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
Official Answers to Offeror Questions

Following are the Department's answers to questions regarding the Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and the Student Employee Health Plan RFP.

Note: If the Offeror's questions included their name, the name has been replaced with "Offeror."

Questions and Answers as of March 11, 2013.

	Section	**Question & Answer**
Q1	Section I Page 1-7 & 1-8	Upon review of Exhibit V.A, it appears the code set provided does not include codes for home based counseling. Will the code(s) associated with this service be provided? If so, when?
A1		Exhibit V.A has been amended to include the 2013 coding set consistent with the changes required by the American Medical Association. If the Offeror uses a different CPT code for home-based counseling from the codes listed, the Offeror may add the CPT code(s) to Exhibit V.A and provide a quoted average contracted amount.
Q2	Section I Page 1-8	Please confirm ambulance and transportation services are claims costs and are not to be included in the vendor's Administrative Fee.
A2		Confirmed.
Q3	Section I Page 1-8	Are the home-based counseling and telephonic counseling requirements claims costs or clinical administration costs that should be included in the vendor's administrative fee?
A3		Home-based counseling and telephonic counseling are part of claims costs.
Q4		Was the Contract award date or a tentative award date omitted from the RFP Timeline/Key Events intentionally?
A4		Yes
Q5	Section II Page 2-30	Are taxes (dollar amounts) to be included in the administrative fee or only the administration of the tax collection process?
A5		Taxes should not be included in the Administrative Fee. The Department and Contractor will mutually agree which of the taxes or assessments will be paid by the Contractor on behalf of the Program and charged back to the Department and which will be paid directly by the Department.
Q6	Section III Page 3-2	Can a company count lives for which they provide both Mental Health/Substances Abuse services as well as Employee Assistance Program (EAP) services toward the 5 million threshold?
A6		Yes, Offerors may count lives for contracts which have both MH/SA and EAP services to demonstrate compliance with the 5 million covered lives minimum.

Q7 Section III Page 3-3

Does a company need to have a Network specific to the Empire Plan, or may they use their existing commercial Network?

A7

An Empire Plan-specific Provider Network is not required. Offerors may propose a Provider Network from their existing book of business.

Q8 Section III Page 3-5

Is the expectation that the Offeror have accreditation for the site we are proposing on day one or can we be in process? Will the fact that we have other sites accredited be permitted?

A8

An Offeror must be fully accredited at the proposed primary location from which Program Services will be delivered on the Proposal Due Date.

Q9 Section IV Page 4-8

Please confirm that the existing vendor is responsible for all claims with dates of service before the new Contract effective date.

A9

Confirmed.

Q10 Section IV Page 4-11

Is the Contractor expected to establish an AT&T network or is it acceptable for the Contractor to use their existing vendor with a transfer line from The Empire Plan's medical carrier/third party administrator (UHC) to accept/transfer calls?

A10

The Contractor may use an AT&T network or an existing vendor to connect to the Empire Plan's consolidated toll-free line. AT&T serves as the vendor that facilitates all calls coming into the Empire Plan toll-free line. Contractors that have AT&T can set up their routing and backup lines with AT&T and then connect to the toll-free line. AT&T would bill the Contractor directly for these services.

If a Contractor does not have AT&T service, the medical carrier sets up all of the routing within the AT&T toll-free system and accepts those calls into the system. The medical carrier then routes those calls to the number set up by the Contractor. The medical carrier will bill the Contractor on a pass-through basis for AT&T services for every call that comes in and has to be routed to the Contractor's phone system.

Q11 Section IV Page 4-13

Call Center Telephone Guarantees: We interpret these guarantees to apply to all calls received via 1-877-7-NYSHIP. However, depending on prompt user selects call may be routed to Customer Service or the CRL. Can the guarantee be made in the aggregate and reporting provided separate for each?

