



NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

REQUEST FOR PROPOSALS #2014-MH-1

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

RELEASE DATE: March 13, 2014

PROPOSAL DUE DATE: May 20, 2014

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

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

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

E-mail: MHSA2014RFP@cs.state.ny.us

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

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

SECTION I: INTRODUCTION**A. Purpose**

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

- (1) It is the Department of Civil Service’s (Department) intent to enter into a contract (Agreement) with one (1) Offeror selected as a result of this RFP. The Agreement will be for a term of five (5) years with one optional extension period of up to eleven (11) months at the sole discretion of the Department, commencing on the first Day of the month following a minimum 90-Day implementation period after the Office of the State Comptroller approves the Agreement, during which the selected Offeror shall be responsible for administering the MHSA Program in accordance with the terms and conditions of the Agreement.

The Offeror must agree to be bound by its Proposal which will be explicitly incorporated by reference into the executed Agreement. The Department will only contract with a single Offeror, which will be the sole contact with regard to all provisions of the Agreement. If the Offeror’s Proposal includes Key Subcontractors or Affiliates, the Offeror will be considered the Prime Contractor, and the Offeror shall assume full responsibility for the fulfillment of all of the Contractor responsibilities under the Agreement. This RFP and other relevant information may be reviewed at: www.cs.ny.gov/MHSA2014RFP/index.cfm

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

B. Overview of the New York State Health Insurance Program

The New York State Health Insurance Program (NYSHIP) was established by the New York State Legislature in 1957 to provide essential health insurance protection to New York State (NYS) Employees, Retirees, and their eligible Dependents. Chapter 56 of the Laws of 2010 amended the law to allow the New York State Employee Health Insurance Plan the option to be self-funded. Specifically, the law states that the President of the Civil Service Commission “may provide health benefits directly to plan participants, in which case the president is hereby authorized to purchase a contract or contracts with one or more firms qualified to administer, on New York State health benefit plan’s behalf, the plan of benefits.” Public authorities, public benefit corporations, and other quasi-public entities, such as the NYS Thruway Authority and the Dormitory Authority may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). Article XI of the NYS Civil Service Law also allows local units of government such as school districts, special districts, and municipal corporations to participate in NYSHIP; those local government units which choose to participate in NYSHIP are called Participating Agencies (PAs). At present, there are approximately 453 NYS agencies, 93 PEs, and 798 PAs in NYSHIP. Under Article XI of the Civil Service Law, as amended, and 4 New York Code of Rules and Regulations (NYCRR) Part 73, as amended, the President of the New York State Civil Service Commission, who also serves as the Commissioner of the Department, through the Department’s Employee Benefits Division (EBD), is responsible for the ongoing administration of NYSHIP.

NYSHIP currently covers over 589,635 NYS, PA and PE Employees and retirees. Eligible covered Dependents bring the total number of covered lives to approximately 1,222,500.

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

through NYSHIP. NYSHIP offers only The Empire Plan and the Excelsior Plan to PAs. PAs may, and frequently do, offer HMOs directly to their own Employees and retirees as an alternative to Empire Plan coverage.

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

The Empire Plan, Excelsior Plan, and SEHP (collectively referred to as the Program) are comprehensive health benefit programs for New York's public Employees and their families. The Program is sponsored by the Council on Employee Health Insurance (CEHI). The Council is composed of the President of the Civil Service Commission, the Director of the Governor's Office of Employee Relations (GOER), and the Director of the Division of the Budget (DOB). The Department holds the contracts with the Program carriers/third party administrators. All components of the Program are self-funded.

This RFP seeks to secure the services of a qualified Offeror under a self-funded Administrative Services Only (ASO) arrangement for the MHSA Program. The Employee Benefits Division (EBD) within the Department is responsible for the administration of the Program. The Empire Plan currently has over 528,000 Enrollees with approximately 1,096,000 covered lives. The Empire Plan benefit design has four (4) main parts including:

1. Hospital Program benefits that include coverage for hospital inpatient stays and Emergency Care that are primarily medical as opposed to psychiatric or substance abuse issues, as well as outpatient services. This program is currently administered by Empire BlueCross BlueShield;
2. Medical Program benefits that include coverage for medical and surgical services under the Participating Provider and the Basic Medical Programs and includes several specialty programs. This program is currently administered by UnitedHealthcare Insurance Company (UHC) of New York;
3. Prescription Drug Program benefits that include coverage for prescription drugs dispensed through retail network pharmacies, and through the Mail Service Pharmacy

Process, through the Specialty Pharmacy Program, and through non-network pharmacies. This program is currently administered by CVS/Caremark [CVS Caremark]; and

4. Mental Health and Substance Abuse Program benefits that include coverage for network services through participating provider and non-network services. This program is currently administered by ValueOptions, Inc. [ValueOptions].

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

The Empire Plan also affords benefits to members of the SEHP through the various Empire Plan contracts with the Administrators. The SEHP was established in 1994 through collective bargaining. The SEHP became part of NYSHIP in 2002 to provide basic health insurance protection to graduate student Employees of the State University of New York and their eligible Dependents. This benefit was extended to the graduate student Employees of the City University of New York (CUNY) on January 1, 2009. Like The Empire Plan, the SEHP includes hospital, medical, managed mental health and substance abuse benefits, and prescription drug benefits. In 2013, the SEHP had a combined hospital, medical, managed mental health and substance abuse, and prescription drug benefit annual limit of \$2,000,000. No annual combined SEHP benefit limit is permitted for plan years beginning January 1,

2014. SEHP covers an average of 5,600 Employees; their eligible covered Dependents bring the total number of average covered lives to approximately 6,900.

As required under the Mental Health Parity and Addiction Equity Act (MHPAEA), effective January 1, 2012, annual Deductibles and out-of-pocket Coinsurance Maximums are shared between the Program's medical, hospital and mental health and substance abuse (MHSA) carriers/third party administrators. The annual shared Deductible and out-of-pocket Coinsurance Maximums vary by group. See **Exhibit II.B** for a summary of shared accumulators by group. Currently, the Program's medical carrier/third party administrator oversees administration of the shared accumulators through daily claims processing files. See **Exhibit II.F5** for the file layout of the shared accumulator claims files.

Also required under MHPAEA, the Program completed a review of the quantitative and non-quantitative treatment limits. See **Exhibit II.L** for a summary of non-quantitative treatment limitations under the Empire Plan Medical Program. As currently designed, the Program is compliant with the MHPAEA interim regulations with regard to Cost Sharing, Pre-Certification requirements, concurrent review and utilization review for inpatient and outpatient services; we anticipate that some modifications will need to be made on January 1, 2015 as a result of the recently issued final regulations. The Program's MHSA and medical carrier/third party administrators interact on a regular basis to ensure that the Program remains parity compliant.

Effective January 1, 2013, the MHSA Program was required to comply with the NYS Autism mandate (Chapters 595 and 596 of the Laws of 2011) to provide coverage for the screening, diagnosis, and treatment of Autism Spectrum Disorder (ASD). This coverage includes assessments, evaluations or tests to diagnose ASD, medications, psychiatric and psychological care, and therapeutic care, including services provided by licensed speech therapists, occupational therapists, social workers and physical therapists. The Program's medical and MHSA carriers/third party administrators currently cover the vast majority of mandated benefits with the exception of Applied Behavioral Analysis (ABA). Effective January 1, 2014, the MHSA Program applies an annual maximum of 680 hours per individual for ABA services allowed by Chapter 56 of the Laws of 2013.

Effective January 1, 2014, the MHSA Program was required to comply with the Provider Non-Discrimination provisions of the Affordable Care Act (citation). The MHSA Program currently provides non-network coverage to MHSA providers acting within the scope of their license.

D. Overview of the Mental Health and Substance Abuse Program

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

A primary component of the Network benefit is a stable and adequate panel of quality behavioral health providers. The MHSA Program network is currently composed of a mix of licensed psychiatrists, psychologists, licensed and registered clinical social workers, psychiatric nurses and nurse practitioners, Certified Structured Outpatient Rehabilitation Programs, residential treatment centers, group homes, Partial Hospitalization Programs, hospitals, group practices and licensed Certified Behavioral Analysts (CBA). To assure there is the opportunity to supplement clinical care with community programs, the Network also includes alternative treatment programs such as half-way houses and treatment programs for dually diagnosed individuals and programs certified by the NYS Office of Alcoholism and Substance Abuse Services. For the Agreement that results from this RFP, the Offeror may include in the Network Provider-types who are licensed at the highest level in their State and who are providing Covered Services within their licensure. For NYS, this includes LCSW-R and LCSW who qualify for the R-designation.

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

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

Clinical Management assesses the medical necessity of the proposed care so as to best meet the treatment needs of the Enrollee and evaluate whether appropriate care is rendered at the least restrictive level. Clinical Management is especially important where the case is complex and continuing review is necessary to determine if treatment goals are being met. Clinical Managers coordinate care with the Enrollee's family, primary care provider, treating facility, and provider to follow the Enrollee through their treatment plan.

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

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

The following services are covered under the MHSA Program, subject to applicable Cost Sharing:

1. Outpatient Care
 - a. Emergency Care at a hospital for treatment of MHSA when there is no inpatient admission following the care;
 - b. Office Visits;
 - c. Psychiatric Second Opinion;
 - d. Substance Abuse-Structured Outpatient Rehabilitation Program;
 - e. Twenty (20) Family Sessions per year when Enrollee is in a Structured Outpatient Substance Abuse Rehabilitation Program and, if the Enrollee is not in active treatment and the family member is covered under the same Empire Plan enrollment, twenty Family Sessions per year;
 - f. Psychological Testing and Evaluations with prior approval from the Contractor;
 - g. Medically Necessary Ambulance Services for MHSA care;
 - h. Electro-Convulsive Therapy with prior approval from the Contractor;
 - i. Crisis Intervention (Copays waived for up to three (3) visits per crisis);
 - j. Home-Based Counseling;
 - k. Registered Nurse Practitioners;
 - l. Telephone Counseling;
 - m. Applied Behavioral Analysis for the treatment of Autism, subject to a 680 hour annual cap, effective January 1, 2014; and
 - n. Medication Management

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2. Inpatient and Alternate Levels of Care
 - a. Hospital Services;
 - b. Residential Treatment Facilities; Halfway Houses and Group Homes. Limited coverage only for SEHP);
 - c. Partial Hospitalization and other Hospital-Based Alternate Levels of Care such as Intensive Outpatient; Day Treatment 23 Hour Extended Bed and 72 Hour Crisis Bed;
 - d. Psychiatric Treatment or Consultation while you are a MHSA Inpatient;
 - e. Psychiatric Consultations on a Medical Unit; and
 - f. Prescription Drugs when dispensed by an Approved Facility, residential or day treatment program.

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

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

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

SECTION II: PROCUREMENT PROTOCOL AND PROCESS

A. Rules Governing Conduct of Competitive Procurement Process**1. Timeline/Key Events**

RFP Release Date	March 13, 2014
Exhibit I.K Procurement Lobbying Offeror's Affirmation of Understanding & Agreement Due Date	See below*
Request for Data Necessary to Submit a Proposal Suggested Date (See Section III.G of this RFP)	March 28, 2014
Pre-Proposal Conference	April 2, 2014
Questions Due Date	April 9, 2014, 5:00pm ET
Release Date of Official Responses to Questions	April 16, 2014
Exhibit I.J Notice of Bidding Intention Due Date	May 19, 2014
Proposals Due Date	May 20, 2014, 3:00pm ET
Anticipated Contract Start Date	Upon OSC Approval of the Agreement

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

2. Procurement Lobbying Limitations

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

proposal on, or be awarded a contract for four years from the date of the second non-responsibility finding. The Procuring Agencies' Policy and associated procedures are included as **Exhibit I.L, "Procurement Lobbying Policy: Restrictions on Contacts During the Procurement Process"** to this RFP. Further information about these requirements can be found at:

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

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

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

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

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

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239
Fax: 518-402-2835
E-mail: MHSA2014RFP@cs.state.ny.us

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

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

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- (5) communications by a successful Offeror(s) who has been tentatively awarded a contract and is engaged in communications with the Department solely for the purpose of negotiating the terms of the Contract after having been notified of tentative award;
 - (6) contact by an Offeror to request the review of a procurement award when done in accordance with the procedure specified in the solicitation document;
 - a. contacts by an Offeror in protests, appeals or other review proceedings (including the apparent successful Offeror and its representatives) before the Department seeking a final administrative determination, or in a subsequent judicial proceeding; or
 - b. complaints of alleged improper conduct in the Procurement when such complaints are made to the NYS Attorney General, Inspector General, District Attorney, or to a court of competent jurisdiction; or
 - c. written protests, appeals or complaints to the NYS Comptroller's office during the process of contract approval, where the NYS Comptroller's approval is required provided that the NYS Comptroller shall make a record of such communications and any response thereto which shall be entered into the procurement record pursuant to State Finance Law Section 163; or
 - d. complaints of alleged improper conduct in a governmental procurement conducted by a municipal agency or local legislative body to the NYS Comptroller's office; and
 - (7) communications between Offerors and governmental entities that solely address the determination of responsibility by a governmental entity of an Offeror.
- d. It is **mandatory** that all prospective Offerors/Offerors complete Part 1 of **Exhibit I.K, "Procurement Lobbying Offeror's Affirmation of Understanding and Agreement"** affirming their understanding of, and agreement to, comply with the procurement lobbying requirements set forth in State Finance Law §139-k and §139-j. A completed **Exhibit I.K** must be submitted to the MHSAs Program Procurement

Manager **prior to a prospective Offeror making its initial contact with the Department** (e.g., attendance at the Pre-Proposal Conference, submission of a Notice of Bidding Intention Form (**Exhibit I.J**), submission of questions, etc. or concurrent with an Offeror's submission of its Proposal, whichever shall occur first). Offerors are advised that whenever any of the Offeror's officers, employees, agents or consultants contacts the Department, they should be prepared to provide their name, address, telephone number, place of principal employment, occupation, and whether they were retained, employed or designated, by or on behalf of the Offeror to appear before or contact the Department in regards to this Procurement. To that end and to streamline the process, Offerors are requested to complete and submit Part 2 of **Exhibit I.K** entitled, "Designated Offeror Contact" for each officer, employee, agent or consultant authorized by the Offeror to appear before or contact the Department in regards to this Procurement before appearing or before or at the time such contact is initiated.

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

3. Notice of Bidding Intention Form

Filing of this notice is **not** mandatory; however, to assist the Department in better managing the procurement process, prospective Offerors, whether they intend to submit a Proposal in response to this RFP or not, are requested to complete a "**Notice of Bidding Intention Form**" (**Exhibit I.J**) and submit it to the MHSA Program Procurement Manager by the Notice of Bidding Intention Deadline as set forth in Section II.A.1. The completed form may be submitted either in hardcopy, at the address provided in Section II.A.2.b. or electronically at: MHSA2014@cs.state.ny.us

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

www.cs.ny.gov/MHSA2014RFP/index.cfm for reference by the bidding community. A

firm requesting inclusion on this list should send a copy of its NYS M/WBE certification with its completed Notice of Bidding Intention Form. Nothing prohibits an M/WBE vendor from proposing as a prime contractor.

4. Pre-Proposal Conference

A Pre-Proposal Conference will be held on April 2, 2014 at 10:00 a.m. in the Office of General Services Meeting Room 125 - Southeast Concourse Level of the Empire State Plaza, Albany, NY. Attendance is not mandatory, but is strongly encouraged for Offerors intending to submit a Proposal.

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

5. Submission of Errors or Omissions in the RFP Document

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

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

- (1) ***Time Frame***: Assertions of errors or omissions in the procurement process which are or should have been apparent prior to the Proposal Due Date must be received by the Department, in writing, five (5) business days after the Release Date of Official Responses to Questions specified in Section II.A.1.

(2) **Content:** The submission alleging the error or omission must clearly and fully state the legal and/or factual grounds for the assertion and must include all relevant documentation.

(3) **Format of Submission:** All submissions asserting an error or omission must be in writing and submitted to the MHSA Program Procurement Manager at the following address:

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

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

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

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

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

**"Submission of Errors or Omissions for the
Mental Health and Substance Abuse Program for the
Empire Plan, Excelsior Plan and Student Employee Health Plan
Request for Proposals # 2014MH-1"**

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

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

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

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

The Department reserves the right to determine and to act in the best interests of the State in resolving any assertion of error or omission in the RFP document. As a consequence of reviewing the assertion, the Department may elect to extend the Proposal Due Date as may be appropriate. Notice of any such extension will be provided to all organizations who registered via mail, facsimile or e-mail. Notice of any extension will also be posted to: www.cs.ny.gov/MHSA2014RFP/index.cfm

6. Submission of Questions

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

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

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

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

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239
Fax: 518-402-2835
E-Mail: MHSA2014RFP@cs.state.ny.us

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

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

After the Questions Due Date, the Department will provide to all organizations who have registered, e-mail notification of the posting of all questions received and the Department's Official Responses to said questions. The aforementioned information will be posted to: www.cs.ny.gov/MHSA2014RFP/index.cfm and all registered potential Offerors will be notified of the posting to this site.

7. **Submission of Proposal**

a. **Submission Requirements**

The Offeror's Proposal must be organized and separated into three (3) separate parts: Administrative Proposal, Technical Proposal, and Cost Proposal. To facilitate the evaluation process, Offerors must submit fourteen (14) separately bound hard copies (two (2) ORIGINALS and twelve (12) copies) and one (1) electronic copy (CD) **of each of the three (3) parts** of the Offeror's Proposal. Electronic submissions must be in Adobe Acrobat, as applicable. These forty-two (42) documents and three (3) CDs are collectively hereafter referred to as "Submissions."

Each ORIGINAL hard copy of each part must be marked "ORIGINAL," contain original signatures of an official(s) authorization to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature and should be numbered sequentially, i.e. Original #1, Original #2. The remaining twelve (12) hard copies of each part may contain a copy of the official's signature and should be numbered sequentially (e.g. Copy #1, Copy #2, etc). Please note that for each of the three (3) parts, hard copies of each marked "Original #1" will be deemed controlling by the Department when viewing the Proposal.

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

**New York State Department of Civil Service
Request for Proposals # 2014MH-1
"Mental Health and Substance Abuse Program for the
Empire Plan, Excelsior Plan and Student Employee Health Plan"**

**OFFEROR NAME
OFFEROR ADDRESS**

Indicate content, as applicable

ADMINISTRATIVE, TECHNICAL or COST PROPOSAL

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

All Proposals must be sent to the following:

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

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

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

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

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

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

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

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

b. Formatting Requirements

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

- (1) ***Binding of Proposal:*** The Administrative, Technical, and Cost Proposals must be separately bound. The official name of the organization(s), the Proposal Due Date, and “Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan” must appear on the outside front cover of each copy of the Offeror's Administrative, Technical, and Cost Proposal. If the Proposals are submitted in loose-leaf binders, the official name(s) of the organization(s) and “Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan” also must appear on the spine of the binders;
- (2) ***Table of Contents:*** Each Proposal must include a table of contents;
- (3) ***Index Tabs:*** Each major Section of the Proposal and each Exhibit must be labeled with an index tab that completely identifies the title of the Section or Exhibit as named in the table of contents;
- (4) ***Pagination:*** Each page of the Proposal, including Exhibits, must be labeled on the upper right with the Section title and Section reference, page number, and date. Pages within each Section and Exhibit must be numbered consecutively;

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- (5) ***Proposal Updates/Corrections:*** Each Offeror must submit its Proposal so that any update pages required by the Department can be easily incorporated into the Proposal. Should it be necessary for an Offeror to submit additional information in support of its Proposal, it must be submitted in accordance with the following: upon written notification by the Offeror and agreement by the Department, new or replacement pages may be placed in the Proposal. All new or replacement pages will show the date of the revision and indicate the portion of the page being changed. This latter requirement will be fulfilled by drawing vertical lines down both margins of all affected passages. All new/ replacement pages will be noted by the Department on the errata sheet to be placed at the front of the Proposal copy; and,
- (6) ***Required Content of Proposals:*** The Proposal shall consist of three parts: 1) the Administrative Proposal, which must respond to the requirements set forth in Section III of this RFP; 2) the Technical Proposal, which must respond to the requirements set forth in Section IV of this RFP; and 3) the Cost Proposal, which must respond to the requirements set forth in Section V of this RFP.

c. Material Deviations

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

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

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

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

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

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

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

1. independently satisfy the applicable requirement(s) of the RFP on its own merits;

2. be clearly and separately identified as an “Extraneous Term” within the Administrative, Technical and/or Cost Proposals - Extraneous Terms Submission; and
3. be separately evaluated and scored in accordance with the bid evaluation criteria.

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

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

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

Extraneous Term(s) submitted on standard, pre-printed forms (including but not limited to: product literature, order forms, manufacturer’s license agreements, standard contracts or other pre-printed documents), which are physically attached or summarily referenced in the Proposal, or that, in the State’s sole judgment, have not been submitted in compliance with the above requirements (a) through (d) above, will not be considered as having been

submitted with or intended to be incorporated as part of the official offer contained in the Proposal, but rather will be deemed by the State to have been included by Offeror for informational or promotional purposes only.

