REQUEST FOR PROPOSALS

ENTITLED:

"Mental Health and Substance Use (MHSU) Disorder Program"

RELEASE DATE:

March 24, 2022

PROPOSAL DUE DATE:

May ~~12~~19, 2022

IMPORTANT NOTICE: A Restricted Period under the Procurement Lobbying Law is currently in effect for this Procurement and it 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 Designated Contact as listed in Section 2.1(1) of this RFP and shall be in compliance with the Procurement Lobbying Law and the New York State Department of Civil Service "*Rules Governing Conduct of Competitive Procurement Process*" (refer to RFP, Section 2: Procurement Protocol and Process).

All inquiries, questions, filings, and submission of Proposals must be directed in writing to:

New York State Department of Civil Service
Attn: Office of Financial Administration, Floor 17
Agency Building 1, Empire State Plaza
Albany, New York 12239
DCSprocurement@cs.ny.gov

Rebecca Corso
Acting Commissioner
New York State Department of Civil Service

Daniel Yanulavich
Acting Director
Employee Benefits Division

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SECTION 1: INTRODUCTION

1.1 Purpose

The New York State Department of Civil Service (Department or DCS) has issued this Request for Proposal (RFP) to secure the services of a vendor to administer the Mental Health and Substance Use (MHSU) Disorder Program. This RFP defines minimum contract requirements, details response requirements, and outlines the Department's process for evaluating responses and selecting a qualified organization (Offeror). Project Services are set forth in detail in Section 3.

The Department will only contract with a single Offeror, which will be the sole contact regarding all provisions of the Contract.

This RFP and other relevant information may be reviewed at: https://www.cs.ny.gov/MHSURFP/.

1.2 Period of Performance

It is the Department's intent to execute a Contract for a term beginning with an Implementation Period of a minimum of 90 calendar days followed by an additional five years of service which shall begin January 1, 2023 and end December 31, 2027. In accordance with New York State policy and New York State Finance Law section 112(2), the resulting contract is deemed executory until it has been approved by the New York State Attorney General's Office (AG) and approved and filed by the New York State Office of the State Comptroller (OSC).

1.3 Overview of the Mental Health and Substance Use Disorder 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 eligible New York State (NYS) employees, retirees, and their Eligible Dependents[1].

[1] Eligible dependent means the spouse, domestic partner, and children under twenty-six (26) years of age of an Enrollee (defined as the policyholder). Young adult dependent children aged twenty-six (26) or over are also eligible if they are incapable of supporting themselves due to a mental or physical disability acquired before termination of their eligibility for coverage under NYSHIP. For additional details on eligible dependents and requirements, please see the following links to the NYSHIP General Information Books for State, PE, and PA enrollees below:
2021 General Information Book NYS Active Employees
(https://www.cs.ny.gov/employee-benefits/nyship/shared/publications/general-information-book/2021/ny-gib-2021.pdf
2021 General Information Book NYS Retirees
https://www.cs.ny.gov/employee-benefits/nyship/shared/publications/general-information-book/2021/ny-retiree-gib-2021.pdf
2019 General Information Book Participating Agencies
https://www.cs.ny.gov/employee-benefits/nyship/shared/publications/general-information-book/2019/pa-gib-2019.pdf
2020 General Information Book Participating Employers (link)
https://www.cs.ny.gov/employee-benefits/nyship/shared/publications/general-information-book/2020/pe-gib-2020.pdf

NYSHIP is sponsored by the Council on Employee Health Insurance (Council), which 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).

NYSHIP is currently comprised of four health insurance plans:

1. The Empire Plan provides health insurance benefits to eligible employees and their enrolled dependents and consists of four main components: hospital program benefits, medical program benefits, mental health and substance use program benefits, and prescription drug program benefits.

2. The Excelsior Plan is a variation of the Empire Plan available to New York State local government units that choose to participate in NYSHIP. The Excelsior Plan offers many of the same features of the Empire Plan with a higher degree of cost-sharing between the employer and plan participants.

3. The NYSHIP Health Maintenance Organizations (HMOs) options are available to State employees and Participating Employers (PEs) of NYSHIP such as public authorities, public benefit corporations, and other quasi-public entities.

4. The Student Employee Health Plan (SEHP) is a health insurance plan for graduate student employees of the State University of New York system that provides benefits through the various Empire Plan insurance contracts. Like the Empire Plan, the SEHP includes hospital, medical, managed mental health and substance use benefits, and prescription drug benefits.

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

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 benefit design of The Empire Plan is the result of collective bargaining between NYS and the various unions representing its employees. Therefore, the benefit design is subject to change from time to time as the result of those negotiations. In addition, 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. Benefits are administratively extended to non-represented NYS employees, employees of PAs and PEs, and retirees.

A primary component of the network benefit is a stable and adequate panel of quality behavioral health providers. The MHSU Disorder Program network is currently

composed of a mix of licensed psychiatrists, psychologists, licensed and registered clinical social workers, psychiatric nurses and nurse practitioners, Licensed Marriage and Family Therapists (LMFTs), Licensed Mental Health Counselors (LMHCs), physician assistants Certified Structured Outpatient Rehabilitation Programs, residential treatment centers, group homes, Partial Hospitalization Programs, hospitals, group practices, licensed Certified Behavioral Analysts (CBA), and Applied Behavioral Analysis (ABA) Agencies. To assure there is the opportunity to supplement clinical care with community programs, the network also includes alternative treatment programs such as halfway houses and treatment programs for dually diagnosed individuals and programs certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

Since the MHSU Disorder 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 (defined as the successful Offeror to whom a contract has been awarded) must make a Single Case Agreement with a Non-Network Provider[2] for services at the network level of benefits.

Recognizing the importance of providing individualized, appropriate treatment in the least restrictive option possible, the MHSU Disorder Program utilizes a Clinical Referral Line and Clinical Management:

a. The Clinical Referral Line must be staffed by licensed clinicians experienced in the assessment and treatment of mental health and substance use disorders, and 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 the network level of benefits even if the provider is not in the network.

b. Clinical Management assesses the medical necessity of the proposed care so as to best meet the treatment needs of the Member, and evaluate whether appropriate care is rendered at the least restrictive level. Clinical Management is especially important where the case is complex and

[2] Network Provider means either a Network Practitioner or a Network Facility. Network Practitioner means a practitioner who has entered into a network agreement with the Contractor. Network Facility means an Approved Facility that has entered into a network agreement with the Contractor. 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 NYS OASAS 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 use treatment or accredited by the appropriate State agency for the level of care received. Single Case Agreement means a unique agreement that the Contractor negotiates with a Non-Network Provider to provide Program Network-level services for a specific Member (policyholder and their dependents) 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. A Non-Network Provider means a practitioner or facility that has not entered into an agreement with the Offeror as an independent contractor to provide Covered Services.

continuing review is necessary to determine if treatment goals are being met. Clinical Managers coordinate care with the Member's family, primary care provider, treating facility, and provider to follow the Member through their treatment plan. Facility means a general acute care or psychiatric hospital or clinic under the supervision of a physician. 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 and in accordance with New York State regulations. If the Member 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 Member's transition from inpatient to outpatient care with appropriate discharge planning to make certain that appointments are kept and the Member is compliant with medications.

The following services are covered under the MHSU Disorder Program, subject to applicable cost sharing such as copays, coinsurance and deductible: [**Note**: Additional information on these services, including definitions, can be found at *Excelsior Plan and SEHP At A Glance* (Attachment 20)]

1. Outpatient Services

    a. Emergency Care at a hospital for treatment of MHSU Disorder when there is no inpatient admission following the care;

    b. Office Visits;

    c. Psychiatric Second Opinion;

    d. Substance Use-Structured Outpatient Rehabilitation Program;

    e. Twenty Family Sessions per year when Enrollee is in a Structured

Outpatient Substance Use 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;

g. Medically Necessary Ambulance Services for MHSU Disorder care;

h. Electro-Convulsive Therapy;

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;

n. Medication Management; and

o. Transcranial Magnetic Stimulation (TMS)

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 a MHSU Disorder Inpatient;

    e. Psychiatric Consultations on a Medical Unit; and

    f. Prescription Drugs when dispensed by an Approved Facility, residential or day treatment program

Benefits by Bargaining Unit (Attachment 30) 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 *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20).

The MHSU Disorder Program does not have an Employee Assistance Program (EAP) component. There is a Statewide EAP for New York State employees staffed by New York State employees who participate as volunteers; however, EAPs do not have a formal role in the MHSU Disorder Program. They are permitted to make referrals; however, the Contractor may not accept clinical information from the EAP unless the Contractor has a Health Insurance Portability and Accountability Act (HIPAA) release form on file for the EAP or 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 MHSU Disorder Program and are encouraged to assist employees in accessing MHSU Disorder services through the MHSU Disorder Program. PEs and PAs 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 MHSU Disorder network services. The Offeror is not responsible for the production and distribution of identification cards, nor will a MHSU Disorder Program-specific identification card be accepted as part of the MHSU Disorder Program benefit design.

The Offeror must provide a voluntary opt-in program for Attention Deficit Hyperactivity Disorder (ADHD), depression management, and eating disorders. The Offeror may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to not participate in any program offered and the right to opt-out of any program at any time.

1.4 Offeror Eligibility

Offeror means any responsible and eligible entity submitting a responsive Proposal to this RFP. It shall be understood that references in the RFP to "Offeror" shall include an entity's proposed Subcontractors or Affiliates (as defined in Section 4.3 of this RFP), if any. The Department requests Proposals only from qualified Offerors, as specified below.

1. The Offeror must, at time of Proposal submission and throughout the term of the Contract, possesses the legal capacity to enter into a Contract with the Department.

2. The Offeror, at time of Proposal submission and throughout the term of the Contract, must be authorized to conduct business in New York State, or, if the Offeror is not so authorized at time of Proposal Due Date (as specified in Section

1.5 of this RFP), then the Offeror must, at the time of Proposal Due Date, have filed an application for authority to do business in New York State with the New York State Secretary of State. Such application must be approved prior to Contract Award. (For details concerning this requirement, refer to: https://dos.ny.gov/form-corporation-or-business. To register with the Secretary of State, contact: https://www.dos.ny.gov/corps/index.html). The Offeror shall notify the Department immediately in the event that there is any change in the above corporate status.

3. The Offeror must represent and warrant that, at time of Proposal submission, it has completed, obtained, or performed all registrations, filings, approvals, authorizations, consents, and examinations required by any governmental authority for the provision of the delivery of Project Services (as detailed in Section 3 of this RFP) and agree that it will, during the term of the Contract, comply with any requirements imposed upon it by law or regulation.

4. As of the Proposal Due Date, the Offeror must have experience providing behavioral management and associated claims adjudication services for, in aggregate, a minimum of 3.6 million total covered lives in its full book of business.

5. The Offeror must represent and warrant that, at time of Proposal submission, it possesses adequate staffing resources, financial resources, and organizational capacity to perform the type, magnitude, and quality of work specified in the RFP.

6. The selected Offeror must agree to contractual provisions to maintain and make available, as required by the State, a complete and accurate set of records for review by the State. Contractual provisions are set forth in the RFP and *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), and *Information Security Requirements* (Appendix C). Such records shall include any and all financial records deemed necessary by the State to discharge its fiduciary responsibilities to MHSU Disorder Program participants and to ensure that public dollars are spent appropriately.

7. At least thirty calendar days prior to the commencement of Full MHSU Disorder Services, and throughout the term of the Contract, the Offeror must possess a Participating Provider/Facility network that meets or exceeds the accessibility standards specified in Section 3.10 of this RFP.

8. The Offeror must understand and indicate its agreement to comply with all specific duties and responsibilities set forth in Section 3.2. of this RFP, entitled “Implementation Plan,” including Section 3.2(1)(e) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.

9. As of the Proposal Due Date, the Offeror must have current Utilization Review Accreditation Commission (URAC)-case management, Joint Commission (TJC) , Accreditation Commission for Health Care (ACHC), National Committee for Quality assurance (NCQA) or Commission on Accreditation of Rehabilitation Facilities (CARF) full accreditation at the proposed primary worksite where case management will be performed for the Project Services.

1.5 Timeline of Key Events

EVENT	DATE
RFP Release Date	March 24, 2022
Deadline for Submission of *Offeror Affirmation of Understanding and Agreement* (Attachment 1)	See below*
Pre-Proposal Conference	April 7, 2022
Deadline for Submission of Offeror Questions	April 14, 2022
Release Date of Official Responses to Offeror Questions	~~April 28~~**May 2**, 2022
Proposal Due Date	May ~~12~~**19**, 2022
Anticipated Technical Management Interviews	May 26, 2022
Anticipated Tentative Contract Award	July 7, 2022
Anticipated OSC Approval of Contract Award and Commencement of Implementation Period	October 1, 2022
Full MHSU Disorder Project Services Start Date	January 1, 2023

*Prior to the Offeror's initial contact with the Department, the Offeror must complete and submit *Offeror Affirmation of Understanding and Agreement* (Attachment 1) to the Designated Contact identified in Section 2.1(1) of this RFP.

SECTION 2: PROCUREMENT PROTOCOL AND PROCESS

2.1 Rules Governing Conduct of Competitive Procurement Process

All inquiries, questions, filings, and submission of Proposals in regard to the RFP must be directed in writing to the Designated Contact listed below. Proposals may not be submitted by e-mail or facsimile. Any inquiries, questions, filings, or submission of Proposals that are submitted to any other contact or physical address shall not be considered as official, binding or as having been received by the Department.

1. **Designated Contact**

   In accordance with New York State Finance Law § 139-j(2)(a) (Procurement Lobbying Law (PLL)), the following individual is the Designated Contact for this Solicitation. All questions relating to this Solicitation must be addressed to the following Designated Contact:

   George Powers
   New York State Department of Civil Service
   Attn: Office of Financial Administration, Floor 17
   Agency Building 1, Empire State Plaza
   Albany, New York 12239
   DCSprocurement@cs.ny.gov

2. **Restrictions on Contacts Between Offerors and State Staff During the Procurement Process**

   a. Pursuant to New York State Finance Law sections 139-j and 139-k, this Procurement imposes certain restrictions on communications between the Department and an Offeror during the procurement process. An Offeror is restricted from making contacts from the earliest posting, on the Department's website, in a newspaper of general circulation, or in the procurement opportunities newsletter in accordance with Article 4-C of the Economic Development Law, of written notice, advertisement or solicitation of a request for Proposal, invitation for bids, or solicitation of proposals, or any other method provided for by law or regulation for soliciting a response from Offerors intending to result in a contract with the Department through final award and approval of the contract by the Department and, if applicable, the Office of the State Comptroller to other than the Designated Contact (unless it is a Contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a)). This time period is defined as the Restricted Period. The Designated Contact for this procurement is set forth in Section 2.1(1) of this RFP. Staff is required to obtain certain information from an Offeror whenever contacted 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 statutory requirements. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4-year period, the Offeror is debarred from obtaining governmental Procurement Contracts. The Department's policy and procedures can be found in the *Procurement Lobbying Policy* (Attachment 2). Further information about these requirements can be found at: https://www.ogs.ny.gov/ACPL/.

b. The Department strictly controls communications between any Offeror and participants in the procurement process. "Offeror" means the individual or entity, or any employee, agent or consultant or person acting on behalf of such individual or entity, who contacts the Department about a governmental procurement during the restricted period of such governmental procurement whether or not the caller has a financial interest in the outcome of the procurement; provided, however, that a governmental agency or its employees that communicate 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.

3. Pre-Proposal Conference

A Pre-Proposal Conference will be held approximately 14 calendar days after the RFP Release Date at 10:00 a.m. using a virtual platform. Attendance is not mandatory but is strongly encouraged for Offerors intending to submit a Proposal. If Offeror's organization plans to attend the Pre-Proposal Conference, please notify the Designated Contact identified in Section 2.1(1) of this RFP via e-mail at the address noted in Section 2.1(1) at least 24 hours before the conference with the name, email address, and affiliation of each person attending.

4. Submission of Errors or Omissions in this RFP Document

By participating in activities related to this RFP, and/or by submitting a Proposal in response to this RFP, an Offeror agrees to be bound by its terms, including, but not limited to, this process by which an Offeror may submit errors or omissions for consideration. If an Offeror believes there is an error or omission in this RFP, the Offeror may raise such issue as follows:

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

i. *Time Frame:* The Department must receive assertions of errors or omissions in the RFP process which are or should have been apparent prior to the Proposal Due Date, in writing, five Business Days after the Release Date of Official Responses to

Questions specified in Section 1.5 of this RFP. Business Day(s) means every Monday through Friday, from 8:00 a.m. to 5:00 p.m. ET, except for days designated as state holidays by the Department.

ii. *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.

iii. *Format of Submission:* All submissions asserting an error or omission must be in writing and submitted to the Designated Contact in hard copy at the address provided in Section 2.1(1) of this RFP.

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

"Submission of Errors or Omissions for the Mental Health and Substance Use (MHSU) Disorder Program Request for Proposals"

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 Offeror and the Offeror shall have no further recourse.

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

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. At the discretion of the Commissioner, or the Commissioner's designee, the Offeror may be given the opportunity to meet with the Commissioner or the Commissioner's designee 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 designee.

The Commissioner or designee shall review the matter, and the Commissioner shall issue a written decision within twenty 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 act in the best interests of the State in resolving any assertion of error or omission in this RFP document. 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 provided an email address on the submitted *Offeror Affirmation of Understanding and Agreement* form (Attachment 1). Notice of any extension will also be posted to: https://www.cs.ny.gov/MHSURFP/.

