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 MHSA 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 submitted by the Offeror.

Note: 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.

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 the Offeror's and the Offeror's key Subcontractor's 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 $180 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?

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, operation and transition.

(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 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, litigation, 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 MHSA Program material.

b. <u>Required Submission</u>

(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 dedicated account 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 dedicated account team interfaces with senior management and ultimate decision makers within your organization;

(b) Names, qualifications, and job descriptions of those individuals selected to comprise the dedicated operational and clinical account team for the Offeror. Complete **Exhibit I.B** of this RFP, Biographical Sketch Form, for all key members of the proposed dedicated account 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 dedicated account team to manage the MHSA Program?

(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.

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 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. <u>Required Submission</u>

(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 MHSA Program. Responses may **NOT** include any specific cost information or values relative to the development of cost/rate projections and trends for the MHSA Program; that information must be restricted to your Cost Proposal.

3. Implementation

The Contractor must ensure that the MHSA Program is fully functional by the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities within the 90-day implementation period.

a. Duties and Responsibilities

(1) During the 90-day 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(2)(a)--(e). Such implementation activities must be completed no later than the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement.

(2) ***Implementation and Start-up Guarantee:*** The Contractor must guarantee that all Implementation and Start-up activities will be completed the first day of the month following a 90-day implementation period after the Office of the State Comptroller approves the Agreement (Implementation Date) so that Contractor can assume full operational responsibility for the MHSA Program on the designated date. For the purpose of this guarantee, the Contractor must, on the designated date, have in place and operational;

(a) A contracted Provider network that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP;

(b) A fully operational Dedicated 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. The Dedicated Call Center must be open and operational a minimum of thirty (30) days prior to Program Implementation Date to assist Enrollees with questions concerning Program transition;

(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 available a minimum of thirty (30) days prior to the Program Implementation Date, 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. <u>Required Submission</u>

(1) Provide an implementation plan (via a detailed narrative, diagram, and timeline) that results in the implementation of the Dedicated Call Center and customized website a minimum of thirty (30) days prior to the Program Implementation Date and implementation of all other MHSA Program services by the Implementation Date, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. For all tasks that require Department review and approval, a minimum review period of five (5) Business Days must be built into the implementation plan. Include key activities such as member and Provider communications, training of a Dedicated Call Center and Clinical Referral Line 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 the Implementation Date, with the exception of opening the Dedicated Call Center and completing work on the customized website each of which must be completed a minimum of thirty (30) days prior to the Implementation Date. The Offeror shall propose the forfeiture of a

percentage of the 2015 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 2015 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 2015 Administrative Fee (prorated on a daily basis).

4. Customer Service

The MHSA Program requires that the Contractor provide quality customer service to Enrollees and Providers. 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 MHSA Program 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 2013, the customer service line received 127,498 calls and the Clinical Referral Line received 90,423 calls for a total of 218,408 calls. The Offeror/Contractor is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.I provides the number of members who have utilized the DCS customized MHSA Program website in 2013.

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 Dedicated 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. Programming and scripting changes to The Empire Plan's consolidated phone line takes 4-6 weeks. 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 (preferably in New York State) 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 a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday, except for Business Holidays; and

(c) Meets the Contractor's proposed call center telephone guarantees set forth in Section IV.B.4.b.(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: Transition of Care; 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 Call 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 Dedicated Call Center becomes unavailable;

(7) Maintaining and timely updating a secure online Empire Plan specific customized website accessible by Enrollees a minimum of thirty (30) days prior to the Implementation Date, 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 website may not contain any links to the Contractor's standard website used for other customers. The website Provider search may only contain Provider types that are covered under The Empire Plan. 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 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 weekly for the first month of the Agreement and then monthly for the remainder of the Agreement 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 exceed three percent (3%). The telephone abandonment rate shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement 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 Contractor's telephone line be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month of the