A11

Yes, the Contractor may separately report Customer Service and Clinical Referral Line calls. However, if the Contractor chooses to separately report Customer Service and Clinical Referral Line calls, the Contractor will be required to demonstrate that it has complied with the combined Call Center performance standards.

Q12 Section IV Page 4-13

The performance guarantees seem to indicate the statistics are for the customer service department but state "or a clinical manager if after hours." However on page 4-29, the Quarterly Performance Guarantee Report indicates call stats/performance is for customer service only. Do the call center performance guarantees apply to only Customer Service or are CRL business and after hour call stats also included?

A12

The Call Center performance guarantees apply to both Customer Service and Clinical Referral Line calls.

Q13 Section IV Page 4-14

Requesting confirmation that call center staff (clinical and customer service) are located in the United States, but not required to be in NY as previously required in the 2009 RFP.

A13

Confirmed.

Q14	Section IV Page 4-15	Is the requested first call resolution rate for the Customer Service only or does it include calls to CRL?
A14		The first call resolution rate is for the Customer Service line only.
Q15	Section IV Page 4-21	It is the responsibility of the Offeror to ensure that their Provider Network accepts The Empire Plan Employee Benefit Card as evidence of coverage. What is the process for notifying Providers in the current Contractor's Network as outlined in the Transition and Termination provision of their Agreement? In the event current Contractor is not awarded the Contract, we are trying to understand how providers in current Contractor's Network will know where claims need to be submitted for services rendered on or after 1/1/14.
A15		As noted in Section IV.B.10.a (4) - Network Management, the Contractor is expected to use its best efforts to substantially maintain the participation of the Network Providers included in the MHSA Program's current Provider Network. Under the current agreement, during transition the contractor is required to provide a file listing Provider name, address, TIN, licensure type, and dollar spend. This file will be shared with the incumbent Contractor. As such, current Providers should be contacted by the Contractor to offer participation in the Provider Network and advised of the change in administrators.
Q16	Section VI Page 4-26	Required reporting list does not include the Provider Audits mentioned on page 4-53. Is this an oversight?
A16		See amended Section IV.B.7.a(7) of the RFP dated March 11, 2013.
Q17	Section IV Page 4-37	Will the MH/SA vendor be responsible for any audit costs? If so, please confirm that these should be included in the Administrative Fee and provide a cost estimate. If not, are these costs to be charged back to the Department or is the vendor requirement to only participate in Department-funded audit activity?
A17		The MHSA vendor is responsible for providing adequate resources to support Department or Office of the State Comptroller audits, both during the term of the Agreement and post-termination. These services are a contractual obligation and the associated costs should be included in the Administrative Fee. The Department will not reimburse the Contractor for audit costs.
Q18	Section IV Page 4-38	What is the process outlined in the Transition and Termination provision of current Contractor's Agreement for clinically managing and paying for Covered Services of Enrollees who are confined on or before December 31, 2013?
A18		The incumbent contractor will provide the Department with a Transition Plan explaining the process for clinical and financial management of services for members who are confined at contract termination. Prior to member discharge, the incumbent contractor is responsible for contacting the new Contractor to ensure a smooth transition to clinically appropriate Outpatient Services to the new Contractor. The Transition Plan will be shared with the new Contractor during implementation.
Q19	Section IV Page 4-40	Will the Contractor be expected to contract with Providers at the request of the Department even if the Provider will not agree to Network standard rates?
A19		Yes. However, any Network Provider who is explicitly requested to be contracted by the Department will be excluded from the pricing guarantee.