5. Submission of Questions

Using the *Questions Template* (Attachment 4), a prospective Offeror may submit questions concerning the content of this RFP via email to the Designated Contact's address specified in Section 2.1(1) of this RFP. Only those questions received prior to the Questions Due Date specified in Section 1.5 of this RFP, will be accepted. After the Questions Due Date, the Department will provide an email notification of the posting of all questions and the Department's official answers to all those individuals who provided an email address on the submitted *Offeror Affirmation of Understanding and Agreement* form (Attachment 1), the *Questions Template* (Attachment 4), and those individuals who register to attend the pre-proposal conference. The questions and answers will also be posted to: https://www.cs.ny.gov/MHSURFP/. [**Note**: See Bid Deviations section below, specifically 7(b) with regard to submission of questions.]

6. Submission of Proposal

a. The Offeror's Proposal must be organized and separated into three separate sections: Administrative Proposal; Technical Proposal; and Financial Proposal. To facilitate the evaluation process, an Offeror must follow the submission requirements described below:

   i. One ORIGINAL hard copy and five hard copy versions of each of the three sections of the RFP, separated into Administrative, Technical and Financial sections.

   ii. Each ORIGINAL hard copy of each section must be marked "ORIGINAL," contain original signatures of an official(s) authorized to bind the Offeror to its provisions on all forms submitted that require the Offeror's signature. The remaining hard copies of each section may contain a copy of the official's signature on all forms submitted that require the Offeror's signature and should be numbered sequentially (i.e., Copy #1, Copy #2).

   iii. A master electronic submission containing all of the ORIGINAL hard copy sections of the proposal must be provided on

electronic media. Electronic media shall be included on unprotected Microsoft Windows formatted USB 2.0 or higher storage drive and must be clearly labeled by proposal section and identified as the master electronic submission. In situations where proposal content differs between the ORIGINAL bound hard copies and the master electronic submission, the master electronic submission is deemed controlling. The master electronic submission should be inserted in the Financial Proposal box.

iv. The Offeror must submit five additional USB drives which each contain an electronic copy of the Administrative and Technical Proposal ONLY. The USB drives must conform to the technical specifications outlined in Section 2.1(6)(a)(iii) of this RFP. Each of the five electronic copies should be labeled by section and uniquely designated with a number (e.g., “TECHNICAL & ADMINISTRATIVE COPY 1”, “TECHNICAL & ADMINISTRATIVE COPY 2, etc.”).

v. Each Proposal must include a table of contents.

vi. Each major section of the Proposal, including attachments, must be labeled with an index tab that completely identifies the title of the section, subsection or attachment as named in the table of contents.

vii. Each page of the Proposal, including attachments, must be dated and numbered consecutively.

b. Proposals should be placed and packaged together, by section, in sealed boxes/envelopes (i.e., all Administrative Proposals in one box, all Technical Proposals in a second box, and all Financial Proposals in a third box). Each sealed box/envelope should contain a label on the outside, which contains the information below. Each sealed box/envelope should be submitted to the Designated Contact at the address provided in Section 2.1(1) of this RFP.

New York State Department of Civil Service
Request for Proposals
"Mental Health and Substance Use (MHSU) Disorder Program"

OFFEROR NAME
OFFEROR ADDRESS

Indicate content, as applicable
ADMINISTRATIVE, TECHNICAL, or FINANCIAL PROPOSAL
There must be no Financial/cost information included in the Offeror's Administrative Proposal or Technical Proposal, except for proposed performance guarantees.

c. All Proposals must be mailed or hand-delivered to the address provided in Section 2(1)(1) of this RFP. To make arrangements for hand-delivery, the Offeror must notify the Designated Contact twenty-four 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 1.5 of the RFP.

d. Any proposal received after 3:00 p.m. ET on the Proposal Due Date, as specified in Section 1.5, shall not be accepted by the Department and may be returned to the submitting entity at the Department's discretion. All Proposals submitted become the property of the Department.

e. The Department will accept amendments and/or additions to an Offeror's Proposal if the amendment and/or addition is received by the Proposal Due Date. All amendments to an Offeror's Proposal must be submitted in accordance with the format set forth in Section 2.1(6) of this RFP and will be included as part of the Offeror's Proposal.

f. An Offeror is solely responsible for timely delivery of the Proposal to the Department prior to the Proposal Due Date stated in Section 1.5 of this RFP. Delays in United States mail deliveries or any other carrier, including couriers or agents of New York State, shall not excuse late bid submissions. If the Proposals is delivered by mail or courier, the Department recommends that it be sent "Returned Receipt Requested", so the Offeror obtains proof of timely delivery. No phone, facsimile or e-mail submission of Proposals will be accepted for this RFP. In addition, it is the sole responsibility of the Offeror to verify that all elements of the proposal submission are complete, correct and without error.

7. Bid Deviations

a. The Department will not entertain bid deviations to *Standard Clauses for New York State Contracts* (Appendix A). The Department will also not entertain material and substantive bid deviations to the solicitation to

Standard Clauses for All Department Contracts (Appendix B), *Information Security Requirements* (Appendix C) and the *Glossary for Appendix B and C* (Appendix C-1). New York State law precludes awarding a contract based on material deviation(s) from the specifications, terms, and/or conditions set forth in the solicitation. Therefore, Proposals containing a bid deviation (including additional, inconsistent, conflicting, or alternative terms) that are a material and substantive change from the specifications, terms, and conditions set forth in the solicitation may render the Proposal non-responsive and may result in rejection of the Proposal.

b. If an Offeror has an issue or concern regarding provisions in the solicitation and is considering submission of a proposal containing a bid deviation, the Offeror is strongly advised to raise such issues and/or concerns during the question and answer period so that the Department may give due consideration to the issue prior to the submission of Proposals. Failure to use the question and answer period and instead submitting a Proposal containing a bid deviation could render the entire Proposal non-responsive and rejected in its entirety.

c. In general, a material and substantive bid deviation is one that would (i) impair the interests of New York State, (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 solicitation, could have formed a reasonable basis for an otherwise qualified Offeror to change its determination concerning the submission of a Proposal. For example, a deviation that would substantially shift liability (risk) or financial responsibility from the Offeror to New York State would be considered material.

d. Unless specifically required by the solicitation to be submitted as part of an Offeror's proposal, an Offeror is further advised that its 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 are not considered as having been submitted with or intended to be incorporated as part of the official offer contained in the Proposal. Rather, such material shall be deemed by the Department to have been included by Offeror for informational or promotional purposes only. If such materials are requested by the solicitation, an Offeror must ensure that the materials are properly referenced.

e. To submit a non-material bid deviation, an Offeror must complete and submit the proposed deviation(s) using the *Non-Material Deviations Template* (Attachment 8), as part of the Administrative Proposal. Any non-material deviations proposed by an Offeror must be submitted on the *Non-*

Material Deviations Template (Attachment 8), not an alternative document. If a non-material bid deviation does not meet these requirements, it shall not be considered by the State and shall be rejected.

f. An Offeror who does not submit the *Non-Material Deviations Template* (Attachment 8), as part of the Administrative Proposal is presumed to have no bid deviations.

8. Notification of Tentative Contract Award

A tentative award letter will be sent to the selected Offeror indicating a tentative award subject to successful contract negotiations. The remaining Offerors will be notified of the tentative award and the possibility that failed negotiations could result in an alternative award.

9. Debriefing

Unsuccessful Offerors will be advised of the opportunity to request a Debriefing and the timeframe by which such requests must be made. Debriefings are subject to the *NYS Department of Civil Service Debriefing Guidelines* (Attachment 5). An unsuccessful Offeror's written request for a debriefing shall be submitted to the Designated Contact at the address provided in Section 2.1(1) of this RFP.

10. Submission of a Protest

By participating in activities related to this Procurement, and/or by submitting a Proposal in response to this RFP, an Offeror agrees to be bound by its terms including, but not limited to, the process by which an Offeror may submit a protest of a non-responsive determination or the selection award for consideration. In the event the Offeror elects to submit a protest of a non-responsive determination, the Offeror agrees it shall not be permitted to also submit a protest on the selection decision. In the event that an Offeror decides to submit a protest, the Offeror may raise such issue according to the following provisions.

a. Process for Submitting a Protest of a Non-Responsive Determination or a Selection Decision

i. Time Frame*:* Any protest must be received no later than 5:00 p.m. ET on the tenth Business Day after an Offeror's receipt of written notification by the Department of a non-responsive determination or tentative award.

ii. Content: The protest must fully state the legal and factual grounds for the protest and must include all relevant documentation.

iii. Format of Submission: The protest must be in writing and submitted to the Designated Contact at the address provided in Section 2.1(1) of this RFP.

iv. A protest of either a non-responsive determination or a selection decision must have one of the following statements clearly and prominently displayed on the envelope or package:

"Submission of Non-Responsive Determination Protest for Request for Proposals Mental Health and Substance Use (MHSU) Disorder Program"

OR

"Submission of Tentative Award Protest for Request for Proposals Mental Health and Substance Use (MHSU) Disorder Program"

v. 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**

i. 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 Proposal, the determination of non-responsiveness, 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 the Commissioner's designee, to support its submission. The Offeror may, but need not, be represented by counsel at such a meeting. The Department shall be represented by counsel at such meeting. Any issues concerning the way the review process is conducted shall be determined solely by the Commissioner, or the Commissioner's designee.

ii. The Commissioner, or the Commissioner's designee, shall review the matter, and shall issue a written decision within twenty Business Days after the close of the review process. If additional time is necessary for the issuance of the decision, the Offeror shall be advised 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.

iii. If an Offeror protests the selection decision or a non-responsive determination, the Department shall continue contract negotiations regarding the terms and conditions of the contract with the selected Offeror.

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 this RFP, such amendments will also be posted to: https://www.cs.ny.gov/MHSURFP/;

c. Prior to the bid opening, direct Offerors to submit Proposal modifications addressing subsequent RFP amendments;

d. Withdraw this RFP, at any time, in whole or in part, 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 this RFP;

g. Require clarification at any time during the Procurement process and/or require correction of 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;

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 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 this RFP in the best interests of the Department;

p. Utilize any and all ideas submitted in the Proposal(s) received except to the extent such information/ideas are protected under the New York State Freedom of Information Law, Article 6 of the Public Officers Law as critical infrastructure information or trade secrets;

q. If the Department determines that contract negotiations between the Department and the selected Offeror are unsuccessful, the Department may invite the Offeror with the next highest Total Combined Score to enter into negotiations for purposes of executing a contract. Prior to negotiating with the Offeror with the next highest Total Combined Score, the Department will notify the Offeror originally selected and provide the date when negotiations shall cease should an agreement not be reached. Scores will not be recalculated for any remaining Offerors should contract negotiations between the Department and the selected Offeror be unsuccessful because of material differences in key provision(s);

r. Unless otherwise specified in this RFP, every offer is firm and non-revocable for a minimum period of 365 days from the Proposal Due Date as set forth in the RFP; and

s. Any Offeror whose Proposal might become eligible for a tentative award

may be asked to extend the time for which its Proposal shall remain valid if the original award is withdrawn.

12. Disclaimers

The Department is not liable for any cost incurred by any Offeror prior to approval of the contract by OSC. Additionally, no cost will be incurred by the Department for any prospective Offeror or Offeror's participation in any Procurement-related activities. Further, the Department shall not be liable for any costs incurred prior to the Implementation Period performing activities set forth in Section 3 of this RFP. The Department has taken care in preparing the data accompanying this RFP (hard copy attachments, website attachments, and sample document attachments). However, the Department does not warrant the accuracy of the data. The numbers or statistics which appear in hardcopy attachments, website attachments, and sample document attachments 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. Accordingly, prospective Offerors should rely upon and use such numbers or statistics in preparing their Proposal at their own discretion.

2.2 Compliance with Applicable Laws, Rules and Regulations, and Executive Orders

This Procurement is subject to the New York State competitive bidding laws and also governed by, at a minimum, the legal authorities referenced below. An Offeror must fully comply with the provisions set forth in this section of the RFP, as well as the provisions of the *Standard Clauses for New York State Contracts* (Appendix A), the *Standard Clauses for All Department Contracts* (Appendix B) and *Information Security Requirements* (Appendix C), which will become a part of the resulting contract. The Department will consider for evaluation and selection purposes only those Offerors who agree to comply with these provisions and whose proposal contains the submission required hereunder.

1. **Disclosure of Proposal Contents – Freedom of Information Law (FOIL)**

    a. NOTICE TO OFFEROR AND ITS 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

New York State agencies interested in the provision of the subject services including, but not limited to, GOER and DOB, 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.

The Department shall take reasonable steps to protect from public disclosure any records or portions thereof relating to this solicitation that are exempt from disclosure under FOIL. Information constituting trade secrets or critical infrastructure information for purposes of FOIL must be clearly marked and identified as such by the Offeror upon submission. To request that materials be protected from FOIL disclosure, the Offeror must follow the procedures below regarding FOIL. If an Offeror believes that any information in its Proposal or supplemental submission(s) constitutes proprietary and/or trade secret or critical infrastructure information and desires that such information not be disclosed 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 a *Freedom of Information Law Request for Redaction Chart* (Attachment 11). 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 *Freedom of Information Law Request for Redaction Chart* (Attachment 11) contains information regarding appropriate justification for protection from FOIL disclosure. Vague, non-specific, or summary assertions that material is proprietary or trade-secret are inadequate and will not result in protection from FOIL disclosure.

The completed *Freedom of Information Law Request for Redaction Chart* (Attachment 11) must be submitted to the Department at the time of its Proposal submission; it should be included with the Requested Redactions (USB storage drive 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 *Freedom of Information Law Request for Redaction Chart* (Attachment 11) and submitting it to the Department at the time of its Proposal submission, but separately from its Proposal. If a completed *Freedom of Information Law Request for Redaction Chart* (Attachment 11) 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 are not considered part of the

Offeror's Proposal and shall not be reviewed as a part of the Procurement's evaluation process.

Acceptance of the identified information by the Department does not constitute a determination that the information is exempt from disclosure under FOIL. Determinations as to whether the materials or information may be withheld from disclosure will be made in accordance with FOIL at the time a request for such information is received by the Department.

b. Requested Redactions (USB Storage Drive 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 the event that its Proposal is the subject of a FOIL request as follows.

The Offeror must provide an electronic copy of the Administrative Proposal, the Technical Proposal, and the Financial Proposal on a separate USB storage drive of the type outlined in RFP Section 2, which reflect the Offeror's requested redactions. Additionally, the Offeror must provide a separately bound hardcopy of each of the three Proposal documents with redactions marked, but not applied, that are included on the USB storage drives. The electronic documents must be prepared in PDF format. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using either:

i. The Adobe "Mark for Redaction" function; do not use the "Apply Redactions" function; or

ii. By highlighting such portions in yellow.

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 USB storage drives and in hard copy must be complete Proposals, including all Attachments. No section may be omitted from the USB storage drive or hard copy even if the entire section is requested to be redacted; such sections should be marked for redaction, not removed. For forms, attachments, and charts, please mark for redaction only those cells/fields/entries that meet the criteria for protection from FOIL, not the entire page. Do not request redaction of Department-supplied materials or information.

During the Proposal evaluation process, the Department may request additional information through clarifying letters. 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.

2. **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 State employees. Failure to comply with these provisions may result in disqualification from the Procurement process, termination, suspension or cancelation of the Contract and criminal proceedings as may be required by law. An Offeror 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 *New York State Required Certifications* (Attachment 7), in the Offeror's Administrative Proposal.

3. **New York State Required Certifications**

An Offeror is required to submit the signed *New York State Required Certifications* (Attachment 7) with its Administrative Proposal. This attachment sets forth the Offeror's required statements on the MacBride Fair Employment Principles, Non-Collusive Bidding Certification, compliance with the New York State Public Officers Law, and certifications required under Executive Order No. 177 and New York State Finance Law section 139-l.

4. **New York Subcontractors and Suppliers**

An Offeror is required to complete *New York State Subcontractors and Suppliers* (Attachment 12). 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, an Offeror for this RFP is 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. *New York State Subcontractors and Suppliers* (Attachment 12) must be submitted with the Offeror's Technical Proposal.

SECTION 3: PROJECT SERVICES

The Department is seeking a qualified Offeror to provide comprehensive administration of the MHSU Disorder Program. Delivery of Project Services will impact over 1.2 million covered lives.

For the purpose of submitting a Proposal, an Offeror must provide:

1. Mental health and substance use disorder services through a contracted nationwide Provider network;

2. Comprehensive administration services including customer service, claims processing and reporting; and

3. A Clinical Referral Line for the MHSU Disorder Program which must be operational 24 hours a day, seven days a week, 365 days a year.

3.1 Account Team

The Offeror must provide a knowledgeable, experienced account leader and team dedicated solely to the MHSU Disorder Program who have the responsibility and authority to command the appropriate resources necessary to implement and deliver Project Services (hereinafter "Account Team").

1. Duties and Responsibilities

a. The Account Team must respond to any and all administrative and clinical concerns and inquiries posed by the Department, other staff on behalf of the Council on Employee Health Insurance, or union representatives regarding Member-specific claims issues within two Business Days to the satisfaction of the Department.

b. The proposed Account Team must guarantee that the MHSU Disorder Program complies with all legislative and statutory requirements. In the event the Offeror is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately.

c. The Offeror must ensure that its Account Team immediately notifies the Department of actual or anticipated events impacting MHSU Disorder Program costs and delivery of services to Enrollees and their dependents, including proposed legislative or statutory requirements. Enrollee, for purposes of this RFP, is defined as the policyholder.

d. The Offeror will have a process for the Account Team to gain immediate access to corporate resources and senior management necessary to meet

all MHSU Disorder Program requirements and deal immediately with any issues that may arise.