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

8. Notification of Award

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

9. Debriefing

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

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

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

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

MHSA Program Procurement Manager
NYS Department of Civil Service
Employee Benefits Division
Agency Building 1
Empire State Plaza
Albany NY 12239
Fax: 518-402-2835
E-Mail: MHSA2014RFP@cs.state.ny.us

10. Submission of Award Protests

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

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

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

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

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

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

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

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

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

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

b. Review of Submitted Protests

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

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

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

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

11. Department of Civil Service Reservation of Rights

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

- a. Make or not make an award under the RFP, either in whole or in part.
- b. Prior to the bid opening, amend the RFP. If the Department elects to amend any part of the RFP, notification of the amendment will be provided to all organizations who submitted a Procurement Registration Form and/or a Procurement Lobbying Offeror's Affirmation of Understanding and Agreement (Exhibit I.K.) via e-mail, facsimile or mail. Any amendments will also be posted to:
www.cs.ny.gov/MHSA2014RFP/index.cfm
- c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent RFP amendments;
- d. Withdraw the RFP, at any time, in whole or in part, at the Department's sole discretion, prior to OSC approval of award of the contract.
- e. Waive any requirements that are not material;

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

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- p. Utilize any and all ideas submitted in the Proposal(s) received;
 - q. Conduct contract negotiations with the next responsible bidder, should the Department be unsuccessful in negotiating with the selected Offeror; and
 - r. Unless otherwise specified in the RFP, every offer is firm and not revocable for a minimum period of 365 days from the Proposal Due Date as set forth in the RFP.

12. Limitation of Liability

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

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

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

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

1. Public Officers Law

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

2. Omnibus Procurement Act of 1994 and its 2000 Amendment

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

The list of jurisdictions subject to this provision is set forth in Article 20 of Appendix A.

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

New York State Law:

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

In 2006, the State of New York commissioned a disparity study to evaluate whether minority and women-owned business enterprises had a full and fair opportunity to participate in state contracting. The findings of the study were published on April 29, 2010, under the title "The State of Minority and Women-Owned Business Enterprises: Evidence from New York" (the "Disparity Study"). The Disparity Study can be accessed through Google search keywords :

http://www.esd.ny.gov/MWBE/Data/NERA_NYS_Disparity_Study_Final_NEW.pdf .

The report found evidence of statistically significant disparities between the level of participation of minority and women-owned business enterprises in state procurement contracting versus the number of minority and women-owned business enterprises that were ready, willing and able to participate in state procurements. As a result of these findings, the Disparity Study made recommendations concerning the implementation and operation of the statewide certified minority and women-owned business enterprises program. The recommendations from the Disparity Study culminated in the enactment and the implementation of New York State Executive Law Article 15-A, which requires, among other things, that the Department establish goals for maximum feasible participation of New York State Certified minority and women-owned business enterprises ("MWBE") and the employment of minority groups members and women in the performance of New York State contracts.

Business Participation Opportunities for MWBEs:

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

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

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

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

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

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

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

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

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

Contractors are required to submit a Contractor's Quarterly M/WBE Contractor Compliance Reports - Form MWBE-103 to the Department's Contract Manager, at the address set forth in the Agreement, by the 10th day following each end of quarter over the term of the Contract documenting the progress made toward achievement of the MWBE goals of the Contract. Form MWBE-103 is available at:

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

Equal Employment Opportunity Requirements:

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

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

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

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

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

Per RFP Section III.C, executed copies of:

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

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

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

4. Americans with Disabilities Act

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

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

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

employment and freedom of workplace opportunity regarding such operations in Northern Ireland, and shall permit independent monitoring of their compliance with such principles.

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

6. Vendor Responsibility Requirements – State Finance Law §163

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

To assist the Department in evaluating the responsibility of Offerors, a completed “**New York State Standard Vendor Responsibility Questionnaire**” must be submitted in the Offeror's Administrative Proposal. A person legally authorized to represent the Offeror must execute the questionnaire. To the extent that the Contractor is proposing the use of Key Subcontractors or Affiliates (i.e., part of the Offeror's proposed Account Team) and expected to receive more than \$100,000 in payments during the term of the Agreement, the Offeror must submit a completed “New York State Standard Vendor Responsibility Questionnaire” for each Key Subcontractor or Affiliate completed by a person legally authorized to represent the Key Subcontractor or Affiliate.

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

http://www.osc.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep System online at: <https://portal.osc.state.ny.us>.

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

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

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

Section 5-a of the New York Tax Law requires that any contract valued at more than \$100,000 entered into by a NYS agency shall not be valid, effective, or binding against the agency unless the Contractor certifies to the Tax Department that it is registered to collect New York State and local sales and compensating use taxes, if the Contractor made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000, measured over a specified period. In addition, the Contractor must certify to the Tax Department that each Affiliate and Key Subcontractor of such Contractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. For the purpose of this requirement, "affiliate" means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent. The Contractor also must certify to the procuring state entity that it filed the certification with the Tax Department and that the certification is correct and complete. Accordingly, in the event the value of the Agreement exceeds \$100,000, the Contractor

must file a properly completed Form ST-220-CA (**Exhibit I.E**) with the Department and a properly completed Form ST-220-TD (**Exhibit I.F**) with the Department of Taxation & Finance before the Contract may take effect. In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Department if the Agreement's term is renewed. Further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

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

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

NOTICE TO OFFEROR'S LEGAL COUNSEL

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

To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding the New York State Freedom of Information Law (FOIL). If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret information and desires that such information not be disclosed if requested pursuant to the New York State Freedom of Information Law, Article 6 of the Public Officers Law, the Offeror must make that assertion by

completing **Exhibit I.C “Freedom of Information Law – Request for Redaction Chart.”** The Offeror must complete the form specifically identifying by page number, line, or other appropriate designation, the specific information requested to be protected from FOIL disclosure and the specific reason why such information should not be disclosed. Page 2 of Exhibit I.C contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, summary allegations that material is proprietary or trade-secret are inadequate and will not result in protection from FOIL disclosure.

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

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

Requested Redactions (CD and Hard Copy):

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

The Offeror must provide an electronic copy of the Administrative Proposal, the Cost Proposal and the Technical Proposal, each on a separate CD, which reflect the Offeror’s requested redactions. Additionally, the Offer must provide a separately bound hardcopy of each of the three Proposal documents with redactions marked that are included on the

CDs. The electronic documents must be prepared in PDF format using the Redaction Function in Adobe Acrobat Professional software, version 8 or higher. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using the Adobe “**Mark for Redaction**” function; **do not use the “Apply Redactions” function**. The resulting documents must show the Offeror’s requested redactions as outlined, while the content remains visible. This will allow the Department to either apply or remove requested redactions when responding to FOIL requests. The documents included on the CD and in hard copy must be complete Proposals, including all Exhibits and Attachments. No section may be omitted from the CD or hard copy even if the entire section is requested to be redacted; such sections should be marked for redaction, not removed. For forms, exhibits and charts please mark for redaction only those cells/fields/entries that meet the criteria for protection from FOIL, not the entire page.

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

9. Compliance with New York State Workers’ Compensation Law

Sections 57 and 220 of the New York State Workers’ Compensation Law (WCL) provide that the Department shall not enter into any contract unless proof of workers’ compensation and disability benefits insurance coverage is produced. Prior to entering into a contract with the Department, the selected Offeror and Key Subcontractor(s) or Affiliates, with more than \$100,000 in expected expenses over the life of the contract, if any, will be required to verify for the Department, on forms authorized by the New York State Workers’ Compensation Board, the fact that they are properly insured or are otherwise in compliance with the insurance provisions of the WCL. The forms to be used to show compliance with the WCL are listed in **Exhibit I.W – Compliance with NYS Workers’ Compensation Law**. Any questions relating to either workers’ compensation or disability benefits coverage should be directed to the State of New York Workers’

Compensation Board, Bureau of Compliance at 518-486-6307. You may also find useful information at their website: <http://www.wcb.ny.gov>.

Submission of the proof of workers' compensation and disability benefits insurance coverage is required at the time of Proposal submission. Failure to provide verification of either of these types of insurance coverage with the Offeror's Administrative Proposal may be grounds for disqualification of an otherwise successful Proposal.

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

10. Iran Divestment Act

By submitting a proposal in response to this solicitation or by assuming the responsibility of a Contract awarded hereunder, Offeror/Contractor (or any assignee) certifies that it is not on the "Entities Determined To Be Non-Responsive Bidders/Offerers Pursuant to The New York State Iran Divestment Act of 2012" list ("Prohibited Entities List") posted on the OGS website at: <http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf> and further certifies that it will not utilize on such Contract any subcontractor that is identified on the Prohibited Entities List. Additionally, Offeror/Contractor is advised that should it seek to renew or extend a Contract awarded in response to the solicitation, it must provide the same certification at the time the Contract is renewed or extended.

During the term of the Contract, should the Department of Civil Service receive information that a person (as defined in State Finance Law §165-a) is in violation of the above-referenced certifications, the Department of Civil Service will review such information and offer the person an opportunity to respond. If the person fails to demonstrate that it has ceased its engagement in the investment activity which is in violation of the Act within 90 days after the determination of such violation, then the

Department of Civil Service shall take such action as may be appropriate and provided for by law, rule, or contract, including, but not limited to, seeking compliance, recovering damages, or declaring the Contractor in default.

The Department of Civil Service reserves the right to reject any proposal, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

11. New York Subcontractors and Suppliers

New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the State and the nation. In recognition of their economic activity and leadership in doing business in New York State, Offerors for this contract for MHSa Program Services or are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles.

Offerors need to be aware that all authorized users of this contract will be strongly encouraged, to the maximum extent practical and consistent with legal requirements, to use responsible and responsive New York State businesses in utilizing services and technology. Furthermore, Offerors are reminded that they must continue to utilize small, minority and women-owned businesses, consistent with current State law.

Utilizing New York State businesses in State contracts will help create more private sector jobs, rebuild New York's infrastructure, and maximize economic activity to the mutual benefit of the Contractor and its New York State business partners. New York State businesses will promote the Contractor's optimal performance under the contract, thereby fully benefiting the public sector programs that are supported by associated procurements.

Public procurements can drive and improve the State's economic engine through promotion of the use of New York businesses by its contractors. The State therefore expects Offerors to provide maximum assistance to New York businesses in their use of the contract. The potential participation by all kinds of New York businesses will deliver great value to the State and its taxpayers. Offerors are required to complete **Exhibit I.U.2**, NYS Subcontractors and Supplies.

SECTION III: ADMINISTRATIVE PROPOSAL REQUIREMENTS

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

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

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

A. Formal Offer Letter

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

negotiable.) If an Offeror proposes to include the services of a Key Subcontractor(s) or Affiliate(s), the Offeror shall be required to assume responsibility for those services as “Prime Contractor.” The Department will consider only the Prime Contractor in regard to contractual matters.

B. Minimum Mandatory Requirements

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

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

3. as of the Proposal Due Date, the Offeror's Empire Plan MHSA Provider Network, as proposed, meets or exceeds all of the following minimum Network access guarantees:

URBAN AREAS

- a. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Inpatient, ALOC and Outpatient Clinic Groups – Mental Health within five (5) miles; and,
 - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Substance Abuse within five (5) miles.
- b. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Psychiatrist within three (3) miles; and,
 - one (1) Psychologist within three (3) miles; and,
 - one (1) Masters Level Clinician (who qualifies for R designation in NYS or who has highest level of licensure outside of NYS) within three (3) miles.

SUBURBAN AREAS

- c. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Inpatient, ALOC and Outpatient Clinic Groups – Mental Health within fifteen (15) miles; and,
 - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Substance Abuse within fifteen (15) miles.
- d. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Psychiatrist within fifteen (15) miles; and,
 - one (1) Psychologist within fifteen (15) miles; and,
 - one (1) Masters Level Clinician (who qualifies for R designation in NYS or who has highest level of licensure outside of NYS) within fifteen (15) miles.

RURAL AREAS

- e. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Inpatient, ALOC and Outpatient Clinic Groups – Mental Health within forty (40) miles; and,
 - one (1) Inpatient, ALOC and Outpatient Clinic Groups – Substance Abuse within forty (40) miles.
- f. Seventy-five percent (75%) of Enrollees will have at least:
- one (1) Psychiatrist within forty (40) miles; and,
 - one (1) Psychologist within forty (40) miles; and,
 - one (1) Masters Level Clinician (who qualifies for R designation in NYS or who has highest level of licensure outside of NYS) within forty (40) miles.

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

- (1) **Exhibit I.Y.2** – Offeror’s Proposed MHSA Provider Network File, following the instructions and file layout contained in **Exhibit I.Y.1**;
- (2) **Exhibit I.Y.3** – Offeror’s MHSA Provider Network Access Prerequisite Worksheet, following the instruction contained therein;
- (3) Offeror’s GeoAccess Managed Care Accessibility Analysis Report (on CD only) which supports the Offeror’s attainment of the Minimum Mandatory Requirements (access standards) reported on **Exhibit I.Y.3**;
- (4) **Attestation** – The Offeror must attest that, as of the Proposal Due Date, it holds executed contracts and has completed its credentialing of all Empire Plan MHSA Providers in its proposed Empire Plan MHSA Provider Network File, **Exhibit I.Y.2**. The Offeror must agree to provide documentation, including provider contracts, as required to demonstrate satisfaction of this requirement.

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

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

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

Note: The Offeror must propose a minimum Implementation and Start-Up Guarantee as a credit to the MHSA Program of at least 50% of the Administrative Fee for each day that all Implementation and Start-up requirements are not met for the period commencing the first day of the month following a 90 day implementation period after the Office of the State Comptroller approves the Agreement resulting from this RFP.

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

7. The Offeror will execute the duties and responsibilities set forth in Section IV of this RFP in strict conformance to the requirements described in that section of the RFP.
8. The Offeror, as of Proposal Due Date, has current URAC-case management, JCAHO, ACHC, NCQA or CARF full accreditation at the proposed primary worksite where case management will be performed for the Program services.

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

C. Exhibits

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

Exhibit Name	Exhibit #
Proposal Submission Requirement Checklist	Exhibit I.A
MacBride Statement and Non-Collusive Bidding Certification	Exhibit I.D
EEO Staffing Plan (form EEO-100)	Exhibit I.G
Offeror's Affirmation of Understanding and Agreement	Exhibit I.K
Compliance with Public Officers Law Requirements	Exhibit I.M
Compliance with Americans with Disabilities Act	Exhibit I.N
MWBE Utilization Plan (form MWBE-100)	Exhibit I.O
Offeror's Certification of Compliance Pursuant to State Finance Law §139-k	Exhibit I.P
Certification of Good Faith Efforts (form MWBE-104)	Exhibit I.Q
Formal Offer Letter	Exhibit I.S
Offeror Attestations Form	Exhibit I.T
Key Subcontractors or Affiliates	Exhibit I.U.1
NYS Supplier & Subcontractor	Exhibit I.U.2
Program References	Exhibit I.V
Extraneous Terms Template	Exhibit I.X
Offeror's Proposed MHSA Participating Provider Network File	Exhibit I.Y.2
Offeror's MHSA Provider Network Access Prerequisite Worksheet	Exhibit I.Y.3
Confidentiality Agreement and Certificate of Non-Disclosure	Exhibit I.Z

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

D. Key Subcontractors or Affiliates

At this part of its Administrative Proposal, the Offeror must provide a statement identifying all Key Subcontractors or Affiliates, if any, that the Offeror will be contracting with to provide MHSA Program services and must, for each such Key Subcontractor or Affiliate identify, complete and submit **Exhibit I.U.1** “Key Subcontractors or Affiliates”:

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

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

E. Reference Checks

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

F. Financial Statements

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

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

G. Request for Data Necessary to Submit a Proposal

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

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

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

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

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

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

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

1. Market basket of Empire Plan MHSA Program 2013 claims for reference in preparing Exhibit V.A.2 and V.A.3 of the RFP;
2. Empire Plan Geocoded Census data file to be used to prepare the analysis required to complete Exhibit I.Y.3 of the RFP; and
3. Representative sample of MHSA Program providers to be used to complete Exhibit I.Y.4 of the RFP.

Note: Prospective Offerors are solely responsible for the delivery of the pre-requisite letter and properly executed Exhibit I.Z.

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

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 MHSAs 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 MHSAs 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 MHSAs Program material.

b. Required Submission

- (1) Provide an organizational chart and description illustrating how you propose to administer, manage, and oversee all aspects of the MHSAs 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

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- (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 MHSAs Program Year. Analysis of all MHSAs Program components impacting the MHSAs Program cost shall be performed including, but not limited to claims, trend factors, Administrative Fees and changes in enrollment; and
- (3) Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

b. Required Submission

- (1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the MHSAs Program. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.
- (2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.
- (3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

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

3. **Implementation**

The Contractor must ensure that the 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;

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- (c) A claims processing system that processes claims in accordance with the MHSAs 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 MHSAs Program benefit design and contractual obligations; and
 - (e) A fully-functioning, customized MHSAs 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. Required Submission

- (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 MHSAs 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;

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- (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. Required Submission

- (1) Confirm that you will provide Enrollees access to the Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day 365 Days a year, as described above.
- (2) Confirm you will enter into a shared service agreement with The Empire Plan medical carrier/ third party administrator, or other party designated by the Department, and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.
- (3) Confirm you maintain a Dedicated Call Center for the MHSA Program located in the United States, employing a staff of Clinicians and a staff of fully trained customer service representatives (CSR's) and supervisors. Confirm that customer service representatives will be available, 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. Required Submission

- (1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreement. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror’s legal department. Provide several examples of the MHSA Program communications you have developed for Enrollees. Confirm your understanding that all MHSA Program communications developed by the Offeror are subject to the Department’s final approval.
- (2) Describe the resources that will be available to the Department to support the Department’s development of various Enrollee communications and your ability to provide input into such communications quickly.
- (3) Confirm that the Offeror will pay the allocated portion of Shared Communication Expenses covering the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees , 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. Duties and Responsibilities

- (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 an electronic format* (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Quarterly and Monthly 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.

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. Required Submission

- (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. Duties and Responsibilities

- (1) The Contractor must maintain a credentialed and contracted MHSa Provider Network that meets or exceeds the MHSa Program's minimum access standards (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 Clinician who 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 within five (5) miles;
- (b) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;
- (c) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;
- (d) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;
- (e) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,
- (f) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

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

Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two (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 Clinician 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. Required Submission

- (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 Network or 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 to 1.0% 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 to 1.0% 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 to 1.0% 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 to 1.0% 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. Required Submission

- (1) Confirm that you will utilize a credentialing verification organization or establish credentialing criteria for Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.

- (2) Describe the Offeror's process to ensure that Network Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?
- (3) Describe your approach for credentialing Network Providers.
- (a) Specify if you utilize an external credentialing verification organization. When was this process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?
- (b) What steps do you take between credentialing periods to ensure that Network Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Provider Network as soon as possible? What steps, if any, do you take to advise members when a Provider has been removed from the Provider network? Under what circumstance would you notify the Department of the removal of a Network Provider?
- (4) How does Provider Relations staff keep abreast of Provider practices, attitudes, and concerns in New York State and other areas? Do you have Provider Relations staff that is located in NYS? How do you support a strong information infrastructure for your Network Providers?
- (5) How do you help your Network Providers achieve patient-centered care? How do you help Network Providers improve their diagnosis and assessment abilities to ensure that the care they provide is based upon the best available scientific knowledge? How do you ensure that your Network Providers collaborate with other clinicians to ensure an appropriate exchange of Enrollee information and coordination of care?
- (6) Confirm that you will maintain credentialing records and make them available for review by the Department upon request.

- (7) ***Provider Credentialing Guarantee:*** The 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 Contractor may choose to enter into MHSA Program-specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's Proposed Provider Network File upon the submission date of its proposal.

a. Duties and Responsibilities

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

- (1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;
- (2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;
- (3) Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program Copayments;
- (4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Provider contracts utilized by the MHSA Program;
- (5) Negotiating Single Case Agreements with Non-Network Providers on a case-by-case basis when the Contractor determines that it is clinically appropriate or to address guaranteed access issues;

b. Required Submission

- (1) Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.).
- (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 MHSAs 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 MHSAs 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 MHSAs Program.

Provider Audit and Quality Assurance

The Contractor must support a high quality and cost-effective MHSAs Program. The protection of MHSAs 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 MHSAs services to MHSAs 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. Required Submission

- (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 for Network 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 implementation.
- (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, and Exhibit V.A.3?