Q20	Section IV Page 4-40	Can the Department define what it considers an “appropriate mix” of licensed and/or certified psychiatrists, and psychologists, licensed and registered CSWs, Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists, etc. to be?
A20		In the context of Network Management, an “appropriate mix” is defined as the mix of Network Providers that would result from a well-managed, clinically appropriate Program that meets the access standard.
Q21	Section IV Page 4-41	The request states the MHSA Provider Network must include Providers throughout NYS and in areas with high concentrations of employees outside of NYS. Is the Guaranteed Access applicable to only NYS, to all US areas, or only highly populated states designated by the Department? If guaranteed access is within NYS only, does that mean Single Case Agreements for access will not be required outside of NYS?
A21		Guaranteed Access applies nationwide. Single Case Agreements may be necessary in certain areas of the United States in order to meet the Guaranteed Access requirement. Single Case Agreements are not included when calculating the Contractor’s compliance with the Network Provider Access Performance Guarantee.
Q22	Section IV Page 4-41	Network Composition Guarantee requests agreement for Psychiatrists, Psychologists and LCSW-R, and Certified Behavioral Analysts however, Nurse Practitioners and Clinical Nurse Specialists are included as covered providers in the Certificate. Should those providers be added to the LCSW-R category for composition or excluded?
A22		The Network Composition Guarantee applies to all Provider types. See amended Section IV.B.10 of the RFP dated March 11, 2013.
Q23	Section IV Page 4-43	Request is for access guarantees for the Provider Network excluding Certified Behavior Analysts on page 4-42 but it is requested separately on page 4-43 with the term “guarantees.” Was this an oversight or is access to Certified Behavior Analysts not part of the Guaranteed Access requirement?
A23		Certified Behavior Analysts are not included in the Network Provider Access Guarantee, however, are included in the Network Composition Guarantee.
Q24	Section IV Page 4-51	Please define what is meant by “Substantial change related to number, composition, or terms of the Provider Contracts.”
A24		A “substantial change” to the Network is one that would cause a material change to cost or disrupt Enrollees by causing a material change to access to Network Providers.
Q25	Section IV Page 4-51	Can the Department provide more detail regarding the requirement associated with establishing a tiered Network? Does the current MHSA Contractor offer a tiered Network structure?
A25		There is currently a tiered network for Physical Therapy Providers under the Empire Plan’s Medical Program. To comply with Mental Health Parity regulations, the Empire Plan’s MHSA Program should also have a tiered network. Regarding whether the current Contractor offers a tiered network, no response to the question is being provided as it is not required information in order for Offerors to submit a Proposal.

Q26 Section IV Page 4-51 — Negotiating Single Case Agreements: Is the expectation that Non-Network Providers will agree to the same terms in Offeror's Network Provider Agreement for the case vs. terms specifically outlined in the Single Case Agreement as agreed to by both parties.

A26 — Yes, it is expected that the Contractor offer the standard terms to Providers when negotiating a Single Case Agreement. The terms may have to be modified to reach an Agreement.

Q27 Section IV Page 4-51 & 52 — Can the Department provide more detail on the expectations regarding the process for Single Case Agreements for non-network providers, LMHC and Licensed Marriage and Family Counselors?

A27 — LMHCs and LMFTs are not covered Providers under the MHSA Program. Single Case Agreements should be used sparingly and only entered into with prior written approval by the Department when necessary to comply with Guaranteed Access, the Provider has a unique specialty, and/or the Provider has expanded hours and already provides services to Empire Plan Enrollees.

Q28 Section IV Page 4-53 — How often does the Department require the Provider Audit Reports?

A28 — Actual Audit reports will be requested upon completion of the audits while a status report is required quarterly.

Q29 Section IV Page 4-53 — To what level of detail is the State looking to be included for reporting Fraud and Abuse investigations. We have daily ongoing referrals, received from our service center, sent for preliminary investigation that are reviewed and determined not to be fraudulent. Should this report include identified cases that warrant a further review based off of the initial fraud and abuse investigation?

A29 — Under normal circumstances, the Department must be informed in writing of potential fraudulent activity after a preliminary investigation has been performed and a determination has been made that the activity warrants further review.

Q30 Section IV Page 4-54 — Extrapolation of errors: It is our understanding that DFS has previously issued a regulation limiting the use of extrapolation of audit findings. Please confirm your understanding of this regulation and confirm that having Provider Contracts that do not support extrapolation will not be deemed non-responsive and result in elimination from consideration of the bid.

