirements set forth by the Department in the solicitation document.

**III. Offeror Affirmation of Understanding and Agreement to Comply**

As a threshold requirement to participating in a procurement, the Department shall require each Offeror to provide written affirmation of its understanding of and agreement to comply with the Department's policy and procedures relating to permissible contacts during the governmental procurement's restricted period. Such a written affirmation by an Offeror shall be deemed to apply to any amendments to a procurement submitted by the Department after an initial affirmation is received with an initial bid.

**IV. Contact Documentation**

Upon any contact during the procurement's restricted period, the Department's staff shall obtain the name, address, telephone number, place of principal employment, and occupation of the person or organization making the contact, and also shall inquire whether the person or organization making the contact was the Offeror or was retained, employed, or designated by or on behalf of the Offeror to appear before or contact the Department about the procurement. All recorded contacts shall be recorded on the appropriate form(s) and included in the procurement record.

**V. Non-responsibility Disclosure**

The Procuring Agencies' staff shall ensure that all solicitation documents require Offerors to disclose findings of non-responsibility made within the previous four years by any State governmental entity where such prior finding of non-responsibility was due to:

- a) a violation of the procurement lobbying requirements established at SFL section 139-j; or
- b) the intentional provision of false or incomplete information to a government entity.

**VI. Non-responsibility Determination**

The failure of an Offeror to timely disclose accurate or complete information to the Department regarding the above shall be considered by the Department in their determination of the Offeror's responsibility. No procurement contract shall be awarded to any such Offeror, its subsidiaries, and any related or successor entity with substantially similar function, management, board of directors, officers and shareholders unless the Department finds that the award of the contract to that entity is necessary to protect public property or public health or safety, and that the entity is the only source capable of supplying the required article of procurement within the necessary timeframe, provided however, that the Department shall include in the procurement record a statement describing the basis for such finding.

**VII. Contractor Certification**

A contract award subject to SFL sections 139-j and 139-k shall contain a certification by the successful Offeror that all information provided to the Department with respect to the procurement lobbying requirements established by those sections is complete, true and accurate.

Each contract shall contain a provision authorizing the Department to terminate such contract in the event such certification is found to be intentionally false or intentionally incomplete. The Department shall include in the procurement record a statement describing the basis for such termination.

Any employee of the Department who becomes aware that an Offeror has made an impermissible contact(s) during the procurement shall immediately notify the DCS Ethics Officer or the DCS Director of Internal Audit. If an Offeror violates these requirements with regard to permissible contacts at a governmental entity other than the Department, the employee of that entity who becomes aware of the violation shall notify that entity's Ethics Officer, Inspector General, if any, or other official of that entity responsible for reviewing or investigating such matters, who shall in turn notify the DCS Ethics Officer or the DCS Director of Internal Audit.

**VIII. DCS Review of Alleged Violations and the Imposition of Sanctions**

- a) If the DCS Ethics Officer or the DCS Director of Internal Audit receives notification of an allegation that an Offeror has made an impermissible contact during the procurement's restricted period as described above, the DCS Director of Internal Audit shall immediately investigate such allegation. If the position of Director of Internal Audit is vacant, the Ethics Officer shall conduct the investigation, or the Commissioner may appoint a designee to investigate the allegation. In no event shall the person conducting the investigation be someone who has participated in the preparation of the solicitation document, the evaluation of Proposals, or the selection decision.

- b) If the investigation indicates that sufficient cause exists to believe that the allegation is true, the Department shall give the Offeror reasonable notice that an investigation is ongoing and an opportunity to be heard in response to the allegation. At the Department's discretion, such opportunity to be heard may be provided by giving the Offeror the opportunity to meet with the Department staff conducting the investigation or by the Offeror's submission of a written statement, or both. The Offeror may, but need not, be represented by counsel during the investigation. Any and all issues concerning the manner in which the investigation process is conducted shall be determined solely by the Department staff conducting the investigation.
- c) If it is found that an Offeror has knowingly and willfully made an impermissible contact in violation of these requirements, then the Department staff making such findings shall report to the President of the Civil Service Commission related instances, if any, of any Department employee's violation of Public Officers Law sections 73(5) and 74.

**IX. Sanctions**

- a) A finding that an Offeror has knowingly and willfully made an impermissible contact shall result in a determination of non-responsibility for such Offeror. Concomitantly, such Offeror and its subsidiaries, and any related or successor entity with substantially similar function, management, board of directors, officers and shareholders, shall not be awarded the procurement contract, unless the Department finds that the award of the procurement contract to that entity is necessary to protect public property or public health or safety, and that the entity is the only source capable of supplying the required article of procurement within the necessary timeframe. If such in the case, the Department shall include in the procurement record a statement describing the basis for such a finding.
- b) Any subsequent determination of an Offeror's non-responsibility due to violation of these requirements within four years of a prior determination of non-responsibility due to a violation of these requirements shall result in the Offeror being rendered ineligible to submit a proposal on or be awarded any procurement contract for a period of four years from the date of the second non-responsibility determination.

**X. Model Language For Solicitation Documents**

The Department's staff shall ensure that the model language set forth below is included in all solicitation documents issued by the Department, subject to final review by their Offices of Counsel:

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

## Exhibit I.L – Procurement Lobbying Policy

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- a) Pursuant to State Finance Law sections 139-j and 139-k, this procurement imposes certain procurement lobbying limitations. Offerors are restricted from making contacts during the procurement's "Restricted Period" to other than designated staff of the Department and the Executive Branch of New York State government, unless the contact falls within certain statutory exceptions ("permissible contacts"). Staff is required to obtain certain information from Offerors and others whenever there is a contact about the procurement during the Restricted Period, and are required to make a determination of the Offeror's responsibility that addresses the Offeror's compliance with the statutes' requirements. Findings of non-responsibility result in rejection for contract award, and if an Offeror is subject to two non-responsibility findings within four years the Offeror also will be determined ineligible to submit a proposal on or be awarded a contract for four years from the date of the second non-responsibility finding. The Department's policy and procedures are attached as Exhibit (TBD) to this RFP. Further information about these requirements can be found at:

<http://www.ogs.ny.gov/aboutOGS/regulations/defaultAdvisoryCouncil.html>

- b) In order to ensure public confidence and integrity in the procurement process, the Department will control strictly all communications between any Offeror and participants in the evaluation process from the earliest notice of intent to solicit offers in this procurement through the final award and approval of the procurement contract by the Department and OSC, if applicable. "Offeror" means any individual or entity, or any employee, agent, consultant, or person acting on behalf of such individual or entity, who contacts the Department or any other State governmental entity about a governmental procurement during that procurement's restricted period whether or not the caller has a financial interest in the outcome of the governmental procurement; provided, however, that a governmental agency or its employees that communicates with the Department regarding a governmental procurement in the exercise of its oversight duties shall not be considered an Offeror. "Offeror" includes prospective Offerors prior to the due date for the submission of offers/bids in response to the solicitation document. All contacts and inquiries concerning this procurement must be made to the Procurement Manager. The Department shall disqualify any Offeror who fails to comply with this requirement.

MHSA Benefit Services Procurement Manager

Attn: Robert Kennedy

NYS Civil Service

Agency Bldg. 1

Empire State Plaza

Albany, NY 12239

Fax: (518) 402-2835

E-mail: 2013MHSARFP@cs.state.ny.us

Additionally, any Offeror is strictly prohibited from making any contacts or inquiries concerning the procurement with any member, officer or employee of



## **Exhibit I.L – Procurement Lobbying Policy**

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any governmental entity other than the Department from the date the public announcement, public notice, or public communication to any potential vendor of a determination of need for a procurement, which shall include, but not be limited to, the date the RFP is released until the end of the procurement, subject only to the specific exceptions listed below. Further, any Offeror shall not attempt to influence the procurement in any manner that would result in a violation or an attempted violation of Public Officers Law sections 73(5) or 74.

- c) The following contacts are exempted from the provisions of paragraph 3 of section 139-j and as such do not need to be directed to the Procurement Manager pursuant to section 139-k:
- (1) the submission of written proposals in response to the solicitation document;
  - (2) the submission of written questions by a method set forth in the solicitation document when all written questions and responses are to be distributed to all Offerors who have expressed an interest in the procurement;
  - (3) participation in a demonstration, conference or other means for exchange of information in a setting open to all potential bidders provided for in the solicitation document;
  - (4) complaints by an Offeror regarding the failure of the Department's Procurement Manager to respond to an Offeror's authorized contacts, when such complaints are made in writing to the Department's Office of the General Counsel, provided that any such written complaints shall become a part of the procurement record;
  - (5) communications by a successful Offeror(s) who has been tentatively awarded a contract and is engaged in communications with the Department solely for the purpose of negotiating the terms of the contracts after having been notified of tentative award;
  - (6) contact by an Offeror to request the review of a procurement award when done in accordance with the procedure specified in the solicitation document;
  - (7) A. contacts by an Offeror in protests, appeals or other review proceedings (including the apparent successful Offeror and its representatives) before the Department seeking a final administrative determination, or in a subsequent judicial proceeding; or  
B. complaints of alleged improper conduct in the procurement when such complaints are made to the State Attorney General, Inspector General, District Attorney, or to a court of competent jurisdiction; or

**Exhibit I.L – Procurement Lobbying Policy**

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- C. protests, appeals or complaints to the State Comptroller's office during the process of contract approval, where the State Comptroller's approval is required provided that the state comptroller shall make a record of such communications and any response thereto which shall be entered into the procurement record pursuant to State Finance Law section 163; or
  - D. complaints of alleged improper conduct in a governmental procurement conducted by a municipal agency or local legislative body to the state comptroller's office; and
- (8) communications between Offerors and governmental entities that solely address the determination of responsibility by a governmental entity of an Offeror.

Revised 4/2011



State of New York  
**Department of Civil Service**  
Alfred E. Smith State Office Building  
Albany, NY 12239

**Compliance with Public Officers Law Requirements**

ADM-992 (1/07)

The New York State Public Officers Law ("POL"), particularly POL Sections 73 and 74, as well as all other provisions of New York State law, rules and regulations, and policy establishes ethical standards for current and former State employees. In submitting its Proposal, the Offeror must guarantee knowledge and full compliance with such provisions for purposes of this RFP and any other activities including, but not limited to, contracts, bids, offers, and negotiations. Failure to comply with these provisions may result in disqualification from the procurement process, termination, suspension or cancellation of the contract and criminal proceedings as may be required by law.

The Offeror hereby submits its affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations.

Please provide below an affirmative statement as to the existence of, absence of, or potential for conflict of interest on the part of the Offeror because of prior, current, or proposed contracts, engagements, or affiliations. Please attach additional pieces of paper as necessary.

Name of Offeror: \_\_\_\_\_

Name & Title of Representative: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Exhibit I.N - Compliance with Americans with Disabilities Act**



State of New York  
**Department of Civil Service**  
Albany, NY 12239

**Compliance with Americans with Disabilities Act**

ADM-987 (1/07)

The Offeror hereby provides assurance of its compliance with the Americans With Disabilities Act (42 USC§12101 et. seq.), in that any services and programs provided during the course of performance of the Agreement resultant from this RFP shall be accessible under Title II of the Americans With Disabilities Act, and as otherwise may be required under the Americans With Disabilities Act.

Name of Offeror: \_\_\_\_\_

Name & Title of Representative: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



State of New York  
 Department of Civil Service  
 Alfred E. Smith State Office Building  
 Albany, NY 12239

MWBE UTILIZATION PLAN

OFFICE OF FINANCIAL ADMINISTRATION

MWBE-100 (9/2011)

**INSTRUCTIONS: All Offerors must complete this MWBE Utilization Plan and submit it as part of their Proposal. The Plan must contain a detailed description of the services to be provided by each Minority and/or Woman-Owned Business Enterprise (M/WBE) identified by the Offeror.**

<b>Offeror Name:</b>			<b>Federal Identification No.:</b>			
<b>Address:</b>			<b>Solicitation No.:</b>			
<b>City, State, Zip Code:</b>			<b>M/WBE Goals for the Solicitation: MBE:      % WBE:      %</b>			
<b>1. M/WBE Subcontractors/Suppliers Name, Address, Email Address, Telephone No.</b>	<b>2. Classification</b>	<b>3. Federal ID No.</b>	<b>4. Detailed Description of Work (Attach additional sheets, if necessary.)</b>	<b>5. Dollar Value of Subcontracts/Supplies</b>		
<b>A.</b>	NYS ESD Certified <input type="checkbox"/> MBE <input type="checkbox"/> WBE					
<b>B.</b>	NYS ESD Certified <input type="checkbox"/> MBE <input type="checkbox"/> WBE					
<b>6. WAIVER REQUESTED: MBE: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, submit form MWBE101 / WBE: <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, submit form MWBE101</b>						
<b>PREPARED BY (Signature):</b>			<b>TELEPHONE NO.:</b>	<b>EMAIL ADDRESS:</b>		
<b>NAME AND TITLE OF PREPARER (Print or Type):</b>						
<b>DATE: Offeror's Certification Status: <input type="checkbox"/> MBE <input type="checkbox"/> WBE</b>						
<b>SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR'S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FINDING OF NONCOMPLIANCE AND/OR PROPOSAL DISQUALIFICATION.</b>			<b>*****FOR DEPARTMENT USE ONLY*****</b>			
			<b>REVIEWED BY:</b>		<b>DATE:</b>	
			<b>UTILIZATION PLAN APPROVED: <input type="checkbox"/> YES <input type="checkbox"/> NO Date: _____</b>			
			<b>MBE CERTIFIED: <input type="checkbox"/> YES <input type="checkbox"/> NO</b>			
			<b>WBE CERTIFIED: <input type="checkbox"/> YES <input type="checkbox"/> NO</b>			
<b>WAIVER GRANTED: <input type="checkbox"/> YES <input type="checkbox"/> NO</b>						
<input type="checkbox"/> Total Waiver <input type="checkbox"/> Partial Waiver						
<b>NOTICE OF DEFICIENCY ISSUED: <input type="checkbox"/> YES <input type="checkbox"/> NO</b>						
<b>Date: _____</b>						

**Offeror’s Certification of Compliance Pursuant to State Finance Law §139-k(5)**

**Instructions:**

New York State Finance Law (SFL) §139-k(5) requires that every contract award subject to the provisions of SFL §§139-k or 139-j shall contain a certification by the Offeror that all information provided to the Department with respect to SFL §139-k is complete, true and accurate.

At the time an Offer or Bid is submitted to the Department, the Offeror must provide the following certification that the information it has and will provide to the Department pursuant to SFL §139-k is complete, true and accurate including, but not limited to, disclosures of findings of non-responsibility made within the previous four years by any State governmental entity where such finding of non-responsibility was due to a violation of SFL §139-j or due to the intentional provision of false or incomplete information to a State governmental entity.

**Offeror Certification**

*I certify that all information provided to the Governmental Entity with respect to State Finance Law §139-k is complete, true and accurate.*

Name of Offeror: \_\_\_\_\_

By: \_\_\_\_\_  
(Signature)

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_



State of New York  
 Department of Civil Service  
 Alfred E. Smith State Office Building  
 Albany, NY 12239

**M/WBE GOAL REQUIREMENTS  
 CERTIFICATION OF GOOD FAITH EFFORTS**

OFFICE OF FINANCIAL ADMINISTRATION MWBE-104 (1/2012)

The Contractor must document “good faith efforts” to provide meaningful participation by New York State Certified M/WBE subcontractors or suppliers in the performance of the State Contract.

The undersigned hereby certifies that he/she has taken the following actions on behalf of the Contractor to demonstrate the aforesaid good faith efforts [check actions as applicable]:

- (a) The Contractor attended any pre-bid meetings that were scheduled by the Department or the NYS Department of Economic Development or its designee to inform minority and women business enterprises of contracting and subcontracting opportunities available on the project;
- (b) The Contractor identified economically feasible units of the project that could be contracted or subcontracted to minority and women small business enterprises in order to increase the likelihood of participation by such enterprises;
- (c) The Contractor advertised in general circulation, trade association, and trade-oriented, minority and women-focused publications, if any, concerning the contracting or subcontracting opportunity;
- (d) The Contractor solicited and provided written notice to a reasonable number of minority and women business enterprises identified from current certified lists of such business enterprises provided or maintained by the NYS Empire State Development’s Division of Minority and Women Owned Business Development, or its designee, of the contracting or subcontracting opportunity in sufficient time to allow the enterprises to participate effectively;
- (e) The Contractor followed up initial solicitations by contacting the enterprises to determine whether the enterprises were interested in such contracting or subcontracting opportunity;
- (f) The Contractor provided interested minority and women business enterprises with adequate information about the plans, specifications and requirements for the contracting or subcontracting opportunity;
- (g) The Contractor used the services of community organizations, contractor groups, state and federal business assistance offices and other organizations identified by the NYS Department of Economic Development or its designee that provide assistance in the recruitment and placement of minority and women business enterprises; and
- (h) The Contractor negotiated in good faith with minority and women business enterprises submitting bids, proposals, or quotations and did not, without justifiable reason, reject as unsatisfactory any bids, proposals or quotations prepared by any minority or women business. "Good faith" negotiating means engaging in good faith discussions with minority or women businesses about the nature of the work, scheduling, requirements for special equipment, opportunities for dividing of work among the bidders, proposers, and various subcontractors and the bids of the minority or women businesses, including sharing with them any cost estimates from the request for proposal or invitation to bid documents, if available.

Signature:	Date:
Print Name:	
Title:	
Company:	

Sworn to before me this \_\_\_\_ day of 20 \_\_\_\_

\_\_\_\_\_  
 Notary Public

**New York State Department of Civil Service**  
**“Mental Health and Substance Abuse Program for the Empire Plan,**  
**Excelsior Plan, and Student Employee Health Plan RFP”**

**Questions Template**

Question Number	RFP Page #	Section and Sub-Section Reference	Question

Offerors are requested to use the Question Template table above in submitting questions. Offerors’ questions must be submitted to the MHSA Program Procurement Manager at the address specified in Section II.A.6 of this RFP, with an electronic copy (in Microsoft Word format) of the Offeror’s questions sent to the MHSA Program Procurement Manager’s attention at: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us).



**[TO BE COMPLETED ON OFFEROR'S LETTERHEAD]**

Date

Ms. Linda Burk  
Procurement Manager  
Employee Benefits Division – Room 1106  
NYS Department of Civil Service  
Albany, NY 12239

**RE: Request for Proposals entitled:  
“Mental Health and Substance Abuse Program for the  
Empire Plan, Excelsior Plan, and Student Employee Health Plan”  
Firm Offer to the State of New York**

**[INSERT OFFEROR NAME]** hereby submits this firm and binding offer to the State of New York in response to the Department’s Request for Proposals entitled **“Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan”** (RFP). The Proposal hereby submitted meets or exceeds all terms, conditions, and requirements set forth in the above-referenced RFP and in the manner set forth in this RFP.

**[INSERT OFFEROR NAME]** accepts the terms and conditions as set forth in RFP, Section VII and Appendices A, B, C, and D and agrees to satisfy the comprehensive programmatic duties and responsibilities outlined in this RFP in the manner set forth in this RFP.

**[INSERT OFFEROR NAME]** agrees to execute a contractual agreement composed substantially of the terms and conditions set forth in the draft contract included in the RFP, and accepts as non-negotiable the terms and conditions set forth in Appendices A, B, C and D to the draft contract.

**[INSERT OFFEROR NAME]** further agrees, if selected as a result of the RFP, to comply with 1) the provisions of Tax Law Section 5-a, Certification Regarding Sales and Compensating Use Tax; and 2) the Workers’ Compensation Law as set forth in Section II.B.7 of the RFP.

This formal offer will remain firm and non-revocable for a minimum period of 365 days from the Proposal Due Date as set forth in the RFP. In the event that a contract is not approved by the NYS Comptroller within the 365 day period, this offer shall remain firm and binding beyond the 365 day period and until a contract is approved by the NYS Comptroller, unless **[INSERT OFFEROR NAME]** delivers to the Department of Civil Service written notice of withdrawal of its Proposal.

**[INSERT OFFEROR NAME]**’s complete offer is set forth as follows:

Administrative Proposal: Total of twelve (12) hard copy volumes [two (2) original and ten (10) copies] and one (1) electronic copy on CD.

Technical Proposal: Total of twelve (12) hard copy volumes [two (2) original and ten (10) copies] and one (1) electronic copy on CD.

Cost Proposal: Total of twelve (12) hard copy volumes [two (2) original and ten (10) copies] and one (1) electronic copy on CD.

**Exhibit I.S - Formal Offer Letter**

The undersigned affirms and swears s/he has the legal authority and capacity to sign and make this offer on behalf of, **[INSERT OFFEROR NAME]** and possesses the legal authority and capacity to act on behalf of **[INSERT OFFEROR NAME]** to execute a contract with the State of New York.

The undersigned affirms and swears as to the truth and veracity of all documents included in this offer.

Date: \_\_\_\_\_

**[INSERT OFFEROR NAME]**

By: \_\_\_\_\_  
(signature)

\_\_\_\_\_  
(name)

\_\_\_\_\_  
(title)

\_\_\_\_\_  
(phone number)

**CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT**

STATE OF \_\_\_\_\_ }  
COUNTY OF \_\_\_\_\_ } : SS.:

On the \_\_\_\_ day of \_\_\_\_\_ in the year 2013, before me personally appeared: \_\_\_\_\_, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that \_he resides at \_\_\_\_\_, Town of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_; and further that:

**[Check One]**

( \_\_\_ If a corporation): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, \_he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

( \_\_\_ If a partnership): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the partnership described in said instrument; that, by the terms of said partnership, \_he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

\_\_\_\_\_  
Notary Public

**Exhibit I.T - Offeror Attestations Form**

An authorized representative of the Offeror who is legally authorized to certify the information requested in the name of and on behalf of the Offeror is required to complete and sign the Offeror Attestations and provide all requested information. Offeror's authorized representative must certify as to the truth of the representations made by signing where indicated, below.

**CERTIFICATION:**

The Offeror (1) recognizes that the following representations are submitted for the express purpose of assisting the State of New York in making a determination to award a contract; (2) acknowledges and agrees by submitting the Attestation, that the State may at its discretion, verify the truth and accuracy of all statements made herein; (3) certifies that the information submitted in this certification and any attached documentation is true, accurate and complete.

Name of Business Entity Submitting Bid:		
Entity's Legal Form:		<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other _____
No.	RFP Ref.	RFP Requirement:
1.	Section III.B.1	At time of Proposal Due Date, Offeror represents and warrants that it: <input type="checkbox"/> possesses <input type="checkbox"/> does not possess the legal capacity to enter into a contract with the Department.
2.	Section III.B.2	At time of Proposal Due Date, Offeror represents and warrants that it: <input type="checkbox"/> attests <input type="checkbox"/> does not attest provides behavioral management and associated claims adjudication services for a minimum of five million (5,000,000) lives as specified below. The Offeror must provide a list of client organizations with the number of lives served through each client to clearly demonstrate that the Offeror meets the minimum requirement of five million (5,000,000) lives. In determining lives, the Offeror should:  <ul style="list-style-type: none"> <li>• Include both at-risk and fee-for-service business;</li> <li>• Include Medicaid business;</li> <li>• Count all lives [e.g., an employee, a spouse and two (2) eligible dependents count as four (4)];</li> <li>• Exclude any non-behavioral health management business;</li> <li>• Exclude any employee assistance program business</li> </ul>

**Exhibit I.T - Offeror Attestations Form**

<p>3.</p>	<p>Section III.B.3</p>	<p>At time of Proposal Due Date, Offeror represents and warrants that it:</p> <p><input type="checkbox"/> attests  <input type="checkbox"/> does not attest</p> <p>its Empire Plan MHSA Provider Network, as proposed, meets or exceeds all of the following <u>minimum</u> Network access guarantees:</p> <p style="text-align: center;"><u>URBAN AREAS</u></p> <p>a. Seventy-five percent (75%) of Enrollees will have at least:</p> <ul style="list-style-type: none"> <li>• one (1) Facility – Inpatient within five (5) miles; and,</li> <li>• one (1) Facility – ALOC within five (5) miles.</li> </ul> <p>b. Seventy-five percent (75%) of Enrollees will have at least:</p> <ul style="list-style-type: none"> <li>• one (1) Psychiatrist within three (3) miles; and,</li> <li>• one (1) Psychologist within three (3) miles; and,</li> <li>• one (1) Licensed Clinical Social Worker (with R designation in NYS) within three (3) miles.</li> </ul> <p style="text-align: center;"><u>SUBURBAN AREAS</u></p> <p>c. Seventy-five percent (75%) of Enrollees will have at least:</p> <ul style="list-style-type: none"> <li>• one (1) Facility – Inpatient within fifteen (15) miles; and,</li> <li>• one (1) Facility – ALOC within fifteen (15) miles.</li> </ul> <p>d. Seventy-five percent (75%) of Enrollees will have at least:</p> <ul style="list-style-type: none"> <li>• one (1) Psychiatrist within fifteen (15) miles; and,</li> <li>• one (1) Psychologist within fifteen (15) miles; and,</li> <li>• one (1) Licensed Clinical Social Worker (with R designation in NYS) within fifteen (15) miles.</li> </ul> <p style="text-align: center;"><u>RURAL AREAS</u></p> <p>e. Seventy-five percent (75%) of Enrollees will have at least:</p> <ul style="list-style-type: none"> <li>• one (1) Facility – Inpatient within forty (40) miles; and,</li> <li>• one (1) Facility – ALOC within forty (40) miles.</li> </ul> <p>f. Seventy-five percent (75%) of Enrollees will have at least:</p> <ul style="list-style-type: none"> <li>• one (1) Psychiatrist within forty (40) miles; and,</li> <li>• one (1) Psychologist within forty (40) miles; and,</li> <li>• one (1) Licensed Clinical Social Worker (with R designation in NYS) within forty (40) miles.</li> </ul>
<p>4.</p>	<p>Section III.B.4</p>	<p>At time of Proposal Due Date, Offeror represents and warrants that it:</p> <p><input type="checkbox"/> attests  <input type="checkbox"/> does not attest</p> <p>understands and agrees to comply with all specific duties and responsibilities set forth in Section IV.B.3. of this RFP, entitled "Implementation," including Section IV.B.3.b.(2) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.</p>
<p>5.</p>	<p>Section III.B.5</p>	<p><u>As of the Proposal Due Date</u>, Offeror represents and warrants that it:</p> <p><input type="checkbox"/> attests  <input type="checkbox"/> does not attest</p> <p>will maintain and make available as required by the Department a complete and accurate set of records related to the Agreement resulting from this RFP as required by Appendices A and B and the draft Agreement set forth in Section VII of this RFP. This includes, but is not limited to, provider contracts, detailed claim records, and any and all other financial records as deemed necessary by the Department to perform its fiduciary responsibilities to the Empire Plan MHSA Program's participants and to ensure that public dollars are spent appropriately.</p>

**Exhibit I.T - Offeror Attestations Form**

6.	Section III.B.6	At time of Proposal Due Date, Offeror represents and warrants that it: <input type="checkbox"/> attests <input type="checkbox"/> does not attest has submitted as part of its Proposal, if so required by the RFP, or will submit all Transmittal letters, Statements, Formal Certifications and Exhibits as required in Section II of this RFP related to the Offeror's compliance with all rules, laws, regulations and executive orders.
7.	Section III.B.7	At time of Proposal Due Date, Offeror represents and warrants that it: <input type="checkbox"/> attests <input type="checkbox"/> does not attest will execute the duties and responsibilities set forth in Section IV of this RFP in strict conformance to the requirements described in that section of the RFP.
8.	Section III.B.8	At time of bid submission, Offeror represents and warrants that it: <input type="checkbox"/> attests <input type="checkbox"/> does not attest has current URAC-case management, JCAHO, ACHC, NCOA or CARF full accreditation.

Date: \_\_\_\_\_

\_\_\_\_\_

Signature

[INSERT OFFEROR NAME]  
 [INSERT TITLE]  
 [INSERT COMPANY NAME]

**CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT**

STATE OF \_\_\_\_\_ }  
 : SS.:

COUNTY OF \_\_\_\_\_ }

On the \_\_\_\_ day of \_\_\_\_\_ in the year 2013, before me personally appeared: \_\_\_\_\_, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that \_he resides at \_\_\_\_\_, Town of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_; and further that:

**[Check One]**

( \_\_\_ If a corporation): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, \_he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

( \_\_\_ If a partnership): \_he is the \_\_\_\_\_ of \_\_\_\_\_, the partnership described in said instrument; that, by the terms of said partnership, \_he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

\_\_\_\_\_  
**Notary Public**

**Exhibit I.U - Key Subcontractors**

The Offeror must complete and submit this Exhibit as part of its Administrative Proposal. A separate form should be completed for each Key Subcontractor, if any. If the Offeror will not be subcontracting with any Key Subcontractor(s) to provide any of the services required under the RFP, the Offeror must complete and submit a single Exhibit I.U to that affect.

<b>INSTRUCTION: Prepare this form for each Key Subcontractor</b>	
<b>Offeror's Name:</b>	
<p>The Offeror:</p> <p><input type="checkbox"/> is</p> <p><input type="checkbox"/> is not</p> <p>proposing to utilize the services of a subcontractor(s) to provide Program Services</p>	
<b>Subcontractor's Legal Name:</b>	
<b>Business Address:</b>	
<b>Subcontractor's Legal Form:</b>	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Other _____
<p>As of the date of the Offeror's Proposal, a subcontract</p> <p><input type="checkbox"/> has</p> <p><input type="checkbox"/> has not</p> <p>been executed between the Offeror and the subcontractor(s) for services to be provided by such subcontractor(s) relating to the Mental Health and Substance Abuse Program Services.</p>	
<p>In the space provided below, describe the Subcontractor's role(s) and responsibilities regarding Program Services to be provided by the subcontractor:</p>	
<b>Relationship between Offeror and Subcontractor for Current Engagements:</b> (Complete items 1 through 5 for each client engagement identified)	
1. Client:	
2. Client Reference Name and Phone #	
3. Program Title:	
4. Program Start Date:	
5. In the space provided below, Program Status:	
6. In the space provided below, describe the roles and responsibilities of the Offeror and subcontractor in regard to the program identified in 3, above:	

**Exhibit I.V - Program References**

---

Reference #: \_\_\_\_\_

Current or Former Customer?: \_\_\_\_\_

Abstract
Customer For Whom Services Were Performed: _____
Number of covered Lives: _____
Customer Address: _____ _____ _____
Program Description: (The Offeror should submit specific details concerning the program identified in satisfaction of the requirements in RFP, Section III.E. This information should be provided as an attachment to this form and the information provided should support the Offeror's assertion that it can successfully implement and administer programs of the scope and complexity as set forth in this RFP.)
Program Contact References: (Required And Will Be Verified) (Attach Additional References If Desired)
Contact Name: _____ Contact Title: _____
Phone Number: _____ E-Mail Address: _____
Contact Name: _____ Contact Title: _____
Phone Number: _____ E-Mail Address: _____

## **Exhibit I.W - Compliance with NYS Workers' Compensation Law**

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Sections 57 and 220 of the New York State Workers' Compensation Law (WCL) provide that the Procuring Agencies shall not enter into any contracts unless proof of workers' compensation and disability benefits insurance coverage is produced. Prior to entering into contracts with DCS/NYSIF, the selected Offeror will be required to verify for DCS/NYSIF, on forms authorized by the New York State Workers' Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed below. DCS/NYSIF would prefer Offeror submit this insurance verification information with their Proposals, if possible. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the State of New York Workers' Compensation Board, Bureau of Compliance at (518)486-6307. You may also find useful information at their website <http://www.wcb.state.ny.us>. Failure to provide verification of either of these types of insurance coverage by the time the winning Offeror is selected and the Contract is ready to be executed will be grounds for disqualification of an otherwise successful Proposal.

### **Workers' Compensation Requirements under WCL § 57:**

To comply with coverage provisions of the WCL, businesses must:

- A) be legally exempt from obtaining workers' compensation insurance coverage; or
- B) obtain such coverage from insurance carriers; or
- C) be a Board-approved self-insured employer or participate in an authorized group self-insurance plan.

To assist State and municipal entities in enforcing WCL Section 57, businesses requesting permits or seeking to enter into contracts **MUST provide ONE** of the following forms to the government entity issuing the permit or entering into a contract:

- A) CE-200, Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage <sup>(1)</sup>; **OR**
- B) C-105.2 -- Certificate of Workers' Compensation Insurance (the business's insurance carrier will send this form to the government entity upon request) **PLEASE NOTE:** The State Insurance Fund provides its own version of this form, the U-26.3; **OR**
- C) SI-12 -- Certificate of Workers' Compensation Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247), **OR** GSI-105.2 -- Certificate of Participation in Worker's Compensation Group Self-Insurance (the business's Group Self-Insurance Administrator will send this form to the government entity upon request).

### **Disability Benefits Requirements under Workers' Compensation Law §220(8)**

To comply with coverage provisions of the WCL regarding disability benefits, businesses may:

- A) be legally exempt from obtaining disability benefits insurance coverage; or
- B) obtain such coverage from insurance carriers; or
- C) be a Board-approved self-insured employer.

Accordingly, to assist State and municipal entities in enforcing WCL Section 220(8), businesses requesting permits or seeking to enter into contracts **MUST provide ONE** of the following forms to the entity issuing the permit or entering into a contract:

- A) CE-200, Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage <sup>(1)</sup>; **OR**
- B) DB-120.1 -- Certificate of Disability Benefits Insurance (the business's insurance carrier will send this form to the government entity upon request); **OR**
- C) DB-155 -- Certificate of Disability Benefits Self-Insurance (the business calls the Board's Self-Insurance Office at 518-402-0247).

<sup>(1)</sup> Starting December 1, 2008, Form CE-200 can be filled out electronically on the Board's website, [www.wcb.state.ny.us](http://www.wcb.state.ny.us), under the heading "Forms." Applicants filing electronically are able to print a finished Form CE-200 immediately upon completion of the electronic application. Applicants without access to a computer may obtain a paper application for the CE-200 by writing or visiting the Customer Service Center at any District Office of the Workers' Compensation Board. Applicants using the manual process may wait up to four weeks before receiving a CE-200. Once the applicant receives the CE-200, the applicant can then submit that CE-200 to the government agency from which he/she is getting the permit, license or contract.



**Extraneous Terms Template**  
**(Instructions for Documentation and Submission)**

---

Offerors shall identify all Extraneous Terms in the table provided on the following page, and shall adhere to all instructions below for preparing the table.

**INSTRUCTIONS:**

**RFP Section  
and Sub-Section  
Reference:**

The Offeror must insert the exact RFP Section, and Sub-Section number of the requirement(s) that the Offeror is proposing to modify. The Offeror must insert the nature of the proposed change and its impact on the Requirement.

**RFP Requirement:**

The Offeror must insert a concise description of the requirement(s) that the Offeror is proposing to modify.

**Proposed  
Extraneous Term  
Type:**

The Offeror must insert a one-word description, of the type of modification to each of the requirement(s) that the Offeror is proposing to modify, selected from the following list:

- Additional;
- Supplemental;
- “Or Equal”; or
- Alternative

**Proposed  
Extraneous  
Term:**

The one-word description must be followed by proposed alternate wording of the requirement(s).

**Impact on RFP  
Requirement:**

The Offeror should describe the impact of the alternate wording. Then, the comments should explain how the modification(s) would benefit the State and provide best value. If there is a corresponding impact on the Administrative, Technical or Financial Proposal(s), that impact should be explained here with reference(s) to the parts of the volume(s) that are affected. However, **DO NOT INCLUDE ANY COST DATA IN THE ADMINISTRATIVE OR TECHNICAL PROPOSALS.**

**The Offeror must use the table format described above and detailed on the following page to summarize its proposed Extraneous Terms, if any. The Offeror may refer to more voluminous narratives, tables, figures and appendices that more fully describe aspects of the Extraneous Terms, provided that the additional material is fully cross-referenced by this required table.**

### Extraneous Terms Template

EXTRANEIOUS TERM(S)			
No.	RFP Section and Sub-Section Reference	RFP Requirement	Proposed Extraneous Term Type
1.			<input type="checkbox"/> Additional; <input type="checkbox"/> Supplemental; <input type="checkbox"/> "Or Equal"; or <input type="checkbox"/> Alternative
<u>Proposed Extraneous Term(s):</u>			
<u>Impact on RFP Requirement:</u>			

## **Empire Plan MHA Program File Layout Specifications for the Offeror's Proposed MHA Provider Network File**

**Instructions:** Utilize this file layout to prepare Exhibit I.Y.2 of your technical proposal and submit on a CD. This file must include each Provider that you have an executed or contingent contract with for participation in the MHA Network commencing on January 1, 2014. The providers listed in this file must be included in the MHA Network implemented for the Program on 1/1/14 in accordance with Section IV.B.3.a(2)(a) "Implementation" and Section IV.B.10 "Network Management" of this RFP.

- 1) The Provider Tax ID is a number that represents a unique identifier of the contracting or bargaining entity. Place this identifier in Column 1 for each Network Provider included in this file.**
  
- 2) Enter the Provider Name, Street Address, City, State and five-digit zip code for each provider listed in this file in Columns 2 through 6.**
  
- 3) Include all Facilities, Alternative Levels of Care and the following Practitioner types:**
  - a. psychiatrist**
  - b. psychologist**
  - c. A licensed and registered clinical social worker with at least six 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.**
  - d. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses hold a master's or doctoral degree in a specialized area of psychiatric nursing psychiatric nurse**
  - e. 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 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**

f. A Certified Behavioral Analyst who provides covered services solely limited to diagnosed autism spectrum disorders.

g. 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.

4) Only include Providers who are accepting new patients.

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

6) In Column 7 enter the Facility or Practitioner Licensure type, as follows:

<b>MHF</b>	Mental Health Facility
<b>SAF</b>	Substance Abuse Facility
<b>MHALOC</b>	Mental Health ALOC
<b>SAALOC</b>	Substance Abuse ALOC
<b>PSYI</b>	Psychiatrist
<b>PSYCH</b>	Psychologist
<b>LCSW-R</b>	Licensed Clinical Social Worker with "R" designation in NYS
<b>CBA</b>	Certified Behavioral Analyst Provider
<b>ABA</b>	Applied Behavioral Analysis Agency
<b>RNP</b>	Registered Nurse Practitioner
<b>RNCS</b>	Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist

7) In column 8 identify the contracting /credentialing status of the MHSA Network Provider by indicating the following:

"1" participating in 2014 Provider Network, fully contracted and credentialed as of Proposal Due date

"2" participating in 2014 Provider Network, contingent contract and/or not fully credentialed as of Proposal Due Date

8) Each Provider should be represented once at the primary location. If a provider practices at more than one location, include it in the primary location.

9) Return the file on CD using Microsoft Excel.

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8
<b>Provider Tax ID</b>	<b>Provider Name</b>	<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip code</b>	<b>Facility Type or Licensure Type</b>	<b>Contracting / Credentialing Status (1 or 2)</b>

**Empire Plan MHSA Program  
Offeror's Proposed MHSA Provider Network File**

All Offerors are required to submit their proposed MHSA provider network as Exhibit I.Y.2 entitled, "Offeror's Proposed MHSA Provider Network File" in the format specified by Exhibit I.Y.1.

**Empire Plan MHPA Program  
Offeror's Proposed MHPA Provider Network Access Prerequisite Worksheet**

**Psychiatrists**

<b>Location Column (2)</b>	<b># of Empire Plan Enrollees With Access Column (3)</b>	<b># of Empire Plan Enrollees Without Access Column (4)</b>	<b>Total Empire Plan Enrollees Column (5)</b>	<b>% With Access Column (6)</b>
Urban	0	0	0	#DIV/0!
Suburban	0	0	0	#DIV/0!
Rural	0	0	0	#DIV/0!
<b>Total</b>	<u>0</u>	<u>0</u>	<u>0</u>	<u>#DIV/0!</u>

**Psychologists**

<b>Location Column (2)</b>	<b># of Empire Plan Enrollees With Access Column (3)</b>	<b># of Empire Plan Enrollees Without Access Column (4)</b>	<b>Total Empire Plan Enrollees Column (5)</b>	<b>% With Access Column (6)</b>
Urban	0	0	0	#DIV/0!
Suburban	0	0	0	#DIV/0!
Rural	0	0	0	#DIV/0!
<b>Total</b>	<u>0</u>	<u>0</u>	<u>0</u>	<u>#DIV/0!</u>

**Licensed Clinical  
Social Workers**

<b>Location Column (2)</b>	<b># of Empire Plan Enrollees With Access Column (3)</b>	<b># of Empire Plan Enrollees Without Access Column (4)</b>	<b>Total Empire Plan Enrollees Column (5)</b>	<b>% With Access Column (6)</b>
Urban	0	0	0	#DIV/0!
Suburban	0	0	0	#DIV/0!
Rural	0	0	0	#DIV/0!
<b>Total</b>	<u>0</u>	<u>0</u>	<u>0</u>	<u>#DIV/0!</u>

**Alternate Level of Care**

Location Column (2)	# of Empire Plan Enrollees With Access Column (3)	# of Empire Plan Enrollees Without Access Column (4)	Total Empire Plan Enrollees Column (5)	% With Access Column (6)
Urban	0	0	0	#DIV/0!
Suburban	0	0	0	#DIV/0!
Rural	0	0	0	#DIV/0!
Total	0	0	0	#DIV/0!

**Facilities**

Location Column (2)	# of Empire Plan Enrollees With Access Column (3)	# of Empire Plan Enrollees Without Access Column (4)	Total Empire Plan Enrollees Column (5)	% With Access Column (6)
Urban	0	0	0	#DIV/0!
Suburban	0	0	0	#DIV/0!
Rural	0	0	0	#DIV/0!
Total	0	0	0	#DIV/0!

A. Enter the number of Empire Plan enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (column 3)

B. Enter the number of Empire Plan enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries. (column 4)

C. Column (5) equals Column (3) plus Column (4).

D. Column (6) equals Column (3) divided by Column (5).

E. The Offeror's proposed MHSA provider network access %'s in column (6) must equal, the Program's minimum mandatory access requirements, defined in this RFP, in order for their proposal to be evaluated.

F. The Total Number of Empire Plan Enrollees in the Offeror's Geo Access Accessibility Summaries should equal the totals in Column (5).

**Note: All enrollees must be counted in calculating whether the Offeror meets the MHSA provider Network access guarantees. No enrollee may be excluded even if there is no provider located within the minimum mandatory access requirements.**



**Comparison of Current MHSA Program Providers  
and the Offeror's Proposed Provider Network**

**INSTRUCTIONS/FILE LAYOUT:**

- 1) The first four columns in the Exhibit I.Y.4 file list DCS Provider Identifier, Provider Tax ID, Provider Name and Provider Zip Code.
  
- 2) In Column 5, identify whether each of the Providers will or will not participate in the Offeror's proposed 2014 MHSA Network by indicating the following:  
  
"0"- not participating in 2014 Provider Network  
"1"- participating in 2014 Provider Network, fully contracted and credentialed as of Proposal Due Date  
"2"- participating in 2014 Provider Network, contingent contract and/or not fully credentialed as of Proposal Due Date
  
- 3) Submit completed Exhibit I.Y.4 in a paper format in the Technical Proposal as well as an electronic format, using Microsoft Excel. Do not password protect the file or use any other security measures.

File Layout:

Column 1	Column 2	Column 3	Column 4	Column 5
DCS Provider Identifier	Provider Tax ID	Provider Name	Provider Zip Code	Network Indicator (0, 1 or 2)

**Mental Health and Substance Abuse Program for  
The Empire Plan, Excelsior Plan, and Student Employee Health Plan,**

**CONFIDENTIAL AGREEMENT AND CERTIFICATE OF NON-DISCLOSURE**

**This Exhibit MUST be filled out by all Offerors and Key Subcontractors**

**THIS AGREEMENT** is between the New York State Department of Civil Service (DCS) its successors and assigns, acting on behalf of the State of New York, and having its principal place of business at: DCS; Empire State Plaza, Albany, New York, 12239, and

\_\_\_\_\_ (Respondent), its successors and assigns, having its principal place of business at:  
\_\_\_\_\_.

\_\_\_\_\_ being duly sworn, deposes and says that he/she is \_\_\_\_\_  
(Print or type full name) (Title or Capacity)

of \_\_\_\_\_, the firm that executed this instrument and that he/she is authorized by said firm to execute  
(Name of firm)

this instrument, and further, in consideration of release of detailed claims data and enrollee demographic data by DCS, the firm hereby agrees that any information pertaining to the Program and its documentation, including the information contained on the detailed claims and enrollee demographic data as referenced in the Request for Proposals entitled, Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan, and Student Employee Health Plan, which has been or may be supplied to or obtained by the firm, its officers, agents and employees, based upon the representations made above in relation to the procurement of a Contractor to administer the Programs under New York State Civil Service Law, Article XI, is confidential and may not be used for any purpose other than the formulation of a good faith offer for said procurement, and that any other use, release or dissemination to any party, of any such confidential information, without the prior written consent of DCS, shall constitute a breach of this Confidentiality Agreement and Statement of Non-Disclosure and may result in disqualification of the firm from said procurement, or the imposition of other sanctions as determined by the DCS or as required by the State of New York or by law.

The firm further acknowledges that receipt to the detailed claims and enrollee demographic data is subject to the following warranty disclaimer by the DCS: all detailed claims data supplied for the Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan, and Student Employee Health Plan, Request for Proposal contain information provided by the current insurer/administrator which has not been audited by the DCS and is provided on an “as is” basis. For purposes of the data, any interested Offeror’s or Offerors’ use of the data, or the results of any interested Offeror’s or Offerors’ use of the data, the DCS and State of New York make no warranties, guarantees or representations of any kind expressed or implied, or arising by custom or trade usage, as to any matter whatsoever, without limitation, and specifically make no implied warranty of fitness for any particular purpose or use, including but not limited to adequacy, accuracy, completeness or conformity to any representation, description, sample or model.

<b>Please complete to receive detailed claims and enrollee demographic data</b>			
<b>Designated Contact Information</b>		<b>Alternate Contact Information</b>	
Contact Name:		Contact Name:	
Address:		Address:	
Phone Number:		Phone Number:	
Fax:		Fax:	
E-Mail:		E-Mail:	

Complete Exhibit I.Z and submit it to the MHSA Program Procurement Manager specified in Section II.A.2.b. of this RFP. The completed Exhibit I.Z may be emailed at: [MHSA2013RFP@cs.state.ny.us](mailto:MHSA2013RFP@cs.state.ny.us), faxed at: 518-402-2835 and/or mailed (see address provided in RFP, Section II.A.2.b.)