Agreement and then monthly for the remainder of the Agreement and calculated annually.

b. <u>Required Submission</u>

(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, for the MHSA Program a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday except for Business holidays. 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; and

(d) A description of the capabilities of your phone system to record calls, and 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 Dedicated 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 system 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 back-up 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 back-up 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 an Empire Plan specific customized website for the MHSA Program that will be complete a minimum of thirty (30) days prior to the Implementation Date. Also, confirm that the following information, at a minimum, will be available on the

website: MHSA Program benefits; Network Provider locations; eligibility; Copayment information Pre-authorization information; claim status and clinically-based educational material. 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.*

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 twelve (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 customization 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 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 XIII 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 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. <u>Required Submission</u>

(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 , and will bill the

MHSA Program for reimbursement in accordance with Article XIII of the Agreement.

(4) Confirm that staff will attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States at the request of the Department. Describe the experience and qualifications of staff that will attend these events.

(5) 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 and appeal letters. Provide samples of customized communications you have produced for other large clients.

(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. The Department 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.A.4.

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. <u>Duties and Responsibilities</u>

(1) 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.

(2) The Contractor must provide enrollment management services including but not limited to:

(a) ***Initial Testing:***

(i) Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department;

(ii) Testing to determine if the initial enrollment file and daily enrollment transaction files 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;

(b) 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, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. 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 standard 005010x220 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;

(c) 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;

(d) 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;

(e) 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;

(f) 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; and

(g) 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;

b. Required Submission

(1) Describe your testing plan to ensure that the initial enrollment load and daily enrollment transition files 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 numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system; and

(e) Confirm you will, on a daily basis, manually review and load any transactions which did not process correctly from the daily 834 file.

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

(4) Describe the back-up 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 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.

In order to fulfill its obligations to enrolled members and ensure contract compliance, the MHSA Program requires that the Contractor provide detailed claims data on a monthly basis, as well as specific summary reports concerning the administration of the MHSA Program 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 reports;

(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 XV "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)

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

(7) ***Supplying reports in paper format and/or in a***n electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Quarterly and Monthly 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 Shared Communication Expenses, 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 include, 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 are due each May after the end of each complete Calendar Year with the exception of the May following termination of the Agreement for which only the report is due; and

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 health plans 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 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;

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;

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 call center availability, 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 thirty (30) Days after the end of the month. For the first month of the Agreement, these reports will be due on a weekly basis; and

Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor, currently Truven Health Analytics, 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 month and submit a summarized report by month utilizing a format acceptable to the Department. The Contractor must continue to send the Detailed Claim File each month after termination of the Agreement until such time as the Department and Contractor mutually agree that the claims run-out is complete; and

Amended April 17, 2014

In-Network Triangle Report: Total Paid In-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP. The report is due the fifteenth (15th) Calendar Day after the end of the month;

Out-of-Network Triangle Report:Total Paid Out-of-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP. The report is due the fifteenth (15th) Calendar Day after the end of the month;

Claim Production Report: Summary of claims processed for the month just ended (also aging of claims): paid, declined, deductible not satisfied, other and # outstanding. The report is due fifteenth (15th) Calendar Day after the end of the month;

Copayment Savings Report: Outpatient Participating Provider Paid Claim Dollars per Month and Related Per Month Co-Payment Dollars. The report is due the fifteenth (15th) Calendar Day after the end of the month; and

Coordination of Benefits Savings Report: Medicare and Other COB Savings for the month just ended (and all prior current calendar year months). The report is due the fifteenth (15th) Calendar Day after the end of the month.