A30 — Network Provider contracts are not required to contain language requiring a refund of extrapolated overpayments. It is expected that the Contractor would utilize extrapolated audit findings to identify the magnitude of issues discovered and expand the scope of the audit, if warranted.

Q31 Section IV Page 4-55 — If there is a current, existing Contract between the Network Provider and Contractor with a different claim turnaround Agreement, does the 18 Business Day timeframe guarantee still apply or will the Contractor be allowed to follow the existing Contractual Agreement with their Network Providers?

A31 — See amended Section IV.B.11.a.4 of the RFP dated March 11, 2013.

Q32 Section IV Page 4-56 — Must utilize all edits as proposed and utilized by the Department: Will the Department define the edits that will be proposed and/or are currently in place? If so, when?

A32 — See amended Section IV.B.11.a(1)(d) of the RFP dated March 11, 2013.

Q33	Section IV Page 4-56	Maintaining claims histories for 24 months: What date does the 24 month clock initiate from? Claim received date? Claim adjudication date? Claim paid date?
A33		The start of the 24-month period pertains to the claim adjudication date.
Q34	Section IV Page 4-58	Pursuing collection of up-to-date coordination of benefit information: If COB information is not on file, will it be required to verify this information prior to processing a received claim (pursue and pay), or follow the GNYHA guideline of pay the claim in hand and pursuing the COB verification (pay and pursue)?
A34		Although this is a self-funded Program, as required by Chapter 56 of the Laws of 2010, the Program must follow all Department of Financial Services requirements of an insured plan.. The Program will use a pay and pursue approach.
Q35	Section IV Page 4-59	Please clarify, should the language for Financial accuracy reflect that it be measured by dividing the number of claims paid correctly by the total dollars vs. the total number of claims?
A35		The Financial Accuracy performance guarantee is stated correctly.
Q36	Section IV Page 4-60 Section 11.4	Network Claims to be turned around within eighteen (18) Business Days of receipt. Can turn around time be stated in Calendar Days? For example equate the Business Day figure into a Calendar Day figure that represents the same turn-around time requirement.
A36		See amended Section IV.B.11.a.(4) of the RFP dated March 11, 2013.
Q37	Section IV Page 4-60 Section 11.5	Non Network Claims to be turned around within eighteen (18) Business Days of receipt. Can turn around time be stated in Calendar Days? For example equate the Business Day figure into a Calendar Day figure that represents the same turn-around time requirement.
A37		See amended Section.IV.B.11.a(5) of the RFP dated March 11, 2013.
Q38	Section IV Page 4-61	Please confirm that the COB data will be included in the 834 Enrollment file.
A38		COB data will not be included in the 834 Enrollment file.
Q39	Section IV Page 4-67	Is the expectation for the Clinical Referral Line (CRL) to only be staffed by clinicians and every call be answered by a licensed clinician? Would the State permit calls to be answered by trained non-clinicians, if access to licensed clinical staff is provided for assessments, clinical review and referral, etc., and immediate access to a clinician is provided in life-threatening emergencies?
A39		The Clinical Referral Line must be staffed by licensed clinicians to meet the MHSA Program requirements.
Q40	Section IV Page 4-67Therapy	On page 4-66, this statement is made: "Under the MHSA Program, Recurring Outpatient visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit." However, under pre-certification of care, "Recurrent Therapy Visits" is listed. Is Recurrent Therapy visits after the initial assessment considered pre-certification or concurrent review?
A40		The review of Recurrent Therapy Visits occurs after the initial assessment and is considered by the Program to be pre-certification in the sense that future visits are being pre-certified.

Q41 Section IV Page 4-69

Urgent CRL Guarantee – it states provider will call member back within 48 hours, unlike the one's above it (12.a.8.a and 12.a.8.b) there is no option for the CRL clinician to call them back. Is that an omission? Is it an option for the CRL clinician to also recontact?