**VENDOR**

Name/Address of Corporate Headquarters

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Exhibit I.Z – Confidentiality Agreement**

**IN WITNESS WHEREOF**, Vendor has caused this Agreement to be signed as of the date set forth below.

**VENDOR’S AUTHORIZED LEGAL REPRESENTATIVE**

Name/Title/Address (If Different from Above)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Signature of Authorized Legal Representative as the act and deed and on behalf of Vendor is Required.\**

\* \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned affirms and swears s/he has the legal authority and capacity to sign and make this offer on behalf of, **[INSERT OFFEROR NAME]** and possesses the legal authority and capacity to act on behalf of **[INSERT OFFEROR NAME]** to execute a contract with the State of New York.

The undersigned affirms and swears as to the truth and veracity of all documents included in this offer.

Date: \_\_\_\_\_

**[INSERT OFFEROR NAME]**

**By:** \_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Title)

**CORPORATE OR PARTNERSHIP ACKNOWLEDGMENT**

**STATE OF** }  
: **SS.:**  
**COUNTY OF** }

On the \_\_\_ day of \_\_\_\_\_ in the year 2013, before me personally appeared: \_\_\_\_\_, known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that \_he resides at: \_\_\_\_\_, Town of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_; and further that:

**[Check One]**

( \_\_\_ **If a corporation:** \_he is the \_\_\_\_\_ of \_\_\_\_\_, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, \_he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

( \_\_\_ **If a partnership:** \_he is the \_\_\_\_\_ of \_\_\_\_\_, the partnership described in said instrument; that, by the terms of said partnership, \_he is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that, pursuant to that authority, \_he executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

\_\_\_\_\_  
**Notary Public**

**Exhibit II.A Enrollment by Contact Type**

**NEW YORK STATE DEPARTMENT OF CIVIL SERVICE'S**

**"MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAM FOR THE EMPIRE PLAN,  
EXCELSIOR PLAN, STUDENT EMPLOYEE HEALTH PLAN RFP"**

**ENROLLMENT BY CONTRACT TYPE - October 2012**

	NEW YORK STATE					PARTICIPATING EMPLOYERS					PARTICIPATING AGENCIES					Total
	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	Actives	Retirees	COBRA	Other	Subtotal	
<b>EMPIRE</b>																
Individual	58,998	64,965	477	13,038	137,478	8,233	4,317	325	1,229	14,104	30,866	41,727	361	6,761	79,715	231,297
Drug	58,998	64,952	477	13,031	137,458	7,524	4,098	319	1,229	13,170	30,866	41,724	361	6,756	79,707	230,335
No Drug	0	13	0	7	20	709	219	6	0	934	0	3	0	5	8	962
Family	91,663	49,488	147	952	142,250	19,965	8,932	89	430	29,416	74,034	44,211	271	618	119,134	290,800
Drug	91,663	49,488	147	952	142,250	18,513	8,502	87	430	27,532	74,034	44,211	271	618	119,134	288,916
No Drug	0	0	0	0	0	1,452	430	2	0	1,884	0	0	0	0	0	1,884
<b>Total Empire</b>	<b>150,661</b>	<b>114,453</b>	<b>624</b>	<b>13,990</b>	<b>279,728</b>	<b>28,198</b>	<b>13,249</b>	<b>414</b>	<b>1,659</b>	<b>43,520</b>	<b>104,900</b>	<b>85,938</b>	<b>632</b>	<b>7,379</b>	<b>198,849</b>	<b>522,097</b>
<b>SEHP</b>																
Individual (all with Drug)	2,679	0	215	0	2,894	1,754	0	89	0	1,843						4,737
Family (all with Drug)	366	0	19	0	385	366	0	16	0	382						767
<b>Total SEHP</b>	<b>3,045</b>		<b>234</b>	<b>0</b>	<b>3,279</b>	<b>2,120</b>		<b>105</b>	<b>0</b>	<b>2,225</b>						<b>5,504</b>
<b>EXCELSIOR PLAN</b>																
Individual											36	65	0	25	126	126
Drug											36	65	0	25	126	126
No Drug											0	0	0	0	0	0
Family											50	58	0	2	110	110
Drug											50	58	0	2	110	110
No Drug											0	0	0	0	0	0
<b>Total Excelsior</b>											<b>86</b>	<b>123</b>	<b>0</b>	<b>27</b>	<b>236</b>	<b>236</b>
<b>TOTAL EMPIRE EXCELSIOR &amp; SEHP</b>																
Individual	61,677	64,965	692	13,038	140,372	9,987	4,317	414	1,229	15,947	30,902	41,792	361	6,786	79,841	236,160
Drug																
No Drug																
Family	92,029	49,488	166	952	142,635	20,331	8,932	105	430	29,798	74,084	44,269	271	620	119,244	291,677
Drug																
No Drug																
<b>Total</b>	<b>153,706</b>	<b>114,453</b>	<b>858</b>	<b>13,990</b>	<b>283,007</b>	<b>30,318</b>	<b>13,249</b>	<b>519</b>	<b>1,659</b>	<b>45,745</b>	<b>104,986</b>	<b>86,061</b>	<b>632</b>	<b>7,406</b>	<b>199,085</b>	<b>527,837</b>
<b>HMO's</b>																
Individual	13,459	11,674	72	1,381	26,586	2,281	929	17	133	3,360						29,946
Drug	13,459	11,674	72	1,381	26,586	2,150	868	17	133	3,168						29,754
No Drug	0	0	0	0	0	131	61	0	0	192						192
Family	19,004	7,121	12	129	26,266	3,666	1,047	6	38	4,757						31,023
Drug	19,004	7,121	12	129	26,266	3,427	981	6	38	4,452						30,718
No Drug	0	0	0	0	0	239	66	0	0	305						305
<b>Total HMO</b>	<b>32,463</b>	<b>18,795</b>	<b>84</b>	<b>1,510</b>	<b>52,852</b>	<b>5,947</b>	<b>1,976</b>	<b>23</b>	<b>171</b>	<b>8,117</b>						<b>60,969</b>

	<u>Actives</u>	<u>Retirees</u>	<u>COBRA</u>	<u>Other</u>	<u>Subtotal</u>	<u>Actives</u>	<u>Retirees</u>	<u>COBRA</u>	<u>Other</u>	<u>Subtotal</u>	<u>Actives</u>	<u>Retirees</u>	<u>COBRA</u>	<u>Other</u>	<u>Subtotal</u>	<u>Total</u>
<b>NYSHIP TOTAL</b>	<b>186,169</b>	<b>133,248</b>	<b>942</b>	<b>15,500</b>	<b>335,859</b>	<b>36,265</b>	<b>15,225</b>	<b>542</b>	<b>1,830</b>	<b>53,862</b>	<b>104,986</b>	<b>86,061</b>	<b>632</b>	<b>7,406</b>	<b>199,085</b>	<b>588,806</b>

\* NYBEAS Run 10/4/2012

Note: There are 1,899 (1,382 family, 517 individual) Opt-Out enrollees (former NYSHIP enrollees who have opted out of NYSHIP) as of 10/4/12.

**Covered Lives by Bargaining Unit**

Exhibit ILA2

**New York State Department of Civil Service's**

**"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP"**

**Covered Lives by Bargaining Unit or Other Group**

**October 2012**

<b>Bargaining Unit or Other Group</b>	<b>Coverage</b>	<b>Enrollee</b>	<b>Spouse</b>	<b>Dependent Child</b>	<b>Total Covered Lives</b>	<b>Medicare Primary Lives(1)</b>
CSEA	Individual	19,580	-	-	19,580	37
	Family	25,319	18,529	37,264	81,112	
	Total	44,899	18,529	37,264	100,692	
PEF	Individual	14,203	-	-	14,203	38
	Family	20,281	17,047	29,208	66,536	
	Total	34,484	17,047	29,208	80,739	
UUP	Individual	8,925	-	-	8,925	27
	Family	12,523	11,240	16,796	40,559	
	Total	21,448	11,240	16,796	49,484	
NYSCOPBA	Individual	4,757	-	-	4,757	9
	Family	13,392	10,955	22,722	47,069	
	Total	18,149	10,955	22,722	51,826	
PBA Troopers	Individual	486	-	-	486	-
	Family	1,756	1,642	3,368	6,766	
	Total	2,242	1,642	3,368	7,252	
PBA Supervisors	Individual	63	-	-	63	-
	Family	539	502	1,154	2,195	
	Total	602	502	1,154	2,258	
PIA	Individual	110	-	-	110	-
	Family	805	745	1,704	3,254	
	Total	915	745	1,704	3,364	
APSU	Individual	317	-	-	317	-
	Family	598	540	992	2,130	
	Total	915	540	992	2,447	
DC-37	Individual	126	-	-	126	-
	Family	113	89	156	358	
	Total	239	89	156	484	
C-82	Individual	81	-	-	81	-
	Family	421	370	714	1,505	
	Total	502	370	714	1,586	
UUP Lifeguards	Individual	4	-	-	4	-
	Family	-	-	-	-	
	Total	4	-	-	4	
M/C (2)	Individual	5,270	-	-	5,270	18
	Family	7,560	6,635	10,492	24,687	
	Total	12,830	6,635	10,492	29,957	
Office of Court Administration (OCA) (3)	Individual	5,067	-	-	5,067	15
	Family	8,350	6,833	12,367	27,550	
	Total	13,417	6,833	12,367	32,617	
NYS Other (4)	Individual	13,525	-	-	13,525	11,818
	Family	1,104	573	1,461	3,138	
	Total	14,629	573	1,461	16,663	
NYS Retirees (5)	Individual	64,965	-	-	64,965	113,709
	Family	49,488	48,035	13,475	110,998	
	Total	114,453	48,035	13,475	175,963	
PE (6)	Individual	14,104	-	-	14,104	11,643
	Family	29,416	26,103	34,913	90,432	
	Total	43,520	26,103	34,913	104,536	
PA Empire Plan (7)	Individual	79,715	-	-	79,715	103,609
	Family	119,134	109,013	123,094	351,241	
	Total	198,849	109,013	123,094	430,956	
PA Excelsior Plan (8)	Individual	126	-	-	126	166
	Family	110	102	82	294	
	Total	236	102	82	420	
Graduate Student Employee Union (GSEU) (9)	Individual	4,433	-	-	4,433	-
	Family	732	690	423	1,845	
	Total	5,165	690	423	6,278	
Graduate Student Employee Union (GSEU) Other (10)	Individual	304	-	-	304	-
	Family	35	34	34	103	
	Total	339	34	34	407	
<b>TOTAL</b>	<b>Individual</b>	<b>236,161</b>	<b>-</b>	<b>-</b>	<b>236,161</b>	<b>241,089</b>
	<b>Family</b>	<b>291,676</b>	<b>259,677</b>	<b>310,419</b>	<b>861,772</b>	
	<b>Total</b>	<b>527,837</b>	<b>259,677</b>	<b>310,419</b>	<b>1,097,933</b>	

(1) Represents Total Medicare Primary Lives included within the Total Covered Lives for each respective group.

(2) Management Confidential Employees and other unrepresented NYS employees.

(3) Represents all Court System employees; excludes all Court System COBRA, YAO and other Post Employment Court System enrollees.

- (4) Represents all NYS (including OCA) Dependent Survivor, Preferred List, Vestee, Extended Benefits, LTD enrollees, COBRA and YAO enrollees.
- (5) Represents all NYS (including OCA) Retirees.
- (6) Represents all Participating Employer enrollees (employees and all others).
- (7) Represents all Participating Agency Empire Plan enrollees (employees and all others).
- (8) Represents all Participating Agency Excelsior Plan enrollees (employees and all others).
- (9) GSEU employees only.
- (10) Represents GSEU COBRA and YAO enrollees.

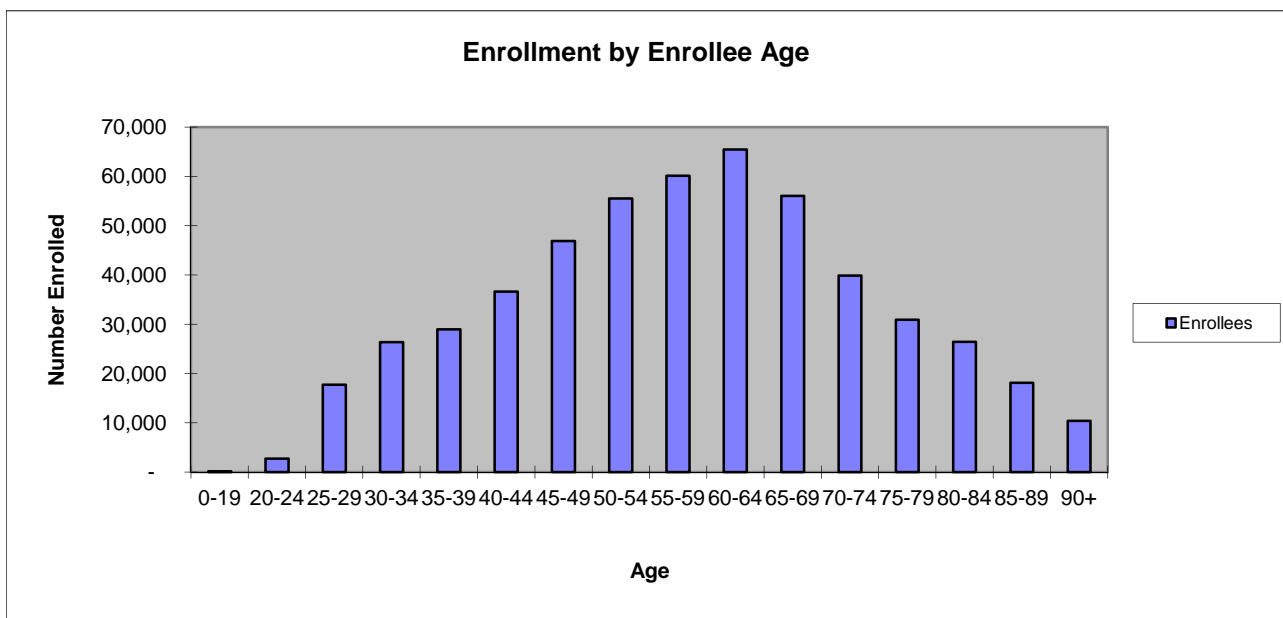
## New York State Department of Civil Service's

### Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP

#### ENROLLMENT BY AGE

#### EMPIRE PLAN AS OF DECEMBER 6, 2012

Age Group	Enrollees	Spouses	Dependents	Total
0-19	133	29	221,232	221,394
20-24	2,756	445	76,147	79,348
25-29	17,760	4,941	11,641	34,342
30-34	26,338	13,070	509	39,917
35-39	28,977	18,355	346	47,678
40-44	36,645	24,770	289	61,704
45-49	46,862	29,701	207	76,770
50-54	55,498	33,180	131	88,809
55-59	60,107	33,661	63	93,831
60-64	65,421	33,127	21	98,569
65-69	56,032	26,592	6	82,630
70-74	39,868	17,677	2	57,547
75-79	30,916	11,397	-	42,313
80-84	26,448	7,378	-	33,826
85-89	18,135	3,531	-	21,666
90+	10,423	1,115	-	11,538
<b>Total:</b>	<b>522,319</b>	<b>258,969</b>	<b>310,594</b>	<b>1,091,882</b>



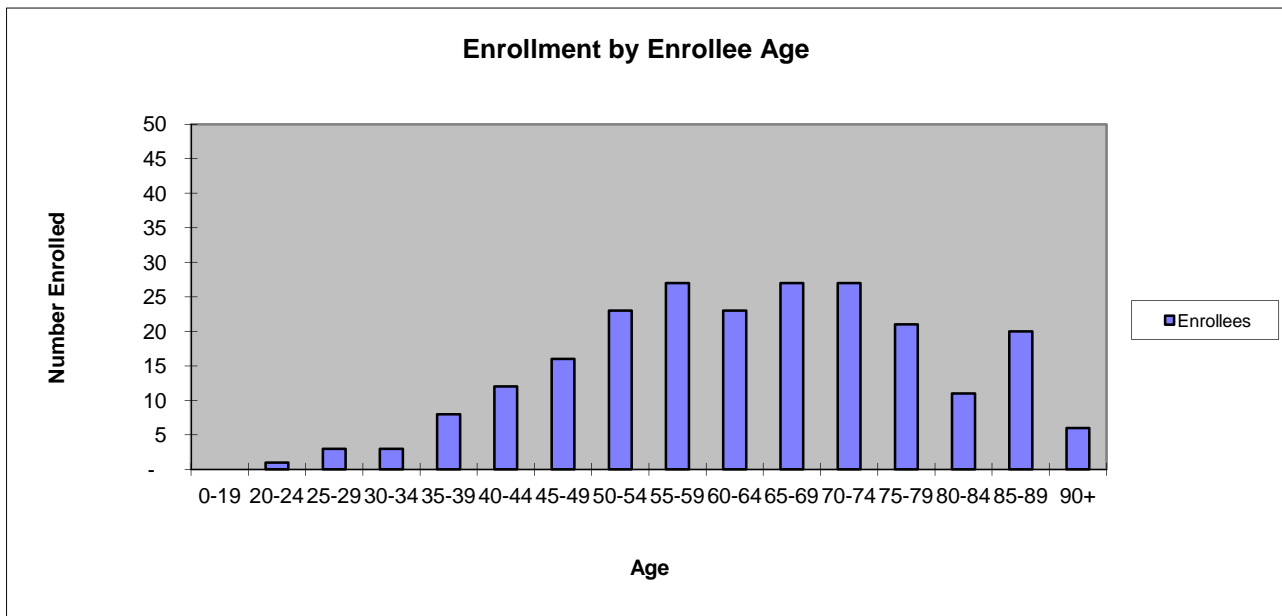
Source: NYBEAS



**Empire Plan Mental Health and Substance Abuse Program  
ENROLLMENT BY AGE**

**EXCELSIOR PLAN  
AS OF DECEMBER 6, 2012**

Age Group	Enrollees	Spouses	Dependents	Total
0-19	-	-	55	55
20-24	1	-	25	26
25-29	3	1	3	7
30-34	3	4	-	7
35-39	8	5	-	13
40-44	12	6	-	18
45-49	16	8	-	24
50-54	23	7	1	31
55-59	27	18	-	45
60-64	23	9	-	32
65-69	27	15	-	42
70-74	27	10	-	37
75-79	21	5	-	26
80-84	11	9	-	20
85-89	20	2	-	22
90+	6	-	-	6
<b>Total:</b>	<b>228</b>	<b>99</b>	<b>84</b>	<b>411</b>

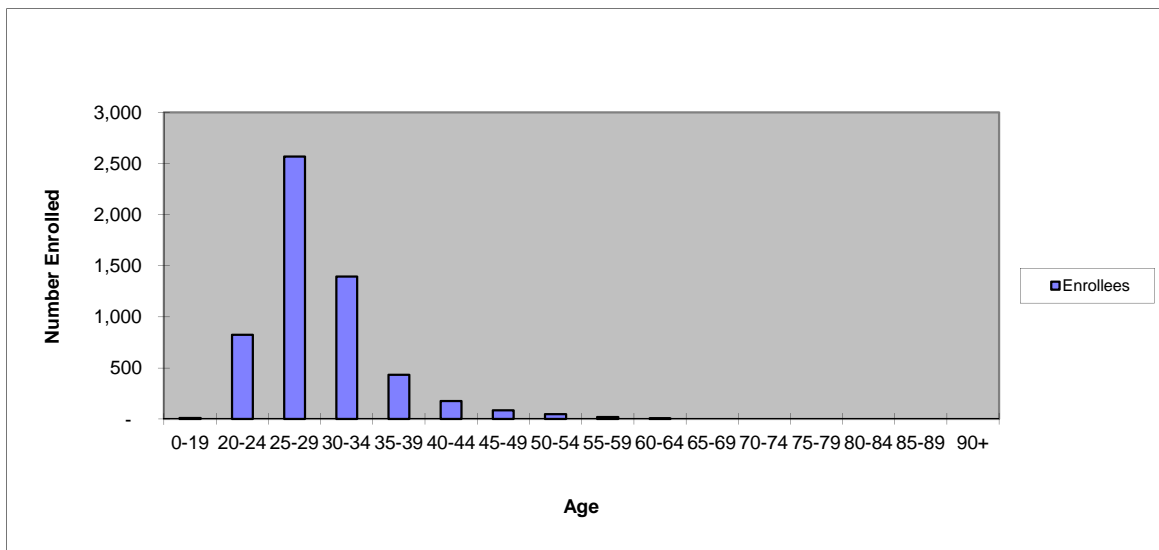


Source: NYBEAS

**Empire Plan Mental Health and Substance Abuse Program  
ENROLLMENT BY AGE**

**STUDENT EMPLOYEE HEALTH PLAN (SEHP)  
AS OF DECEMBER 6, 2012**

Age Group	Enrollees	Spouses	Dependents	Total
0-19	9	2	460	471
20-24	825	23	15	863
25-29	2,570	218	-	2,788
30-34	1,395	264	-	1,659
35-39	432	123	-	555
40-44	177	64	-	241
45-49	84	22	-	106
50-54	48	13	-	61
55-59	21	9	-	30
60-64	8	3	-	11
65-69	-	2	-	2
70-74	-	-	-	-
75-79	-	-	-	-
80-84	-	-	-	-
85-89	-	-	-	-
90+	-	-	-	-
<b>Total:</b>	<b>5,569</b>	<b>743</b>	<b>475</b>	<b>6,787</b>



Source: NYBEAS

**Empire Plan Mental Health and Substance Abuse Program  
Enrollment by Month**

**Empire Plan**

	Individual Coverage	Family Coverage	Total
Jan-07	221,875	286,529	508,404
Feb-07	222,375	286,541	508,916
Mar-07	222,560	286,522	509,082
Apr-07	223,004	286,797	509,801
May-07	223,420	286,667	510,087
Jun-07	223,478	286,718	510,196
Jul-07	223,637	287,023	510,660
Aug-07	223,404	286,929	510,333
Sep-07	224,337	287,580	511,917
Oct-07	225,488	288,001	513,489
Nov-07	226,534	288,596	515,130
Dec-07	226,649	288,916	515,565
Jan-08	227,961	289,250	517,211
Feb-08	228,138	289,456	517,594
Mar-08	228,677	289,649	518,326
Apr-08	229,029	289,577	518,606
May-08	229,202	289,637	518,839
Jun-08	229,736	289,713	519,449
Jul-08	229,521	290,184	519,705
Aug-08	229,041	290,069	519,110
Sep-08	229,978	290,506	520,484
Oct-08	230,884	290,681	521,565
Nov-08	231,394	291,018	522,412
Dec-08	230,989	291,140	522,129

	Individual Coverage	Family Coverage	Total
Jan-09	232,227	292,858	525,085
Feb-09	232,102	292,760	524,862
Mar-09	232,106	292,780	524,886
Apr-09	232,199	292,647	524,846
May-09	232,170	292,354	524,524
Jun-09	232,270	292,303	524,573
Jul-09	233,443	291,263	524,706
Aug-09	232,599	291,029	523,628
Sep-09	232,964	291,253	524,217
Oct-09	233,291	291,385	524,676
Nov-09	233,388	291,644	525,032
Dec-09	233,338	291,873	525,211
Jan-10	242,310	288,664	530,974
Feb-10	240,678	290,469	531,147
Mar-10	243,969	287,165	531,134
Apr-10	241,697	289,427	531,124
May-10	241,955	289,228	531,183
Jun-10	241,265	290,237	531,502
Jul-10	240,799	290,738	531,537
Aug-10	239,753	291,157	530,910
Sep-10	240,205	291,470	531,675
Oct-10	240,489	291,769	532,258
Nov-10	240,494	292,037	532,531
Dec-10	240,497	292,117	532,614

	Individual Coverage	Family Coverage	Total
Jan-11	238,042	294,037	532,079
Feb-11	237,377	294,068	531,445
Mar-11	236,929	294,234	531,163
Apr-11	236,294	294,182	530,476
May-11	235,955	293,990	529,945
Jun-11	235,666	293,927	529,593
Jul-11	234,841	293,672	528,513
Aug-11	234,183	293,679	527,862
Sep-11	233,884	293,624	527,508
Oct-11	233,851	293,336	527,187
Nov-11	233,653	293,184	526,837
Dec-11	233,244	292,909	526,153
Jan-12	232,807	292,247	525,054
Feb-12	232,094	291,451	523,545
Mar-12	231,794	291,369	523,163
Apr-12	231,683	291,321	523,004
May-12	231,510	290,984	522,494
Jun-12	231,390	290,584	521,974
Jul-12	231,667	291,035	522,702
Aug-12	231,018	290,672	521,690
Sep-12	231,140	290,733	521,873
Oct-12	231,297	290,800	522,097
Nov-12			
Dec-12			

\* Does not include Excelsior Plan and Student Employee Health Plan enrollees.

**Empire Plan Mental Health and Substance Abuse Program  
Enrollment by Month**

**Student Employee Health Plan**

	Individual Coverage	Family Coverage	Total
Jan-07	3,094	457	3,551
Feb-07	3,150	464	3,614
Mar-07	3,115	446	3,561
Apr-07	3,151	448	3,599
May-07	3,165	455	3,620
Jun-07	3,147	460	3,607
Jul-07	2,587	392	2,979
Aug-07	2,575	392	2,967
Sep-07	3,000	455	3,455
Oct-07	3,242	464	3,706
Nov-07	3,439	474	3,913
Dec-07	3,415	459	3,874
Jan-08	3,397	453	3,850
Feb-08	3,304	443	3,747
Mar-08	3,392	458	3,850
Apr-08	3,420	467	3,887
May-08	3,427	464	3,891
Jun-08	3,218	463	3,681
Jul-08	2,543	368	2,911
Aug-08	2,622	367	2,989
Sep-08	3,031	417	3,448
Oct-08	3,500	459	3,959
Nov-08	3,530	462	3,992
Dec-08	3,547	461	4,008

	Individual Coverage	Family Coverage	Total
Jan-09	4,325	532	4,857
Feb-09	4,474	562	5,036
Mar-09	4,315	544	4,859
Apr-09	4,324	560	4,884
May-09	4,361	575	4,936
Jun-09	4,364	582	4,946
Jul-09	3,700	513	4,213
Aug-09	3,720	522	4,242
Sep-09	3,983	551	4,534
Oct-09	4,537	593	5,130
Nov-09	4,752	622	5,374
Dec-09	4,739	639	5,378
Jan-10	4,755	644	5,399
Feb-10	4,724	647	5,371
Mar-10	4,745	657	5,402
Apr-10	4,753	672	5,425
May-10	4,734	687	5,421
Jun-10	4,705	684	5,389
Jul-10	4,121	608	4,729
Aug-10	4,074	617	4,691
Sep-10	4,502	687	5,189
Oct-10	4,857	706	5,563
Nov-10	4,994	733	5,727
Dec-10	5,017	744	5,761

	Individual Coverage	Family Coverage	Total
Jan-11	5,012	741	5,753
Feb-11	4,967	753	5,720
Mar-11	4,960	764	5,724
Apr-11	4,862	766	5,628
May-11	4,751	777	5,528
Jun-11	4,736	784	5,520
Jul-11	4,134	709	4,843
Aug-11	4,060	704	4,764
Sep-11	4,355	746	5,101
Oct-11	4,693	758	5,451
Nov-11	4,839	767	5,606
Dec-11	4,892	775	5,667
Jan-12	4,924	789	5,713
Feb-12	4,888	780	5,668
Mar-12	4,844	783	5,627
Apr-12	4,834	779	5,613
May-12	4,782	785	5,567
Jun-12	4,621	771	5,392
Jul-12	4,106	689	4,795
Aug-12	4,066	696	4,762
Sep-12	4,633	784	5,417
Oct-12	4,737	767	5,504
Nov-12			
Dec-12			

**New York State Department of Civil Service's**

**"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan,  
Student Employee Health Plan RFP"**

**Enrollment by Month**

**Excelsior Plan**

	Individual Coverage	Family Coverage	Total
Jan-09	132	156	288
Feb-09	128	156	284
Mar-09	128	152	280
Apr-09	127	150	277
May-09	126	148	274
Jun-09	131	148	279
Jul-09	132	145	277
Aug-09	131	145	276
Sep-09	131	143	274
Oct-09	130	143	273
Nov-09	130	142	272
Dec-09	129	142	271
Jan-10	127	139	266
Feb-10	129	138	267
Mar-10	150	120	270
Apr-10	138	133	271
May-10	135	134	269
Jun-10	131	139	270
Jul-10	121	128	249
Aug-10	45	17	62
Sep-10	44	16	60
Oct-10	44	16	60
Nov-10	44	17	61
Dec-10	43	15	58

	Individual Coverage	Family Coverage	Total
Jan-11	43	20	63
Feb-11	44	20	64
Mar-11	44	22	66
Apr-11	40	20	60
May-11	40	20	60
Jun-11	41	20	61
Jul-11	42	21	63
Aug-11	41	21	62
Sep-11	41	20	61
Oct-11	41	20	61
Nov-11	39	21	60
Dec-11	32	20	52
Jan-12	124	120	244
Feb-12	127	121	248
Mar-12	127	121	248
Apr-12	127	121	248
May-12	128	120	248
Jun-12	128	119	247
Jul-12	130	121	251
Aug-12	130	119	249
Sep-12	127	121	248
Oct-12	126	110	236
Nov-12			
Dec-12			

## New York State Department of Civil Service's

**“Mental Health and Substance Abuse Program for the Empire Plan,  
Excelsior Plan, Student Employee Health Plan RFP”**

**Non-Network Mental Health Practitioner Services Deductibles &  
Coinsurance Maximums - Effective January 1, 2013**

<b>Employee Group</b>	<b>Annual Deductible *</b> <i>(per enrollee; per spouse or domestic partner; per all dependent children combined)</i>	<b>Coinsurance Maximum *</b> <i>(Out-of-Pocket Expense per contract)</i>
<b>Executive Branch</b>		
<b>CSEA</b>	\$1,000/\$500***	\$3,000/\$1,500***
<b>DC 37</b>	\$322 CPI **	\$690 CPI**/\$300***
<b>PBA – Troopers</b>	\$417 CPI**	\$919 CPI**
<b>PBA – Supervisors</b>	\$417 CPI**	\$919 CPI**
<b>PIA</b>	\$417 CPI**	\$919 CPI**
<b>Council 82</b>	\$1,000	\$3,000
<b>APSU (formerly ALESU)</b>	\$1,000	\$3,000
<b>NYSCOPBA</b>	\$1,000/\$500***	\$3,000/\$1,500***
<b>UUP</b>	\$417 CPI**	\$1,148 CPI**
<b>UUP Lifeguards</b>	\$417 CPI**	\$1,545 CPI**
<b>PEF</b>	\$1,000/\$500***	\$3,000/\$1,500***
<b>M/C</b>	\$1,000/\$500***	\$3,000/\$1,500***
<b>Legislature</b>	\$1,000/\$500***	\$3,000/\$1,500***
<b>Participating Employers</b>	\$1,000	\$3,000
<b>Unified Court System</b>	\$1,000/\$500***	\$3,000/\$1,500***
<b>Retirees, Vesteas, Dependent Survivors and Preferred List</b>	\$1,000	\$3,000
<b>Student Employee Health Plan (GSEU)</b>	\$100	N/A
<b>Participating Agencies</b>	\$1,000	\$3,000
<b>Excelsior Plan</b>	\$750	\$2,500

\*\* These changes reflect the 4.2% increase in the medical care component of the Consumer Price Index for Urban Wage Earners and Clerical workers, all Cities (C.P.I.-W) for the period July 1, 2011 through June 30, 2012.

\*\*\* The annual deductible and coinsurance maximum out-of-pocket expense will be reduced for calendar year 2013 for employees in (or equated to) salary grade 6 or below on January 1, 2013.

## New York State Department of Civil Service's

**“Mental Health and Substance Abuse Program for the Empire Plan,  
Excelsior Plan, Student Employee Health Plan RFP”**

**Network Copays - Effective January 1, 2013**

<b>Employee Group</b>	<b>Outpatient Substance Abuse Treatment</b>	<b>Visit to Mental Health Professional</b>	<b>Emergency Room Care</b>	<b>Inpatient Hospital Services</b>
<b>Executive Branch</b>				
<b>CSEA</b>	\$20	\$20	\$60	N/A
<b>DC 37</b>	\$20	\$20	\$70	N/A
<b>PBA – Troopers</b>	\$20	\$20	\$70	N/A
<b>PBA – Supervisors</b>	\$20	\$20	\$70	N/A
<b>PIA</b>	\$20	\$20	\$70	N/A
<b>Council 82</b>	\$20	\$20	\$70	N/A
<b>APSU (formerly ALESU)</b>	\$20	\$20	\$70	N/A
<b>NYSCOPBA</b>	\$20	\$20	\$70	N/A
<b>UUP</b>	\$20	\$20	\$70	N/A
<b>UUP Lifeguards</b>	\$18	\$18	\$60	N/A
<b>PEF</b>	\$20	\$20	\$70	N/A
<b>M/C</b>	\$20	\$20	\$70	N/A
<b>Legislature</b>	\$20	\$20	\$70	N/A
<b>Participating Employers</b>	\$20	\$20	\$70	N/A
<b>Unified Court System</b>	\$20	\$20	\$60	N/A
<b>Retirees, Vesteas, Dependent Survivors and Preferred List</b>	\$20	\$20	\$70	N/A
<b>Student Employee Health Plan</b>	\$10	\$10	\$25	\$200
<b>Participating Agencies</b>	\$20	\$20	\$70	N/A
<b>Excelsior Plan</b>	\$30	\$30	\$100	\$250



# 2012 NYSHIP Benefit Plan Comparison

Program Component					
	Network	Non-Network	Network	Non-Network	
<b>Hospital Benefits<sup>1</sup></b>					
Covered Inpatient Services <i>Preadmission Certification Required</i>	\$250 copayment per stay for enrollee, \$250 per stay for spouse/domestic partner, and \$250 per stay for all dependent children combined	No coverage in a non-network hospital except network benefits apply in the event of an emergency or when there is no network hospital available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.	Paid-in-full	Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of \$3,000 per enrollee, \$3,000 per spouse/domestic partner, and \$3,000 per all dependent children combined. <sup>2</sup> When the combined coinsurance maximum is satisfied, benefits are provided at network levels.	
Skilled Nursing Facility Care (No coverage if Medicare primary)	Paid-in-full in an approved facility when medically necessary		Paid-in-full in an approved facility when medically necessary		
Hospice Care	Paid-in-full when provided by an approved network program		Paid-in-full when provided by an approved network program		
Outpatient chemotherapy, radiation therapy, dialysis, preadmission testing	Paid-in-full		Paid-in-full		
Covered Outpatient Services (diagnostic radiology/laboratory)	\$75 copayment per visit		\$40 copayment per visit		Coinsurance of 10 percent of billed charges or \$75 (whichever is greater) up to combined annual coinsurance maximum of \$3,000 per enrollee, \$3,000 per spouse/domestic partner, and \$3,000 per all dependent children combined. <sup>2</sup> When the combined coinsurance maximum is satisfied, benefits are provided at network levels.
Covered Outpatient Surgery	\$100 copayment per visit		\$60 copayment per visit		
Physical Therapy following related Hospitalization or Inpatient/Outpatient Surgery	\$30 copayment when medically necessary		\$20 copayment when medically necessary		
Emergency Room Visit	\$100 copayment (waived if admitted)	Network benefit applies	\$70 copayment (waived if admitted)	Network benefit applies	
<b>Medical/Surgical Benefits<sup>1</sup></b>	<b>Participating Providers</b>	<b>Non-Participating</b>	<b>Participating Providers</b>	<b>Non-Participating</b>	
Physician Office Visits and covered services provided during office visit	Single \$30 copayment for all covered services provided during the visit and billed by the provider. No copayment for prenatal visits, well child care and preventive care services.	Basic Medical Program: After the combined annual deductible of \$750 per enrollee, \$750 per spouse/domestic partner, and \$750 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services. <sup>3</sup> After the combined coinsurance maximum of \$2,500 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates. <sup>4</sup>	\$20 copayment for each of the following services: Office visit/office surgery; laboratory/radiology; contraceptives (maximum two copayments per visit). No copayment for prenatal visits, well child care and preventive care services.	Basic Medical Program: After the combined annual deductible of \$1,000 per enrollee, \$1,000 per spouse/domestic partner, and \$1,000 per all dependent children combined is met, Plan pays 80 percent of reasonable and customary charges for covered services. <sup>3</sup> After combined coinsurance maximum of \$3,000 per enrollee, \$3,000 per spouse/domestic partner, and \$3,000 per all dependent children combined is met, Plan pays 100 percent of reasonable and customary charges. <sup>2</sup>	
Diagnostic Laboratory Services	Single \$30 copayment for all covered services provided during the visit and billed by the provider		\$20 copayment		
Diagnostic Radiology and Imaging Services (Certain radiology procedures subject to a Prospective Procedure Review)	\$30 copayment per visit \$75 copayment per visit for procedures subject to Prospective Procedure Review		\$20 copayment		
Routine Pediatric Care	Paid-in-full	Subject to deductible and coinsurance	Paid-in-full	Subject to deductible and coinsurance	
Routine Newborn Care	Paid-in-full	Not subject to deductible or coinsurance	Paid-in-full	Not subject to deductible or coinsurance	
Routine Health Exams	\$30 copayment per visit	Basic Medical Benefits for an active employee age 50 or older. This benefit is not subject to deductible or coinsurance. There is no Basic Medical coverage for routine health exams for spouses, retirees, vestees or dependent survivors.	\$20 copayment for the office visit. An additional \$20 copayment for any laboratory/radiology services provided during the visit.	Routine health exams are covered for you, the active employee if you are age 50 or over and for your spouse or domestic partner age 50 or older. This benefit is not subject to deductible or coinsurance.	
Adult Immunizations	\$30 copayment per visit	No coverage	\$20 copayment	No coverage	
Outpatient Surgical Locations	\$75 copayment per visit	Basic Medical Benefits	\$30 copayment	Basic Medical Benefits	



<sup>1</sup> Certain covered preventive care services are paid in full when received from a participating provider or at a network hospital.

<sup>2</sup> The annual coinsurance maximum for The Empire Plan is shared among the Basic Medical Program and non-network coverage under the Hospital Program and Mental Health and Substance Abuse Program.

<sup>3</sup> The annual deductible for both The Empire Plan and Excelsior Plan is shared among the Basic Medical Program, non-network coverage under the Home Care Advocacy Program and the Mental Health and Substance Abuse Program.

<sup>4</sup> The annual coinsurance maximum for the Excelsior Plan is shared among the Basic Medical Program and non-network coverage under the Mental Health and Substance Abuse Program.



Program Component				
	Participating Providers	Non-Participating	Participating Providers	Non-Participating
<b>Medical/Surgical Benefits</b>				
Emergency Ambulance Service	Local commercial ambulance covered except first \$35		Local commercial ambulance covered except first \$35	
Prostheses and Orthotic Devices	Paid-in-full	Basic Medical benefits for Prostheses/Orthotic devices that meet the individual's functional needs when obtained from a non-participating provider.	Paid-in-full	Basic Medical benefits for Prostheses/Orthotic devices that meet the individual's functional needs when obtained from a non-participating provider.
External Mastectomy Prostheses	Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing \$1,000 or more requires approval through HCAP.		Paid-in-full benefit once each calendar year for one single or double external mastectomy prosthesis. Any single external mastectomy prosthesis costing \$1,000 or more requires approval through HCAP.	
Chiropractic Treatment and Physical Therapy	\$30 copayment for all covered services provided during the visit and billed by the provider.	No coverage	\$20 copayment for each office visit. An additional \$20 copayment for radiology and diagnostic laboratory services provided during the visit (maximum of two copayments per visit).	\$250 annual deductible per enrollee; \$250 per enrolled spouse/domestic partner; \$250 per all dependent children combined. The plan pays up to 50 percent of the network allowance after you meet the annual deductible. There is no coinsurance maximum.
Home Care Services, Skilled Nursing Services and Durable Medical Equipment	Paid-in-full through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After meeting Basic Medical deductible, Plan pays up to 50 percent of HCAP network allowance.	Paid-in-full through Home Care Advocacy Program (HCAP).	First 48 hours of nursing care not covered. After meeting Basic Medical deductible, Plan pays up to 50 percent of HCAP network allowance.
<b>Mental Health and Substance Abuse Benefits</b>	<b>Network Providers/Facilities</b>	<b>Non-Network</b>	<b>Network Providers/Facilities</b>	<b>Non-Network</b>
Inpatient Services – Approved Facilities	\$250 copayment per stay for enrollee, \$250 per spouse/domestic partner, and \$250 per all dependent children combined.	No coverage in a non-network facility except network benefits apply in the event of an emergency or when there is no network facility available within 30 miles of your residence or when no network facility within 30 miles of your residence can provide the covered service you require.	Paid-in-full No deductibles No annual or lifetime benefit maximums	Coinsurance of 10 percent of billed charges up to combined annual coinsurance maximum of \$3,000 per enrollee, \$3,000 per spouse/domestic partner and \$3,000 per all dependent children combined. <sup>2</sup> When combined coinsurance maximum is satisfied, benefits are provided at network levels.
Inpatient Practitioner Treatment or Consultation	Paid-in-full	After the combined annual deductible of \$750 per enrollee, \$750 per spouse/domestic partner, and \$750 per all dependent children combined is met, Plan pays 80 percent of allowed amount for covered services. After the combined coinsurance maximum of \$2,500 is reached, Plan pays 100 percent of allowed amount for covered services. Allowed amount is based on Medicare reimbursement rates. <sup>4</sup>	Paid-in-full	
Outpatient Services	Paid-in-full benefit for up to three visits per crisis; Additional visits subject to a \$30 copayment.		Paid-in-full benefit for up to three visits per crisis Additional visits subject to a \$20 copayment	
Covered Outpatient Substance Abuse Services	\$30 copayment per visit		\$20 copayment per visit	
Emergency Room Visit	\$100 copayment (waived if admitted)	Network benefit applies	\$70 copayment (waived if admitted)	Network benefit applies
Emergency Ambulance Service	Local commercial ambulance covered except first \$35		Ambulance service covered when medically necessary	
<b>Prescription Drug Program<sup>5,6</sup></b>				
<b>Prescription Drug Benefits</b>	<b>Mail Order Pharmacy</b>		<b>Participating Retail Pharmacy</b>	
<b>Level 1</b>	<b>Excelsior Plan</b> (most generics)	<b>Empire Plan</b> (generics)	<b>Excelsior Plan</b> (most generics)	<b>Empire Plan</b> (generics)
Up to 30 Days	\$10	\$5	\$10	\$5
31-90 Days	\$20	\$5	\$25	\$10
<b>Level 2</b>	<b>Excelsior Plan</b> (most Preferred Brand-Name Drugs)	<b>Empire Plan</b> (Preferred Brand-Name Drugs)	<b>Excelsior Plan</b> (most Preferred Brand-Name Drugs)	<b>Empire Plan</b> (Preferred Brand-Name Drugs)
Up to 30 Days	\$30	\$25	\$30	\$25
31-90 Days	\$60	\$50	\$75	\$50
<b>Level 3</b>	<b>Excelsior Plan</b> (all other covered drugs)	<b>Empire Plan</b> (all other covered drugs)	<b>Excelsior Plan</b> (all other covered drugs)	<b>Empire Plan</b> (all other covered drugs)
Up to 30 Days	\$65	\$45	\$65	\$45
31-90 Days	\$130	\$90	\$160	\$90

<sup>4</sup> The annual coinsurance maximum for the Excelsior Plan is shared among the Basic Medical Program and non-network coverage under the Mental Health and Substance Abuse Program.

<sup>5</sup> Empire Plan: If enrollee's doctor believes a brand drug is medically necessary, enrollee may appeal mandatory generic substitution. If approved, level 3 copayment applies and ancillary fee is waived. Quantity level limits exist for erectile dysfunction and migraine medications.

<sup>6</sup> Excelsior Plan: No generic appeal, Level 3 copayment and applicable ancillary fee is charged. Quantity level limits are included in most therapeutic categories. Plan benefit maximums are included for all smoking cessation and infertility therapies.

## **Section IV: UHIC-NY CERTIFICATE OF INSURANCE**

### **Mental Health and Substance Abuse Program**

#### **Overview**

The Empire Plan Mental Health and Substance Abuse Program provides comprehensive coverage for mental health and substance abuse care, including alcoholism. UHIC-NY is the Program insurer and OptumHealth is the administrator of the Program.

Review the benefits and exclusions in this Certificate before you obtain services. Excluded services and conditions will not be covered under the Program. If your inpatient or outpatient treatment is found not medically necessary, you will not receive any Empire Plan benefits, and you will be responsible for the full cost of care.

#### **Coverage**

Covered services for mental health and substance abuse care, including care for alcoholism, include:

- Emergency assessments at all times;
- Inpatient psychiatric care and aftercare for psychiatric cases following hospital discharge;
- Alternatives to inpatient care (such as certified residential treatment facilities and certified halfway houses, etc.);
- Outpatient mental health services;
- Inpatient/residential rehabilitation and aftercare following hospital discharge for substance abuse treatment;
- Substance abuse structured outpatient rehabilitation and aftercare;
- Electro-convulsive therapy;
- Medication management;
- Ambulance services; and
- Psychiatric second opinions.

#### **You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth**

**Before** you seek non-emergency mental health or substance abuse care, including treatment for alcoholism, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. You should call within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

If you do not call, or if you call but do not follow OptumHealth's recommendations, you may receive a lower level of benefits for non-emergency services. Calling OptumHealth is the first step in ensuring that you will be eligible to receive the highest level of benefits. OptumHealth is always open, 24 hours a day, every day of the year.

The Empire Plan Mental Health and Substance Abuse Program has two levels of benefits for covered services: network coverage and non-network coverage.

#### **Highest level of benefits when you call and follow OptumHealth's recommendations**

##### **You qualify for network coverage when:**

- You call OptumHealth before your treatment begins, and
- You are treated by a provider OptumHealth recommends.