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;

(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 and Decision Support Vendor, as applicable, 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 and Decision Support Vendor, as applicable, 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 and State/Federal legislative 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 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 Providers; 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 carry-out 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, receipt of all information necessary to transfer administration of 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, submit to the Department for approval a detailed written Transition Plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

(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 licensure types and tax identification numbers, detailed Coordination of Benefits data, High Volume Provider 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 such as a Single Case Agreement, 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 of data files should include but not be limited to the following;

(i) Providing a test file to the successor contractor at least seventy-five (75) days 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 eight (8) weeks prior to implementation that contains the above MHSA Program data as specified by the Department and working in conjunction with the successor contractor;

(iii) Providing a second production file four (4) weeks prior to implementation; and

(iv) Providing a third production file to the successor contractor by the close of business three (3) days after the Agreement terminates;

(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 and, manual submit claims including but not limited to: Medicaid; out-of-network claims; foreign claims;Coordination of Benefit claims; 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 XXI of the Agreement and Appendices A and B;

(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 XXI "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 XXI, "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 Call Center phone lines open with adequate 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 and communicate with the successor Contractor , 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 as inpatient and in Residential Treatment Centers on or before the Agreement termination date until the earlier of the step down of care or midnight on the 90th day subsequent to the Agreement termination date;

(12) The Contractor must forward to the successor contractor on a weekly basis all mis-directed authorization requests received by the Contractor after the Agreement termination date for a period of ninety (90) days.

(13) The Contractor must agree that, if the Contractor does not meet all 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.

b. <u>Required Submission</u>

(1) Confirm that the Contractor will commit to fully cooperate with the successor contractor to ensure the timely, receipt of all information necessary to transfer administration of 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 transferring duties to a successor 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 all the Transition Plan requirements in the timeframes 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 MHSA Covered Services through the Provider Network. Through this RFP, the MHSA Program is seeking a Provider Network that delivers cost-effective, clinically appropriate MHSA Covered Services, while meeting the minimum guarantees for Network Provider access. 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; elsewhere they must have the highest licensure offered in the state for a MLC), 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.

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 the Implementation Date. 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. <u>Duties and Responsibilities</u>

(1) The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the MHSA Program's minimum access standards (or the Contractor's proposed access standards, if greater) throughout the term of the Agreement.

(2) The MHSA Program requires that the Contractor have available to Enrollees on the Implementation Date 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 MHSA Provider Network.

(3) The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria if the Provider is a high volume provider or 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.

(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 Masters Level Clinician (MLC) (in NYS, MLCs must qualify for the "R" designation issued by the State Education Department; elsewhere, they must have the highest licensure offered in the state for a MLC), 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;

(5) ***Network Composition Guarantee:*** The Contractor must guarantee that throughout the five-year term of the Agreement and optional eleven (11) month extension period, if exercised at the sole discretion of the Department, that at least ninety percent (90%) of the Providers in each of the Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinicianwho qualifies for the "R" designation in NYS or in other states a Masters Level Clinician with highest licensure, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner-Other Prescriber, listed on **Exhibit I.Y.2**; will be maintained. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee. This standard shall be measured annually.

(6) ***Network Provider Access Guarantee:*** The Contractor must guarantee that effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement:

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

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

(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 (2) Provider types: Network Facility (Inpatient, ALOC and Outpatient Clinic Group for Mental Health and Substance Abuse combined) and Network Practitioner types (Psychiatrist; Psychologist; Masters Level Clinican combined) for a total of six (6) separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home address to the nearest MHSA Provider Network Provider location.

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).

(7) ***Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee:*** The Contractor must propose a guarantee for access to Network Certified Behavioral Analysts and Applied Behavioral Analysis Facilities that will be effective the first day of the month following 90 day

implementation period after OSC approves the Contract, and throughout the term of the Agreement:

b. <u>Required Submission</u>

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding all Certified Behavior Analysts, Applied Behavior Analysis Agencies, Mental Health & Substance Abuse Practitioners – Other Prescribers,) 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.

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

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

(2) Understanding that Applied Behavioral Analysis is often provided in a home setting and it is most applicable to young children, confirm which of the sixty-two (62) counties within the State of New York are served by Network Certified Behavioral Analysts and Applied Behavioral Analysis Agencies.