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- (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. Claims Processing

The Contractor must process all claims submitted under the MHSA Program according to the benefit design, including Network Provider claims and manual submit claims including but not limited to Medicaid, out-of-network claims, foreign claims, 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. Duties and Responsibilities

- (1) The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:
- (a) Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;
 - (b) Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;
 - (c) Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance, annual maximums and Coinsurance Maximums, at the time the claim was incurred as specified to the Contractor by the Department;
 - (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 V of 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;

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- (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 Enrollee upon 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. Required Submission

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating Non-Network and Network claims. Provide a description of the comprehensive edits you propose to ensure proper claim adjudication.

- (2) Describe your claims processing system platform including any 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 electroconvulsive 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.

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- (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 the 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 \$_____.

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- (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:

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- (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;
- (7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received; and
- (8) Clinical Referral Line Guarantees: The Contractor must meet or exceed the following three (3) performance guarantees as follows:
 - (a) ***Non-Network CRL Guarantee:*** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate MHSA Non-Network Provider or program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases 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.

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- (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. Required Submission

- (1) Describe in detail how you propose to precertify services including;
- (a) An overview of your Clinical Referral Line (CRL) and proposed precertification process as well as the criteria you use to identify the services that the Program should consider for pre-certification or prior authorization.
 - (b) Your proposed Clinical Referral Line staffing and qualifications of each level of clinician rendering authorizations and denials of care. Will clinical management staff be dedicated to the Program or will they service other customers as well?
 - (c) For the calendar year 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.

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- (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.
- (5) Confirm the Contractor will load into the clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.
- (6) ***Non-Network CRL Guarantee:*** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.
- The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is \$10,000 per year. However, the Offeror may propose higher or lesser amounts.*

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Offeror's proposed guarantee) 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 \$_____.

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- (7) ***Emergency CRL Guarantee:*** The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life- threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care, contact will be made by either the Network Provider or the Contractor's 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 \$_____.

- (8) ***Urgent Care CRL Guarantee:*** The MHSA Program's service level standard requires that at least ninety-nine percent (99%) of Enrollees who call the CRL in need of urgent care will be contacted by the 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 \$10,000 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) 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.

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- (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 adherence with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:
- (a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;
 - (b) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services. The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;
 - (c) Is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;
 - (d) 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

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- 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 Contractor 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. Required Submission

- (1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the MHSA Program, including:

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- (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.

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- (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. Required Submission

- (1) Confirm the Contractor will perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer.
- (2) Confirm the Contractor will administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.
- (3) Describe in detail how you would administer the required appeal processes for the Program, including:
 - (a) Turnaround time;
 - (b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;
 - (c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;
 - (d) Do you currently administer an appeals process as described above for 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.

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- (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

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- (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. Required Submission

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

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

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

B. Cost Proposal components

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

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

- 1) In accordance with Section IV of the RFP, the Contractor must contract with Network Providers. The amount charged to the MHSA Program shall be the contracted Network Provider fee, less any applicable Copayment and after the coordination of benefits when the claim is processed as secondary coverage.
- 2) Claim Payments are to be made based on the requirements contained in Section IV and Articles 6.11.0 and 12.1.0 of Section VII of this RFP, including but not limited to each group's Copayment as reflected in Exhibit II.B; and Exhibit II.B2 of this RFP as well as the annual maximum for Applied Behavioral Analysis (ABA) services as reflected in the most current Plan Communication materials.
- 3) Throughout each Plan Year, the selected Contractor shall charge to the Program the incurred claims cost for Network services based on the amounts actually paid by the Contractor to Network Providers.

- 4) ***Network Pricing Guarantee:*** The Offeror must develop and propose a Guarantee Average Unit Cost (GAUC) for the Network Outpatient Services presented in Exhibit V.A.2 and the Network Inpatient/Alternative Level of Care (ALOC) Services presented in Exhibit V.A.3. The Contractor is required to guarantee that the Actual Average Unit Cost (AAUC) for each category shall not exceed the proposed GAUC.
- a) Based on incurred claims for each Plan Year that are paid as of June 30th of the following year, the Contractor shall calculate the AAUC for the Inpatient Services and Outpatient Services categories. Such Network Services shall include all services/days paid at the Network benefit level including services/days rendered by Non-Network Providers when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to the Network Provider for Plan primary claims only and prior to the application of the Copayment and Bad Debt and Charity assessments.
- b) The Contractor acknowledges that the GAUC for the Inpatient Services set forth in Exhibit V.A.3 may incorporate the inpatient professional service component pertaining to global reimbursement arrangements. Amounts actually paid and reported to the Department for Inpatient Services will include the inpatient professional service component of global arrangements. Any adjustments in the calculation of the AAUC shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

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- c) If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee, as follows:

For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in Exhibit V.A.2, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charged to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in Exhibit V.A.3, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charge to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

- d) For the first Plan Year (2015), no change to the proposed GAUC will be allowed, except in the event of circumstances outside the control of the Contractor that may have a significant effect on cost, such as legislation or substantial enrollment risk profile fluctuations. Any proposed change made by the Contractor in the GAUCs for the 2015 Plan year shall be at the sole

discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

- e) For each Plan year after 2015, the Contractor may request in writing an increase in the GAUC. The annual increase shall not exceed the percentage increase in CPI-W for Medical Care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year. If the prior increase in the GAUC occurred more than 12 months prior to the effective date of the requested increase, the maximum increase shall not exceed the cumulative CPI-W observed since the implementation of the prior increase. Any increase in the GAUC requires written approval by the Department and amendment of the Agreement, upon documentation by the Contractor to the satisfaction of the Department, that such increase is required to maintain adequate Network access.

- f) For purposes of both the development of the GAUC and AAUC, claims processed as secondary to the Plan shall be excluded from the calculations and network pricing guarantees. In addition, the GAUC and AAUC shall not include any fees or assessments set forth in Section V.B.3, V.B.4 and V.B.5 of this RFP

C. Required Submission

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.1a. above, Section IV of the RFP and Section VII, Articles 6.10.0 and 12.1.0 of the RFP.

- 2) The Offeror must complete Exhibit V.A.2, Guaranteed Average Unit Cost of Outpatient Services, including ABA services, Exhibit V.A.3, Guaranteed Average Unit Cost of Inpatient Services and ALOC services by Revenue Code in accordance with the instructions contained in Exhibit V.A.1 of the RFP.

2. Non-Network Claims

a. Duties and Responsibilities

- 1) The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee (or Approved Facility) in a timely manner.
- 2) The Contractor will process Non-Network claims, as follows:
 - a. For the Empire Plan and Excelsior Plan: using Reasonable and Customary charges based on the 90th percentile of charges for each service performed, as determined by Fair Health. Reasonable and Customary means the lowest of:
 1. The actual charge for services; or
 2. The usual charge for services by the Provider for the same or similar service; or
 3. The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.
 - b. For the Student Employee Health Plan: using the Network Provider allowed amount applicable for Downstate New York;
- 3) The claim payments are to be made based on the requirements contained in Section IV of the RFP, including but not limited to each group's Co-insurance and Deductible as reflected in Exhibit II.B; and Exhibit II.B.2 as well as the annual maximum for ABA services.
- 4) Where a Network Provider is not available because of clinical or access considerations, the Contractor must negotiate a Single Case Agreement with a Non-Network Provider in a manner consistent with what is typically allowed for a Network Provider in the same discipline for the same service. The Contractor must pay the claim and charge the MHSA Program as if the services were

incurred in-network and include these charges in the calculations of the annual AAUC.

- 5) The Contractor will update its database with Fair Health's Reasonable and Customary amounts in a timely manner, at a minimum of twice a year.

b. Required Submission

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.2.a. above, Section IV of the RFP and Section VII, Article 12.2.0 of the RFP.
- 2) Does the Offeror establish a different allowed amount for Non-Network Provider charges based on licensure type or some other clinical criteria for the same CPT code? Please describe the Offeror's methodology in developing the allowed amount for each CPT code if it varies based on licensure type or some other clinical criteria.

3. Administrative Fee

The Administrative Fee is the fee quoted by the Offeror representing the charge to the MHSA Program to cover all of the administrative services provided by the Contractor, with the exception of Shared Communication Expenses. Do not include amounts for the Patient-Centered Outcomes Research Institute (PCORI) fee as that will be paid directly by the Plan.

a. Duties and Responsibilities

The Contractor is required to:

- 1) Be bound by its quoted Administrative Fee, as proposed in the Contractor's Cost Proposal for the entire term of the Agreement, unless amended in writing;
- 2) Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;

- 3) Implement any changes necessary to accommodate MHSa Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice;
- 4) Implement all benefit designs as required by the Department with or without final resolution of any request for an Administrative Fee adjustment. Refusal to implement benefit design changes will constitute a material breach of the Agreement and the Department will seek compensation for all damages resulting;
- 5) Agree not to request a higher Administrative Fee, and the Department will not consider any increase to the Administrative Fee that is not based on a material change to the MHSa Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Department;
- 6) Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Administrative Fee resulting from a material change in the benefit structure of the MHSa Program. The Department reserves the right to request and the Contractor agrees to provide any additional information and documentation the Department deems necessary to verify that the request for an increase to the Administrative Fee is warranted. The Department's decision to modify the Administrative Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal amendment to the Agreement by the New York State Attorney General and New York State Office of State Comptroller;
- 7) Agree that the Administrative Fee shall be calculated based on the number of covered MHSa Program Enrollees as reported by NYBEAS on the first Thursday of each month. The Department shall furnish to the Contractor a written statement for each month showing the number of Enrollee contracts then in force.

- 8) Claims incurred during the coverage period of the contract but processed/paid after the last day of coverage, as well as applicable Disabled Lives claims incurred after the last day of coverage of the agreement will be administered by the Contractor selected in response to this RFP. An Administrative Fee will not be payable/due beyond the date the last day of coverage; therefore, Offerors should take this into consideration in developing their proposed Administrative Fee.

b. Required Submission

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.3.a. above.
- 2) The Offeror is required to provide the Offeror's Administrative Fee quote in Exhibit V.B.

4. Assessments

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

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

a. Duties and Responsibilities

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

b. Required Submission

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.4.a. above.
- 2) Disclose other applicable assessments, if any, including the amount and basis of the assessment, made by other states/federal government that are applicable to the MHSA Program. Advise whether these assessments can be paid by the Offeror on behalf of the MHSA Program or if they would be directly paid by the Department.

5. Shared Communication Expense

The cost of Empire Plan communication expenses, including Empire Plan reports, At-A-Glance summaries and general information books are allocated among the four Empire Plan Program components. The MHSA Program allocation of shared communication expenses was \$532,000 in 2014 and \$456,000 in 2013.

a. Duties and Responsibilities

- 1) The Contractor will pay the medical carrier/third party administrator on a quarterly basis an amount billed for Shared Communication Expenses. The Contractor will be notified prior to the beginning of each Plan Year the amount of Shared Communication Expenses that will be billed.

- 2) The Contractor shall seek reimbursement of the Shared Communications Expense from the Department by including the amount with the voucher for the payment of the next Administrative Fee to be paid.

b. Required Submission

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

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

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

The following information is presented for use by Offerors in developing their Cost Proposal. As of January 2014, there were 233,912 individual contracts and 288,551 family contracts with Empire Plan Mental Health and Substance Abuse coverage. In addition to the Empire Plan contracts, there are 112 individual contracts and 105 family contracts with the Excelsior Plan and 4,837 individual contracts and 804 family contracts with the Student Employee Health Plan (SEHP) benefits. The contract totals include Empire Plan and Medicare primary enrollees. The enrollment mix and benefit characteristics are presented in Exhibit II.A through Exhibit II.A.4; Exhibit II.C; Exhibit II.C.2; and Exhibit II.D. of this RFP. However, the Department cannot guarantee that, during the term of the Agreement, the same enrollment mix and benefit characteristics as those set forth in Exhibit II.A through Exhibit II.A.4; Exhibit II.C; Exhibit II.C.2; and Exhibit II.D will exist.

a. Duties and Responsibilities

- 1) The Contractor will bill the Department periodically, as proposed, by the Contractor, after claims have been processed. The Department shall pay the Contractor by "wire transfer" within seven days have receiving a bill of the claims processed by the

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- Contractor. The Department may consider comparable alternatives to this approach during implementation.
- 2) The Plan will pay an Administrative Fee on a monthly basis within thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the Department for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program. Alternatively, the Department may request and receive payment of any performance guarantee amount directly from the Contractor, as opposed to a credit against the Administrative Fee payable to the Contractor.
 - 3) The Contractor will be billed the MHSA Program's portion of the Shared Communications Expense by the medical carrier/third party administrator in 2015 and each Plan Year thereafter in four (4) equal installments. The Contractor will pay the medical carrier/third party administrator the amount billed and may seek reimbursement from the MHSA Program. Subsequent years' amounts will be calculated by the Department and communicated to the Contractor during the annual rate renewal process. Upon receipt of each Shared Communications Expense bill, the Contractor may bill and the Plan will pay the Contractor an identical amount within thirty (30) Days.
 - 4) Upon final audit determination by the Department, any audit liability amount assessed by the Department shall be paid/credited to the MHSA Programs within thirty (30) Days of the date of the Department's final determination, or within thirty (30) Days of receipt of recoveries related to fraud or abuse or Department errors.
 - 5) The Contractor shall analyze and monitor claim submissions to promptly identify errors, fraud and/or abuse and report to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment made by the Contractor regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error. The Contractor shall

report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Program within thirty (30) Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.

- 6) Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.
- 7) The Agreement resulting from this RFP is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that MHSA Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due dates as set forth in Article XV of the Agreement. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice, as set forth in Article XV of the Agreement, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.

b. Required Submission

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

D. Cost/Transparency Related Questions

1. Network Provider Questions

- a. Describe fully the nature of your reimbursement arrangements with Network Facilities. Distinguish between per diems, case rates, percent of charges versus other types of reimbursement arrangements. Also, distinguish between how your reimbursement arrangements are structured in NYS versus other states that have a high concentration of Empire Plan members, such as New Jersey and Florida.
- b. Is there an escalator clause in your Network Facilities contracts to increase fees periodically or are any increases negotiated on a case by case basis? What is your Facility contracting cycle? When were the Network Facility fees last increased?
- c. What is your current average Network Facility reimbursement as a percentage of covered charges for your book of business in NYS?
- d. Is there an escalator clause in your Network Practitioner contracts to increase fees periodically or are any increases negotiated on a case by case basis? What is your Network Practitioners contracting cycle? When were Network Practitioner fees last increased?
- e. What is your current average Network Practitioner reimbursement as: 1) a percentage of covered charges for your book of business in NYS; and 2) a percentage of the Fair Health 90th percentile reasonable and customary charges? Does Network Practitioner reimbursement vary based on licensure of some other credentialing criteria? If so, please describe methodology.
- f. Some Offerors negotiate global reimbursement arrangements with Network Facilities to cover certain services such as professional inpatient visits that are normally billed by Practitioners. With respect to global reimbursement, please respond to the following:
 - 1) Do you reimburse Network Facilities globally for any Practitioners' services?
 - 2) If yes, describe completely the types of services that are globally reimbursed and the prevalence of such reimbursement both within and outside NYS. What

percent of your Network Facility claim dollars do you estimate are attributable to global reimbursement?

- g. Confirm your willingness to provide the Department with information pertaining to specific fee arrangements made with Network Providers, if requested, both during the procurement process and throughout the term of the Agreement resulting from this RFP.
- h. Is the Offeror's Proposed Network a standard Network or has it been specifically contracted to administer the Empire Plan MHSA Program? Are the proposed Network Provider fees included in this RFP response currently in place in NYS?
- i. Does the Offeror have a single standard contract with Network Providers with consistent terms applied to all of the Offeror's clients? If no, please describe the basis and reasons for the differences.
- j. In addition to negotiating agreements with Network Providers on behalf of clients, does the Offeror or any of its Affiliates or any Key Subcontractor's Affiliates have other business arrangements with Network Providers from which the Offeror or any of its Affiliates or any Key Subcontractor's Affiliates have derived revenues? If the Offeror and/or any of its Affiliates or any Key Subcontractor's Affiliates derive revenue or obtain other consideration or compensation from agreements with Network Providers, please identify the recipient(s) of such Network Provider revenue and explain the business relationship from which the revenue is derived. Please detail how the Offeror's business model ensures that these relationships do not create a real or perceived conflict with the clinical and financial interests of the MHSA Program.
- k. Are the Offeror's Network fee schedules incorporated in formally adopted corporate policies and procedures? Please explain.
- l. Does the Offeror maintain more than one Network fee schedule for purposes of reimbursing Network Providers? Or, does the Offeror have multiple reimbursement

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- agreements with individual Network Providers that are assigned and utilized based on client and/or different Offeror network products?
- m. Describe how Alternative Level of Care (ALOC) services are billed by providers and reimbursed by the Offeror. Are these services billed on a per service or per diem basis?
 - n. Describe how outpatient alcohol treatment center services are billed by providers and reimbursed by the Offeror. Are these services billed on a per service or per diem basis?

2. Transparency of Financial Interests - Post Contract Award Requirements

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

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

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

SECTION VI: EVALUATION AND SELECTION CRITERIA

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

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

The Department will consider for evaluation and selection purposes only those Proposals:

- 1) determined to have met the Minimum Mandatory Requirements specified in Section III of this RFP; and 2) determined to be responsive to the duties and responsibilities set forth in the RFP.

The Department's desire is to select a single Offeror to administer the MHSA Program for The

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

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

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

A. Technical Evaluation

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

1. Technical Score Ratings

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

a. Excellent (5)

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

b. Good (4)

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

c. Meets Criteria (3)

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

d. Fair (2)

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

e. Poor (1)

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

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

2. Performance Guarantee Ratings

A rating of “excellent” equates to a score of 5 for each evaluated service level standard. Each reduction in the ratings results in a one point reduction in the score such that a rating of “poor” equates to a score of 1. Offerors may propose performance guarantees that exceed the MHSA Program’s service level standards presented in this RFP. Proposed performance guarantees are contained within the respective technical areas and will be evaluated using the following criteria:

a. Excellent (5)

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

b. Good (4)

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

c. Meets Criteria (3)

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

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- (2) The Offeror's proposed credit amount equals the standard credit amount stated within this RFP.

d. Fair (2)

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

e. Poor (1)

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

3. Performance Guarantee Standard Credit Amounts

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

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

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- e. Telephone Blockage Rate (Section IV.B.4.b.(8.d)) : \$25,000 per year;
 - f. Enrollment Management (Section IV.B.6.b(8)): \$5,000 for each 24 hour period beyond 24 hours from the release of the MHSA Program enrollment records;
 - g. Reporting (Section IV.B.7.b.(6)): \$1,000 per report per Business Day between the due date and the date the report is received by the Department inclusive of the day the report is received;
 - h. Network Composition (Section IV.B.10.b.(12)under the subheading “Provider Network”): \$25,000 per year;
 - i. Network Provider Access (Section IV.B.10.b.(13)under the subheading “Provider Network”): \$6,000 per each quarter for each performance guarantee in each of the two (2) Provider types in each of the three (3) areas in which the performance guarantee is not met;
 - j. Network Provider Access (Section IV.B.10.b.(14) under the subheading “Provider Network”): \$1,000 for each quarter that the Offeror’s proposed performance guarantee for access to Applied Behavioral Analysis services is not met;
 - k. Provider Credentialing (Section IV.B.10.b.(7)), under the subheading “Provider Credentialing: \$1,500 per instance;
 - l. Financial Accuracy (Section IV.B.11.b.(17)): \$10,000 per year;
 - m. Non-Financial Accuracy (Section IV.B.11.b (18)): \$10,000 per year;
 - n. Turnaround Time for Network Claims (Section IV.B.11.b.(19)): \$6,000 per each quarter;
 - o. Turnaround Time for Non-Network Claims (Section IV.B.11.b.(20)): \$6,000 per each quarter;
 - p. Non-Network Referrals (Section IV.B.12.b.(6)): \$10,000 per year;

- q. Emergency Care Follow-up (Section IV.B.12.b.(7)): \$10,000 per year;
- r. Urgent Care Follow-up (Section IV.B.12.b.(8)): \$10,000 per year;
- s. Outpatient Treatment Utilization Review (Section IV.B.12.b. (9)), under subheading “Concurrent Review”: \$10,000 per year;
- t. Inpatient Treatment Utilization Review (Section IV.B.12.b.(10)), under subheading “Concurrent Review”: \$10,000 per year;
- u. Inpatient Appeals (Section IV.B.12.b.(5)), under subheading “Appeals Process”: \$10,000 per year; and
- v. Outpatient & ALOC Appeals (Section IV.B.12.b.(6)), under subheading “Appeals Process”: \$10,000 per year.

4. Technical Scoring

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

B. Cost Evaluation Component

The Cost Proposal of any Offeror that meets the Minimum Mandatory Requirements will be evaluated by the Department, and others deemed appropriate by the Department. The Department reserves the right to conduct Cost Proposal oral interviews and/or seek written

responses from Offerors to clarify any aspect of the Offeror's cost Proposal. The Department will then calculate a Cost Score for each Offeror.