Usually, you will be referred to a network provider or facility. However, you will still qualify for network coverage if OptumHealth refers you to a non-network provider or facility.

## **Lower benefits when you don't call OptumHealth, you don't use a recommended provider**

Benefits are available for medically necessary care when you don't call OptumHealth and use a recommended provider. These benefits are lower than those available when you call OptumHealth and seek care from a recommended provider.

### **You will receive non-network coverage for covered services when:**

- You do not call OptumHealth, and/or
- You call OptumHealth but do not follow their recommendations.

The mental health and substance abuse care you obtain will be covered by UHIC-NY only if it meets the conditions for coverage stated in this Certificate. Read this entire Certificate in order to understand the Program.

Program benefits and responsibilities apply to you and your enrolled dependents whenever you seek Empire Plan coverage for these services, even if you have Medicare or other health insurance coverage, as well.

Key terms are used throughout the Certificate. Read the section of the Certificate called "Meaning of Key Terms" for definitions of these terms.

**If you have questions about The Empire Plan Mental Health and Substance Abuse Program, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. TTY (Teletypewriter) for enrollees who use a TTY because of a hearing or speech disability: 1-800-855-2881.**

## **Meaning of Key Terms**

Here are definitions of the key terms used throughout this Certificate. In order to understand them fully, read the entire Certificate to see how these terms are used in the context of the coverage provided to you.

- A. **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 OptumHealth.

Under network coverage, residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by OptumHealth.

- B. **Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.
- C. **Certification or Certified** means a determination by OptumHealth that mental health care or substance abuse care or proposed care is a medically necessary, covered service in accordance with the terms of this Certificate.
- D. **Clinical Referral Line** means the clinical resource and referral service which you must call prior to receiving any covered services. You may call 24 hours a day, every day of the year. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

- E. **Coinsurance** means, for Approved Facility services, the difference between the billed charge and the percentage covered; and, for Practitioner services, the difference between the reasonable and customary charge and the percentage covered. Coinsurance applies to non-network covered services.
- F. **Concurrent Review** means OptumHealth's utilization review and medical management program under which OptumHealth reviews the medical necessity of mental health care and substance abuse services. OptumHealth's review is conducted by a team of licensed psychiatric nurses, social workers, board-certified or board-eligible psychiatrists and clinical psychologists, to determine whether proposed services are medically necessary for your diagnosed condition(s). This program includes combined outpatient and inpatient review as described in this Certificate.
- G. **Copayment** means the amount you are required to pay for covered services you obtain from a network provider for outpatient services under the Mental Health and Substance Abuse Program. Please refer to the "Schedule of Benefits for Covered Services" for the exact amount of copayment. Copayment applies only to network covered services and non-network emergency room covered services.
- H. **Course of Treatment** means the period of time, as determined by OptumHealth, required to provide mental health and substance abuse care to you for the resolution or stabilization of specific symptoms or a particular disorder. A course of treatment may involve multiple providers.
- I. **Covered Expenses** means:
  - 1. For care under the network portion of the Program, the network allowance for any medically necessary covered services provided to you under the Program by a network provider.
  - 2. For non-network Practitioner care, the Reasonable and Customary charge for medically necessary covered services provided to you under the Program. No more than the Reasonable and Customary charge less coinsurance will be considered by the Program for medically necessary covered services.
  - 3. For care in a non-network Approved Facility, the billed amount for medically necessary covered services provided to you under the Program. No more than the billed amount less coinsurance will be considered by the Program for medically necessary covered services.

A covered expense is incurred on the date you receive the service.

- J. **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.
- K. **Crisis Intervention Visits** means visits for treatment of an acute emotional disturbance which results in a temporary inability to function in one's daily life.

Examples of situations meeting this definition include:

- 1. An acute psychotic reaction,
- 2. Loss of coping capacity, and
- 3. Any situation endangering the patient, others or property.

Such crisis is usually precipitated by an adverse event such as:

- 4. Loss of crucial person through death, divorce or separation,
  - 5. Serious illness, accident or sudden heart attack,
  - 6. Onset of disabling psychiatric symptoms, or
  - 7. A social trauma such as rape or robbery.
- L. **Deductible** means the amount you must pay each calendar year for covered services under the non-network portion of the Mental Health and Substance Abuse Program before payment will be made to you. Deductibles apply only to the non-network coverage. The Substance Abuse outpatient deductible, and the Mental Health outpatient deductible for Practitioner services are separate deductibles and cannot be combined.

The amount applied toward satisfaction of the deductible will be the lower of the following:

1. The amount you actually paid for a medically necessary service or supply covered under the non-network portion of the Program; or
2. For Practitioner services, the reasonable and customary charge less coinsurance for such service; or
3. For Approved Facility services, the billed amount less coinsurance for such service.

The Mental Health and Substance Abuse Program deductibles are separate from the Basic Medical and Managed Physical Medicine Program annual deductibles. The mental health and substance abuse deductibles cannot be combined with any other deductible or out-of-pocket provision.

- M. **Emergency Care** is 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:
1. 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;
  2. Serious impairment to such person's bodily functions;
  3. Serious dysfunction of any bodily organ or part of such person; or
  4. Serious disfigurement of such person.
- N. **Inpatient Services** means those services rendered in an approved facility to a patient who has been admitted for an overnight stay and is charged for room and board.
- O. **Medically Necessary** means a service which OptumHealth has certified to be:
1. Medically required;
  2. Having a strong likelihood of improving your condition; and
  3. Provided at the lowest appropriate level of care, for your specific diagnosed condition, in accordance with both generally accepted mental health and substance abuse practices and the professional and technical standards adopted by OptumHealth.

Although a practitioner may recommend that a covered person receive a service or be confined to an approved facility, that recommendation does not mean:

4. That such service or confinement will be deemed to be medically necessary; or
  5. That benefits will be paid under this Program for such service or confinement.
- P. **Mental Health Care** means medically necessary care rendered by an eligible practitioner or approved facility and which, in the opinion of OptumHealth, is directed predominately at treatable behavioral manifestations of a condition that OptumHealth determines:
1. Is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
  2. Substantially or materially impairs a person's ability to function in one or more major life activities; and
  3. Has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
- Q. **Network Allowance** means the amount network providers have agreed to accept as payment in full for services they render to you under the network provider portion of the Program.
- R. **Network Coverage** means the level of benefits provided by the Program when you receive medically necessary services from a provider recommended to you by OptumHealth.
- S. **Network Facility** means an approved facility that has entered into a network provider agreement as an independent contractor with OptumHealth. The records of OptumHealth shall be conclusive as to whether an institution has a network provider agreement in effect on the date that you obtain services. A non-network facility can be considered a network facility on a case-by-case basis when approved by OptumHealth.
- T. **Network Practitioner** means a practitioner who has entered into an agreement with OptumHealth as an independent contractor to provide covered services to you. The records of OptumHealth shall be conclusive as to whether a person had a network provider agreement in effect on the date that you obtained services. A

non-network practitioner can be considered a network practitioner on a case-by-case basis when approved by OptumHealth.

- U. **Network Provider** means either a network practitioner or a network facility.
- V. **Non-network Coverage** means the level of reimbursement paid by the Program when you receive medically necessary covered services from a non-network provider and you comply with the Program requirements outlined in this Certificate.
- W. **Non-network Facility** means an approved facility that has not entered into an agreement with OptumHealth to provide covered services to you.
- X. **Non-network Provider** means a practitioner or approved facility that has not entered into an agreement with OptumHealth to provide covered services to you.
- Y. **OptumHealth Behavioral Solutions** (also referred to as OptumHealth) is the company selected by the State of New York to administer The Empire Plan Mental Health and Substance Abuse Program. OptumHealth provides services for UnitedHealthcare Insurance Company of New York in the administration of this Program.
- Z. **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.
- AA. **Partial Hospitalization** (day or night care center) means a visit in a center maintained by an approved facility that has a program certified in New York State, according to the Mental Hygiene Law of New York State. If the facility is located in another state, it must be certified by the appropriate state agency to provide this kind of care or, if not regulated by a state agency, it must be certified by the Joint Commission on Accreditation of Health Care Organizations as a mental health care program.
- BB. **Peer Advisor** means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who maintains an active clinical practice and who renders medical necessity decisions.
- CC. **Practitioner** means:
  - 1. A psychiatrist; or
  - 2. A psychologist; or
  - 3. A licensed and registered social worker with at least six years of postdegree 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
  - 4. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist; or
  - 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; must be certified and have a practice agreement in effect with a network physician; or A professional corporation; or A university faculty corporation.
- DD. **Program** means The Empire Plan Mental Health and Substance Abuse Program.
- EE. **Provider** means a practitioner or approved facility that supplies you with covered services under the Mental Health and Substance Abuse Program. The fact that a practitioner or approved facility claims to supply you with mental health or substance abuse services has no bearing on whether that practitioner or approved facility is a provider covered under the Program. A service or supply which can lawfully be provided only by a licensed practitioner or approved facility will be covered by this Program only if such practitioner or approved facility is in fact properly licensed and is permitted, under the terms of that license, to do so at the time you receive a covered service or supply. A person or facility that is not properly licensed cannot be a covered provider under the Program. The records of any agency authorized to license persons or facilities who supply covered services shall be conclusive as to whether that person or facility was properly licensed at the time you receive any service or supply.
- FF. **Reasonable and Customary** means the lowest of:
  - 1. The actual charge for services; or
  - 2. The usual charge for services by the Practitioner; or
  - 3. The usual charge for services of other Practitioners in the same or similar geographic area for the same or similar service.
- GG. **Referral** means the process by which OptumHealth's 24-hour, toll-free Clinical Referral Line refers you to a provider to obtain covered mental health and substance abuse care.
- HH. **Structured Outpatient Rehabilitation Program** 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, which includes an intensive phase involving more than oneweekly treatment, as well as an aftercare component, which includes weekly follow-up/support visits. In addition, Structured Outpatient Rehabilitation Programs include elements such as participation in support groups like Alcoholics Anonymous or Narcotics Anonymous.

- II. **Substance Abuse Care** means medically necessary care provided by an eligible provider for the illness or condition that OptumHealth has determined:
1. Is a clinically significant behavioral or psychological syndrome or pattern;
  2. Substantially or materially impairs a person's ability to function in one or more major life activities; and
  3. 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.
- JJ. **UHC-NY** means UnitedHealthcare Insurance Company of New York, which is the insurer for The Empire Plan Mental Health and Substance Abuse Program.
- KK. **You/Your** means any Empire Plan enrollee covered by this Program and any dependent member of an enrollee's family who is also covered. Enrollee and dependent are defined in your NYSHIP General Information Book. Where this Certificate refers to "you" making the call to obtain network coverage, "you"/"your" can also mean a member of your family or household.

## How to Receive Benefits for Mental Health and Substance Abuse Care

### You must call

Before you seek treatment for mental health or substance abuse, including alcoholism, you must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth, even if another plan is your primary coverage.

You must call OptumHealth even when a doctor refers you to a mental health professional or facility. You may ask OptumHealth to refer you to a particular provider. However, OptumHealth will determine the appropriateness of this referral.

The advantages of making this call are:

- You will receive help in choosing the right provider. You don't have to guess which professional can help you.
- You will have access to an extensive network of quality providers in your area, carefully chosen for their training and experience.
- You may reduce out-of-pocket expenses and you can get the recommended care without worrying about the bill. Except for any copayments, the bill is paid when you follow OptumHealth's recommendation, and there are no claim forms.
- When you use OptumHealth for intervention following a significant life crisis, such as a death, trauma, divorce, illness or work and life issues, you are eligible for up to three outpatient visits without a copayment.
- You will receive confidential help - no one needs to know you are making the call.

## **The OptumHealth network and the referral process**

The Mental Health and Substance Abuse Program has two levels of benefits: network coverage and non-network coverage. By following the Program requirements for network coverage, you will receive the highest level of benefits. Please refer to the “Schedule of Benefits for Covered Services” for a complete description of the two benefit levels.

OptumHealth’s network gives you access to a wide range of providers when you need mental health or substance abuse care. These providers are in your community and many of them have been caring for Empire Plan enrollees and their families for years.

## **Program requirements apply nationwide, even if another plan is your primary coverage**

You must follow the requirements for the Mental Health and Substance Abuse Program whenever you will be seeking Empire Plan coverage for these services. Program requirements apply nationwide regardless of where you seek mental health and substance abuse services.

## **Program requirements for network coverage**

In order to receive network coverage, the highest level of benefits:

- You must call OptumHealth before outpatient treatment begins;
- You must call OptumHealth before you are admitted as an inpatient. (Requirements are different for an emergency. See “Emergency Services”); **and**
- You must be treated by a provider or admitted to a facility recommended to you by OptumHealth.

When you follow these requirements for network coverage, the network provider will be responsible for obtaining certification from OptumHealth. Both you and your provider will receive written confirmation from OptumHealth indicating the care (number of visits or length of stay) that has been certified.

## **Lower benefits apply if you don’t call OptumHealth or if you don’t use a recommended provider**

Benefits are available for medically necessary care when you do not follow the Program requirements for network coverage. These benefits are lower than those available when you call OptumHealth and seek care from a recommended provider. See the “Schedule of Benefits for Covered Services” for a description of non-network coverage.

Before you choose a non-network provider, consider the high cost of treatment.

## **Program requirements if you choose to use a non-network provider**

For a non-emergency inpatient admission to a non-network facility, you must call OptumHealth before the admission to have the medical necessity of the admission certified.

If you choose a non-network provider for outpatient treatment, call OptumHealth early in your treatment so that OptumHealth can begin the process of determining whether your treatment will be covered. You must call before the sixth visit to begin the certification process. OptumHealth must certify any outpatient visits beyond the tenth such visit during any course of treatment.

When you use a non-network provider, you are responsible for obtaining certification from OptumHealth. You will receive written confirmation from OptumHealth indicating the care (number of visits or length of stay) which has been certified.



## **Emergency services**

In an emergency situation, you should go or be taken to the nearest hospital emergency room for treatment. If you are admitted to a facility for emergency care, you should call OptumHealth within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization for certification.

You must pay the first \$60 in charges (copayment) for emergency care in a hospital emergency room. You will not have to pay this \$60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

When you receive medically necessary covered services from a non-network provider in a certified emergency, the Program will provide network coverage until you can be transferred to a network facility.

## **Call OptumHealth**

You or a member of your family or household may place the call to The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth. In the case of an emergency or urgent situation, your doctor, a member of your doctor's staff, or the hospital admitting office, may place the call for you. Where this Certificate refers to "you" making the call, keep in mind that other people listed may also call. **But it is your responsibility to see that the call is made.**

## **Clinical Referral Line**

You must call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth for referrals to providers. Whenever you or your family faces a mental health or substance abuse problem, including alcoholism, getting help begins with a call to OptumHealth. By making the call before you receive services, and then obtaining care from a provider referred to you by OptumHealth, you will qualify for network coverage. Usually, OptumHealth will refer you to a network practitioner or network facility. However, you will also qualify for network coverage if no network provider is available and OptumHealth refers you to a non-network provider.

The Clinical Referral Line is available 24 hours a day, every day of the year. It is staffed by clinicians who have professional experience in the mental health and substance abuse field. These highly trained and experienced clinicians are available to help you determine the most appropriate course of action.

## **Call when you use a non-network provider**

To be certain that your care is medically necessary when you choose to use a non-network provider, you must call OptumHealth to start the certification process. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth between 8 am and 5 pm Eastern time on business days and select the Customer Service Line. Ask OptumHealth to mail an Outpatient Treatment Report to your non-network provider. If you do not call when you use a non-network provider, and your inpatient or outpatient treatment is not found to be medically necessary, you will not receive any Empire Plan benefits and you will be responsible for the full cost of care.

## **Show your identification card**

You must show your identification card every time you request covered services from network providers. Possession and use of an identification card is not entitlement to benefits. Coverage for benefits is subject to verification of eligibility for the date covered services are rendered, and all the terms, conditions, limitations and exclusions set out in this Certificate.

## **Release of medical records**

As a condition of receiving benefits under this Program, you authorize any provider who has provided services to you to provide OptumHealth and UHIC-NY with all information and records relating to such services. At all times, OptumHealth and UHIC-NY will treat medical records and information in strictest confidence.

## **Concurrent Review**

### **OptumHealth reviews treatment**

After the initial certification, OptumHealth monitors your care throughout your course of treatment to make sure it remains consistent with your medical needs. The Concurrent Review is based on the following criteria and applies whether you choose a network or non-network provider:

- Medical necessity of treatment to date,
- Diagnosis,
- Severity of illness,
- Proposed level of care, and
- Alternative treatment approaches.

OptumHealth must continue to certify the medical necessity of your care for your Empire Plan benefits to continue.

If OptumHealth determines that inpatient treatment is no longer necessary, OptumHealth will notify you, your doctor and the facility no later than the day before the day on which inpatient benefits cease. OptumHealth will assist you in making the transition from inpatient care to the appropriate level of treatment with a network provider.

### **Certification denial and appeal process: deadlines apply**

Only an OptumHealth peer advisor can deny certification. If certification for any covered service is denied, OptumHealth will notify you and the applicable provider of the denial and provide information on how to request an appeal of such decision by telephone. You will have 60 days to request an appeal.

When you or your provider requests an appeal involving a clinical matter, another OptumHealth peer advisor will review your case and make a determination. The determination will be made as soon as your provider provides all pertinent information to the OptumHealth peer advisor in a telephone review. You and your provider will be advised in writing of OptumHealth's decision.

If the peer advisor's determination is to continue to deny certification, you and your provider will be provided with written information on how to request a second level appeal of OptumHealth's decision. You have 30 days from the date of your receipt of OptumHealth's written denial notice to request a second level appeal.

Level 2 Clinical appeals are conducted by a panel of two board-certified psychiatrists from OptumHealth and a Clinical Manager. Panel members have not been involved in the previous determinations of the case. A determination will be made within 10 business days of the date OptumHealth received all pertinent medical records from your provider. You and your provider will be notified in writing of the decision. See "Appeals: 60-day deadline" for additional information. Administrative appeals are reviewed by OptumHealth, in consultation with UHIC-NY as needed.

## What is Covered Under the Mental Health and Substance Abuse Program

This section describes Program coverage for inpatient and outpatient care.

### Inpatient care

Coverage for inpatient care includes the following medically necessary services:

- A. **Hospital Services** for the treatment of mental health and substance abuse are covered.
- B. **Residential Treatment Facilities, Halfway Houses and Group Homes.** Covered charges will be payable in full under the network coverage if the admission is certified by OptumHealth. Confinements for these services are covered only under the network portion of the Program. **No benefits are available under non-network coverage.**
- C. Mental health care in a **partial hospitalization** program (day or night care center), maintained by an approved facility, on its premises, is covered.
- D. **Psychiatric Treatment or Consultation While You Are a Mental Health, Substance Abuse or Medical Inpatient in an Approved Facility.** If you are receiving inpatient mental health/substance abuse treatment from a practitioner who bills separately from the hospital or approved facility, you are covered for medically necessary visits.

If you are admitted to a hospital for a medical condition and the admission interrupts your certified outpatient mental health and substance abuse care, you may continue to receive certified care from your practitioner during your inpatient stay.

- E. **Inpatient Psychiatric Consultations on a Medical Unit.** You are covered for medically necessary inpatient mental health visits by a practitioner while you are on the medical unit of a hospital.

### Outpatient care

Coverage for outpatient care includes the following medically necessary services:

- A. **Emergency Care** at a hospital for treatment of mental health/substance abuse, where you are not admitted as an inpatient following that care, is considered an outpatient service.
- B. **Office Visits.** You are covered for office visits for general mental health care.
- C. **Psychiatric Second Opinion.** You are covered for second opinions by a practitioner of equal or higher credentials. Example: Only another psychologist or a psychiatrist may give a second opinion on a psychologist's diagnosis.
- D. **Family Sessions.** For each patient's alcoholism, alcohol abuse, or substance abuse treatment program, benefits are allowed for covered family sessions. When the covered alcoholic, alcohol abuser or substance abuser is participating in a Structured Outpatient Substance Abuse Rehabilitation Program, up to 20 family sessions (per calendar year) for family members covered under the same Empire Plan enrollment are included in the program. If the alcoholic, alcohol abuser, or substance abuser is not in active treatment, non-addicted family members covered under the same Empire Plan enrollment are eligible for up to 20 family sessions (per calendar year), subject to OptumHealth certification.
- E. **Substance Abuse-Structured Outpatient Rehabilitation Program.** Covered benefits are allowed for Substance Abuse Structured Outpatient Rehabilitation Programs.
- F. **Psychological Testing and Evaluations.** These services are covered if OptumHealth authorizes them and determines that they are medically necessary for the condition(s) indicated. If these services are provided on an outpatient basis, the network provider must obtain OptumHealth certification of this care before testing begins. If testing is being provided by a non-network provider, you must have your practitioner call OptumHealth and obtain certification of the care before testing begins. There are no network or non-network benefits available if testing is not certified by OptumHealth in advance.
- G. **Ambulance Services for Mental Health and Substance Abuse Care.** You are covered for medically necessary hospital-based ambulance services, commercial ambulance services or organized voluntary

ambulance services for transfers from non-network facilities to network facilities approved in advance by OptumHealth. You are also covered for emergency transport to an approved facility.

You are not covered under this Program for ambulance service to a facility in which you do not receive mental health and substance abuse care.

- H. **Crisis Intervention Visits.** Crisis intervention visits are covered under the network coverage and will be payable in full up to the network allowance for up to three visits in a given crisis. OptumHealth reviews documentation of each crisis for approval.

A statement of necessity satisfactory to OptumHealth must be submitted by the network provider in order for a period of treatment to be considered a crisis. **Paid-in-full benefits for these services are available under network coverage only.**

- I. **Electro-Convulsive Therapy.** Electro-Convulsive therapy is a procedure conducted by a psychiatrist in the treatment of certain mental disorders through the application of controlled electric current. All Electro-Convulsive therapy must be certified by OptumHealth before the service is received.
- J. **Medication Management.** You are covered for office visits to a psychiatrist specializing in psychopharmacology for the ongoing review and monitoring of psychiatric medications.
- K. **Home-Based Counseling.** You are covered for home-based care provided by a Network Practitioner. **Benefits for these services are available under network coverage only.**
- L. **Registered Nurse Practitioner.** Services provided by a Registered Nurse Practitioner under the direct supervision of a network physician are covered under the Plan when medically necessary. Services include prescribing medication refills and other services performed within the scope of the Registered Nurse Practitioner's license in the state where the services are performed. **Benefits for these services are available under network coverage only.**
- M. **Telephone Counseling.** Telephone counseling provided by a network practitioner is covered. **Benefits for these services are available under network coverage only.**

## Schedule of Benefits for Covered Services

**OPTUMHEALTH MUST CERTIFY ALL COVERED SERVICES AS MEDICALLY NECESSARY. IF OPTUMHEALTH DOES NOT CERTIFY YOUR INPATIENT OR OUTPATIENT TREATMENT AS MEDICALLY NECESSARY, YOU WILL NOT RECEIVE ANY EMPIRE PLAN BENEFITS AND YOU WILL BE RESPONSIBLE FOR THE FULL COST OF CARE.**

## NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE

If you follow the requirements for network coverage, you are responsible for paying only the following copayments:

- A. No copayments are required for inpatient care.
- B. You pay the first \$15 charged for each visit to an approved Structured Outpatient Rehabilitation Program for substance abuse.
- C. You pay the first \$15 charged for any other outpatient visit including Home-Based and Telephone Counseling in place of an office visit, except no copayment is required for:
- Crisis Intervention, up to three visits per crisis
  - Electro-Convulsive Therapy - facility and therapist charges, if certified by OptumHealth
  - Psychiatric Second Opinion, if requested and certified by OptumHealth
  - Ambulance Service
  - Mental Health Psychiatric Evaluations, if requested and certified by OptumHealth
  - Prescription drugs, if billed by an approved facility
  - Home-based counseling when provided in place of inpatient care

- D. You pay the first \$60 charged for emergency care in a hospital emergency room. You will not have to pay this \$60 copayment if you are treated in the emergency room and it becomes necessary for the hospital to admit you at that time as an inpatient.

The network provider from whom you receive covered services is responsible for collecting the copayment from you.

**Note** - Copayments do **NOT** count toward meeting your non-network coverage deductibles, Basic Medical deductible or Basic Medical Coinsurance Maximum. Copayments count toward meeting your non-network outpatient practitioner coinsurance maximum.

Except for the copayment that the network provider obtains directly from you, a network provider does not bill you directly for services or supplies you obtain as a network benefit. Your payment to the network provider is limited to the copayment. The network provider requests payment directly from UHIC-NY.

## **NON-NETWORK COVERAGE FOR MENTAL HEALTH AND SUBSTANCE ABUSE CARE**

### **YOU ARE RESPONSIBLE FOR OBTAINING OPTUMHEALTH CERTIFICATION FOR CARE OBTAINED FROM A NON-NETWORK PROVIDER**

If you do **NOT** follow the requirements for network coverage, UHIC-NY pays the following covered percentages:

- A. For Practitioner Services: 80 percent of reasonable and customary charges for covered services after you meet the annual deductible for outpatient practitioner services. There are two separate deductibles for this program – one for mental health services and one for substance abuse care. Each deductible is \$250 per enrollee, \$250 per covered spouse/domestic partner and \$250 for all covered dependents combined. The covered percentage becomes 100 percent of the reasonable and customary charge for covered services once the coinsurance maximum is met.

There are two separate coinsurance maximums for this program – one for mental health services and one for substance abuse care. Each coinsurance maximum is \$515 for the enrollee, \$515 for the enrolled spouse/dependent partner and \$515 for all dependent children combined.

The \$515 coinsurance maximum expense for the enrollee, the spouse/domestic partner and all children combined will be reduced to \$309 in calendar year 2011 for employees in or equal to a salary grade 6 or below as of January 1, 2011.

- B. For Approved Facility Services: 90 percent of billed charges for covered services. There are two separate coinsurance maximums for this program—one for mental health services and one for substance abuse care. Each coinsurance maximum is \$1,500 for you, the enrollee, \$1,500 for your enrolled spouse/domestic partner and \$1,500 for all enrolled dependent children combined. Each coinsurance maximum is applied as follows:
1. You are responsible for the first \$500 of coinsurance, then
  2. You may apply for reimbursement of the next \$500 of coinsurance, upon written request of the enrollee, then
  3. You are responsible for the final \$500 of coinsurance.

OptumHealth will consider non-network coverage for covered expenses after you meet your annual deductible. You are responsible for the coinsurance amount up to the coinsurance maximum. And, for practitioner services, any charges in excess of the reasonable and customary charge.

**Note** - The amount you pay for inpatient and outpatient services does **NOT** count toward meeting your Basic Medical deductible or Basic Medical coinsurance maximum under the Medical/Surgical Program or toward the non-

network coinsurance maximum under the Hospital Program. No deductible, coinsurance or maximum coinsurance amount may be counted toward satisfying any other deductible, coinsurance or maximum coinsurance amount.

## Maximums

Mental Health and Substance Abuse coverage is unlimited (no maximum) for outpatient and inpatient services, except that outpatient treatment sessions for family members of an alcoholic, alcohol abuser, or substance abuser are covered for a maximum of 20 visits per year for all family members combined.

## Exclusions and Limitations

Covered services do not include and no benefits will be provided for the following:

- A. Expenses incurred prior to your effective date of coverage or after termination of coverage, except under conditions described in the “Miscellaneous Provisions” section.
- B. Services or supplies which are not Medically Necessary as defined in the section “Meaning of Key Terms”.
- C. Treatment which is not Mental Health Care or Substance Abuse Care as defined in the section “Meaning of Key Terms”.
- D. Services or supplies which are solely for the purpose of professional or personal growth, marriage counseling, development training, professional certification, obtaining or maintaining employment or insurance, or solely pursuant to judicial or administrative proceedings.
- E. Services to treat conditions that are identified in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as non disorder conditions which may be a focus of clinical attention (V codes); except for family visits for substance abuse or alcoholism.
- F. Services deemed Experimental or Investigational are not covered under this Plan. However, OptumHealth and UHIC-NY may deem an Experimental or Investigational Service is covered under this Plan for treating a life-threatening sickness or condition if they determine that the Experimental or Investigational Service at the time of the determination:
  - Is proved to be safe with promising efficacy; and
  - Is provided in a clinically controlled research setting; and
  - Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- G. Custodial care, except when medically necessary. Custodial care means the spectrum of services and supplies provided expressly for protection and monitoring in a controlled environment, regardless of setting, and assistance to support essentials of daily living in patients whose persistent symptoms, behavior management, and/or medical and psychological problems result in serious ongoing impairment in central life role function. Such care includes, but is not limited to, state hospital care which is custodial for children who are wards of the state or for enrollees or eligible dependents who are incarcerated in a state hospital facility.
- H. Prescription drugs, except when medically necessary and when dispensed by an approved facility, residential or day treatment program to a covered individual who, at the time of dispensing, is receiving inpatient services for mental health and/or substance abuse care at that approved facility. Take-home drugs are not covered.
- I. Private duty nursing.
- J. Any charges for missed appointments, completion of a claim form, medical summaries and medical invoice preparations including, but not limited to, clinical assessment reports, outpatient treatment reports and statements of medical necessity.
- K. Charges for services, supplies or treatments that are covered charges under any other portion of The Empire Plan, including but not limited to detoxification of newborns and medically complicated detoxification cases.
- L. Services, treatment or supplies provided as a result of any Workers’ Compensation Law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof.

- M. Services or supplies you receive for which no charge would have been made in the absence of coverage under the Mental Health and Substance Abuse Program, including services from an Employee Assistance Program.
- N. Services or supplies for which you are not required to pay, including amounts charged by a provider which are waived by way of discount or other agreements made between you and the provider of care.
- O. Any charges for professional services performed by a person who ordinarily resides in your household or who is related to you, such as a spouse, parent, child, brother or sister or by an individual or institution not defined by OptumHealth as a provider.
- P. Services or supplies for which you receive payment or are reimbursed as a result of legal action or settlement other than from an insurance carrier under an individual policy issued to you, to the extent that medical expenses are identified in the judgment or settlement.
- Q. Conditions resulting from an act of war (declared or undeclared) or an insurrection which occurs after December 5, 1957.
- R. Services provided in a veteran's facility or other services furnished, even in part, under the laws of the United States and for which no charge would be made if coverage under the Mental Health and Substance Abuse Program were not in effect. However, this exclusion will not apply to services provided in a medical center or hospital operated by the U.S. Department of Veterans' Affairs for a non-service connected disability in accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 and amendments.

## Coordination of Benefits

If you are covered by an additional group health insurance program (such as a program provided by your spouse's employer) which contains coverage for mental health or substance abuse, The Empire Plan will coordinate benefit payments with the other program. One program pays its full benefit as the primary insurer and the other program pays secondary benefits.

Coordination of benefits helps ensure that you receive all the benefits to which you are entitled from each plan, while preventing duplicate payments and overpayments. In no event shall payment exceed 100 percent of a charge. The Empire Plan does not coordinate benefits with any health insurance policy which you or your dependent carries on a direct-pay basis with a private carrier.

The procedures followed when Empire Plan benefits are coordinated with those provided under another program are detailed below. Each of The Empire Plan carriers follows these procedures.

- A. "Coordination of Benefits" means that the benefits provided for you under The Empire Plan are coordinated with the benefits provided for you under another plan. The purpose of coordination of benefits is to avoid duplicate benefit payments so that the total payment under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for a service covered under both group plans.
- B. Definitions
  - 1. "Plan" means a plan which provides benefits or services for or by reason of mental health or substance abuse care and which is:
    - a. A group insurance plan; or
    - b. A blanket plan, except for blanket school accident coverages or such coverages issued to a substantially similar group where the policyholder pays the premium; or
    - c. A self-insured or non-insured plan; or
    - d. Any other plan arranged through any employee, trustee, union, employer organization or employee benefit organization; or
    - e. A group service plan; or
    - f. A group prepayment plan; or
    - g. Any other plan which covers people as a group; or
    - h. A governmental program or coverage required or provided by any law except Medicaid or a law or plan when, by law, its benefits are excess to those of any private insurance plan or other nongovernmental plan; or
    - i. A mandatory "no fault" automobile insurance plan.

2. "Order of Benefit Determination" means the procedure used to decide which plan will determine its benefits before any other plan. Each policy, contract or other arrangement for benefits or services will be treated as a separate plan. Each part of The Empire Plan which reserves the right to take the benefits or services of other plans into account to determine its benefits, will be treated separately from those parts which do not.
- C. When coordination of benefits applies and The Empire Plan is secondary, payment under The Empire Plan will be reduced so that the total of all payments or benefits payable under The Empire Plan and under another plan is not more than the actual charge or the Reasonable and Customary Charge, whichever is less, for the service you receive. The amount payable under The Empire Plan plus the amount payable under the primary plan will sometimes be less than 100 percent of the allowable expense due to annual deductible and coinsurance requirements. If The Empire Plan is secondary to Medicare, the amount payable will be determined as denoted below in the section entitled "Impact of Medicare on This Plan."
- D. Payments under The Empire Plan will not be reduced on account of benefits payable under another plan if the other plan has coordination of benefits or similar provision with the same order of benefit determination as stated in Item E. Empire Plan benefits are to be determined, in that order, before the benefits under the other plan.
- E. When more than one plan covers the person making the claim, the order of benefit payments is determined using the first of the following rules which applies:
1. The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
  2. When this plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are not divorced or separated: (For coverage of a dependent of parents who are divorced or separated, see paragraph 3 below.)
    - a. The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
    - b. If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
    - c. If the other plan does not have the rule described in subparagraphs a. and b. above, but instead has a rule based on gender of the parent, and if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits;
    - d. The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.
  3. If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
    - a. First, the plan of the parent with custody of the child;
    - b. Then, the plan of the spouse of the parent with custody of the child;
    - c. Then, the plan of the parent not having custody of the child; and
    - d. Finally, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such actual knowledge.
  4. The benefits of a plan which cover a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laidoff or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule 4. is ignored.
  5. If none of the rules in 1. through 4. above determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.
- F. For the purpose of applying this provision, if both spouses/domestic partners are covered as employees under The Empire Plan, each spouse/domestic partner will be considered as covered under separate plans.
- G. Any information about covered expenses and benefits which is needed to apply this provision may be given or received without consent of or notice to any person, subject to the provisions in Article 25 of the General Business Law.



- H. If an overpayment is made under The Empire Plan before it is learned that you also had other coverage, The Empire Plan carriers have the right to recover the overpayment. You will be required to return any overpayment to the appropriate Empire Plan carrier; or at UHIC-NY's discretion, future benefits may be offset by this amount. In most cases, this will be the amount that was paid by the other plan.
- I. If payments which should have been made under The Empire Plan have been made under other plans, the party that paid will have the right to recover the appropriate amount from The Empire Plan carriers.
- J. There is a further condition which applies under the network provider program. When either Medicare or a plan other than The Empire Plan pays first, and if for any reason the total sum reimbursed by the other plan and The Empire Plan is less than the network provider billed the other plan, the network provider may not charge the balance to you.

### **When The Empire Plan is secondary to another insurance plan**

If a provider receives prior approval to provide services from the primary carrier, The Empire Plan will not deny a claim for services on the basis that no prior approval from The Empire Plan was received. However, the fact that the primary carrier has given prior approval for services does not preclude The Empire Plan from determining that the services that were provided were not medically necessary or otherwise not covered under the certificate language.

### **Impact of Medicare on this Plan**

Even if Medicare or another plan provides your primary coverage, you must follow OptumHealth's requirements whenever you will be seeking Empire Plan coverage for mental health or substance abuse services.

### **Definitions**

- A. **Medicare** means the Health Insurance for the Aged and Disabled Provisions of the Social Security Act of the United States as it is now and as it may be amended.
- B. **Primary Payor** means the plan that will determine the medical benefits which will be payable to you first.
- C. **Secondary Payor** means a plan that will determine your medical benefits after the primary payor.
- D. **Active Employee** refers to the status of you, the enrollee, prior to your retirement and other than when you are disabled.
- E. **Retired Employee** means you, the enrollee, upon retirement under the conditions set forth in the General Information section of this book.
- F. You will be considered **disabled** if you are eligible for Medicare due to your disability.
- G. You will be considered to have **end-stage renal disease** if you have permanent kidney failure.

### **Coverage**

When you are eligible for primary coverage under Medicare, the benefits under this Plan may change.

*Please refer to the General Information section of this book for information on when you must enroll for Medicare and when Medicare becomes your primary coverage. **If you or your dependent is eligible for primary Medicare coverage - even if you or your dependent fails to enroll - your covered medical expenses will be reduced by the amount available under Medicare, and UHIC-NY will consider the balance for payment, subject to copayment, deductible and coinsurance.***

**If you or your dependent is eligible for primary coverage under Medicare and you enroll in a Health Maintenance Organization under a Medicare Advantage plan, your Empire Plan benefits will be dramatically reduced under some circumstances, as explained in the last paragraph of this section, "Medicare Advantage Plans and your Empire Plan coverage" below.**

- A. **Retired Employees and/or their Dependents** – If you or your dependents are eligible for primary coverage under Medicare - even if you or they fail to enroll - your covered medical expenses will be

reduced by the amount that would have been paid by Medicare, and UHIC-NY will consider the balance for payment, subject to copayment, deductible and coinsurance.

If the provider has agreed to accept Medicare assignment, covered expenses will be based on the provider's reasonable charge or the amount approved by Medicare, whichever is less. If the provider has not agreed to accept Medicare assignment, covered expenses will be based on Medicare's limiting charge, as established under federal, or in some cases, state regulations.

*No benefits will be paid for services or supplies provided by a skilled nursing facility.*

- B. **Active State Employees and/or their Dependents** – This Plan will automatically be the primary payor for active employees, regardless of age, and for the employee's enrolled dependents (except for a domestic partner or same-sex spouse eligible for Medicare due to age) unless end-stage renal disease provisions apply; Medicare, the secondary payor. As the primary payor, UHIC-NY will pay benefits for covered medical expenses under this Plan; as secondary payor, Medicare's benefits will be available to the extent they are not paid under this Plan or under the plan of any other primary payor.

The only way you can choose Medicare as the primary payor is by canceling this Plan; if you do so, there will be no further coverage for you under this Plan.

Note to domestic partners or same-sex spouses: Under Social Security law, Medicare is primary for an active employee's domestic partner or same-sex spouse who becomes Medicare eligible at age 65. If the domestic partner or same-sex spouse becomes Medicare eligible due to disability, NYSHIP is primary.

- C. **Disability.** Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must be enrolled in Parts A and B of Medicare when first eligible and apply for available Medicare benefits. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you.
- D. **End-Stage Renal Disease.** For those eligible for Medicare due to end-stage renal disease, whose coordination period began on or after March 1, 1996, NYSHIP will be the primary insurer for the first 30 months of treatment, then Medicare becomes primary. See "Medicare end-stage renal disease coordination" in the General Information section. Benefits under this Plan are reduced to the extent that Medicare benefits could be available to you. Therefore, you must apply for Medicare and have it in effect at the end of the 30-month period to avoid a loss in benefits.
- E. **Veterans' Facilities.** Where services are provided in a U.S. Department of Veterans' Affairs facility or other facility of the federal government, benefits under this Plan are determined as if the services were provided by a nongovernmental facility and covered under Medicare. The Medicare amount payable will be subtracted from this Plan's benefits. The Medicare amount payable is the amount that would be payable to a Medicare-eligible person covered under Medicare. You are not responsible for the cost of services in a governmental facility that would have been covered under Medicare in a non-governmental facility.
- F. *If you or your dependents are eligible and enrolled for primary coverage under Medicare and receive services from a health care provider who has elected to opt-out of Medicare, or whose services are otherwise not covered under Medicare due to failure to follow applicable Medicare program guidelines, we will estimate the Medicare benefit that would have been payable and subtract that amount from the allowable expenses under this Plan.*

## Medicare Advantage Plans and your Empire Plan coverage

If you or your dependent enrolls in a Medicare Advantage plan, in addition to your Empire Plan coverage, The Empire Plan will not provide benefits for any services available through your Medicare Advantage plan or services that would have been covered by your Medicare Advantage plan if you had complied with the plan's requirements for coverage. Covered medical expenses under The Empire Plan are limited to expenses not covered under your Medicare Advantage plan. If your Medicare Advantage plan has a Point-of-Service option that provides partial

coverage for services you receive outside the plan, covered medical expenses under The Empire Plan are limited to the difference between the Medicare Advantage plan's payment and the amount of covered expenses under The Empire Plan.

## Claims

OptumHealth as administrator for UHIC-NY is responsible for processing claims at the level of benefits determined by OptumHealth and for performing all other administrative functions under The Empire Plan Mental Health and Substance Abuse Program.

### Claim payment for covered services

Claim payments for covered services you receive under this Program will be made only as follows:

- A. **Network Coverage:** When you receive network coverage, UHIC-NY will make any payment due under this Program directly to the provider, except for the copayment amount which you pay to the provider.
- B. **Non-Network Coverage:** When you receive non-network coverage, any payment due under the Program will be made **ONLY** to you. You are responsible for payment of charges at the time they are billed to you. You must file a claim with OptumHealth for services rendered under nonnetwork coverage in order to receive reimbursement. UHIC-NY pays you the non-network covered amount for the covered service you obtained. You are always required to pay the deductible, coinsurance amounts and the amount billed to you in excess of the non-network covered amount. Also, you are ultimately responsible for paying your provider any amount not paid by UHIC-NY. However, UHIC-NY may pay the non-network covered amount directly to an approved facility in lieu of paying you.
- C. **Assignment Prohibited:** Your right under this Program to receive reimbursement for outpatient covered services when such services are provided under non-network coverage, except inpatient services and partial hospitalization where agreed to by UHIC-NY, may not be assigned or otherwise transferred to any other person or entity including, without limitation, any such provider. Such assignments or transfers are prohibited, will not be honored and will not be enforceable against the Program, UHIC-NY or OptumHealth.

## How, When and Where to Submit Claims

### How

If you use non-network coverage, you must submit a claim. You may obtain a claim form from:

OptumHealth Behavioral Solutions  
P.O. Box 5190  
Kingston, NY 12402-5190

or

You may call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

### When

If you are enrolled in Medicare, an "Explanation of Medicare Benefits" form **must be submitted with the completed claim form or detailed bills** to receive benefits in excess of the Medicare payment. Make and keep a duplicate copy of the "Explanation of Medicare Benefits" form and other documents for your records.

**Remember - If you are enrolled with Medicare as the primary payor, bills must be submitted to Medicare first.**

- A. If you use network coverage, your provider will submit a claim to OptumHealth.
- B. If you use non-network coverage, you must meet the Mental Health and Substance Abuse Program annual deductibles before the claims are paid. These deductibles are separate from the other Empire Plan annual deductibles.

**Claims must be submitted to either OptumHealth or Medicare, if applicable, within 90 days (120 days-for claims incurred in Calendar Year 2010 or later) after the end of the calendar year in which covered expenses were incurred. If the claim is first sent to Medicare, it must be submitted to OptumHealth within 90 days (120 days-for claims incurred in Calendar Year 2010 or later) after Medicare processes the claim.**

**Benefits will not be paid for claims submitted after the 90 days regardless of whether you or a provider submits the claim unless meeting this deadline has not been reasonably possible (for example, due to your illness).**

## **Where**

Send completed claim forms for non-network coverage with supporting bills, receipts, and, if applicable, an "Explanation of Medicare Benefits" form to: OptumHealth Behavioral Solutions, P.O. Box 5190, Kingston, NY 12402-5190.

## **Fraud**

**Any person who intentionally defrauds an insurance company by filing a claim which contains false or misleading information, or conceals information which is necessary to properly examine a claim has committed a crime.**

## **Verification of claims information**

OptumHealth and UHIC-NY have the right to request from approved facilities, practitioners or other providers any information that is necessary for the proper handling of claims. This information is kept confidential.

## **Questions**

For questions about referrals for treatment, certification of medical necessity, case management services or payment of claims, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose OptumHealth.

## **COBRA: Continuation of Coverage**

Your rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA), a federal continuation of coverage law for you and your covered dependents, are explained in your *NYSHIP General Information Book*.

## **Miscellaneous Provisions**

### **Confined on effective date of coverage**

If you become covered under this Plan and on that date are confined in a hospital or similar facility for care or treatment or are confined at home under the care of a doctor for an illness or injury, your Empire Plan benefits will be coordinated with any benefits payable through your former health insurance plan. Empire Plan benefits will be payable only to the extent that they exceed benefits payable through your former health insurance plan.

## **Benefits after termination of coverage**

If you are Totally Disabled due to a mental health or substance abuse condition on the date coverage ends on your account, UHIC-NY will pay benefits for covered expenses for that Total Disability, on the same basis as if coverage had continued without change, until the day you are no longer Totally Disabled or 90 days after the day your coverage ended, whichever is earlier.

“Total Disability” and “Totally Disabled” mean that because of a mental health/substance abuse condition you, the enrollee, cannot do your job or your dependent cannot do his or her usual duties.

## **Confined on date of change of options**

“Option” means your choice under the New York State Health Insurance Program of either The Empire Plan, which includes the Mental Health and Substance Abuse Program, or a Health Maintenance Organization (HMO). See your NYSHIP General Information Book for information on option transfer. If, on the effective date of transfer without break from one option to the other, you are confined in a hospital or similar facility for mental health/substance abuse care or confined at home under the care of a practitioner for mental health/substance abuse care:

- A. If the transfer is out of The Empire Plan, and you are confined on the day coverage ends, benefits will end on the effective date of option transfer; and
- B. If the transfer is into The Empire Plan, benefits under the Mental Health and Substance Abuse Program are payable for covered expenses to the extent they exceed or are not paid through your former HMO.

## **Termination of coverage**

- A. Coverage will end when you are no longer eligible to participate in The Empire Plan. Refer to your NYSHIP General Information Book.
- B. If this Program ends, your coverage will end.
- C. Coverage of a dependent will end on the date that dependent ceases to be a dependent as defined in your NYSHIP General Information Book.
- D. If a payment which is required by the State of New York for coverage is not made, the coverage will end on the last day of the period for which a payment required by the State was made.

If coverage ends, any claim which is incurred before your coverage ends will not be affected.

## **Refund to UHIC-NY for overpayment of benefits**

If UHIC-NY pays benefits under this Program for covered expenses incurred on your account, and it is found that UHIC-NY paid more benefits than should have been paid because all or some of those expenses were not paid by you, or you were also paid for all or some of those expenses by another source, UHICNY will have the right to a refund from you.