(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 updated **Exhibits I.Y.2, I.Y.3** and **I.Y.4** thirty (30) days prior to the Implementation Date confirming that the Offeror's proposed Provider Network will be implemented as required on the first day of the month following a 90 day implementation period after OSC approves the Contract. 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. Provide a listing of Comprehensive Care Centers for Eating Disorders and continuum of care providers (as established by Article 27-j of the NYS Public Health law) that are included in the Provider Network.

(6) For the Master Level Clinician category, provide a chart listing the licensure types that you include in your network in each State and indicate which of those licensure types the Offeror considers to be the highest licensure type in each State.

(7) Explain how you determine the highest licensure type in each State.

(8) 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.

(9) Describe the criteria the Offeror will use to determine Providers to recruit into the Network to allow Enrollees to continue successful therapy plans with current Network Providers that are not in the Offeror's Networkor who are in an underserved area).

(10) Describe your strategy for maintaining the MHSA Program's Network throughout the term of the Agreement resulting from the RFP.

(11) 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?

(12) ***Network Composition Guarantee:*** The MHSA Program's service level standard requires that at the least ninety percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the"R" designation in NYS or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement and optional eleven (11) month extension. Providers who are retired, deceased or 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 Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the "R" designation in NYS or a MLC with highest licensure in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse

*Practitioner – Other Prescriber) 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 to1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or MLC with highest licensure level in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber) listed on **Exhibit I.Y.2** as reported quarterly and calculated on an annual basis is $_____. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

(13) ***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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 to1.0% below the ninety-five percent (95%) minimum access

guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* 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 Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) 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 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined)* 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined)

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 *(Psychiatrist, Psychologist and Master's Level Clinician, combined)* 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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 *(Psychiatrist, Psychologist and Master's Level Clinician, combined)* 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 (Psychiatrist, Psychologist and Master's Level Clinician, combined) 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 *(Psychiatrist, Psychologist and Master's Level Clinician, combined*)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 each quarter.

(14) ***Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee:*** (The Offeror must quote a performance standard and amount to be credited against the Administrative Fee for access that is below the Offeror's proposed guarantee for any quarter in which the Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee is not met by the Offeror.)

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.

(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. <u>Required Submission</u>

(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 MHSA Program's service level standard requires that within sixty (60) Days of receipt of a completed Provider application to join the MHSA Program's Network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or Facility notified of the determination. 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 MHSA Program's Network where the review, including credentialing, and notification of 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 to 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 Contactor 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;

b. <u>Required Submission</u>

(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.).

(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:

Facilities/ALOCs/Practitioners	**2013**	**2012**	**2011**
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			
Voluntary terminations as a 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.

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 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 MHSA 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 Article XIV, "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. <u>Required Submission</u>

(1) Describe the Provider audit program you would conduct for the MHSA 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 Article XIV, "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.

(6) Describe the Offeror's ongoing quality assurance procedures forNetwork Practitioners. With respect to Network Practitioners, do you:

(a) Share practice pattern with the respective Network Practitioners?

(b) Validate patient satisfaction?

(7) Describe the Offeror's ongoing quality assurance procedures for Network Facilities including inpatient, ALOC and other healthcare Facilities. With respect to Network Facilities do you:

(a) Require that treatment protocols be used?
(b) Investigate whether changes to quality controls are made after adverse outcomes?
(c) Monitor readmission rates after inpatient discharge?

Value Based Initiatives

The Offeror will play a key role in promoting and enhancing the value-based services under the Program.

a. Duties and Requirements

(1) The Contractor must establish a tiered MHSA Provider Network and/or incentives including but not limited to financial, administrative and continuing professional education to promote value-based MHSA Services and enhance Provider performance and clinical outcomes.

b. Required Submission

(1) Describe the tiering criteria and/or incentives you propose for the MHSA Program to promote value-based MHSA services.