A41

See amended Section IV.B.12 of the RFP dated March 11, 2013.

Q42 Section IV Page 4-69

Please provide the following data by month:
- By business hours/ non–business hours
- By number of calls to the CRL by members
- By number of emergency calls to the CRL
- By number of urgent calls to the CRL

A42

This information is not available.

Q43 Section IV Page 4-74

Does this statement mean that there is no concurrent review required for enrollees seeking Outpatient or Inpatient Services from a Non-Network Provider or Facility: (d) The Contractor must perform concurrent review of Outpatient and Inpatient Services rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

A43

No. In addition to the Contractor's standard concurrent review procedures, the Contractor must also perform concurrent review of Outpatient and Inpatient Services rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider.

Q44 Section IV Page 4-79

Is the correct understanding of this requirement that the review must be completed within 10 Business Days of receipt of complete form and the determination letter be sent within 3 Business Days of the determination, not complete form as its written?

(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.

(2) 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.

A44

See amended Section IV.B.12a.(2) of the RFP dated March 11, 2013.

Q45 Section IV Page 4-79

Other than letter notification, are there any other reporting requirements associated with "Disabled Dependent Determinations"?

A45

No, the only reporting requirements for the Disabled Dependent Determinations are to send the Department the completed PS-451 form and notify the Enrollee in writing of the determination.

Q46 Section IV Page 4-85

Is there an ability to data share among NYSHP vendors, in particular Pharmacy, to create a comprehensive DM program around Depression and ADHD – with pharmaceutical data? If so, what would the frequency be of the data sharing – real time, monthly, etc? If a data sharing process is allowed, who would be financially obligated to establish?

A46

Yes, there is the ability to share certain data between the other Empire Plan vendors and the Contractor. The frequency and content of the data would be determined by mutual agreement between the Department and the Contractor. The Department does not guarantee that an Offeror's proposed Disease Management Program which is based solely, or in part, on the receipt of specific Plan data from other Plan vendors would be acceptable to the Department.

Q47 Section IV Page 4-8

Can interested bidders obtain a copy of or get access to the existing Program descriptions for the ADHD, Depression Management and Eating Disorders Programs? Is each Program required to be stand-alone or part of a larger care management program?

A47

Links to information regarding the current Depression Management, ADHD and Eating Disorder Disease Management Programs may be found at: **https://www.liveandworkwell.com/member/**. The Programs may be stand-alone Programs or part of a larger care management Program.

Q48 Section V Page 5-2

Please confirm that the Network pricing guarantee calculation will exclude BD&C charges.

A48

Confirmed.

Q49 Section V Page 5-2

1. Please confirm that the calculation of the aggregate impact of the modification of Network Provider fees combines both Inpatient and Outpatient claims/Services.
2. Please confirm that out-of-network claims paid as in-network due to clinical or access considerations, are included in the calculation of the aggregate annual impact of Provider fees

A49

1. Confirmed
2. Confirmed

Q50 Section V Page 5-3

RFP states that an annual credit against the Administrative Fee for each for each 0.01 to 1% increase in the aggregate MHSA Program Network costs in excess of the annual increase in the July CPI-W for medical care will be $250K. Does this mean that if the increase is between 0.01% and 1% the credit will be $250K and $500K if it is between 1.01% and 2.0% and $750K if it is between 2.01% and 3% and so forth?

A50

Yes.

Q51 Section V Page 5-3

Note: The question as submitted was applicable to a single Offeror. The question has been paraphrased to be more broadly applicable.

Network pricing guarantee. Would a Proposal that does not provide a Network pricing guarantee for those Network Providers outside of the Offeror's direct control, for example providers in a leased network, be deemed non-responsive and eliminated from consideration? Would a Proposal that does not include a guaranteed annual increase less than CPI-W for medical care for Providers outside our control be deemed non-responsive?