The amount of the refund is the difference between the amount of benefits paid by UHIC-NY for those expenses and the amount of benefits which should have been paid by UHIC-NY for those expenses.

If benefits were paid by UHIC-NY for expenses not covered by this Program, UHIC-NY will have the right to a refund from you.

## **Time limit for starting lawsuits**

Lawsuits to obtain benefits may not be started less than 60 days or more than two years following the date you receive notice that benefits have been denied.

## Appeals

### Appeals: 60-day deadline

In the event a certification or claim has been denied, in whole or in part, you can request a review. This request for review must be sent within 60 days after you receive a notice of denial of the certification or claim to:

OptumHealth Behavioral Solutions  
Attn: BH Appeals Dept.  
900 Watervliet Shaker Road, Suite 103  
Albany, NY 12205-1002

When requesting a review, please state the reason you believe the certification or claim was improperly denied and submit any data, questions or comments you deem appropriate.

Please refer to “Certification denial and appeal process: deadlines apply” for information about the appeals process.

If you are unable to resolve a problem with an Empire Plan carrier, you may contact the Consumer Services Bureau of the New York State Insurance Department at: New York State Department of Insurance, One Commerce Plaza, Albany, New York 12257. Phone: 1-800-342-3736, Monday - Friday, 9am - 5pm Eastern time.

### Your right to an external appeal

Under certain circumstances, you have a right to an external appeal of a denial of coverage. Specifically, if UHIC-NY has denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, including treatment of a rare disease, you or your representative may appeal for review of that decision by an External Appeal Agent, an independent entity certified by the New York State Department of Insurance to conduct such appeals.

#### Your right to appeal a determination that a service is not medically necessary

If you have been denied coverage on the basis that the service is not medically necessary, you may appeal for review by an External Appeal Agent if you satisfy the following two criteria:

- A. The service, procedure or treatment must otherwise be a Covered Service under the Policy; and
- B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedures was presented for consideration, UHIC-NY must have upheld the denial; **or** you and UHIC-NY must agree in writing to waive any internal appeal.

#### Your right to appeal a determination that a service is experimental or investigational

If you have been denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the following two criteria:

- A. The service must otherwise be a Covered Service under the Policy; and
- B. You must have received a final adverse determination through the internal appeal process described above and, if any new or additional information regarding the service or procedures was presented for consideration, UHIC-NY must have upheld the denial; **or** you and UHIC-NY must agree in writing to waive any internal appeal.

In addition, your attending physician must certify that you have a lifethreatening or disabling condition or disease. A “life-threatening condition or disease” is one which, according to the current diagnosis of your attending physician,

has a high probability of death. A “disabling condition or disease” is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders you unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a “disabling condition or disease” is any medically determinable physical or mental impairment of comparable severity.

Your attending physician must also certify that your life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate **or** one for which there does not exist a more beneficial standard service or procedure covered by the Plan **or** one for which there exists a clinical trial (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A. A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard Covered Service (only certain documents will be considered in support of this recommendation - your attending physician should contact the New York State Department of Insurance in order to obtain current information as to what documents will be considered acceptable) or, in the case of a rare disease, a health service or procedure that is likely to benefit you in the treatment of a rare disease; or
- B. A clinical trial for which you are eligible (only certain clinical trials can be considered).

For the purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the area appropriate to treat your life-threatening or disabling condition or disease.

## **The External Appeal process**

If, through the internal appeal process described above, you have received a final adverse determination upholding a denial of coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, you have 45 days from receipt of such notice to file a written request for an external appeal. If you and UHIC-NY have agreed in writing to waive any internal appeal, you have 45 days from receipt of such waiver to file a written request for an external appeal. UHIC-NY will provide an external appeal application with the final adverse determination issued through UHIC-NY’s internal appeal process described above or its written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Insurance at 1-800-400-8882. Submit the completed application to the Insurance Department at the address indicated on the application. If you satisfy the criteria for an external appeal, the Insurance Department will forward the request to a certified External Appeal Agent.

You will have an opportunity to submit additional documentation with your request. If the External Appeal Agent determines that the information you submit represents a material change from the information on which UHIC-NY based its denial, the External Appeal Agent will share this information with UHIC-NY in order for it to exercise its right to reconsider its decision. If UHIC-NY chooses to exercise this right, UHIC-NY will have three business days to amend or confirm its decision. Please note that in the case of an expedited appeal (described below), UHIC-NY does not have a right to reconsider its decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of your completed application. The External Appeal Agent may request additional information from you, your physician or UHIC-NY. If the External Appeal Agent requests additional information, it will have five additional business days to make its decision. The External Appeal Agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health, you may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify you and UHIC-NY by telephone or facsimile of that decision. The External Appeal Agent must also notify you in writing of its decision. If the External Appeal Agent overturns UHIC-NY’s decision that a service is not medically necessary or approves coverage of an experimental or

investigational treatment, UHIC-NY will provide coverage subject to the other terms and conditions of the Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, UHIC-NY will only cover the costs of services required to provide treatment to you according to the design of the trial. UHIC-NY shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the Policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both you and UHIC-NY. The External Appeal Agent's decision is admissible in any court proceeding.

The insurer will charge you a fee of \$50 for an external appeal. The external appeal application will instruct you on the manner in which you must submit the fee. UHIC-NY will also waive the fee if it is determined that paying the fee would pose a hardship to you. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to you.

### **Your responsibilities in filing an External Appeal**

It is **YOUR RESPONSIBILITY** to initiate the external appeal process. You may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to you, your physician may file an external appeal application on your behalf, but only if you have consented to this in writing.

### **45-day deadline**

Under New York State law, your completed request for appeal must be filed within 45 days of either the date upon which you receive written notification from UHIC-NY that it has upheld a denial of coverage or the date upon which you receive a written waiver of any internal appeal. UHIC-NY has no authority to grant an extension of this deadline.





## **SEHP**

### **The New York State Health Insurance Program's Student Employee Health Plan (SEHP):**

For Graduate Student Employees and their enrolled dependents, COBRA enrollees with SEHP benefits and Young Adult Option enrollees

#### **Call Toll Free 1-877-7-NYSHIP (1-877-769-7447)**

For preauthorization of services or if you have a question about eligibility, providers or claims, call the Plan and choose the program you need.

Medical/Surgical Program representatives are available Monday through Friday, 8 a.m. to 4:30 p.m. Eastern time and Hospital Program representatives are available Monday through Friday 8 a.m. to 5 p.m. Eastern time. Mental Health and Substance Abuse and Prescription Drug Program representatives are available 24 hours a day, seven days a week. This number is for both The Empire Plan (another NYSHIP plan) and NYSHIP SEHP (except for the NurseLine<sup>SM</sup> option, which is for The Empire Plan only). SEHP dental and vision care plans have separate toll-free numbers (see inside cover).

#### **State of New York Department of Civil Service Employee Benefits Division**

Alfred E. Smith State Office Building  
Albany, NY 12239

web site: <https://www.cs.state.ny.us>

This guide briefly describes the principal NYSHIP SEHP benefits. It is not a complete description and is subject to change.

If you have questions about eligibility, enrollment procedures or the cost of health insurance, contact the Health Benefits Administrator (HBA) on your SUNY campus.

CUNY SEHP enrollees with questions may contact their Health Benefits Administrator (HBA) at the CUNY University Benefits Office.

#### **This publication also includes:**

- The 2011 Empire Plan Flexible Formulary

JANUARY 1, 2011

# **Summary of Benefits**

# Benefit Summary

The NYSHIP Student Employee Health Plan (SEHP) is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan provides medical, dental and vision care benefits.

## What's New

- **Federal Health Care Reform** - Effective January 1, 2011, the federal Patient Protection and Affordable Health Care Act extends health insurance coverage to eligible children up to age 26 and eliminates annual limits for non-network routine health exams and newborn care.
- **Combined Annual Maximum** - There is now a combined annual maximum of \$750,000 for Network and Non-network Services, Basic Medical, Mental Health and Substance Abuse and Prescription Drugs.
- **2011 Empire Plan Flexible Formulary**

## Contact Information

### Hospital Program

Empire BlueCross BlueShield  
New York State Service Center  
P.O. Box 1407, Church Street Station  
New York, NY 10008-1407

### Medical/Surgical Program

UnitedHealthcare  
P.O. Box 1600, Kingston, NY 12402-1600

### Mental Health and Substance Abuse Program

OptumHealth Behavioral Solutions  
P.O. Box 5190, Kingston, NY 12402-5190

### Prescription Drug Program

The Empire Plan Prescription Drug Program  
P.O. Box 5900, Kingston, NY 12402-5900

### Dental Care Plan

GHI, NYS Dental Service  
P.O. Box 12365, Albany, NY 12212-2365

### Vision Care Plan

EyeMed Vision Care  
4000 Luxottica Place, Mason, OH 45040-7111

Teletypewriter (TTY) numbers for callers who use a TTY because of a hearing or speech disability:

<b>Hospital Program</b>	<b>TTY only 1-800-241-6894</b>
<b>Medical/Surgical Program</b>	<b>TTY only 1-888-697-9054</b>
<b>Mental Health and Substance Abuse Program</b>	<b>TTY only 1-800-855-2881</b>
<b>Prescription Drug Program</b>	<b>TTY only 1-800-759-1089</b>

# Quick Reference

**The NYSHIP Student Employee Health Plan (SEHP) is a health insurance plan for CUNY and SUNY graduate and teaching assistant employees and their families. The Plan has six main parts:**

- (1) Hospital Program**  
insured and administered by Empire BlueCross BlueShield  
Provides coverage for inpatient and outpatient services provided by a hospital or birthing center and for hospice care. Also provides inpatient Benefits Management Program services for preadmission certification of scheduled hospital admissions or within 48 hours after an emergency or urgent admission.  
Services provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association, an association of independent BlueCross and BlueShield plans.
- (2) Medical/Surgical Program**  
insured and administered by UnitedHealthcare  
Provides coverage for medical services, such as office visits, surgery and diagnostic testing under the network and non-network programs. Coverage for chiropractic care and physical therapy is provided through the Managed Physical Medicine Program. Home care services provided in lieu of hospitalization and diabetic supplies provided by the Home Care Advocacy Program (HCAP). Benefits Management Program services for Prospective Procedure Review for MRI, MRA, CT, PET scan and Nuclear Medicine tests.
- (3) Mental Health and Substance Abuse Program**  
insured by UnitedHealthcare and administered by OptumHealth Behavioral Solution (OptumHealth)  
Provides coverage for inpatient and outpatient mental health and substance abuse services.
- (4) Prescription Drug Program**  
insured and administered by UnitedHealthcare  
UnitedHealthcare utilizes the administrative and mail distribution services of Medco Health Solutions, Inc. (Medco) for services including the retail pharmacy network and mail pharmacy services.  
Provides coverage for prescription drugs, oral contraceptives and diaphragms through network pharmacies, the Medco Pharmacy (mail service) and non-network pharmacies.
- (5) Dental Care Plan**  
administered by GHI 1-800-947-0101  
Provides coverage for dental examinations, cleaning and bitewing X-rays. Also provides discounts on other services.
- (6) Vision Care Plan**  
administered by EyeMed 1-877-226-1412  
Provides coverage for routine eye examinations, eyeglasses or contact lenses.

# 2011 SEHP Copayments at a Glance

## Medical/Surgical Program\*

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### Participating Provider Program

\$10 copayment - office visit, office surgery, urgent care visit, contraceptive drugs and devices (injections, insertions or other physician intervention provided during visit subject to additional copayment), infertility treatment visit, allergy testing, mammography, cervical cytology screening.

\$10 copayment - diagnostic laboratory tests and radiology (not performed during an office visit)

\$10 copayment - ambulatory surgical center (including same day on-site testing and anesthesiology)

### Chiropractic Treatment or Physical Therapy Services (Managed Physical Medicine Program)

\$10 copayment - office visit, up to 15 chiropractic visits per person per calendar year; up to 60 physical therapy visits per diagnosis

\$10 copayment - diagnostic laboratory tests or radiology

\*Note: some medically necessary services are paid in full; others are subject to copayment or a 15-visit per person limit.

## Hospital Program

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\$15 copayment - surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital or an extension clinic (including outpatient surgical locations)

\$25 copayment - emergency room care

\$200 copayment - per admission for covered inpatient hospital stays

\$10 copayment - per visit for medically necessary physical therapy (following related hospitalization or surgery); up to 60 visits

## Mental Health and Substance Abuse Program

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\$10 copayment - visit to network practitioner, for up to 15 visits per person per calendar year (for visits 16 and beyond, non-network outpatient coverage applies)

\$25 copayment - emergency room care

\$200 copayment - per admission for covered network, inpatient mental health stay or inpatient care in a residential treatment center, group home or halfway house

## Prescription Drug Program

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*Up to a 30-day supply from a participating retail pharmacy, mail service or designated specialty pharmacy:*

\$5 copayment - Level 1 or generic drug

\$15 copayment - Level 2 or preferred brand-name drug

\$40 copayment - Level 3 or non-preferred brand-name drug

*31 to 90-day supply through the mail service or designated specialty pharmacy:*

\$5 copayment - Level 1 or generic drug

\$20 copayment - Level 2 or preferred brand-name drug

\$65 copayment - Level 3 or non-preferred brand-name drug

## Dental Care

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\$20 copayment - participating provider visit

\$10 copayment - filling

## Vision Care

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\$10 copayment - routine eye exam

# SEHP Health Insurance Benefit Summary

## Annual Benefit Maximum

For all services combined, including network and non-network hospital, medical, mental health and substance abuse, and prescription drugs, there is one annual maximum of \$750,000.

All services must be medically necessary. "Allowable amount" means the amount you actually paid for medically necessary services covered under SEHP, or the network allowance as determined by the carriers, whichever is lower.

## Benefits Management Program



### *for preadmission certification*

#### **If NYSHIP SEHP coverage is primary for you or your covered dependents:**

You must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Hospital Program:

- Before a scheduled (non-emergency) hospital admission
- Before a maternity hospital admission
- Within 48 hours or as soon as reasonably possible after an emergency or urgent hospital admission

If you do not call, or if the Hospital Program does not certify the hospitalization, the Plan pays up to 50 percent of the allowable amount after your \$200 copayment. If the Hospital Program does not certify the hospitalization, you will be responsible for the entire cost of care determined not to be medically necessary.



### *for Prospective Procedure Review - MRI, MRA, CT, PET scan or Nuclear Medicine tests*

#### **If NYSHIP SEHP coverage is primary for you or your covered dependents:**

You must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program for prior authorization before having a scheduled (non-emergency) Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Positron Emission Tomography (PET) scan or a Nuclear Medicine test, unless you are having the test as an inpatient in a hospital. If you do not call, your out of pocket cost will be substantially higher. If the test is determined not to be medically necessary, you will be responsible for the entire cost.

# Hospital Program

The Hospital Program pays for covered services provided in an inpatient or outpatient hospital setting or hospice organization. The Medical/Surgical Program provides benefits for certain medical and surgical care provided in a hospital setting when it is not covered by the Hospital Program. Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Hospital Program if you have questions about your hospital benefits, coverage or an Explanation of Benefits (EOB) Statement.

## Hospital Inpatient • *Semi-Private Room or Birthing Center*



### *for preadmission certification*

#### **Network Coverage**

**Copayment:** \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

**Coverage Level:** The Plan pays 100 percent of allowable amount after you pay the copayment.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

**Maternity Care:** First 48 hours of hospitalization for mother and newborn after any delivery other than a cesarean section or first 96 hours following a cesarean section are presumed medically necessary and covered at the same copayment and coverage level as other inpatient admissions. If you choose early discharge following delivery, you may request one paid-in-full home care visit.

#### **Non-network Coverage**

**Copayment:** \$200 per person per admission; new copayment required if hospitalization occurs more than 90 days after previous discharge.

**Coverage Level:** The Plan pays 80 percent of allowable amount after you pay the copayment. You are responsible for the balance.

Unlimited days for covered medical or surgical care in a hospital, including inpatient detoxification.

**Maternity Care:** Same as network coverage.

## Hospital Outpatient

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### Network Coverage

Surgery, diagnostic radiology, diagnostic laboratory tests, bone mineral density screening and administration of Desferal for Cooley's Anemia in the hospital outpatient department of a network hospital (or an extension clinic, including outpatient surgical locations) are subject to one copayment of \$15 per visit. The copayment is waived if you are admitted as an inpatient directly from the outpatient department.

You must have prior authorization for an MRI, MRA, CT, PET scan or a Nuclear Medicine test (see page 3).

\$10 copayment per visit for up to 60 visits for medically necessary physical therapy following a related hospitalization or related inpatient or outpatient surgery.

Emergency room services, including use of the facility for emergency care and services of the attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services are subject to one copayment of \$25 per visit. The copayment is waived if you are admitted as an inpatient directly from the emergency room.

Emergency is defined as the sudden onset of symptoms of sufficient severity, including severe pain, that a prudent layperson could reasonably expect the absence of immediate care to put the person's life in jeopardy or cause serious impairment of bodily functions.

Paid-in-full benefits for chemotherapy, radiation therapy or dialysis and for preadmission testing and/or presurgical testing prior to an inpatient admission.

### Non-network Coverage

**Outpatient Care:** Same as network coverage, except subject to an annual deductible of \$100 per covered individual. (Not combined with physical therapy deductible.)

**Coinsurance:** The Plan pays 80 percent of allowable amount after you meet the \$100 deductible.

Non-network coverage subject to a separate \$100 deductible for all physical therapy. (Not combined with hospital outpatient deductible.)

**Emergency Care:** Same as network coverage.

Same as network coverage.

## Infertility

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### Network Coverage

The following services provided in the inpatient or outpatient departments of a hospital are covered: artificial/intra-uterine insemination, inpatient and/or outpatient surgical or medical procedures, performed in the hospital, which would correct malfunction, disease or dysfunction resulting in infertility and associated diagnostic tests and procedures including but not limited to those described in New York State Insurance Law as set forth in Chapter 82 of the Laws of 2002.

### Non-network Coverage

Same as network coverage.

## Hospice Care

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### Network Coverage

Paid-in-full benefit for up to 210 days when provided by an approved hospice program.

### Non-network Coverage

Plan pays up to 100 percent of allowable amount for up to 210 days.

# Medical/Surgical Program

The Medical/Surgical Program pays for covered medical/surgical services by physicians and other covered providers under either network or non-network coverage. Some medically necessary services are paid in full; others are subject to copayment or to a 15-visit per person limit. Note: Any visit you make to your SUNY Campus Student Health Center (which is not a network provider), does not count toward the 15-visit per person limit or network dollar maximum. (This does not apply to CUNY SEHP enrollees). Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program if you have questions about your coverage.

## Network Coverage

Some covered services received from a network provider are paid in full and others are subject to a copayment as described below.

The Plan does not guarantee that participating providers are available in all specialties or geographic locations.

To learn whether a provider participates, check with the provider directly, call the Plan and choose the Medical/Surgical Program or visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online then click on Find a Provider. Always confirm the provider's participation **before** you receive services.

## Non-network Coverage

**Annual Deductible:** \$100 per covered individual.

**Coinsurance:** Plan pays 80 percent of allowable amount for covered services after you meet the annual deductible.

## Inpatient in a Hospital or Birthing Center

### Network Coverage

Covered services received from a network provider while you are an inpatient are paid in full and do not count toward the 15-visit per person limit.

Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, radiology, anesthesiology and pathology.

### Non-network Coverage

Non-network benefits for covered services by a non-network provider.

Same as network coverage.

## Outpatient Department of a Hospital

### Network Coverage

Paid-in-full benefits for covered outpatient services provided in the outpatient department of a hospital by a network provider.

For medical emergency; paid-in-full benefits for attending emergency room physician and providers who administer or interpret radiological exams, laboratory tests, electrocardiogram and pathology services when these services are not covered by the Hospital Program. Services of other physicians are considered under network coverage or non-network coverage as appropriate.

### Non-network Coverage

Non-network benefits for covered services by a non-network provider.

Same as network coverage.



## Outpatient Department of a Hospital, continued

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### Network Coverage

Paid-in-full benefit for preadmission testing and/or presurgical testing prior to an inpatient admission, chemotherapy, anesthesiology, radiology, pathology or dialysis when not covered by Empire BlueCross BlueShield; does not count toward 15-visit per person limit.

Medically necessary physical therapy covered under the Managed Physical Medicine Program when not covered by the Hospital Program.

### Non-network Coverage

Plan pays up to 100 percent of allowable amount.

Non-network coverage under the Managed Physical Medicine Program when not covered by the Hospital Program.

## Doctor's Office Visit, Office Surgery, Laboratory and Radiology

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### Network Coverage

You have network coverage for up to 15 visits per person per calendar year to a participating provider, subject to a \$10 copayment per visit. The copayment includes diagnostic laboratory tests and radiology done during the office visit.

The following types of office visits and services are paid in full and do not count toward the 15-visit per person limit: dialysis, chemotherapy and radiation therapy, well-child care, prenatal and postnatal office visits included in your provider's delivery charge. Prenatal and postnatal office visits that are not included in the delivery charge are subject to a \$10 copayment but do not count toward 15-visit per person limit.

Diagnostic laboratory tests and radiology not performed during an office visit, including interpretation of mammograms and analysis of cervical cytology screening, are covered subject to a \$10 copayment and do not count toward the 15-visit per person limit.

Office-based surgery visits are subject to copayment and count toward the 15-visit per person limit.

Visit to a participating Urgent Care Center are subject to a \$10 copayment and do not count toward the 15-visit per person limit.

You must have prior authorization for an MRI, MRA, CT, PET scan or a Nuclear Medicine test (see page 3).

### Non-network Coverage

Non-network benefits for covered services received from non-participating providers or after the 15th visit to a participating provider.

## Doctor's Office Visit, Office Surgery, Laboratory and Radiology *continued*

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### Network Coverage

**Contraceptive Drugs and Devices:** \$10 copayment for required injections, insertion or other physician intervention provided during an office visit. (This copayment is in addition to your \$10 copayment for the office visit.)

**Infertility Treatment:** \$10 copayment for covered services such as artificial/intrauterine insemination (See Infertility on page 5) provided during an office visit.

**Second Surgical Opinion:** \$10 copayment for one out-of-hospital specialist consultation in each specialty field per condition per calendar year; counts toward 15-visit per person limit. One paid-in-full in-hospital consultation in each field per confinement.

**Second Opinion for Cancer Diagnosis:** \$10 copayment for a second medical opinion by an appropriate specialist in the event of a positive or negative diagnosis of cancer or recurrence of cancer or a recommendation of course of treatment for cancer.

### Non-network Coverage

**Contraceptive Drugs and Devices:** Same as network coverage, subject to deductible and coinsurance.

**Infertility Treatment:** Same as network coverage, subject to deductible and coinsurance.

**Second Surgical Opinion:** Same as network coverage, subject to deductible and coinsurance.

**Second Opinion for Cancer Diagnosis:** Same as network coverage.

## Routine Health Exams

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### Network Coverage

Same as non-network coverage.

### Non-network Coverage

Routine Physicals are covered once every two years for the active employee under age 40, or annually for the active employee over age 40. The Plan pays 80 percent of the allowable amount for covered services. There is no coverage for routine health exams for a spouse or domestic partner. This benefit is not subject to copayment or 15-visit per person limit or deductible.

## Allergy Care

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### Network Coverage

Office visits are covered subject to a \$10 copayment and count toward 15-visit per person limit. No separate copayment for basic skin tests done during an office visit. Tests provided on different date or different location require a separate \$10 copayment, but do not count toward 15-visit per person limit. Allergy injections and extracts are not covered; see *Exclusions*, page 18.

### Non-network Coverage

Not covered

## Routine Well-Child Care

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### Network Coverage

Paid-in-full benefit for children up to age 19 including examinations and immunizations administered pursuant to pediatric guidelines. Well-child care visits do not count toward the 15-visit per person limit.

### Non-network Coverage

Plan pays 100 percent of allowable amount. This benefit is not subject to deductible or coinsurance.

## Mammograms and Cervical Cytology Screening

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### Network Coverage

\$10 copayment for mammography received from a network provider following recommended guidelines; \$10 copayment for cervical cytology screening. (Also see Hospital Outpatient, page 5.)

### Non-network Coverage

Plan pays 80 percent of allowable amount after you meet the annual deductible.

## Pregnancy Termination

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### Network Coverage

Paid-in-full benefit; does not count toward 15-visit per person limit.

### Non-network Coverage

Plan pays 80 percent of allowable amount after you meet the annual deductible.

## Ambulatory Surgical Center

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### Network Coverage

\$10 copayment covers facility, same-day on-site testing and anesthesiology charges for covered services at a participating surgical center.

### Non-network Coverage

Non-network benefits for covered services provided by non-participating surgical centers.

## Ambulance Service

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### Network Coverage

Plan pays for local commercial ambulance charges for emergency transportation, subject to a \$15 copayment.

**Emergency Ambulance Transportation** is covered when the service is provided by a licensed ambulance service to the nearest hospital where emergency care can be performed and ambulance transportation is required because of an emergency condition.

### Non-network Coverage

Same as Network Coverage.

**Emergency Ambulance Transportation** is covered the same as network coverage. This benefit is not subject to deductible or coinsurance.

## Enteral Formulas; Modified Solid Food Products

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### Network Coverage

Same as non-network coverage.

### Non-network Coverage

For prescribed enteral formulas, Plan pays up to 80 percent of allowable amount after you meet the annual deductible. For certain prescribed modified solid food products, Plan pays up to 80 percent of allowable amount after you meet the annual deductible, up to a total maximum reimbursement of \$2,500 per covered person per calendar year.

## Managed Physical Medicine Program *administered by Managed Physical Network (MPN)*

### Chiropractic Treatment and Physical Therapy

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#### **Network Coverage** *(When you use MPN)*

You pay a \$10 copayment for each office visit to an MPN provider. You pay an additional \$10 copayment for related radiology and diagnostic laboratory services billed by the MPN provider.

**Chiropractic Treatment:** Up to 15 visits per person per calendar year.

**Physical Therapy:** Up to 60 visits per diagnosis, if determined by MPN to be medically necessary.

Access to network benefits is guaranteed for chiropractic treatment and physical therapy. If there is no network provider in your area, call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program.

#### **Non-network Coverage** *(When you don't use MPN)*

**Annual Deductible:** \$100 per covered individual. This deductible is separate from other plan deductibles.

**Coinsurance:** Plan pays up to 80 percent of allowable amount after you meet the annual deductible. Non-network benefits for covered services received from non-network providers, or after the 15<sup>th</sup> chiropractic visit per year, or after the 60<sup>th</sup> physical therapy visit per diagnosis, by a network provider.

*Program requirements apply even if Medicare or another health insurance plan is primary.*

## Home Care Advocacy Program (HCAP)

### Home Care Services in Lieu of Hospitalization and Diabetic Equipment/Supplies

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#### *for prior authorization*

#### **Network Coverage** *(When you use HCAP)*

Home care services provided in lieu of hospitalization are paid in full for 365 visits. To receive this benefit, you must call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program's Home Care Advocacy Program (HCAP) for prior authorization.

Diabetic equipment and supplies, including insulin pumps and Medijectors are paid in full. To receive diabetic equipment and supplies, (except insulin pumps and Medijectors) call The Empire Plan Diabetic Supplies Pharmacy at **1-888-306-7337**. For insulin pumps and Medijectors you must use a network provider. Call the Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Medical/Surgical Program's HCAP for prior authorization.

**Important: If Medicare is your primary coverage, and you do not use a Medicare contracted provider, your benefits will be further reduced.**

*Program requirements apply even if Medicare or another health insurance plan is primary.*

#### **Non-network Coverage** *(When you don't use HCAP)*

Home care services are not covered unless precertified. If precertified, Plan pays 80 percent of allowable amount after you meet the annual deductible.

Diabetic equipment and supplies are covered up to 100 percent of allowable amount; not subject to deductible and coinsurance.

# Mental Health and Substance Abuse Program



## **for prior authorization**

**Precertification required. Call the Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and choose the Mental Health and Substance Abuse Program before seeking any treatment for mental health or substance abuse, including alcoholism.** The Mental Health and Substance Abuse Program's Clinical Referral Line is available 24 hours a day, every day of the year. By following the Program requirements for network coverage, you will receive the highest level of benefits. Access to network benefits is guaranteed.

In an emergency, the Mental Health and Substance Abuse Program will either arrange for an appropriate provider to call you back (usually within 30 minutes) or direct you to an appropriate facility for treatment. In a life-threatening situation, go to the emergency room. If you are admitted as an inpatient, you or someone acting on your behalf should call the Mental Health and Substance Abuse Program within 48 hours or as soon as reasonably possible after an emergency mental health or substance abuse hospitalization.

**Program requirements apply even if Medicare or another health insurance plan is primary.**

Only treatment determined medically necessary by OptumHealth is covered.

*If you are in treatment for mental health or alcohol/substance abuse at the time your NYSHIP SEHP coverage begins, please contact OptumHealth for help in making the transition to your NYSHIP coverage.*

## Facility Charges

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### Network Coverage

**Inpatient care in an Approved General Acute or Psychiatric Hospital or Clinic: inpatient and partial hospitalization, intensive outpatient and day treatment programs, 23 hour extended and 72 hour crisis beds.**

**Copayment:** \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays up to 100 percent of the network allowance after you pay the copayment.

**Inpatient care in a Residential Treatment Center, Group Home or Halfway House.** Coverage for up to 30 days per person per year in an approved facility. \$200 copayment per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: Plan pays up to 80 percent of the network allowance after the copayment. You pay the remaining balance.

**Hospital Emergency Room:** You pay a \$25 copayment (waived if you are admitted as an inpatient directly from the emergency room).

### Practitioner Visits

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#### Network Coverage

Network coverage for up to 15 visits per person per calendar year to a network practitioner, subject to a \$10 copayment per visit. You pay the copayment. For visit 16 and beyond, non-network outpatient coverage applies.

#### Non-network Coverage

**Inpatient care in an Approved General Acute or Psychiatric Hospital or Clinic: inpatient and partial hospitalization, intensive outpatient and day treatment programs, 23 hour extended and 72 hour crisis beds.**

**Copayment:** \$200 per person per admission; new copayment required if admission occurs more than 90 days after the previous admission. Coverage level: The Plan pays 80 percent of the allowable amount after you pay the copayment. You pay the remaining balance.

**Inpatient care in a Residential Treatment Center, Group Home or Halfway House.** Not a covered benefit.

**Hospital Emergency Room:** Same as network benefits.

#### Non-network Coverage

Non-network benefits for covered services received from non-network practitioners or after the 15<sup>th</sup> visit to a network practitioner. Annual deductible: \$100 per covered individual. Plan pays 80 percent of OptumHealth's allowable amount for covered services after the deductible. You pay the deductible and the remaining balance. The annual deductible is separate from the medical deductible.

# Prescription Drug Program

## Benefit Maximum

Prescription drug coverage is included in the combined \$750,000 annual benefit maximum.

## Copayments

You have the following copayments for drugs purchased from a participating pharmacy or through the mail service pharmacy.

<b>Up to a 30-day supply from a participating retail pharmacy, mail service pharmacy or designated specialty pharmacy</b>	<b>31- to 90-day supply through the mail service pharmacy or designated specialty pharmacy</b>
Level 1 or Generic Drug.....\$5	Level 1 or Generic Drug .....\$5
Level 2 or Preferred Brand-name Drug.....\$15	Level 2 or Preferred Brand-name Drug .....\$20
Level 3 or Non-preferred Brand-name Drug .....\$40	Level 3 or Non-preferred Brand-name Drug .....\$65

When you fill a prescription for a covered brand-name drug that has a generic equivalent, you pay the Level 3 non-preferred brand-name copayment plus the difference in cost between the brand-name drug and the generic (ancillary charge), not to exceed the full retail cost of the drug. Certain drugs are excluded from this requirement. You pay only the applicable copayment for these brand-name drugs with generic equivalents: Coumadin, Dilantin, Lanoxin, Levothroid, Mysoline, Premarin, Synthroid, Tegretol, and Tegretol XR. You have coverage for prescriptions for more than a 30-day supply through the mail service pharmacy or designated specialty pharmacy. Oral contraceptives are covered as brand-name or generic. Prescriptions may be refilled for up to one year.

**Note: At certain SUNY Campus Student Health Centers, SUNY SEHP enrollees and/or their dependents are able to fill prescriptions for a \$7 copayment for up to a 30-day supply. See your Health Benefits Administrator for more information. (This does not apply to CUNY SEHP enrollees.)**

## Mail Service Pharmacy

You may fill your prescription by mail through Medco Pharmacy by using the mail service envelope. For envelopes and refill orders, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Prescription Drug Program. To refill a prescription on file with Medco Pharmacy, you may order by phone or download order forms online at the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online. Click on Find a Provider and scroll down to Medco Pharmacy Mail-Order Form.

## Non-Participating Pharmacy

If you do not use your benefit card at a participating or non-participating pharmacy and pay the full retail cost of your prescription, you must submit a claim for reimbursement to Medco, P.O. Box 14711, Lexington, KY, 40512. If your prescription was filled with a generic drug or a covered brand-name drug with no generic equivalent, you will be reimbursed up to the amount the program would reimburse a participating pharmacy for that prescription. If your prescription was filled with a covered brand-name drug that has a generic equivalent, you will be reimbursed up to the amount the program would reimburse a participating pharmacy for filling the prescription with that drug's generic equivalent. In most cases, you will not be reimbursed the total amount you paid for the prescription.

## Specialty Pharmacy Program

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The Empire Plan Specialty Pharmacy Program offers individuals using specialty drugs enhanced services including disease and drug education, compliance management, side-effect management and safety management. Most specialty drugs will only be covered when dispensed by The Empire Plan's designated specialty pharmacy, Accredo, a subsidiary of Medco. Also included in this Program are expedited, scheduled delivery of your medications at no additional charge, refill reminder calls and all necessary supplies such as needles and syringes applicable to the medication.

For a complete list of specialty medications included in the Specialty Pharmacy Program, visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online. Click on Find a Provider, scroll down to Prescription Drug Program and then select Specialty Drug Program to see a complete list of specialty medications included in the Specialty Pharmacy Program. Specialty medications must be ordered through the Specialty Pharmacy Program using the Medco Pharmacy Mail-Order Form. Prior authorization is required for some specialty medications.

To request refills or to speak to a specialty-trained pharmacist or nurse regarding the Program, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)**, choose Option 4 for the Prescription Drug Program, and ask to speak with Accredo, 24 hours a day, seven days a week.

## Prior Authorization Required

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***You must have prior authorization for the following drugs, including generic equivalents:***

- |             |                    |            |              |                     |
|-------------|--------------------|------------|--------------|---------------------|
| • Actemra   | • Dysport          | • Intron-A | • Peg-Intron | • Synagis           |
| • Adcirca   | • Enbrel           | • Iplex    | • Provigil   | • Tracleer          |
| • Amevive   | • Epogen/Procrit   | • Kineret  | • Rebif      | • Tysabri           |
| • Ampyra    | • Flolan           | • Kuvan    | • Remicade   | • Tyvaso            |
| • Aranesp   | • Forteo           | • Lamisil  | • Remodulin  | • Ventavis          |
| • Avonex    | • Growth Hormones  | • Letairis | • Revatio    | • Weight Loss Drugs |
| • Betaseron | • Humira           | • Myobloc  | • Ribavirin  | • Xolair            |
| • Botox     | • Immune Globulins | • Nuvigil  | • Simponi    | • Xyrem             |
| • Cimzia    | • Increlex         | • Orencia  | • Sporanox   |                     |
| • Copaxone  | • Infergen         | • Pegasys  | • Stelara    |                     |

Certain medications that require prior authorization based on age, gender or quantity limit specifications are not listed here. Compound Drugs that have a claim cost to the Program that exceeds \$100 will also require prior authorization under this Program. The above list of drugs is subject to change as drugs are approved by the Food and Drug Administration and introduced into the market. For the most current Empire Plan drug list, prior authorization requirements, or the current list of drugs requiring authorization, call The Empire Plan toll free at **1-877-7-NYSHIP (1-877-769-7447)** and choose the Prescription Drug Program. Or, go to the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to NYSHIP Online. Select Find a Provider and scroll to Prescription Drug Program and click The Empire Plan: Drugs that Require Prior Authorization.



## Half Tablet Program

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Effective January 1, 2011, the Half Tablet Program can dramatically lower your costs on select medications that you take on a regular basis. To participate in the Program, your doctor must write a new prescription for twice the dosage and half the quantity. Then when you fill the prescription, you will automatically pay only half your usual copayment. Split each tablet and take half to get your usual dosage at half the cost. To see a list of medications available under this program, go to the New York State Department of Civil Service web site at <http://www.cs.state.ny.us> and select Benefit Programs. Follow the prompts to access NYSHIP Online and choose Find a Provider. Scroll to the Prescription Drug Program links and click on Empire Plan Half Tablet Program. The Empire Plan will provide participants with one free tablet splitter by mail upon request.

## Flexible Formulary

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The Empire Plan Prescription Drug Program has a flexible formulary for prescription drugs. The Empire Plan Flexible Formulary drug list is designed to provide enrollees and the Plan with the best value in prescription drug spending. This is accomplished by:

- excluding coverage for a small number of drugs;
- placing brand-name drugs that provide the best value to the Plan on the Flexible Formulary drug list; and
- applying the highest copayment to non-preferred brand-name drugs that provide no clinical advantage over generic or preferred brand-name drug alternatives.

***An excluded drug is not subject to any type of appeal or coverage review, including a medical necessity appeal.***

## 2011 Flexible Formulary Changes

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Certain drugs have been added to the list of drugs excluded from coverage under the 2011 Flexible Formulary. A list of accepted alternatives to these excluded drugs, along with a complete list of all excluded drugs, is available online. Visit the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. From the home page, click on Benefit Programs and follow the prompts to access NYSHIP Online. Click on Using Your Benefits and then 2011 Empire Plan Flexible Formulary.

New prescription drugs may be subject to exclusion when they first become available on the market. Check the web site for current information regarding exclusions of newly launched prescription drugs. Coverage for prescription drugs excluded under the benefit plan design are not subject to exception. This includes prescription medications excluded from coverage under the Empire Plan Flexible Formulary.

### Newly Excluded drugs:

- |             |                |  |            |                  |
|-------------|----------------|--|------------|------------------|
| • Acuvail   | • Epiduo       | • Naprelan   | • Ryzolt   | • Zegrid Capsule |
| • Aplenzin  | • Extavia      | • Neobenz Micro  | • Terbinex | • Ziana          |
| • BenzEfoam | • Metozolv ODT | • Omeprazole/sodium bicarbonate capsule (generic Zegrid) | • Triaz    | • Zipsor         |
| • Edluar    | • Momexin Kit  |  | • Twynsta  |                  |

# SEHP Dental Care Benefit Summary

## Dental Program

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Each visit is subject to a \$20 copayment, up to two visits per 12-month period when you visit a participating provider in the SEHP dental program for covered services.

### Covered Services

- Initial examination, including charting
- Periodic examination
- Cleaning
- Bitewing X-rays, maximum four X-rays per year

Up to two fillings per 12-month period are covered subject to a \$10 copayment per filling when you visit a participating provider in the SEHP dental program.

**Participating Provider:** To locate a participating provider in the SEHP dental program, you can link to the GHI web site by accessing <https://www.cs.state.ny.us>. From the home page, click on Other Benefits and then choose Dental, or call **1-800-947-0101**.

## GHI's Discounted Dental Access Program

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When you enroll in the SEHP dental program you are automatically enrolled in GHI's Discounted Dental Access Program. If you utilize a provider who participates in the GHI Discounted Dental Access Program (and receive services other than the covered services above), you are required to pay the provider directly for all care received, and your liability is reduced to a prearranged discounted access rate. You are not subject to precertification or eligibility verification when you utilize the discounted program.

**Participating Provider:** To locate a participating provider in the GHI Discounted Dental Access Program, please call GHI's Dedicated Customer Service Center at **1-800-947-0101** for a list or a CD-ROM identifying GHI Discounted Dental Access Program participating providers.

## Administration

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For **Eligibility** questions, please contact the Health Benefits Administrator (HBA) on your campus.

For **Customer Service**, please contact GHI's Dedicated Customer Services Center at **1-800-947-0101** after you have enrolled.

**Correspondence:** Please direct your correspondence to:

GHI, Attn: NYS Dental Customer Service, P.O. Box 12365, Albany, NY 12212-2365

Please be sure to include your identification number on all correspondence.

**ID Card:** If you go to a provider who participates in the SEHP dental program and/or the GHI Discounted Dental Access Program, present your GHI identification card before you receive services.

# SEHP Vision Care Benefit Summary

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## Network Benefits

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A routine eye examination (subject to a \$10 copayment) is covered once in any 24-month period (based on your last date of service).

A limited selection of frames and lenses or daily wear, disposable or planned replacement contact lenses offered by a participating provider at the time and place of an eye exam will be paid in full. This benefit is available only once in any 24-month period. There is no coverage for services received from a non-participating provider.

## To Confirm Eligibility or Locate a Network Provider

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Contact EyeMed, the plan administrator, at **1-877-226-1412** or link to their web site by accessing <https://www.cs.state.ny.us>. Choose Benefit Programs then NYSHIP Online, and choose your group, if prompted. From the home page, click on Other Benefits and then choose Vision.

## To Receive Services from a Network Provider

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- Contact the network provider and schedule an appointment.
- Identify yourself as covered under the SEHP vision care program available through the NYS Vision Plan, which is administered by EyeMed.
- Give the provider your name and date of birth, or member ID number.

The provider will confirm your eligibility and obtain an authorization to provide services. At the time of your appointment, be sure to pay the provider your \$10 eye examination copayment.

# Exclusions

## Services not covered under the SEHP include, but are not limited to, the following:

- Combined expenses in excess of \$750,000 for network and non-network hospital, medical, mental health and substance abuse, and prescription drugs;
- Care that is not medically necessary;
- Experimental or investigative procedures;
- Custodial care;
- Cosmetic surgery;
- Routine foot care;
- Sex change;
- Durable medical equipment and supplies unless provided under the Home Care Advocacy Program (HCAP);
- Prosthetics (except breast prostheses, which are paid in full);
- Orthotics;
- TMJ treatment (except when caused by a medical condition);
- Hearing aids;
- Weight loss treatment (except for otherwise covered medical care and prescription drugs for treatment of morbid obesity);
- Adult immunizations (except as part of a covered routine physical);
- Skilled nursing facility care including rehabilitation;
- Allergy extracts and injections;
- Inpatient alcohol and substance abuse rehabilitation;
- Psychological testing and evaluation and outpatient psychiatric second opinion;
- Drugs furnished solely for the purpose of improving appearance rather than physical function or control of organic disease;
- Reversal of sterilization; assisted reproductive technology and other infertility services (except artificial/intra-uterine insemination and other services for which coverage is mandated by New York State Insurance Law); cloning;
- Cardiac rehabilitation;
- Occupational therapy;
- Speech therapy.

# Benefits On the Web

You'll find NYSHIP Online, the Employee Benefits Division home page, on the New York State Department of Civil Service web site at <https://www.cs.state.ny.us>. Click on Benefit Programs and follow the prompts to NYSHIP Online.

On your first visit, you will be asked what group and benefit plan you have. Thereafter, you will not be prompted to enter this information if you have your cookies enabled. Cookies are simple text files stored on your web browser to provide a way to identify and distinguish the users of this site. If enabled, cookies will customize your visit to the site and group-specific pages will then display each time you visit unless you select Change Your Group on a toolbar near the top left of the page.

Without enabling cookies, when you select your group and health benefits plan to view your group-specific health insurance benefits, you will be required to reselect your group and benefits plan each time you navigate the health benefits section of the web site or revisit the site from the same computer at another time.

NYSHIP Online is a complete resource for your health insurance benefits, including up-to-date publications. You'll also find links to select Empire Plan carrier web sites. These web sites include the most current list of providers. You can search by location, specialty or name. Announcements, an event calendar, prescription drug information and handy contact information are only a click or two away.

# Federal Health Care Reform

## Grandfathered Health Plans

Under the Patient Protection and Affordable Care Act, a grandfathered health plan is permitted to preserve certain basic health coverage that was already in effect when the Act was signed into law on March 23, 2010. Being a grandfathered health plan means that the plan may delay implementation of certain features of health care reform that apply to other non-grandfathered health plans. For example, the requirement for the provision of preventive health services without any cost sharing does not need to be included under a health care plan until the plan is no longer grandfathered. However, grandfathered health plans must comply with certain other consumer protections in the Act such as the elimination of lifetime limits on certain benefits. The benefit package provided to your group is a grandfathered plan.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan status can be directed to the New York State Department of Civil Service Employee Benefits Division, Alfred E. Smith State Office Building, Albany, NY 12239. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

The *NYSHIP SEHP Summary of Benefits* is published by the Employee Benefits Division of the State of New York Department of Civil Service. The Employee Benefits Division administers the New York State Health Insurance Program (NYSHIP). NYSHIP provides your health insurance benefits. If you have questions, call 1-877-7-NYSHIP (1-877-769-7447) and choose the program you need.



New York State Department of Civil Service  
Employee Benefits Division, Albany, NY 12239

518-457-5754 (Albany area) 1-800-833-4344  
(U.S., Canada, Puerto Rico, Virgin Islands)  
<https://www.cs.state.ny.us>

*This document provides a brief look at SEHP medical, dental and vision care benefits. If you have any questions or need claim forms, call the appropriate benefits carrier.*

State of New York  
Department of Civil Service  
Employee Benefits Division  
P.O. Box 1068  
Schenectady, NY 12301-1068  
<https://www.cs.state.ny.us>

**Address Service Requested**

**Save this document**



Information for the Enrollee, Enrolled Spouse/  
Domestic Partner and Other Enrolled Dependents

SEHP Summary of Benefits – January 2011



**Please do not send mail  
or correspondence to  
the return address  
above. See boxed  
address on page 19.**

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It is the policy of the State of New York Department of Civil Service to provide reasonable accommodation to ensure effective communication of information in benefits publications to individuals with disabilities. These publications are also available on the Department of Civil Service web site (<https://www.cs.state.ny.us>). Check the web site for timely information that meets universal accessibility standards adopted by New York State for NYS agency web sites. If you need an auxiliary aid or service to make benefits information available to you, please contact your agency Health Benefits Administrator. COBRA Enrollees: Contact the Employee Benefits Division at 518-457-5754 (Albany area) or 1-800-833-4344 (U.S., Canada, Puerto Rico, Virgin Islands).