(2) Describe any experience you currently have with emerging alternative care delivery models (e.g. Accountable Care Organizations – ACOs).

(a) Are you currently working with any Medicare or other ACOs? What are your goals and objectives for working with these groups?

(b) Provide an overview of the general ACO structure, including the breadth of the networks.

(c) What requirements do you have for working with these groups, such as size requirements, for credentialing; for monitoring their care and services; for measuring their quality; and for measuring and managing their cost and utilization?

(d) What are the lengths, start dates, and end dates of your existing ACO contracts?

(e) Do you use different reimbursement models with these groups? Do not include any cost information in the technical proposal.

(f) List all methods of payment utilized for your various ACO relationships.

(g) Describe steps you have taken to further integrate care, such as behavioral health, reducing readmissions and preventing unnecessary emergency room visits.

(h) How do you monitor and measure the ongoing care, quality results, cost results, and outcomes provided by these organizations?

(i) What performance guarantees are offered?

(j) What are your plans for adding ACO delivery in the future?

(k) Describe important outcomes you have achieved as a result of ACOs with which you have been involved. This might include improved health, reduced utilization of expensive services, improved member experience, and reduced costs.

(l) What have you learned from initiatives that have already been implemented, and how has this program evolved from these learnings?

(3) Do you ever incorporate pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers? If yes, describe.Describe any potential future plans to develop any of these care delivery models, including a timeline for implemenation.

(4) How do or will your alternative provider contract payment methodologies reflect quality performance (i.e., measured against standard)?

(5) To what extent, if any, would your MHSA Network Practitioners and Facilities be paid under an alternative (non-fee-for-service) provider payment structure

(a) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will be or is expected to be paid exclusively on an alternative basis, and therefore, not paid according to the schedule shown on Exhibit V.A.2, andExhibit V.A.3?

(b) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will or is expected to optionally be paid on an alternative basis, and therefore, the State can choose to pay these providers according to the schedule shown on Exhibit V.A.2 and Exhibit V.A.3?

(6) How do your Network Provider contract payments encourage adherence to clinical guidelines?

(7) How will the Network Provider payment structures result in savings to the State and its members, and ensure high quality of care is provided? Do not include cost information in the technical proposal.

(8) Does the Offeror utilize a predictive modeling tool to identify individuals at risk for mental health or substance abuse admissions or re-admissions? Explain how the tool is used, including the type of data utilized.

(9) Describe any emerging provider payment or delivery system pilot initiatives in which the State's population would eligible to participate.

11. <u>Claims Processing</u>

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, coordination of benefits and

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.

To be covered, 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 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.G.3 of this RFP.

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

(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;

(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 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 at no additional cost. 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 Accumulators 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 Accumulators;

(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 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 system through a pursue and pay methodology 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 Program 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 processed under the Disabled Lives Benefit in accordance with Section Vof this RFP;

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

(s) Mailing Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service.. Explanation of Benefits for all MHSA services must be mailed to the Enrolleeupon request from the Contractor's Dedicated Call Center and available for download by register users of the Contractor's customized website. An annual Explanation of Benefits statement must be mailed to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year; and

(t) Following the guidelines for escheatment as outlined on the NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm

(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%);

(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 or twenty-four (24) 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 Provider payment is received by the U.S. Post Office or Contractor's mailing agent; and

(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. <u>Required Submission</u>

(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 back-up 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 electro-convulsive treatment, Applied Behavioral Analysis, 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, Coinsurance, Copayments).

(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.

(9) Describe your pursue and pay procedures for the collection, storage and investigation of coordination of benefit (COB) information other than Medicare. Explain how frequently COB information is updated.

(10) Explain how your claims processing system collects overpayments from your Provider network.

(11) Describe how your adjudication system feeds the reporting systems, 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. 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.