3.2 Implementation Plan

The Offeror must deliver an overall Implementation Plan and designate an Implementation Team composed of individuals who have completed an implementation for a least one large client. A large client is considered any employer with at least 50,000 covered lives. Implementation activities must be completed no later than December 31, 2022, so that MHSU Disorder Project Services can commence on January 1, 2023 (Full MHSU Project Services Start Date" or "Project Services Start Date").

1. Duties and Responsibilities

a. The Implementation Plan must include evaluation and assessment activities and development of a project plan to achieve Contract requirements and deliver the Project Services.

b. The Offeror must, by December 31, 2022, be operationally ready as described by, but not limited to, the following:

i. The Offeror must have a contracted Provider network in place, that meets or exceeds the required access standards set forth in Section 3.10 of this RFP.

ii. The Offeror must have a fully operational, dedicated Call Center, including a Clinical Referral Line, available for the use of Members and health benefits administrators. As detailed in Section 3.5(1)(b), the dedicated Call Center must be open and operational a minimum of 30 Calendar Days prior to the commencement of Full MHSU Disorder Project Services. Members, for purposes of this RFP, are defined as all policyholders and their dependents.

iii. The Offeror must accurately process all claims, as submitted.

iv. The Offeror must have Clinical Management programs, as described in Section 3.11, operational and ready to support the MHSU Disorder Program as set forth in Section 3 of this RFP.

v. The Offeror must have a fully functioning, customized MHSU Disorder Program website available for a minimum of 30 calendar Days prior to the commencement of the MHSU Disorder Services.

c. The Offeror must provide, subject to Department final approval, an Implementation Plan that results in the implementation of all services by the required timeframes, indicating estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. The Implementation Plan must include key activities such as training of call center staff, website development, network development, transition of benefits, eligibility feeds and testing claims processing. Also, it must identify and describe areas where complications may be expected and what steps Offeror will take to ensure timely implementation.

d. The Offeror shall provide a comprehensive Implementation Plan , at least 90 calendar days prior to the MHSU Project Services Start Date, which will allow the Department to review the Offeror's readiness in the areas outlined in Section 5.3.1.

e. Implementation Guarantee: The Offeror must guarantee that all of the tasks identified in the Department approved Implementation Plan identified above will be in place on or before the MHSU Project Services Start Date of January 1, 2023 (hereafter "MHSU Project Services Start Date" or "Project Services Start Date") following completion of the Implementation Period, with the exception of opening the dedicated Call Center and completing work on the customized website. The dedicated Call Center must be opened at least thirty calendar days prior to the MHSU Project Services Start Date. The customized website must be live and operational at least 30 calendar days prior to the Full MHSU Services Start Date. This guarantee is not subject to the limitation of liability provisions of the Contract.

3.3 Member Communication Support

The Department regularly provides information regarding Program benefits to Members through publications, the Department's website, media, and attendance at various meetings. The successful Offeror will be required to assist the Department with the creation, review and presentation of MHSU Disorder Program materials that will enhance a Member's understanding of the MHSU Disorder Program benefits.

1. Duties and Responsibilities

a. All Member communications developed by the Offeror are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Members or their Physicians in connection with Member utilization or the processing of Member claims, either through mail, e-mail, fax or telephone. The

Department in its sole discretion reserves the right to require any change it deems necessary.

b. The Offeror will be responsible for providing Member communication services to the Department including, but not limited to:

    i. Developing language describing the MHSU Disorder Program for inclusion in the Empire Plan Certificate of Insurance, NYSHIP General Information Book, and any other form of communication, subject to the Department's review and approval;

    ii. Developing articles for inclusion in Empire Plan Reports and other MHSU Disorder Program publications on an "as needed" basis;

    iii. Timely reviewing and commenting on proposed MHSU Disorder Program communication material developed by the Department;

    iv. Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program administrators for the Empire Plan, the Excelsior Plan and the SEHP. Presently, the Department posts the SBCs on NYSHIP Online. Upon Member request, the Offeror must direct Members to the Department's website to view the SBC or distribute a copy of the SBC to the Member within the federally required period; and

    v. Distributing MHSU Disorder Program materials to Members; including but not limited to annual mailings of summary plan documents. An Offeror shall have the ability to send member communication materials through both U.S. mail and email.

c. The Offeror must develop appropriate customized forms and letters for the MHSU Disorder Program, including but not limited to Member claim forms, Explanation of Benefits, certification letters and appeal letters. The Department reserves the right to review and approve these communications prior to distribution.

d. Upon the Department's request, on an "as needed" basis, the Offeror agrees to provide staff to participate in health fairs, select conferences, benefit design information sessions and Union events in New York State and elsewhere in the United States. A calendar year summary of health fairs is available in *2019 Health Fairs* (Attachment 31). The Offeror agrees that the costs associated with these services, including all fees associated with travel, meals and lodging to attend the events, are included in the

Offeror's Administrative Fee.

e. The Offeror shall assist in developing the Empire Plan Participating Provider Directories on an annual basis as required by New York State Insurance Law §§ 3217-a(a)(17) and 4324(a)(17) and Public Health Law § 4408(r). Printed directories are provided for each State, except Florida which has two regional directories, as well as a separate directory for four different regions of New York State; Upstate, Long Island, Mid-Hudson, and New York City. The Offeror must provide a MHSU Disorder Program specific online directory that is functional and available 24 hours a day, 7 days a week, except for scheduled maintenance. The Offeror must provide a web link, for the Department's website, that is accessible to the general public and does not require Member log in. In addition to complying with the requirement of the *Standard Clauses for All Department Contracts* (Appendix B) and *Information Security Requirements* (Appendix C), this online directory must be branded consistent with all New York State branding protocols and provide Members with a user-friendly interface that allows them to search for Providers and Facilities, as indicated in the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance (*Attachment 20*),* based on geographic location, name, or specialty. The directory must detail all MHSU Provider information as required by State and federal law. Information about all types of MHSU Providers in all geographic locations shall be accessible through this single link and search functions. The directory shall be updated weekly or more frequently, if necessary, to ensure Members have access to the most up-to-date information. The Offeror must ensure the directory contains the most up-to-date information regarding network MHSU Providers and Facilities, including if the MHSU Provider is accepting new patients. Presently, MHSU Providers can be found by accessing the Department's website at http://www.cs.ny.gov (under Benefit Programs -NYSHIP online - choose a group, choose Empire Plan Enrollee, and then Find a Provider).

f. The selected Offeror is required to provide Member Program Benefit information through a link on the Department's website. Content accessible through this link shall be strictly limited to information that pertains to the Program. No other links or content are permitted on the Offeror's Program Benefits website without the written approval of the Department. The Department shall be notified of all regularly scheduled maintenance or material modifications to the site no later than one Business Day prior to such maintenance being performed. Any and all costs associated with the Program Benefits website including development, maintenance, hosting customization or establishing a dedicated link for the MHSU Disorder Program shall be included in the Administrative Fee charged by the Offeror. Information provided through this link shall include, but not be limited to:

i. Program Benefits;

ii. Eligibility;

iii. Copayment and cost-sharing information;

iv. Year-to-date combined annual deductible and coinsurance amounts;

v. Claim status and submission information;

vi. Explanation of Benefits Statements;

vii. Access to the customized Empire Plan Provider Directories; and

viii. Clinically-based educational information for Members based upon medical issues.

g. The fully functioning, customized MHSU Disorder Program Benefits website, approved and accepted by the Department, must be available a minimum of 30 calendar days prior to commencement of the MHSU Project Services Start Date with a secure dedicated link from the Department's website with the ability to provide Members with online access to the specific website requirements as set forth in Section 3.3(1)(e) of this RFP. The website must conform to the New York State website style provided by the Department of Civil Service and meet all NYS Web Accessibility requirements

h. The Offeror must include a web-based user interface compatible with:

i. Google Chrome current version for Windows, or

ii. Mozilla Firefox current version, or

iii. Safari current version, or

iv. Microsoft Edge current version

i. The websites must be mobile friendly, fully functional, and display correctly on devices such as:

i. Smartphones;

ii. iPhones;

iii. iPads;

iv. Tablets; and

v. Laptops

3.4 Reporting Services

The Offeror must provide the Department with regular, periodic reports that are designed to document that Member, network, and account management service levels are being maintained and that claims are being paid in accordance with the Contract. The Offeror may on occasion be requested to provide ad-hoc reporting and analysis within twenty four hours.

In order to fulfill its obligations to Members and ensure Contract compliance, the Offeror must provide accurate claims data information on a claim processing cycle basis as well as summary reports concerning the MHSU Disorder Program and its administration.

All electronic files must be in a format acceptable to the Department. The Department will initially review and approve the proposed file format during the Implementation Period, but this file format may be adjusted during the term of the Contract at the discretion of the Department. Upon receipt by the Department, all electronic files are first validated for compliance with the agreed-upon format. Files that fail to adhere to this structure are rejected in their entirety and must be re-submitted.

1. Duties and Responsibilities

a. The Offeror must be responsible for reporting services including, but not limited to:

i. Developing and delivering accurate and timely management, financial, and utilization reports as specified in *Program Reporting* (Attachment 16). These reports will be delivered to the Department no later than their respective due dates and are required by the Department for its use in the review, management, monitoring, and analysis of the MHSU Disorder Program. The exact format (paper and/or electronic Microsoft Access, Excel, Word), frequency, and due dates for such reports will be specified by the Department;

ii. Ensuring that all financial reports including claim reports are generated from amounts billed to each component of the MHSU Disorder Program and reconciled to amounts reported in quarterly and annual financial experience reports;

iii. Reporting of all performance guarantees as specified within the Contract and for any occurrence when a performance guarantee is not met, Contractor will provide a root cause analysis and detail corrective action;

iv. Providing ad hoc reports and other data analysis at no additional fee to the Department. The exact format, frequency, and due dates for such reports shall be specified by the Department. Any ad hoc report generated for the Department must be reflective of the Program's actual claims experience and Member population. Information required in the ad hoc reports may include, but is not limited to:

1) Forecasting and trend analysis data;

2) Utilization data;

3) Utilization review savings;

4) Benefit design modeling analysis;

5) Reports to meet clinical Program review needs;

6) Reports segregating claims experience for specific populations including Department assigned Benefit Programs (see *Benefit Programs* chart (Attachment 18)); and

7) Reports to monitor Contract compliance.

v. 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 MHSU Program and the State;

2) Developing projected aggregate claim, trend and Administrative Fee amounts for each MHSU Program Year. Analysis of all MHSU Program components impacting the MHSU 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. Reporting Services Guarantee: The MHSU Disorder Program's service level standard requires that management reports and claim files listed in *Program Reporting* (Attachment 16), will be accurate and delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Administrative Fee.

3.5 Customer Service

The Plan requires that the Offeror provide quality customer service to Members. The Plan provides access to customer service representatives through the Empire Plan Consolidated Toll-Free Number. Through this Empire Plan Consolidated Toll-Free Number, Members and Providers access representatives who respond to questions, complaints, and inquiries regarding Plan benefits, Network Providers, clinical management programs, claim status and appeals. The average number of calls received per month in 2020 by the MHSU Disorder Program was approximately 15,737. Detailed call center statistics can be found in *Call Center Statistics* (Attachment 17). The Offeror is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service.

1. Duties and Responsibilities

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

a. Providing Members access to information on all MHSU benefits and services 24 hours a day, 7 days a week, 365 days a year, through the Empire Plan Consolidated Toll-Free Number, which currently is 1-877-769-7447 (1-877-7NYSHIP).

b. Maintaining a fully operational dedicated Call Center, including a MHSU Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section 3 of this RFP. The dedicated Call Center must be open and operational a minimum of 30 Calendar days prior to the MHSU Project Services Start Date to assist Members with questions concerning transition. The Call Center line shall have the additional capability to transfer calls internally to the appropriate areas of the MHSU Disorder Program. The Call Center shall be staffed by trained customer service representatives (CSRs) available during the required

customer service hours of operation.

i. The Offeror must maintain a dedicated Call Center staffed by fully trained CSRs and supervisors providing direct access to trained Clinicians who direct Members to appropriate Network Providers who are accepting new patients, provide clinical MHSU information and if requested by the caller, assist in scheduling appointments on behalf of the Member 24 hours a day, 7 days a week, 365 days a year.

ii. CSRs must be able to identify calls requiring transfer to a Clinician and they must be trained and capable of responding to a wide range of questions, complaints, and inquiries, including but not limited to: Transition of Care; MHSU Disorder Program benefits levels; status of pre-certification requests; eligibility and claim status.

iii. The Offeror must provide access to a teletypewriter (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 the Call Center as the non-TTY number.

iv. In accordance with federal and State law, the Offeror must provide access to a translation line or interpretation service to Members who do not read, speak, write or understand English as their primary language in order to remove potential barriers to accessing services.

v. Customer service representative(s) must use an integrated system to log and track all Member calls. The system must track the total number of calls entering the Empire Plan Consolidated Toll-Free Number and the date, time, duration, and reason for all calls. The system must create a record of the Member contacting the call center, the call type, and all customer service actions and resolutions.

vi. The Offeror must maintain designated backup customer service staff with MHSU Disorder Program specific training to handle any overflow when the dedicated customer service center is unable to meet the Offeror's proposed customer service performance guarantees. This backup system would also be utilized in the event the primary customer service center becomes unavailable.

vii. The Offeror must prepare and enter into a shared service agreement with the toll-free vendor and the Empire Plan's medical

carrier/third party administrator (currently UnitedHealthcare) to address billing and maintenance issues with the provision of the Empire Plan Consolidated Toll-Free Number.

viii. The Offeror must establish a process through which Providers can verify eligibility of Enrollees and Members during Call Center hours.

c. Call Center Telephone Guarantees: The Offeror must provide guarantees for the following four measures of service:

i. Call Center Response Time Guarantee: The MHSU Disorder Program's service level standard requires that, at a minimum, 90% of incoming calls to the Contractor's telephone line will be answered by a CSR within thirty seconds. Response time is defined as the time it takes incoming calls to the Offeror's telephone line to be answered by a customer service representative. The call center telephone response time shall be reported to the Department on a weekly basis for the first month of the Contract, and then reported monthly for the remainder of the Contract and calculated quarterly. [**Note**: this guarantee is separate from the Clinical Referral Line guarantees in Section 3.5(1)(e) of this RFP].

ii. Availability Guarantee: The MHSU Disorder Program's service level standard requires that the Offeror's telephone line will be operational and available to Members and Providers equal to or better than 99.5% of the Offeror's required up-time (24 hours a day, 7 days a week, 365 days a year). The telephone line availability shall be reported monthly and calculated quarterly.

iii. Telephone Abandonment Rate Guarantee: The MHSU Disorder Program's service level standard requires that the percentage of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a call center representative will not exceed 3%. The telephone abandonment rate shall be reported weekly for the first month of the Contract, and then reported monthly for the remainder of the Contract and calculated quarterly.

iv. Telephone Blockage Rate Guarantee: The MHSU Disorder Program's service level standard requires that not more than 0% of incoming calls to the Offeror's telephone line will be blocked by a busy signal. The telephone blockage rate shall be reported weekly for the first month of the Contract, and then reported monthly for the remainder of the Contract and

calculated quarterly.

d. Members are strongly encouraged to seek clinical referrals prior to receiving MHSU services. This is accomplished through the use of a Clinical Referral Line (CRL), which must be operational and available to Members 24 hours a day, 7 days a week, 365 days a year. The CRL is staffed by clinicians, 24 hours a day, 7 days a week, 365 days a year, who determine the medical appropriateness of MHSU care and direct Members to the most appropriate Network Provider and level of care. The CRL is a menu option within the Offeror's telephone line. For purposes of the MHSU Disorder Program, a Clinician is a: Psychiatrist; Psychologist; licensed and registered clinical social worker; Licensed Marriage and Family Therapists; Licensed Mental Health Counselor; Physician Assistant; Registered Nurse Clinical Specialist; Psychiatric Nurse/Clinical Specialist; Registered Nurse Practitioner; Applied Behavioral Analysis provider; Certified Behavioral Analyst; and Master Level Clinician. To ensure that the resources available to Members are utilized for appropriate, medically necessary care, the Offeror is required to perform Pre-certification of care which includes, at a minimum:

    i. Use of a voluntary CRL to evaluate Member MHSU care needs and direct the Member to the most appropriate, cost-effective MHSU Providers and levels of care. The CRL must be structured to facilitate a Clinician's assessment of the callers' MHSU treatment needs and provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;

    ii. Use of alternate procedures to pre-certify care when the Member fails to call the CRL, as follows:

        1) When a Member contacts a Network Provider directly for treatment without calling the CRL, the Offeror is ultimately responsible for ensuring that a Member receives the network level of benefits and obtaining all necessary authorizations.

        2) When a Member contacts a Network Provider directly and the Network Provider is not the appropriate Provider to treat that Member, the Offeror is responsible for ensuring that its Network Providers take responsibility for assisting the Member in obtaining an appropriate referral.