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NF0423 SEHP-1/11

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## **Notice of Access to Women's Health Services**

This notice is provided in accordance with the NYS Women's Health and Wellness Act. The Plan provides direct access to primary and preventive obstetric and gynecologic services for no fewer than two examinations annually. The Plan covers services required as a result of such examinations. The Plan covers services required as a result of an acute gynecologic condition. The Plan covers all care related to pregnancy. Benefits for these services are paid according to the terms of network or non-network coverage.

**Benefits Management Program requirements apply. See page 3.**


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## **Annual Notice of Mastectomy and Reconstructive Surgery Benefits**

The Plan covers inpatient hospital care for lymph node dissection, lumpectomy and mastectomy for treatment of breast cancer for as long as the physician and patient determine hospitalization is medically necessary. The Plan covers all stages of reconstructive breast surgery following mastectomy, including surgery of the other breast to produce a symmetrical appearance. The Plan also covers treatment for complications of mastectomy, including lymphedema and breast prostheses.

**Benefits Management Program requirements apply. See page 3.**

**EMPIRE PLAN MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM  
EMPIRE PLAN BENEFIT CARD**

**THE EMPIRE PLAN**  **NYSHIP**

**123456789** **Copay Code A**

**JEANNIE EMPIRE PLAN ENROLLEE  
JANE EMPIRE PLAN ENROLLEE  
JOHN EMPIRE PLAN ENROLLEE  
MICHAEL EMPIRE PLAN ENROLLEE  
JAMES EMPIRE PLAN ENROLLEE**

*NEW YORK STATE HEALTH INSURANCE PROGRAM*

**For enrollee services, precertification & provider relations, please call:**  
**1-877-7-NYSHIP (1-877-769-7447)**

**Providers:** This card represents but does not guarantee enrollment in the New York State Health Insurance Program (NYSHIP) for Government Employees.

**Submit hospital, skilled nursing facility and hospice claims to your local Blue Cross and/or Blue Shield Plan.** Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

  **BLUE CROSS PLAN 303** **Blue Cross Prefix: YLS**

Submit medical provider claims in accordance with your participating provider agreement.

**UnitedHealthcare\***  **MultiPlan**

All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.

Administered by the NYS Department of Civil Service.

**New York State Department of Civil Service's**

**"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP"**

**STUDENT EMPLOYEE HEALTH PLAN CARD**



**Student Employee Health Plan**

1-877-7-NYSHIP (1-877-769-7447)

**JOHN SAMPLE**

**890490010**

Effective until 08/31/13 or when coverage ends, whichever is sooner

**Hospital benefits**

- \$200 copayment per admission / inpatient hospital stays
- \$15 copayment / outpatient hospital visits
- \$25 copayment / Emergency Room
- \$10 copayment / Physical Therapy

**Medical benefits**

- \$10 copayment / office visit, laboratory services, chiropractic treatment, Physical Therapy

**Mental Health / Substance Abuse**

- \$200 copayment per admission / general acute or psychiatric hospital, clinic, residential treatment center, group home or halfway house
- \$10 copayment / outpatient visit

**Rx benefits**

Network Pharmacy 30 days/ Mail Service or Specialty Pharmacy 90 days\*

- \$5/\$5\* Level 1 or generic
- \$15/\$20\* Level 2 or preferred brand-name
- \$40/\$65\* Level 3 or nonpreferred brand-name



**New York State Department of Civil Service's**

**“Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP”**

**STUDENT EMPLOYEE HEALTH PLAN CARD**

This card represents but does not guarantee enrollment in the New York State Health Insurance Program. It is insurance fraud for an enrollee or dependent to use the card to obtain services after eligibility for coverage ends.



**You must call**

**Toll Free  
1-877-7-NYSHIP  
1-877-769-7447**

**Precertification required for:**

Admission to a hospital or birthing center: Select the Hospital Program. For an emergency admission, call within 48 hours.

Outpatient MRI, MRA, CT, PET and nuclear medicine tests: Select the Medical Program

Mental Health and/or Substance Abuse Services: Psychological testing, electro-convulsive therapy and non-network non-emergency inpatient admission: Select the Mental Health and Substance Abuse Program

Home Care and Diabetic Supplies/Equipment: Select the Medical Program

**Submit hospital and hospice claims to your local Blue Cross and/or Blue Shield Plan.** Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent BlueCross and BlueShield Plans.



**PPO  
HOSPITAL ONLY**

**BLUE CROSS  
PLAN 303**

**Blue Cross Prefix: YLS**

Administered by the New York State Department of Civil Service.

## EMPIRE PLAN MENTAL HEALTH/SUBSTANCE ABUSE PROGRAM EXCELSIOR HEALTH PLAN CARD



**123456789**

**JEANNIE EMPIRE PLAN ENROLLEE  
JANE EMPIRE PLAN ENROLLEE  
JOHN EMPIRE PLAN ENROLLEE  
MICHAEL EMPIRE PLAN ENROLLEE  
JAMES EMPIRE PLAN ENROLLEE**

**\$30 Office Visit \$100 Emergency Room**

**For enrollee  
services,  
precertification &  
provider relations,  
please call:**

**1-877-7-NYSHIP  
(1-877-769-7447)**

**Providers:** This card represents but does not guarantee enrollment in the New York State Health Insurance Program (NYSHIP) for Government Employees.

**Submit hospital, skilled nursing facility and hospice claims to your local Blue Cross and/or Blue Shield Plan.** Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



**BLUE CROSS  
PLAN 303**

**Blue Cross Prefix: YLS**

Submit medical provider claims in accordance with your participating provider agreement.

**UnitedHealthcare®**

Bin# 610014 Group# UH0712959

All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.

Administered by the New York State Department of Civil Service.

**Mental Health & Substance Abuse Program**  
**Reports Due Dates**

Report Name	Brief Description	Frequency	Due Date(s)
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**Contract Management Reports**

Utilization	Quarterly summary of utilization trends for I/P, ALOC, and O/P services, as well as compliance with performance standards.	Quarterly	60 days from the end of the quarter
Performance Guarantees	Quarterly summary of compliance with performance standards.	Quarterly	60 days from the end of the quarter
Annual Report	Annual summary of utilization, performance, and future direction of the program	Annual	March 15th

**Financial Management Reports**

Annual Financial Statement	Financial Settlement for the Plan Year just ended	Annually	March 15th
Annual Premium Renewal	Proposal for Forthcoming Plan Year Premium Rates and Retention charges	Annually	September 1st
Quarterly Statement of Experience	Plan Year financial experience through the quarter just ended plus projected financial experience for the entire Plan Year (also includes projected rate development for the forthcoming Plan Year and Qtrly Trend Statistics)	Quarterly	15th day after end of quarter
Monthly Paid Claims by Month of Incurral	Paid claims by core, enhancements, and benefit program	Monthly	15th day after end of month
Quarterly Paid Claims by Type of Service	Paid Claims (\$ amt and # of svcs) during the quarter just ended by Type of Service; broken out by BP, EE/DEP, Year of Incurral, In/Out Network, Core/Enhancements	Quarterly	15th day after end of quarter
PA Mediprime Claims	Paid Claims (\$ amt and # of svcs) per PA during the quarter just ended; broken out by Coverage Type, Year of Incurral, In/Out Network, EE/DEP, Medicare/No Medicare, Core/Enhancements	Quarterly	15th day after end of quarter
Claim Production Report	Summary of claims processed for the month just ended (also aging of claims): paid, declined, deductible not satisfied, other and # outstanding	Monthly	15th day after end of month
Coordination of Benefits Report	Medicare and Other COB Savings for the month just ended (and all prior current calendar year months)	Monthly	15th day after end of month
Copayment Savings Report	Outpatient Participating Provider Paid Claim Dollars per Month and Related Per Month Co-Payment Dollars	Monthly	15th day after end of month
In-Network Triangle Report	Total Paid In-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP.	Monthly	15th day after end of month
Out-Network Triangle Report	Total Paid Out-of-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP.	Monthly	15th day after end of month
Claims Paid by Agency	Enrollee and Dependent Paid Claims per agency for the Plan Year just ended	Annually	January 31st

**Audit Reports**

Claim Data	Individual claim transactions	Monthly	
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**Empire Plan Mental Health & Substance Abuse  
Financial Reports Specifications and Due Dates  
REQUIRED DATA FIELDS FOR MHSA MIS REPORTS**

(a)	Report	Description	Field Name
(a)	IA. Monthly Paid Claims by Month of Incurral	1 Month Paid	MONTH PAID
		2 Year Paid	YEAR PAID
		3 Month Incurred	MONTH INC
		4 Year Incurred	YEAR INC
		5 Benefit Program Code	PROGRAM/BPI
		6 Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		7 Network (In-Network or Non-Network)	NETWORK
		8 Medicare Primary (Yes or No)	MEDICARE
		9 # of Services: Enrollees	EE SERVICES
		10 \$ Amount Paid: Enrollees	EE PAID
		11 # of Services: Dependents	DEP SERVICES
		12 \$ Amount Paid: Dependents	DEP PAID
		13 # of Services: Total	TOTAL SERVICES
		14 \$ Amount Paid: Total	TOTAL PAID
(b)	IIA. Quarterly Paid Claims by Type of Service	1 Quarter and Year Paid	QTR PAID
		2 Year Incurred	YEAR INC
		3 Benefit Program Code	PROGRAM/BPI
		4 Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		5 Network (In-Network or Non-Network)	NETWORK
		6 Type of Service & Type for GAUC	TOS
		7 # of Services: Enrollees	EE SERVICES
		8 \$ Amount Covered: Enrollees	EE COVERED
		9 \$ Amount Paid: Enrollees	EE PAID
		10 # of Services: Dependents	DEP SERVICES
		11 \$ Amount Covered: Dependents	DEP COVERED
		12 \$ Amount Paid: Dependents	DEP PAID
		13 # of Services: Total	TOTAL SERVICES
		14 \$ Amount Covered: Total	TOTAL COVERED
		15 \$ Amount Paid: Total	TOTAL PAID
(c)	IB. PA Claims (Medicare/Non Medicare)	1 Quarter and Year Paid	QTR PAID
		2 Year Incurred	YEAR INC
		3 Benefit Type (Core, NY Enhancement or PA Enhancement)	BENEFIT TYPE
		4 Network (In-Network or Non-Network)	NETWORK
		5 Agency Code	AGNCYCD
		6 Coverage (Individual or Family)	COV
		7 Medicare Primary (Yes or No)	MEDICARE
		8 # of Services: Enrollees	EE SERVICES
		9 \$ Amount Paid: Enrollees	EE PAID
		10 # of Services: Dependents	DEP SERVICES
		11 \$ Amount Paid: Dependents	DEP PAID
		12 # of Services: Total	TOTAL SERVICES
		13 \$ Amount Paid: Total	TOTAL PAID
(d)	IVG. Annual Claims & Credits Paid by Agency	1 Year Paid	YEARPD
		2 Year Incurred	YEARINC
		3 Network (In-Network or Non-Network)	NETWORK
		4 Agency Code	AGNCYCD
		5 Enrollee or Dependent Claim	EEDEP
		6 Enrollee Type (Active, Retiree or Other)	EE Type
		7 Number of Claims	CLAIMS
		8 Amount Paid	AMTPD
		9 Name of MHSA Program Carrier	CARRIER

Empire Plan MHA Program Selected Utilization Data

Exhibit II.F2

**Year 2009**

**Participating**

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	1,434,671	68,624	1,062,551	1350.21	20.91
	SA	65,232	2,817	1,062,551	61.39	23.16
Inpatient	MH/SA	Admits Authorized	Unique Members			
	MH	2,792	2,176			
	SA	926	771			
Partial Hospitalization	MH/SA	Admits Authorized	Unique Members			
	MH	583	486			
	SA	78	77			
Residential	MH/SA	Admits Authorized	Unique Members			
	MH	64	54			
	SA	385	365			

**Subtotal- Participating** 1,504,731 75,370

**Non-Participating**

	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
Outpatient	MH	479,168	23,932	1,062,551	450.96	20.02
	SA	17,980	920	1,062,551	16.92	19.54
Inpatient	MH/SA	Admits Authorized	Unique Members			
	MH	508	422			
	SA	127	117			
Partial Hospitalization	MH/SA	Admits Authorized	Unique Members			
	MH	54	45			
	SA	56	54			
Residential	MH/SA	Admits Authorized	Unique Members			
	MH	5	2			
	SA	29	27			

**Subtotal-Non-Participating** 497,927 25,519

**Total -2009** 2,002,658 100,889

**Year 2010**

Exhibit II.F2

**Participating**

Outpatient	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
	MH	1,209,337	63,774	1,077,271	1122.59	18.96
SA	79,626	3,279	1,077,271	73.91	24.28	

Inpatient	MH/SA	Admits Authorized	Unique Members
	MH	2,661	2,071
SA	712	600	

Partial Hospitalization	MH/SA	Admits Authorized	Unique Members
	MH	586	489
SA	150	140	

Residential	MH/SA	Admits Authorized	Unique Members
	MH	52	47
SA	262	243	

**Subtotal - Participating**

1,293,386

70,643

**Non-Participating**

Outpatient	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
	MH	278,358	14,024	1,077,271	258.39	19.85
SA	4,784	329	1,077,271	4.44	14.54	

Inpatient	MH/SA	Admits Authorized	Unique Members
	MH	410	362
SA	227	205	

Partial Hospitalization	MH/SA	Admits Authorized	Unique Members
	MH	34	32
SA	89	77	

Residential	MH/SA	Admits Authorized	Unique Members
	MH	0	0
SA	23	23	

**Subtotal - Non-Participating**

283,925

15,052

**Total-2010**

1,577,311

85,695

**Year 2011**

Exhibit II.F2

Participating

Outpatient	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
	MH	1,316,823	65,604	1,100,707	1196.34	20.07
SA	101,388	3,809	1,100,707	92.11	26.62	

Inpatient	MH/SA	Admits Authorized	Unique Members
	MH	2,612	2,082
SA	568	511	

Partial Hospitalization	MH/SA	Admits Authorized	Unique Members
	MH	540	459
SA	200	185	

Residential	MH/SA	Admits Authorized	Unique Members
	MH	52	44
SA	382	361	

**Subtotal - Participating** 1,422,565 73,055

Non-Participating

Outpatient	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
	MH	303,589	13,425	1,100,707	275.81	22.61
SA	5,018	296	1,100,707	4.56	16.95	

Inpatient	MH/SA	Admits Authorized	Unique Members
	MH	337	299
SA	661	530	

Partial Hospitalization	MH/SA	Admits Authorized	Unique Members
	MH	41	38
SA	197	172	

Residential	MH/SA	Admits Authorized	Unique Members
	MH	2	2
SA	20	20	

**Subtotal- Non-Participating** 309,865 14,782

**Total -2011** 1,732,430 87,837

**Year 2012 (through November 2012)**

**Participating**

Outpatient	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
	MH	1,053,628	55,362	1,098,064	959.53	19.03
SA	96,163	3,542	1,098,064	87.58	27.15	

Inpatient	MH/SA	Admits Authorized	Unique Members
	MH	2,512	1,973
SA	592	523	

Partial Hospitalization	MH/SA	Admits Authorized	Unique Members
	MH	534	456
SA	144	133	

Residential	MH/SA	Admits Authorized	Unique Members
	MH	38	30
SA	529	496	

**Subtotal - Participating**

1,154,140

62,515

**Non-Participating**

Outpatient	Service Type	Visits Authorized	Unique Members	Members	Visits/1000	Visits/Member
	MH	244,435	10,701	1,098,064	222.61	22.84
SA	3,442	206	1,098,064	3.13	16.71	

Inpatient	MH/SA	Admits Authorized	Unique Members
	MH	324	286
SA	646	536	

Partial Hospitalization	MH/SA	Admits Authorized	Unique Members
	MH	51	42
SA	285	224	

Residential	MH/SA	Admits Authorized	Unique Members
	MH	0	0
SA	13	13	

**Subtotal- Non-Participating**

249,196

12,008

**Total - 2012**

1,403,336

74,523



**Empire Plan Mental Health / Substance Abuse Program  
Abbreviated Sample of a Quarterly Performance Guarantee Report**

**Exhibit II.F3**

<b>PERFORMANCE GUARANTEE CATEGORY</b>	<b>PERFORMANCE GUARANTEE STANDARD</b>	<b>1<sup>st</sup> QTR</b>	<b>2<sup>nd</sup> QTR</b>	<b>3<sup>rd</sup> QTR</b>	<b>4<sup>th</sup> QTR</b>
<b>Network Access Facility</b>	<b>NYS Urban:</b> The Contractor guarantees at least ninety-five percent (95%) of Enrollees in urban areas will have access to a Network Facility. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Facility within five (5) miles of an Enrollee's home.				
	<b>NYS Suburban:</b> The Contractor guarantees at least ninety-five percent (95%) of Enrollees in suburban areas will have access to a Network Facility. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Facility within fifteen (15) miles of an Enrollee's home.				
	<b>NYS Rural:</b> The Contractor guarantees at least ninety-five percent (95%) of Enrollees in rural areas will have access to a Network Facility. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Facility within forty (40) miles of an Enrollee's home.				
<b>Network Access Practitioner</b>	<b>NYS Urban:</b> The Contractor guarantees at least ninety-five percent (95%) of Enrollees in urban areas will have access to a Network Practitioner. The minimum access guarantee for Enrollees in urban areas is at least one (1) Network Practitioner within three (3) miles of an Enrollee's home.				
	<b>NYS Suburban:</b> The Contractor guarantees at least ninety-five percent (95%) of Enrollees in suburban areas will have access to a Network Practitioner. The minimum access guarantee for Enrollees in suburban areas is at least one (1) Network Practitioner within fifteen (15) miles of an Enrollee's home.				
	<b>NYS Rural:</b> The Contractor guarantees at least ninety-five percent (95%) of Enrollees in rural areas will have access to a Network Practitioner. The minimum access guarantee for Enrollees in rural areas is at least one (1) Network Practitioner within forty (40) miles of an Enrollee's home.				
<b>Provider Credentialing</b>	The Contractor guarantees that within sixty (60) Days of receipt of a complete Provider application to join the Empire Plan Network, the review, including credentialing, will be completed and the Practitioner, program or facility notified of the determination.				

**This Exhibit is intentionally left blank.**

**Empire Plan MHSA Program, Shared Accumulator file layout**

**Exhibit II.F5**

**Header Record**

Seq	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required ?	Outbound (From UHG)	Inbound (To UHG)
1	Record Code	N	1	1	1	Always a zero (0) - indicating file header record.	9(1)		Yes	'1'	'1'
2	Sender ID	A/N	2	11	10	Indicates sender of file	X(10)	Left Justified	Yes	UHG	
3	Processor Name	A/N	12	31	20	Vendor Name	X(20)	Left Justified	Yes	UNITEDHEALTH GROUP	
4	Processor Address	A/N	32	51	20	Vendor Address	X(20)	Left Justified	Yes	9900 BREN ROAD EAST	
5	Processor City	A/N	52	69	18	Vendor City	X(18)	Left Justified	Yes	HOPKINS	
6	Processor State	A/N	70	71	2	Vendor State	X(2)	Left Justified	Yes	MN	
7	Processor Zip	A/N	72	80	9	Vendor Zip Code	X(9)	Left Justified	Yes	55343	
8	Processor Phone	N	81	90	10	Format: AAEEEENNNN	AAEEEENNNN	Right Justified	Yes	9529361300	
9	Receiver ID	A/N	91	100	10	Indicates receiver of file. (Vendor assigned Id to indicate UHG)	X(10)	Left Justified	Yes	TBD	UHG
10	Run Date	N	101	108	8	Date on which File was generated by processor.	CCYYMMDD		Yes	Date as of the beginning of processing	Date as of the beginning of processing
11	Run Time	A/N	109	116	8	Time the file was generated by processor.	HH:MM:SS		Yes	Time as of the beginning of processing	Time as of the beginning of processing
12	File Content Type	A/N	117	117	1	T - Test, P - Production	X(1)		Yes	'T' OR 'P'	'T' OR 'P'
13	Version Number	A/N	118	120	3	Indicates the Claim Detail Layout version number of the file. (Current verion = 001)	X(3)		Yes	Always 001	Always 001
14	Filler	A/N	121	600	480	Filler			Yes		

## Detail Record

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
1	Record Code	N	1	1	1	Always a four (4) - indicates that this record is a detail record.	9(1)		Yes	'4'	
2	Batch Number	N	2	6	5	Assigned by the processor, Julian Date Format YYDDD.	YYDDD		Yes	For a weekly file, the batch number will be the end of the week date in Julian format.	
3	Transaction ID	A/N	7	26	20	Number assigned by vendor to uniquely identify the transaction.	x(20)	Right Justified	NO		
4	Record Type Code	A/N	27	27	1	Identifies the type of Claim 1 - Pharmacy Claim 2 - Medical Claim 3 - Mental Health/Substance Abuse Claim 4 - Durable Medical Equipment Claim 5 - Dental Claim 6 - Vision Claim ? - Future Values	X(1)		Yes		
5	Carrier Number	A/N	28	35	8	Account Number assigned by vendor during installation.	X(8)	Left Justified - Trailing Spaces	Yes	UHG POLICY NUMBER (FIRST 6 POSITIONS POPULATED)	
6	Adjustment Type	A/N	36	36	1	Type of adjustment: 1 - Claim 2 - Adjustment	X(1)		Yes	If adjustment is negative, the claim amounts sent need to be negative.	

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
7	Adjustment Code	A/N	37	38	2	A two position field representing the type of adjustment: AJ - Supplement CR - Credit	X(2)		NO	BLANK	
8	Adjustment Reason Code	A/N	39	41	3	Reason for adjustment Values TBD - Future Reporting	X(3)	Left Justified	NO	BLANK	
9	Group ID	A/N	42	57	16	To indicate which Plan Eligibility/Benefit is applicable for the claim.	X(16)	Left Justified with trailing spaces.	NO	BLANK	
10	Prescription/Service Reference Number	A/N	58	66	9	Number assigned to uniquely identify the claim.	X(9)	Left Justified with trailing spaces.	NO	BLANK	
11	Fill Number	N	67	68	2	Code identifying whether the prescription is an original (00) or by refill number (01-99)  00 - New 01-99 - Refill Number  This field represents the Fill Number as submitted by the pharmacy. The "Fill Number Calculated" field provides the Fill Number	9(2)	Right Justified	NO	BANK	
12	Adjudication Date	N	69	76	8	Indicates the date the transaction was processed by vendor.	CCYYMMD D		NO		
13	First Date Of Service	N	77	84	8	Indicates the first date that the prescription/service was dispensed/provided as submitted by the dispensing pharmacy, or source documents for direct claims.	CCYYMMD D		Yes		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
14	Last Date Of Service	N	85	92	8	Indicates the last date that the prescription/service was dispensed/provided as submitted by the dispensing pharmacy, or source documents for direct claims.	CCYYMMD D		Yes		
15	Cardholder ID	A/N	93	112	20	Cardholder Id number as submitted by vendor or provided on direct claim.	X(20)	Left Justified	Yes	ID USED TO ADJUDICATE THE CLAIM. COULD BE ALT ID OR SSN.	
16	Cardholder Id Qualifier	A/N	113	114	2	Code qualifying the 'Cardholder ID' field. Values: Blank - Not Specified 01 - Social Security Number 99 - Other	X(2)	Left Justified	NO		
17	Patient Id	A/N	115	134	20	ID assigned to the patient as provided in eligibility.	X(20)	Left Justified	NO	BLANK	
18	Patient First Name	A/N	135	159	25	Patient's first name as it appears in eligibility data provided to vendor.	X(25)	Left Justified	Yes		
19	Patient Middle Initial	A/N	160	184	25	Patient's middle name as it appears in eligibility or submitted by member for direct claims.	X(25)	Left Justified	NO	BLANK	
20	Patient Last Name	A/N	185	219	35	Patient's last name as provided in eligibility data if available.	X(35)	Left Justified	Yes		
21	Patient Gender	N	220	220	1	Gender of patient based on eligibility data Values: 0 - Unknown 1 - Male 2 - Female	9(1)		Yes		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
22	Patient Date of Birth	N	221	228	8	Patient's birth date as provided in eligibility data.	CCYYMMDD		Yes		
23	Patient Relationship Code	A/N	229	229	1	The relationship code as defined by NCPDP indicating the patient's relationship to the subscriber.  Values: 1 - Cardholder 2 - Spouse 3 - Child 4 - Other	X(1)		Yes		
24	Service Provider ID Qualifier	A/N	230	231	2	Identifies the type of data being submitted in the Service Provider ID field.  Values: Blank - Not Specified 01 - National Provider Identifier (NPI) 02 - Blue Cross 03 - Blue Shield 04 - Medicare 05 - Medicaid 06 - UPIN 07 - NCPDP Provider ID 08 - State	X(2)	Left Justified	NO	BLANK	
25	Service Provider ID	A/N	232	241	10	Code assigned to identify the provider as qualified by the Service Provider ID Qualifier.	X(10)	Left Justified	NO	BLANK	
26	Pharmacy Chain/Region	A/N	242	245	4	PBM assigned number used to link pharmacies that are part of a chain.	X(4)	Left Justified	NO	BLANK	
27	Provider Name	A/N	246	280	35	Name of Provider	X(35)	Left Justified	NO		

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
28	Provider Address	A/N	281	335	55	Address of Provider	X(55)	Left Justified	NO		
29	Provider City	A/N	336	365	30	City of Provider	X(30)	Left Justified	NO		
30	Provider State	A/N	366	367	2	State Abbreviation of Provider	X(2)	Left Justified	NO		
31	Provider Zip	A/N	368	382	15	Zip code of Provider	X(15)	Left Justified	NO		
32	Provider Phone Number	A/N	383	392	10	Phone Number of Provider	X(10)	Left Justified	NO		
33	Provider TAX ID Number	A/N	393	401	9	Provider Tax ID Number	X(9)	Left Justify	NO		
34	Pharmacy County Code	A/N	402	404	3	Indicates the county of the pharmacy using the FIPS codeset (Federal Information Processing Standards).  Values: A full list of values can be found at: <a href="http://www.itl.nist.gov/fipspubs/codes/states.txt">http://www.itl.nist.gov/fipspubs/codes/states.txt</a>	X(3)	Left Justified	NO	BLANK	
35	Pharmacy Class Code	A/N	405	405	1	Indicates class of the pharmacy:  Values: 1 - Class 1 Pharmacy 2 - Class 2 Pharmacy 3 - Mail Service Pharmacy 4 - Home Health Care (Class 1) 5 - Home Health Care (Class 2) 6 - Nursing Home (Class 1) 7 - Nursing Home (Class 2) 8 - Medicaid Agency 9 - Dept	X(1)		NO	BLANK	
36	IN/OUT of Network Indicator	A/N	406	406	1	Indicates whether the amount was applied to the In or Out of Network benefits.  Values: I - In Network O - Out of Network	X(1)	Left Justified	Yes		



Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
37	Client Amount Due	N	407	414	8	Amount to be paid to the provider representing the cost of the product/service less patient/other payer amounts.	s9(6)v9(2)	Right Justified	NO	For future expansion.	
38	Other Payer Amount Paid	N	415	422	8	Amount paid by another payer (Primary, coupon, major medical, Medicare, Medicaid).  If multiple other payers exist, this field represents the total of all payments.	s9(6)v9(2)	Right Justified	NO	For future expansion.	
39	COINS	N	423	430	8	Amount to be collected from the patient that is included in 'Patient Paid Amount' that is due to a per prescription copay/coinsurance.	s9(6)v9(2)	Right Justified	YES	COINSURANCE	
40	Deductible	N	431	438	8	Portion of Patient Paid Amount applied to deductible.	s9(6)v9(2)	Right Justified	Yes	DEDUCT ATTACHED TO THE CLAIM	
41	Deductible Total Remaining Amount	N	439	448	10	Indicates the updated accumulated deductible total amount for the patient.	s9(8)v9(2)	Right Justified	NO	TOTAL DEDUCT FOR THE PROCESS DATE	
42	Deductible Remaining Amount/Limit	N	449	458	10	From UHG to the vendor, indicates amount of deductible remaining until deductible limit is reached for the patient.  From vendor to UHG, indicates the deductible limit.	s9(8)v9(2)	Right Justified	NO	TOTAL REMAINING DEDUCT (LIMIT – YTD DEDUCT DOLLARS)	
43	Out Of Pocket Apply Amount	N	459	466	8	Amount applied to out of pocket expense.	s9(6)v9(2)	Right Justified	Yes	OOP ATTACHED TO THE CLAIM	

Seq #	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Required	Outbound (From UHG)	Inbound (To UHG)
44	Out of Pocket Total Accumulated Amount	N	467	476	10	Indicates the updated accumulated out of pocket total amount for the patient.	s9(8)v9(2)	Right Justified	NO	TOTAL OOP FOR THE PROCESS DATE	
45	Out of Pocket Remaining Amount/Limit	N	477	486	10	From UHG to the vendor, indicates the amount of OOP remaining until out of pocket maximum is reached for the patient.  From vendor to UHG, indicates the OOPM limit.	s9(8)v9(2)	Right Justified	NO	TOTAL REMAINING OOP (LIMIT – YTD OOP DOLLARS)	
46	Plan Year	N	487	494	8	Plan year in which the claim is effective.	CCYYMMD D		Yes	EFFECTIVE DATE	
47	Filler	A/N	495	600	106	Default to Spaces	X(106)	Left Justified - Trailing Spaces	Optional	For future expansion - default to spaces.	

### Trailer Record

Seq	Field Name	Data Type	Start	End	Length	Description	Format	Justification	Outbound (From UHG)	Inbound (To UHG)
1	Record Code	N	1	1	1	Always an eight (8) - indicating a file trailer record.	9(1)		'8'	'8'
2	Sender ID	A/N	2	11	10	Indicates sender of file	X(10)	Left Justified	UHG	
	Transaction Count		12	21	10	Sum of all Record Code "4" transactions included on file.	9(10)	Right Justified	9999999999	
3	Total Record Count	N	22	31	10	Sum of all records (including header, detail and trailer) on file.	9(10)	Right Justified	9999999999	
4	Filler	N	32	600	569	Filler		Right Justified		



## Exhibit II.G

## New York State Department of Civil Service's

**"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP"****Paid Claims by Benefit Type****Calendar Years 2009, 2010 and 2011 plus January 1 - September 30, 2012**

Year	Type	<u>Enrollee</u>		<u>Dependent</u>		<u>Total</u>	
		# of Services (1)	Amount Paid	# of Services (1)	Amount Paid	# of Services (1)	Amount Paid
2009	Core	507,279	\$ 39,430,701	451,764	\$ 47,107,454	959,044	\$ 86,538,155
	NY Enhancement	11,304	\$ 1,588,364	9,394	\$ 1,430,754	20,698	\$ 3,019,118
	PA Enhancement	11,892	\$ 1,388,504	9,647	\$ 1,248,322	21,539	\$ 2,636,826
	<b>Total</b>	<b>530,475</b>	<b>\$ 42,407,569</b>	<b>470,805</b>	<b>\$ 49,786,529</b>	<b>1,001,280</b>	<b>\$ 92,194,098</b>
2010	Core	607,432	\$ 46,329,585	533,515	\$ 53,619,442	1,140,947	\$ 99,949,027
	NY Enhancement	14,980	\$ 2,755,713	12,450	\$ 2,649,805	27,429	\$ 5,405,518
	PA Enhancement	16,235	\$ 2,380,864	14,507	\$ 2,532,391	30,742	\$ 4,913,255
	<b>Total</b>	<b>638,647</b>	<b>\$ 51,466,163</b>	<b>560,472</b>	<b>\$ 58,801,638</b>	<b>1,199,119</b>	<b>\$ 110,267,801</b>
2011	Core	639,257	\$ 51,099,105	622,428	\$ 68,865,728	1,261,686	\$ 119,964,833
	NY Enhancement	17,331	\$ 3,396,977	17,794	\$ 4,853,832	35,125	\$ 8,250,808
	PA Enhancement	18,635	\$ 3,060,269	20,957	\$ 5,181,635	39,592	\$ 8,241,904
	<b>Total</b>	<b>675,223</b>	<b>\$ 57,556,350</b>	<b>661,179</b>	<b>\$ 78,901,196</b>	<b>1,336,402</b>	<b>\$ 136,457,546</b>
2012 (2)	Core	471,452	\$ 35,369,724	493,551	\$ 53,414,161	965,003	\$ 88,783,884
	NY Enhancement	10,168	\$ 2,352,527	12,407	\$ 4,464,197	22,575	\$ 6,816,725
	PA Enhancement	9,861	\$ 1,699,153	14,792	\$ 4,618,890	24,653	\$ 6,318,042
	<b>Total</b>	<b>491,481</b>	<b>\$ 39,421,404</b>	<b>520,750</b>	<b>\$ 62,497,247</b>	<b>1,012,231</b>	<b>\$ 101,918,651</b>

(1) Represents days/visits

(2) Represents paid claims for 01/01/2012 - 09/30/2012

New York State Department of Civil Service"

"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP"

Selected Financial Data

**Empire Plan Monthly Premium Rates: Groups With Plan Changes/Ratified Contracts (1)**

Effective Date	Individual			Family		
	Core	NY	PA	Core	NY	PA
		Enhancement	Enhancement		Enhancement	Enhancement
1/1/2009	\$ 7.94	\$ 0.50	\$ 0.79	\$ 25.58	\$ 1.88	\$ 2.32
1/1/2010	\$ 9.15	\$ 0.54	\$ 0.85	\$ 29.49	\$ 1.78	\$ 2.35
1/1/2011	\$ 9.25	\$ 0.64	\$ 0.80	\$ 29.29	\$ 1.83	\$ 2.43
1/1/2012	\$ 9.92	\$ 1.13	\$ 1.59	\$ 33.79	\$ 3.65	\$ 5.61
1/1/2013	\$ 9.36	\$ 0.84	\$ 1.25	\$ 38.53	\$ 4.18	\$ 7.49

**Empire Plan Monthly Premium Rates: Groups Not With Plan Changes/Not With Ratified Contracts)**

Effective Date	Individual		Family	
	Core	NY	Core	NY
		Enhancement		Enhancement
1/1/2009	\$ 8.02	\$ 0.50	\$ 25.84	\$ 1.90
1/1/2010	\$ 9.29	\$ 0.55	\$ 29.95	\$ 1.82
1/1/2011	\$ 9.39	\$ 0.65	\$ 29.73	\$ 1.86
1/1/2012	\$ 10.36	\$ 1.18	\$ 35.29	\$ 3.81
1/1/2013	\$ 9.78	\$ 0.88	\$ 40.25	\$ 4.37

**Empire Plan Monthly Premium Rates: UUP Lifeguards**

Effective Date	Individual		Family	
	Core	NY	Core	NY
		Enhancement		Enhancement
1/1/2009	\$ 8.02	\$ 0.50	\$ 25.84	\$ 1.90
1/1/2010	\$ 9.29	\$ 0.55	\$ 29.95	\$ 1.82
1/1/2011	\$ 9.39	\$ 0.65	\$ 29.73	\$ 1.86
1/1/2012	\$ 10.47	\$ 1.19	\$ 35.63	\$ 3.83
1/1/2013	\$ 9.89	\$ 0.89	\$ 40.73	\$ 4.42

**Excelsior Plan Monthly Premium Rates**

Effective Date	Individual	Family
1/1/2009	\$ 7.34	\$ 23.55
1/1/2010	\$ 8.45	\$ 27.04
1/1/2011	\$ 8.37	\$ 26.52
1/1/2012	\$ 10.02	\$ 34.40
1/1/2013	\$ 9.23	\$ 40.19

**Student Employee Health Plan Monthly Premium Rates**

Effective Date	Individual	Family
1/1/2009	\$ 9.05	\$ 20.91
1/1/2010	\$ 15.88	\$ 22.02
1/1/2011	\$ 17.87	\$ 32.15
1/1/2012	\$ 23.60	\$ 49.30
1/1/2013	\$ 26.18	\$ 63.26

- (1) Represents CSEA, PEF, M/C's and Unrepresented Enrollees for each of these years. At various points in time during 2011 and 2012 NYSOPBA, APSU and Council-82 became part of this group.  
 (2) Represents UUP, PBA Troopers, PBA Supervisors, PIA and DC-37.

**Empire Plan Average Enrollment**

Period	Active		Retired		Total Contracts
	Individual	Family	Individual	Family	
Jan 2010 through Dec 2010	115,770	192,728	125,406	97,645	531,549
Jan 2011 through Dec 2011	105,792	191,109	129,535	102,628	529,064
Jan 2012 through Oct 2012	100,607	187,195	131,033	103,925	522,760

**Excelsior Plan Average Enrollment**

Period	Active		Retired		Total Contracts
	Individual	Family	Individual	Family	
Jan 2010 through Dec 2010	68	76	28	8	180
Jan 2011 through Dec 2011	20	15	21	5	61
Jan 2012 through Oct 2012	37	50	90	69	246

**Student Employee Health Plan Average Enrollment**

Period	Individual	Family	Total
Jan 2010 through Dec 2010	4,665	674	5,339
Jan 2011 through Dec 2011	4,688	754	5,442
Jan 2012 through Oct 2012	4,644	762	5,406

**NYS MHSA Experience**

	<u>2008 (1)</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012 (2)</u>
Premium	\$ 108,449,577	\$ 120,763,967	\$ 137,726,119	\$ 139,059,341	\$ 166,458,782
Paid Claims (3)	111,387,223	93,709,449	112,247,862	139,245,444	141,786,871
Change in Reserves (Credits)	(15,958,341)	22,604,882	(2,915,874)	1,845,503	(2,764,801)
	<u>(135,387)</u>	<u>(582,147)</u>	<u>-</u>	<u>-</u>	<u>-</u>
Net Incurred Claim Cost	\$ 95,293,495	\$ 115,732,184	\$ 109,331,988	\$ 141,090,947	\$ 139,022,070
Net Retention	<u>18,784,612</u>	<u>18,130,019</u>	<u>19,674,973</u>	<u>20,599,446</u>	<u>18,725,207</u>
Dividend/(Loss)	\$ (5,628,530)	\$ (13,098,236)	\$ 8,719,158	\$ (22,631,052)	\$ 8,711,505

- (1) Final year close-out experience for prior contract holder (prior contract term: 2004-2008)  
 (2) Represents projected experience for 2012 as of October 15, 2012 (2012 Third Quarter Report)  
 (3) Includes Paid Bad Debt and Charity

## New York State Department of Civil Service's

**"Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan, Student Employee Health Plan RFP"****2010 and 2011 Incurred Claims By Type of Service - Paid through September 30, 2012**

<b>IN-NETWORK</b>						
<b><u>Type of Service Category</u></b>	<b>Enrollees</b>		<b>Dependents</b>		<b>Total</b>	
	<b><u>Services (1)</u></b>	<b><u>Amount Paid</u></b>	<b><u>Services (1)</u></b>	<b><u>Amount Paid</u></b>	<b><u>Services (1)</u></b>	<b><u>Amount Paid</u></b>
Mental Health Acute Inpatient (2)	10,035	\$6,214,921	15,348	\$12,777,568	25,383	\$18,992,489
Substance Abuse Acute Inpatient (2)	1,238	\$702,465	1,546	\$801,880	2,784	\$1,504,345
Alcohol Rehab Acute Inpatient	1,992	\$986,065	940	\$443,141	2,932	\$1,429,206
Day Treatment	3,040	\$918,959	4,628	\$1,687,990	7,668	\$2,606,949
Residential	1,931	\$705,261	2,353	\$1,006,719	4,284	\$1,711,980
Professional Services: Physician (3)	3,971	\$180,942	3,599	\$253,192	7,570	\$434,134
Professional Services: Psychologist	5,853	\$105,892	573	\$12,990	6,426	\$118,882
Professional Services: Other	499	\$45,303	285	\$41,313	784	\$86,616
Outpatient & Med Mgt: Physician	126,810	\$7,318,802	129,654	\$7,576,635	256,464	\$14,895,437
Outpatient & Med Mgt: Psychologist	137,247	\$8,135,522	116,332	\$7,306,420	253,579	\$15,441,943
Outpatient & Med Mgt: Other	221,879	\$9,616,603	180,936	\$8,918,789	402,815	\$18,535,392
Substance Abuse & Structured Outpatient	6,121	\$803,086	6,103	\$844,699	12,224	\$1,647,784
Mental Health Structured Outpatient	1,994	\$272,563	2,347	\$524,163	4,341	\$796,726
Electro Convulsive Therapy	644	\$200,159	591	\$212,425	1,235	\$412,584
Ancillary Services	1,077	\$266,675	942	\$370,224	2,019	\$636,899
<b>Total</b>	<b>524,331</b>	<b>\$36,473,219</b>	<b>466,177</b>	<b>\$42,778,146</b>	<b>990,508</b>	<b>\$79,251,365</b>

(1) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(2) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(3) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

**Empire Plan Mental Health/Substance Abuse Program  
2010 Incurred Claims Paid through September 30, 2012**

<u>Type of Service Category</u>	<b>Enrollees</b>		<b>Dependents</b>		<b>Total</b>	
	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>
	Mental Health Acute Inpatient (2)	2,354	\$1,634,404	2,376	\$2,164,370	4,730
Substance Abuse Acute Inpatient (2)	712	\$712,435	649	\$572,400	1,361	\$1,284,835
Alcohol Rehab Acute Inpatient	92	\$68,793	94	\$40,172	186	\$108,965
Day Treatment	1,020	\$704,061	1,381	\$1,017,843	2,401	\$1,721,904
Residential	106	\$109,058	74	\$58,542	180	\$167,600
Professional Services: Physician (3)	3,822	\$405,726	2,843	\$505,807	6,665	\$911,533
Professional Services: Psychologist	2,274	\$70,730	336	\$15,181	2,610	\$85,911
Professional Services: Other	260	\$23,922	170	\$28,419	430	\$52,341
Outpatient & Med Mgt: Physician	22,001	\$2,909,516	19,595	\$2,817,781	41,596	\$5,727,297
Outpatient & Med Mgt: Psychologist	32,268	\$3,024,295	28,879	\$3,017,642	61,147	\$6,041,937
Outpatient & Med Mgt: Other	49,164	\$4,812,523	36,679	\$4,576,021	85,843	\$9,388,544
Substance Abuse & Structured Outpatient	937	\$490,466	691	\$402,098	1,628	\$892,564
Mental Health Structured Outpatient	667	\$109,449	393	\$97,486	1,060	\$206,935
Electro Convulsive Therapy	229	\$56,843	131	\$48,905	360	\$105,748
Ancillary Services	2,537	\$820,992	3,007	\$1,446,085	5,544	\$2,267,077
<b>Total</b>	<b>118,443</b>	<b>\$15,953,213</b>	<b>97,298</b>	<b>\$16,808,753</b>	<b>215,741</b>	<b>\$32,761,966</b>

(1) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(2) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(3) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.