(15) Confirm that the Offeror will:

(a) mail Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service;

(b) mail Explanation of Benefits for all MHSA services to the Enrollee upon request from the Contractor's Dedicated Call Center;

(c) make available Explanation of Benefits for all MHSA services for download by register users of the Contractor's customized website; and

(d) mail an annual Explanation of Benefits statement to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year.

(16) Confirm the Offeror will follow the guidelines for escheatment as outlined on te NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm

(17) ***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 reported quarterly and calculated on an annual basis is $_____.

(18) ***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 reported quarterly and calculated on an annual basis is $_____.

(19) ***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 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 Provider payment 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 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 Provider payment 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 or twenty-four (24) Days from the date the claim is received in the

Offeror's designated post office box to the date the Provider payment is received by the mailing agent, as calculated on a quarterly basis, is $_____.

(20) ***Turnaround Time for Non-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 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 (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 and located in the United States (preferably New York State) 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.

Currently, under the MHSA Program, outpatient therapy visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit. Based on the Final Regulations issued in November 2013, the Contractor will be responsible for proposing a Mental Health Parity and Addiction Equity Act (MHPAEA) compliant concurrent review process. Please refer to Exhibit II.L for a listing of how the Plan's medical carrier addresses the Non-Qualitative Treatment Limitations (NQTL) identified in the Final Regulations.

For the period January 1, 2013 through December 31, 2013 clinical management of the MHSA Program resulted in authorization of approximately 1,504,914 outpatient visits and the certification of nearly 6,232 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 inpatient services, electroconvulsive therapy, psychological testing and Applied Behavioral Analysis.

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' assessments of the callers, MHSA treatment needs and to 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;

(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;

Amended April 17, 2014

(7) Upon denial of pre-certification for Inpatient care, the Contractor is required to provide the Enrollee with facility options where the Enrollee may receive the pre-certified lower level of care. If the Enrollee confirms with the Contractor which facility is chosen, the Contractor is required to promptly notify the facility of the pre-certification of the lower level of care. The Contractor must follow-up with the Enrollee and selected facility within twenty-four (24) hours to confirm that the lower level of care has commenced.

(8) 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 Implementation Date, once acceptable files are received; and

(9) 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 as calculated annually.

(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 (30) 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 re-contacted by the CRL clinician within thirty (30) minutes of the Enrollee's call to the CRL.

(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 Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.

b. <u>Required Submission</u>

(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 2013, 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 and efficiency 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 Implementation Date, once acceptable files are received.

(k) The guidelines you use to determine length of stay. Have these guidelines been peer reviewed?

(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.

(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.

Amended April 17, 2014

(5) Describe the steps the Contractor will take to ensure that upon denial of pre-certification for Inpatient care, the Contractor will provide the Enrollee with facility options where the Enrollee may receive the pre-certified lower level of care. Also, confirm the Contractor will notify the chosen facility of the pre-certification of the lower level of care and will follow-up with the Enrollee and

the selected facility within twenty-four (24) hours to confirm that the lower level of care has commenced.

(6) 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 Implementation Date, once acceptable files are received.

(7) 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) that 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 reported quarterly and calculated on an annual basis, is $_____.

(8) ***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 Clinical Managers within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line reported quarterly and calculated on an annual basis, is $_____.

(9) ***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 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 Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, is $10,000per 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) when an Enrollee requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL reported quarterly and calculated on an annual basis, is $_____.

Transition of Care

The MHSA Program offers a ninety (90) day Transition of Care benefit to allow Enrollees who are receiving MHSA services from a network Provider in the incumbent contractor's network to continue therapy at the network level of benefits. The Transition of Care benefit will apply to Enrollees who are currently receiving Outpatient or Alternate Level of Care services. Care for Enrollees who are Inpatient or in a Residential Treatment Center will continue to be managed by the incumbent contractor through the end of the ninety (90) day Transition of Care period or until step down of care, whichever occurs first.

a. Duties and Responsibilities

(1) The Contractor must identify members who are receiving MHSA services from the incumbent contractor's network from a Provider who is not in the Contractor's network. The Contractor must send these members a letter notifying them of the Transition of Care benefit 3-4 weeks prior to the Implementation Date.