        3) When a Member contacts an out-of-network Facility for treatment and the Offeror is notified in advance of the admission, the Offeror must provide the Member, or other HIPAA authorized representative of the Member, with a

written determination of medical necessity of care in advance of the inpatient admission, where feasible.

iii. Timely written notification to the Member, or other HIPAA authorized representative of the Member, of the potential financial consequence of remaining in an out-of-network Facility when the initial determination of medical necessity occurs;

iv. Preparing and sending communications to notify Members and/or their MHSU Providers of the outcome of their Pre-certification or prior authorization request and notifying them in writing of the date through which MHSU Services are approved;

v. Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Offeror;

vi. Pre-certifying inpatient hospital admissions for alcohol detox for facilities outside of New York State as permissible under DFS Circular No. 14 (2017), advising the Facility to send the claim to the MHSU Program vendor and managing the Member's care if transferred to rehabilitative care;

vii. Upon denial of Pre-certification for Inpatient care, providing the Member with Facility options where the Member may receive the pre-certified lower level of care. If the Member confirms with the Offeror which Facility is chosen, the Offeror is required to promptly notify the Facility of the Pre-certification of the lower level of care. The Offeror must follow-up with the Member and selected Facility within twenty-four hours to confirm that the lower level of care has commenced;

viii. Loading into the Offeror's clinical management and/or claims processing system one or more files of Pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received; and

e. The CRL must meet or exceed the following three performance standards, which will be calculated annually:

i. Out-of-Network CRL Guarantee: When a Member calls the CRL for a non-emergency, or non-urgent referral and a network MHSU Provider is not available for an appointment within a time frame that meets the Member's clinical needs, a referral will be made to an appropriate MHSU Out-of-Network MHSU Provider or program within two Business Days of the call in a minimum of at least 90%

of the cases.

ii. Emergency CRL Guarantee: 100% of Members who call the CRL in need of life-threatening emergency care will be referred to the nearest emergency room and be contacted within thirty minutes to assure their safety. Additionally, 100% of Members in need of non-life-threatening emergency care shall be contacted by telephone, by an MHSU clinical care manager within thirty minutes of the Member's call to the CRL to ensure the member was scheduled for and attended the urgent appointment. If the MHSU Administrator is unable to reach the Member and/or MHSU Provider to confirm that the Member received treatment, then multiple attempts must be made over several days to recontact by telephone either the MHSU Provider or the Member for confirmation.

iii. Urgent Care CRL Guarantee: At least 99% of Members in need of urgent care will be contacted by the Offeror to ensure that the network MHSU Provider contacted the Member within forty-eight hours of the Member's call to the CRL.

3.6 Enrollment Management

The Department currently utilizes a web-based enrollment system for the administration of employee benefits known as the New York Benefits Eligibility and Accounting System (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Members. Enrollment information is outlined in *Enrollment by Month* (Attachment 27), *Total Empire Plan, SEHP, and Excelsior Enrollment by Age* (Attachment 28) and *Covered Lives by Bargaining Unit or Other Group* (Attachment 29).

1. Duties and Responsibilities

a. The selected Offeror must maintain accurate, complete, and up-to-date enrollment files, based on information provided by the Department. In the case of conflict, the Offeror must agree that the Department-provided enrollment system information governs. These enrollment files shall be used by the Offeror to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files. The Offeror must provide enrollment management services including but not limited to:

i. Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the Implementation Period. The file must be EDI Benefit Enrollment and Maintenance Transaction set 834 (ANSI x.12 834 standard) and be 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 loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The selected Offeror shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSU Disorder Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;

iii. Developing and maintaining an enrollment system capable of receiving, reading, interpreting, and storing secure enrollment transactions (Monday through Friday) and having all transactions loaded to the claims processing system within twenty-four hours of the release of a retrievable file by the Department. The Offeror 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 Offeror shall immediately notify the Department of each transaction that did not process correctly and any delay in loading enrollment transactions. In the event the Offeror experiences a delay due to the quality of the data supplied by the Department, the Offeror shall immediately load all records received (that meet the quality standards for loading) within twenty-four hours of their release, as required. The Department will release enrollment changes to the Offeror in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four hour period. The Offeror must be capable of loading all enrollment files within the twenty-four 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 *NYBEAS Enrollment Record Layout - Transaction Set Header* (Attachment 19). The Offeror 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;

iv. 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 data contained in the enrollment file. Any transfers of enrollment data within the Offeror's system or to external parties must be completed via a secured process, compliant with the information security requirements set forth in *Information Security Requirements* (Appendix C);

v. Providing a back-up system or have a process in place where, if enrollment information is unavailable, Members can obtain CRL services without interruption;

vi. Cooperating fully with the Department or third parties on behalf of the Department on any Department or 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 Contract;

vii. Maintaining a read-only connection to the Department-provided enrollment system for the purpose of providing the Offeror's staff with access to current MHSU Disorder Program enrollment information. Offeror's staff must be available to access enrollment information through the Department-provided enrollment system, Monday through Friday, from 8:00 a.m. to 5:00 p.m., with the exception of holidays observed by the State as indicated on the Department's website;

viii. Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), (For eligibility requirements for a QMCSO see General Information Books referenced in Section 1.3 above) or the child's custodial parent, legal guardian, or the provider of services to the child, or a New York State agency to the extent assigned the child's rights, may file claims and the Offeror must make payment for covered benefits or reimbursement directly to such party. The Offeror will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Offeror, including access to information on the Offeror's Program Benefits website would go to the person designated in the QMCSO;

ix. Sharing data with entities to be determined by New York State including, but not limited to, health benefits administrators for New York State agencies, PEs, and PAs;

x. Agreeing to the State-defined eligibility periods as they relate to waiting periods and duration of coverage as a member (See General Information Books referenced in Section 1.3 above for additional information on State-defined eligibility periods);

xi. Administering insurance coverage for any employee and their Eligible Dependents whom the Department determines is eligible for coverage;

xii. Adhering to the Option Transfer Period which shall be the period announced by the State to allow eligible Enrollees to join the plan, change coverage, or add eligible dependents;

xiii. Providing the State with online access to their enrollment information in real-time;

xiv. Using the Department's enrollment and accounting system as the controlling system for Member enrollment and demographic information;

xv. Updating enrollment and eligibility information solely based on the 834 transaction file for the NYSHIP population;

xvi. Agreeing to complete a full reconciliation between the Department's enrollment system and the Offeror's eligibility system monthly;

xvii. Maintaining a dedicated team to manually review enrollment and eligibility transactions that do not upload to the Offeror's system and report transactions that did not process in a format acceptable to the Department within one Business Day of discovery;

xviii. Reporting to the Department data changes of name, date of birth, gender, or Medicare Beneficiary Identifier (MBI) from the federal Centers for Medicare and Medicaid Services (CMS) so that the Department can update its system as appropriate to report these changes on the eligibility enrollment file; and

xix. Reporting address changes made to the Offeror to the Department via a file. The Department will update its system as appropriate and report these changes on the 834 transaction file.

b. Enrollment Management Guarantee: The Offeror must guarantee 100% of all MHSU Disorder Program enrollment records that meet the quality

standard for loading will be loaded into the Offeror's enrollment system within twenty-four hours of release by the Department.

3.7 Claims Processing

The Offeror must process all Network Provider claims and out-of-network claims submitted under the MHSU Disorder Program, including but not limited to claims submitted manually, foreign claims, and Medicare primary claims, Medicaid, and Veterans Administration. The Offeror shall have the ability to process claims for the Empire Plan, the Excelsior Plan, and the SEHP, which have different benefit designs and different out-of-network payment methodologies. 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, MHSU Disorder Program provisions and negotiated agreements with MHSU Providers. The Offeror must coordinate benefits in order to prevent an overpayment and to avoid duplicate benefit payments so that total payment under the MHSU Disorder Program is not more than the MHSU Disorder Program's liability. For a detailed description of coordination of benefits under the Empire Plan, please see the Certificate included as *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20).

To be covered, Member submitted claims are required to be submitted to the Offeror no later than one hundred twenty days after the end of the calendar year in which the service was rendered, or one hundred twenty days after another plan processes the claim, unless it was not reasonably possible for the Member to meet this deadline. The Plan service counts and net payments can be found in *Empire Plan Service Counts and Net Payments by Program – All Claims* (Attachment 26) of this RFP. Upon receipt of a completed, notarized Confidentiality and Non-Disclosure Agreement (Attachment 15), the Department shall provide the Offeror with *Empire Plan Service Counts and Net Payments by Program – All Claims* (Attachment 26). The confidentiality and non-disclosure agreement is required to be submitted by an Offeror requiring access to the *Empire Plan Service Counts and Net Payments by Program – All Claims* (Attachment 26).

1. Duties and Responsibilities

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

   i. Maintaining a claims processing center located in the Continental United States staffed by fully trained claims processors and supervisors;

   ii. Verifying that the MHSU Disorder Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost-sharing and other edits correctly. The claims processing system must be capable of integrating and enforcing

the various clinical management and utilization review components of the Plan including Pre-certification, concurrent review, and benefit maximums;

iii. Assuming the costs for all customizations made by the Offeror to their claims processing system during the term of the Contract to accurately process claims for the MHSU Disorder Program;

iv. Paying claims based on a definition of medical necessity, as defined in the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20);

v. Developing and maintaining claim payment procedures, guidelines, and system edits (i.e., control measures to prevent unauthorized payments) that guarantee the accuracy of claim payments for covered expenses only, utilizing all edits as approved by the Department. The Offeror's system must ensure that payments are made only for authorized services;

vi. Maintaining claims histories for twenty four months online and archiving older claim histories for a minimum of six years and the balance of the calendar year in which they were made with procedures to retrieve and load claim records easily;

vii. Reversing all attributes of claim records processed in error;

viii. Agreeing that all claims data is the sole property of the State. Upon the request of the Department, the Offeror shall share appropriate claims data with other Plan carriers and consultants for various programs (e.g., Other Clinical Management Programs) and the Department's Decision Support System (DSS) vendor at no additional cost. The Offeror cannot share, release, or make the data available to third parties in any manner without the prior written consent of the Department;

ix. Maintaining a backup system and disaster recovery plan for processing claims, compliant with the information security requirements set forth in *Information Security Requirements* (Appendix C), in the event that the primary claims payment system fails or is not available or accessible;

x. Analyzing and monitoring claim submissions to promptly identify errors, fraud, and/or abuse and reporting to the State, and appropriate authorities. Such information shall be provided in a timely fashion in accordance with a State-approved process.

The Plan shall be charged only for accurate (i.e., the correct dollar amount) claims payments for covered expenses. The Offeror will credit the MHSU Disorder Program the amount of any overpayments that Offeror agrees resulted from Offeror's (including subcontractors) error or fraud in the performance of Project Services. These credits will be made without additional administrative charge to the MHSU Disorder Program and regardless of whether any overpayments are recovered from the Provider and/or Member. The Offeror 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 as a result of fraud and abuse by Members and/or Providers, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSU Disorder Program upon receipt;

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

xii. Providing Members with hardcopy Explanation of Benefits (EOBs) in accordance with New York State Insurance Law §3234 and §3235. An EOB is a statement received by the Member either by mail or electronically that provides claim payment detail. The Offeror shall also provide Members with access to electronic EOBs for network and Non-network claims via the Offeror's Program Benefits website. At a minimum, EOBs will include the following information:

1) Type of service;

2) Enrollee's Name;

3) Provider of Service;

4) Date of service;

5) Amount billed;

6) Amount plan paid;

7) Amount Enrollee owes;

8) Copayment, Deductible and Coinsurance responsibility;

9) Summary of In-Network Out-of-Pocket Limit;

10) Summary of Out-of-Network Combined Annual Deductible;

11) Summary of Out-of-Network Combined Coinsurance Maximum;

12) Information about claims for Emergency Services and Surprise Bills;

13) Information about the appeal process, including external appeal; and

14) Telephone number to call if Member has questions about claims.

xiii. When the Plan is secondary to any other plan, reducing payment under the Empire Plan so that the total of all payments or benefits payable under the Empire Plan and the other plan is not more than the reasonable and customary charge for services received;

xiv. Providing direct, secure access to the Offeror's claims system at Department offices, and any online web-based reporting tools, to authorized Department representatives;

xv. Developing and securely routing a MHSU 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 MHSU Disorder Program, using the *Shared Accumulator File Layout* (Attachment 24) template;

xvi. Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports Shared Accumulators, using the *Shared Accumulator File Layout* (Attachment 24) template;

xvii. Participating in Medicare Crossover by entering into an agreement with the Empire Plan administrator to accept electronic claims data record files from the administrator for Empire Plan Members who have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health and substance use outpatient claims which also involve Medicare coverage. The claims information sent from the administrator will include claims filed with CMS that should be considered by the Contractor for

secondary coverage. The Empire Plan administrator will sort out any claims for benefits that are for mental health or substance use services and electronically forward the claim to the Contractor for consideration;

xviii. 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 MHSU Disorder Program from other payers or Members who have primary MHSU coverage through another carrier;

xix. Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. 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 days after the date the coverage ended, whichever is earlier. Totally Disabled means that because of a mental health/substance use disorder condition, the Enrollee, cannot perform his/her job or the Dependent cannot perform the normal activities of a person that age;

xx. Submitting a file including all processed claims to the Department's DSS vendor no later than twelve calendar days following the end of each calendar month; and

xxi. Integrating appeal decisions into the claims processing system.

b. Claims Processing Guarantees: The Offeror must provide for the following ~~three~~two program service level standards:

i. Claims Payment Accuracy Guarantee: The MHSU Disorder Program's service level standard requires that claims payment accuracy is achieved for a minimum of 99% of all claims processed and paid each calendar year on an annual basis. Claims payment 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 a periodic audit conducted by the Department using statistical estimate techniques at the 95% confidence level with precision of +/- 3%.

ii. Claims Processing Guarantee – Twenty Four Calendar Days Turnaround Time: The MHSU Disorder Program's service level standard requires that a minimum of 99.5% of submitted claims

that require no additional information in order to be properly adjudicated that are received by the Offeror are processed within twenty four calendar days from the date the claim is received electronically or in the Offeror's designated post office box to the date of Claim Adjudication. Claim Adjudication is defined as when the Offeror has processed the claim and the claim has been finalized for payment or denial.

3.8 Plan Audit and Fraud Protection

The protection of the MHSU Disorder Program assets must be a top priority of the selected Offeror. The selected Offeror must have a strong audit presence throughout its organization. Article 4 of New York State Insurance Law provides a framework and sets forth certain requirements related to fraud and fraud prevention. Throughout the term of the Contract, the selected Offeror shall provide fraud and abuse detection and prevention services at least at the same level and using the same tools, software, and techniques as used for its health insurance plans that are regulated by the New York State Department of Financial Services (DFS). If the Offeror has no such health insurance plans, the selected Offeror shall provide fraud and abuse detection and prevention services at least at the same level and using the same tools, software, and techniques as used for its health insurance plans that are regulated by the insurance department of another state. The Offeror is responsible for the recovery of benefit payments resulting from fraud and/or abuse to the extent possible.

1. Duties and Responsibilities

a. The Offeror must conduct routine and targeted audits of Providers, including Facilities. Providers that deviate significantly from normal patterns in terms of cost, Current Procedural Terminology (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 Offeror that indicates a pattern of conduct by a Provider that is not consistent with the MHSU Disorder Program's design and objectives. Any modifications to the proposed audit program must receive written prior approval by the State.

b. The Offeror must utilize payment integrity algorithms and software to monitor waste, fraud, and abuse in the Plan at no extra cost to the Department.

c. The Offeror must inform the Department in writing of any allegation or other indication of potential fraud and/or abuse identified within seven 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 Plan upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State.

d. The Offeror shall cooperate with all Department and/or OSC audits whether conducted by State staff or by a third party on the Department's or OSC's behalf. Cooperation shall be consistent with the requirements of *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), and *Information Security Requirements* (Appendix C), including the 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 Offeror must respond to all State (including OSC) audit requests for information and/or clarification within fifteen Business Days. The Offeror must perform timely reviews and respond within a period specified by the Department to preliminary findings submitted by the Department or the OSC audit unit in accordance with the contractual requirements. Use of statistical sampling of claims and extrapolation of findings resulting from such samples shall be acceptable techniques for identifying claims errors. The selected Offeror shall facilitate audits, including on-site audits, as requested by the Department or OSC.

e. The Offeror shall remit to the Department 100% of audit findings that are agreed by the Offeror to be the result of Offeror (including subcontractors) error or Offeror (including subcontractors) fraud in the performance of Project Services within thirty days of the issuance of the final audit report including the response from the Offeror. Additionally, the Offeror shall remit 100% of any other Provider and Member audit recoveries to the Department as applicable within thirty days of receipt. Remittances shall be credited to the subsequent Administrative Fee invoice.

f. The Offeror must agree that audit activity may include, but not necessarily be limited to, the following activities:

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

    ii. Comparison of the information in the selected Offeror's enrollment file to that on the enrollment reports issued to the selected Offeror by the Department; and

    iii. Assessment of the selected Offeror'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 Section 3.4 of this RFP.

g. The selected Offeror shall maintain and make available documentary evidence necessary to perform the reviews. Documentation maintained and made available by the Offeror 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.

h. The selected Offeror shall make available for audit all data in its computerized files that is relevant to and subject to the Contract. 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 Offeror under the direction of the Department.

i. The selected Offeror 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 Offeror shall make sufficient resources available for the efficient performance of audit procedures.

j. The selected Offeror 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 Offeror agrees with the recommendation, the response will include a work plan and timetable to implement the recommendation. If the Offeror 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 *Standard Clauses for All Department Contracts* (Appendix B).

k. If the selected Offeror has an independent audit performed of the records relating to this Contract, a certified copy of the audit report shall be provided to the Department within ten Business Days after receipt of such audit report by the Offeror.