**Empire Plan Mental Health/Substance Abuse Program  
2010 Incurred Claims Paid through September 30, 2012**

**COMBINED: IN-NETWORK PLUS OUT-OF-NETWORK**

<u>Type of Service Category</u>	<u>Enrollees</u>		<u>Dependents</u>		<u>Total</u>	
	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>
Mental Health Acute Inpatient (2)	12,389	\$7,849,325	17,724	\$14,941,938	30,113	\$22,791,263
Substance Abuse Acute Inpatient (2)	1,950	\$1,414,900	2,195	\$1,374,280	4,145	\$2,789,180
Alcohol Rehab Acute Inpatient	2,084	\$1,054,858	1,034	\$483,313	3,118	\$1,538,171
Day Treatment	4,060	\$1,623,020	6,009	\$2,705,833	10,069	\$4,328,854
Residential	2,037	\$814,319	2,427	\$1,065,261	4,464	\$1,879,580
Professional Services: Physician (3)	7,793	\$586,668	6,442	\$759,000	14,235	\$1,345,668
Professional Services: Psychologist	8,127	\$176,622	909	\$28,171	9,036	\$204,793
Professional Services: Other	759	\$69,225	455	\$69,731	1,214	\$138,956
Outpatient & Med Mgt: Physician	148,811	\$10,228,319	149,249	\$10,394,416	298,060	\$20,622,734
Outpatient & Med Mgt: Psychologist	169,515	\$11,159,818	145,211	\$10,324,062	314,726	\$21,483,880
Outpatient & Med Mgt: Other	271,043	\$14,429,127	217,615	\$13,494,809	488,658	\$27,923,936
Substance Abuse & Structured Outpatient	7,058	\$1,293,551	6,794	\$1,246,797	13,852	\$2,540,348
Mental Health Structured Outpatient	2,661	\$382,012	2,740	\$621,649	5,401	\$1,003,662
Electro Convulsive Therapy	873	\$257,002	722	\$261,330	1,595	\$518,332
Ancillary Services	3,614	\$1,087,667	3,949	\$1,816,309	7,563	\$2,903,976
<b>Total</b>	<b>642,774</b>	<b>\$52,426,432</b>	<b>563,475</b>	<b>\$59,586,900</b>	<b>1,206,249</b>	<b>\$112,013,331</b>

(1) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(2) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(3) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

**Empire Plan Mental Health/Substance Abuse Program  
2011 Incurred Claims Paid through September 30, 2012**

**IN-NETWORK**

<u>Type of Service Category</u>	<u>Enrollees</u>		<u>Dependents</u>		<u>Total</u>	
	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>
Mental Health Acute Inpatient (2)	9,426	\$6,274,979	17,722	\$15,441,779	27,148	\$21,716,758
Substance Abuse Acute Inpatient (2)	2,947	\$1,565,112	3,495	\$1,916,566	6,442	\$3,481,678
Alcohol Rehab Acute Inpatient	487	\$215,761	218	\$132,897	705	\$348,658
Day Treatment	2,365	\$743,369	6,459	\$2,413,224	8,824	\$3,156,592
Residential	2,029	\$733,445	2,848	\$1,230,480	4,877	\$1,963,925
Professional Services: Physician (3)	7,087	\$243,591	5,617	\$340,609	12,704	\$584,199
Professional Services: Psychologist	7,182	\$113,218	905	\$22,423	8,087	\$135,642
Professional Services: Other	518	\$21,635	274	\$24,544	792	\$46,178
Outpatient & Med Mgt: Physician	131,956	\$7,503,827	158,617	\$9,024,704	290,573	\$16,528,531
Outpatient & Med Mgt: Psychologist	138,090	\$8,089,102	126,097	\$7,882,958	264,187	\$15,972,060
Outpatient & Med Mgt: Other	222,215	\$9,883,437	200,724	\$11,120,056	422,939	\$21,003,493
Substance Abuse & Structured Outpatient	5,123	\$753,545	8,885	\$1,414,860	14,008	\$2,168,405
Mental Health Structured Outpatient	2,012	\$233,290	3,028	\$621,446	5,040	\$854,736
Electro Convulsive Therapy	824	\$214,194	825	\$311,622	1,649	\$525,816
Ancillary Services	1,385	\$107,989	889	\$105,150	2,274	\$213,139
<b>Total</b>	<b>533,646</b>	<b>\$36,696,494</b>	<b>536,603</b>	<b>\$52,003,316</b>	<b>1,070,249</b>	<b>\$88,699,810</b>

(1) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(2) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(3) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

**Empire Plan Mental Health/Substance Abuse Program  
2011 Incurred Claims Paid through September 30, 2012**

<u>Type of Service Category</u>	<b>Enrollees</b>		<b>Dependents</b>		<b>Total</b>	
	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>
	Mental Health Acute Inpatient (2)	2,398	\$1,564,856	3,322	\$3,114,735	5,720
Substance Abuse Acute Inpatient (2)	736	\$857,037	1,219	\$1,381,812	1,955	\$2,238,849
Alcohol Rehab Acute Inpatient	59	\$60,228	125	\$71,679	184	\$131,907
Day Treatment	1,179	\$820,183	2,707	\$1,975,082	3,886	\$2,795,266
Residential	19	\$20,417	122	\$125,445	141	\$145,861
Professional Services: Physician (3)	8,780	\$1,027,135	7,859	\$1,974,076	16,639	\$3,001,212
Professional Services: Psychologist	2,778	\$78,650	432	\$19,993	3,210	\$98,643
Professional Services: Other	249	\$24,631	180	\$50,643	429	\$75,274
Outpatient & Med Mgt: Physician	23,226	\$3,244,426	22,726	\$3,502,288	45,952	\$6,746,713
Outpatient & Med Mgt: Psychologist	34,676	\$3,369,980	37,330	\$4,094,276	72,006	\$7,464,256
Outpatient & Med Mgt: Other	52,697	\$5,482,379	44,194	\$6,225,362	96,891	\$11,707,741
Substance Abuse & Structured Outpatient	914	\$604,939	2,907	\$1,980,075	3,821	\$2,585,014
Mental Health Structured Outpatient	686	\$96,307	546	\$255,531	1,232	\$351,838
Electro Convulsive Therapy	397	\$79,851	261	\$114,988	658	\$194,839
Ancillary Services	5,767	\$1,215,937	6,169	\$2,357,611	11,936	\$3,573,548
<b>Total</b>	<b>134,561</b>	<b>\$18,546,955</b>	<b>130,099</b>	<b>\$27,243,596</b>	<b>264,660</b>	<b>\$45,790,552</b>

(1) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(2) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(3) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

**Empire Plan Mental Health/Substance Abuse Program  
2011 Incurred Claims Paid through September 30, 2012**

**COMBINED: IN-NETWORK PLUS OUT-OF-NETWORK**

<u>Type of Service Category</u>	<u>Enrollees</u>		<u>Dependents</u>		<u>Total</u>	
	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>	<u>Services (1)</u>	<u>Amount Paid</u>
Mental Health Acute Inpatient (2)	11,824	\$7,839,835	21,044	\$18,556,514	32,868	\$26,396,349
Substance Abuse Acute Inpatient (2)	3,683	\$2,422,149	4,714	\$3,298,378	8,397	\$5,720,527
Alcohol Rehab Acute Inpatient	546	\$275,989	343	\$204,576	889	\$480,565
Day Treatment	3,544	\$1,563,552	9,166	\$4,388,306	12,710	\$5,951,858
Residential	2,048	\$753,862	2,970	\$1,355,925	5,018	\$2,109,786
Professional Services: Physician (3)	15,867	\$1,270,726	13,476	\$2,314,685	29,343	\$3,585,411
Professional Services: Psychologist	9,960	\$191,868	1,337	\$42,417	11,297	\$234,285
Professional Services: Other	767	\$46,266	454	\$75,187	1,221	\$121,452
Outpatient & Med Mgt: Physician	155,182	\$10,748,253	181,343	\$12,526,991	336,525	\$23,275,244
Outpatient & Med Mgt: Psychologist	172,766	\$11,459,082	163,427	\$11,977,233	336,193	\$23,436,315
Outpatient & Med Mgt: Other	274,912	\$15,365,816	244,918	\$17,345,418	519,830	\$32,711,234
Substance Abuse & Structured Outpatient	6,037	\$1,358,484	11,792	\$3,394,935	17,829	\$4,753,419
Mental Health Structured Outpatient	2,698	\$329,597	3,574	\$876,977	6,272	\$1,206,574
Electro Convulsive Therapy	1,221	\$294,045	1,086	\$426,610	2,307	\$720,655
Ancillary Services	7,152	\$1,323,925	7,058	\$2,462,761	14,210	\$3,786,687
<b>Total</b>	<b>668,207</b>	<b>\$55,243,450</b>	<b>666,702</b>	<b>\$79,246,912</b>	<b>1,334,909</b>	<b>\$134,490,361</b>

(1) Services represent the number of days for inpatient services and the number of visits/services for outpatient services.

(2) Includes those global fee arrangements covering both the inpatient service as well as the professional component (Physician fee).

(3) Amounts and counts do not include any professional component of services billed globally under the Mental Health Inpatient and Substance Abuse Inpatient categories.

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Empire Plan  
Paid Through September 30, 2012**

**2009 Incurred**

Month Paid	Month Incurred												Total	
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09		
Jan-09	\$ 75,538													\$ 75,538
Feb-09	\$ 688,539	\$ 113,472												\$ 802,011
Mar-09	\$ 1,381,343	\$ 1,110,187	\$ 172,851											\$ 2,664,381
Apr-09	\$ 728,769	\$ 1,096,272	\$ 1,219,664	\$ 93,868										\$ 3,138,571
May-09	\$ 312,077	\$ 351,167	\$ 801,087	\$ 506,970	\$ 50,576									\$ 2,021,877
Jun-09	\$ 179,980	\$ 221,827	\$ 373,137	\$ 565,077	\$ 652,517	\$ 126,626								\$ 2,119,164
Jul-09	\$ 285,903	\$ 228,417	\$ 738,404	\$ 658,909	\$ 733,692	\$ 977,704	\$ 158,178							\$ 3,781,207
Aug-09	\$ 75,012	\$ 150,112	\$ 132,419	\$ 279,500	\$ 295,624	\$ 488,223	\$ 819,434	\$ 75,430						\$ 2,315,754
Sep-09	\$ 185,322	\$ 156,548	\$ 159,395	\$ 191,831	\$ 193,563	\$ 548,975	\$ 584,032	\$ 715,207	\$ 81,360					\$ 2,816,234
Oct-09	\$ 45,107	\$ 69,266	\$ 130,129	\$ 163,268	\$ 113,098	\$ 209,203	\$ 406,312	\$ 544,197	\$ 743,251	\$ 89,075				\$ 2,512,905
Nov-09	\$ 28,426	\$ 42,507	\$ 48,117	\$ 116,439	\$ 80,289	\$ 146,263	\$ 163,509	\$ 231,055	\$ 637,600	\$ 723,699	\$ 82,940			\$ 2,300,843
Dec-09	\$ 14,978	\$ 32,936	\$ 64,699	\$ 71,582	\$ 140,193	\$ 82,457	\$ 108,475	\$ 164,434	\$ 309,981	\$ 574,968	\$ 756,854	\$ 129,836		\$ 2,451,392
Jan-10	\$ 29,284	\$ 19,905	\$ 36,186	\$ 44,914	\$ 67,153	\$ 63,565	\$ 69,327	\$ 113,121	\$ 186,417	\$ 231,280	\$ 492,704	\$ 820,568		\$ 2,174,424
Feb-10	\$ 14,234	\$ 13,536	\$ 12,074	\$ 24,419	\$ 188,534	\$ 36,275	\$ 76,023	\$ 105,457	\$ 86,704	\$ 195,509	\$ 316,715	\$ 496,351		\$ 1,565,833
Mar-10	\$ 9,131	\$ 35,839	\$ 34,482	\$ 49,701	\$ 42,821	\$ 87,158	\$ 60,089	\$ 108,221	\$ 91,452	\$ 105,735	\$ 203,347	\$ 387,468		\$ 1,215,444
Apr-10	\$ 6,951	\$ 23,165	\$ 27,355	\$ 20,005	\$ 25,142	\$ 31,576	\$ 34,186	\$ 46,199	\$ 46,746	\$ 79,784	\$ 90,180	\$ 118,349		\$ 549,639
May-10	\$ (1,255)	\$ (350)	\$ 805	\$ 32,020	\$ (2,294)	\$ (515)	\$ 6,176	\$ 34,295	\$ 7,756	\$ 14,716	\$ 41,926	\$ 40,791		\$ 174,072
Jun-10	\$ 1,106	\$ 50	\$ 10,002	\$ 1,751	\$ 1,489	\$ (98)	\$ 37,075	\$ 18,410	\$ 4,435	\$ 26,580	\$ 22,891	\$ 20,555		\$ 144,245
Jul-10	\$ 94,515	\$ (2,191)	\$ (14,856)	\$ 4,775	\$ 27,969	\$ 629	\$ 4,249	\$ 1,418	\$ 61,221	\$ 13,004	\$ 24,263	\$ 35,548		\$ 250,544
Aug-10	\$ (5,440)	\$ (5,586)	\$ 11,804	\$ (3,110)	\$ 7,806	\$ 5,244	\$ 2,442	\$ 1,859	\$ 3,606	\$ 4,138	\$ 6,450	\$ 7,490		\$ 36,702
Sep-10	\$ 4,111	\$ 10,833	\$ 6,091	\$ 2,364	\$ 4,021	\$ 4,619	\$ 8,104	\$ 8,479	\$ 4,342	\$ 13,139	\$ (692)	\$ 35,701		\$ 101,113
Oct-10	\$ 53,618	\$ 610	\$ 11,122	\$ 7,757	\$ 6,502	\$ 2,896	\$ 8,450	\$ 2,575	\$ 8,376	\$ 7,305	\$ 12,714	\$ 11,688		\$ 133,614
Nov-10	\$ 18,063	\$ 1,154	\$ 3,882	\$ (1,386)	\$ 350	\$ 4,493	\$ 1,900	\$ (2,936)	\$ 1,794	\$ 2,000	\$ 50,741	\$ 38,687		\$ 118,744
Dec-10	\$ (528)	\$ (4,663)	\$ (305)	\$ (30,573)	\$ 353	\$ 2,002	\$ 8,396	\$ (61)	\$ 33,224	\$ 5,958	\$ 6,594	\$ 82		\$ 20,479
Jan-11	\$ 51	\$ (690)	\$ (2,328)	\$ 354	\$ (3,273)	\$ (241)	\$ (270)	\$ 8,228	\$ 30,951	\$ 7,387	\$ 5,777	\$ 3,351		\$ 49,296
Feb-11	\$ (1,158)	\$ (18)	\$ 175	\$ 833	\$ 8,297	\$ 21,114	\$ 27,904	\$ 2,409	\$ 204	\$ 4,133	\$ 596	\$ 548		\$ 65,038
Mar-11	\$ 1,452	\$ (329)	\$ 2,262	\$ 3,962	\$ 2,047	\$ 3,852	\$ 2,958	\$ 2,284	\$ 104,031	\$ 87,931	\$ 13,939	\$ 11,011		\$ 235,400
Apr-11	\$ 792	\$ 1,070	\$ 3,729	\$ 4,623	\$ 9,443	\$ 9,335	\$ 15,192	\$ 30,503	\$ 14,820	\$ 21,166	\$ 26,075	\$ 39,401		\$ 176,151
May-11	\$ 179	\$ 61	\$ 945	\$ 360	\$ 996	\$ 1,645	\$ 1,217	\$ 83	\$ 619	\$ 624	\$ 2,397	\$ 7,156		\$ 16,282
Jun-11	\$ 43	\$ (697)	\$ (1,370)	\$ 1,815	\$ (3,217)	\$ 161	\$ 25	\$ 54	\$ 2,113	\$ 1,384	\$ 319	\$ (18)		\$ 612
Jul-11	\$ 1,006	\$ (542)	\$ (272)	\$ (1,968)	\$ (718)	\$ 3,654	\$ 9,853	\$ (1,026)	\$ 48	\$ (817)	\$ 3,537	\$ 1,093		\$ 13,848
Aug-11	\$ (1,719)	\$ 4,106	\$ 10,643	\$ (1,573)	\$ (351)	\$ 456	\$ (31)	\$ 230	\$ (7,040)	\$ 28,016	\$ 2,612	\$ 573		\$ 35,922
Sep-11	\$ (6)	\$ (326)	\$ (254)	\$ (628)	\$ 332	\$ 1,408	\$ 32	\$ 1,430	\$ 212	\$ 278	\$ 2,429	\$ 108		\$ 5,012
Oct-11	\$ (2,093)	\$ (1,433)	\$ (130)	\$ (428)	\$ 2,086	\$ 293	\$ 375	\$ 2,795	\$ 6,016	\$ 76,776	\$ 142,965	\$ (156)		\$ 227,065
Nov-11	\$ 337	\$ (37)	\$ 330	\$ 201	\$ 463	\$ (109)	\$ 1,027	\$ (54)	\$ 1,084	\$ 1,281	\$ 135	\$ (366)		\$ 4,292
Dec-11	\$ 4,712	\$ 1,800	\$ 870	\$ 363	\$ 923	\$ 371	\$ 240	\$ (636)	\$ 1,829	\$ 1,453	\$ 1,364	\$ 498		\$ 13,787
Jan-12	\$ (483)	\$ (404)	\$ (6)	\$ (1,624)	\$ 134	\$ (404)	\$ (191)	\$ 258	\$ (14)	\$ 188				\$ (2,544)
Feb-12	\$ 66	\$ (255)	\$ (885)	\$ (116)	\$ 0	\$ (1,259)	\$ (148)	\$ (1,156)	\$ (744)					\$ (4,498)
Mar-12	\$ 60	\$ (197)	\$ (394)	\$ (883)	\$ (396)	\$ 163	\$ 333	\$ 394	\$ (7,274)	\$ (344)	\$ (121)	\$ 39		\$ (8,620)
Apr-12	\$ (763)	\$ (769)	\$ (1,110)	\$ (1,579)	\$ (315)	\$ (130)	\$ 105	\$ (44)	\$ (7)					\$ (4,611)
May-12	\$ 1,128	\$ 81	\$ (74)	\$ (810)	\$ (30)	\$ (62)	\$ (487)	\$ 541	\$ 56	\$ 262	\$ (20)	\$ 46		\$ 631
Jun-12	\$ (64)	\$ (2,880)	\$ (1,612)	\$ (1,262)	\$ (110)	\$ (364)	\$ (190)	\$ (269)	\$ (190)		\$ (265)	\$ (1,104)		\$ (8,310)
Jul-12	\$ (689)	\$ (480)	\$ (1,260)	\$ (1,547)		\$ (219)	\$ (50)	\$ (150)	\$ (6,277)					\$ (10,672)
Aug-12	\$ (69)	\$ 242	\$ (1,374)	\$ (1,364)	\$ 13,722	\$ 46	\$ 850	\$ 71	\$ (3,892)	\$ (1,195)	\$ 1,435	\$ (472)		\$ 8,000
Sep-12	\$ 89	\$ (498)	\$ (210)	\$ (841)	\$ (338)	\$ (156)	\$ 13,994	\$ (330)	\$ -	\$ -	\$ (78)	\$ 425		\$ 12,058
<b>Total</b>	<b>\$ 4,227,653</b>	<b>\$ 3,662,817</b>	<b>\$ 3,986,219</b>	<b>\$ 2,797,968</b>	<b>\$ 2,659,096</b>	<b>\$ 2,857,254</b>	<b>\$ 2,628,885</b>	<b>\$ 2,213,681</b>	<b>\$ 2,444,669</b>	<b>\$ 2,315,225</b>	<b>\$ 2,309,965</b>	<b>\$ 2,205,436</b>	<b>\$ 34,308,869</b>	

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Empire Plan  
Paid Through September 30, 2012**

**2010 Incurred**

Month Paid	Month Incurred												Total	
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10		
Jan-10	\$ 8,372													\$ 8,372
Feb-10	\$ 398,671	\$ 36,155												\$ 434,826
Mar-10	\$ 447,321	\$ 773,843	\$ 118,144											\$ 1,339,308
Apr-10	\$ 166,870	\$ 455,658	\$ 1,194,532	\$ 112,186										\$ 1,929,245
May-10	\$ 81,676	\$ 174,464	\$ 634,153	\$ 1,045,159	\$ 82,502									\$ 2,017,953
Jun-10	\$ 119,444	\$ 128,659	\$ 315,298	\$ 874,589	\$ 1,094,866	\$ 153,939								\$ 2,686,795
Jul-10	\$ 62,453	\$ 168,348	\$ 357,288	\$ 333,164	\$ 724,186	\$ 1,118,792	\$ 166,816							\$ 2,931,046
Aug-10	\$ 51,890	\$ 59,639	\$ 209,856	\$ 208,367	\$ 408,918	\$ 511,694	\$ 1,083,401	\$ 280,499						\$ 2,814,265
Sep-10	\$ 37,352	\$ 35,567	\$ 67,135	\$ 86,135	\$ 169,366	\$ 228,370	\$ 477,006	\$ 1,008,450	\$ 249,780					\$ 2,359,160
Oct-10	\$ 20,153	\$ 32,464	\$ 53,043	\$ 60,060	\$ 118,592	\$ 175,123	\$ 246,702	\$ 474,382	\$ 1,066,926	\$ 281,394				\$ 2,528,839
Nov-10	\$ 69,387	\$ 16,614	\$ 38,698	\$ 50,930	\$ 91,211	\$ 168,983	\$ 145,631	\$ 230,476	\$ 564,859	\$ 1,135,866	\$ 300,848			\$ 2,813,502
Dec-10	\$ 39,558	\$ 15,617	\$ 15,207	\$ 45,935	\$ 59,756	\$ 69,997	\$ 103,190	\$ 151,940	\$ 271,910	\$ 559,442	\$ 1,160,452	\$ 244,089		\$ 2,737,092
Jan-11	\$ 10,953	\$ 20,122	\$ 96,229	\$ 129,104	\$ 35,315	\$ 52,105	\$ 74,422	\$ 95,064	\$ 213,035	\$ 334,079	\$ 630,619	\$ 1,114,967		\$ 2,806,014
Feb-11	\$ 22,663	\$ 11,960	\$ 27,262	\$ 52,106	\$ 41,718	\$ 46,083	\$ 62,585	\$ 61,852	\$ 129,536	\$ 187,627	\$ 397,446	\$ 568,322		\$ 1,609,160
Mar-11	\$ 11,313	\$ 16,302	\$ 19,060	\$ 37,212	\$ 38,189	\$ 62,885	\$ 114,900	\$ 108,731	\$ 97,101	\$ 120,602	\$ 232,795	\$ 301,943		\$ 1,161,035
Apr-11	\$ 50,233	\$ 35,823	\$ 44,870	\$ 36,740	\$ 49,059	\$ 36,001	\$ 55,183	\$ 48,166	\$ 89,294	\$ 102,667	\$ 143,689	\$ 210,759		\$ 902,481
May-11	\$ 2,790	\$ 5,510	\$ 11,418	\$ 9,613	\$ 6,513	\$ 44,739	\$ 15,790	\$ 35,464	\$ 15,940	\$ 36,296	\$ 59,627	\$ 69,267		\$ 312,968
Jun-11	\$ 6,245	\$ 18,124	\$ 4,708	\$ 5,264	\$ 11,634	\$ 7,434	\$ 9,218	\$ 10,995	\$ 11,300	\$ 25,902	\$ 24,460	\$ 47,368		\$ 182,651
Jul-11	\$ 1,694	\$ 17,531	\$ 3,289	\$ 10,790	\$ 10,121	\$ 12,622	\$ 39,286	\$ 10,847	\$ 19,885	\$ 41,758	\$ 28,812	\$ 31,867		\$ 228,503
Aug-11	\$ 4,772	\$ 6,167	\$ 8,650	\$ 4,266	\$ 2,554	\$ 5,036	\$ 12,644	\$ 4,563	\$ 15,989	\$ 9,792	\$ 60,090	\$ 18,692		\$ 153,217
Sep-11	\$ 20,654	\$ (7,719)	\$ 723	\$ 1,736	\$ 9,533	\$ 1,148	\$ 3,359	\$ 4,335	\$ 3,932	\$ 4,220	\$ 10,399	\$ 43,924		\$ 96,243
Oct-11	\$ 361	\$ 7,241	\$ 2,881	\$ 12,099	\$ 1,591	\$ 9,204	\$ 8,477	\$ 2,014	\$ (620)	\$ 18,714	\$ 3,656	\$ 5,490		\$ 71,108
Nov-11	\$ 1,934	\$ 2,860	\$ 224	\$ 571	\$ 408	\$ 1,763	\$ 18,956	\$ 1,151	\$ 1,709	\$ 4,448	\$ 3,709	\$ 3,153		\$ 40,885
Dec-11	\$ 824	\$ 749	\$ 1,918	\$ 2,365	\$ 3,357	\$ 7,210	\$ 1,285	\$ 18,601	\$ 1,504	\$ 3,612	\$ 1,847	\$ 3,413		\$ 46,685
Jan-12	\$ 395	\$ 1,385	\$ 1,309	\$ 291	\$ 305	\$ 1,370	\$ 691	\$ 582	\$ 308	\$ 2,145	\$ 4,353	\$ 4,052		\$ 17,186
Feb-12	\$ 686	\$ (243)	\$ (107)	\$ -	\$ (339)	\$ 2,057	\$ 339	\$ 213	\$ 10,256	\$ 660	\$ 487	\$ 2,807		\$ 16,816
Mar-12	\$ 2,771	\$ 116	\$ 667	\$ 1,250	\$ 541	\$ 1,127	\$ 971	\$ 2,951	\$ 2,330	\$ 327	\$ 198	\$ 139		\$ 13,386
Apr-12	\$ (103)	\$ (238)	\$ (105)	\$ 108	\$ 189	\$ (1,236)	\$ (1,000)	\$ (1,320)	\$ 1,506	\$ (30)	\$ 122	\$ (158)		\$ (2,265)
May-12	\$ (133)	\$ (256)	\$ (157)	\$ 912	\$ (9,551)	\$ (12,069)	\$ 192	\$ 1,619	\$ 870	\$ 950	\$ 565	\$ (128)		\$ (17,185)
Jun-12	\$ 440	\$ 276	\$ 139	\$ 3,859	\$ 358	\$ 696	\$ (120)	\$ -	\$ 1,110	\$ (26)	\$ 862	\$ 155		\$ 7,749
Jul-12	\$ -	\$ (162)	\$ (121)	\$ (272)	\$ -	\$ 432	\$ (40)	\$ 363	\$ 510	\$ -	\$ 1,100	\$ 42		\$ 1,853
Aug-12	\$ (511)	\$ 654	\$ 1,348	\$ (1,160)	\$ (345)	\$ (1,341)	\$ (60)	\$ 1,488	\$ (754)	\$ 540	\$ 936	\$ 33		\$ 827
Sep-12	\$ 84	\$ (152)	\$ -	\$ (31)	\$ (60)	\$ (385)	\$ (1,128)	\$ (197)	\$ 116	\$ 732	\$ (80)	\$ -		\$ (1,102)
<b>Total</b>	<b>\$ 1,641,207</b>	<b>\$ 2,033,078</b>	<b>\$ 3,227,560</b>	<b>\$ 3,123,346</b>	<b>\$ 2,950,488</b>	<b>\$ 2,703,779</b>	<b>\$ 2,638,695</b>	<b>\$ 2,553,232</b>	<b>\$ 2,768,331</b>	<b>\$ 2,871,716</b>	<b>\$ 3,066,991</b>	<b>\$ 2,670,195</b>		<b>\$ 32,248,619</b>

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Empire Plan  
Paid Through September 30, 2012**

**2011 Incurred**

Month Paid	Month Incurred												Total	
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11		
Jan-11	\$ 73,669													\$ 73,669
Feb-11	\$ 920,767	\$ 140,862												\$ 1,061,628
Mar-11	\$ 534,552	\$ 1,222,900	\$ 242,438											\$ 1,999,889
Apr-11	\$ 374,876	\$ 548,235	\$ 1,397,443	\$ 173,659										\$ 2,494,212
May-11	\$ 153,785	\$ 263,347	\$ 885,245	\$ 1,191,790	\$ 184,018									\$ 2,678,184
Jun-11	\$ 114,348	\$ 256,824	\$ 467,344	\$ 856,811	\$ 1,438,992	\$ 199,057								\$ 3,333,376
Jul-11	\$ 56,987	\$ 186,802	\$ 270,973	\$ 460,399	\$ 1,174,854	\$ 1,728,665	\$ 345,471							\$ 4,224,152
Aug-11	\$ 192,305	\$ 150,338	\$ 203,621	\$ 224,795	\$ 468,851	\$ 1,016,530	\$ 2,032,234	\$ 585,781						\$ 4,874,455
Sep-11	\$ 28,844	\$ 95,579	\$ 62,899	\$ 102,097	\$ 262,626	\$ 442,894	\$ 606,949	\$ 1,670,565	\$ 425,011					\$ 3,697,463
Oct-11	\$ 65,422	\$ 25,158	\$ 42,811	\$ 89,005	\$ 207,675	\$ 169,193	\$ 264,616	\$ 760,009	\$ 1,854,121	\$ 533,163				\$ 4,011,173
Nov-11	\$ 40,633	\$ 37,205	\$ 76,899	\$ 7,754	\$ 107,110	\$ 114,839	\$ 195,611	\$ 326,314	\$ 798,498	\$ 2,081,021	\$ 445,461			\$ 4,231,346
Dec-11	\$ 29,685	\$ 25,183	\$ 24,528	\$ 35,415	\$ 50,457	\$ 89,391	\$ 75,632	\$ 205,417	\$ 439,064	\$ 982,694	\$ 2,219,556	\$ 705,425		\$ 4,882,448
Jan-12	\$ 43,243	\$ 6,116	\$ 24,561	\$ 34,115	\$ 42,006	\$ 73,409	\$ 100,223	\$ 79,044	\$ 142,519	\$ 424,247	\$ 770,484	\$ 1,628,663		\$ 3,368,629
Feb-12	\$ 18,422	\$ 12,507	\$ 23,626	\$ 36,813	\$ 31,849	\$ 39,000	\$ 49,100	\$ 71,812	\$ 145,089	\$ 206,123	\$ 386,518	\$ 816,204		\$ 1,837,064
Mar-12	\$ 11,975	\$ 9,527	\$ 20,936	\$ 6,068	\$ 25,215	\$ 44,655	\$ 67,430	\$ 49,688	\$ 68,301	\$ 129,974	\$ 189,676	\$ 296,161		\$ 919,605
Apr-12	\$ 9,428	\$ 15,006	\$ 24,809	\$ 45,866	\$ 28,362	\$ 20,911	\$ 38,710	\$ 37,313	\$ 59,324	\$ 81,539	\$ 204,469	\$ 141,591		\$ 707,327
May-12	\$ (815)	\$ (6,455)	\$ 395	\$ 13,827	\$ 6,862	\$ 12,978	\$ 31,348	\$ 7,333	\$ 19,830	\$ 24,415	\$ 46,897	\$ 124,993		\$ 281,608
Jun-12	\$ 540	\$ 3,242	\$ 1,471	\$ 6,006	\$ 3,181	\$ 2,636	\$ 2,887	\$ 20,684	\$ 10,850	\$ 16,440	\$ 19,005	\$ 21,459		\$ 108,403
Jul-12	\$ (1,841)	\$ 769	\$ (1,583)	\$ 2,444	\$ (4,587)	\$ 730	\$ 1,871	\$ 5,082	\$ 5,447	\$ 44,375	\$ 11,507	\$ 12,838		\$ 77,052
Aug-12	\$ (4,391)	\$ 536	\$ 1,720	\$ 728	\$ 3,585	\$ 3,446	\$ 5,206	\$ 10,008	\$ 17,641	\$ 5,528	\$ 56,466	\$ 34,000		\$ 134,473
Sep-12	\$ 4,294	\$ 20,971	\$ 14,331	\$ 5,253	\$ 786	\$ 1,919	\$ (5,726)	\$ (4,556)	\$ (24,236)	\$ (11,015)	\$ 2,308	\$ 93,198		\$ 97,525
<b>Total</b>	<b>\$ 2,666,726</b>	<b>\$ 3,014,652</b>	<b>\$ 3,784,468</b>	<b>\$ 3,292,844</b>	<b>\$ 4,031,840</b>	<b>\$ 3,960,254</b>	<b>\$ 3,811,562</b>	<b>\$ 3,824,496</b>	<b>\$ 3,961,458</b>	<b>\$ 4,518,505</b>	<b>\$ 4,352,347</b>	<b>\$ 3,874,531</b>		<b>\$ 45,093,683</b>

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Empire Plan  
Paid Through September 30, 2012**

**2012 Incurred**

Month Paid	Month Incurred												Total	
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12		
Jan-12	\$ 391,257													\$ 391,257
Feb-12	\$ 1,020,227	\$ 459,579												\$ 1,479,806
Mar-12	\$ 438,427	\$ 1,249,265	\$ 560,513											\$ 2,248,205
Apr-12	\$ 122,675	\$ 404,827	\$ 1,482,484	\$ 546,652										\$ 2,556,638
May-12	\$ 124,087	\$ 174,025	\$ 440,947	\$ 1,449,295	\$ 476,110									\$ 2,664,464
Jun-12	\$ 101,278	\$ 196,185	\$ 215,378	\$ 858,083	\$ 1,990,686	\$ 512,875								\$ 3,874,484
Jul-12	\$ 37,345	\$ 116,033	\$ 139,961	\$ 318,147	\$ 667,627	\$ 1,721,672	\$ 518,863							\$ 3,519,647
Aug-12	\$ 75,411	\$ 54,471	\$ 128,881	\$ 248,784	\$ 327,670	\$ 652,777	\$ 1,850,102	\$ 831,467						\$ 4,169,563
Sep-12	\$ 52,472	\$ 21,053	\$ 92,146	\$ 62,766	\$ 122,507	\$ 389,343	\$ 861,852	\$ 2,059,053	\$ 594,301					\$ 4,255,494
<b>Total</b>	<b>\$ 2,363,181</b>	<b>\$ 2,675,437</b>	<b>\$ 3,060,310</b>	<b>\$ 3,483,726</b>	<b>\$ 3,584,600</b>	<b>\$ 3,276,667</b>	<b>\$ 3,230,816</b>	<b>\$ 2,890,520</b>	<b>\$ 594,301</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 25,159,558</b>



**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Excelsior Plan  
Paid Through September 30, 2012**

**2009 Incurred**

Month Paid	Month Incurred												Total	
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09		
Jan-09														\$ -
Feb-09	\$ 1,520													\$ 1,520
Mar-09	\$ 110													\$ 110
Apr-09			\$ 45											\$ 45
May-09		\$ 410	\$ 190	\$ 193										\$ 793
Jun-09	\$ 380	\$ 675	\$ 345	\$ 305	\$ 400									\$ 2,105
Jul-09	\$ 190	\$ 95	\$ 190											\$ 475
Aug-09														\$ -
Sep-09			\$ 36	\$ 66	\$ 446									\$ 548
Oct-09				\$ 30	\$ 10	\$ 106								\$ 146
Nov-09				\$ (193)				\$ 500	\$ 300					\$ 607
Dec-09										\$ 45				\$ 45
Jan-10														\$ -
Feb-10														\$ -
Mar-10											\$ 300	\$ 300		\$ 600
Apr-10								\$ 240	\$ 460	\$ 800	\$ 1,100			\$ 2,600
May-10														\$ -
Jun-10														\$ -
Jul-10														\$ -
Aug-10														\$ -
Sep-10														\$ -
Oct-10														\$ -
Nov-10														\$ -
Dec-10														\$ -
Jan-11														\$ -
Feb-11														\$ -
Mar-11														\$ -
Apr-11														\$ -
May-11														\$ -
Jun-11														\$ -
Jul-11														\$ -
Aug-11														\$ -
Sep-11														\$ -
Oct-11														\$ -
Nov-11														\$ -
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12														\$ -
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 2,200</b>	<b>\$ 1,180</b>	<b>\$ 806</b>	<b>\$ 401</b>	<b>\$ 856</b>	<b>\$ 106</b>	<b>\$ -</b>	<b>\$ 500</b>	<b>\$ 540</b>	<b>\$ 505</b>	<b>\$ 1,100</b>	<b>\$ 1,400</b>	<b>\$ 9,594</b>	





**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Excelsior Plan  
Paid Through September 30, 2012**

**2012 Incurred**

Month Paid	Month Incurred												Total		
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12			
Jan-12														\$	-
Feb-12														\$	-
Mar-12		\$ 120	\$ 360											\$	480
Apr-12			\$ 120	\$ 360										\$	480
May-12				\$ 265	\$ 240									\$	505
Jun-12					\$ 240	\$ 120								\$	360
Jul-12						\$ 360								\$	360
Aug-12							\$ 646							\$	646
Sep-12							\$ 37	\$ 360						\$	397
<b>Total</b>	\$ -	\$ 120	\$ 480	\$ 625	\$ 480	\$ 480	\$ 683	\$ 360	\$ -	\$ -	\$ -	\$ -	\$ -	\$	3,228

**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Excelsior Plan  
Paid Through September 30, 2012**

**2009 Incurred**

Month Paid	Month Incurred												Total	
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09		
Jan-09	\$ 90													\$ 90
Feb-09	\$ 42													\$ 42
Mar-09	\$ 1,970	\$ 605	\$ 55											\$ 2,630
Apr-09	\$ 60	\$ 2,130	\$ 585	\$ 30										\$ 2,805
May-09	\$ 315	\$ 96	\$ 1,455	\$ 400	\$ 130									\$ 2,396
Jun-09			\$ 91	\$ 301	\$ 480	\$ 155								\$ 1,027
Jul-09	\$ 765	\$ 120	\$ 235	\$ 295	\$ 1,176	\$ 11,061	\$ 667							\$ 14,319
Aug-09				\$ 60	\$ 60	\$ 555	\$ 743	\$ 246						\$ 1,664
Sep-09			\$ 90	\$ 30		\$ 45	\$ 220	\$ 1,046	\$ 315					\$ 1,746
Oct-09							\$ 132	\$ 166	\$ 810	\$ 210				\$ 1,318
Nov-09							\$ 75		\$ 142	\$ 661	\$ 360			\$ 1,238
Dec-09						\$ 1,880	\$ 36	\$ 118	\$ 138	\$ 60	\$ 611	\$ 220		\$ 3,063
Jan-10									\$ 120	\$ 463	\$ 306	\$ 611		\$ 1,500
Feb-10								\$ 60	\$ 30	\$ 45	\$ 60	\$ 191		\$ 386
Mar-10														\$ -
Apr-10														\$ -
May-10														\$ -
Jun-10														\$ -
Jul-10								\$ 30	\$ 60	\$ 30				\$ 120
Aug-10														\$ -
Sep-10														\$ -
Oct-10														\$ -
Nov-10														\$ -
Dec-10														\$ -
Jan-11														\$ -
Feb-11														\$ -
Mar-11														\$ -
Apr-11														\$ -
May-11														\$ -
Jun-11														\$ -
Jul-11														\$ -
Aug-11														\$ -
Sep-11														\$ -
Oct-11														\$ -
Nov-11														\$ -
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12														\$ -
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 3,242</b>	<b>\$ 2,951</b>	<b>\$ 2,511</b>	<b>\$ 1,116</b>	<b>\$ 1,846</b>	<b>\$ 13,696</b>	<b>\$ 1,873</b>	<b>\$ 1,666</b>	<b>\$ 1,615</b>	<b>\$ 1,469</b>	<b>\$ 1,337</b>	<b>\$ 1,022</b>		<b>\$ 34,345</b>

**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Excelsior Plan  
Paid Through September 30, 2012**

**2010 Incurred**

Month Paid	Month Incurred												Total	
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10		
Jan-10	\$ 78													\$ 78
Feb-10	\$ 560	\$ 203												\$ 763
Mar-10	\$ 125	\$ 820	\$ 60											\$ 1,005
Apr-10			\$ 3,090	\$ 45										\$ 3,135
May-10			\$ 4,680	\$ 505	\$ 200									\$ 5,385
Jun-10				\$ 1	\$ 430	\$ 80								\$ 511
Jul-10		\$ 10		\$ 80	\$ 151	\$ 3,818	\$ 80							\$ 4,139
Aug-10						\$ 6,045	\$ 470	\$ 50						\$ 6,565
Sep-10				\$ 105			\$ 3	\$ 75						\$ 183
Oct-10	\$ 65	\$ 130	\$ 130	\$ 75	\$ 90	\$ (2,749)	\$ 396	\$ 1	\$ 95	\$ 30				\$ (1,737)
Nov-10			\$ 130		\$ 130	\$ 95	\$ 30		\$ 4	\$ 60	\$ 5			\$ 454
Dec-10					\$ 90	\$ 15			\$ 19	\$ 30	\$ 4	\$ 22		\$ 176
Jan-11						\$ 7					\$ 4	\$ 30		\$ 41
Feb-11											\$ 4			\$ 4
Mar-11														\$ -
Apr-11														\$ -
May-11														\$ -
Jun-11														\$ -
Jul-11														\$ -
Aug-11														\$ -
Sep-11														\$ -
Oct-11														\$ -
Nov-11														\$ -
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12														\$ -
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 828</b>	<b>\$ 1,163</b>	<b>\$ 8,090</b>	<b>\$ 811</b>	<b>\$ 1,001</b>	<b>\$ 7,379</b>	<b>\$ 1,001</b>	<b>\$ 126</b>	<b>\$ 99</b>	<b>\$ 109</b>	<b>\$ 39</b>	<b>\$ 56</b>		<b>\$ 20,701</b>

**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Excelsior Plan  
Paid Through September 30, 2012**

**2011 Incurred**

Month Paid	Month Incurred												Total		
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11			
Jan-11														\$	-
Feb-11	\$ 98														\$ 98
Mar-11		\$ 60													\$ 60
Apr-11	\$ 44	\$ 44	\$ 60	\$ 20											\$ 168
May-11			\$ 3	\$ 48											\$ 51
Jun-11			\$ 70		\$ 60										\$ 130
Jul-11						\$ 30	\$ 20								\$ 50
Aug-11						\$ 3	\$ 58								\$ 61
Sep-11								\$ 30	\$ 80						\$ 110
Oct-11									\$ 226	\$ 113					\$ 339
Nov-11									\$ 90	\$ 113					\$ 203
Dec-11											\$ 17				\$ 17
Jan-12													\$ 6		\$ 6
Feb-12															\$ -
Mar-12															\$ -
Apr-12															\$ -
May-12															\$ -
Jun-12															\$ -
Jul-12															\$ -
Aug-12															\$ -
Sep-12															\$ -
<b>Total</b>	<b>\$ 141</b>	<b>\$ 104</b>	<b>\$ 133</b>	<b>\$ 68</b>	<b>\$ 60</b>	<b>\$ 33</b>	<b>\$ 78</b>	<b>\$ 30</b>	<b>\$ 396</b>	<b>\$ 226</b>	<b>\$ 17</b>	<b>\$ 6</b>		<b>\$ 1,292</b>	

**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Excelsior Plan  
Paid Through September 30, 2012**

**2012 Incurred**

Month Paid	Month Incurred												Total	
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12		
Jan-12	\$ 249													\$ 249
Feb-12	\$ 8,965	\$ 290												\$ 9,255
Mar-12	\$ 170	\$ 547	\$ 100											\$ 817
Apr-12		\$ 127	\$ 764	\$ 140										\$ 1,031
May-12			\$ 173	\$ 656	\$ 1,415									\$ 2,244
Jun-12					\$ 2,003	\$ 275								\$ 2,278
Jul-12				\$ 140	\$ 39	\$ 461	\$ 205							\$ 845
Aug-12				\$ 90	\$ 200	\$ 183	\$ 481	\$ 310						\$ 1,265
Sep-12							\$ 50	\$ 688	\$ 174					\$ 912
<b>Total</b>	<b>\$ 9,384</b>	<b>\$ 963</b>	<b>\$ 1,037</b>	<b>\$ 1,026</b>	<b>\$ 3,657</b>	<b>\$ 919</b>	<b>\$ 736</b>	<b>\$ 998</b>	<b>\$ 174</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 18,896</b>



**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Student Employee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2009 Incurred**

Month Paid	Month Incurred												Total	
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09		
Jan-09	\$ 2,483													\$ 2,483
Feb-09	\$ 6,576	\$ 4,536												\$ 11,112
Mar-09	\$ 23,374	\$ 15,342	\$ 5,453											\$ 44,169
Apr-09	\$ 7,236	\$ 6,515	\$ 15,727	\$ 4,824										\$ 34,302
May-09	\$ 806	\$ 587	\$ 2,867	\$ 15,821	\$ 3,233									\$ 23,315
Jun-09	\$ 1,110	\$ 961	\$ 1,621	\$ 12,652	\$ 26,039	\$ 7,697								\$ 50,080
Jul-09	\$ 1,763	\$ 1,958	\$ 1,398	\$ 2,004	\$ 13,592	\$ 17,506	\$ 7,304							\$ 45,524
Aug-09	\$ 754	\$ 530	\$ 144	\$ 544	\$ 996	\$ 2,430	\$ 12,468	\$ 6,068						\$ 23,936
Sep-09	\$ 50	\$ 195	\$ 50	\$ 578	\$ 706	\$ 800	\$ 4,219	\$ 11,726	\$ 4,938					\$ 23,262
Oct-09		\$ 30	\$ 1,373	\$ 185	\$ 389	\$ 2,023	\$ 3,188	\$ 4,457	\$ 20,420	\$ 9,850				\$ 41,914
Nov-09	\$ 890	\$ 115	\$ 230	\$ 446	\$ 467	\$ 585	\$ 850	\$ 1,174	\$ 5,719	\$ 18,378	\$ 9,805			\$ 38,659
Dec-09	\$	\$ (75)	\$	\$ 81	\$ 313	\$ 325	\$ 68	\$ 513	\$ 1,314	\$ 5,816	\$ 25,934	\$ 10,723		\$ 45,012
Jan-10				\$ 250	\$ 840	\$ 505	\$ 470	\$ (112)	\$ 458	\$ 1,712	\$ 5,273	\$ 18,414		\$ 27,810
Feb-10				\$ 401	\$ 231	\$ 272	\$ 380	\$ (58)	\$ 208	\$ 863	\$ (3,516)	\$ 3,643		\$ 2,424
Mar-10				\$	\$ 207	\$	\$ 100	\$	\$ 165	\$ 7,344	\$ 75	\$ 7,566		\$ 15,457
Apr-10				\$ 185	\$ 223	\$ 75	\$ 845	\$ 56	\$ 185	\$ 303	\$ 553	\$ 1,791		\$ 4,216
May-10	\$ (289)				\$ 178									\$ (451)
Jun-10	\$ (775)											\$ 130		\$ (645)
Jul-10					\$ 95		\$ (224)			\$ 191				\$ 62
Aug-10									\$ 5,658					\$ 5,658
Sep-10								\$ -	\$ -			\$ 29		\$ 29
Oct-10		\$ 55		\$ 55	\$ 140									\$ 250
Nov-10														\$ -
Dec-10								\$ 999	\$ 130					\$ 1,129
Jan-11														\$ -
Feb-11														\$ -
Mar-11														\$ -
Apr-11														\$ -
May-11								\$ (336)			\$ (196)			\$ (532)
Jun-11														\$ -
Jul-11														\$ -
Aug-11														\$ -
Sep-11														\$ -
Oct-11														\$ -
Nov-11								\$ 65						\$ 65
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12														\$ -
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 43,978</b>	<b>\$ 30,748</b>	<b>\$ 28,864</b>	<b>\$ 38,028</b>	<b>\$ 47,648</b>	<b>\$ 32,219</b>	<b>\$ 29,668</b>	<b>\$ 24,551</b>	<b>\$ 33,536</b>	<b>\$ 49,775</b>	<b>\$ 37,928</b>	<b>\$ 42,296</b>	<b>\$ 439,240</b>	

**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Student Employee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2010 Incurred**