1. Cost Evaluation

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

a. Claim Costs:

- i. **Projected Cost of Network Claims:** The projected cost of Network claims shall be calculated by the Department by multiplying the Guaranteed Average Unit Cost (GAUC) for Network Outpatient Services as presented by the Offeror in response to Exhibit V.A.2 of this RFP, and the GAUC for Network Inpatient Services as presented by the Offeror in response to Exhibit V.A.3 of this RFP, by the number of units of Network service pertaining to plan primary services as projected and normalized by the Department; plus,
- ii. **Projected Cost of Non-Network Claims:** The projected cost of Non-Network claims pertaining to plan primary services as calculated and normalized by the Department; plus,
- iii. **Projected Bad Debt and Charity (BDC) Assessment:** The projected BDC assessment shall be calculated by multiplying a fixed BDC percentage by the Network and Non-Network claim amounts calculated in i and ii above.

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

- b. Administrative Fee(s):** The Department shall multiply the Administrative Fee quoted in Exhibit V.B of this RFP by the number of covered Enrollees, multiplied by twelve (12 months).
- c. The Department reserves the right to Analyze and/or Normalize:** The Department reserves the right to make other cost calculation adjustments as necessary to

determine the evaluated cost of the Offeror's Proposal. Any such adjustments shall be made with the intent to evaluate Offeror's Proposals on a fair and consistent basis, without prejudice. These normalization adjustments may include but are not limited to unforeseen circumstances whereby the normalization of specific factors among Offerors shall result in a more accurate and fair comparison of the Offerors' Cost Proposals as applied to the normalized claim base.

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

2. Cost Score

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

C. Total Combined Score of Technical and Cost

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

D. Best Value Determination

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

shall be deemed made when notice of proposed contingent award is issued by the Department to the selected Offeror.

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

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

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

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

Mental Health and Substance Abuse Program RFP #2014-MH-1 for the Empire Plan, Excelsior Plan and Student Employee Health Plan Model Contract

SECTION VII: CONTRACT PROVISIONS

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AGREEMENT NO. C000XXX

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

and

INSERT Contractor NAME

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

WITNESSETH

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

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

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

WHEREAS, on March 13, 2014, the Department of Civil Service issued a Request for Proposal (RFP) entitled “Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Health Plan” to secure the services of a qualified organization to provide Program Services as defined in the RFP; and

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

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

THEREFORE, the Parties agree as follows:

ARTICLE I: DEFINITION OF TERMS

- 1.1.0 Actual Average Unit Cost (AAUC)** means the average unit cost for Network Coverage/Services paid during the Plan Year. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to Network Providers for Network Outpatient Services and Network Inpatient/ALOC Services for Plan primary claims only and prior to the application of Copayment and Bad Debt and Charity assessments.
- 1.2.0 Administrative Fee** means the monthly fee that the Contractor charges the MHSA Program for all administrative services exclusive of the Shared Communication Expense as calculated on a per Enrollee per Month basis.
- 1.3.0 Affiliate** means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.
- 1.4.0 Alternate Level of Care (ALOC)** means residential treatment centers, halfway houses, group homes, partial hospitalization programs or continuing day treatment programs which satisfy the requirements of an Approved Facility.
- 1.5.0 Applied Behavioral Analysis (ABA)** means a behavioral health service for teaching children with Autism Spectrum Disorder through intensive skill training.

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- 1.6.0 Approved Facility** means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by the Contractor. Residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by the Contractor.
- 1.7.0 Business Day(s)** means every Monday through Friday, except for days designated as Business Holidays.
- 1.8.0 Business Holiday(s)** means legal holidays observed by the State and any days designated by the Contractor as a holiday and approved as such by the State prior to January 1 of each Calendar Year.
- 1.9.0 Calendar Year/Annual** means a period of 12 months beginning with January 1 and ending with December 31.
- 1.10.0 Call Center Hours** means 24 hours a Day, 365 Days a year.
- 1.11.0 Certification or Certified** means a determination by the Contractor that mental health care or substance abuse care or proposed care is a Medically Necessary, Covered Service in accordance with the terms of the Agreement.
- 1.12.0 Child(ren)** means children under 26 years of age, including natural children, legally adopted children, children in a waiting period prior to finalization of adoption, Enrollee stepchildren and children of the Enrollee's domestic partner. Other children who reside permanently with the Enrollee in the Enrollee's household and are chiefly dependent on the Enrollee are also eligible, subject to a statement of dependence and documentation.

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SECTION VII: CONTRACT PROVISIONS

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- 1.13.0 Clinical Manager** means licensed Ph.D.; clinical psychologist, licensed professional registered nurse, or licensed master's level certified social worker with a minimum of three to five years of previous position-related clinical experience in mental health and/or substance abuse treatment or other licensed, qualified individual as approved by the MHSA Program.
- 1.14.0 Clinical Referral Line** means the clinical resource and referral service called prior to receiving any Covered Services to obtain network referrals or benefit information. Available 24 hours a Day, 365 Days a year.
- 1.15.0 Coinsurance** means, for Non-Network Approved Facility services, the difference between the billed charge and the percentage covered; and, for non-network Practitioner services, the difference between the Reasonable and Customary charge and the percentage covered. The Plan's Coinsurance Maximum is shared between Basic Medical, the Hospital Program and the Mental Health and Substance Abuse Program. Copayments paid to a Network Practitioner count toward meeting the Plan's Coinsurance Maximum.
- 1.16.0 Coinsurance Maximum** means the sum of coinsurance costs incurred under the Basic Medical Program and Non -Network Coverage under the Hospital Program and Mental Health and Substance Abuse Program. After the combined annual Coinsurance Maximum is reached, benefits are paid at 100 percent of Reasonable and Customary charges for Covered Services.
- 1.17.0 Contractor** means (TBD), the successful Contractor selected as a result of the evaluation of Offerors' Proposals submitted in response to the RFP and the Contractor who executes an Agreement with the Department to provide Program Services.
- 1.18.0 Copayment** means the amount the Enrollee is required to pay per visit for Covered Services as specified by the benefit design of the MHSA Program.
- 1.19.0 Cost Sharing** means the Enrollee's financial responsibility for Covered Services including Copayment, Deductible and Coinsurance.
- 1.20.0 Covered Services** means Medically Necessary mental health and substance abuse care as defined under the terms of the MHSA Program, except to the extent that such care is otherwise limited or excluded under the MHSA Program.

- 1.21.0 Crisis Intervention Visits** means an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.
- 1.22.0 Day(s)** means calendar days unless otherwise noted.
- 1.23.0 DCS or Department** means the New York State Department of Civil Service.
- 1.24.0 Dedicated Call Center** means a group of customer service representatives trained and capable of responding to a wide range of questions, complaints, and inquiries specific to the MHSA Program. The customer service representatives are dedicated to the MHSA Program and do not work on any other accounts.
- 1.25.0 Deductible** means the amount paid by the Enrollee each Calendar Year for Covered Services under the non-network portion before a Plan payment is made. Plan deductibles are shared between the Medical Program and the Mental Health and Substance Abuse Program. The amount applied toward satisfaction of the deductible will be the lower of the following: the amount actually paid for a Medically Necessary service under the non-network portion of the MHSA Program; or for Practitioner services, the Reasonable and Customary charge; or for Approved Facility services, the billed amount for such service.
- 1.26.0 Dependent** means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee. Young adult dependent children age twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to mental or physical disability acquired before termination of their eligibility for coverage under the New York State Health Insurance Program.
- 1.27.0 Dependent Survivor** means the unremarried spouse, dependent child, or domestic partner who has not acquired another domestic partner, of an Enrollee who died after having had at least ten (10) years of service, who was covered as a dependent of the deceased Enrollee at the time of

the Enrollee's death and who elects to continue coverage under NYSHIP following the three (3) month extended benefits period.

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

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

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

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

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

1.33.0 ET means prevailing Eastern Time.

1.34.0 Guaranteed Average Unit Cost (GAUC) means the amounts as proposed by the Contractor for Network Outpatient Services and Network Inpatient/Alternative Level of Care (ALOC) Services in RFP Exhibits V.A.2 and V.A.3, respectively. The GAUC amounts shall be based on Plan primary claims only and be prior to the application of Copayment and Bad Debt and Charity assessments. The GAUC for Network Inpatient/ALOC Services may incorporate the inpatient professional service component pertaining to global reimbursement arrangements.

1.35.0 HIPAA means Health Insurance Portability and Accountability Act of 1996.

1.36.0 Implementation Date means the first day of the month following a minimum implementation period of 90 days subsequent to the Office of State Comptroller's approval of the Agreement that results from this RFP.

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

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

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

1.40.0 Maximum Out-of-Pocket means the maximum out-of-pocket costs incurred by an Enrollee for network Copayments for the Medical, Hospital and Mental Health/Substance Abuse Programs, as required by the Affordable Care Act (ACA) for non-grandfathered Plans.

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

1.42.0 Mental Health Care means Medically Necessary care rendered by a covered Practitioner or Approved Facility and which, in the opinion of the Contractor, is directed predominately at treatable behavioral manifestations of a condition that the Contractor determines: is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and substantially

or materially impairs a person's ability to function in one or more major life activities; and has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

- 1.43.0 MHSA Program/Plan** means the New York State Health Insurance Program's Empire Plan Mental Health and Substance Abuse Program, the Excelsior Plan Mental Health and Substance Abuse Program and the Student Employee Health Plan Mental Health and Substance Abuse Program administered by the New York State Department of Civil Service.
- 1.44.0 Mixed Services Protocol** means the methodology for allocating the financial liability for covered MHSA services between the Medical Program contractor, Hospital Program contractor and the MHSA Program contractor.
- 1.45.0 Network Coverage / Services** means all Medically Necessary services/days paid at the Network benefit level including Medically Necessary services/days rendered by a Non-Network Provider when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services.
- 1.46.0 Network Facility** means an Approved Facility that has entered into a Network Provider agreement with the Contractor as an independent contractor. The records of the Contractor shall be conclusive as to whether a facility has a Network Provider agreement in effect on the date services are obtained. A non-network facility can be considered a network facility on a case-by-case basis when approved by the Contractor.
- 1.47.0 Network Practitioner** means a Practitioner who has entered into an agreement with the Contractor as an independent contractor to provide Covered Services. The records of the Contractor shall be conclusive as to whether a person had a Network Provider agreement in effect on the date services are obtained. A Non-Network Practitioner can be considered a Network Practitioner on a case-by-case basis when approved by the Contractor.
- 1.48.0 Network Provider** means either a Network Practitioner or a Network Facility.

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- 1.49.0 Non-Network Coverage** means the level of reimbursement paid by the MHSA Program for Covered Services from a Non-Network Provider in compliance with the MHSA Program requirements outlined in the Agreement.
- 1.50.0 Non-Network Facility** means an Approved Facility that has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services.
- 1.51.0 Non-Network Practitioner** means a Practitioner who has not entered into an agreement with the Contractor as an independent contractor to provide Covered Services. A Non-Network Practitioner can be considered a Network Practitioner on a case-by-case basis when approved by the Contractor.
- 1.52.0 Non-Network Provider** means a Non-Network Practitioner or Non-Network Facility.
- 1.53.0 NYS** means New York State.
- 1.54.0 NYSHIP** means the New York State Health Insurance Program.
- 1.55.0 Outpatient Services** means those services rendered in a Practitioner's office or in the department of an Approved Facility where services are rendered to persons who have not had an overnight stay and are not charged for room and board.
- 1.56.0 Partial Hospitalization** means a freestanding or hospital-based program that maintains hours of service for at least 20 hours per week and may also include half-day programs that provide services for less than 4 hours per day. A partial hospital/day treatment program may be used as a step up from a less intensive level of care or as a step down from a more intensive level of care and does not include an overnight stay.
- 1.57.0 Participating Agency (PA)** means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.
- 1.58.0 Participating Employer (PE)** means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the

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

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

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

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

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

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

1.64.0 PPACA or ACA means Patient Protection and Affordable Care Act of 2010 and it's implementing regulations.

1.65.0 Practitioner means:

1.65.1A psychiatrist; or

1.65.2A psychologist; or

1.65.3A licensed clinical social worker with at least six (6) years of post-degree experience who qualifies for the New York State Board for Social Work "R designation". If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or

1.65.4A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses who hold a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; or

1.65.5A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat, and prescribe for a patient's condition that falls within their specialty area of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols; or

1.65.6 Applied behavioral analysis provider or Certified Behavioral Analyst (CBA) provider: A licensed provider who is certified as a behavior analyst pursuant to a behavioral analyst certification board; or

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

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

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

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

1.69.0 **Proposal** means the Contractor's Administrative Proposal, Technical Proposal, and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

1.70.0 Provider means a Practitioner or Approved Facility that supplies Covered Services under the MHSA Program.

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

1.72.0 Reasonable and Customary means the lowest of:

1.72.1The actual charge for services; or

1.72.2The usual charge for services by the Provider; or

1.72.3The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.

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

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

1.75.0 Renewal Date means January 1, 2016 and annually thereafter up to and including January 1, 2019.

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

1.77.0 RFP or Procurement means the Request for Proposals entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan, dated March 13, 2014.

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

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

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

1.81.0 State means New York State as a whole.

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

1. 83.0 Substance Abuse Care means Medically Necessary care provided by an eligible provider for the illness or condition that the Contractor has determined: is a clinically significant behavioral or psychological syndrome or pattern; and substantially or materially impairs a person's ability to function in one or more major life activities; and is a condition which has been classified as a substance abuse disorder in the current American Psychiatric Association Diagnostic and

Statistical Manual of Mental Disorders, unless such condition is otherwise excluded under this MHS A Program.

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

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

1.86.0 Transition of Care means a benefit that provides Enrollees with the Network level of benefits for a period of 90 days to continue Covered Services that commenced with a Network Provider of the former Program contractor.

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

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

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

ARTICLE II: AGREEMENT DURATION AND AMENDMENTS

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- 2.1.0** This Agreement shall be subject to and effective upon the approval of the New York State Attorney General’s Office (“AG”) and the NYS Office of the State Comptroller (“OSC”). The term of the Agreement shall include a minimum 90-day implementation period followed by five (5) years of Program Services, with up to an 11-month extension, at the sole discretion of the Department. It is the Department’s intent that this implementation period shall begin following OSC approval of the Agreement, with all other contractual responsibilities (with the exception of the Contractor’s Dedicated Call Center and customized website) to begin on the first day of the month following the 90-day implementation period after OSC approves the Contract and subject to the termination provisions contained herein.
- 2.2.0** The Agreement is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by the AG and the OSC.

ARTICLE III: INTEGRATION

- 3.1.0** This Agreement, including all Exhibits, copies of which are attached hereto and incorporated by reference, constitutes the entire Agreement between the Parties. All prior Agreements, representations, statements, negotiations, and undertakings are superseded hereby.
- 3.2.0** All statements made by the Department shall be deemed to be representations and not warranties.

ARTICLE IV: DOCUMENT INCORPORATION AND ORDER OF PRECEDENCE

- 4.1.0** The Agreement consists of:
- 4.1.1** The body of the Agreement (that portion preceding the signatures of the Parties in execution), and any amendments thereto;
 - 4.1.2** Appendix A – Standard Clauses for All New York State Contracts;
 - 4.1.3** Appendix B – Standard Clauses for All Department Contracts;
 - 4.1.4** Appendix C – Third Party Connection and Data Sharing Agreement;
 - 4.1.5** Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;
 - 4.1.6** The following Exhibits attached and incorporated by reference to the body of the Agreement:

- 4.1.6a** Exhibit A: which includes: the MacBride Act Statement; and the Non-Collusive Bidding Certification;
 - 4.1.6b** Exhibit B: the Request for Proposals entitled “Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan,” dated March 13, 2014 and Exhibit B-1, the official Department response to questions raised concerning the RFP, dated **(TBD)**;
 - 4.1.6c** Exhibit C: the Contractor's Proposal; and, Exhibit C-1: Written responses to the Management Interview and related materials clarifying the Contractor's Proposal; and
 - 4.1.6d** Exhibit D: the Summary Plan Descriptions.
 - 4.1.6e** Exhibit E: Guaranteed Average Unit Costs
- 4.1.7** In the event of any inconsistency in, or conflict among, the document elements of the Agreement identified above, such inconsistency or conflict shall be resolved by giving precedence to the document elements in the following order:
- 4.1.7a** First, Appendix A – Standard Clauses for All New York State Contracts;
 - 4.1.7b** Second, Appendix B – Standard Clauses for All Department of Civil Service Contracts;
 - 4.1.7c** Third, Appendix C –Third Party Data Connection and Data Exchange Agreement;
 - 4.1.7d** Fourth, Appendix D – Participation by Minority Group Members and Women With Respect to State Contracts: Requirements and Procedures;
 - 4.1.7e** Fifth, any Amendments to the body of the Agreement;
 - 4.1.7f** Sixth, the body of the Agreement;
 - 4.1.7g** Seventh, Exhibit B, the Request for Proposals entitled “Mental Health and Substance Abuse Benefit Services for The Empire Plan, Excelsior Plan and Student Employee Health Plan dated March 13, 2014” and Exhibit B-1, the official Department response to questions raised concerning the RFP, dated **(TBD)**;

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- 4.1.7h** Eighth, Exhibit C: the Contractor's Proposal; and, Exhibit C-1: Written responses to the Management Interview and related materials clarifying the Contractor's Proposal; and
- 4.1.7i** Ninth, Exhibit D, the Summary Plan Description and Benefit Summaries
- 4.1.7j** Tenth, Exhibit E, Guaranteed Average Unit Costs
- 4.2.0** The terms, provisions, representations and warranties contained in the Agreement shall survive performance hereunder.

ARTICLE V: LEGAL AUTHORITY TO PERFORM

- 5.1.0** The Contractor shall maintain appropriate corporate and/or legal authority, which shall include but is not limited to the maintenance of an administrative organization capable of delivering the Program Services in accordance with the Agreement and the authority to do business in the State of New York or any other governmental jurisdiction in which the Program Services are to be delivered.
- 5.2.0** Contractor agrees that it shall perform its obligations under this Agreement in accordance with all applicable federal and NYS laws, rules and regulations, policies and/or guidelines now or hereafter in effect, including but not limited to the requirements set forth in Chapter 56 of the Laws of 2010.
- 5.3.0** The Contractor shall provide the Department with immediate notice in writing of the initiation of any legal action or suit which relates in any way to the Agreement, or which may affect the performance of Contractor's duties under the Agreement.

ARTICLE VI: PROGRAM SERVICES

- 6.1.0** The Contractor shall provide all of the Program Services as set forth herein this Article VI of the Agreement for the entire term of the Agreement pursuant to the Summary Plan Description(s) incorporated into this Agreement as Exhibit D. All Program Services shall be provided in accordance with the New York State Civil Service Law and its implementing regulations, and other NYS and Federal Law as may be applicable. In addition, the Contractor shall deliver the Program Services in such a manner so as to comply with all provisions of this

Agreement. The Contractor may provide certain services through Key Subcontractors or Affiliates with the prior review and approval of the Department. Each subcontract entered into with a corporate entity separate from the Contractor for the purpose of delivering Program Services must be maintained throughout the term of the Agreement unless such change is approved in writing by the Department. All Key Subcontracts shall expressly name the State of New York, through the Department, as the sole intended beneficiary of any such Key Subcontract. The Contractor must maintain significant financial, legal, and audit oversight of any of its Key Subcontractors or Affiliates. The Contractor remains fully responsible for all services and actions performed under this Agreement. The Contractor shall submit all Key Subcontracts to the Department for its approval. The Contractor shall submit all such Key Subcontracts with no redactions to the Department before execution for its review and approval.

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

6.2.0 Account Team

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

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

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

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

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

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

6.2.3 The Contractor's dedicated account team must ensure that the MHSAs 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 MHSAs Program material.

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

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

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

6.3.3 Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate

recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

6.4.0 Implementation

6.4.1 The Contractor must 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 Contractor to complete all implementation activities within the 90-day implementation period.

6.4.2 *Implementation and Start-up Guarantee:* The Contractor must guarantee that all Implementation and Start-up activities will be 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 have in place and operational:

6.4.2a A contracted Provider network (including Certified Behavior Analysts) that meets or exceeds the access and density standards set forth in Section IV.B.10 of this RFP;

6.4.2b 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;

6.4.2c 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;

6.4.2d 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

6.4.2e A fully-functional, customized MHSA Program website available a minimum of thirty (30) days prior to Program the 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.

6.5.0 Customer Service

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

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

6.5.1b The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the 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 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 Agreement;

- 6.5.1c** Maintaining a Dedicated Call Center for the MHSA Program located in the United States (preferably in New York State) that:
- 6.5.1d** Providing direct access to trained Clinicians who direct members to appropriate Network Providers, provide clinical MHSA information and if requested by the caller, assist in scheduling appointments on behalf of the member twenty-four (24) hours a Day, 365 Days a year;
- 6.5.1e** Providing 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 8:00a.m.to 5:00p.m. Monday through Friday, except for Business Holidays; and
- 6.5.1f** Meets the Contractor's proposed call center telephone guarantees set forth in Section 7.3.0 through 7.6.0 of this Agreement.
- 6.5.2** Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions;
- 6.5.3** Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries, including but not limited to: 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;
- 6.5.4** Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the Dedicated 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; and

6.5.5 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's website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal.