3.9 Appeal Process

When claim benefits, requests for Pre-certification, or a utilization review results in a denial, Members or their Providers may appeal to the Offeror. The MHSU Disorder Program provides Members with two internal appeal levels and an external appeal process. In 2020, the MHSU Disorder Program had 739 internal appeals and 29

external appeals. The Offeror must also have a process in place to review out-of-network referrals and refer denials to external review. The Offeror shall comply with the requirements of the appeal process as prescribed by Article 49 of the New York State Insurance Law. For detailed information regarding the MHSU Disorder Program's appeal process, see information found within the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20).

1. Duties and Responsibilities

a. The Offeror must establish a formal appeals resolution procedure which includes the responsibility for notifying Members of their rights to appeal and the steps necessary for filing an appeal.

b. The Offeror must establish an expedited appeals resolution procedure to be followed if a Member or someone on behalf of a Member requests an urgent appeal review, where a delay in treatment could significantly increase risk to health, the ability to regain maximum function, or cause severe pain. Such appeals, by New York State Law, will be decided within no more than 72 hours upon receipt of appeal.

c. The Offeror's internal appeals processes must be consistent with New York State Insurance Law and DFS model language: https://www.dfs.ny.gov/apps_and_licensing/health_insurers/model_language.

d. The Offeror must respond to all External Appeals on behalf of the Department as requested by DFS through a process that provides an opportunity for Members to appeal when denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

3.10 Provider Network

Provider Network means the Offeror's credentialed and contracted network of MHSU Providers. The Department expects the Offeror to maintain industry standards in the MHSU care delivery system to make quality care available while providing cost containment measures. NYSHIP currently monitors key quality and utilization metrics, supports value-based contracting, and participates in regional healthcare initiatives.

1. Duties and Responsibilities

a. The Offeror's proposed network within NYS must meet the network adequacy standards as defined by the DFS. The Offeror must also provide 24 hours a day, 7 days a week, 365 days a year access to a telemedicine service for behavioral health visits that Members can utilize

online. The telemedicine portal must be accessible to members 24/7 for treatment, or referral to higher level of care, when members have urgent or crisis related episodes.

b. In developing its proposed MHSU Provider Network, the Offeror is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSU Disorder Program's current Provider Network. The Offeror's proposed MHSU Provider Network must be composed of a mix of the following professionals to meet the Members' needs: licensed and/or certified psychiatrists and psychologists, licensed Masters Level Clinicians, Licensed Clinical Social Workers, Licensed Mental Health Counselors, Licensed Marriage and Family Therapists, Physician Assistants, Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Licensed Marriage and Family Therapists (LMFTs), Licensed Mental Health Counselors (LMHCs), Certified Behavioral Analysts, Applied Behavioral Analysis (ABA) Agencies, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, halfway houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance use diagnosis). Programs certified by the New York State Office of Addiction Services and Supports (OASAS) must be included in the MHSU Provider Network. The MHSU 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 Contract are fully satisfied.

c. The Offeror shall monitor network physicians to ascertain if their practices are open or closed to new patients. Provider availability must be taken into account in relation to Member accessibility.

d. The Offeror must utilize value-based contracting strategies to enhance MHSU Provider performance and clinical outcomes.

e. The Offeror shall offer participation in its MHSU Provider Network to any Provider who meets the Offeror's credentialing criteria if the MHSU 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 Members, even if not otherwise necessary to meet the minimum access guarantees.

f. The Offeror may choose to enter into MHSU Disorder Program specific contracts that are contingent on award and/or utilize existing agreements that can be made applicable to the MHSU Disorder Program to meet the requirement that the Offeror has executed contracts with all the MHSU

Providers included in the Offeror's proposed MHSU Provider Network on the Full MHSU Services Start Date.

g. The Offeror will be responsible for contracting with MHSU Providers as defined by the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20) and credentialing according to Offeror guidelines and all applicable State and federal law, rules, and regulations. Contracts with MHSU Providers must be written to obtain competitive reimbursement rates while ensuring that MHSU Disorder Program access and quality guarantees are met. Such contracting services must include, but are not limited to:

    i. Ensuring that all MHSU Network Providers contractually agree to and comply with all of the MHSU Disorder Program's requirements and benefit design specifications;

    ii. Ensuring that MHSU Network Providers accept as payment-in-full, the Offeror's contractual reimbursement for all claims for Covered Services, subject to the applicable MHSU Disorder Program Copayments;

    iii. Negotiating Single Case Agreements with Out-of-Network MHSU Providers when the Offeror determines that it is clinically appropriate or to address guaranteed access issues;

    iv. Contracting with MHSU Network Providers and negotiating pricing arrangements that optimize discounts, including the promotion of the value of care over volume;

    v. Notifying the Department, in writing, within one Business Day from the time Offeror received notice, if there is a substantial change to either the number, composition or terms of the Provider contracts utilized by the MHSU Disorder Program, even if access standards are still met; and

    vi. Having adequate network management and staff to manage the network, handle Provider inquiries and ensure updated MHSU Provider information is entered into the Offeror's system and transmitted to the online directory. An adequate MHSU Provider relations staff must be dedicated to New York State, where the majority of MHSU Disorder Program utilization occurs.

h. The Offeror shall negotiate agreements on a case-by-case basis with mental health practitioners licensed under Article 163 of the New York Education Law, when such MHSU Provider possesses a particular subspecialty that is clinically appropriate or to address access issues.

i. The Offeror must ensure that MHSU Providers are credentialed promptly, and that Providers meet the licensing and quality standards required by the state in which they operate. The Offeror's credentialing organization must maintain NCQA or URAC certification for credentials verification. Credentials shall be provided to the Department upon request.

j. The Offeror must have an effective process by which to confirm MHSU Providers continuing compliance with credentialing standards.

k. The Offeror must conduct a comprehensive quality assurance program which includes, but is not limited to:

    i. Monitoring the quality of care provided by MHSU Network Providers;

    ii. Monitoring technical competency and customer service skills of MHSU network Provider staff;

    iii. MHSU Network Provider profiling;

    iv. Peer review procedures;

    v. Outcome and Quality Measurement analysis; and

    vi. Maintaining an ongoing training and education program that will be offered to MHSU Network Providers.

l. Network Access Guarantees: Upon the Full MHSU Services Start Date and throughout the term of the Contract, the Offeror's MHSU Provider Network must meet or exceed the Department's minimum access standards as follows. MHSU Providers must be contracted for participation to commence with the Full MHSU Services Start Date. Urban, Suburban and Rural classifications are based on United States Census Department classifications. The access standards must be provided in terms of actual distance from Enrollees' residences. [**Note:** In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no Enrollee may be excluded even if an MHSU Provider is not located within the minimum access area.]

    i. **URBAN AREAS:** 95% of Enrollees will have at least:

        1) one Psychiatrist within three miles;

        2) one Psychologist within three miles;

        3) one Substance Use Counselor within three miles;

4) one Psychiatric Residential Facility within five miles;

5) one Substance Use Facility within five miles;

6) one Licensed Social Worker within three miles; and

7) one All Other Master's Level Counselor within three miles.

ii. **SUBURBAN AREAS:** 95% of Enrollees will have at least:

1) one Psychiatrist within fifteen miles;

2) one Psychologist within fifteen miles;

3) one Substance Use Counselor within fifteen miles;

4) one Psychiatric Residential Facility within fifteen miles;

5) one Substance Use Facility within fifteen miles;

6) one Licensed Social Worker within fifteen miles; and

7) one Other Master's Level Counselor within fifteen miles.

iii. **RURAL AREAS:** 95% of Enrollees will have at least:

1) one Psychiatrist within forty miles;

2) one Psychologist within forty miles;

3) one Substance Use Counselor within forty miles;

4) one Psychiatric Residential Facility within forty miles;

5) one Substance Use Facility within forty miles;

6) one Licensed Social Worker within forty miles; and

7) one All Other Master's Level Counselor within forty miles.

m. Network Composition Guarantee: Upon the Full MHSU Services Start Date and throughout the term of the Contract, the Offeror's MHSU Program's service level standard requires that at the least 90% of the

Providers in each of the eleven Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Use Facility, Mental Health and Substance Use Facility, Mental Health Outpatient Clinic Group, Substance Use Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Use Practitioner – Other Prescriber), listed on *Offeror's Proposed Provider Network Files* (Attachment 23), will be maintained throughout the term of the Contract. Providers who are retired, deceased, or no longer actively practicing will be excluded from the annual calculation and guarantee. The Offeror must provide a target number for each of the eleven network composition categories for which they are required to maintain at least 90% of providers in each of those categories.

3.11 Other Clinical Management Programs

The MHSU Disorder Program includes treatment of Attention Deficit Hyperactivity Disorder (ADHD), depression, and eating disorders.

1. Duties and Responsibilities

a. The Offeror must provide a voluntary opt-in program for Attention Deficit Hyperactivity Disorder (ADHD), depression management, and eating disorders. The selected Offeror may receive a data feed from the Empire Plan's Prescription Drug Program to be used as a method to identify members with ADHD, depression, and eating disorders. The voluntary opt-in programs must minimally include:

   i. A method to identify Members with ADHD, depression, and eating disorders using screening tools, both on-line and by mail;

   ii. Methods to educate Members about the symptoms, effects and treatment of ADHD, depression, and eating disorders;

   iii. Accepting referrals to Network Providers;

   iv. Telephonic support, coordination with treating providers and referrals to community services; and

   v. A method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of ADHD, depression, and eating disorders in order to educate medical Providers about the availability of the ADHD, depression, and eating disorder programs.

3.12 Pre-Certification and Concurrent Review for Mental Health and Substance Use Disorder Services

The following services require pre-certification under the MHSU Disorder Program:

a) Intensive Outpatient Program for mental health

b) Structured Outpatient Program for substance use

c) 23-hour bed mental health/substance use disorder

d) 72-hour bed mental health/substance use disorder

e) Outpatient detoxification

f) Transcranial Magnetic Stimulation (TMS)

g) Applied Behavior Analysis (ABA)

h) Group home

i) Halfway house

j) Residential treatment center mental health

k) Residential treatment center substance use

l) Partial hospitalization mental health

m) Partial hospitalization substance use

Precertification is not required for OASAS-Certified Network Facilities located within New York State.

Mental health inpatient services for children under 18 at a NYS Office of Mental Health facility does not require prior authorization, in accordance with DFS Circular No. 13 of 2019 https://www.dfs.ny.gov/industry_guidance/circular_letters/cl2019_13

The Concurrent Utilization Review process assists the Provider in identifying inpatient or outpatient care that is medically necessary and cost-effective, without compromise to the quality of care. The *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20) includes information relative to Concurrent Review.

1. Duties and Responsibilities

a. To safeguard Member health and ensure adherence with the MHSU Disorder Program's benefit design and requirements of Mental Health

Parity and New York State regulations, the Offeror must administer a concurrent utilization review program in the Continental United States which:

i. Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and Diagnostic and Statistical Manual of Mental Disorders (DSM–V) diagnosis;

ii. Is conducted in a manner that is parity compliant as required by the federal Mental Health Parity and Addiction Equity Act (the "Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008", as set forth at 29 USC section 1185a), as amended from time to time;

iii. Is performed by the Offeror for outpatient and inpatient care rendered by Non-Network Providers when requested by the Member or Non-Network Provider;

iv. For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care, when medically appropriate. The Offeror must have procedures to identify when transfer to an alternate inpatient or outpatient setting is appropriate and arrange such transfers; and

v. Renders Pre-certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions. Peer Advisor means a psychiatrist or Ph.D. psychologist with a minimum of five years of clinical experience who renders medical necessity decisions.

b. For Members admitted to Out-of-network Facilities, the Offeror must have procedures to either arrange to transfer the Member 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.

c. Inpatient Treatment Utilization Review Guarantee: The Offeror must guarantee that at least 90% of requests for Pre-certification of inpatient MHSU care, when applicable under New York State regulations, be reviewed within twenty-four hours from the receipt of the request and the Member and MHSU Provider notified within one Business Day of the determination as reported and calculated on an annual basis.

3.13 Consolidated Appropriations Act

The Consolidated Appropriations Act (CAA) requires all applicable health plans conduct and document a Non-Quantitative Treatment Limitation (NQTL) comparative analysis.

1. Duties and Responsibilities

a. The Offeror must conduct and document a Non-Quantitative Treatment Limitation (NQTL) comparative analysis and provide that analysis in response to federal and state audits, as well in response to enrollee requests. [**Note**: The Department's third party consultant will perform the Quantitative Treatment Limitation (QTL) comparative analysis; it is not the responsibility of the Offeror].

b. The Offeror must ensure it is in compliance with all other provisions of the CAA.

3.14 Disabled Dependent Determinations

The Offeror shall be responsible for making Disabled Dependent Determinations for dependents with a mental health and substance use-related disability in accordance with Insurance Law section 4305(c)(1)(A)(ii) and 4 NYCRR section 73.1(h). Disabled dependents of NYSHIP Enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age limits if those dependents are incapable of self-support. From time to time, the Offeror will be asked to make a determination of disability for a Dependent of an individual not currently enrolled in the Plan, but enrolled in other NYSHIP benefit programs, such as the Dental or Vision Plan. The Offeror should expect to receive approximately sixty applications per month. However, the number will vary. An application form, *PS-451 Statement of Disability* (Attachment 21) is completed by the Enrollee, the Dependent's Physician, the Enrollee's employer and then evaluated by the Offeror to determine if the Dependent is disabled. All determinations are subject to review by the Offeror on a periodic basis. Permanent disability determinations are not allowed. The following guidelines are used for all disabled dependent reviews:

If a Dependent is currently disabled and improvement of the Dependent's condition is:

a) "Expected" - the case will typically be reviewed again within six to eighteen months unless the Offeror determines a need for a more frequent review.

b) "Possible" - the case will typically be reviewed again no sooner than three years unless the Offeror determines a need for more frequent review.

c) "Not expected" - the case will typically be reviewed again in no sooner than seven years unless the Offeror determines a need for more frequent review.

1. **Duties and Responsibilities**

a. The Offeror must establish a process to review the medical documentation of the PS-451 Form and if needed, request additional information from the Enrollee. The review must be completed by staff located in the Continental United States and the clinical determination completed within seven Business Days of receipt of a completed form.

b. The Offeror must transmit a determination of the length of disability (for example, three years) to the Department, within three Business Days of the clinical determination, advising of the recommendation. The Department will formally advise the Enrollee of the determination in writing.

3.15 Transition and Termination of Contract

To ensure that the transition to a successor entity provides Members with uninterrupted access to all MHSU Disorder Program benefits and associated customer services, the Contractor is required to provide Contractor-related obligations and deliverables (Transition Services) to the MHSU Disorder Program until the final Program Claim (as defined in Section 6.1(1) of this RFP) incurred during the Contract term is submitted to the Department for payment. The Department anticipates that certain claims incurred during the Contract term will not have been settled before the end date (Open Claims). Transition Services are organized into two phases: Phase One and Phase Two. Phase One consists of those Transition Services that are provided prior to the Contract termination or expiration (End Date). Phase Two consists of those Transition Services that are required after the End Date until the Contractor invoices the Department for the final Program Claim incurred during the Contract term and payment submitted by the Department. Collectively, Phase One and Phase Two comprise the Transition Period. The obligations and responsibilities of the Offeror with regard to this Section 3.15, Transition and Termination of Contract, shall survive termination of the Contract and will remain in effect until all Open Claims have been settled to the satisfaction of the Department.

1. Duties and Responsibilities

The transition process shall be governed as follows:

a. Length of Transition Period:

i. Phase One - Phase One of the Transition Period shall commence six months prior to the End Date or immediately if the Contract is terminated on notice pursuant to Appendix B section 30 (Termination). Phase One is concluded at midnight on the End Date.

ii. Phase Two - Phase Two of the Transition Period will commence at 12:01 a.m. on the first day after the End Date and will continue until all claims incurred as of the End Date have been settled (i.e., closed and payment submitted by Department to the Contractor).

iii. The Department reserves the right to amend the length of Phase One or Two Transition Period upon thirty days prior written notice to the Contractor.

b. No Interruption in Service:

i. At all times during Phase One of the Transition Period and unless directed otherwise in writing by the Department, the Contractor shall continue all contractual obligations set forth in the Contract in addition to those set forth in the section. The Contractor shall be required to meet its contractual obligations notwithstanding the issuance of a termination notice by the State.

ii. During Phase Two of the Transition Period, the Contractor shall continue all activities necessary to complete the processing and settlement of all Open Claims as set forth below.

c. Transition Plan

i. Within thirty calendar days of receipt of a notice of termination of the Contract or six months prior to the expiration of the Contract, whichever event occurs first, the Contractor shall provide to the Department a detailed written plan for transition (Transition Plan) for review and approval. The Transition Plan shall outline the Contractor's plan to transition the tasks, milestones and deliverables associated with the Project Services to the Department, a third party or the successor entity. The Transition Plan shall detail the Phase One and Phase Two activities. Contractor agrees to amend the Transition Plan to include all other information deemed reasonable and necessary by the Department. There will be no additional charge to the Department for the development or implementation of the Transition Plan.

ii. Within fifteen 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 to make it acceptable to the Department.

iii. Within fifteen Business Days from the Offeror'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 for approval.

iv. The Transition Plan, at a minimum, shall describe the tasks, timeframes, milestones, and deliverables by Phase associated with:

1) Transitioning of the MHSU Disorder Project Services' data. All such data transfers must be approved by the Department and provided in a format acceptable to the Department. This requirement includes, but is not limited to, providing a minimum of one year of historical Member claim data. Members' claim data shall consist of:

(a) Providers' names, types, addresses, zip codes, telephone numbers and tax identification numbers;

(b) Detailed coordination of benefits (COB) data;

(c) High-volume Provider data;

(d) Report formats;

(e) Pre-certification/prior authorization approved-through dates;

(f) Disability determination approved-through dates;

(g) Any exceptions that have been entered into the adjudication system on behalf of the Member such as a Single Case Agreement; and

(h) Any other data the successor entity may need.