Month Paid	Month Incurred												Total	
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10		
Jan-10	\$ 9,881													\$ 9,881
Feb-10	\$ 31,802	\$ 10,840												\$ 42,643
Mar-10	\$ 4,415	\$ 32,949	\$ 15,780											\$ 53,144
Apr-10	\$ 2,019	\$ 8,360	\$ 22,627	\$ 12,937										\$ 45,943
May-10	\$ 302	\$ 1,090	\$ 4,375	\$ 22,218	\$ 10,453									\$ 38,439
Jun-10	\$ 1,115	\$ 679	\$ 2,097	\$ 7,117	\$ 20,091	\$ 10,278								\$ 41,377
Jul-10	\$ 50	\$ 692	\$ 1,784	\$ 1,268	\$ 5,281	\$ 18,118	\$ 13,656							\$ 40,848
Aug-10	\$ 220	\$ 295	\$ 504	\$ 1,369	\$ 2,349	\$ 5,562	\$ 40,495	\$ 11,489						\$ 62,283
Sep-10					\$ 655	\$ 2,610	\$ 4,396	\$ 15,731	\$ 12,150					\$ 35,541
Oct-10	\$ 130	\$ 98	\$ 108	\$ (311)	\$ 724	\$ 987	\$ 1,277	\$ 35,943	\$ 26,800	\$ 14,010				\$ 79,766
Nov-10		\$ -	\$ -		\$ (74)	\$ 118	\$ 308	\$ 1,269	\$ 6,284	\$ 29,465	\$ 14,275			\$ 51,645
Dec-10					\$ -	\$ 64	\$ 424	\$ (65)	\$ 23,113	\$ 4,737	\$ 24,526	\$ 15,235		\$ 68,033
Jan-11	\$ 48				\$ 105	\$ 120	\$ 460	\$ 1,587	\$ 2,364	\$ 1,315	\$ 3,826	\$ 21,165		\$ 30,989
Feb-11	\$ 884				\$ -	\$ -	\$ -	\$ -	\$ 334	\$ 818	\$ 1,986	\$ 4,452		\$ 8,474
Mar-11					\$ 29		\$ 90	\$ -	\$ 210	\$ 354	\$ 472	\$ 1,687		\$ 2,842
Apr-11									\$ 244	\$ 375	\$ 356			\$ 975
May-11					\$ 6				\$ -	\$ -	\$ -			\$ 6
Jun-11									\$ 75	\$ 150	\$ 75			\$ 300
Jul-11						\$ (346)	\$ 346	\$ (356)	\$ 340	\$ (50)				\$ (66)
Aug-11									\$ (48)	\$ (96)	\$ 32	\$ 218		\$ 106
Sep-11														\$ -
Oct-11							\$ (133)	\$ -						\$ (133)
Nov-11										\$ 96				\$ 96
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12					\$ (35)									\$ (35)
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 50,866</b>	<b>\$ 55,004</b>	<b>\$ 47,276</b>	<b>\$ 44,599</b>	<b>\$ 39,584</b>	<b>\$ 37,510</b>	<b>\$ 61,319</b>	<b>\$ 65,598</b>	<b>\$ 71,547</b>	<b>\$ 51,018</b>	<b>\$ 45,592</b>	<b>\$ 43,187</b>		<b>\$ 613,098</b>

**NYS Mental Health and Substance Abuse Program  
In-Network Claims Paid - Student Employee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2011 Incurred**

Month Paid	Month Incurred												Total	
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11		
Jan-11	\$ 15,672													\$ 15,672
Feb-11	\$ 21,705	\$ 14,103												\$ 35,808
Mar-11	\$ 9,145	\$ 25,982	\$ 18,237											\$ 53,364
Apr-11	\$ 8,235	\$ 8,129	\$ 31,480	\$ 15,805										\$ 63,649
May-11	\$ 681	\$ 15,078	\$ 6,610	\$ 26,776	\$ 12,297									\$ 61,442
Jun-11	\$ 295	\$ 410	\$ 13,473	\$ 11,601	\$ 26,095	\$ 10,593								\$ 62,467
Jul-11	\$ 56	\$ 535	\$ 1,143	\$ 2,239	\$ 10,096	\$ 29,761	\$ 8,738							\$ 52,568
Aug-11	\$ 133	\$ 303	\$ 323	\$ 849	\$ 16,586	\$ 8,076	\$ 19,794	\$ 10,996						\$ 57,059
Sep-11				\$ (270)	\$ 29,632	\$ 579	\$ 5,862	\$ 19,989	\$ 10,810					\$ 66,602
Oct-11	\$ 406	\$ (315)	\$ 215	\$ (10)	\$ 1,056	\$ 605	\$ 2,220	\$ 6,432	\$ 25,571	\$ 10,832				\$ 47,011
Nov-11			\$ 1,156	\$ 208	\$ 203	\$ 240	\$ 203	\$ 984	\$ 4,921	\$ 33,677	\$ 11,685			\$ 53,277
Dec-11			\$ 75			\$ 565	\$ 6,635	\$ 620	\$ 1,601	\$ 6,552	\$ 25,353	\$ 15,689		\$ 57,090
Jan-12		\$ (50)	\$ (265)		\$ 194	\$ 64	\$ 174		\$ 639	\$ 1,935	\$ 13,566	\$ 22,702		\$ 38,958
Feb-12				\$ 68	\$ 340	\$ 272	\$ 370	\$ 651	\$ 211	\$ 1,184	\$ 3,023	\$ 4,346		\$ 10,465
Mar-12					\$ 28,158	\$ 136		\$	\$ 230	\$ 90	\$ 12,809	\$ 1,905		\$ 43,328
Apr-12	\$ 377		\$ 75	\$ 588	\$ 750	\$ 448	\$ 384	\$ 144	\$ 502	\$ 530	\$ 465	\$ 1,351		\$ 5,614
May-12				\$ 48	\$ 96	\$ 48					\$ 100	\$ 50		\$ 342
Jun-12										\$ 120	\$ (265)			\$ (145)
Jul-12									\$ 225	\$ 455	\$ 225	\$ 494		\$ 1,399
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 56,705</b>	<b>\$ 64,174</b>	<b>\$ 72,521</b>	<b>\$ 57,902</b>	<b>\$ 125,503</b>	<b>\$ 51,387</b>	<b>\$ 44,380</b>	<b>\$ 39,815</b>	<b>\$ 44,710</b>	<b>\$ 55,375</b>	<b>\$ 67,226</b>	<b>\$ 46,272</b>		<b>\$ 725,970</b>



**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2009 Incurred**

Month Paid	Month Incurred												Total	
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09		
Jan-09	\$ 76													\$ 76
Feb-09	\$ 8,685	\$ 1,045												\$ 9,730
Mar-09	\$ 8,395	\$ 13,059	\$ 2,464											\$ 23,918
Apr-09	\$ 5,400	\$ 15,249	\$ 13,557	\$ 2,619										\$ 36,825
May-09	\$ 3,915	\$ 4,564	\$ 3,024	\$ 7,297	\$ 2,363									\$ 21,162
Jun-09	\$ 1,473	\$ 2,436	\$ 12,820	\$ 6,554	\$ 11,485	\$ 1,945								\$ 36,713
Jul-09	\$ (3,504)	\$ (440)	\$ 4,558	\$ 4,232	\$ 4,461	\$ 10,679	\$ 2,790							\$ 22,776
Aug-09	\$ 1,440	\$ 14,197	\$ 1,154	\$ 904	\$ 2,729	\$ 5,272	\$ 7,683	\$ 1,211						\$ 34,589
Sep-09	\$ 4,463	\$ 1,230	\$ 3,250	\$ 845	\$ 853	\$ 2,100	\$ 4,478	\$ 4,554	\$ 1,065					\$ 22,839
Oct-09	\$ (600)	\$ (194)	\$ (276)	\$ 426	\$ 847	\$ 794	\$ 3,781	\$ 3,021	\$ 9,420	\$ 1,761				\$ 18,981
Nov-09	\$ (120)	\$ 56	\$ 200	\$ 400	\$ 588	\$ 1,273	\$ 2,080	\$ 2,231	\$ 6,309	\$ 15,569	\$ 2,546			\$ 31,132
Dec-09	\$ 152	\$ 709	\$ 55	\$ (100)	\$ 180	\$ 900	\$ 895	\$ 444	\$ 2,327	\$ 8,332	\$ 12,591	\$ 3,643		\$ 30,128
Jan-10	\$ 465	\$ 120	\$ 50	\$ 252	\$ 40	\$ 196	\$ 742	\$ 1,748	\$ 1,380	\$ 3,705	\$ 7,938	\$ 14,809		\$ 31,445
Feb-10	\$ 370	\$ 400	\$ 583	\$ 573	\$ 567	\$ 570	\$ 325	\$ 160	\$ 845	\$ 3,060	\$ 9,160	\$ 4,933		\$ 21,547
Mar-10	\$ (14)	\$ 121			\$ 200	\$ 664	\$ 928	\$ 680	\$ 440	\$ 902	\$ 2,328	\$ 4,681		\$ 10,930
Apr-10	\$ (299)			\$ 1,360	\$ 1,499			\$ 1,718	\$ 2,060	\$ 1,760	\$ 387	\$ 828		\$ 9,313
May-10	\$ 12									\$ 180				\$ 192
Jun-10			\$ 240	\$ 60		\$ 480			\$ 90	\$ 90	\$ 210	\$ 600		\$ 1,770
Jul-10	\$ 12			\$ (80)						\$ 270	\$ 42			\$ 244
Aug-10				\$ 27		\$ (180)					\$ 1,601			\$ 1,448
Sep-10										\$ -	\$ -			\$ -
Oct-10												\$ 2,771		\$ 2,771
Nov-10			\$ -	\$ 52										\$ 52
Dec-10			\$ -											\$ -
Jan-11				\$ 468										\$ 468
Feb-11											\$ 120	\$ 100		\$ 220
Mar-11								\$ 1,000						\$ 1,000
Apr-11					\$ 100	\$ 100	\$ 400	\$ 300		\$ 740	\$ 1,680	\$ 3,560		\$ 6,880
May-11										\$ -	\$ -			\$ -
Jun-11														\$ -
Jul-11														\$ -
Aug-11														\$ -
Sep-11														\$ -
Oct-11														\$ -
Nov-11														\$ -
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12														\$ -
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 30,321</b>	<b>\$ 52,551</b>	<b>\$ 41,680</b>	<b>\$ 25,889</b>	<b>\$ 25,912</b>	<b>\$ 24,793</b>	<b>\$ 24,102</b>	<b>\$ 16,067</b>	<b>\$ 24,937</b>	<b>\$ 36,099</b>	<b>\$ 38,831</b>	<b>\$ 35,967</b>		<b>\$ 377,149</b>

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2010 Incurred**

Month Paid	Month Incurred												Total	
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10		
Jan-10	\$ 1,046													\$ 1,046
Feb-10	\$ 9,037	\$ 1,958												\$ 10,995
Mar-10	\$ 6,505	\$ 14,087	\$ 4,690											\$ 25,281
Apr-10	\$ 5,057	\$ 9,466	\$ 20,606	\$ 3,664										\$ 38,793
May-10	\$ 1,404	\$ 4,456	\$ 9,276	\$ 21,588	\$ 2,595									\$ 39,319
Jun-10	\$ 344	\$ 758	\$ 1,635	\$ 8,297	\$ 21,461	\$ 3,485								\$ 35,979
Jul-10	\$ -	\$ 354	\$ 2,407	\$ 3,933	\$ 7,918	\$ 18,029	\$ 3,027							\$ 35,669
Aug-10	\$ 977	\$ 1,076	\$ 922	\$ 1,685	\$ 2,483	\$ 11,333	\$ 17,438	\$ 4,936						\$ 40,849
Sep-10	\$ 340	\$ 1,024	\$ 1,123	\$ 2,093	\$ 1,919	\$ 5,375	\$ 11,105	\$ 17,964	\$ 5,825					\$ 46,768
Oct-10	\$ (340)	\$ (420)	\$ (210)		\$ 216	\$ 3,868	\$ 3,865	\$ 10,608	\$ 19,276	\$ 4,739				\$ 41,601
Nov-10		\$ 760	\$ 1,735	\$ 1,564	\$ 2,234	\$ 1,434	\$ 4,336	\$ 3,232	\$ 7,951	\$ 20,093	\$ 6,683			\$ 50,021
Dec-10				\$ 1,210	\$ 1,680	\$ 1,680	\$ 3,108	\$ 2,108	\$ 4,829	\$ 9,692	\$ 21,791	\$ 5,488		\$ 51,586
Jan-11						\$ 166	\$ 117	\$ 938	\$ 8,605	\$ 1,840	\$ 7,765	\$ 14,405		\$ 33,837
Feb-11	\$ 540	\$ 412		\$ 100	\$ 1,000	\$ 100		\$ 172	\$ 1,462	\$ 3,454	\$ 3,638	\$ 11,046		\$ 21,924
Mar-11	\$ 240	\$ -		\$ 325		\$ 320	\$ 638	\$ 100	\$ 3,942	\$ 760	\$ 3,064	\$ 4,203		\$ 13,592
Apr-11	\$ 184	\$ 336	\$ 176			\$ 240	\$ 475	\$ 765	\$ 1,314	\$ 3,333	\$ 1,292	\$ 3,868		\$ 11,983
May-11	\$ 88	\$ 200	\$ 280	\$ 280	\$ 112		\$ -	\$ -	\$ -	\$ 296	\$ 554	\$ 660		\$ 2,470
Jun-11		\$ 724		\$ 112	\$ 168	\$ 312	\$ 300	\$ 412	\$ 568	\$ 524	\$ 368	\$ 464		\$ 3,952
Jul-11												\$ 156		\$ 156
Aug-11														\$ -
Sep-11			\$ (286)											\$ (286)
Oct-11														\$ -
Nov-11							\$ 50							\$ 50
Dec-11														\$ -
Jan-12														\$ -
Feb-12														\$ -
Mar-12														\$ -
Apr-12														\$ -
May-12														\$ -
Jun-12														\$ -
Jul-12														\$ -
Aug-12														\$ -
Sep-12														\$ -
<b>Total</b>	<b>\$ 25,421</b>	<b>\$ 35,190</b>	<b>\$ 42,354</b>	<b>\$ 44,851</b>	<b>\$ 41,787</b>	<b>\$ 46,342</b>	<b>\$ 44,459</b>	<b>\$ 41,235</b>	<b>\$ 53,773</b>	<b>\$ 44,731</b>	<b>\$ 45,154</b>	<b>\$ 40,290</b>		<b>\$ 505,585</b>

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2011 Incurred**

Month Paid	Month Incurred												Total	
	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11		
Jan-11	\$ 836													\$ 836
Feb-11	\$ 15,075	\$ 2,860												\$ 17,935
Mar-11	\$ 11,522	\$ 21,049	\$ 4,283											\$ 36,855
Apr-11	\$ 4,640.80	\$ 9,511	\$ 25,568	2958.8										\$ 42,679
May-11	\$ 2,097	\$ 4,626	\$ 10,018	\$ 14,819	\$ 1,244									\$ 32,804
Jun-11	\$ 1,068	\$ 2,102	\$ 8,193	\$ 11,637	\$ 24,434	\$ 2,364								\$ 49,798
Jul-11	\$ 1,504	\$ 533	\$ 2,139	\$ 7,895	\$ 12,429	\$ 26,968	\$ 2,841							\$ 54,309
Aug-11	\$ 360	\$ 451	\$ 804	\$ 4,232	\$ 8,915	\$ 18,391	\$ 29,359	\$ 7,534						\$ 70,046
Sep-11	\$ 949	\$ 1,515	\$ 601	\$ 1,016	\$ 3,545	\$ 1,179	\$ 4,388	\$ 10,109	\$ 5,497					\$ 28,801
Oct-11	\$ -	\$ 200	\$ 632	\$ 1,456	\$ 2,262	\$ 2,942	\$ 6,524	\$ 8,611	\$ 29,351	\$ 6,835				\$ 58,813
Nov-11	\$ 256	\$ 192	\$ 1,248	\$ 484	\$ 692	\$ 1,372	\$ 4,090	\$ 2,498	\$ 14,571	\$ 35,369	\$ 7,392			\$ 68,164
Dec-11	\$ 1,800	\$ 564	\$ 897	\$ 1,792	\$ 944	\$ 2,720	\$ 1,079	\$ 1,152	\$ 15,950	\$ 50,494	\$ 33,631	\$ 6,667.68		\$ 117,691
Jan-12	\$ 300	\$ 200	\$ 300	\$ 508	\$ 500	\$ 866	\$ 1,440	\$ 1,220	\$ 7,245	\$ 6,970	\$ 10,615	\$ 21,344.00		\$ 51,509
Feb-12					\$ 560	\$ 560		\$ 200	\$ 1,128	\$ 2,393	\$ 4,882	\$ 16,103.44		\$ 25,826
Mar-12		\$ 464	\$ 528	\$ 1,004	\$ 1,160	\$ 348	\$ 708	\$ 364	\$ 1,668	\$ 1,236	\$ 3,345	\$ 5,418.84		\$ 16,244
Apr-12		\$ 150			\$ 450	\$ 936	\$ 879	\$ 879	\$ 2,336	\$ 7,176	\$ 1,302	\$ 1,402.00		\$ 15,510
May-12				\$ (144)	\$ 104		\$ 104	\$ 124	\$ 104	\$ 532	\$ 979	\$ 1,724.40		\$ 3,527
Jun-12				\$ 300	\$ 150					\$ 450				\$ 900
Jul-12						\$ 960	\$ 720	\$ 960	\$ 240	\$ 809		\$ (174.00)		\$ 3,515
Aug-12														\$ -
Sep-12										\$ 260	\$ 260	\$ 390.00		\$ 910
<b>Total</b>	<b>\$ 40,409</b>	<b>\$ 44,417</b>	<b>\$ 55,212</b>	<b>\$ 47,958</b>	<b>\$ 57,388</b>	<b>\$ 59,608</b>	<b>\$ 52,133</b>	<b>\$ 33,652</b>	<b>\$ 78,089</b>	<b>\$ 112,524</b>	<b>\$ 62,407</b>	<b>\$ 52,876</b>	<b>\$ 696,673</b>	

**NYS Mental Health and Substance Abuse Program  
Out-of-Network Claims Paid - Student Enrollee Health Plan (SEHP)  
Paid Through September 30, 2012**

**2012 Incurred**

Month Paid	Month Incurred												Total	
	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12		
Jan-12	\$ 5,986													\$ 5,986
Feb-12	\$ 29,517	\$ 6,264												\$ 35,781
Mar-12	\$ 11,306	\$ 37,783	\$ 9,936											\$ 59,025
Apr-12	\$ 4,067	\$ 10,460	\$ 31,268	\$ 8,194										\$ 53,989
May-12	\$ 1,091	\$ 4,080	\$ 16,976	\$ 35,539	\$ 8,653									\$ 66,338
Jun-12	\$ 2,092	\$ 3,919	\$ 6,175	\$ 10,485	\$ 32,452	\$ 7,227								\$ 62,349
Jul-12	\$ 470	\$ 3,385	\$ 3,806	\$ 9,342	\$ 14,693	\$ 20,788	\$ 4,355							\$ 56,839
Aug-12	\$ 1,200	\$ 1,440	\$ 2,502	\$ 1,870	\$ 8,344	\$ 17,229	\$ 27,087	\$ 6,162						\$ 65,835
Sep-12	\$ 620		\$ 150	\$ 360	\$ 1,912	\$ 3,778	\$ 7,610	\$ 17,117	\$ 4,790					\$ 36,337
<b>Total</b>	<b>\$ 56,348</b>	<b>\$ 67,330</b>	<b>\$ 70,813</b>	<b>\$ 65,790</b>	<b>\$ 66,054</b>	<b>\$ 49,022</b>	<b>\$ 39,052</b>	<b>\$ 23,279</b>	<b>\$ 4,790</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 442,478</b>



**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Mapping Notes
										Min	Max		
ISA		Interchange Header		ISA		<b>Interchange Control Header</b>			Required			Identifies an interchange of functional groups and interchange control data.	ISA*00* *00* *30*141788609*30*123456789*000309*1356*U*00401*000000001*1*P*:-
					ISA01	Author Info Qualifier	Author Information Qualifier		M	2	2	00 = No Authorization Information Present 03 = Additional Data Identification	Set to 00 (zero zero)
					ISA02	Author Information	Authorization Information		M	10	10		n/a
					ISA03	Security Info Qual	Security Information Qualifier		M	2	2	00 = No Security Information Present 01 = Password	Set to 00 (zero zero)
					ISA04	Security Information	Security Information		M	10	10		n/a
					ISA05	Interchange Id Qual	Interchange Id Qualifier		M	2	2	01 = Duns Number 14 = Duns Plus Prefix 20 = Health Industry Number 27 = Carrier Identification Num 28 = FIIN Number 29 = Medicare Provider Num 30 = Federal Tax Id Num 33 = NAIC Company Code ZZ = Mutually Defined	Set to 30
					ISA06	Interchange Sender Id	Interchange Sender Id		M	15	15		Set to 146013200
					ISA07	Interchange ID Qual	Interchange Id Qualifier		M	2	2	01 = Duns Number 14 = Duns Plus Prefix 20 = Health Industry Number 27 = Carrier Identification Num 28 = FIIN Number 29 = Medicare Provider Num 30 = Federal Tax Id Num 33 = NAIC Company Code ZZ = Mutually Defined	Set to 30
					ISA08	Interchange Receiver Id	Interchange Receiver Id		M	15	15	In absence of a value from the Carrier, defaulted to the Benefit Plan Name.	Set to Trading partner ID
					ISA09	Interchange Date	Interchange Date		M	8	8	CCYYMMDD	System generated. Format: yymmdd
					ISA10	Interchange Time	Interchange Time		M	4	4	HHMM	System generated. Format: hhmm
					ISA11	Inter Ctrl Stand Ident	Interchange Control Standards Identifier		M	1	1	U = US EDI ASC X12, TDCC, and USC	Set to U
					ISA12	Inter Ctrl Version Num	Interchange Control Version Number		M	5	5		Set to 00501
					ISA13	Inter Ctrl Number	Interchange Control Number		M	9	9		System generated
					ISA14	Ack Requested	Acknowledgement Requested		M	1	1	0 = No Acknowledgement Requested 1 = Acknowledgement Requested	Set to 1
					ISA15	Test Indicator	Test Indicator		M	1	1	P = Production Data T = Test Data	set to P
					ISA16	Component Elem Sepera	Component Element Separator		M	1	1		Set to :

<b>Functional Group Header</b>													
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Mapping Notes
										Min	Max		
GS		Group Header		GS		<b>Functional Group Header</b>			Required			Identifies the start of a functional group and provides control data.	GS*BE*146013200*123456789*20031009*1700*1*X*004010X095A1~
					GS01	Functional ID Code	Functional Identifier Code		M	2	2	BE = Benefit Enrollment and Maintenance (834)	Set to BE
					GS02	Application Send's Code	Application Sender's Code		M	2	15		Set to 146013200
					GS03	Application Rec's Code	Application Receiver's Code		M	2	15		By agreement between partners
					GS04	Date	Date		M	8	8	CCYYMMDD	System generated. Format: ccyymmdd
					GS05	Time	Time		M	4	8	Can be HHMM, HHMMSS, HHMMSSD, or HHMMSSDD (D = decimal seconds)	System generated. Format: hhmm
					GS06	Group Ctrl Number	Group Control Number		M	1	9		System generated.
					GS07	Responsible Agency Code	Responsible Agency Code		M	1	2		Set to X
					GS08	Ver/Release ID Code	Version/Release/Industry Identifier Code		M	1	12		Set to 005010X220A1

EDI 834 Transaction Set File Layout													
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Mapping Notes
										Min	Max		
<b>Functional Group Trailer</b>													
GE	Trailer			GE		<b>Functional Group Trailer</b>			Required			Indicates the end of a functional group and provides control information	GE*6542*1~
					GE01	Number of TS Included	Number of Transactions Sets Included	M	1	6		Total number of transaction sets in the functional group or interchange group	System generated.
					GE02	Group Ctrl Number	Group Control Number	M	1	9		Unique control number .	System generated.
<b>Interchange Control Trailer</b>													
IEA	Trailer			IEA		<b>Interchange Control Trailer</b>			Required			Indicates the end of an interchange functional groups and related control segments	IEA*1*00000001~
					IEA01	Num of Inc Funct Group	Number of Included Functional Groups	M	1	5		The number of functional groups included in the interchange	System generated.
					IEA02	Inter Ctrl Number	Interchange Control Number	M	9	9		An assigned control number .	System generated.

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
<b>Header</b>													
ST	Header	Header	010	ST		<b>Transaction Set Header</b>			Required			Indicates start of transaction set and assigns control number.	ST*834*6 ~
834					ST01	TS ID Code	Transaction Set Identifier Code		M	3	3	Code to identify transaction set type. Set benefit enrollment transaction set to 834.	Set to 834.
					ST02	TS Control Number	Transaction Set Control Number		M	4	9	Unique control number.	The transaction set control numbers in ST02 and SE02 must be identical. Assign starting with 0001 and increment forward. Control numbers are unique within a specific functional group but can repeat in other groups and interchanges.
					ST03	Implementation Convention Reference	Implementation Convention Reference		M	1	35	Reference assigned to identify Implementation Convention	Set to 005010X220A1.  This field contains the same value as GS08.
<b>BGN</b>													
BGN	Header	Header	020	BGN		<b>Beginning Segment</b>			Required			Indicates the beginning of a transaction set.	BGN*00*000000000000196*20000309*1356****2~
					BGN01	TS Purpose Code	Transaction Set Purpose Code		M	2	2	00 = Original. First time transaction sent 15 = Resubmission. Corrected transaction, original not yet processed by receiver. 22 = Information Copy. Same as original transmission.	Default to '00'
					BGN02	Reference Ident	Reference Identification Transaction Set Identifier Code		M	1	30	Unique control number.	Set to a unique identifying reference number.
					BGN03	Date	Date Transaction Set Creation Date		M	8	8	CCYYMMDD	System generated. Set to 8 positions. Format: ccyyymmdd
					BGN04	Time	Time Transaction Set Creation Time		M	4	8	Can be HHMM, HHMMSS, HHMMSSD, or HHMMSSDD (D = decimal seconds)	System generated. Format: hhmmss
					BGN05	Time Code	Time Code Time Zone Code		S	2	2	CD Central Daylight Time,CS Central Standard Time,CT Central Time,ED Eastern Daylight Time,ES Eastern Standard Time,ET Eastern Time,MD Mountain Daylight Time,MS Mountain Standard Time,MT Mountain Time,PT Pacific Time. If BGN05 , then BGN04 is required.	Optional. Not used.
					BGN06	Reference Ident	Reference Identification Transaction Set Identifier Code		O	1	30	If BGN01 = 15 or 22, then cross reference Reference Ident of the original transaction.	Optional. If 00 then not used. If 15 or 22 then write original transaction ref id number.
					BGN07	Transaction Type Code - Not Used			n/a	2	2		n/a
					BGN08	Action Code	Reference Identification Transaction Set Identifier Code		M	1	2	2 = Change (Update) - Identifies transactions for additions, terminations and changes to current enrollment 4 = Verify - Identifies system compare or verify partner's systems	Required Default = 2
<b>REF</b>													
REF	Header	Header	030	REF		<b>Transaction Set Policy Number</b>			Situational			Segment is used if a unique ID number applies to the entire transaction set.	REF*38*0000~
38					REF01	Reference Ident Qual	Reference Identification Qualifier		M	2	3	38 = Master policy number code.	Set to 38.
					REF02	Reference Ident	Reference Identification Master Policy Number		X	1	30	Master Policy Number. At least one REF02 is required.	Set to master policy number. Value to be supplied by Carrier Default =00000
<b>DTP</b>													
DTP	Header	Header	040	DTP		<b>File Effective Date</b>			Situational				Carrier information requirement can adequately be satisfied without it. Data element is not used.

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	007 = Effective 303 = Maintenance Effective 382 = Enrollment 388 = Payment Commencement	Not used
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Not used
					DTP03		Date Time Period	Date Time Period	M	1	35		Not used

1000A Sponsor Name													
N1	Header	1000A Sponsor Name	070	N1		Sponsor Name			Required			Identifies the organization paying for the coverage by type, name, and code. At least one N102 or N103 is required.	N1*P5*NEW YORK STATE*FI*141788609~
P5					N101	Entity ID Code	Entity Identifier Code		M	2	3	P5 = Plan Sponsor.	Set to P5.
					N102	Name			X	1	0	NEW YORK STATE	NEW YORK STATE
					N103	ID Code Qualifier	Entity Identifier Code		X	1	2	FI = Federal Taxpayers Identification Number. ZZ = Mutually Defined (HIPAA Id) If N104 present then required.	Set to FI = Federal Taxpayers Identification Number. Once National Payer ID is mandated, then use ZZ.
					N104	ID Code	Identification Code Sponsor Identifier		X	2	80	Sponsor Identifier. If N103 present then required.	Set to 146013200

1000B Payer Name													
N1	Header	1000B Payer Name	070	N1		Payer Name			Required			Identifies the insurance company (receiver) type, name, and code. At least one N102 or N103 is required.	N1*IN**FI*123456789~
IN					N101	Entity ID Code	Entity Identifier Code		M	2	3	IN = Insurer.	Set to IN.
					N102	Name			n/a	1	60	Not used.	Set to placeholder.
					N103	ID Code Qualifier	Entity Identifier Code		X	1	2	FI = Federal Taxpayers Identification Number. XV = Health Care Financing Administration National Payer Identification. If N104 present then required.	FI = Federal Taxpayers Identification Number. XV = Health Care Financing Administration National Payer Identification. Once National Payer ID is mandated, then use only XV
					N104	ID Code	Identification Code Insurer Identification Code		X	2	80	Insurer identification code. If N103 present then required.	Data not captured by a PS field. Value to be supplied by carrier.

1000C Broker Name													
N1	Header	1000C Broker Name	70	N1		TPA/Broker Name			Situational			Identifies TPA/broker organization by type, name, and code. At least one N102 or N103 is required.	Segment does not apply.
n/a					N101	Entity ID Code	Entity Identifier Code		M	2	3	BO = Broker TV = Third party admin	n/a
Not used					N102	Name - Not Used			n/a	1	60	Not used.	n/a
n/a					N103	ID Code Qualifier	Entity Identifier Code		X	1	2	94 = Code assigned by receiving organization FI = Federal Taxpayers Identification Number. XV = Health Care Financing Administration National Payer Identification. If N104 present then required.	n/a
n/a					N104	ID Code	Identification Code TPA or Broker Identification		X	2	80	TPA or Broker Identification code. If N103 present then required.	n/a

1100C Broker Account													
ACT	Header	1100C Broker Account	120	ACT		TPA/Broker Account Information			Situational			Specifies account information if different than account number of sponsor.	Segment does not apply.
n/a					ACT01	Account Number	TPA or Broker Account Number		M	1	35	Account number assigned.	n/a
Not used					ACT02	Name - Not Used			n/a	1	60		n/a
Not used					ACT03	ID Code Qual - Not Used			n/a	1	2		n/a
Not used					ACT04	ID Code - Not Used			n/a	2	80		n/a
Not used					ACT05	Acct Num Qual-Not Used			n/a	1	3		n/a
n/a					ACT06	Account Number			X	1	35	Account number - more than one account number applies to this transaction.	n/a

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
INS	Detail	2000 Member Detail	010	INS		<b>Member Level Detail</b>			Optional			Provides insured benefit information for subscriber and dependents. Subscriber information must precede dependent information or have been submitted in a previous transmission.	INS*Y*18*021**A*E**FT**N~
					INS01	Yes/No Cond Resp Code	Yes/No Condition or Response Code Subscriber Indicator		M	1	1	N = No Status of Insured is dependent. Y = Yes Status of insured is subscriber.	N = No Status of Insured is dependent. Y = Yes Status of insured is subscriber.
					INS02	Individual Relat Code	Individual Relationship Code		M	2	2	01 = Spouse 18 = Self 19 = Child 25 = Ex-spouse 53 = Life partner 38 = Collateral dependent	Set SP = 01 Set subscriber = 18 Set S and D = 19 Set X = 25 Set DP = 53 Set O = 38
					INS03	Maintenance Type Code	Maintenance Type Code		O	3	3	001 = Change 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or compare	001 = Change 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or compare
					INS04	Maintain Reason Code	Maintenance Reason Code		O	2	3	01 = Divorce 02 = Birth 03 = Death 04 = Retirement 05 = Adoption 06 = Strike 07 = Termination of Benefits 08 = Termination of Employment 09 = COBRA 10 = COBRA Premium Paid 11 = Surviving Spouse 14 = Voluntary Withdrawal 15 = Primary Care Provider Change 16 = Quit 17 = Fired 18 = Suspended 20 = Active 21 = Disability 22 = Plan Change 25 = Change in Identifying Data Elements 26 = Declined Coverage 27 = Pre-Enrollment 28 = Initial Enrollment 29 = Benefit Selection 31 = Legal Separation 32 = Marriage 33 = Personnel Data 37 = Leave of Absence with Benefits 38 = Leave of Absence without Benefits 39 = Lay Off with Benefits 40 = Lay Off without Benefits 41 = Re-enrollment 43 = Change of Location XN = Notification Only XT = Transfer	Use of this segment is limited to identify a change in Benefit Program and Termination Reason for Conversion of Coverage.  Set Termination of Benefits = 07 Set Termination of Employment = 08 Set change in Benefit Program = 22 Set Plan Change = 22 Set Alternate Identifier Change = 25 Set Initial Enrollment = 28 Set Re-enrollment = 41
					INS05	Benefit Status Code	Benefit Status Code		O	1	1	Type coverage for which benefits paid A= Active  C = Cobra  S = Surviving Insured  T = Tax equity and fiscal responsibility act	Type of Set default to 'A' unless termination, Cobra or surviving spouse  Valid values are 'A', 'C', and 'S'  TEFRA is a medical assistance program for families with children with disabilities. Eligibility is determined based on medical and level of care criteria.

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
					INS06		Medicare Plan Code	Medicare Plan Code	O	1	1	A = Medicare Part A B = Medicare Part B C = Medicare Part A and B D = Medicare E = No Medicare	Currently only track Medicare Part B  Valid values are 'B' and 'E'
					INS07		Cobra Qual Event Code	Cobra Qualifying Event Code	O	1	2	1 = Termination of Employment 2 = Reduction of work hours 3 = Medicare 4 = Death 5 = Divorce 6 = Separation 7 = Ineligible Child 8 = Bankruptcy of a Retired Employee	1 = Termination of Employment 2 = Reduction of work hours 3 = Medicare 4 = Death 5 = Divorce 6 = Separation 7 = Ineligible Child 8 = Bankruptcy of a Retired Employee
					INS08		Employment Status Code	Employment Status Code	O	2	2	If enrollment is in a non employment based program such as medicare, then use status of subscriber in that program. AO = Active Military - Overseas AU = Active Military - USA FT = Full Time Active L1 = Leave of Absence PT = Part Time Active RT = Retired TE = Terminated	Subscriber only  Valid values are: FT PT TE RT L1
					INS09		Student Status Code	Student Status Code	O	1	1	F = Full-time N = Not a student P = Part-time	F = Full-time N = Not a student
					INS10		Yes/No Cond Resp Code	Yes/No Condition or Response Code Handicap Indicator	O	1	1	Handicap indicator: N = no Y = yes	For dependent only
D8					INS11		Date Time Format Qual	Date Time Period Format Qualifier	X	2	3	D8 = Date expressed in CCYYMMDD If INS12 present then required.	Set to D8
					INS12		Date Time Period	Date Time Period Insured Individual Death Date	X	1	35	Date of Death If INS11 present then required.	Dependent date of death not captured on the database
Not used					INS13		Confidentiality - Not Used		n/a			Not used.	Set to placeholder.
Not used					INS14		City Name - Not Used		n/a			Not used.	Set to placeholder.
Not used					INS15		State Code - Not Used		n/a			Not used.	Set to placeholder.
Not used					INS16		Country Code - Not Used		n/a			Not used.	Set to placeholder.
					INS17		Number	Number	O	1	9	Not available	Not a PeopleSoft delivered database element. Data for this element is not available.

REF	Detail	2000 Member Detail	020	REF	Subscriber Number		Required			Specifies identifying information. Segment contains a unique <b>SUBSCRIBER</b> Id Number (SSN or other) This occurrence identified by the OF qualifier. Identifier is used in order to link subscriber with dependents.	REF*0F*123456789~
OF				REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3	OF = Subscriber Number.	Set to 0F (zero f ).
				REF02	Reference Ident	Reference Identification Subscriber Identifier	X	1	30	At least one REF02 is required.	Social security number should be used until the National identifier is available.

REF	Detail	2000 Member Detail	020	REF	Member Policy Number		Situational			Specifies identifying information. Segment is used if group number applies to all coverage data for the member.	REF*1L*NYSLWOP~
				REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3	1L = Group or Policy Number	Set to 1L.
				REF02	Reference Ident	Reference Identification Insured Group or Policy Number	X	1	30	At least one REF02 is required	Join Company and Ben_Status Valid Company Values: PA ,PE ,NYS, MTH Valid Benefit Statuses: DISP,FAML,IMIL,LPTA,LTDS,LWOP, MILL,PRFL,STDS,WCDF,WCLV, WCMC,WCLR, RTNA. If 'CBL' then = '0030666'

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
REF	Detail	2000 Member Detail	020	REF		Member Identification Number			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*23*891234567~
					REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3		23 = Client Number	Set to 23
					REF02	Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30		Subscriber Supplemental Identifier. At least one REF02 is required.	Bea_Altid
REF	Detail	2000 Member Detail	020	REF		Member Identification Number			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*DX*00001~
					REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3		DX = Department/Agency Number	Set to DX
					REF02	Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30		Subscriber Supplemental Identifier. At least one REF02 is required.	Cust_Id If 'HIP' and CUSTID = '00001' then map DEPTID If 'UHG' and txn for dep then add dep # to end of CUSTID field
REF	Detail	2000 Member Detail	020	REF		Member Identification Number			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*F6*123456789A~
					REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3		F6 = Health Insurance Claim(HIC) Number	Set to F6
					REF02	Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30		Subscriber Supplemental Identifier. At least one REF02 is required.	Health Insurance Claim(HIC) Number
REF	Detail	2000 Member Detail	020	REF		Member Identification Number			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*Q4*999999999~
					REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3		Q4 = Prior Identification Number	Set to Q4
					REF02	Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30		Subscriber Supplemental Identifier. At least one REF02 is required.	Previous Subscriber SSN covered under.
REF	Detail	2000 Member Detail	020	REF		Member Identification Number			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*60*999999999~
					REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3		60 = Cross Reference Number	Set to 60
					REF02	Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30		Subscriber Supplemental Identifier. At least one REF02 is required.	This number is used to tie the Surviving Insured back to the original Subscriber ID.
REF	Detail	2000 Member Detail	020	REF		Member Identification Number			Situational			Specifies identifying information. Segment is used to send additional member information.	REF*ZZ*E~
					REF01	Reference Ident Qual	Reference Identification Qualifier	M	2	3		ZZ = Mutually Defined	Set to ZZ
					REF02	Reference Ident	Reference Identification Subscriber Supplemental Identifier	X	1	30		Subscriber Supplemental Identifier. At least one REF02 is required.	Valid values are: 'E' = Employee Rate 'T' = Total Rate
DTP	Detail	2000 Member Detail	025	DTP		Member Level Dates			Situational			Specifies date, time, and time period for member enrollment and benefit changes.	DTP*336*D8*20000207~

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	286 = Retirement 296 = Return to Work 297 = Date Last Worked 300 = Enrollment Signature Date 301 = Cobra Qualifying Event 303 = Maintenance Effective 336 = Employment Begin 337 = Employment End 338 = Medicare Begin 339 = Medicare End 340 = Cobra Begin 341 = Cobra End 350 = Education Begin 351 = Education End 356 = Eligibility Begin 357 = Eligibility End 383 = Adjusted Hire 393 = Plan Participation Suspension 394 = Rehire 473 = Medicaid Begin 474 = Medicaid End	Valid values are: 303 = Maintenance Effective 336 = Employment Begin 338 = Medicare Begin 339 = Medicare End
DTP	Detail	2000 Member Detail	025	DTP		<b>Member Level Dates</b>			Situational			Specifies date, time, and time period for member enrollment and benefit changes.	DTP*336*D8*20000207~
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	286 = Retirement 296 = Return to Work 297 = Date Last Worked 300 = Enrollment Signature Date 301 = Cobra Qualifying Event 303 = Maintenance Effective 336 = Employment Begin 337 = Employment End 338 = Medicare Begin 339 = Medicare End 340 = Cobra Begin 341 = Cobra End 350 = Education Begin 351 = Education End 356 = Eligibility Begin 357 = Eligibility End 383 = Adjusted Hire 393 = Plan Participation Suspension 394 = Rehire 473 = Medicaid Begin 474 = Medicaid End	Valid values are: 303 = Maintenance Effective 336 = Employment Begin 338 = Medicare Begin 339 = Medicare End
					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8
					DTP03		Date Time Period	Date Time Period Status Information Effective Date	M	1	35		Effective Date



EDI 834 Transaction Set File Layout													
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
NM1	Detail	2100A	030	NM1		<b>Member Name</b>			Required			Segment identifies member being enrolled, changed, or corrected.	NM1*IL*1*SMITH*JOHN*M**SR*34*123456789~
							Entity ID Code	Entity Identifier Code	M	2	3	74 = Transmission is correcting the identifier information on a member already enrolled. Usage of this code requires the sending of an NM1 with code '70' in loop 2100B. IL = Enrollment of a new member or update of a member with no change in identifying information. The identifying information for a member is specified under the insurance contract between the sponsor and payer.	Set to 74 if changing existing identifying information.  Set to IL for new enrollment or change not related to identifying information.
1							Entity Type Qualifier	Entity Type Qualifier	M	1	1	1 = Person.	Set to 1.
							Name Last/ Org Name	Name Last or Organization Name Subscriber Last Name	O	1	35		Member Last Name
							Name First	Name First Subscriber First Name	O	1	25		Member First Name
							Name Middle	Name Middle Subscriber Middle Name	O	1	25		Member Middle Name
							Name Prefix - Not Used						Not used
							Name Suffix	Name Suffix Subscriber Name Suffix	O	1	10		Member Name Suffix
							ID Code Qualifier		X	1	2	34 = Social security number. <b>ZZ = Mutually defined</b> Use of NM109 is required with NM108.	For BCBS,CBL,ESI, set to ZZ. All other carriers, set to 34 If value is invalid ssn then set to ZZ
							ID Code	Identification Code Subscriber Identifier	X	2	80	Use of NM108 is required with NM109.	For BCBS, CBL,ESI set to ssn + dependent_benef. All other carriers set to ssn until the National identifier is available

PER	Detail	2100A	040	PER		<b>Member Communications Numbers</b>			Situational			Identifies where administrative communication should be sent.	PER*IP**TE*518/229-0457~
IP							Contact Funct Code	Contact Function Code	M	2	2	IP = Insured Party	Set to IP
									n/a	1	60	Name - Not Used.	Set to placeholder.
TE							Comm Number Qual	Communication Number Qualifier	X	2	2	EM = Electronic Mail EX = Telephone Extension FX = Facsimile HP = Home Phone Number TE = Telephone WP = Work Phone Number If PER04 present then required.	Set to TE (if available)
							Comm Number	Communication Number	X	1	80	If PER03 present then required.	Format: 9999999999
TE							Comm Number Qual	Communication Number Qualifier	X	2	2	EM = Electronic Mail EX = Telephone Extension FX = Facsimile HP = Home Phone Number TE = Telephone WP = Work Phone Number If PER06 present then required.	Not used
							Comm Number	Communication Number	X	1	80	If PER05 present then required.	Not used
							Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	Not used
							Comm Number	Communication Number	X	1	80	If PER07 present then required.	Not used

N3	Detail	2100A	050	N3		<b>Member Residence Strt Addr - DCS use field for Mailing address</b>			Situational			DCS is sending the mailing address for the member. Send for subscriber and dependents.	N3*81 COLUMBIA STREET~
							Address Information	Address Information Subscriber Address Line	M	1	55		Address line 1
							Address Information	Address Information Subscriber Address Line	O	1	55		Address line 2

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
N4	Detail	2100A Member Name	060	N4		<b>Member Residence City, State, ZIP Code - DCS mail address</b>			Situational			Identifies location of member. Send for subscriber and dependents.	N4*ALBANY*NY*122100000*USA*~
					N401	City Name	City Name Subscriber City Name		O	2	30		City Name
					N402	State or Prov Code	State or Province Code Subscriber State Code		O	2	2		State or Prov Code
					N403	Postal Code	Postal Code Subscriber Postal Code		O	3	15		Postal Code
					N404	Country Code	Country Code		O	2	3		Country
CY					N405	Location Qualifier	Location Qualifier		O	1	2	CY = County	Set to CY
					N406	Location Identifier	Location Identifier Location Identification Code (County)		O	1	30	If N406 is present then N405 is required.	County

DMG	Detail	2100A Member Name	080	DMG		<b>Member Demographics</b>			Situational			This segment is required for dependents until the national identifier for individuals is available. Once a national identifier is available, the national identifier should be sent in NM109. If DMG01 or DMG02 is present, then other is required.	DMG*D8*19720310*M*1~
D8					DMG01	Date Time format Qual	Date Time Format Qualifier		X	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DMG02	Date Time Period	Date Time Period Member Birth Date		X	1	35	Date of Birth.	Date of Birth.
					DMG03	Gender Code	Gender Code		O	1	1	F = female M = male U = unknown	F = female M = male U = unknown
					DMG04	Marital Status Code	Marital Status Code		O	1	1	B = Registered Domestic Partner D = Divorced I = Single M = Married R = Unreported S = Separated U = Unmarried(single,divorced,widowed) W = Widowed X = Legally Separated	Set C, Common Law = M Set D, Divorced = D Set E, Separated = S Set H, Head Household = U Set M, Married = M Set S, Single = I Set U, Unknown = R Set W, Widowed = W
					DMG05	Race or Ethnic Code	Race or Ethnic Code		O	1	1		Not Used
					DMG06	Citizen Status Code	Citizen Status Code		O	1	2		Not Used

LUI	Detail	2100A Member Name	150	LUI		<b>Member Language</b>			Situational			Used if member's language is other than english. This data should only be transmitted when required by the insurance contract and allowed by federal and state regulations.	Not used
					LUI01	ID Code Qualifier	Identification Code Qualifier		X	1	2	Use of LUI02 is required with LUI01.	Not used
					LUI02	ID Code	Identification Code Language Code		X	2	80	Use of LUI01 is required with LUI02.	Not used
					LUI03	Description	Description Language Description		X	1	80		Not used
					LUI04	Use of Lang Indica	Use of Language Indicator Language Use Indicator		O	1	2		Not used