6.6.0 Enrollee Communication Support:

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

- 6.6.2** The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:
- 6.6.2a** Developing language describing the MHSA Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;
 - 6.6.2b** Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing MHSA Program benefit features and/or highlighting trends in MHSA utilization;
 - 6.6.2c** Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department;
 - 6.6.2d** Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period; and
 - 6.6.2e** Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XIII of the Agreement resulting from this RFP.
- 6.6.3** Upon request, subject to the approval of the Department, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United

States. The Contractor agrees that the costs associated with these services are included in the Contractor's Administrative Fee.

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

6.7.0 Enrollment Management:

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

6.7.1a *Initial Testing:* Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department; and

6.7.1b 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.

6.7.2 Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims

processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall, 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 B of the Agreement. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

- 6.7.3** Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;
- 6.7.4** Providing a back-up system or have a process in place where, if enrollment information is unavailable, Enrollees can obtain Clinical Referral Line services without interruption;
- 6.7.5** Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement;

- 6.7.6** Maintaining a read-only connection to the enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS Monday through Friday, from 8:00 am to 5:00 pm EST, with the exception of NYS holidays as indicated on the Department's website; and
- 6.7.7** Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO.
- 6.8.0 Reporting:** The Contractor is responsible for accurate reporting services including, but not limited to:
- 6.8.1** Ensuring that all financial reports including claim reports are generated from amounts billed to the MHSA Program, and reconcile to amounts reported in the quarterly and annual financial experience reports;
- 6.8.2** Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the MHSA Program. These reports must tie to the amounts billed to the MHSA Program. The final format of reports is subject to the Department review and approval;
- 6.8.3** Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The

reports include, but are not limited to, reports and data files listed in Article XV “Reports and Claim Files” section of this Agreement;

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

6.8.4a Forecasting and trend analysis data

6.8.4b Utilization data

6.8.4c Utilization review savings

6.8.4d Benefit design modeling analysis

6.8.4e Reports to meet clinical program review needs

6.8.4f Reports segregating claims experience for specific populations

6.8.4g Reports to monitor Agreement compliance

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

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

6.9.1 Informing the Department in a timely manner concerning such matters as cost containment strategies, technological improvements, Provider best practices and State/Federal legislation (e.g., Federal parity legislation, etc.) that may affect the MHSA Program. The Contractor must also make available to the Department one or more members of the clinical or account management team to discuss the implications of new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

6.9.2 Assisting the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all

associated costs, a clinical evaluation, and the anticipated impact of proposed MHSA Program modifications and contemplated benefit design changes on Enrollees. In the event of a design change and should the Contractor requests any change in compensation, any such change will be processed in accordance with Article VIII, Modification of Program Services.

6.10.0 Network Management

6.10.1 Provider Network

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

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

6.10.1b The Contractor must meet or exceed the Contractor’s proposed access standards for credentialed and contracted Certified Behavior Analysts in the MHSA Program’s Provider Network throughout the term of the Agreement, as follows: (TBD by Offeror’s proposal)

6.10.1c 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 6.4.0 of this Agreement guaranteeing effective implementation of their proposed MHSA Provider Network.

6.10.1d The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria 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.

6.10.1e In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed and registered Clinical Social Workers (CSW) (in NYS social workers must have an "R" number issued by the State Education Department), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied.

6.10.2 Provider Credentialing

- 6.10.2a** The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.
- 6.10.2b** The Contractor must establish credentialing criteria for Network Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the MHSA Provider Network, including, but not limited to, years of experience, level of education/certification, Licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments;
- 6.10.2c** The Contractor must credential MHSA Network Providers in a timely manner and shall have an effective process by which to confirm MHSA Network Providers continuing compliance with credentialing standards.
- 6.10.2d** The Contractor must maintain a Provider Relations staff presence within New York State.
- 6.10.2e** The Contractor must maintain credentialing records and make them available for review by the Department upon request.

6.10.3 Provider Contracting

- 6.10.3a** The Contractor will be responsible for providing Provider contracting services including but not limited to:
- 6.10.3a(1)** Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;
- 6.10.3a(2)** Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;
- 6.10.3a(3)** Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for

covered services, subject to the applicable MHSA Program

Copayments;

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

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

6.10.4 Provider Audit and Quality Assurance

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

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

6.10.4a(2) Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and abuse identified within seven (7) Business Days of receipt of such allegations or

identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the MHSA Program upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State;

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

6.10.4a(4) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt consistent with the process specified in Article XIV, "Payments/ (credits) to/from the Contractor" of this Agreement; and

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

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

6.10.4b(1) Monitoring the quality of care provided by Network Providers;

6.10.4b(2) Monitoring technical competency and customer service skills of Network Provider staff;

6.10.4b(3) Network Provider profiling;

6.10.4b(4) Peer review procedures;

6.10.4b(5) Outcome and Quality Measurement analysis; and

6.10.4b(6) Maintaining an ongoing training and education program that will be offered to Network Providers.

6.10.5 Value Based Initiatives

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.

6.11.0 Claims Processing

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

- 6.11.1a** Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;
- 6.11.1b** Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;
- 6.11.1c** Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance and Coinsurance Maximums, at the time the claim was incurred as specified to the Contractor by the Department;
- 6.11.1d** Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed by the Contractor and approved by the Department. The Contractor's system must ensure that payments are made only for authorized services;
- 6.11.1e** Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for the balance of the calendar year in which they were

made and for six (6) additional years thereafter, per Appendix A, with procedures to easily retrieve and load claim records;

- 6.11.1f** Maintaining the security of the claim files and ensuring HIPAA compliance;
- 6.11.1g** Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error;
- 6.11.1h** Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor 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;
- 6.11.1i** Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;
- 6.11.1j** Maintaining a claims processing system capable of integrating and enforcing the various clinical management and utilization review components of the MHSA Program including: pre-certification, prior authorization, concurrent review and benefit maximums;
- 6.11.1k** Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been applied to the Shared Accumulators; between the Empire Plan Hospital Program, Medical Program and MHSA Program;
- 6.11.1l** Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports Shared Accumulators;
- 6.11.1m** Participating in Medicare Crossover by entering into an agreement with the Empire Plan medical carrier/third party administrator to accept electronic claims data record files from the medical carrier/third party administrator for

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

- 6.11.1n** Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing 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;

- 6.11.1o** Analyzing and monitoring claim submissions to promptly identify errors, fraud and/or abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error, without additional administrative charge to the MHSA Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Programs upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered;

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

- 6.11.1q** Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Article XIV Payments/(Credits) to/from the Contractor.
- 6.11.1r** Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year; and
- 6.11.1s** Mailing Explanation of Benefits to Enrollees for Non-Network claims only. Explanation of Benefits for all MHSA Services must be available upon request from the Contractor's and available for download from the Contractor's customized website. An annual statement of network EOBs must be mailed to Enrollees

6.12.0 Clinical Management

6.12.1 Pre-Certification of Care

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

6.12.1a(1) Use of a voluntary Clinical Referral Line (CRL) located in the United States to evaluate Enrollees MHSA care needs and direct Enrollees to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate Clinicians' 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;

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

6.12.1a(2)i When an Enrollee contacts a Network Provider directly for treatment without calling the CRL, the

Contractor is ultimately responsible for ensuring that Enrollees receive the Network level of benefits and obtaining all necessary authorizations for treatments for Network outpatient services for “Recurrent Therapy Visits” and Network inpatient care, when an Enrollee contacts a Network Provider directly for treatment without calling the CRL;

6.12.1a(2)ii 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

6.12.1a(2)iii When an Enrollee contacts a Non-Network Facility for treatment and the Contractor is notified in advance of the admission, the Contractor must provide the Enrollee or other HIPAA authorized representative of the Enrollee, with a written determination of medical necessity of care in advance of the inpatient admission, where feasible.

6.12.1a(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;

6.12.1a(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;

6.12.1a(5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;

6.12.1a(6) Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program vendor and managing the patient's care if transferred to rehab: and

6.12.1a(7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the during the implementation period, once acceptable files are received.

6.12.2 Concurrent Review

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

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

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

The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;

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

6.12.2a(4) Performed by the Contractor for t outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

6.12.2a(5) For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care when medically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers;

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

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

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

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

6.12.2a(10) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is

appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by clinical Manager, as follows:

6.12.2a(10)i 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

6.12.2a(10)ii 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.

6.12.2a(11) 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;

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

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

6.12.3 Disabled Dependent Determinations

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

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

6.12.4 Appeal Process

6.12.4a The Contractor must:

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

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

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- 6.12.4a(2)a** Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment;
- 6.12.4a(2)b** Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and
- 6.12.4a(2)c** Integrating the appeal decisions into the clinical management and claims processing systems.
- 6.12.4a(3)** Establish two levels of internal clinical appeals as follows:
- 6.12.4a(3)a** A level 1 clinical appeal must be performed by an independent Peer Advisor; and
- 6.12.4a(3)b** A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case.
- 6.12.4a(3)c** Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:
- 6.12.4a(3)c(1)** For a second level clinical appeal of a post-service claim, within thirty (30) days of the member's request;
- 6.12.4a(3)c(2)** For a second level clinical appeal of a pre-service request for benefits, within fifteen (15) days of the member's request;

6.12.4a(3)c(3) For appeals involving urgent

situations, in no more than seventy-two (72) hours following receipt of the appeal.

6.12.4a(4) 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.

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

6.12.5 Other Clinical Management Programs

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

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

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- 6.12.5a(2)** methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;
 - 6.12.5a(3)** accepting referrals to Network Providers;
 - 6.12.5a(4)** telephonic support, coordination with treating providers and referrals to community services; and
 - 6.12.5a(5)** a method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of depression, eating disorders and ADHD in order to educate medical Providers about the availability of the depression, eating disorder and ADHD programs.

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

6.12.6 Transition of Care

6.12.6a 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.

6.12.6b 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.

ARTICLE VII: PERFORMANCE GUARANTEES

7.1.0 The Parties agree that the following guarantees and the corresponding credit amounts for failure to meet the Contractor Performance Guarantees shall be implemented effective the first day of

the month following a 90 day implementation period after the Office of the State Comptroller approves the Contract. The Contractor acknowledges and agrees that failure to perform the Program Services features in such a manner which either meets or exceeds any, and/or all of the Contractor Performance Guarantee(s) as set forth in this Article VII, and/or fails to make any payment(s) of any such credit amounts for such failure to meet any Performance Guarantee(s) does not relieve the Contractor of the performance of the activities, duties, and obligations as otherwise set forth in the Agreement. Credit amounts are cumulative. Amounts due from the Contractor to the Department for failure to perform and audit credit amounts, as determined pursuant to Article XIV of this Agreement, shall be made in such amounts as determined by the Department to be final. Upon such determination, the Department shall notify the Contractor, in writing, and the Contractor shall apply such amounts as a credit against the Administrative Fee in accordance with Article XIV of this Agreement within thirty (30) Days of receiving such notification by the Department. These amounts must also be applied as a credit against the Administrative Fee and reported in the Annual Financial Report.

7.2.0 Implementation and Start-up Guarantee and Credit Amount:

7.2.1 *Guarantee:* The Contractor 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 State Comptroller approves the Contract 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;

7.2.1a A contracted Provider network that meets the access standards set forth in Section 6.10.1 of this Agreement;

7.2.1b 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 6.5.0 of this Agreement; The Dedicated Call Center must be open and operational a minimum of thirty days prior to Program Implementation date to assist Enrollees with questions concerning Program transition;

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- 7.2.1c** A claims processing system that processes claims in accordance with the MHSa Program's plan design and benefits, as set forth in Section 6.11.0 of this Agreement;
- 7.2.1d** A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSa Program benefit design and contractual obligations; and
- 7.2.1e** A fully functioning customized MHSa Program website available a minimum of 30 days prior to 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 6.5.5 of this Agreement.

7.2.2 Credit Amount: The Contractor's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is **(TBD)** percent (%) of the 2015 Administrative Fee (prorated on a daily basis).

7.3.0 Call Center Availability Guarantee and Credit Amount

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

7.3.2 Credit Amount: The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Contractor's proposed guarantee) that the Contractor's telephone line is not operational and available to Enrollees, Dependents and Providers during the Contractor's Call Center Hours calculated on an annual basis is \$___ per year.

7.4.0 Call Center Telephone Response Time Guarantee and Credit Amount

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

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

7.5.0 Telephone Abandonment Rate Guarantee and Credit Amount

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

7.5.2 *Credit Amount:* The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%) (or the Contractor's proposed guarantee), calculated on an annual basis, is \$(**TBD**) per year.

7.6.0 Telephone Blockage Rate and Credit Amount:

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

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

7.7.0 Enrollment Management Guarantee and Credit Amount

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

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

7.8.0 Management Reports and Claim File Guarantee and Credit Amount

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

7.8.2 *Credit Amount:* The Contractor's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not

received by its respective due date, is \$(**TBD**) per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department and Decision Support Vendor, as applicable, inclusive of the date of receipt.

7.9.0 Network Composition Guarantee and Credit Amount

7.9.1 *Guarantee:* The Contractor must propose a Network Composition performance guarantee. The MHSA Program’s service level standard requires, that 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 Clinician who 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.

7.9.2 *Credit Amount:* The Contractor’s quoted amount to be credited against the Administrative Fee is \$___ for each .01 to 1.0% below the standard of ninety percent (90%) (or the Contractor’s proposed guarantee) of the 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 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** as

calculated on an annual basis is \$_(TBD). Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

7.10.0 Network Provider Access Guarantee and Credit Amount:

7.10.1 *Guarantee:* The Contractor guarantees that effective the first day of the month following a 90 day implementation period after OSC approves the Contract and throughout the term of the Agreement:

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

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

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

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

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

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

7.10.2 *Credit Amounts:*

7.10.2a The Contractor's quoted amount to be credited against the Administrative Fee is \$(TBD) for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined*) Access-for Urban Areas Guarantee, is not met by the Contractor.

- 7.10.2b** The Contractor's quoted amount to be credited against the Administrative Fee is \$(**TBD**) for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined*) Access-for Suburban Areas Guarantee, is not met by the Contractor.
- 7.10.2c** The Contractor's quoted amount to be credited against the Administrative Fee is \$(**TBD**) for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Facility (*Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined*) Access-for Rural Areas Guarantee, is not met by the Contractor.
- 7.10.2d** The Contractor's quoted amount to be credited against the Administrative Fee is \$(**TBD**) for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner (*Psychiatrist, Psychologist and Master's Level Clinician, combined*) Access-for Urban Areas Guarantee, is not met by the Contractor.
- 7.10.2e** The Contractor's quoted amount to be credited against the Administrative Fee is \$(**TBD**) for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner (*Psychiatrist, Psychologist and Master's Level Clinician, combined*) Access-for Suburban Areas Guarantee is not met by the Contractor.
- 7.10.2f** The Contractor's quoted amount to be credited against the Administrative Fee is \$(**TBD**)___ for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Contractor's proposed guarantee) for any quarter in which the Network Practitioner (*Psychiatrist, Psychologist and*

Master's Level Clinician, combined) Access-for Rural Areas Guarantee, is not met by the Contractor.

7.10.2.g (The Contractor's quoted amount to be credited against the Administrative Fee is \$(**TBD**)___ 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.)

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

7.11.0 Provider Credentialing Guarantee and Credit Amount

7.11.1 *Guarantee:* The Contractor must propose a Provider Credentialing performance guarantee. The MHSA Program's service level standard requires that within sixty (60) Days of receipt of a completed MHSA Provider application to join the MHSA Program's network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or facility notified of the determination.

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

7.12.0 Financial Accuracy Guarantee and Credit Amount

7.12.1 *Guarantee:* The Contractor must propose a financial accuracy performance guarantee. The Program's service level standard requires that the MHSA Program's financial accuracy be maintained for a minimum of ninety-nine percent (99%) of all claims processed and paid each Plan Year. Financial accuracy shall be measured by dividing

the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). This standard shall be measured on an annual basis;

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

7.13.0 Non-Financial Accuracy Guarantee and Credit Amount

7.13.1 Guarantee: The Contractor must propose a non-financial accuracy performance guarantee. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Non-financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code, as well as incorrect application of Deductibles and/or Coinsurance amounts to the shared accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

7.13.2 Credit Amount: The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (of the Contractor's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Contractor's proposed

guarantee) in years two through five of the Agreement) that the MHSA Program's non-financial accuracy rate isn't achieved, as calculated on an annual basis is \$(TBD).

7.13.3 Turnaround Time for Network Claims Adjudication 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

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

7.14.0 Turnaround Time for Non-Network Claims Adjudication Guarantee

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

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

7.15.0 Clinical Referral Line Guarantees and Credit Amounts

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

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

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

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

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

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

7.16.0 Utilization Review Guarantees and Credit Amounts

7.16.1 Outpatient Treatment Utilization Review Guarantee and Credit Amount

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

7.16.1b Credit Amount: The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Contractor's proposed guarantee) of outpatient treatment plans

not reviewed and the Enrollee and Provider notified within twelve (12)

Business Day of receipt of the report as reported quarterly and calculated on an annual basis, is \$(TBD).

7.17.0 Inpatient Treatment Utilization Review Guarantee and Credit Amount

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

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

7.18.0 Appeal Guarantees and Credit Amounts

7.18.1 Inpatient Appeal Guarantee and Credit Amount

7.18.1a *Inpatient Appeal Guarantee:* The Contractor must propose a performance guarantee. The MHSA Program's service level standard requires that at least ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included

as having met the standard. This standard will be calculated on an annual basis;

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

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

7.18.1d *Outpatient and ALOC Appeal Credit Amount:* The Contractor's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Contractor's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal as reported quarterly and calculated on an annual basis, is \$(TBD).

ARTICLE VIII: MODIFICATION OF PROGRAM SERVICES

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- 8.1.0** In the event that laws or regulations enacted by the Federal government and/or the State have an impact upon the conduct of this Agreement in such a manner that the Department determines that any design elements or requirements of the Agreement must be revised, the Department shall notify the Contractor of any such revisions and shall provide the Contractor with a reasonable time within which to implement such revisions.
- 8.2.0** In the event that the NYS and the unions representing State Employees enter into collective bargaining agreements, or the State otherwise requires changes in Plan design elements or requirements of the Agreement, the Department shall notify the Contractor of such changes and shall provide the Contractor with reasonable notice to implement such changes.
- 8.3.0** To the extent that any of the events as set forth in this Article shall take place and constitute a material and substantial change in the delivery of services that are contemplated in accordance with the terms of the MHSA Program as of the Effective Date and which the Contractor is required to perform or deliver under the Agreement, either Party may submit a written request to initiate review of the fee(s) received by the Contractor for services provided and guarantees made by the Contractor under the terms of the Agreement, accompanied by appropriate documentation. The DCS reserves the right to request, and the Contractor shall agree to provide additional information and documentation the DCS deems necessary to verify that a modification of the fees or guarantees is warranted. The DCS will agree to modify the fee(s) to the extent necessary to compensate the Contractor for documented additional costs determined by DCS to be reasonable and necessary. The Contractor will agree to modify the fee (s) to the extent necessary to relieve the DCS of the obligation to pay for Program services that are no longer required. The DCS will agree to modify guarantees as determined by DCS to be necessary to reflect MHSA Program modifications. Should the Parties agree to modify the fee(s) and/or guarantees, such approval shall be subject to written amendment and approval by OSC and the AG. The Contractor shall implement changes as required by the DCS with or without final resolution of any fee proposal.

ARTICLE IX: DEVELOPMENT OF SUMMARY PLAN DESCRIPTIONS AND BENEFIT SUMMARIES

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

ARTICLE X: ENROLLMENT INFORMATION AND RECORDS

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

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

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

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

ARTICLE XI: DATA SHARING AND OWNERSHIP

11.1.0 All claims and other data related to the Department Program is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other NYSHIP

carriers Department consultants and the Department's Decision Support System contractor and Department of Health's all payer claims database.

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

ARTICLE XII: DCS PROGRAM CLAIMS REIMBURSEMENT

12.1.0 Provider Network Claims

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

12.1.2 Claim Payments are to be made based on the requirements contained in Section IV and Articles 6.11.0 and 12.1.0 of this Agreement, including but not limited to each group's Copayment as reflected in Exhibit II.B; and Exhibit II.B2 of the RFP as well as the annual maximum for Applied Behavioral Analysis (ABA) services as reflected in the most current Plan Communication materials.

12.1.3 Throughout each Plan Year, the selected Contractor shall charge to the Program the incurred claims cost for Network services based on the amounts actually paid by the Contractor to Network Providers.