2) The transitioning of the MHSU Disorder Program data shall at a minimum include:

(a) Providing a test file to the Department or a successor entity at least twenty weeks in

advance of the End Date or within four weeks after notice of Termination is provided by the Department, to allow the Department, a third party or successor entity to address any formatting issues. Offeror will cooperate and coordinate with the Department, a third party or successor entity to address any issues in the test file.

(b) Providing one or more pre-production files at least twelve weeks prior to the End Date. The file will contain the above-described Members' claim data or additional data elements as specified by the Department. Contractor will cooperate and coordinate with the Department, a third party or successor entity to address any issues in the data files.

(c) Providing a production file six weeks prior to the successor entity's Implementation Date. The Department will notify the Contractor of the successor entity's Implementation Date.

(d) Providing a second production file to the successor entity by the close of business three days prior to the End Date.

3) Transferring of information necessary to ensure continuity of a Member's on-going treatment or future treatment.

4) Incorporating a written plan for Knowledge Transfer. A Knowledge Transfer (KT) plan shall be developed by the Contractor for approval by the Department as part of the Transition Plan. This KT Plan will be incorporated into the overall Transition Plan's methods and timeframes and will outline mechanisms for transferring knowledge of Contractor's personnel to Department employees, a third party or the successor entity. As part of the KT, Contractor shall document relevant processes, procedures, methods, tools, and techniques of its personnel with special skills or responsibilities performed during the Contract.

5) A description of how the Contractor will implement the Transition Services for Phase One and Phase Two.

Such description shall address how the Contractor will perform the tasks and services set forth in section 4 below.

d. Transition Services

i. “Transition Services” shall be deemed to include Offeror’s responsibility for performing all tasks and services outlined in the Contract, and for transferring in a planned manner as specified in the approved Transition Plan all tasks and services to the State, a third party or successor entity. It is expressly agreed between the Parties that the level of service during Phase One of the Transition Period shall be maintained in accordance with all the terms and conditions of the Contract.

ii. During Phase One and Phase Two, the Department shall continue to have access to key personnel of the Contractor’s dedicated Account Team, maintain access to online systems and receipt of data/reports and other information regarding the MHSU Disorder Program as necessary to ensure Members are provided with uninterrupted access to benefits and associated customer services.

iii. Phase One of the Transition Services shall include:

1) All Project Services associated with processing of claims incurred on or before the End Date. This obligation includes but is not limited to:

(a) Paying claims, including but not limited to: Medicaid, out-of-network claims, foreign claims, COB claims, and Medicare claims and In-network claims. “In-network” refers to Providers or Facilities that are part of a health plan's network of Providers with which the Contractor has negotiated a discount;

(b) Reimbursing late-filed claims if warranted;

(c) Repaying or recovering monies on behalf of the MHSU Disorder Program for Medicare claims;

(d) Retaining NYBEAS access; and

(e) Continuing to provide updates on pending litigation and settlements that the Offeror or the AG has/may file on behalf of the MHSU Disorder Program.

2) Providing the Department access to any online claims processing data and history and online reporting systems until the Contractor invoices the Department for the final Program Claim incurred during the Contract term and payment submitted by the Department unless the Department notifies the Offeror that access may be ended at an earlier date;

3) Completing all reports required under Section 3.4 of this RFP;

4) Providing sufficient staff resources to address State audit requests and reports in a timely manner;

5) Agreeing to fully cooperate with all Department and/or OSC audits consistent with the requirements of the Contract;

6) Performing timely reviews and responses to audit findings submitted by the Department and the OSC in accordance with the requirements set forth in the Contract;

7) Remitting reimbursement due to the Department upon final audit determination consistent with the process specified in the Contract;

8) Receiving and applying enrollment updates and verifying enrollment;

9) Keeping dedicated telephone lines open with adequate available staffing to provide customer service at the levels required in the Contract and adjust phone scripts, and transfer calls to the successor entity’s lines during the Transition Period;

10) Preparing, on a case by case basis, a plan to extend and manage the care of high-risk Members who are nearing the end of a course of treatment beyond the Transition Period;

11) Developing a strategy for addressing those Members in treatment with Providers that are not in the successor entity's network; and

12) Notifying Members currently in care with a Network Provider, per New York State guidelines, of their rights to continue to receive a network level of benefits if their Provider is not in the Offeror's network. In addition, for the first year of the Contract, the Contractor will commit to sending Provider disruption letters based on information received from the incumbent.

iv. Phase Two of the Transition Services shall include, but not be limited to the following activities.

1) Process all Open Claims to final settlement;

(a) Paying claims, including but not limited to: Medicaid, out-of-network claims, foreign claims, COB claims, and Medicare claims and In-network claims. "In- network" refers to Providers or Facilities that are part of a health plan's network with which the Contractor has negotiated a discount;

(b) Reimbursing late-filed claims if warranted;

(c) Repaying or recovering monies on behalf of the Plan for Medicare claims;

(d) Retaining NYBEAS access; and

(e) Continuing to provide updates on pending litigation and settlements that the Offeror or the New York State Attorney General's Office has/may file on behalf of the Plan.

2) Continuing to provide the Department access to any online claims processing data and history and online reporting systems until the Contractor invoices the Department for the Final Program Claim incurred during the Contract term and payment is submitted by the Department, unless the Department notifies the Offeror that access may be ended at an earlier date;

3) Completing of all reports required under Section 3.4 of this RFP;

4) Providing sufficient staff resources to address State audit requests and reports in a timely manner;

5) Agreeing to fully cooperate with all Department and/or OSC audits consistent with the requirements set forth in the Contract;

6) Performing timely reviews and responses to audit findings submitted by the Department and OSC's audit unit in accordance with the requirements set forth in the Contract;

7) Remitting reimbursement due the Plan upon final audit determination consistent with the process specified in the Contract;

8) Receiving and applying enrollment updates;

9) Keeping dedicated telephone lines open for a minimum of six months (unless otherwise agreed to in writing by the Department and Contractor), with adequate available staffing to provide customer service at the same levels provided prior to the End Date, adjusting phone scripts;

10) transferring calls to the successor Contractor's lines during this period;

11) Preparing, on a case by case basis, a plan to extend and manage the care of high-risk Members who are nearing the end of a course of treatment; and

12) Providing sufficient staffing to ensure Members continue to receive appropriate customer service and clinical management service after the End Date.

e. Compensation for Transition Services

i. Phase One:

No additional compensation outside the monthly Administrative Fee will be paid to the Contractor for the performance of the Phase One Transition Services. The Department shall retain

the final monthly Administrative Fees payment from the Contractor until completion of all Transition Plan requirements.

ii. Phase Two:

1) Offeror will receive no Administrative Fees but will be reimbursed for all claims settled (i.e., closed) per section 6.1.

2) Reimbursement for claims will be made on a monthly basis upon the Department's receipt of an accurate invoice.

f. Department Responsibilities for Transition

The Department shall assume responsibility for the project management activities for the Transition. The Department shall appoint a project manager to be responsible for coordinating Transition activities, maintaining the transition task schedule, and approving transition deliverables. Weekly project review meetings shall be held with representatives of the Offeror, Department, and the third party or the successor entity. The Department shall also ensure that all Departmental and third-party resources (e.g., technical, administrative) deemed necessary by the Transition Plan are available to carry out tasks and functions defined in the Transition Plan and in accordance with the defined timelines specified in the Transition Plan.

g. Cooperation

Offeror shall cooperate with the Department to facilitate a smooth and orderly transition. Periodic project review meetings shall be held with representatives of the Contractor, the Department, and the successor entity.

h. Transition and Termination Guarantee: The Offeror must guarantee that the Offeror will complete the Transition Plan requirements in the time frames stated above, to the satisfaction of the Department.

SECTION 4: ADMINISTRATIVE PROPOSAL

This section of the RFP sets forth the requirements for the Offeror's Administrative Proposal. The Department 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 of the RFP. Any Offeror which fails to satisfy any of these requirements shall be eliminated from further consideration.

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 this RFP. Additional details pertaining to the required forms are found in Section 2 of this RFP.

4.1 Formal Offer Letter

The Offeror must submit a formal offer in the form of the *Formal Offer Letter* (Attachment 3). 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. The copy 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. Except as otherwise permitted under section 2.1(7), Bid Deviations, the Offeror must accept the terms and conditions as set forth in this RFP, *Standard Clauses for New York State Contracts* (Appendix A), *Standard Clauses for All Department Contracts* (Appendix B), *Information Security Requirements* (Appendix C) and *Glossary for Appendix B and C* (Appendix C-1), and agree to enter into a Contractual Agreement with the Department containing, at a minimum, the terms and conditions identified in this RFP and appendices as cited herein. If an Offeror proposes to include the services of a Subcontractor(s) or Affiliate(s), the Offeror must be required to assume responsibility for those services as "Prime Contractor". The Department will consider the Prime Contractor solely responsible for contractual matters.

4.2 Offeror Attestation Form

The Offeror must complete and submit an executed copy of the *Offeror Attestations Form* (Attachment 13) attesting that it meets or exceeds the criteria for eligibility to bid as set forth in Section 1 of this RFP. A person legally authorized to represent the Offeror must execute this certification.

4.3 Subcontractors or Affiliates

The Offeror must complete the *Subcontractors or Affiliates* form (Attachment 9) to identify all Subcontractors or Affiliates with whom the Offeror subcontracts to provide Project Services. For purposes of reporting in the *Subcontractors or Affiliates* form (Attachment 9), Subcontractors include (1) all vendors who will provide $100,000 or

more in Project Services over the term of the Contract that results from this RFP and (2) any vendor who will provide Project Services in an amount lower than the $100,000 threshold, and who is a part of the Offeror's Account Team (described in section 3.1, Account Team). For each Subcontractor identified, the Offeror must complete and submit the *Subcontractors or Affiliates* form (Attachment 9) and indicate whether or not, as of the date of the Offeror's Proposal, a subcontract has been executed between the Offeror and the Subcontractor for services to be provided by such subcontractor relating to the RFP. For the purpose of this RFP, Affiliate is defined as 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. On the *Subcontractors or Affiliates* (Attachment 9) form, the Offeror must:

1. Mark the applicable box if the Offeror will not be subcontracting with any Subcontractor(s) or Affiliate(s) to provide Project Services.

2. 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 Subcontractor or Affiliate for services to be provided by the Subcontractor or Affiliate relating to this RFP.

3. Provide a brief description of the services to be provided by the Subcontractor or Affiliate.

4. Provide a description of any current relationships with such Subcontractor or Affiliate and the clients/projects that the Offeror and 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.

4.4 New York State Standard Vendor Responsibility Questionnaire

The Offeror must complete and submit an executed copy of the New York State Vendor Responsibility Questionnaire. A person legally authorized to represent the Offeror must execute the questionnaire. The questionnaire must be completed by all Subcontractors as defined above.

The Department recommends each Offeror file the required Questionnaire online via the New York State VendRep System. To use the VendRep System, please refer to **https://www.osc.state.ny.us/files/state-vendors/vendrep/pdf/ac3290s.pdf**.

By submitting a Proposal, the Offeror agrees to fully and accurately complete the Questionnaire. The Offeror acknowledges that the State's execution of the Contract will be contingent upon the State's determination that the Offeror is responsible, and that the State will rely on the Offeror's responses to the Questionnaire when making its responsibility determination. The Offeror agrees that if it is found by the State that the

Offeror's responses to the Questionnaire were intentionally false or intentionally incomplete, on such finding, the Department may terminate the Contract. In no case shall such termination of the Contract by the State be deemed a breach thereof, nor shall the State be liable for any damages for lost profits or otherwise, which may be sustained by the Contractor as a result of such termination.

4.5 New York State Tax Law Section 5-a

Tax Law § 5-a requires certain Offerors awarded state Contracts for commodities, services and technology valued at more than $100,000 to certify to New York State Department of Taxation and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to Contracts where the total amount of such Offeror's sales delivered into New York State is in excess of $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any Affiliates and Subcontractors whose sales delivered into New York State exceeded $300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

An Offeror is required to file the completed and notarized Form ST-220-CA with the Department certifying that the Offeror filed the ST-220-TD with DTF. The Offeror should complete and return the certification forms within five Business Days from the date of request (if the forms are not completed and returned with bid submission). Failure to make either of these filings may render an Offeror non-responsive and non-responsible. The Offeror must take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

Website links to the Offeror certification forms and instructions are provided below.

1. Form ST-220-TD must be filed with and returned directly to DTF and can be found at: http://www.tax.ny.gov/pdf/current_forms/st/st220td_fill_in.pdf. Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the Offeror, its Affiliate(s), or its Subcontractor(s), a new Form ST-220-TD must be filed with DTF.

2. Form ST-220-CA must be submitted to the Department. This form provides the required certification that the Offeror filed the ST-220-TD with DTF. This form can be found at: http://www.tax.ny.gov/pdf/current_forms/st/st220ca_fill_in.pdf.

4.6 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. Failure to

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

Prior to entering into a Contract with the Department, the selected Offeror and 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 Compliance with NYS Workers' Compensation Law (Attachment 10). An ACORD form is not acceptable proof of New York State workers' compensation or disability benefits insurance coverage. Any questions relating to either workers' compensation or disability benefits coverage should be directed to the New York State Workers' Compensation Board, Bureau of Compliance at 518-486-6307. Information can also be found at http://www.wcb.ny.gov.

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

4.7 Insurance Requirements

In addition to the insurance requirement set forth in Section 4.6 of this RFP, prior to the start of work the Offeror shall procure, at its sole cost and expense, and shall maintain in force at all times during the term of any Contract resulting from this RFP, policies of insurance as required by this section, written by companies that have an A.M. Best Company rating of "A-," Class "VII" or better. In addition, companies writing insurance intended to comply with the requirements of this Section 4.7 should be licensed or authorized by DFS to issue insurance in the State of New York. The Department may, in its sole discretion, accept policies of insurance written by a non-authorized carrier or carriers when certificates and/or other policy documents are accompanied by a completed Excess Lines Association of New York (ELANY) affidavit or other documents demonstrating the company's strong financial rating. If, during the term of a policy, the carrier's A.M. Best rating falls below "A-," Class "VII," the insurance must be replaced, on or before the renewal date of the policy, with insurance that meets the requirements above. These policies must be written in accordance with the requirements of the paragraphs below, as applicable.

An Offeror shall deliver to the Department evidence of the insurance required by this RFP and any Contract resulting from this RFP in a form satisfactory to the Department. Policies must be written in accordance with the requirements of the paragraphs below, as applicable. While acceptance of insurance documentation shall not be unreasonably withheld, conditioned or delayed, acceptance and/or approval by the Department does

not, and shall not be construed to, relieve an Offeror of any obligations, responsibilities or liabilities under this RFP or any Contract resulting from this RFP.

The Offeror shall not take any action or omit to take any action that would suspend or invalidate any of the required coverages during the term of any Contract resulting from this RFP.

