New York State Department of Civil Service
Request for Proposals #2014-MH-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 April 17, 2014

	Section	Question & Answer
Q1	Section I Page 1-5	The autism insurance benefit is described as: *Effective January 1, 2014, the MHSA Program applies an annual maximum of 680 hours per individual for ABA services allowed by Chapter 56 of the Laws of 2013.* With the final MHPAEA regulations issued in November 2013, will DCS be removing this benefit cap in 2014 or 2015?
A1		DCS is evaluating the final Mental Health Parity and Addiction Equity Act Regulations which will be effective for the Program on January 1, 2015. Should the Department determine that the cap must be removed, the Department will inform the Contractor of its decision.
Q2	Section I Page 1-6	Does the State acknowledge that this will mean that the network licensing levels will vary among states and will NOT be uniform?
A2		Yes
Q3	Section I Page 1-8	In the 2013 RFP, residential treatment centers, nurse practitioners services, telephonic counseling and home-based counseling were available as a network benefits only. Has the benefit changed for the 2014 RFP?
A3		Telephonic Counseling will continue to be covered as network only. Residential Treatment Centers, Nurse Practitioners and home-based counseling are covered as network and non-network.
Q4	Section I Page 1-10	Is there any requirement for a sticker or other identification item (not an I.D. card) to specify the MH/SA access or membership number?
A4		No. Furthermore, there is insufficient space on the current employee benefit card, so a sticker should not be proposed by the Offerors.

Q5 Section II Page 2-28

"Vendor Responsibility Requirements – State Finance Law §163" indicates that *"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."* This item is also listed in the bidder submission checklist. However, in the RFP, Exhibit I.I indicates that "This exhibit has intentionally been left blank." Please indicate whether bidders must submit a Vendor Responsibility Questionnaire.

A5

Yes. A Vendor Responsibility Questionnaire must be submitted in the Offeror's Administrative Proposal. Offerors are encouraged to complete an online questionnaire following the directions specified in Section II of the RFP.

Q6 Section IV Page 4-4

B.1.a describes the dedicated account team interaction with clinical and operational departments yet b(2) requires a dedicated operational and clinical account team. Please provide examples of the type of positions which would make up the "account team" that is required to be dedicated.

A6

The positions that should be included, at a minimum, as part of the MHSA Program dedicated account team are the Account Director, Director of Clinical Operations and Clinical Referral Line and Customer Service Center Managers.

Q7 Section IV Page 4-7

Does the aggregate claim projection refer to second and subsequent contract year's projections?

A7

With regard to providing rate estimates for an upcoming Program year, each Program year, the Contractor should submit the aggregate claim projection for the current Program year and the following Program year.

Q8 Section IV Page 4-9

In the event the State is unable to reach a decision within the timeframe allotted (whether 5 or more days), will that grant day-for-day relief from implementing the deliverable per the scheduled delivery date? And, do the artifacts listed in the RFP represent the complete listing of documents that the State will need to approve? If not, will the State provide that list?

A8

The Offeror must propose an implementation plan that includes reasonable timeframes for the review of Program materials. If the State is unable to complete their review of implementation materials within the stated timeframes in the Offeror's implementation plan the State, in its sole discretion, will determine whether the delay directly caused a delay in the Program implementation and whether any modifications of implementation timeframes or guarantees are warranted. The State will review all Program material that the Contractor intends to send or make available to Program enrollees including the customized website, customer service scripts, certification and appeal letters, as well as Program design matrices.

Q9 Section IV Page 4-10

Are any written communication expenses related to "providing enrollees access to information…" chargeable to the Program as part of the shared communication expenses?

A9

The production of documents that are related to the Empire Plan, Excelsior Plan and Student Employee Health Plan including SBCs, Empire Plan Reports, certificates and general information books, At A Glances and the Choices Guide are included in the Shared Communication Expense. Program-specific communications should be included in the Offeror's Administrative Fee and will not be a component of the Shared Communication Expense.

Q10 Section IV Page 4-11 — Will the chosen Contractor be reimbursed for the cost of line charges on the AT&T line or should we include these in the administrative fee?

A10 — The cost of line charges on the AT&T Empire Plan consolidated phone line should be included in the Offeror's quoted Administrative Fee.

Q11 Section IV Page 4-11 — Requirement states the dedicated call center will *(a) Provides direct access to trained Clinicians.* Is a direct telephone line incoming to CRL required for regular business hours or may the caller be transferred via customer service to a clinician?

A11 — The integrated voice response (IVR) system must offer a caller the option of connecting directly to a Clinician. The caller may also be transferred from customer service to a Clinician.

Q12 Section IV Page 4-12 — Do these requirements constitute the complete list of requirements of the "customized web site"? If not, please provide the complete requirements list. This is needed to make sure the site is up 30 days prior to Go-Live date.