(2) The Contractor must notify the corresponding Providers of the Transition of Care benefit, including how to submit claims so that the member is responsible only for the applicable Copayment.

b. Required Submission

(1) Confirm that the Offeror will identify appropriate members and mail Transition of Care letters to members and Providers in a timely manner.
(2) Confirm that the Offeror will process Transition of care benefits so that the member is responsible only for the applicable Copayment.

Concurrent Review

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

(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) Is performed by the Contractor for outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

(e) For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care, when medically appropriate. The Contractor must have procedures to identify when transfer to an alternate inpatient or outpatient setting is appropriate and arrange 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 it was a Network Facility, 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 clinical Manager, as follows:

(a) Clinical 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) Clinical 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 intensive 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 Mixed Services Protocol (MSP) guidelines established by the Department. Under those

MSP 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 MSP 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; the current MSP is presented in Exhibit II.M.

(5) The Contractor must use Clinical 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 Contactor must guarantee 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 reported quarterly and calculated on an annual basis; and

(8) ***Inpatient Treatment UR Guarantee:*** The Contractor 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 and Provider notified within one (1) Business Day of the determination as reported and calculated on an annual basis.

b. <u>Required Submission</u>

(1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the MHSA 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) Intensive 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 MHSA Program and how medical necessity is determined.

(4) Explain which of the Offeror's staff (and their clinical licensure level) has the authority to deny payment for services rendered.

(5) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.

(6) Describe the methods you utilize to measure MHSA Program effectiveness (*Do not include any reference to specific monetary savings).*

(7) Confirm that you will adhere to the Empire Plan Mixed Services Protocol.

(8) Will you be providing the Empire Plan with a dedicated Clinical team including the Medical Director and Clinician Referral Line staff? Please provide an organizational chart that indicates the titles and number of people associated with the Clinical team.

(9) ***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.

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 Enrollee and 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 Enrollee and Provider notified within twelve (12) Business Day of receipt of the report as reported quarterly and calculated on an annual basis, is $_____.

(10) ***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 and 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 and 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 and the Enrollee and Provider notified within one (1) Business Day of the determination as reported quarterly and calculated on an annual basis, is $_____.

Disabled Dependent Determinations

During the term of the Agreement, 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 program 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) , see Exhibit II.is completed by the Enrollee, the Dependent's Physician and, the Enrollee's employer and then evaluated by the Contractor to determine if the Dependent is disabled. All determinations are subject to re-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 (preferably in New York State) and a clinical determination must be completed within ten (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 three (3) Business Days of the determination.

b. Required Submission

(1) Provide a description of your process when evaluating 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 ten (10) Business Days of receipt of a complete form.

(2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within three (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 ten (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 thirty (30) days of the member's request;

(ii) For a second level clinical appeal of a pre-service request for benefits, within fifteen (15) days of the member's request; and

(iii) For clinical appeals involving urgent situations, in no more than seventy-two (72) 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;

(5) Respond to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services through a 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. <u>Required Submission</u>

(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 other MHSA Programs? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the MHSA 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 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 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 be 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 as reported quarterly and calculated on an annual basis, is $_____.

(6) ***Outpatient and ALOC Appeal Guarantee***: The MHSA Program's service level standard requires that at 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

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, as reported quarterly and calculated on an annual basis 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 decide whether or not to participate in any program offered and the right to opt out of any program at any time.

b. <u>Required Submission</u>

(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.

(5) If you are proposing to receive a data feed from the Empire Plan's Prescription Drug Program to be used as a method to identify members with depression, eating disorders and ADHD, please include a copy of your Non-Disclosure Agreement you have executed with CaremarkPCS Health, LLC.