1. General Conditions

a. All policies of insurance required by this Solicitation or any Contract resulting from this RFP shall comply with the following requirements:

i. Coverage Types and Policy Limits. The types of coverage and policy limits required from the selected Offeror are specified in Section 4.7(2) of this RFP.

ii. Policy Forms. Except as may be otherwise specifically provided herein or agreed to in any Contract resulting from this RFP, all policies of insurance shall be written on an occurrence basis.

iii. Certificates of Insurance/Notices. The selected Offeror shall provide the Department with a Certificate or Certificates of Insurance, in a form satisfactory to the Department, as detailed below, and pursuant to the timelines set forth in Section 4.7(1)(m) of this RFP. Certificates should reference the Solicitation or award number and shall name the New York State Department of Civil Service, Agency Building 1, Empire State Plaza, Albany, NY 12239, as the certificate holder.

b. Certificates of Insurance shall:

i. Be in the form acceptable to the Department and in accordance with the New York State Insurance Law (e.g., an ACORD certificate);

ii. Disclose any deductible, self-insured retention, aggregate limit, or any exclusion to the policy that materially changes the coverage required by this Solicitation or any Contract resulting from this Solicitation;

iii. Be signed by an authorized representative of the insurance carrier of the referenced insurance carriers; and

iv. Contain the following language in the Description of Operations / Locations / Vehicles section of the Certificate or on a submitted endorsement as applicable: Additional insured protection

afforded is on a primary and non-contributory basis. A waiver of subrogation is granted in favor of the additional insureds.

c. Only original documents (Certificates of Insurance and any endorsements and other attachments) or electronic versions of the same that can be directly traced back to the insurer, agent or broker via e-mail distribution or similar means will be accepted. The Department generally requires an Offeror to submit only certificates of insurance and additional insured endorsements, although the Department reserves the right to request other proof of insurance. An Offeror should refrain from submitting entire insurance policies, unless specifically requested by the Department. If an entire insurance policy is submitted but not requested, the Department shall not be obligated to review and shall not be chargeable with knowledge of its contents. In addition, submission of an entire insurance policy not requested by the Department does not constitute proof of compliance with the insurance requirements and does not discharge an Offeror from submitting the requested insurance documentation.

d. Primary Coverage: All liability insurance (excluding Professional Liability insurance) policies where the Department is required to be included as an additional insured, shall provide that the required coverage shall be primary and non-contributory to other insurance available to the Department and their officers, agents, and employees. Any other insurance maintained by the Department and their officers, agents, and employees shall be excess of and shall not contribute with the Offeror's insurance.

e. Breach for Lack of Proof of Coverage: The failure to comply with the requirements of this RFP at any time during the term of any Contract resulting from this Solicitation shall be considered a breach of the terms of any Contract resulting from this Solicitation and shall allow the Department and their officers, agents, and employees to avail themselves of all remedies available under any Contract resulting from this Solicitation, at law or in equity.

f. Self-Insured Retention/Deductibles: Certificates of Insurance must indicate the applicable deductibles/self-insured retentions for each listed policy. Deductibles or self-insured retentions above $100,000.00 are subject to approval from the Department. Such approval shall not be unreasonably withheld, conditioned or delayed. An Offeror shall be solely responsible for all claim expenses and loss payments within the deductibles or self-insured retentions. If the Offeror is providing the required insurance through self-insurance, evidence of the financial capacity to support the self-insurance program along with a description of that program, including, but not limited to, information regarding the use of a third-party administrator shall be provided upon request.

g. Subcontractors: Prior to the commencement of any work by a Subcontractor, the Offeror shall require such Subcontractor to procure policies of insurance as required by this section and maintain the same in force during the term of any work performed by that Subcontractor. An Additional Insured Endorsement (ISO coverage form CG 20 38 04 13), or the equivalent, evidencing such coverage shall be provided to the Offeror prior to the commencement of any work by a subcontractor and pursuant to the timelines set forth in Section 4.7(1)(m) of this RFP, as applicable, and shall be provided to the Department upon request. For subcontractors that are self-insured, the subcontractor shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the subcontractor would have been required to pursuant to this section had the subcontractor obtained such insurance policies.

h. Waiver of Subrogation: For all liability policies (with the exception of Professional Liability Insurance and Cyber Liability Insurance), the Offeror shall cause to be included in its policies insuring against loss, damage or destruction by fire or other insured casualty a waiver of the insurer's right of subrogation against the Department and their officers, agents, and employees, or, if such waiver is unobtainable (i) an express agreement that such policy shall not be invalidated if the Offeror waives or has waived before the casualty, the right of recovery against the Department and their officers, agents, and employees or (ii) any other form of permission for the release of the Department or any entity authorized by law or regulation to use any Contract resulting from this Solicitation and their officers, agents, and employees. A Waiver of Subrogation Endorsement shall be provided upon request. A blanket Waiver of Subrogation Endorsement evidencing such coverage is also acceptable.

i. Additional Insured: The Offeror shall cause to be included in each of the liability policies required below (excluding Professional Liability Insurance) coverage for on-going work and operations naming as additional insureds (via ISO coverage forms CG 20 10 04 13 or 20 38 04 13 and form CA 20 48 10 13, or a form or forms that provide equivalent coverage) the Department and their officers, agents, and employees. An Additional Insured Endorsement evidencing such coverage shall be provided to the Department pursuant to the timelines set forth in Section 4.7(1)(m) of this RFP. A blanket Additional Insured Endorsement evidencing such coverage is also acceptable. For Offerors who are self-insured, the Offeror shall be obligated to defend and indemnify the above-named additional insureds with respect to Commercial General Liability and Business Automobile Liability, in the same manner that the Offeror would

have been required to pursuant to this RFP had the Contractor obtained such insurance policies.

j. Excess/Umbrella Liability Policies: Required insurance coverage limits may be provided through a combination of primary and excess/umbrella liability policies. If coverage limits are provided through excess/umbrella liability policies, then a Schedule of underlying insurance listing policy information for all underlying insurance policies (insurer, policy number, policy term, coverage and limits of insurance), including proof that the excess/umbrella insurance follows form must be provided upon request. Unrelated underlying policies included in the Schedule that are not required to meet the insurance requirements may be redacted from the Schedule.

k. Notice of Cancellation or Non-Renewal: Policies shall be written so as to include the requirements for notice of cancellation or non-renewal in accordance with the New York State Insurance Law. Within five Business Days of receipt of any notice of cancellation or nonrenewal of insurance, the Offeror shall provide the Department with a copy of any such notice received from an insurer together with proof of replacement coverage that complies with the insurance requirements of this Solicitation and any Contract resulting from this Solicitation.

l. Policy Renewal/Expiration: Upon policy renewal/expiration, evidence of renewal or replacement of coverage that complies with the insurance requirements set forth in this Solicitation and any Contract resulting from this Solicitation shall be delivered to the Department. If, at any time during the term of any Contract resulting from this Solicitation, the coverage provisions and limits of the policies required herein do not meet the provisions and limits set forth in this Solicitation or any Solicitation and any Contract resulting from this Solicitation, or proof thereof is not provided to the Department, the Offeror shall immediately cease work. The Offeror shall not resume work until authorized to do so by the Department.

m. Deadlines for Providing Insurance Documents after Renewal or Upon Request: As set forth herein, certain insurance documents must be provided to the Department contact identified in the Contract Award Notice after renewal or upon request. This requirement means that the Offeror shall provide the applicable insurance document to the Department as soon as possible but in no event later than the following time periods:

    i. For certificates of insurance: 5 Business Days from request or renewal, whichever is later;

    ii. For information on self-insurance or self-retention programs: 15 Calendar Days from request or renewal, whichever is later;

iii. For other requested documentation evidencing coverage: 15 Calendar Days from request or renewal, whichever is later;

iv. For additional insured and waiver of subrogation endorsements: 30 Calendar Days from request or renewal, whichever is later; and

v. For notice of cancellation or non-renewal and proof of replacement coverage that complies with the requirements of this section: 5 Business Days from request or renewal, whichever is later.

Notwithstanding the foregoing, if the Offeror shall have promptly requested the insurance documents from its broker or insurer and shall have thereafter diligently taken all steps necessary to obtain such documents from its insurer and submit them to the Department, the Department shall extend the time period for a reasonable period under the circumstances, but in no event shall the extension exceed 30 Calendar Days.

2. <u>Specific Coverage and Limits</u>

a. Commercial General Liability: Commercial General Liability Insurance, (CGL) shall be written on the current edition of ISO occurrence form CG 00 01, or a substitute form providing equivalent coverage and shall cover liability arising from premises operations, independent contractors, broad form property damage, personal & advertising injury, cross liability coverage, and liability assumed in a contract (including the tort liability of another assumed in a contract). Insurance policies that remove or restrict blanket contractual liability located in the "insured contract" definition (as stated in Section V, Number 9, Item f in the Insurance Services Offices (ISO) Commercial General Liability (CGL) policy) so as to limit coverage against Claims that arise out of the work, or that remove or modify the "insured contract" exception to the employers' liability exclusion, or that do not cover the Additional Insured for Claims involving injury to employees of the Named Insured or subcontractors, are not acceptable. Policy shall include bodily injury, property damage, and broad form contractual liability coverage. The limits under such policy shall not be less than the following:

i. Each Occurrence – $1,000,000

ii. General Aggregate – $2,000,000

iii. Personal Advertising Injury – $1,000,000

Coverage shall include, but not be limited to, the following:

i. Premises liability;

ii. Independent contractors/subcontractors;

iii. Blanket contractual liability, including tort liability of another assumed in a contract;

iv. Defense and/or indemnification obligations, including obligations assumed under any Contract resulting from this Solicitation;

v. Cross liability for additional insureds.

b. Business Automobile Liability Insurance: The Offeror shall maintain Business Automobile Liability Insurance in the amount of at least $1,000,000 each accident, covering liability arising out of automobiles used in connection with performance under any Contract resulting from this RFP, including owned, leased, hired and non-owned automobiles bearing or, under the circumstances under which they are being used, required by the Motor Vehicles Laws of the State of New York to bear, license plates.

c. Professional Errors and Omissions Insurance: The Offeror shall maintain Professional Errors and Omissions (Professional Liability) in the amount of at least $5,000,000 each occurrence, for claims arising out of but not limited to delay or failure in diagnosing a disease or condition and alleged wrongful acts, including breach of contract, bad faith, and negligence. Such insurance shall apply to professional errors, acts, or omissions arising out of the scope of services. The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of this Contract.

If coverage is written on a claims-made policy, the Contractor warrants that any applicable retroactive date precedes the start of work; and that continuous coverage will be maintained, or an extended discovery period exercised, throughout the performance of the services and for a period of not less than three years from the time work under this Contract is completed. Written proof of this extended reporting period must be provided to the Department prior to the policy's expiration or cancellation.

d. Data Breach/Cyber Liability Insurance: An Offeror is required to maintain during the term of any Contract and as otherwise required herein, Data Breach and Privacy/Cyber Liability Insurance in the amount of at least $5,000,000 each claim, including coverage for failure to protect confidential information and failure of the security of the Offeror's computer systems or the Department systems due to the actions of the Offeror which results in unauthorized access to the Department or their data. Coverage may be satisfied through alternative insurance policies. Said insurance shall provide coverage for damages arising from, but not limited to the following:

    i. Breach of duty to protect the security and confidentiality of nonpublic proprietary corporate information;

    ii. Personally, identifiable nonpublic information (e.g., medical, financial, or personal in nature in electronic or non-electronic form);

    iii. Privacy notification costs;

    iv. Regulatory defense and penalties;

    v. Website media liability; and

    vi. Cybertheft of customer's property, including but not limited to money and securities.

If the policy is written on a claims-made basis, Contractor must submit to the Department an Endorsement providing proof that the policy provides the option to purchase an Extended Reporting Period ("tail coverage") providing coverage for no less than one year after work is completed in the event that coverage is cancelled or not renewed. This requirement applies to both primary and excess liability policies, as applicable.

SECTION 5: TECHNICAL PROPOSAL REQUIREMENTS

The purpose of Section 5 of the RFP is to set forth the submissions required of the Offeror. The Offeror's Technical Proposal must contain responses to all required submissions from the Offeror in the format requested. Each Offeror may submit only one Technical Proposal. Each Offeror's Technical Proposal will be evaluated based on the responses to the required submissions contained in Section 5 of this RFP. An Offeror must not include any cost information in the Technical Proposal, including attachments. Specific savings estimates (dollars or percentages) must not be quoted in the Technical Proposal or in any attachments submitted with the Technical Proposal.

5.1 Executive Summary

In an Executive Summary, the Offeror must describe its capacity and proposed approach to administering the MHSU Disorder Program, which covers over 1.2 million lives and incurs claims costs of approximately $400 million annually. The Offeror must have the ability, experience, reliability, and integrity to fulfill the requirements of this RFP. The Executive Summary must include a list of client organizations to clearly demonstrate and support that it meets the minimum requirement of 3.6 million total covered lives in its full book of business. In determining covered lives, the Offeror should count all lives (i.e., an employee, a spouse, and two eligible dependents counts as four covered lives).

5.2 Account Team

The Offeror must complete the *Biographical Sketch Form* (Attachment 14) for all key personnel including Subcontractor key staff, if any, of the proposed Account Team. Where individuals are not named, include qualifications of the individuals that will fill the positions. The Offeror must provide:

1. The name and address of the Offeror's main and branch offices, and the name of the senior officer(s) who will be responsible for this account;

2. An organizational and staffing plan that includes the roles and responsibilities of key personnel involved in administering the MHSU Disorder Program, their planned level of effort, their anticipated duration of involvement, and their daily level of availability. An organizational chart must be included in the proposal which identifies the Offeror's staff and staff from any Subcontractor, including their name and title, to be used in delivering the Project Services;

3. Reporting relationships and the responsibilities of key personnel on the Account Team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within Offeror's organization. Describe how the Account Team interfaces with

senior management and ultimate decision-makers within Offeror's organization; and

4. Identification of where Offeror's account services, enrollment, claims processing, clinical management, Clinical Referral Line and customer service staff will be located and approximately how many staff will work in each functional area.

5.3 Implementation Plan

The Offeror must provide a detailed Implementation Plan in narrative, diagram, and timeline formats, designed to meet the implementation by the specified completion dates.

1. The Implementation Plan must include estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. It must include key activities such as:

    a. Training of call center staff;

    b. Website development;

    c. Network development;

    d. Transition of benefits; and

    e. Eligibility feeds and testing claims processing.

2. Implementation Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all of the Implementation requirements listed in Section 3.2 will be in place on or before January 1, 2023 following completion of the Implementation Period, with the exception of opening the Dedicated Call Center and completing work on the customized website. The Dedicated Call Center must be opened at least 30 calendar days prior to the MHSU Project Services Start Date. The customized website must be live and operational at least 30 calendar days prior to the MHSU Project Services Start Date. This guarantee is not subject to the limitation of liability provisions of the Contract.

    Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each calendar day or part thereof, that all Implementation requirements are not met. The forfeited amount (Standard Credit Amount) is $10,000.00 a day for each calendar day the guarantee is not met. However, an Offeror may propose higher amounts.

5.4 Member Communication Support

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Member communications specified in Section 3.3 of this RFP, including the following:

1. Describe the role of the Offeror's legal department.

2. Provide two examples of communications the Offeror has developed for other clients.

3. Describe the Offeror's approach to developing appropriate customized forms, letters, and SBCs for the MHSU Disorder Program, and incorporating the Department's feedback.

4. Provide information about how the Offeror has worked with other large clients to produce customized communications. A large client is defined as an entity with over 50,000 or more covered lives.

5. Describe the resources that will be available to the Department to support the Department's development of various Enrollee communications and the ability to provide input into such communications quickly.

6. Confirm the commitment to work with the Department to develop appropriate customized forms and letters for the Programs. Provide examples of how the Offeror has worked with other large clients to produce customized communications.

7. Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, in New York State and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.

8. Describe how the Offeror proposes to maintain an updated file of nationwide MHSU Provider information for purposes of printed directories understanding the Department requires that a printed provider directory be available for each state, except New York and Florida which have greater requirements. Specify whether the Offeror proposes to use the same file source for print directories and the online directory.

9. Describe how the online directory will be available to Members 24 hours a day, 7 days a week, 365 days a year and the anticipated protocol for updating the site for regular maintenance; the amount of time it will take Offeror to add or remove MHSU Providers and Facilities from the directory upon joining or leaving the network; and what controls will be in place to ensure the listed information is accurate and up to date.

10. Detail the Offeror's experience in working with large clients who have required customized websites or web portals for benefits information.

11. Complete a second *Biographical Sketch Form* (Attachment 14), for all staff proposed for involvement in Member Communication Support.

5.5 Reporting Services

The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in the Reporting Services as specified in Section 3.4 of this RFP, including the following:

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 MHSU Disorder Program. Provide an overview of the reporting capabilities with the value it is believed the reporting capabilities will bring to the MHSU Disorder Program;

    a. Confirm that reports will be provided in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department;

    b. Confirm that direct, secure access will be provided to the claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement proposed for Department staff to execute in order to obtain systems access; and

    c. Confirm that the ability and willingness to provide ad hoc Reports and other data analysis. Provide examples of ad hoc reporting that have been performed for other clients.

2. Reporting Services Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all MHSU Disorder Program management reports and claim files listed in *Program Reporting* (Attachment 16) will be accurate and delivered to the Department no later than their respective due dates. The Offeror shall propose the forfeiture of a specific dollar amount of the Offeror's Administrative Fee.

    Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each calendar day the Department has not received the MHSU Disorder Program management report and claims file by their respective due date. The forfeited amount (Standard Credit Amount) for each management report or claim file that is not received by

its respective due date is $100 per calendar day per report. However, an Offeror may propose a higher amount.

5.6 Customer Service

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to develop Customer Service specified in Section 3.5 of this RFP, including the following:

    a. Summarize how Offeror will comply with federal and State law to assist Members who need translation services.

    b. Summarize how Offeror will track calls for reporting and change phone prompts and voice recordings as needed, without an additional charge to the State.

    c. Indicate the hours CSRs will be available; the requirement is between the hours of 8:00 a.m. and 5:00 p.m., ET, Monday through Friday, except for legal holidays observed by the State.

    d. Describe the Call Center technology that will be utilized for the MHSU Disorder Program, and a description of customizable options, if any, Offeror proposes for the MHSU Disorder Program.

    e. Provide a narrative on the Call Center which describes the information and resources that will be available to CSRs to assist them in addressing and resolving inquiries; the internal controls and reviews that will be performed to ensure quality service is being provided to Members; including outlining if there is a Quality Assurance team of representatives to monitor and develop the CSR staff; the first call resolution rate for the proposed call center; Offeror's company-wide average staff and turnover rate for call center employees; the proposed staffing levels; and how Offeror will ensure adequate staffing during call volume peaks. Explain the logic used to arrive at the proposed staffing levels, including the ratio of management to CSR staff.

    f. Describe the back-up systems for Offeror's primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a backup system is activated, explain how and in what order calls from Members will be handled. Confirm whether backup staff will have MHSU Disorder Program specific training. Indicate the number of times a backup system has been utilized over the past two years. Confirm that calls will be handled exclusively by Offeror's Call Center and that the backup call center would only be used in case of system failure or call overflow.

g. Define how frequently Offeror conducts customer satisfaction surveys for large clients as defined above. Include whether the Offeror conducts a customer satisfaction survey or if surveys are performed by an independent third party; and provide a sample of a survey Offeror used for a large client and advise of the typical response rate for a large client.

h. Detailed information about the location(s) where call center and customer service work shall be performed. [**Note:** In accordance with New York State Labor Law section 773, the head of each State agency is required to use reasonable best efforts to ensure that all state-business-related contracts for call centers and customer service work be performed by contractors, agents, or subcontractors entirely within the State of New York.]