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		

<b>2100B Incorrect Member Name</b>													
NM1	Detail	2100B Incorrect Member Name	030	NM1		<b>Incorrect Member Name</b>			Situational			Segment is used only with a corrected name in loop 2100A.	NM1*70*1*SMITH*JON***34*987654321~
70					NM101	Entity ID Code	Entity Identifier Code		M	2	3	70 = Prior Incorrect Insured Use if correcting identifier information on a member already enrolled. Send NM1 with code 74 in loop 2100A.	Set to 70.
1					NM102	Entity Type Qualifier	Entity Type Qualifier		M	1	1	1 = Person	Set to 1
					NM103	Name Last/ Org Name	Name Last or Organization Name Prior Incorrect Insured Last Name		O	1	35		Prior Incorrect Insured Last Name
					NM104	Name First	Name First Prior Incorrect Insured First Name		O	1	25		Prior Incorrect Insured First Name
					NM105	Name Middle	Name Middle Prior Incorrect Insured Middle Name		O	1	25		Prior Incorrect Insured Middle Name
					NM106	Name Prefix	Name Prefix Prior Incorrect Insured Name Prefix		O	1	10		Set to placeholder.
					NM107	Name Suffix	Name Suffix Prior Incorrect Insured Name Suffix		O	1	10		Prior Incorrect Insured Name Suffix
34					NM108	ID Code Qualifier	Identification Code Qualifier		X	1	2	34 = Social security number. ZZ = Mutually Defined Use of NM109 is required with NM108.	For BCBS,CBL,ESI, set to ZZ All other carriers, set to 34
					NM109	ID Code	Identification Code Prior Incorrect Insured Identifier		X	2	80	Use of NM108 is required with NM109.	For BCBS, CBL,ESI set to ssn + dependent_benef. All other carriers set to ssn

DMG	Detail	2100B Incorrect Member Name	080	DMG		<b>Incorrect Member Demographics</b>			Situational			Segment used only if demographic information, such as date of birth is used to identify a member and it is being changed.	DMG*D8*19740311~
D8					DMG01	Date Time Format Qual	Date Time Period Format Qualifier		M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DMG02	Date Time Period	Date Time Period Prior Incorrect Insured Birth Date		X	1	35	Prior incorrect insured birth date. Use of DMG01 is required with DMG02.	Prior Incorrect Insured Birth Date
					DMG03	Gender Code	Gender Code		O	1	1	F = female M = male U = unknown	F = female M = male U = unknown

<b>2100C Member Address - DCS using for residence address</b>													
NM1	Detail	2100C Member Address	030	NM1		<b>Member Mailing Address - DCS use field for residence address</b>			Situational			DCS is sending the residence address when the mailing address is a PO Box address in loop 2100A.	NM1*31*1~
31					NM101	Entity ID Code	Entity Identifier Code		M	2	3	31 = Postal Mailing Address	Set to 31
1					NM102	Entity Type Qualifier	Entity Type Qualifier		M	1	1	1 = Person	Set to 1

N3	Detail	2100C Member Address	050	N3		<b>Member Mail Street Addr - DCS use field for residence address</b>			Situational			DCS is sending the residence address when the mailing address is a PO Box address in loop 2100A.	N3*Street 1~
					N301	Address Information	Address Information Subscriber Address Line		M	1	55		Address Information
					N302	Address Information	Address Information Subscriber Address Line		O	1	55		Address Information

N4	Detail	2100C Member Address	060	N4		<b>Member Mail City, State, Zip</b>			Situational			This loop is sent if the member has a different mailing address from the residence address in loop 2100A.	N4*ALBANY*NY*122100000*USA*~
					N401	City Name	City Name Subscriber City Name		O	2	30		City Name
					N402	State or Prov Code	State or Province Code Subscriber State Code		O	2	2		State or Prov Code
					N403	Postal Code	Postal Code Subscriber Postal Code		O	3	15		Postal Code
					N404	Country Code	Country Code		O	2	3		Country Code
Not Used					N405	Location Qualifier-not used			n/a				Not Used
Not Used					N406	Location Identifier-not used			n/a				Not Used

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
<b>2100D Member Employer</b>													
NM1	Detail	2100D Member Employer	030	NM1		Member Employer			Situational			This loop is to be sent when the member is employed by someone other than the sponsor and the insurance contract requires the payer be notified of such employment.	Segment does not apply.
						NM101	Entity ID Code	Entity Identifier Code	M	2	3		n/a
						NM102	Entity Type Qualifier	Entity Type Qualifier	M	1	1		n/a
						NM103	Name Last/ Org Name	Name Last or Organization Name Insured Employer Name	O	1	35		n/a
						NM104	Name First	Name First Insured Employer First Name	O	1	25		n/a
						NM105	Name Middle	Name Middle Insured Employer Middle Name	O	1	25		n/a
						NM106	Name Prefix	Name Prefix Insured Employer Name Prefix	O	1	10		n/a
						NM107	Name Suffix	Name Suffix Insured Employer Name Suffix	O	1	10		n/a
						NM108	ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of NM109 is required with NM108.	n/a
						NM109	ID Code	Identification Code Insured Employer Identifier	X	2	80	Use of NM108 is required with NM109.	n/a
<b>2100D Member Employer Communications Numbers</b>													
PER	Detail	2100D Member Employer	040	PER		Member Employer Communications Numbers			Situational			When employer is applicable, segment identifies to whom administrative communications should be sent.	Segment does not apply.
						PER01	Contact Funct Code	Contact Function Code	M	2	2		n/a
						PER02	Name - Not Used		n/a	1	60	Name - Not Used.	n/a
						PER03	Comm Number Qual	Communication Number Qualifier	X	2	2	If PER04 present then required.	n/a
						PER04	Comm Number	Communication Number	X	1	80	If PER03 present then required.	n/a
						PER05	Comm Number Qual	Communication Number Qualifier	X	2	2	If PER06 present then required.	n/a
						PER06	Comm Number	Communication Number	X	1	80	If PER05 present then required.	n/a
						PER07	Comm Number Qual	Communication Number Qualifier	X	2	2	If PER08 present then required.	n/a
						PER08	Comm Number	Communication Number	X	1	80	If PER07 present then required.	n/a
<b>2100D Member Street Address</b>													
N3	Detail	2100D Member	050	N3		Member Employer Street Address			Situational			When employer is applicable, segment identifies employer address.	Segment does not apply.
						N301	Address Information	Address Information	M	1	55		n/a
						N302	Address Information	Address Information	O	1	55		n/a
<b>2100D Member City, State, Zip</b>													
N4	Detail	2100D Member Employer	060	N4		Member Employer City, State, Zip			Situational			When employer is applicable, segment identifies employer address.	Segment does not apply.
						N401	City Name	City Name	O	2	30		n/a
						N402	State or Prov Code	State or Province Code	O	2	2		n/a
						N403	Postal Code	Postal Code	O	3	15		n/a
						N404	Country Code	Country Code	O	2	3		n/a
						N405	Location Qualifier	Location Qualifier	O	1	2		n/a
						N406	Location Identifier	Location Identifier	O	1	30	If N406 is present then N405 is required.	n/a
<b>2100E Member School</b>													
NM1	Detail	2100E Member School	030	NM1		Member School			Situational			Loop is sent when member is enrolled in school and sponsor is required to notify payer.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
						NM101	Entity ID Code	Entity Identifier Code	M	2	3		Not used
						NM102	Entity Type Qualifier	Entity Type Qualifier	M	1	1		Not used
						NM103	Name Last/ Org Name	Name Last or Organization Name	O	1	35		Not used

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
PER	Detail	2100E Member School	040	PER		<b>Member School Communications Numbers</b>			Situational			When school is applicable, segment identifies to whom administrative communications should be sent.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					PER01	Contact Funct Code	Contact Function Code		M	2	2	SK = School clerk	Not used
					PER02	Name - Not Used			n/a	1	60	Name - Not Used.	Set to placeholder.
					PER03	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER04 present then required.	Not used
					PER04	Comm Number	Communication Number		X	1	80	If PER03 present then required.	Not used
					PER05	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER06 present then required.	Not used
					PER06	Comm Number	Communication Number		X	1	80	If PER05 present then required.	Not used
					PER07	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER08 present then required.	Not used
					PER08	Comm Number	Communication Number		X	1	80	If PER07 present then required.	Not used

N3	Detail	2100E Member School	050	N3		<b>Member School Street Address</b>			Situational			When school is applicable, segment identifies school address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N301	Address Information	Address Information		M	1	55		Not used
					N302	Address Information	Address Information		O	1	55		Not used

N4	Detail	2100E Member School	060	N4		<b>Member School City, State, Zip</b>			Situational			When school is applicable, segment identifies school address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N401	City Name	City Name		O	2	30		Not used
					N402	State or Prov Code	State or Province Code		O	2	2		Not used
					N403	Postal Code	Postal Code		O	3	15		Not used
					N404	Country Code	Country Code		O	2	3		Not used

<b>2100F Custodial Parent</b>													
NM1	Detail	2100F Custodial Parent	030	NM1		<b>Custodial Parent</b>			Situational			Loop is sent when custodial parent of a minor is someone other than the subscriber.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Could customize dependent/beneficiary or dependent/beneficiary comment panels. Customization not recommended.
					NM101	Entity ID Code	Entity Identifier Code		M	2	3		Not used
					NM102	Entity Type Qualifier	Entity Type Qualifier		M	1	1		Not used
					NM103	Name Last/ Org Name	Name Last or Organization Name		O	1	35		Not used
					NM104	Name First	Name First		O	1	25		Not used
					NM105	Name Middle	Name Middle		O	1	25		Not used
					NM106	Name Prefix	Name Prefix		O	1	10		Not used
					NM107	Name Suffix	Name Suffix		O	1	10		Not used
					NM108	ID Code Qualifier	Identification Code Qualifier		X	1	2	Use of NM109 is required with NM108.	Not used
					NM109	ID Code	Identification Code		X	2	80	Use of NM108 is required with NM109.	Not used

PER	Detail	2100F Custodial Parent	040	PER		<b>Custodial Parent Communications Numbers</b>			Situational			When custodial parent is applicable, segment identifies to whom administrative communications should be sent.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					PER01	Contact Funct Code	Contact Function Code		M	2	2		Not used
					PER02	Name - Not Used			n/a	1	60	Name - Not Used.	Not used
					PER03	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER04 present then required.	Not used
					PER04	Comm Number	Communication Number		X	1	80	If PER03 present then required.	Not used
					PER05	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER06 present then required.	Not used
					PER06	Comm Number	Communication Number		X	1	80	If PER05 present then required.	Not used
					PER07	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER08 present then required.	Not used
					PER08	Comm Number	Communication Number		X	1	80	If PER07 present then required.	Not used

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
N3	Detail	2100F Custodial Parent	050	N3		<b>Custodial Parent Street Address</b>			Situational			When custodial parent is applicable, segment identifies custodial address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N301	Address Information	Address Information		M	1	55		Not used
					N302	Address Information	Address Information		O	1	55		Not used
N4	Detail	2100F Custodial Parent	060	N4		<b>Custodial Parent City, State, Zip</b>			Situational			When custodial parent is applicable, segment identifies custodial address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N401	City Name	City Name		O	2	30		Not used
					N402	State or Prov Code	State or Province Code		O	2	2		Not used
					N403	Postal Code	Postal Code		O	3	15		Not used
					N404	Country Code	Country Code		O	2	3		Not used
<b>2100G Responsible Person</b>													
NM1	Detail	2100G Responsible Person	030	NM1		<b>Responsible Person</b>			Situational			Loop identifies person responsible for the member. Responsible person is someone other than the subscriber. Data is intended for coverage programs that are not to be employment related, such as Medicare and Medicaid.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					NM101	Entity ID Code	Entity Identifier Code		M	2	3		Not used
					NM102	Entity Type Qualifier	Entity Type Qualifier		M	1	1		Not used
					NM103	Name Last/ Org Name	Name Last or Organization Name		O	1	35		Not used
					NM104	Name First	Name First		O	1	25		Not used
					NM105	Name Middle	Name Middle		O	1	25		Not used
					NM106	Name Prefix	Name Prefix		O	1	10		Not used
					NM107	Name Suffix	Name Suffix		O	1	10		Not used
					NM108	ID Code Qualifier	Identification Code Qualifier		X	1	2	Use of NM109 is required with NM108.	Not used
					NM109	ID Code	Identification Code		X	2	80	Use of NM108 is required with NM109.	Not used
PER	Detail	2100G Responsible Person	040	PER		<b>Responsible Person Communications Numbers</b>			Situational			When responsible person is applicable, segment identifies to whom administrative communications should be sent.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					PER01	Contact Funct Code	Contact Function Code		M	2	2		Not used
					PER02	Name - Not Used			n/a	1	60	Name - Not Used.	Not used
					PER03	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER04 present then required.	Not used
					PER04	Comm Number	Communication Number		X	1	80	If PER03 present then required.	Not used
					PER05	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER06 present then required.	Not used
					PER06	Comm Number	Communication Number		X	1	80	If PER05 present then required.	Not used
					PER07	Comm Number Qual	Communication Number Qualifier		X	2	2	If PER08 present then required.	Not used
					PER08	Comm Number	Communication Number		X	1	80	If PER07 present then required.	Not used
N3	Detail	2100G Responsible Person	050	N3		<b>Responsible Person Street Address</b>			Situational			When responsible person is applicable, segment identifies responsible address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N301	Address Information	Address Information		M	1	55		Not used
					N302	Address Information	Address Information		O	1	55		Not used
N4	Detail	2100G Responsible Person	060	N4		<b>Responsible Person City, State, Zip</b>			Situational			When responsible person is applicable, segment identifies responsible address.	Not a PeopleSoft delivered database element. Carrier information requirement can adequately be satisfied through the dependent member segments. Segment is not used.
					N401	City Name	City Name		O	2	30		Not used
					N402	State or Prov Code	State or Province Code		O	2	2		Not used
					N403	Postal Code	Postal Code		O	3	15		Not used
					N404	Country Code	Country Code		O	2	3		Not used

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		

2200 Disability Information													
DSB	Detail	2200 Disability Information	200	DSB		Disability Information			Situational			Segment used when enrolling or changing a disabled member. The DSB loop may only appear for the Subscriber.	DSB*3~
					DSB01	Disability Type Code	Disability Type Code		M	1	1	1 = Short Term Disability 2 = Long Term Disability 3 = Permanent or Total Disability 4 = No Disability	Valid Values: Set T = 2 Set P = 3 Set N = 4
Not used					DSB02	Quantity - Not Used						Not used	Not used
Not used					DSB03	Occupation Cd - Not Used						Not used	Not used
Not used					DSB04	Work Inty Code - Not Used						Not used	Not used
Not used					DSB05	Product Opt Cd - Not Used						Not used	Not used
Not used					DSB06	Monetary Amt - Not Used						Not used	Not used
DX					DSB07	Prod/Serv ID Qual	Product Service ID Qualifier		X	2	2	DX = International Classification of Diseases Clinical Modification(lcd-9-cm) Diagnosis If DSB09 present then required.	Not used
585					DSB08	Medical Code Value	Medical Code Value Diagnosis Code		X	1	15	Medical Code Value the only allowed value is 585 - End Stage Renal Disease If DSB08 present then required.	Not used

DTP	Detail	2200 Disability Information	210	DTP		Disability Eligibility Dates			Situational			Segment is used to send first and last date of disability.	DTP*360*D8*1996*1001~
					DTP01	Date/Time Qualifier	Date/Time Qualifier		M	3	3	360 = Disability Begin 361 = Disability End	360 = Disability Begin 361 = Disability End
D8					DTP02	Date Time Format Qual	Date Time Period Format Qualifier		M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DTP03	Date Time Period	Date Time Period Disability Eligibility Date		M	1	35	Disability Eligibility Date	Disability Eligibility Date

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		

2300 Health Coverage													
HD	Detail	2300 Health Coverage	260	HD		Health Coverage			Situational			Segment is used to enroll a new member or add, update, or terminate coverage for an existing member.	HD*021**HLT**IND~
					HD01	Maintenance Type Code	Maintenance Type Code		M	3	3	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 026 = Correction 030 = Audit or compare 032 = Employee Info Not Applicable	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or Compare
Not used					HD02	Maint Reason - Not Used						Not used	Not Used
					HD03	Insurance Line Code	Insurance Line Code		O	2	3	AG = Preventive Care/Wellness AH = 24 Hour Care AJ = Medicare Risk AK = Mental Health DCP = Dental Capitation DEN = Dental EPO = Exclusive Provider Organization FAC = Facility HE = Hearing HLT = Health HMO = Health Maintenance Organization LTC = Long-Term Care LTD = Long-Term Disability MM = Major Medical MOD = Mail Order Drug PDG = Prescription Drug POS = Point of Service PPO = Preferred Provider Organization PRA = Practitioners STD = Short-Term Disability UR = Utilization Review VIS = Vision	Evaluate retro stack Valid Values : HLT PDG DEN VIS
					HD04	Plan Cvr Description	Plan Cvr Description		O	1	50	Use this element when additional information is needed by the insurer to describe the exact type of coverage being provided. If required by an insurer, this information must be included. The insurer establishes the content of this element.	Not applicable
					HD05	Coverage Level Code	Coverage Level Code		O	3	3	CHD = Children Only DEP = Dependents Only E1D = Employee and 1 Dependent E2D = Employee and 2 Dependents E3D = Employee and 3 Dependents E5D = Employee and 1 or More Dependents E6D = Employee and 2 or More Dependents E7D = Employee and 3 or More Dependents E8D = Employee and 4 or More Dependents E9D = Employee and 5 or More Dependents ECH = Employee and Children EMP = Employee Only ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only TWO = Two Party	Valid Values: IND FAM



**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
DTP	Detail	2300 Health Coverage	270	DTP		<b>Health Coverage Eligibility Dates</b>			Required			Segment contains the date that maintenance was performed or effective, and the benefit begin and end dates for the coverage.	DTP*348*D8*20000320~
					DTP01	Date/Time Qualifier	Date/Time Qualifier		M	3	3	303 = Maintenance Effective 348 = Benefit Begin 349 = Benefit End	Valid Values: 348 = Benefit Begin 349 = Benefit End 303 = Maintenance Effective
D8					DTP02	Date Time Format Qual	Date Time Period Format Qualifier		M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DTP03	Date Time Period	Date Time Period		M	1	35	Coverage Period	Coverage Period

REF	Detail	2300 Health Coverage	290	REF		<b>Health Coverage Policy Number</b>			Situational			Segment is used to identify a policy or group number for a particular insurance product if it has not already been identified in either REF02, position 1-030 or REF02, position 2-020. This is necessary when not all coverage types have the same group or policy.	REF*1L*001A01~
					REF01	Reference Ident Qual	Reference Identification Qualifier		M	2	3	17 = Client Reporting Category	Set to 1L
					REF02	Reference Ident	Reference Identification Insured Group or Policy Number		X	1	30	Insured Group or Policy Number At least one REF02 is required.	Join Benefit Plan and Benefit Program

HD	Detail	2300 Health Coverage	260	HD		<b>Health Coverage</b>			Situational			Segment is used to indicate Med D enrollment	HD*021**PDG~ (Medicare D Enrollment)
					HD01	Maintenance Type Code	Maintenance Type Code		M	3	3	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 026 = Correction 030 = Audit or compare 032 = Employee Info Not Applicable	001 = Change 002 = Delete 021 = Addition 024 = Cancellation or termination 025 = Reinstatement 030 = Audit or Compare
Not used					HD02	Maint Reason - Not Used						Not used	Not Used
					HD03	Insurance Line Code	Insurance Line Code		O	2	3	AG = Preventive Care/Wellness AH = 24 Hour Care AJ = Medicare Risk AK = Mental Health DCP = Dental Capitation DEN = Dental EPO = Exclusive Provider Organization FAC = Facility HE = Hearing HLT = Health HMO = Health Maintenance Organization LTC = Long-Term Care LTD = Long-Term Disability MM = Major Medical MOD = Mail Order Drug PDG = Prescription Drug POS = Point of Service PPO = Preferred Provider Organization PRA = Practitioners STD = Short-Term Disability UR = Utilization Review VIS = Vision	Evaluate retro stack Valid Values : PDG
					HD04	Plan Cvrq Description	Plan Cvrq Description		O	1	50	Use this element when additional information is needed by the insurer to describe the exact type of coverage being provided. If required by an insurer, this information must be included. The insurer establishes the content of this element.	Not applicable

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
					HD05		Coverage Level Code	Coverage Level Code	O	3	3	CHD = Children Only DEP = Dependents Only E1D = Employee and 1 Dependent E2D = Employee and 2 Dependents E3D = Employee and 3 Dependents E5D = Employee and 1 or More Dependents E6D = Employee and 2 or More Dependents E7D = Employee and 3 or More Dependents E8D = Employee and 4 or More Dependents E9D = Employee and 5 or More Dependents ECH = Employee and Children EMP = Employee Only ESP = Employee and Spouse FAM = Family IND = Individual SPC = Spouse and Children SPO = Spouse Only TWO = Two Party	Not applicable
DTP	Detail	2300 Health Coverage	270	DTP		<b>Health Coverage Eligibility Dates</b>			Required			Segment contains the date that maintenance was performed or effective, and the benefit begin and end dates for the coverage.	DTP*348*D8*20000320~
					DTP01		Date/Time Qualifier	Date/Time Qualifier	M	3	3	303 = Maintenance Effective 348 = Benefit Begin 349 = Benefit End	Valid Values: 348 = Benefit Begin 349 = Benefit End 303 = Maintenance Effective
D8					DTP02		Date Time Format Qual	Date Time Period Format Qualifier	M	2	3	D8 = Date expressed in CCYYMMDD.	Set to D8.
					DTP03		Date Time Period	Date Time Period Coverage Period	M	1	35	Coverage Period	Coverage Period
REF	Detail	2300 Health Coverage	290	REF		<b>Health Coverage Policy Number</b>			Situational			Segment is used to identify a policy or group number for a particular insurance product if it has not already been identified in either REF02, position 1-030 or REF02, position 2-020. This is necessary when not all coverage types have the same group or policy.	Not applicable
					REF01		Reference Ident Qual	Reference Identification Qualifier	M	2	3	17 = Client Reporting Category	Not applicable
					REF02		Reference Ident	Reference Identification Insured Group or Policy Number	X	1	30	Insured Group or Policy Number At least one REF02 is required.	Not applicable
IDC	Detail	2300 Health Coverage	300	IDC		<b>Identification Card</b>			Situational			Segment is used to request the production of an identification card due to an enrollment add, change, or statement. An enrollment statement refers to no change being made except to request a replacement ID card.	IDC*12345678901016*H~ Not used anymore
					IDC01		Plan Cvrq Description	Plan Coverage Description	M	1	50	A description or number that identifies the plan or coverage. Element used when additional information is needed by the insurer to identify the type of ID card that will be produced. If requested, this information must be established by the insurer. Set IDC01 to a single zero if this does not apply.	Set to the member's card number.
					IDC02		ID Card Type Code	ID Card Type Code	M	1	1	D = Dental Insurance H = Health Insurance P = Prescription Drug Insurance	D = Dental Insurance H = Health Insurance P = Prescription Drug Insurance
					IDC03		Quantity	Quantity Identification Card Count	O	1	15	Send only if quantity is greater than 1	Set to zero

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
					IDC04		Action Code	Action Code	O	1	2	1 = Add 2 = Change RX = Replace (no data change)	Set new enrollee to '1' Set changes to '2'
LX	Detail	2300 Health Coverage	310	LX		<b>Provider Information</b>			Situational			Loop provides information about primary care or capitated physicians and pharmacies chosen by the enrollee in a managed care plan when that selection is made through the sponsor. Use one iteration of the loop to identify each applicable health care service.	The scope of Nybeas does not include the maintenance of a PC P dictionary by DCS and does not provide for maintaining database records to support employee PCP selections and changes. The delivered interface will not include PCP data fields
					LX01		Assigned Number	Assigned Number	M	1	6	Number assigned for differentiation within a transaction set.	Not used

**EDI 834 Transaction Set File Layout**

Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
<b>2310 Provider Information</b>													
NM1	Detail	2310 Provider Information	320	NM1		Provider Name			Required			The National Provider ID should be passed in NM109. Until the NP ID is available the Federal Tax ID should be used. Fields NM103 through NM107 are used when the sponsor has the provider's name but does not pass the standard ID in NM109 because the ID is unknown or local regulations prevent using Social Security Numbers or Federal Tax IDs. If the entity code, NM102, is 1 for person and the name is being passed, NM103 and NM104 must be used and NM105, NM106 and NM107 may be used. When the name is being passed for a non-person entity, then use only NM103. NM104 through NM107 are not populated.	The scope of Nybeas does not include the maintenance of a PC P dictionary by DCS and does not provide for maintaining database records to support employee PCP selections and changes. The delivered interface will not include PCP data fields
						NM101	Entity ID Code	Entity Identifier Code	M	2	3		Not used
						NM102	Entity Type Qualifier	Entity Type Qualifier	M	1	1		Not used
						NM103	Name Last/ Org Name	Name Last or Organization Name	O	1	35		Not used
						NM104	Name First	Name First	O	1	25		Not used
						NM105	Name Middle	Name Middle	O	1	25		Not used
						NM106	Name Prefix	Name Prefix	O	1	10		Not used
						NM107	Name Suffix	Name Suffix	O	1	10		Not used
						NM108	ID Code Qualifier	Identification Code Qualifier	X	1	2	Use of NM109 is required with NM108.	Not used
						NM109	ID Code	Identification Code	X	2	80	Use of NM108 is required with NM109.	Not used
						NM110	Entity Relat Code	Entity Relationship Code	X	2	2		Not used

PLA	Detail	2310 Provider Information	395	PLA		PCP Change Reason			Situational			Segment is used to report the reason and the effective date that a member changes primary care provider.	The scope of Nybeas does not include the maintenance of a PC P dictionary by DCS and does not provide for maintaining database records to support employee PCP selections and changes. The delivered interface will not include PCP data fields
						PLA01	Action Code	Action Code	M	1	2		Not used
						PLA02	Entity ID Code	Entity Identifier Code	M	2	3		Not used
						PLA03	Date	Date	M	8	8		Not used
						PLA05	Maintain Reason Code	Maintain Reason Code	O	2	3		Not used

<b>2320 Coordination of Benefits</b>													
COB	Detail	2320 Coordination of Benefits	400	COB		Coordination of Benefits			Situational			Loop is used when an individual has another insurance plan with benefits similar to those covered by the insurance product specified in the HD segment for this occurrence of Loop ID-2300. COB information is provided by individual, not by subscriber.	COB*S*NYSHIP*1~ Used to indicate NYSHIP is Secondary due to Medicare D enrollment
						COB01	Payer Resp Seq No Code	Payer Responsibility Sequence Number Code	O	1	1	P = Primary S = Secondary T = Tertiary U = Unknown	Valid Values: S = Secondary
						COB02	Reference Ident	Reference Identification Insured Group or Policy Number	O	1	30	Insured Group or Policy Number	NYSHIP
						COB03	Benefits Coord Code	Coordination of Benefits Code	O	1	1	1 = Coordination of Benefits 5 = Unknown 6 = No Coordination of Benefits	1 = Coordination of Benefits

EDI 834 Transaction Set File Layout													
Data Field Values	Level	Loop	Position	Segment ID	Reference Designator	Segment Name	Data Element	Data Element Description	Requirement	Attribute		Comments	Notes / Examples
										Min	Max		
REF	Detail	2320 Coordination of Benefits	405	REF		<b>Additional Coordination of Benefits Identifiers</b>			Situational			Specifies COB identifying information.	The scope of Nybeas does not include the maintenance of a COB data by DCS. The delivered interface will not include PCP data fields
					REF01	Reference Ident Qual	Reference Identification Qualifier		M	2	3	1W = Member Identification Number 6O = Account Suffix Code 6P = Group Number A6 = Employee Identification Number SY = Social Security Number	Not used
					REF02	Reference Ident	Reference Identification		X	1	30	Insured Group or Policy Number At least one REF02 is required.	Not used
N1	Detail	2320 Coordination of Benefits	410	N1		<b>Other Insurance Company Name</b>			Situational			Identifies other insurance company (COB) by type, name, and code.	The scope of Nybeas does not include the maintenance of a COB data by DCS. The delivered interface will not include PCP data fields
IN					N101	Entity ID Code	Entity Identifier Code		M	2	3	IN = Insurer.	Not Used
					N102	Name	Entity Identifier Code		X	1	60	Insurer name.	Not Used
					N103	ID Code Qualifier	Entity Identifier Code		X	1	2	FI = Federal Taxpayers Identification Number. NI = National Association of Insurance Commissioners Identification. XV = Health Care Financing Administration National Payer Identification.	Not used
					N104	ID Code	Plan Sponsor		X	2	80	Insured Group or Policy Number	Not used
DTP	Detail	2320 Coordination of Benefits	450	DTP		<b>Coordination of Benefits Eligibility Dates</b>			Situational			Segment contains the dates for which coordination of benefits is in effect.	The scope of Nybeas does not include the maintenance of a COB data by DCS. The delivered interface will not include PCP data fields
					DTP01	Date/Time Qualifier	Date/Time Qualifier		M	3	3	344 = Coordination of benefits begin. 345 = Coordination of benefits end.	Not Used
D8					DTP02	Date Time Format Qual	Date Time Period Format Qualifier		M	2	3	D8 = Date expressed in CCYYMMDD.	Not Used
					DTP03	Date Time Period	Date Time Period		M	1	35	Date COB is in effect.	Not Used
<b>Transaction Set Trailer</b>													
SE	Trailer			SE		<b>Transaction Set Trailer</b>			Required			Indicates end of transaction set and provides a count of the segments.	SE*39*1 ~
					SE01	Number of Inc Segs	Number of Included Segments		M	1	10	Total number of segments in the transaction set including ST and SE.	System generated.
					SE02	TS Control Number	Transaction Set Control Number		M	4	9	Unique control number .	The transaction set control numbers in SE02 and ST02 must be identical. Assign starting with 0001 and increment forward. Control numbers are unique within a specific functional group but can repeat in other groups and interchanges.

Number of Users Who Accessed Live and Work Well Website by Month

2011	
Nov	Dec
3256	3138

2012											
Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
4401	4306	3781	4044	4521	4132	4323	4626	4177	4256	3127	3659

Note: As of 12/1/02, there were 2573 registered LAWW users.

## Empire Plan Mental Health and Substance Abuse Program

### Union Events and Retiree Meetings

Month	Title	Type	# of attendees
February	UUP Winter Delegates Assembly	Union Event	300
April	PEF Health & Safety Conference	Union Event	350
April	CSEA Women's Conference	Union Event	300
May	UUP Spring Delegates Assembly	Union Event	300
May	CSEA Spring Conference	Union Event	500
August	CSEA Annual Retiree Delegates Meeting	Retiree Meeting	100
Sept thru Nov		Retiree Meetings	100 to 300
September	Council 82 Convention	Union Event	200
September	Council 82 Convention	Retiree Meeting	200
October	PEF Convention	Union Event	1,000
October	UUP Fall Delegates	Union Event	300
October	CSEA Annual Delegates Meeting	Union Event	1,000

**Note** – representative sample of fairs/events that Offeror would likely be invited to attend on an annual basis. Location varies for events.

### 2012 NYSHIP Health Fairs with 80+ Attendees

Date	Location	Date	Location
March 22, 2012	Tax & Finance (Albany)	October 26, 2012	City of White Plains
April 4, 2012	Office of State Comptroller (Albany)	November 7, 2012	Office of Mental Health (Albany)
April 11, 2012	SUNY Fredonia	November 14, 2012	Department of Transportation (Albany)
April 19, 2012	Morrisville State College	November 27, 2012	Rensselaer County (Jail – open to all County Employees)
May 16, 2012	Clinton Correctional Facility	November 28, 2012	City of Poughkeepsie
June 20, 2012	Bare Hill Correctional Facility	November 28, 2012	Dept of Transportation (Hauppauge)
September 18, 2012	Department of Labor (Albany)	December 5, 2012	Cornell University – Veterinary School Gala
October 5, 2012	NYS Thruway & Canal Corp(Albany)	December 6, 2012	Buffalo State University
October 25, 2012	Helen Hayes Hospital	December 7, 2012	Cornell University – Geneva Campus
November 15, 2012	Binghamton University	December 12, 2012	Roswell Park Cancer Institute
November 14, 2012	Office of General Services (Albany)		

**Note** - representative sample of health fairs that Offeror would be invited to attend in first year of contract as well as future years for largest venues



State of New York  
Department of Civil Service  
Albany, NY 12239

## EMPLOYEE BENEFITS DIVISION

Statement of Disability  
Dependent 19 Years of Age or Older PS-451 (4/10)

### PART A (To Be Completed By Enrollee. Keep a copy of the completed form for your records.)

Enrollee's Name (Print)		Health Insurance ID Number		Enrollee's Phone Number	
Home Address (No. and Street)			City		State
					Zip Code
I request continuation of NYSHIP coverage for the below named Dependent, who is disabled and incapable of self-support. * If the child is not my own, legally adopted (including a child in a waiting period prior to finalization of adoption) or dependent stepchild, I have completed and submitted a PS-457 Statement of Dependence with the requested documentation to my Agency Health Benefits Administrator.					
Dependent Information		Relationship (check one): <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Child*			
Dependent's Name		Dependent's Social Security Number		Dependent's Date of Birth	
Is Dependent presently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Dependent married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Percent of support provided by enrollee: _____ %	
Is yes, explain:					
Is disabled dependent enrolled in Medicare A & B? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide copy of dependent's Medicare Card.					
<input type="checkbox"/> Check if Dependent is permanently residing in your household and residence began prior to the age coverage would terminate. If otherwise, explain:					
<b>Personal Privacy Protection Law Notification</b>					
The information you provide on this application is requested for the principal purpose of enabling the NYS Department of Civil Service to process your request to continue enrollment for a disabled dependent 19 years of age or older in the New York State Health Insurance Program, Dental Program, Vision Program, and/ or other employee benefit fund program. The information will be used in accordance with Section 96 (1) of the Public Officers Law, also known as the Personal Privacy Protection Law. Failure to provide the information requested may prevent the Department from processing this application. This information will be maintained by the Director, Division of Employee Benefits, NYS Department of Civil Service, Albany, NY 12239. For information about the Personal Privacy Protection Law, call (518) 457-9375. For information about NYSHIP Eligibility for Disabled Dependents, contact your Agency Health Benefits Administrator. If after calling your Health Benefits Administrator you need more information, please call (518) 457-5754 or 1-800-833-4344 between the hours of 9:00 a.m. and 3:00 p.m.					
<b>HIPAA Privacy Authorization to Release Protected Health Information</b>					
By my signature below, I authorize the attending physician to provide my insurance carrier or health maintenance organization (HMO) with health information (to be indicated in Part D of this form) regarding the mental or physical disability of my dependent for whom I am requesting NYSHIP coverage. I also authorize the insurance carrier or HMO to disclose its determination (to be indicated in Part C of this form) to the Department of Civil Service. The purpose of these disclosures is to determine my dependent's eligibility for NYSHIP coverage and to implement that determination. I understand that I may revoke this authorization in writing at any time, as described in the NYSHIP Notice of Privacy Practices. Unless I revoke this authorization, this authorization will expire after my dependent's eligibility for coverage has been determined and implemented by the Department of Civil Service in its administration of the NYSHIP health plans. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected by HIPAA.					
Enrollee's Signature					Date

### PART B (To Be Completed By Employing Agency)

PLEASE PRINT OR TYPE

Effective Date Of Insurance For Dependent Above.		Previous Statement Submitted?		Was Dependent A Late Enrollment?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Enrollee's Health Insurance Coverage: <input type="checkbox"/> Individual <input type="checkbox"/> Family		Health Insurance Option <input type="checkbox"/> Empire Plan <input type="checkbox"/> HMO (write option and name) _____			
Employing Agency		Agency Code		HBA Phone Number	
I have reviewed the dependent information and have verified that the Dependent meets the eligibility requirements of the Program.					
Authorized Signature					Date







State of New York  
Department of Civil Service  
Albany, NY 12239

## EMPLOYEE BENEFITS DIVISION

Statement of Disability  
*Dependent 19 Years of Age or Older* PS-451I (4/10)

**Health insurance benefits in the New York State Health Insurance Program (NYSHIP) are available for an enrollee's unmarried dependent children age 19 or older who are incapable of supporting themselves because of a mental or physical disability acquired before termination of their eligibility for health insurance, as described below.**

Health insurance benefits in the New York State Health Insurance Program (NYSHIP) are available for an enrollee's dependent children as described under the following circumstances:

1. The enrollee's own, legally adopted (including children in a waiting period prior to finalization of adoption) and dependent stepchildren under age 19;
2. The enrollee's "other" dependent children who reside permanently with the enrollee *and* receive more than 50 percent of their support from the enrollee, including medical expenses under age 19, **You must also complete a PS-457 Statement of Dependence to establish "other" dependent children's eligibility for NYSHIP;**
3. The enrollee's dependent child who is covered as a full-time student between the ages of 19 and 25. Up to four years may be deducted from the dependent student's age for documented service in a branch of the US Military.

Any expenses incurred for the attending physician's statement on the PS-451 Statement of Disability are the responsibility of the enrollee or dependent and are not considered a covered medical expense. See your General Information Booklet for additional information and for whom to contact, if you have questions.

Approval for enrollment in NYSHIP is contingent upon continuance of the enrollee's Family Coverage under the New York State Health Insurance Program. The employing agency or the Employee Benefits Division will notify the enrollee of the coverage determination.

**Note:** The employing agency for retirees, vestees, dependent survivors, enrollees covered under Preferred List provisions and COBRA enrollees of New York State Government and Participating Employers is the Employee Benefits Division of the Department of Civil Service. For enrollees either currently or formerly employed by a Participating Agency, that agency is the employing agency, regardless of the enrollee's status.

### INSTRUCTIONS FOR COMPLETING THE PS-451 STATEMENT OF DISABILITY

1. **Enrollee** completes **Part A**.
2. **Employing Agency** completes **Part B**, (Parts A and B must be completed before any other parts of the form are completed to ensure confidentiality of the Dependent's medical information).
3. Leave **Part C** blank (see step 6)
4. **Attending Physician** completes **Part D** (attending physician cannot complete this section until Parts A and B are complete).
5. **Enrollee** or **Attending Physician** mails the completed form to the appropriate carrier:

Empire Plan Enrollees Mail To:	HMO Enrollees Mail To:
UnitedHealthcare PO Box 1600 Kingston, New York 12402-1600	Mail this form directly to your HMO.

6. If mental health specialist input is required for an Empire Plan enrollee, UnitedHealthCare may forward the PS-451 to OptumHealth. United HealthCare, the HMO or OptumHealth completes **Part C** and mails only Page 1 of the PS-451 to the Employee Benefits Division at the above address.

## Exhibit III.A

### Empire Plan Mental Health and Substance Abuse Program CD of Claim Utilization by Provider and GeoAccess Information

Empire Plan MHSA claims and census data can be obtained by completing and submitting **Exhibit I.Z**, Confidentiality Agreement and Certificate of Non-Disclosure, as required by Section II.A.7 of the RFP.

Upon receipt of the completed, notarized **Exhibit I.Z** and the Offeror's letter containing the required attestation, Prospective Offerors will be sent the following data/information:

	<b>Item</b>	<b>File Name</b>	<b>Comment</b>
1.	Market Basket of 2011 Claims Data	2011 MHSA Claim Detail (comma delimited text file)	To be used for reference in preparing Exhibit V.A of the RFP
2.	Data Dictionary	2011 MHSA Claim Detail layout.xlsx (Excel file)	Descriptions of fields in the detail claim file.
3.	GeoNetwork Report file	2013 MHSA.rpt	GeoNetwork Report template for Offerors to use in preparing Exhibit I.Y.3
4.	Geo-coded Census Database	NY State Dept of Civil Service.mdb (Access database)	Geocoded census data for Offerors to use in preparing Exhibit I.Y.3
5.	MHSA Provider file  Instructions/File Layout	MHSA Program Providers Exhibit I.Y.4.xlsx.....(Excel file)  Exhibit I.Y.4 Comparison of Current MHSA Network and Proposed Network.docx (Microsoft WORD file)	MHSA Provider file to be used to prepare Exhibit I.Y.4 of the RFP.

### **Mental Health and Substance Abuse Program RFP Exhibit V.A Instructions**

Exhibit V.A is a list of CPT, HCPCS and Revenue codes relating to a market basket of 2011 MHSA claims for Empire Plan members. The Offeror is directed to quote an allowable amount for each code presented on Exhibit V.A. The quoted amount should be on a unit basis. For example, if the code is an inpatient service, the quote should represent an allowed amount per day. If the code is an outpatient or office service, the quote should represent the allowed amount per service. If the code is for ambulance mileage, the quote should reflect the allowed amount per mile.

The amounts quoted shall represent a weighted average allowable amount for each code as of January 1, 2014. If selected, the Offeror must prove that the actual weighted allowable amounts (actual allowed amounts by provider times the expected utilization) are less than or equal to the quoted amounts in Exhibit V.A.

The 2011 MHSA Claim Detail file is available for informational purposes. Offerors may utilize the detail claim file to gain insight of the current distribution of claims by provider and service to develop its quoted average allowable amounts, if it so chooses. See Exhibit III.A for instructions on how to obtain this file.

The development of the Offeror's average network allowance quotes and completion of Exhibit V.A is solely the Offeror's responsibility. The Department makes no guarantees that either the services mix or utilization contained in the 2011 MHSA Claim Detail File is representative of future MHSA utilization.

**Mental Health and Substance Abuse Program**  
**Quoted Average Cost Per Each CPT/Revenue Code**

**Amended 3-11-13**

<b>CPT Code</b>	<b>Revenue Code</b>	<b>Quoted Average Contracted</b>
	0001	_____
	0002	_____
	0100	_____
	0101	_____
	0114	_____
	0116	_____
	0120	_____
	0121	_____
	0124	_____
	0126	_____
	0128	_____
	0129	_____
	0130	_____
	0134	_____
	0136	_____
	0138	_____
	0144	_____
	0150	_____
	0151	_____
	0153	_____
	0154	_____
	0158	_____
	0164	_____
	0183	_____
	0190	_____
	0193	_____
	0204	_____
	0220	_____
	0221	_____
	0230	_____
	0250	_____
	0251	_____
	0252	_____
	0257	_____
	0258	_____
	0259	_____
	0260	_____
	0269	_____
	0270	_____
	0271	_____
	0272	_____
	0300	_____
	0301	_____
	0302	_____
	0305	_____

**Mental Health and Substance Abuse Program**  
**Quoted Average Cost Per Each CPT/Revenue Code**

**Amended 3-11-13**

<b>CPT Code</b>	<b>Revenue Code</b>	<b>Quoted Average Contracted</b>
	0306	_____
	0307	_____
	0309	_____
	0320	_____
	0324	_____
	0350	_____
	0351	_____
	0370	_____
	0379	_____
	0402	_____
	0412	_____
	0450	_____
	0451	_____
	0456	_____
	0459	_____
	0460	_____
	0510	_____
	0513	_____
	0540	_____
	0611	_____
	0636	_____
	0637	_____
	0657	_____
	0710	_____
	0730	_____
	0762	_____
	0771	_____
	0888	_____
	0900	_____
	0901	_____
	0902	_____
	0905	_____
	0906	_____
	0910	_____
	0911	_____
	0912	_____
	0913	_____
	0914	_____
	0915	_____
	0918	_____
	0919	_____
	0920	_____
	0939	_____
	0941	_____
	0942	_____

**Mental Health and Substance Abuse Program  
Quoted Average Cost Per Each CPT/Revenue Code**

**Amended 3-11-13**

CPT Code	Revenue Code	Quoted Average Contracted
	0944	_____
	0945	_____
	0949	_____
	0961	_____
	0969	_____
	0981	_____
	0982	_____
	0987	_____
	0988	_____
	1000	_____
	1001	_____
	1002	_____
90785		_____
90791		_____
90792		_____
90832		_____
90833		_____
90834		_____
90836		_____
90837		_____
90838		_____
90839		_____
90840		_____
90845		_____
90846		_____
90847		_____
90849		_____
90853		_____
90856		_____
90863		_____
90865		_____
90867		_____
90868		_____
90870		_____
90876		_____
90887		_____
90889		_____
90899		_____
90901		_____
93000		_____
93010		_____
93042		_____
94760		_____
95819		_____
96101		_____

**Mental Health and Substance Abuse Program**  
**Quoted Average Cost Per Each CPT/Revenue Code**

**Amended 3-11-13**

<b>CPT Code</b>	<b>Revenue Code</b>	<b>Quoted Average Contracted</b>
96102		_____
96103		_____
96116		_____
96118		_____
96119		_____
96120		_____
96150		_____
96151		_____
96152		_____
96360		_____
96372		_____
98968		_____
99050		_____
99051		_____
99053		_____
99201		_____
99202		_____
99203		_____
99204		_____
99205		_____
99211		_____
99212		_____
99213		_____
99214		_____
99215		_____
99217		_____
99218		_____
99220		_____
99221		_____
99222		_____
99223		_____
99224		_____
99225		_____
99231		_____
99232		_____
99233		_____
99234		_____
99236		_____
99238		_____
99239		_____
99241		_____
99242		_____
99243		_____
99244		_____
99245		_____



**Mental Health and Substance Abuse Program  
Quoted Average Cost Per Each CPT/Revenue Code**

**Amended 3-11-13**

CPT Code	Revenue Code	Quoted Average Contracted
99251		
99252		
99253		
99254		
99255		
99281		
99282		
99283		
99284		
99285		
99304		
99305		
99306		
99307		
99308		
99309		
99310		
99406		
99408		
99409		
99443		
99999		
A0382		
A0384		
A0392		
A0394		
A0398		
A0422		
A0425		
A0426		
A0427		
A0428		
A0429		
A0432		
A0999		
G0454		
H0001		
H0002		
H0004		
H0005		
H0014		
H0015		
H0016		
H0020		
J2426		

**Mental Health and Substance Abuse Program**  
**Quoted Average Cost Per Each CPT/Revenue Code**

**Amended 3-11-13**

<b>CPT Code</b>	<b>Revenue Code</b>	<b>Quoted Average Contracted</b>
M0064		_____
S9480		_____
S9485		_____
T1016		_____

(1) Amount quoted per CPT is per service; Amount quoted per Revenue code is per day.

**Mental Health and Substance Abuse Program  
Applied Behavioral Analysis Fee Quote**

<b>Type of Service</b>	<b>Fee Quote</b>	<b>Basis</b>
Behavioral Assessment by BCBA (professional)	_____	<u>Per Service</u>
BCBA (professional) ABA Services	_____	<u>Per Hour of Service</u>
BCBA (paraprofessional) ABA Services	_____	<u>Per Hour of Service</u>
Total		

Mental Health and Substance Abuse Program  
Administrative Fee Evaluation

<u>Administrative Fee Calculation</u>	<u>Fee Quote</u>	<u>Basis</u>
Monthly Administrative Fee Quote	_____	<b>Per Contract Per Month (1)</b>

(1) A contract is defined as either a contract for Individual coverage or Family coverage.