A12 — In addition to the specific customizations listed in this section of the RFP, the Empire Plan logo must appear on each screen of the customized website. With the exception of claim status and pre-authorization information, the customized website must include each item listed in this section of the RFP thirty (30) days prior to the Go-live date.

Q13 Section IV Page 4-13 — *"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".* Please confirm the Call Center performance guarantees are for the customer service line during regular business hours and only applies to CRL for after hours.

A13 — Confirmed.

Q14 Section IV Page 4-18 — Will the requested copies of the SBC distributed to the enrollee be covered under the shared communications expense allocation or will this be a separate charge?

A14 — The production of SBCs are included in the Shared Communication Expense. DCS will provide a supply of SBCs to the Contractor and the Contractor is responsible for the cost of mailing SBCs to Enrollees making a specific request for the SBC. The Contractor may first refer Enrollees to the online version of the SBCs on NYSHIP Online, but must mail an SBC to the Enrollee, if requested.

Q15 Section IV Page 4-20, 4-64, 4-73, 4-79 — These sections reference forms, letters and SBCs; Explanation of Benefits forms and SBCs; transition of care letters; and outcome of pre-certification request letters. Please indicate/confirm if these communication items are included in the shared communications expenses and should not be included in the administrative fee.

A15 — The production and distribution of Program-specific forms, letters and materials, such as Transition of Care letters, Explanation of Benefits and outcome of pre-certification request and appeals letters should be included in the Administrative Fee. As noted in response #14, the production of SBCs are included in the Shared Communication Expense but the projected cost of their distribution to Enrollees making a specific request for the SBC should be included in the Offeror's Administrative Fee

Q16	Section IV Page 4-24	Please confirm that what you describe as daily enrollment transition files are daily transaction update files.
A16		Confirmed.
Q17	Section IV Page 4-39	A description of allowable network providers states *"The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed Masters Level Clinicians (MLC) (in NYS, the MLC must qualify for the "R" designation issued by the State Education Department"* Regarding the "R" designation qualification: Is it the intention of DCS to disallow from the offeror's network the following: LCSWs without 6 years clinical practice experience, LMFTs, LMHCs, psychoanalysts, and other State Education Department licensed master's level counselors?
A17		Yes, in New York State, LMFTs, LMHCs, psychoanalysts and other State Education Department licensed master's level counselors should be excluded as network providers for the Program implemented in 2015. The Department reserves the right to expand the network licensure level types in the future, if warranted.
Q18	Section IV Page 4-39	A description of allowable network providers states *"The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed Masters Level Clinicians (MLC) (in NYS, the MLC must qualify for the "R" designation issued by the State Education Department"* Regarding the "R" designation qualification: Please confirm that all MLCs (not just LCSWs) within NYS and outside NYS are reimbursable as non-network providers practicing within the scope of their licensure.
A18		Confirmed.
Q19	Section IV Page 4-40	Will LMHCs, LMFTs and LPCs be covered under the plan in and outside of New York State?
A19		In New York State, LMHCs, LMFTs and LPCs will be covered as non-network providers only. Outside of New York State, LMHCs, LMFTs and LPCs may be covered as a network provider if they have the highest licensure level in the state in which they perform Program services. Otherwise, they will be covered will be covered as non-network providers.
Q20	Section IV Page 4-41 & 4-43,	Section IV.B.10.a (5) states the Offeror should propose an access standard for Certified Behavior Analysts and Applied Behavior Analysis Agencies. Section IV.B.10.b (1) states the standard must be in terms of miles from the enrollee's residence. Please clarify which of the two options the Contractor will be held to? Other references in the RFP speak to identifying which counties are served by Certified Behavior Analysts. Does this mean if a mileage standard is used, it will be exclusive of those counties?
A20		Section IV.B.10.b.(1) requires Offerors to propose an access guarantee using mileage from Enrollees' residences and specifically excludes CBAs and ABA Agencies. Section IV.B.10.b.(2) requires Offerors to confirm which NYS counties are served by Network CBAs and ABA Agencies. Section IV.B.10.b.(14) requires Offerors to propose an access guarantee for CBAs and ABA Agencies. The structure of this proposed guarantee is at the discretion of the Offeror and does not need to be based on mileage from Enrollees' residences.