A51

Yes, a Proposal in which the Offeror proposed that only a subset of claims costs be covered under the pricing guarantee would be deemed non-responsive. The Contractor is responsible for making sure that all Network Provider claims costs are within the CPI-W cap for the entire term of the Agreement.

Q52 Section V Page 5-7

Please confirm that the GME expense is not part of the MH/SA vendor's Administrative Fee and will not be charged back to the MH/SA vendor.

A52

Confirmed. Please refer to Section V page 5-7.

Q53 Section V Page 5-7

Please provide an estimate of the 2014 BDC percentage. Further, please confirm this percentage is applied across all modalities of care—Inpatient, Alternative and Outpatient—and should not be included in the vendor's Administrative Fee but will be charged back to the Department.

A53

An estimate of the 2014 BDC percentage is not available. The 2012 BDC percentage is approximately 2%. The Contractor is required to calculate the amount of BDC based on the applicable NYS law/regulations and may charge back the Department such amount if paid

directly by the Contractor. This expense should not be included in the Offeror's Administrative Fee quote.

Q54 Section V Page 5-9

Please provide more detail on the banking arrangement / imprest bank account. Will NYS be willing to use an existing banking arrangement an offeror has in place with a current vendor / institution?

A54

No, the imprest bank account will be set up through the Office of the State Comptroller**.**

Q55 Section VI Page 6-4

In order to exceed the Program's service level standard, is there a minimum measurement is that considered exceeding? For example, is the measurement considered exceeding if the measurement for Call Center Availability is 99.51% instead of 99.5%?

A55

Percentages should be rounded to the nearest $1/10^{th}$.

Q56 Section VI Page 6-8

This section states that the projected cost of Network claims will be based on amounts reflected in the bidder's exhibit V.A. In-Network rates vary by facility and the average Network rate can be influenced by utilization differences amongst those facilities. Assumedly, bidder's will estimate facility usage based on the 2011 claims data provided. How will The Department adjust for the significant changes in facility mix and levels of care that have occurred after 12/31/2011?

A56

No response to the question is being provided as it is not required information in order for Offerors to submit a Proposal.

Q57 Section VI Page 6-8

In regards to the Department's calculation of Non-Network claims, if a bidder's proposed Network does not include a current Network Facility, how does the Department assume that utilization will shift? Does the Department assume the utilization will migrate to another proposed Network Facility in the same geographic area or does it assume some or all of the current utilization at the facility will convert to Non-Network cost?

A57

No response to the question is being provided as it is not required information in order for Offerors to submit a Proposal.

Q58 Section VII Page 7-10

Section VII (Draft Contract) and Section VIII (Glossary of Terms) include definitions for Certified Behavioral Analysts but Exhibit II.C2 (Empire Certificate) does not include the same language. Will the Empire Certificate be updated to more accurately reflect the contract language prior to the proposal submission date?

A58

We are currently working on updating the certificates which will include current Certified Behavior Analyst language and various other updates. The updated certificates will not be available prior to the Proposal Due Date.

Q59 Section VII Page 7-19

What is the financial arrangement for the toll-free telephone service? Will the vendor receive a charge-back from the medical vendor or will the vendor be provided with estimated line costs, etc.?

A59

If the Contractor has a business arrangement with AT&T, they will be charged directly by AT&T for their calls and any set-up. A Contractor that does not have AT&T service will receive a charge back from the medical carrier (UHC). United Healthcare has not established an estimated cost because all current Empire Plan contractors on the consolidated toll-free line have a business arrangement with AT&T. The Contractor should include this expense component in its Administrative Fee.