12.1.4 *Network Pricing Guarantee:* The Contractor is required to guarantee that the Actual Average Unit Cost (AAUC) for each category shall not exceed the proposed GAUC.

12.1.4a Based on incurred claims for each Plan Year that are paid as of June 30th of the following year, the Contractor shall calculate the AAUC for the Inpatient

Services and Outpatient Services categories. Such Network Services shall include all services/days paid at the Network benefit level including services/days rendered by Non-Network Providers when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to the Network Provider for Plan primary claims only and prior to the application of the Copayment and Bad Debt and Charity assessments.

12.1.4b The Contractor acknowledges that the GAUC for the Inpatient Services set forth in Exhibit V.A.3 may incorporate the inpatient professional service component pertaining to global reimbursement arrangements. Amounts actually paid and reported to the Department for Inpatient Services will include the inpatient professional service component of global arrangements. Any adjustments in the calculation of the AAUC shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

12.1.4c If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee, as follows:

12.1.4c(1) For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in Exhibit V.A.2, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charged to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for

the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

12.1.4c(2) For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in Exhibit V.A.3, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charge to the MHSA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

12.1.4d For the first Plan Year (2015), no change to the proposed GAUC will be allowed, except in the event of circumstances outside the control of the Contractor that may have a significant effect on cost, such as legislation or substantial enrollment risk profile fluctuations. Any proposed change made by the Contractor in the GAUCs for the 2015 Plan year shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

12.1.4e For each Plan year after 2015, the Contractor may request in writing an increase in the GAUC. The annual increase shall not exceed the percentage increase in CPI-W for Medical Care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year. If the prior increase in the GAUC occurred more than 12 months prior to the effective date of the requested increase, the maximum increase shall not exceed the cumulative CPI-W observed since the implementation of the prior increase. Any increase in the GAUC requires written approval by the Department and

amendment of the Agreement, upon documentation by the Contractor to the satisfaction of the Department, that such increase is required to maintain adequate Network access.

12.1.4f For purposes of both the development of the GAUC and AAUC, claims processed as secondary to the Plan shall be excluded from the calculations and network pricing guarantees. In addition, the GAUC and AAUC shall not include any fees or assessments set forth in Section V.B.3, V.B.4 and V.B.5 of this RFP

12.2.0 Non-Network Claims

12.2.1 The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee (or Approved Facility) in a timely manner.

12.2.2 Payments are to be made based on the requirements contained in Section IV of the RFP, including but not limited to each group's Co-insurance and Deductible as reflected in Exhibit II.B; and Exhibit II.B.2 as well as the annual maximum for ABA services.

12.2.3 The Contractor will process Non-Network claims, as follows:

12.2.3a For the Empire Plan and Excelsior Plan: using Reasonable and Customary charges based on the 90th percentile of charges for each service performed, as determined by Fair Health, Reasonable and Customary means the lowest of:

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

12.2.3b For the Student Employee Health Plan: using the Network Provider allowed amount applicable for Downstate New York;

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

12.2.5 The Contractor will update its database with FAIR Health, Inc.'s database of Reasonable and Customary amounts in a timely manner, at a minimum of twice a year.

ARTICLE XIII: ADMINISTRATIVE FEE

13.1.0 The Contractor shall:

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

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

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

- 13.1.4** Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;
- 13.1.5** Implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice;
- 13.1.6** Agree not to request a higher Administrative Fee, and the Department will not consider any increase to the Administrative Fee, that is not based on a material change to the MHSA Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Department;
- 13.1.7** Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Administrative Fee resulting from a material change in the benefit structure of the MHSA Program. The Department reserves the right to request and the Contractor agrees to provide any additional information and documentation the Department deems necessary to make its determination whether a the Contractor's request for an increase to the Administrative Fee is approved. The Department's decision to modify the Administrative Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal written amendment to the Agreement, signed by the Parties, and approved by the New York State Attorney General and New York State Office of State Comptroller;
- 13.1.8** Implement all benefit designs as required by the Department with or without final resolution of any request by the Contractor for a higher Administrative Fee. Refusal to implement benefit design changes will constitute a material breach of this Agreement and the Department shall take any action as may be appropriate and provided for by law, rule or in this Agreement, including, but not limited to, seeking compliance and recovering damages; and

13.1.9 Administrative claims incurred during the coverage period of the contract but processed/paid after the last day of coverage, as well as applicable Disabled Lives claims incurred after the last day of coverage of the Agreement will be administered by the Contractor. An Administrative Fee will not be payable/due beyond the termination date of the Agreement.

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

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

14.1.1 The Contractor will bill the Department periodically, as proposed, by the Contractor, after claims have been processed. The Department shall pay the Contractor by “wire transfer” within seven days of having received a bill of the claims processed by the Contractor. The Department may consider comparable alternatives to this approach during implementation.

14.1.2 The Plan will pay an Administrative Fee on a monthly basis within thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the Department for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program. Alternatively, the Department may request and receive payment of any performance guarantee amount directly from the Contractor, as opposed to a credit against the Administrative Fee payable to the Contractor.

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

14.1.4 The Contractor shall analyze and monitor claim submissions to promptly identify errors, fraud and/or abuse and report to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment made by the Contractor regardless of whether

any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse, the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Program within thirty (30) Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.

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

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

14.1.7 The Contractor will pay the medical carrier/third party administrator on a quarterly basis an amount billed for Shared Communication Expenses. The Contractor will be notified prior to the beginning of each Plan Year the amount of Shared Communication Expenses that will be billed.

14.1.8 The Contractor shall seek reimbursement of the Shared Communications Expense from the Department by including the amount with the voucher for the payment of the next Administrative Fee to be paid.

14.2.0 The Contractor will be responsible for assessments as follows:

14.2.1 The Contractor shall calculate the applicable BDC each month from the applicable paid claims and may charge the MHSA Program at the time this assessment is paid to the regulatory agency/intermediary by the Contractor.

14.2.2 The Contractor shall advise the Department of any new applicable assessments in a timely manner.

14.2.3 The Contractor shall bill the MHSA Program for any new assessments within thirty (30) days after the amounts are paid to the regulating entity.

ARTICLE XV: REPORTS AND CLAIM FILES

15.1.0 Annual Reports

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

15.1.2 *Annual Premium Renewal Report:* The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must include, but not be limited to: paid claim amounts, projected incurred claims, trend, Administrative Fees and changes in enrollment.

15.1.3 *Annual Summary Reporting:* The Contractor must prepare and present to the Department, GOER, Division of Budget and NYS employee unions an annual report that details MHSA Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSA Program to book of business

statistics, and other similar plan statistics. Clinical, financial and service issues are to be comprehensively addressed. The annual presentation and report is due each May after the end of each complete Calendar Year.

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

15.2.0 Quarterly Reports

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

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

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

15.2.2 *Quarterly Performance Guarantee Report:* The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation, customer service (telephone availability,

telephone response time, abandonment rate and blockage rate); enrollment management, reporting, network composition, provider access, provider credentialing, financial and non-financial accuracy, turnaround time for processing network and non-network claims, non-network Clinical Referral Line, emergency care Clinical Referral Line, urgent care Clinical Referral Line outpatient and inpatient Utilization Review; and inpatient and outpatient appeals. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F.. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

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

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

15.2.5 *Quarterly Coordination of Benefit Report:* The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;

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

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

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

15.3.0 Monthly Reports

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

15.3.2 *MHSA Program Customer Service Monthly Reports:* Each month the Contractor must submit a customer service report that measures the Contractor's customer service performance including 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 customer service report is due thirty (30) Days after the end of the month. For the first two months of the Agreement, this report will be due on a weekly basis. After two months, the Department will re-

examine the required frequency of this report and establish due dates with the Contractor.

15.4.0 Monthly Periodic Claim File

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

ARTICLE XVI: TRANSITION AND TERMINATION OF CONTRACT

16.1.0 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;

16.1.1 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:

16.1.1a 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:

- 16.1.1a(1)** 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;
 - 16.1.1a(2)** 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;
 - 16.1.1a(3)** Providing a second production file four (4) weeks prior to implementation; and
 - 16.1.1a(4)** Providing a third production file to the successor contractor by the close of business three (3) days after the Agreement terminates;
- 16.1.2** Within fifteen (15) Business Days from receipt of the Contractor's proposed Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan so as to make it acceptable to the Department;
- 16.1.3** Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department;
- 16.1.4** The Contractor shall be responsible for transitioning the MHSA Plan in accordance with the approved Transition Plan.
- 16.1.5** 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:

- 16.1.5a** Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims 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;
- 16.1.5b** Complete all reports required in Section IV.B.7.a.(7) of this RFP;
- 16.1.5c** Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner;
- 16.1.5d** Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XVII of the Agreement and Appendices A and B;
- 16.1.5e** Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XVII "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and
- 16.1.5f** Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XVII,

“Audit Authority” and Article XIV “Payments/credits) to/from the Contractor” of Section VII, Contract Provisions and Appendices A and B.

- 16.1.6** 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;
- 16.1.7** The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;
- 16.1.8** 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;
- 16.1.9** 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;
- 16.1.10** 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;
- 16.1.11** The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined as inpatient or in Residential Treatment Centers on 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;
- 16.1.12** 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.

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

ARTICLE XVII: AUDIT AUTHORITY

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

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

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

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

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

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

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

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- 17.4.0** The Contractor shall make available for audit all data in its computerized files that is relevant to and subject to the Agreement. Such data may, at the Department's discretion, be submitted to the Department in machine-readable format, or the data may be extracted by the Department, or by the Contractor under the direction of the Department;
- 17.5.0** The Contractor shall support audits conducted by the Department, Office of the State Comptroller or any designee of these agencies, as follows, including but not limited to:
- 17.5.1** Providing ample audit resources including access to the Contractor's online system to the Department and OSC at their respective offices through the date of the final financial settlement of the Agreement;
- 17.5.2** The capability and contractual right of the State to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors; and
- 17.5.3** Providing full cooperation with all Department and/or OSC audits consistent with the requirements of Appendices A and B and as set forth in this Agreement including provision of access to protected health information and all other confidential information when required for audit purposes as determined by the Department and/or OSC as appropriate. The Contractor must respond to all State (including OSC) audit requests for information and/or clarification within fifteen (15) Business Days. The Contractor must perform timely reviews and respond in a time period specified by the Department to preliminary findings submitted by the Department or the OSC's audit unit in accordance with the requirements of Article XVII "Audit Authority" in this Agreement. Such audits may include, but are not limited to both electronically submitted and paper claims. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The Contractor shall facilitate audits of Network Providers, including on-site audits, as requested by the Department and/or OSC.
- 17.6.0** The Contractor shall, at the Department's request, and in a time period specified by the Department, search its files, retrieve information and records, and provide to the auditors such

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

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

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

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

ARTICLE XVIII: CONFIDENTIALITY

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

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

18.2.0 Except as directed by a court of competent jurisdiction, or as necessary to comply with applicable New York State or Federal law, or with the written consent of the Enrollee/Dependent, no records may be otherwise used or released to any party other than the

Department by the Contractor, its officers, employees, agents, consultants, Key Subcontractors or Affiliates either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement;

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

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

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

ARTICLE XIX: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

19.1.0 For purposes of this Agreement, the term "Protected Health Information" ("PHI") means any information, including demographic information collected from an individual, that relates to the past, present, or future physical or mental health or condition of an individual, to the provision of health care to an individual, or to the past, present, or future payment for the provision of health care to an individual, that identifies the individual, or with respect to which there is a reasonable basis to believe that the information can be used to identify the individual. Within

the context of this Agreement, PHI may be received by the Contractor from the Department or may be created or received by the Contractor on behalf of the Department. All PHI received or created by the Contractor as a consequence of its performance under this Agreement is referred to herein collectively as “Department’s PHI.”

19.2.0 The Contractor acknowledges that the Department administers on behalf of New York State several group health plans as that term is defined in HIPAA’s implementing regulations at 45 CFR Parts 160 and 164, and that each of those group health plans consequently is a “covered entity” under HIPAA. These group health plans include NYSHIP, which encompasses the Empire Plan as well as participating health maintenance organizations; the Dental Plan, and the Vision Plan. In this capacity, the Department is responsible for the administration of these “covered entities” under HIPAA. The Contractor further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Contractor further acknowledges that the Contractor is a HIPAA “business associate” of the Department as a consequence of the Contractor’s provision of services to and/or on behalf of the Department within the context of the Contractor’s performance under this Agreement, and that the Contractor’s provision of such services may involve the disclosure to the Contractor of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Contractor’s disclosure to the Department of individually identifiable health information as a consequence of the services performed under this Agreement.

19.3.0 *Permitted Uses and Disclosures of the Department’s PHI:* The Contractor may use and/or disclose the Department’s PHI solely in accordance with the terms of this Agreement. In addition, the Contractor may use the Department’s PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Contractor may use and disclose the Department’s PHI for the proper management and administration of the Contract if such use is necessary for the Contractor’s proper management and administration or to carry out the Contractor’s legal responsibilities, or if such disclosure is required by law or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it shall be held confidentially and used or further disclosed only as required by law or for

the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware in which the confidentiality of the PHI has been breached.

19.4.0 *Nondisclosure of the Department's PHI:* The Contractor shall not use or further disclose the Department's PHI other than as permitted or required by this Agreement or as otherwise required by law. The Contractor shall limit its uses and disclosures of PHI when practical to the information comprising a Limited Data Set and in all other cases to the minimum necessary to accomplish the intended purpose of the PHI's access, use, or disclosure.

19.5.0 *Safeguards:* The Contractor shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for by this Agreement. The Contractor shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, to reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI that it creates, receives, maintains, or that it transmits on behalf of the Department pursuant to this Agreement.

19.6.0 *Breach Notification:*

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

19.6.2 *Required Information:* The Contractor shall provide the following information to the Department within ten (10) Business Days of discovery except when, despite all reasonable efforts by the Contractor to obtain the information required, circumstances

beyond the control of the Contractor necessitate additional time. Under such circumstances, the Contractor shall provide to the Department the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) Days from the date of discovery:

19.6.2a the date of the breach incident;

19.6.2b the date of the discovery of the breach;

19.6.2c a brief description of what happened;

19.6.2d a description of the types of unsecured PHI that were involved;

19.6.2e identification of each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the breach;

19.6.2f A brief description of what the Contractor is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

19.6.2g any other details necessary to complete an assessment of the risk of harm to the individual.

19.6.3 The Department will be responsible for providing notification to individuals whose unsecured PHI has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach, as well as the Secretary and the media, as required by 45 CFR Part 164.

19.6.4 The Contractor shall maintain procedures to sufficiently investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the Department upon request.

19.6.5 For purposes of this Agreement, “Unsuccessful Security Incidents” include activity such as pings and other broadcast attacks on Business Associate’s firewall, port scans, unsuccessful log-on attempts, denials of service, and any combination of the above, so

long as no such incident results in unauthorized access, use, or disclosure of electronic PHI.

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

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

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

19.9.0 Amendment of the Department's PHI: The Contractor shall make the Department's PHI available to the Department as the Department may require to fulfill the Department's obligations to amend individuals' PHI pursuant to HIPAA and its implementing regulations. The Contractor shall, as directed by the Department, incorporate any amendments to the Department's PHI into copies of the Department's PHI as maintained by the Contractor.

19.10.0 Internal Practices: The Contractor shall make its internal practices, policies and procedures, books, records, and agreements relating to the use and disclosure of the Department's PHI, whether received from the Department or created or received by the Contractor on behalf of the Department, available to Department and/or the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by the Department and/or the Secretary for purposes of determining the Department's compliance with HIPAA and its implementing regulations.

19.11.0 Termination:

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

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

19.12.0 Indemnification: The Contractor agrees to indemnify, defend and hold harmless the State, the Department and Department's respective employees, officers, agents or other members of its workforce (each of the foregoing hereinafter referred to as "Indemnified Party") against all actual and direct losses suffered by the Indemnified Party and all liability to third parties arising from or in connection with any breach of this Article or from any acts or omissions related to this Article by the Contractor or its employees, officers, Key Subcontractors or Affiliates, agents or other members of its workforce. Accordingly, the Contractor shall reimburse any Indemnified Party for any and all actual and direct losses, liabilities, lost profits, fines, penalties, costs or expenses (including reasonable attorneys' fees) which may for any reason be imposed upon any Indemnified Party by reason of any suit, claim, action, proceeding or demand by any third party which results from the Contractor's acts or omissions hereunder. The Contractor's obligation to indemnify any Indemnified Party under this Article shall survive the expiration or termination of this Agreement.

19.13.0 Miscellaneous:

19.13.1 Amendments: This Article may not be modified, nor shall any provision hereof be waived or amended, except in a writing duly signed by authorized representatives of the Parties. The Parties agree to take such action as is necessary to amend this Article from time to time as is necessary to achieve and maintain compliance with the requirements of 45 CFR Parts 160-164.

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

19.13.3 Regulatory References: Any reference herein to a federal regulatory section within the Code of Federal Regulations shall be a reference to such section as it may be subsequently updated, amended or modified.

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

ARTICLE XX: NOTICES

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

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

20.1.2 by facsimile transmission;

20.1.3 by personal delivery;

20.1.4 by expedited delivery service; or

20.1.5 by e-mail.

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

State of New York [Agency Name]

Name: (TBD)

Title: Director, Employee Benefits Division

Address:

Telephone Number: (TBD)

Facsimile Number: (TBD)

E-Mail Address: (TBD)

[Contractor Name]

Name: (TBD)

Title: (TBD)

Address: (TBD)

Telephone Number: (TBD)

Facsimile Number: (TBD)

E-Mail Address: (TBD)

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

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

Mental Health and Substance Abuse Program RFP #2014-MH-1 for the Empire Plan, Excelsior Plan and Student Employee Health Plan Model Contract

SECTION VII: CONTRACT PROVISIONS

Contractor: (TBD) _____

Contract Number: (TBD) _____

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

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

NEW YORK STATE DEPARTMENT OF CIVIL SERVICE

Date: _____

By: _____

Name: _____

Title: _____

CONTRACTOR

Date: _____

By: _____

Name: _____

Title: _____

STATE OF _____) ss:

COUNTY OF

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

My commission expires: _____

NOTARY PUBLIC

Approved as to Form:

ERIC SCHNEIDERMAN
ATTORNEY GENERAL

Approved:

THOMAS P. DINAPOLI
COMPTROLLER

By: _____

By: _____

Date: _____

Date: _____

Actual Average Unit Cost (AAUC) means the average unit cost for Network Coverage/Services paid during the Plan Year. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to Network Providers for Network Outpatient Services and Network Inpatient/ALOC Services for Plan primary claims only and prior to the application of Copayment and Bad Debt and Charity assessments.

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

Affiliate means a person or organization which, through stock ownership or any other affiliation, directly, indirectly, or constructively controls another person or organization, is controlled by another person or organization, or is, along with another person or organization, under the control of a common parent.

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

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

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

Approved Facility means a general acute care or psychiatric hospital or clinic under the supervision of a physician. If the hospital or clinic is located in New York State, it must be certified by the Office of Alcoholism and Substance Abuse Services of the State of New York or according to the Mental Hygiene Law of New York State. If located outside New York State, it must be accredited by the Joint Commission on Accreditation of Health Care Organizations for the provision of mental health, alcoholism or drug abuse treatment. Partial Hospitalization, Intensive Outpatient Program, Day Treatment, 23 Hour Extended Bed and 72 Hour Crisis Bed

will be considered approved facilities if they satisfy the foregoing requirements. In all cases other than an emergency, the facility must also be approved by the Contractor. Residential treatment centers, halfway houses and group homes will be considered approved facilities, if they satisfy the requirements above and admission is certified by the Contractor.

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

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

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

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

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

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

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

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

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

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

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

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

Cost Sharing means the Enrollee's financial responsibility for Covered Services including Copayment, Deductible and Coinsurance.

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

Crisis Intervention Visits means an urgent assessment and history of a crisis state, a mental status exam, and a disposition. The treatment includes psychotherapy, mobilization of resources

to defuse the crisis and restore safety, and implementation of psychotherapeutic interventions to minimize the potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress.

Day(s) means calendar days unless otherwise noted.

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

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

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

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

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

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

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

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

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

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

ET means prevailing Eastern Time.

Guaranteed Average Unit Cost (GAUC) means the amounts as proposed by the Contractor for Network Outpatient Services and Network Inpatient/Alternative Level of Care (ALOC) Services in RFP Exhibits V.A.2 and V.A.3, respectively. The GAUC amounts shall be based on Plan primary claims only and be prior to the application of Copayment and Bad Debt and Charity assessments. The GAUC for Network Inpatient/ALOC Services may incorporate the inpatient professional service component pertaining to global reimbursement arrangements.

Implementation Date means the first day of the month following a minimum implementation period of 90 days subsequent to the Office of State Comptroller's approval of the Agreement that results from this RFP.

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

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

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

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

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

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

Mixed Services Protocol means the methodology for allocating the financial liability for covered MHSA services between the Medical Program contractor, Hospital Program contractor and the MHSA Program contractor.