Q21	Section IV Page 4-42	Please confirm the network provider access guarantee is for two categories of facility and provider but the Network Composition Guarantee on page 4-45 requires a service level standard on each individual provider type.
A21		Confirmed.
Q22	Section IV Page 4-42, 4-43, 4-45, 7-50 & I.Y.1	These sections reference "Mental Health/Substance Abuse Practitioner – Other Prescriber." Does this include Physician Assistants?
A22		Other Prescriber includes any provider type that is licensed to prescribe psychiatric medication.
Q23	Section IV Page 4-58	Please define value purchasing and what measure you would like to see for program penetration and for success.
A23		The RFP makes no reference to "value purchasing".
Q24	Section IV Page 4-65	Please confirm the performance guarantee for network claims turnaround time overrules any contractual language existing with the Offeror's current network contracts.
A24		Confirmed.
Q25	Section V Page 5-8	Is there a current percentage of claims expense we should use for the RFP response? Is the BDC surcharge applicable to all claims – inpatient and outpatient? Please confirm the BDC charge is not to be included in the administrative fee.
A25		No, a specific BDC quote is not required. The calculation of the surcharge should comply with NYS law. Confirmed, the BDC should not be included in the administrative fee quote.
Q26	Section VII Page 7-37	Will the State require collection of prompt pay interest (ISVs)? Will the chosen Contractor be required to obtain Department review and approval on the format of the annual EOB summary? What is to be included in the annual EOB to be sent to members?
A26		Yes, the State will require the Contractor to pay prompt pay interest if it fails to pay claims to Enrollees or Providers in a timely manner. Consistent with response #8, the State will review and provide approval of the annual EOB statement prior to it being sent to Enrollees. The same components displayed on the non-network EOBs should be displayed on the annual EOB statement, including: dates of service, CPT, Revenue or HCPCS code, Provider name, total charges for each service, Enrollee payment responsibility, MHSA Program payment responsibility, accumulation towards combined Deductible, and accumulation towards the combined Coinsurance Maximums.

Q27	Section VIII Page 8-4	Dedicated Call Center is described "group of customer service representatives". Section IV: Page 4-14, 4.b.(3) indicates a Dedicated Call Center includes customer services representatives (CSR) and "staff of clinicians". Is it the expectation of DCS that dedicated call center have incoming calls answered by CSRs during 8-5 and CRL the remaining hours for 24/7 coverage?
A27		Customer Service Representatives must be available to speak to Enrollees from 8:00am to 5:00pm, Monday through Friday, except for Business Holidays; Clinicians on the Clinical Referral Line must be available to speak to Enrollees 24 hours a Day, 365 Days a year. See also response #11.
Q28	Exhibit II.A	Please confirm the HMO members listed in this Exhibit are not part of the Empire program.
A28		Confirmed.
Q29	Exhibit I.Y.4	Regarding this exhibit, will you provide the provider NPI for the disruption analysis?
A29		No, the National Provider Indicator will not be provided; however, the Provider Tax ID# was included in the claims data.
Q30	Exhibit II.A2	Please confirm the Medicare members listed are included in the total covered lives number and not additional to this total.
A30		Confirmed.
Q31	Exhibit II.A4	Are there additional coverage groups aside from Individual and Family, such as Individual + Child, Individual + Spouse etc.?
A31		No.
Q32	Exhibit II.B	Are there any changes in deductibles or co-insurance maximums for the first contract year? Are these combined with the Basic Medical Program as stated in the footnote on Exhibit II.C?
A32		The Deductibles and Coinsurance Maximums stated in Exhibit II.B are Shared Accumulators. Prior to the first Program year, certain of the Employee Groups may ratify their union contracts which may result in an increase to the stated Deductible and/or Coinsurance Maximums. Additionally, the In-Network Out of Pocket Maximum will increase each year to the level permitted by the Affordable Care Act.
Q33	Exhibit II.B2 & Exhibit II.C	In Exhibit II.C the outpatient MH co-pay is $0 for visits 1-3 if there is a crisis situation – is this also true for Exhibit II.B2? Approximately what percent of outpatient admissions are crisis-related?
A33		The standard copayment for an outpatient mental health professional listed in Exhibit II.B2 is waived for up to three crisis intervention visits, as stated in Exhibit II.C. The CPT code for a crisis visit is 90839 and this code is included in the claims data.

Q34	Exhibit II.F2	Can you provide an estimate of what percent of authorized visits materialize into actual visits?
A34		100% of Inpatient and Residential Treatment Center authorizations materialize into actual visits. The percentage of outpatient authorizations that materialize into an actual visit is not available.
Q35	Exhibit II.G	Do paid claims in these Exhibits include bad debt and charity surcharges?
A35		The amounts in Exhibit II.G do not include the bad debt and charity surcharges.
Q36	Exhibit II.G3	Are the services in these Exhibits authorized or paid services?
A36		The services in these exhibits are paid services.
Q37	Exhibit II.G2	Are the enhancements (NY and PA) additive to the core rates depending on state of residence or are they free-standing rates? Also, please confirm that an enrollee can pay a core rate without an enhancement.
A37		Enhancement premium rates are not based on state of residence. The Empire Plan does not offer a core-only benefit; Enrollees have either the NY or PA enhancement depending on the agency categorization.