Q60	Section VII Page 7-22	Understanding that the Shared Communications Expense is not to be included in the Administrative Fee, please provide an estimate of the quarterly cost for these communications. Also, are the items covered in this amount related only to promotion of the Program or are operational communications such as explanations of benefits, provider and clinical letters, claims processing related communications, and mailings (checks) also included?
A60		The 2013 Shared Communication Expense for the MHSA Program is approximately $500,000. The Shared Communications Expense covers the Empire Plan's consolidated communication materials such as certificates and Empire Plan Reports, as well as certain marketing materials. Items such as EOBs and Provider and clinical letters are not a part of the Shared Communications Expense, nor are any expenses associated with the Contractor attending meetings, trainings or Health Benefit Fairs.
Q61	Exhibit II.A4	Are the only tiered premium rates in the Program individual or family coverage; or are there other premium tiers such as employee plus spouse, employee plus child, etc.?
A61		The only premium rates are for individual coverage and family coverage. **Note: This is a self funded program; therefore, we are not paying the Contractor premiums.**
Q62	Exhibit II.B2 & Exhibit II.C	Exhibit II.B2 states that the Empire Plan Outpatient visit MH/SA Copayment is $20. Exhibit II.C indicates the same Copayment is $0 for visits 1-3 if they are Crisis Intervention related, otherwise $20. Please confirm that visits 1-3 that are not the result of a Crisis Intervention have a $20 Copayment.
A62		Confirmed.
Q63	Exhibit II.C2 Page 12	If available, please provide updated projected 2014 figures for the $309 and $1,500 maximums?
A63		Please refer to Exhibit II.B for a listing of the Annual Deductibles and Coinsurance Maximums.
Q64	Exhibit II.E2	Understanding that no separate membership card for MH/SA is required, is there a need for a MH/SA "sticker" to add to the medical ID card?
A64		No, there is not any room on the benefit cards to add a MHSA Program sticker. It is our expectation that the Contractor will communicate with its Provider Network so that Providers will recognize the Empire Plan, SEHP and Excelsior benefit cards and know where to submit claims.
Q65	Exhibit II.F2	Please provide an estimate of what percent of authorized visits materialize in actual visits .
A65		This information is not available. Please refer to Exhibit II.G for the number of Enrollee and Dependent visits/days for 2009, 2010, 2011 and January 1-September 30, 2012.
Q66	Section II.G & Exhibit II.G3	Do the paid claims by benefit type and incurred claims by service type in these two exhibits include bad debt and charity surcharges?
A66		No.
Q67	Exhibit II.G2	Please define "retention" as it is referenced in the NYS MHSA Experience chart.
A67		Retention includes Administrative expenses, taxes, risk charge, interest credits/charges, etc.

Q68 Exhibit V.A — Please confirm the "Quoted Average Contracted Amount" should exclude BD&C.

A68 — The amounts quoted on Exhibit V.A should not include any applicable BDC amount. See amended Exhibit V.A of the RFP dated March 11, 2013.

Q69 Exhibit V.A — Will Offeror's quoted average cost be based on the 2012 or 2013 code set?

A69 — The Offeror's quoted average cost will be based on the 2013 code set. See amended Exhibit V.A of the RFP dated March 11, 2013.

Q70 Exhibit V.C — Can the Per Enrollee Per Month Administrative Fee differ by plan year, or does it need to be the same for the term of the Agreement?

A70 — The Administrative Fee quote must be quoted as one amount and is applicable for the five-year Contract term. See amended Exhibit V.C of the RFP dated March 11, 2013.

Q71 General — Please provide the current Administrative Fee as a per employee per month (PEPM) rate.

A71 — No response to the question is being provided as it is not required information in order for Offerors to submit a Proposal.

Amended March 14, 2013

Q72 CD — The membership file provided by DCS does not include dependents. However, the Network Access definition in the RFP uses "Enrollees" and the "Enrollee" definition in the RFP includes employees and dependents. Please confirm network access should be based on the file provided by DCS which excludes dependents.

A72 — Confirmed. The Geo-Coded data sent was for Enrollees only. The Prerequisite Worksheet (Exhibit I.Y.3) should be completed using the Enrollee access to Participating Providers.