Network Coverage/ Services means all Medically Necessary services/days paid at the Network benefit level including Medically Necessary services/days rendered by a Non-Network Provider when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services.

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

Network Practitioner means a Practitioner who has entered into an agreement with the Contractor as an independent contractor to provide Covered Services. The records of the Contractor shall be conclusive as to whether a person had a Network Provider agreement in effect on the date services are obtained. A Non-Network Practitioner can be considered a network practitioner on a case-by-case basis when approved by the Contractor.

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

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

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

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

Non-Network Provider means a Non-Network Practitioner or Non-Network Facility.

NYS means New York State.

NYSHIP means the New York State Health Insurance Program.

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

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

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

Participating Agency (PA) means any unit of local government such as school districts, special districts and district or municipal corporations which elects, with the approval of the President of the Civil Service Commission, to participate in the New York State Health Insurance Program.

Participating Employer (PE) means a public authority, public benefit corporation, or other public agency, subdivision, or quasi-public organization of the State which elects, with the approval of

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

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

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

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

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

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

Practitioner means:

1. A psychiatrist; or
2. A psychologist; or
3. A licensed clinical social worker with at least six (6) years of post-degree experience who qualifies for the New York State Board for Social Work "R designation". If services are performed outside New York State, the social worker must have the highest level of licensure awarded by that state's accrediting body; or
4. A Registered Nurse Clinical Specialist or psychiatric nurse/clinical specialist: Advanced Practice nurses who hold a master's or doctoral degree in a specialized area of psychiatric nursing practice nurse; or
5. A Registered Nurse Practitioner: a nurse with a master's degree or higher in nursing from an accredited college or university, licensed at the highest level of nursing in the state where services are provided. Nurse Practitioners may diagnose, treat, and prescribe for a patient's

condition that falls within their specialty area of practice. This must be done in collaboration with a licensed psychiatrist qualified in the specialty involved and in accordance with an approved written practice agreement and protocols; or

6. Applied behavioral analysis provider or Certified Behavioral Analyst (CBA) provider: A licensed provider who is certified as a behavior analyst pursuant to a behavioral analyst certification board; or
7. Applied behavioral analysis or ABA Agency: An agency providing ABA services under the program oversight and direct supervision of a licensed provider and certified behavioral analyst. An ABA Agency may also employ ABA aides to deliver the treatment protocol of the ABA Provider.

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

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

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

Proposal means the Contractor's Administrative Proposal, Technical Proposal, and Cost Proposal, including all responses to supplemental requests for clarification, information, or documentation, submitted during the course of the Procurement.

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

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

Reasonable and Customary means the lowest of:

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

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

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

Renewal Date means January 1, 2016 and annually thereafter up to and including January 1, 2019.

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

RFP or Procurement means the Request for Proposals entitled "Mental Health and Substance Abuse Program for The Empire Plan, Excelsior Plan and Student Employee Health Plan" dated March 13, 2014.

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

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

Single Case Agreement means a unique agreement that the Contractor negotiates with a Non-Network Provider to provide MHSA Program Network-level services for a specific Enrollee when there is insufficient access to a Network Provider within a certain geographic area or a

Non-Network Provider possesses a unique specialty that is not currently possessed by a Network Provider within that geographic area.

State means New York State as a whole.

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

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

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

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

Transition of Care means a benefit that provides Enrollees with the Network level of benefits for a period of 90 days to continue Covered Services that commenced with a Network Provider of the former Program contractor.

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

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

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

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

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

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STANDARD CLAUSES FOR NYS CONTRACTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION.

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

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

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES.

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

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

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

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

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

NYS Department of Economic Development
Division of Minority and Women's Business Development
633 Third Avenue
New York, NY 10017
212-803-2414
email: mwbecertification@esd.ny.gov
<https://ny.newnycontracts.com/FrontEnd/VendorSearchPublic.asp>

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

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

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

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

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

21. RECIPROCITY AND SANCTIONS PROVISIONS.

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

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

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

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW.

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

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

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

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

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

26. IRAN DIVESTMENT ACT. By entering into this Agreement, Contractor certifies in accordance with State Finance Law §165-a that it is not on the "Entities Determined to be Non-Responsive Bidders/Offerers pursuant to the New York State Iran Divestment Act of 2012" ("Prohibited Entities List") posted at:

<http://www.ogs.ny.gov/about/regs/docs/ListofEntities.pdf>

Contractor further certifies that it will not utilize on this Contract any subcontractor that is identified on the Prohibited Entities List. Contractor agrees that should it seek to renew or extend this Contract, it must provide the same certification at the time the Contract is renewed or extended. Contractor also agrees that any proposed Assignee of this Contract will be required to certify that it is not on the Prohibited Entities List before the contract assignment will be approved by the State.

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

limited to, imposing sanctions, seeking compliance, recovering damages, or declaring the Contractor in default.

The state agency reserves the right to reject any bid, request for assignment, renewal or extension for an entity that appears on the Prohibited Entities List prior to the award, assignment, renewal or extension of a contract, and to pursue a responsibility review with respect to any entity that is awarded a contract and appears on the Prohibited Entities list after contract award.

APPENDIX B
STANDARD CLAUSES FOR ALL DEPARTMENT CONTRACTS

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1. INTEGRATION

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

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

2. EXECUTORY PROVISION

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

3. CHOICE OF LAW

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

4. DISPUTE RESOLUTION

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

5. WAIVER OF BREACH

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

6. NEW YORK STATE REQUIREMENTS

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

7. OUTSIDE OF SCOPE

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

8. NON-ASSIGNABILITY

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

9. NOTIFICATION

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

10. INDEMNIFICATION

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

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

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

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

11. PATENT, COPYRIGHT OR PROPRIETARY RIGHTS INFRINGEMENT

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

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

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

12. DATE/TIME WARRANTY

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

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

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

13. VIRUS WARRANTY

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

14. TITLE AND OWNERSHIP WARRANTY

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

15. USE RESTRICTIONS AND INTELLECTUAL PROPERTY

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

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

16. OWNERSHIP/TITLE TO PRODUCT DELIVERABLES

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

(A) Definitions

1. Product(s):

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

2. Existing Product(s):

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

3. Custom Product(s):

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

(B) Title to Project Deliverables

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

1. Existing Product(s):

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

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

2. Custom Product(s):

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

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

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

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

3. Documentation, Data & Reports

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

17. FORCE MAJEURE

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

18. TIME OF THE ESSENCE

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

19. RIGHTS AND REMEDIES

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

20. FEDERAL AND STATE COMPLIANCE

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

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

21. TAXES

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

22. INDEPENDENT CONTRACTOR

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

23. NO THIRD PARTY BENEFICIARIES

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

24. HEADINGS OR CAPTIONS

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

25. PARTIAL INVALIDITY

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

26. CONFLICT OF INTEREST

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

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

27. AUDIT AUTHORITY

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

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

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

28. CONFIDENTIALITY

All records maintained by the Contractor and relating to the Agreement are confidential and shall be used by the Contractor and its officers, employees, and subcontractors or agents solely for the purpose of carrying out its obligations under the Agreement. Except as directed by a court of competent jurisdiction or as may be permitted or required by applicable New York State or federal law or regulations, no such records may be otherwise used or released to any person by the Contractor, its employees, subcontractors or agents, either during the term of the Agreement or in perpetuity thereafter. Deliberate or repeated accidental breach of this provision may, at the sole discretion of the Department, be grounds for termination of the Agreement.

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

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

29. INFORMATION SECURITY REQUIREMENTS

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

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

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

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

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

30. NONDISCLOSURE OF CONFIDENTIAL INFORMATION

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

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

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

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

This representation shall survive termination of the Agreement.

31. FREEDOM OF INFORMATION LAW

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

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

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

32. TERMINATION OF AGREEMENT

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

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

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

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

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

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

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

33. CONTRACTOR PERSONNEL

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

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

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

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

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

34. OPERATIONAL CONTACTS

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

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

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

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

35. SUBCONTRACTING

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

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

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

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

36. PUBLICITY AND COMMUNICATIONS

The Contractor shall ensure that all requests for the Contractor's participation in events where the Contractor will be participating on behalf of the Department receive prior written authorization from the Department.

No public discussion or news releases relating to the Agreement shall be made or authorized by the Contractor or the Contractor's agent without the prior written approval of the Department, which written approval shall not be unreasonably withheld or delayed provided, however, that Contractor shall be authorized to provide copies of the Agreement and answer any questions relating thereto to any State or federal regulators or, in connection with its financial activities, to financial institutions for any private or public offering.

37. CONSULTANT DISCLOSURE REQUIREMENTS

Unless directed otherwise by the Department, the Contractor shall demonstrate its compliance with Chapter 10 of the Laws of 2006 throughout the term of the Agreement by submitting to the Department and to the Office of the State Comptroller a "State Consultant Services - Contractor's Annual Employment Report" for each State Fiscal Year. Such report shall be due no later than May 15th of each year following the end of the State Fiscal Year being reported. Such report shall be required of any contract that includes services for analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health and mental health services, accounting, auditing, paralegal, legal, or similar services. Such report shall conform with Bulletin No. G-226 – Form B as issued by the Office of the State Comptroller. The report must be submitted to the Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th floor, Albany, NY 12236, ATTN: Consultant Reporting; and to the Department's Contract Manager.

38. PROCUREMENT LOBBYING RESTRICTIONS UNDER STATE FINANCE LAW SECTIONS 139-j AND 139-k

The Contractor certifies that all information that it has provided or will provide to the Department pursuant to State Finance Law sections 139-j and 139-k is complete, true, and accurate, including but not limited to information regarding prior determinations of non-responsibility within the past four years based upon (i) impermissible contacts of other violations of SFL section 139-j, or (ii) the intentional provision of false or incomplete information to a governmental entity.

The Department reserves the right to terminate the Agreement in the event it is found that the Contractor's certification of its compliance with SFL sections 139-j or 139-k was intentionally false or intentionally incomplete. Upon such finding, the Department may exercise its right to terminate the Agreement by providing written notification to the Contractor in accordance with Article 9 of this Appendix B.

39. VENDOR RESPONSIBILITY

The Contractor is required to provide the Department with an updated Vendor Responsibility Questionnaire when requested to do so by the Department throughout the term of the Agreement. Regardless, the Contractor is required to report to the Department any material changes in the information reported in its initial Vendor Responsibility Questionnaire.

40. TAX LAW SECTION 5-A - CERTIFICATION REGARDING SALES AND COMPENSATING USE TAXES

In the event the value of the Agreement exceeds \$100,000, the Contractor must file a properly completed Form ST-220-CA with the Department and a properly completed Form ST-220-TD with the Department of Taxation & Finance before the Agreement may take effect.

In addition, after the Agreement has taken effect, the Contractor must file a properly completed Form ST-220-CA with the Department if the Agreement's term is renewed; further, a new Form ST-220-TD must be filed with the Department of Taxation & Finance if no ST-220-TD has been filed by the Contractor or if a previously filed Form ST-220-TD is no longer correct and complete.

41. CONTRACT PAYMENT

Contractor shall provide complete and accurate billing invoices to the Department in order to receive payment. Billing invoices submitted to the Department must contain all information and supporting documentation required by the Agreement, the Department and the State Comptroller. Payment for invoices submitted by the Contractor shall only be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The Contractor shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by e-mail at epunit@osc.state.ny.us, or by telephone at 518-474-4032. Contractor acknowledges that it will not receive payment on any invoices submitted under the Agreement if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

May 2011



THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

THIS AGREEMENT (the “Agreement”) by and between the NYS Department of Civil Service (“DCS”), with principal offices in Albany, NY 12239, and

with principal offices at

(hereinafter “Third Party”), is entered into as of the date last written below (“the Effective Date”).

This Agreement consists of this signature page and the following attachments incorporated by reference:

- 1. Attachment 1: Third Party Connection and Data Exchange Agreement Terms and Conditions
- 2. Attachment 2: Third Party Connection and Data Exchange Request Requirements Document
- 3. Attachment 3: Third Party Acceptable Use Policy and Agreement
- 4. Attachment 4: DCS Equipment Loan Agreement (Applicable: Yes No)

This Agreement may only be modified by a written document executed by the parties hereto. Any disputes arising out of or in connection with this Agreement shall be governed by New York State law without regard to choice of law provisions.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed. Each party warrants and represents that its respective signatories whose signatures appear below have been and are on the date of signature duly authorized to execute this Agreement.

<i>Third Party Name:</i>	<i>NYS Department of Civil Service (DCS)</i>
Authorized Signature	Authorized Signature
Name (<i>Print</i>)	Name (<i>Print</i>)
Date	Date



THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 1 – SECURITY REQUIREMENTS

1. *Right to Use Connection*

Third Party may only use the connection and the information obtained from DCS for business purposes as outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2).

2. *Data Exchange*

2.1 Third Party may only use the data obtained for purposes outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2) and the contract or Memoranda of Understanding, if any, that exists between DCS and Third Party for the provision of goods or services or governing conduct between DCS and Third Party with respect to the access to and use of DCS data.

2.2 Data exchange may be conducted only by methods and/or services outlined by the Third Party Connection and Data Exchange Request Requirements Document (Attachment 2). Third Party should expect that access to information and services may be limited, as determined or required by DCS.

3. *Network Security*

3.1 Third Party will allow only its own employees approved in advance by DCS (“Third Party Users”) to access the Network Connection or any DCS-owned equipment. Third Party shall be solely responsible for ensuring that Third Party Users are not security risks, and upon DCS’ request, Third Party will provide DCS with any information reasonably necessary for DCS to evaluate security issues relating to any Third Party User.

3.2 Third Party will promptly notify DCS whenever any Third Party User leaves Third Party’s employ or no longer requires access to the connection or DCS-owned Equipment.

3.3 Each Party will be solely responsible for the selection, implementation, and maintenance of security procedures and policies that are sufficient to ensure that (a) such party’s use of the connection (and Third Party’s use of DCS-owned Equipment) is secure and is used only for authorized purposes, and (b) such Party’s business records and data are protected against improper access, use, loss alteration or destruction.

3.4 The preferred connectivity method is via the Internet to a DCS-approved or DCS-provided Virtual Private Network (VPN) device. If the device is DCS-provided, DCS will loan the Third Party, in accordance with the DCS Equipment Loan Agreement, the required client software for establishing VPN connections with DCS. Normal DCS perimeter security measures will control access to the internal network.

3.5 Extranet – Designated routers are used in combination with firewall rules to allow access to be managed. A second authentication may be required.



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- 3.6 Remote Access - Using the DCS-provided remote access software, Third Party will connect via an Internet browser. The account may be disabled until usage is required and controls are placed and managed by DCS. Third Party will be required to follow procedures to enable the account for each use.
- 3.7 Third Party Connections will be audited. All remote access user accounts for Third Parties will be given an expiration time. Renewals must be requested by Third Party and approved by the Department Sponsor. Obsolete Third Party connections will be terminated.
- 3.8 Software versions on all Third Party computers that connect to the DCS network must be versions that are currently supported by the software manufacturer, and all available security updates and hot fixes for that software must be applied in a timely fashion. Software and firmware for all Third Party networking equipment that is part of the connection to the DCS network must be kept up to date, especially with patches that fix security vulnerabilities.
- 3.9 Anti-virus software and firewalls must be installed and enabled at all times on DCS-owned computers and on Third Party computers that connect to the DCS network. Additionally, virus definition files must be kept up to date.
- 3.10 In no case may a Third Party Connection to DCS be used as an Internet Connection for Third Party or for a Third Party User.

4. Notifications

- 4.1 Third Party shall notify DCS in writing promptly of any change in its Users for the work performed over the Network Connection or whenever Third Party believes a change in the connection and/or functional requirements of the connection is necessary.
- 4.2 Any notices required by this Agreement shall be given in hand, sent by first class mail, or via facsimile to the applicable address set forth below.

Third Party Name:	NYS Department of Civil Service Albany, New York 12239
Address:	
Attention:	Attention:



5. *Citizen Notifications*

If Third Party maintains "identifying personal information" on behalf of the Department and such information is compromised, Third Party shall notify the Department immediately that the information has been compromised, the circumstances under which the information was compromised, and the measures undertaken by Third Party to address those circumstances and to otherwise mitigate the effects of the compromise. If encrypted data is compromised along with the corresponding encryption key and encryption software, the data shall be considered unencrypted and the information will be considered compromised through unauthorized access. If the Department requests Third Party to do so, Third Party shall notify the persons whose identifying information was compromised. Such notification shall be communicated via postal service or email, as directed by the Department, and shall otherwise be executed in accordance with the Department's direction. Notification shall be delayed if a law enforcement agency determines that such notification may impede a criminal investigation. For the purpose of this section, "identifying personal information" shall be any information concerning an individual which, because of name, number, symbol, mark or other identifier in combination with any of the following, is unencrypted: (1) Social Security Number; or (2) driver's license number; or (3) financial account number, credit or debit card number, in combination with any required security code, access code, or password which would permit access to an individual's financial account; or (4) password which would permit access to the individual's account.

6. *Payment of Costs*

Each Party will be responsible for all costs incurred by that Party under this Agreement, including, without limitation, costs for phone charges, telecommunications equipment and personnel for maintaining the connection.

7. *Confidentiality*

- 7.1 Information exchanged for the business purposes outlined in Attachment 2 will be held confidential by the Parties to the maximum extent permitted by law. Each Party may internally use the information received from the other Party hereunder in connection with and as specifically necessary to accomplish the Business Purpose set forth in Attachment 2 and for no other purposes. Each Party may otherwise share such information with other third parties (e.g. consultants, subcontractors, control agencies) as required or permitted by law in order to effect the business purposes outlined in Attachment 2 and for no other purposes, provided that such third parties agree to the confidentiality restrictions set forth herein and as may be required otherwise by State and federal law.
- 7.2 Third Party must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the sensitive information that it creates, receives, maintains, or transmits on behalf of DCS.
- 7.3 Unencrypted DCS information must not be transmitted over email.
- 7.4 Third Party must ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it and report to the DCS Help Desk any security incident of which it becomes aware.



8. *Third Party Users*

- 8.1 Third Party must require that each Third Party User executes a Third Party Acceptable Use Policy and Agreement (Attachment 3). Third Party must ensure that DCS is notified by fax or mail when the user base changes, following the specifications in the Third Party Connection & Data Exchange Agreement.
- 8.2 All aspects of Third Party connections within DCS control may be monitored by the appropriate DCS support group and/or the DCS Information Security Officer. Any unauthorized use or change to devices will be investigated immediately.
- 8.3 All Third Party Connections will be reviewed on a regular basis and information regarding specific Third Party connection will be updated as necessary. Obsolete Third Party connections will be terminated.

9. *DCS-owned Equipment*

- 9.1 DCS may, in DCS' sole discretion, loan to Third Party certain equipment and/or software for use on Third Party premises (the DCS-owned Equipment) under the terms of the DCS Equipment Loan Agreement set forth in Attachment 4. DCS-owned equipment will only be configured for TCP/IP, and will be used solely by Third Party on Third Party's premises or other locations authorized by DCS for the purposes set forth in this Agreement. DCS is responsible for ensuring that it has the right under applicable software licenses to permit third party use.
- 9.2 Third Party may modify the configuration of the DCS-owned equipment only after notification and approval in writing by authorized DCS personnel.
- 9.3 Third Party will not change or delete any passwords set on DCS-owned equipment without prior approval by authorized DCS personnel. Promptly upon any such change, Third Party shall provide DCS with such changed password.

10. *Term, Termination and Survival*

- 10.1 This Agreement will remain in effect until terminated by either Party, but in no event prior to the termination or expiration of any contract or agreement between the Parties for the purchase of goods or services that provides the business purpose for the exchange of data between the Parties, unless both Parties mutually agree to so terminate this Agreement.
- 10.2 Upon termination, Third Party shall return all tangible DCS data to DCS within a timeframe specified by DCS for that purpose, and further shall certify in writing to DCS that all other DCS data in whatever form has been destroyed. Additionally, any DCS-owned equipment and/or software shall be promptly returned to DCS at Third Party's expense.
- 10.3 Notwithstanding the above, the Parties' obligations to safeguard the confidentiality of the data subject to this Agreement shall survive the termination of this Agreement, and shall bind the Parties' employees, subcontractors, agents, heirs, successors and assigns.



11. Severability

If for any reason a court of competent jurisdiction finds any provision or portion of this Agreement to be unenforceable, that provision of the Agreement will be enforced to the maximum extent permissible so as to affect the intent of the Parties, and the remainder of this Agreement will continue in full force and effect.

12. Waiver

The failure of any Party to enforce any of the provisions of this Agreement will not be construed to be a waiver of the right of such Party thereafter to enforce such provisions.

13. Assignment

Third Party may not assign this Agreement, in whole or in part, without the prior written consent from DCS. Any attempt to assign this Agreement, without such consent, will be null and of no effect. Subject to the foregoing, this Agreement is for the benefit of and will be binding upon the parties' respective successors and permitted assigns.

14. Force Majeure

Neither Party will be liable for any failure to perform its obligations if such failure results from any act of God or other cause beyond such Party's reasonable control (including, without limitation, any mechanical, electronic or communications failure) which prevents such party from transmitting or receiving any data.

15. Partial Invalidity

If this Agreement is entered into as a consequence of Third Party's provision of goods or services to DCS pursuant to a contract or other written agreement, that Agreement supersedes this Agreement to the extent the agreements' provisions may be inconsistent.



THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 2 – REQUEST REQUIREMENTS

In accordance with the DCS *Third Party Connection and Data Exchange Policy*, all requests for Third Party connections and data exchanges must be accompanied by this completed requirements document. This document should be completed by the DCS person or group requesting the Third Party connection and/or data exchange. The DCS Department Sponsor must be the Director of the Division whose business requires the Third Party connection and/or data exchange. DCS Divisions are encouraged to work with their IRM Liaison to complete the information in this document.

Part 1 – Business Justification

A. DCS Sponsor *(Division Director)*

Name:

Robert W. DuBois

Division:

Employee Benefits Division

Office Location:

NYS Department of Civil Service
Albany, New York 12239

Phone Number:

518-473-1977

Email Address:

Robert.DuBois@cs.state.ny.us

Back-up Point of Contact: (Data Custodian)

Name:

Barbara Vaughn

Division:

Employee Benefits Division

Office Location:

NYS Department of Civil Service
Albany, New York 12239

Phone Number:

518-549-2328

Email Address:

Barbara.Vaughn@cs.state.ny.us

B. Business Reason for Connection *(To be completed by Sponsor)*

State the purpose of establishing the connection and the purpose of the data transmission. Specify the business needs of the proposed connection. Use additional sheets of paper if needed.



C. Specify the details of the work to be accomplished via the connection. What applications will be used? What information will be used? What transactions will be accomplished?

D. Specify the Third Party Controls to be Implemented for Safeguarding DCS Data:

Access Controls:

Audit Controls:

Working procedures or practices for handling printed material and verbal exchanges:

Method of Disposal of media and paper:

User Account Management, including review of accounts:

Physical Security:

Other:

E. Estimated number of hours of use each week?

1 – 20

21 – 40

More than 40 hours per week

F. Anticipated normal hours of use?

M – F, 8:00 – 5:00 pm Eastern time

Other (specify):

G. What is the requested installation date? (Minimum lead-time is 30 days)

H. Approximately how long will the connection be needed?

Up to 6 months

6 – 12 months

More than 12 months

Specific time period:



Note: If a connection is needed for more than a year, the Connection Agreement must be renewed annually.

I. Other useful information

J. Third Party Information

Name of Third Party: Main Phone Number:

Main Office Address:

Management Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Backup Contact

Name: Department:

Address: Email Address:

Phone Number: Manager's Name:

Manager's Phone:

Technical Contact

Name: Department:

Address: Email Address:

Phone Number:

Manager's Name: Manager's Phone:

Technical Support Hours:

Escalation List:

Domain name(s): Host name(s):



User Names and Contact Information. (*List all employees of the Third Party who will use this access.*)

User 1 (*name, phone, email*):

User 2 (*name, phone, email*):

User 3 (*name, phone, email*):

User 4 (*name, phone, email*):

User 5 (*name, phone, email*):

User 6 (*name, phone, email*):

User 7 (*name, phone, email*):

User 8 (*name, phone, email*):

User 9 (*name, phone, email*):

User 10 (*name, phone, email*):

K. Other information



THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

This Policy and Agreement applies to all forms of computer and networking use, including local access at the Department of Civil Service (DCS) premises, remote access via public or private networks, access using DCS equipment, access using individual or group accounts, and access via other methods.

A signed paper copy of this form must be submitted by any individual (1) for whom authorization of a new user account is requested, (2) who will use a shared third party account, and/or (3) who is requesting reauthorization of an existing use. Modifications to the terms and conditions of this agreement will not be accepted by DCS management.

Indicate here if this is a notification that the User named below no longer requires access:

User's Name (<i>print</i>):			
Organization:			
Telephone Number:	Area code	Number	Extension
Office Address:			

<i>The undersigned acknowledges that he or she has read, understands, and agrees to comply with this Third Party Acceptable Use Policy and Agreement governing the use of DCS computing resources.</i>	
User Signature:	Date:

You must sign this signature page and send it to DCS. Retain a copy of the signature page and the attached Policy for your records. This form must be delivered either by fax or mail to:

MAIL: NYS Department of Civil Service, Albany, NY 12239
 Attention: Help Desk
FAX: 518-485-5588



THIRD PARTY CONNECTION AND DATA EXCHANGE AGREEMENT

ATTACHMENT 3 – THIRD PARTY ACCEPTABLE USE POLICY AND AGREEMENT

I. *Protection of DCS Information*

All records and information maintained in DCS systems accessed by the User are confidential and shall be used by the User solely for the purpose of carrying out the User's official duties. Users may not use any such records and information for any other purpose. No such records or information may otherwise be used or released to any person by the User or by the User's employer or agent, except as may be required by applicable State or federal law or by a court of competent jurisdiction. All accounts and connections will be regularly reviewed.

II. *DCS Log-on Banner*

All users will follow the guidelines of the DCS Log-on Banner as stated below.

NOTICE * The contents of this banner have been recommended to all State agencies by the Office for Technology in the NYS Preferred Standards and Procedures for Information Security. * This electronic system, which includes hardware, software and network components and all data contained therein (the "system"), is the property of the New York State Department of Civil Service (DCS). * Unauthorized use or attempted unauthorized use of this system is not permitted and may constitute a federal or state crime. Such use may subject you to appropriate disciplinary and/or criminal action. Use of this system is only permitted to the extent authorized by DCS. * Use is limited to conducting official business of DCS. Under the Electronic Communications Privacy Act of 1986 (18 U.S.C. 2510, et seq.), notice is hereby given that there are NO facilities provided by this system for sending or receiving private confidential electronic communication. Any use, whether authorized or not, may be monitored, intercepted, recorded, read, copied, accessed or captured in any manner, and used or disclosed in any manner, by authorized DCS personnel without additional prior notice to users. In this regard, users have no legitimate expectation of privacy during any use of this system or in any data on this system. * Use, whether authorized or unauthorized, constitutes expressed consent for DCS to monitor, intercept, record, read, copy, access or capture and use or disclose such information. * DCS policy regarding this matter can be reviewed on the DCS internal website. Copies can also be obtained from the Office of Human Resources Management. Such policies are subject to revision. This notice is consistent with the Acceptable Use Policy issued to DCS employees regarding acceptable use, June 15, 2005. I have read and understand this notification and department policy.

III. *Passwords*

The User is not permitted to share his/her password with anyone. Passwords must never be written down. The User must not use the same password for multiple applications. The User must use passwords that are not easily guessed and must not use their email address as their password.



IV. *Shared Accounts*

All use of shared accounts must be authorized by DCS. Users of shared accounts must be identified to DCS via the completion and signing of this policy/agreement. Third Parties are responsible for notification to DCS when the user base changes. Passwords for shared accounts must not be provided to individuals who have not been identified by Third Party to DCS and who have not completed and signed this policy/agreement.

V. *Virus Protection*

Anti-virus software must be installed and enabled at all times on DCS-owned computers and on third party computers used to conduct DCS business. Virus definition files must be kept up to date. DCS Information Resource Management (IRM) provides anti-virus software and maintains the configuration of that software for all DCS-owned computers.

VI. *Acceptable Use*

DCS computers, computing systems and their associated communication systems are provided to support the official business of DCS. All uses inconsistent with DCS' business activities and administrative objectives are considered to be inappropriate use.

Examples of unacceptable behavior include, but are not limited to the following.

- Any illegal activities that could result in legal actions against and/or financial damage to DCS.
- Computer usage that reasonably harasses or offends other employees, users, or outsiders, or results in public embarrassment to DCS.
- Computer usage that is not specifically approved and which consumes significant amounts of computer resources not commensurate with its benefit to DCS' mission or which interferes with the performance of a worker's assigned job responsibilities.
- Use in connection with compensated outside work or unauthorized not-for-profit business activities.
- Use of sniffers, spyware, ad-ware or other related technology.

VII. *Software Protection*

The User is responsible for complying with copyright, licensing, trademark protection, and fair use restrictions.

VIII. *Reporting Incidents*

Users are required to report incidents of system errors, data discrepancies, application performance problems, to the DCS Help Desk, at 518-457-5406 phone; 518-485-5588 fax.



IX. *DCS Rights*

Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq.), notice is hereby given that there are no facilities provided by this system for sending or receiving private or confidential electronic communications. DCS has access to all access attempts, messages created and received, and information created or stored using DCS resources, and will monitor use as necessary to assure efficient performance and appropriate use. Information relating to or in support of illegal activities will be reported to the appropriate authorities.

DCS reserves the right to log and monitor use. DCS reserves the right to remove a user account from the network. DCS assumes no responsibility or liability for files or information deleted.

The DCS will not be responsible for any damages. This includes the loss of data resulting from delays, non-deliveries, or service interruptions caused by negligence, errors or omissions, or caused by the way the user chooses to use DCS computing facilities.

DCS reserves the right to change its policies and rules at any time.

X. *Penalties*

The User shall hold the State and DCS harmless from any loss or damage to the State and/or DCS resulting from the User's inappropriate disclosure of information covered by this User Agreement. Further, the User's non-compliance with this Agreement may result in the revocation of system privileges, termination of employment or contract with DCS, and/or criminal and/or civil penalties.



Name And Address Of Borrower	DCS Business Unit (Loaning Organization)	
	Point Of Contact	
	Work Location	Telephone
Shipping Address (<i>If different from borrower's</i>)	Manager's Name	
	Date To Be Loaned	
	Date To Be Returned	
Equipment To Be Loaned		
Quantity	Description	Value
Purpose Of Loan		
CONDITIONS OF LOAN		
<ol style="list-style-type: none"> 1. The Borrower of the above equipment agrees to return same in like condition as received from DCS, normal wear and tear excepted, on or before the above return date, unless the loan period is formally extended. 2. Upon termination of this Agreement, Borrower shall uninstall all DCS software included in this Agreement from Borrower's computer and/or network equipment. 3. The Borrower shall not make any copies of DCS software included in this Agreement. 4. In case of loss or damage beyond repair, DCS shall be reimbursed by Borrower at the current price of replacement. 5. The equipment shall not be loaned or transferred to a third party without the written consent of DCS. 6. The right is reserved to cancel the loan or recall the equipment upon ____ days notice. 7. The Borrower shall assume all shipping and/or transportation costs involved. 8. Other conditions: 		



State of New York
 Department of Civil Service
 The State Campus
 Albany, New York 12239

ADMINISTRATIVE SERVICES DIVISION
Third Party Connection and Data Exchange Agreement
Attachment 4 –Equipment Loan Agreement
 ADM-125 (4/06)

Appendix C
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Agreed (Borrower)	Approved (DCS)
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date
RECEIPT OF EQUIPMENT	
Borrower (<i>Upon initial receipt</i>)	DCS Lender (<i>Upon termination of Agreement</i>)
Borrowing Organization	Loaning Organization
Signature Of Authorized Official	Signature Of Authorized Official
Title	Title
Date	Date

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

CONTRACTOR REQUIREMENTS AND OBLIGATIONS UNDER NEW YORK STATE EXECUTIVE LAW, ARTICLE 15-A (PARTICIPATION BY MINORITY GROUP MEMBERS AND WOMEN WITH RESPECT TO STATE CONTRACTS)

I. General Provisions

- A. The Department is required to implement the provisions of New York State Executive Law Article 15-A and 5 NYCRR Parts 142-144 (“MWBE Regulations”) for all “State contracts” as defined therein, with a value (1) in excess of \$25,000 for labor, services, equipment, materials, or any combination of the foregoing or (2) in excess of \$100,000 for real property renovations and construction.
- B. Contractor agrees, in addition to any other nondiscrimination provision of the Contract and at no additional cost to the New York State Department (the “Department”), to fully comply and cooperate with the Department in the implementation of New York State Executive Law Article 15-A. These requirements include equal employment opportunities for minority group members and women (“EEO”) and contracting opportunities for certified minority and women-owned business enterprises (“MWBEs”). Contractor’s demonstration of “good faith efforts” pursuant to 5 NYCRR §142.8 shall be a part of these requirements. These provisions shall be deemed supplementary to, and not in lieu of, the nondiscrimination provisions required by New York State Executive Law Article 15 (the “Human Rights Law”) or other applicable federal, state or local laws.
- C. Failure to comply with all of the requirements herein may result in a finding of non-responsiveness, non-responsibility and/or a breach of contract, leading to the withholding of funds or such other actions, liquidated damages pursuant to section VII of this Appendix or enforcement proceedings as allowed by the Contract.

II. Contract Goals

- A. For purposes of the Contract, the Department established an overall goal of 20% for Minority and Women-Owned Business Enterprises (“MWBE”) participation as subcontractors and suppliers, as relates only to the administrative cost component of the overall cost of the Contract.
- B. For purposes of providing meaningful participation by MWBEs on the Contract and achieving the Contract Goals established in section II-A above, Contractor should reference the directory of New York State Certified MBWEs found at the following internet address:

<http://www.nylovesmwbe.ny.gov/cf/search.cfm>

Additionally, Contractor is encouraged to contact the Division of Minority and Woman Business Development ((518) 292-5250; (212) 803-2414; or (716) 846-8200) to discuss additional methods of maximizing participation by MWBEs on this Contract.

- C. Where MWBE goals have been established herein, pursuant to 5 NYCRR §142.8, Contractor must document “good faith efforts” to provide meaningful participation by MWBEs as subcontractors or suppliers in the performance of the Contract. In accordance with section 316-a of Article 15-A and 5 NYCRR §142.13, the Contractor acknowledges that if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals set forth in the Contract, such a finding constitutes a breach of contract and the Contractor shall be liable to the Department for liquidated or other appropriate damages, as set forth herein.

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

III. Equal Employment Opportunity (EEO)

- A. Contractor agrees to be bound by the provisions of Article 15-A and the MWBE Regulations promulgated by the Division of Minority and Women's Business Development of the Department of Economic Development (the "Division"). If any of these terms or provisions conflict with applicable law or regulations, such laws and regulations shall supersede these requirements.
- B. Contractor shall comply with the following provisions of Article 15-A:
1. Contractor and subcontractors shall undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status. For these purposes, EEO shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation.
 2. The Contractor shall submit an EEO policy statement to the Department within seventy two (72) hours after the date of the notice by Department of proposed award of the Contract to the Contractor.
 3. If Contractor or subcontractor does not have an existing EEO policy statement, the Department may provide the Contractor or subcontractor a model statement (see Form EEO-102 entitled "Minority and Women-Owned Business Enterprises M/WBE - Equal Employment Opportunity (EEO) Policy Statement).
 4. The Contractor's EEO policy statement shall include the following language:
 - a. The Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing EEO programs to ensure that minority group members and women are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force.
 - b. The Contractor shall state in all solicitations or advertisements for employees that, in the performance of the contract, all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex, age, disability or marital status.
 - c. The Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union, or representative will not discriminate on the basis of race, creed, color, national origin, sex age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein.
 - d. The Contractor will include the provisions of sections (a) through (c) of this subsection 4 and paragraph "E" of this section III, which provides for relevant provisions of the Human Rights Law, in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the Contract.
- C. Form EEO-100 – EEO Staffing Plan

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

To ensure compliance with this section III, the Contractor shall submit an EEO Staffing Plan to document the composition of the proposed workforce to be utilized in the performance of the Contract by the specified categories listed, including ethnic background, gender, and Federal occupational categories. The Contractor shall complete the EEO Staffing Plan form and submit it as part of its Proposal or within a reasonable time, but no later than the time of proposed award of the Contract.

- D. Form EEO-101 - Workforce Utilization/Compliance Report (“Workforce Report”)
1. Once proposed contract award has been made and during the term of Contract, Contractor is responsible for updating and providing notice to the Department of any changes to the previously submitted EEO Staffing Plan. This information is to be submitted on a quarterly basis during the term of the Contract to report the actual workforce utilized in the performance of the Contract by the specified categories listed including ethnic background, gender, and Federal occupational categories. The Workforce Report must be submitted to report this information.
 2. Separate forms shall be completed by Contractor and any subcontractor performing work on the Contract.
 3. In limited instances, Contractor may not be able to separate out the workforce utilized in the performance of the Contract from Contractor's and/or subcontractor's total workforce. When a separation can be made, Contractor shall submit the Workforce Report and indicate that the information provided related to the actual workforce utilized on the Contract. When the workforce to be utilized on the Contract cannot be separated out from Contractor's and/or subcontractor's total workforce, Contractor shall submit the Workforce Report and indicate that the information provided is Contractor's total workforce during the subject time frame, not limited to work specifically under the Contract.
- E. Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

IV. MWBE Utilization Plan Form (MWBE-100) and Certification of Good Faith Efforts (Form MWBE-104)

- A. The Contractor represents and warrants that Contractor has submitted an MWBE Utilization Plan (form MWBE-100) either prior to, or at the time of, the execution of the Contract for Department consideration and acceptance. The Contractor shall ensure that enterprises have been identified within the MWBE Utilization Plan, and the Contractor shall attempt, in good faith, to utilize such enterprise(s) at least to the extent indicated in the Contractor’s MWBE Utilization Plan as accepted by the Department. The Contractor must document "good faith efforts" to provide meaningful participation by New York State Certified MWBE subcontractors or suppliers in the performance of the Contract. In support of such efforts, the Contractor will include with its MWBE Utilization Plan submission a Certification of Good Faith Efforts statement (Form MWBE-104).

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- B. Contractor agrees to use such MWBE Utilization Plan, as accepted by the Department, for the performance of MWBEs on the Contract pursuant to the prescribed MWBE goals set forth in section III-A of this Appendix D.
- C. Contractor further agrees that a failure to submit and/or use such MWBE Utilization Plan shall constitute a material breach of the terms of the Contract. Upon the occurrence of such a material breach, Department shall be entitled to any remedy provided herein, including but not limited to, a finding of Contractor non-responsiveness.

V. Waiver Requests (MWBE-101)

- A. For Waiver Requests Contractor should use Form MWBE-101 – Request for Waiver Form.
- B. If the Contractor, after making good faith efforts, is unable to comply with MWBE goals, the Contractor may submit a Request for Waiver Form documenting good faith efforts by the Contractor to meet such goals. If the documentation included with the Waiver Request is complete, the Department shall evaluate the request and issue a written notice of acceptance or denial within twenty (20) days of receipt.
- C. If the Department, upon review of the MWBE Utilization Plan and updated Quarterly M/WBE Contractor Compliance Reports determines that Contractor is failing or refusing to comply with the Contract goals and no waiver has been issued in regards to such non-compliance, the Department may issue a notice of deficiency to the Contractor. The Contractor must respond to the notice of deficiency within seven (7) business days of receipt. Such response may include a request for partial or total waiver of MWBE Contract Goals.

VI. Quarterly M/WBE Contractor Compliance Report (Form MWBE-103)

Contractor is required to submit a Quarterly M/WBE Contractor Compliance Report (Form MWBE-103) to the Department by the 10th day following each end of quarter over the term of the Contract documenting the progress made towards achievement of the MWBE goals of the Contract.

VII. Liquidated Damages - MWBE Participation

- A. Where Department determines that Contractor is not in compliance with the requirements of the Contract and Contractor refuses to comply with such requirements, or if Contractor is found to have willfully and intentionally failed to comply with the MWBE participation goals, Contractor shall be obligated to pay to the Department liquidated damages.
- B. Such liquidated damages shall be calculated as an amount equaling the difference between:
 - 1. All sums identified for payment to MWBEs had the Contractor achieved the contractual MWBE goals; and
 - 2. All sums actually paid to MWBEs for work performed or materials supplied under the Contract.
- C. In the event a determination has been made which requires the payment of liquidated damages and such identified sums have not been withheld by the Department, Contractor shall pay such liquidated damages to the Department within sixty (60) days after they are assessed by the Department unless prior to the expiration of such sixtieth day, the Contractor has filed a complaint with the Director of the Division of Minority and Woman Business Development

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

pursuant to subdivision 8 of section 313 of the Executive Law in which event the liquidated damages shall be payable if Director renders a decision in favor of the Department.

VII. Further Information:

General questions concerning New York's MWBE program should be directed to:

New York State Department of Economic Development
633 Third Avenue
New York, NY 10017
Telephone: (212) 803-2414

New York State Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl Street
Albany, NY 12245
Telephone: (518) 292-5150

All of the EEO and M/WBE forms referenced herein this Appendix D are available for download at the Department's website at: <http://www.cs.ny.gov/pio/mwbe-eeo-forms.cfm>). These forms are to be submitted without change to the goals specified by Department in the Contract.