2. Call Center Telephone Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following four program service level standards:

   a. Call Center Response Time Guarantee: 90% of incoming calls to the Offeror's telephone line must be answered by a CSR within thirty seconds.

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which the number of phone calls answered within thirty seconds falls below 90% of all incoming calls. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

   b. Availability Guarantee: The Offeror's telephone line must be operational and available to Members and Providers equal to or better than 99.5% percent of the Offeror's required up-time (24 hours a day, 7 days a week).

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which the Offeror's telephone line is not operational and available to Members and Providers 99.5% percent of the time. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

   c. Telephone Abandonment Rate Guarantee: No more than 3% of callers to the Offeror's telephone line will disconnect a call prior to the call being answered by a CSR.

      Utilizing the *Performance Guarantees form* (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than 3% of callers disconnect a call prior to the call

being answered by a CSR. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

d. Telephone Blockage Rate Guarantee: No more than 0% of incoming calls to the Offeror's telephone line shall be blocked by a busy signal.

Utilizing the *Performance Guarantees form* (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than 0% of incoming calls to the Offeror's telephone line are blocked by a busy signal. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

3. Clinical Referral Line Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following three program service level standards:

a. Out-of-Network CRL Guarantee: When a Member calls the CRL for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame that meets the Member's clinical needs, a referral shall be made to an appropriate Non-Network MHSU Provider within two Business Days of the call in at least 90% of cases.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than 90% of cases where Members are referred to Out-of-network MHSU Providers within two Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available. The forfeited amount (Standard Credit amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

b. Emergency CRL Guarantee: 100% of Members who call the CRL in need of life-threatening emergency care shall be referred to the nearest emergency room and be contacted within thirty minutes to assure their safety. Additionally, 100% of Members in need of non-life-threatening emergency care shall be contacted within thirty minutes by a network MHSU Provider or the CRL. There must be at least three attempts at outreach which must be documented.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than 100% of Members who call the CRL in need of life-threatening emergency care are referred to the nearest emergency room and contacted within thirty minutes by a network MHSU Provider or the CRL to assure their

safety. Additionally, the Offeror must propose a forfeiture amount for each quarter in which less than 100% of Members in need of non-life-threatening emergency care are contacted within thirty minutes by a Network Provider or the CRL. The forfeited amount (Standard Credit amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

c. Urgent Care CRL Guarantee: At least 99% of Members who call the CRL in need of urgent care shall be contacted by the Offeror to ensure that the network MHSU Provider contacted the Member within forty-eight hours of the call to the CRL.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than 99% of Members in need of urgent care were contacted by the Offeror to ensure that the network MHSU Provider contacted the Member within forty-eight hours of the Member's call to the CRL. The forfeited amount (Standard Credit amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

5.7 Enrollment Management

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to manage enrollment data as specified in Section 3.6 of this RFP, including the following:

   a. Offeror's testing plan to ensure that the initial enrollment load and daily enrollment transition files for the Plan are accurately updated to Offeror's system and that such files interface correctly with Offeror's claims system. The testing plan must include:

      i. The quality controls that are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system.

      ii. How the Offeror's system identifies transactions that will not load into Offeror's enrollment system. How exceptions are identified that will cause enrollment transactions to fail to load into Offeror's enrollment system. What steps are taken to resolve the exceptions, and the turnaround time for the exception records to be added to Offeror's enrollment file.

      iii. How the Offeror will ensure that enrollment and eligibility transactions that do not load into the Offeror's system will be

manually reviewed and reported back to the Department within one Business Day.

b. Offeror's system capabilities for retrieving and maintaining enrollment information within twenty-four hours of its release by the Department as well as:

   i. How Offeror's system maintains a history of enrollment transactions and how long enrollment history is kept online. Identify any limits to the number of historical transactions that can be kept online;

   ii. How Offeror's system handles retroactive changes and corrections to enrollment data;

   iii. How Offeror's 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; and

   iv. How Dependents are linked to the Enrollee in the Offeror's enrollment system and claims processing system, including a description on how Offeror's enrollment and claims processing system can administer a social security number, Employee identification number, and an alternate identification number assigned by the Department; and any special requirements to accommodate these three identification numbers.

c. How Offeror's enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

d. Offeror's ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a QMCSO, including storing this information in Offeror's system, so that information about the Dependent is only released to the individual named in the QMCSO.

2. Enrollment Management Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that 100% of all MHSU Disorder Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four hours of release by the Department.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each twenty-four-hour period or part thereof in which enrollment records that meet the quality standards for loading are not loaded in the Offeror's enrollment system after such enrollment records have

been released by the Department. The forfeited amount (Standard Credit Amount) is $1,000.00 for each twenty-four-hour period or part thereof in which this guarantee is not met. However, an Offeror may propose higher amounts.

5.8 Claims Processing

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in claims processing as specified in Section 3.7 of this RFP, including the following:

    a. Describe whether, with regards to Claims Processing, it owns the adjudication system, licenses the software from a third-party, or contracts out this service.

    b. Describe how any changes to the benefit design would be monitored, verified, and tested for the MHSU Disorder Program, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the MHSU Disorder Program.

    c. Describe how Offeror's claims processing system collects overpayments from Offeror's MHSU Provider network.

    d. 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 MHSU Disorder Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses.

    e. Include a copy of the data-sharing agreement Offeror proposes for Department staff to execute in order to obtain secure systems access to Offeror's claims system and any online and web-based reporting tools.

2. Claims Processing Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following two program service level standards:

    a. Claims Payment Accuracy Guarantee: Claims payment accuracy must be achieved for a minimum of 99% of all claims processed and paid each calendar year.

    Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each year in which 99% of claims payment accuracy is not achieved as determined based on an annual audit conducted by the Department. The forfeited amount (Standard Credit Amount) is $250,000.00 for each year this guarantee is not met. However, an Offeror may propose higher amounts.

b. Claims Processing Guarantee – Twenty Four Calendar Days Turnaround Time: No less than 99.5% of submitted claims received by the Offeror that require no additional information in order to be correctly processed shall be processed within twenty four calendar days from the date the claim is received electronically or in the Offeror's designated post office box to the date of Claim Adjudication.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than 99.5% of claims that require no additional information in order to be correctly processed, are not processed within twenty four calendar days from either the date the claim is received electronically or in the Offeror's designated post office box to the date the payment is transmitted to the Provider or mailed to the Member as calculated on a quarterly basis. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

5.9 Plan Audit and Fraud Protection

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in plan audit and fraud protection as specified in Section 3.8 of this RFP, including the following:

    a. Describe the audit program Offeror would conduct for the MHSU Disorder Program including a description of the criteria Offeror uses to select MHSU Providers/Facilities to audit and a description of the policy that Offeror follows when an audit detects possible fraudulent activity by a MHSU Provider, Facility or Member. Include all types of audits performed and offered by Offeror's organization.

    b. Provide examples of how Offeror's payment integrity algorithms and software have prevented or detected major cases of fraud, waste, and abuse for other large clients.

    c. Describe the corrective action, monitoring, and recovery efforts that take place when Offeror finds that a MHSU Provider or Facility is billing incorrectly or otherwise acting against the interests of Offeror's clients. Please indicate whether Offeror has a fraud and abuse unit within Offeror's organization and describe its role. In the extreme case of potentially illegal activity, identify procedures that the Offeror has in place to address illegal or criminal activities by a MHSU Provider or Facility and confirm Offeror will pursue litigation on the Department's behalf when necessary.

5.10 Appeal Process

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in the appeal process as specified in Section 3.9 of this RFP, including the following:

    a. Describe in detail how the Offeror proposes to notify Members of their right to appeal and the steps to file an appeal. Specify the process for administrative and clinical appeals for level 1 and 2 for each program under this RFP.

    b. Specify the turnaround time for non-urgent administrative and clinical level 1 and 2 appeals for each program.

    c. Specify the turnaround time for urgent administrative and clinical level 1 and 2 appeals for each program under this RFP.

5.11 Provider Network

At least thirty calendar days prior to the commencement of Full MHSU Disorder Services, and throughout the term of the Contract, the Offeror must possess a Participating MHSU Provider/Facility network that meets or exceeds the accessibility standards set forth in Section 3.10 of this RFP. To demonstrate satisfaction of this requirement, the Offeror must submit all information required below based on the Geo-Coded Census file provided by the Department in *Enrollment by ZIP Code & Geo Access Network Report File* (Attachment 22).

An Offeror will need to obtain sensitive information from the Department. Upon receipt of a completed, notarized *Confidentiality and Non-Disclosure Agreement* (Attachment 15), the Department shall provide the Offeror with *Enrollment by ZIP Code and Geo Access Network Report File* (Attachment 22), containing the NYBEAS enrollment file that will ensure that all Offerors perform their analyses consistently. The confidentiality and non-disclosure agreement is required to be submitted by an Offeror requiring access to *Enrollment by ZIP Code and Geo Access Network Report File* (Attachment 22).

The Offeror may execute custom MHSU Provider contracts contingent on award or existing agreements that can be made applicable to the Plan, or a combination thereof. All Providers in the file must be credentialed by the Offeror. The Offeror must agree to provide documentation, including unredacted MHSU Provider contracts, to the Department upon request to demonstrate satisfaction of this requirement. No Enrollee may be excluded from the Offeror's Geo network analysis, even if no Provider is located within the pre-defined access standards.

1. To fulfill the requirements of this Section and Section 3.10 of the RFP, the Offeror

must:

a. Submit their proposed Provider network using the *Offeror's Proposed Provider Network Files* form (Attachment 23). An Offeror is required to submit its proposed MHSU Provider network in two separate files: one for MHSU Facilities; and one for MHSU Practitioners.

b. Perform a GeoAccess analysis, per MHSU Provider type, based on the Access Standards as referenced in Section 3.10 of this RFP. The Offeror should submit the complete Geo network reports in a searchable PDF and the GeoAccess Accessibility Summaries ~~in hard copies~~in both searchable PDFs and hard copies. These analyses should include every ZIP Code that is in the demographic file; even ZIP Codes with no access should be included. The Offeror should use Estimated Driving Distance from the employee's home ZIP Code for calculating distance. The most current version of Quest Analytics software must be used to create these reports. See *Offeror's Participating Provider Quest Analytics Report* (Attachment 35) for instructions.

c. Submit the *Offeror's Proposed Provider Network Summary Worksheet* (Attachment 32), which indicates fulfillment of Urban, Suburban and Rural network Access requirements as outlined in 3.10 of this RFP.

d. Carefully read the instructions in *Comparison of Utilized Provider File and the Offeror's Proposed Provider Network* (Attachment 33) and complete the Attachment. To do this, identify whether each of the Plan's current utilized Providers from the *Utilized Provider File* (Attachment 34) will or will not participate in the Offeror's proposed MHSU Provider network. Please submit a match and match criteria for every provider listed in Attachment 34.

e. Describe how Offeror monitors whether network MHSU Providers are accepting new patients into their practices, including how the Offeror's proposed access standards consider MHSU Provider availability.

f. Detail Offeror's current approach to value-based payment contracting, including approximately what percentage of Offeror's contracts are value-based, what type of risk level the Provider engages in, if any, and how Offeror plans to incorporate the Plan into Offeror's value-based contracting strategy. [**Note**: Specific cost information should not be included].

g. Detail those areas, if any, within New York State and outside of New York State where the Offeror's network does not meet or exceed the access guarantees as detailed in Section 3.10 of this RFP.

h. Describe how the Offeror proposes to provide Members with 24 hours a day, 7 days a week, 365 days a year access to a telemedicine service for behavioral health visits. The Offeror must provide the services on a virtual visit platform with no copay.

2. Provider Network Guarantees: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following three program service level standards:

   a. Network Access Urban Areas Guarantee: The Offeror's network cannot provide less than 95% of urban Enrollees ~~in New York State~~ with access to those MHSU Providers and Facilities outlined in Section 3.10(1)(l)(i).

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which less than 95% of urban Enrollees ~~in New York State~~ do not have MHSU Provider access that meets any network Access-Urban Areas requirement. The amount quoted by the Offeror shall be applied only once per quarter if the Offeror fails to maintain required access for any MHSU Provider type in Urban Areas. The quoted access standard is not an overall aggregate of Provider access in Urban Areas. The forfeited amount (Standard Credit Amount) is $60,000.00 for any MHSU Provider type, calculated quarterly. An Offeror may propose a higher amount.

   b. Network Access Suburban Areas Guarantee: The Offeror's network cannot provide less than 95% of suburban Enrollees ~~in New York State~~ with access to those MHSU Providers and Facilities outlined in Section 3.10(1)(l)(ii).

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which less than 95% of suburban Enrollees ~~in New York State~~ do not have MHSU Provider access that meets any network Access-Suburban Areas requirement. The amount quoted by the Offeror shall be applied only once per quarter if the Offeror fails to maintain required access for any MHSU Provider type in Suburban Areas. The quoted access standard is not an overall aggregate of MHSU Provider access in Suburban Areas. The forfeited amount (Standard Credit Amount) is $60,000.00 for any MHSU Provider type, calculated quarterly. An Offeror may propose a higher amount.

   c. Network Access Rural Areas Guarantee: The Offeror's network cannot provide less than 95% of rural Enrollees ~~in New York State~~ with access to those MHSU Providers and Facilities outlined in Section 3.10(1)(l)(iii).

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which less than 95% of rural Enrollees ~~in New York State~~ do not have MHSU Provider access that meets any network Access-Rural Areas requirement. The amount quoted by the Offeror shall be applied only once per quarter if the Offeror fails to maintain required access for any MHSU Provider type in Rural Areas. The quoted access standard is not an overall aggregate of MHSU Provider access in Rural Areas. The forfeited amount (Standard Credit Amount) is $60,000.00 for any MHSU Provider type, calculated quarterly. An Offeror may propose a higher amount.

3. Network Composition Guarantee:

   In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that at least 90% of the Providers in each of the eleven Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Use Facility, Mental Health and Substance Use Facility, Mental Health Outpatient Clinic Group, Substance Use Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Use Practitioner – Other Prescriber), listed on *Offeror's Proposed Provider Network Files* (Attachment 23), will be maintained throughout the term of the Contract. Providers who are retired, deceased, or no longer actively practicing will be excluded from the annual calculation and guarantee.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which it does not meet 90% of the targeted number of Providers in each of the eleven Facility or Practitioner Licensure type categories. The Offeror must provide a target number for each of the eleven network composition categories for which they are required to maintain at least 90% of providers in each of those categories. The amount quoted by the Offeror shall be applied for each MHSU Provider type per quarter if the Offeror fails to maintain required network composition. The forfeited amount (Standard Credit Amount) is $60,000.00 for any MHSU Provider type, calculated quarterly. An Offeror may propose a higher amount. .

5.12 Other Clinical Management Programs

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in other clinical management programs as specified in Section 3.11 of this RFP, including the following:

   a. Describe the ADHD management program the Offeror is proposing to administer for the MHSU Disorder Program. Include a detailed description of how the program operates and its benefit to the MHSU Disorder

Program and Members. Provide samples of communication material that are proposed for use in the MHSU Disorder Program.

b. Describe the depression management program the Offeror is proposing to administer for the MHSU Disorder Program. Include a detailed description of how the program operates and its benefit to the MHSU Disorder Program and Members. Provide samples of communication material that are proposed for use in the MHSU Disorder Program.

c. Describe the eating disorder management program the Offeror is proposing to administer for the MHSU Disorder Program. Include a detailed description of how the program operates and its benefit to the MHSU Disorder Program and Members. Provide samples of communication material that are proposed for use in the MHSU Disorder Program.

d. Please describe any other voluntary clinical management or utilization review programs the Offeror is proposing to administer for the MHSU Disorder Program. Include a detailed description of how the program operates and its benefit to the MHSU Disorder Program and Members.

5.13 Pre-Certification and Concurrent Review for Mental Health and Substance Use Disorder Services

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in for Pre-certification of benefits and concurrent review for MHSU services in accordance with New York State regulations as specified in Section 3.12 of this RFP, including the following:

    a. Describe the process and procedure the Offeror proposes to use for Pre-certification of benefits. Explain the proposed staffing levels and qualifications of staff responsible for Pre-certification including whether some or all of the same staff will be utilized for predetermination of benefits and Pre-certification of benefits, or if these will be separate functioning units. Describe how the Medical Director of the MHSU Disorder Program will be involved in the predetermination and Pre-certification process.

    b. Detail the full scope of the concurrent Utilization Review (UR) program that Offeror is proposing to utilize for MHSU services, including:

        i. The qualifications of the staff responsible for oversight of Offeror's concurrent UR program;

        ii. Review of outpatient care;

iii. Review of inpatient care;

iv. Discharge planning and follow-up care; and

v. Intensive case management of High-Risk Members.

c. Describe the methods Offeror utilizes to measure effectiveness for MHSU services. Do not include any reference to specific monetary savings.

2. Inpatient Treatment Utilization Review Guarantee: In this part of its Technical Proposal the Offeror must state its agreement and guarantee that at least 90% of requests for Pre-certification of inpatient MHSU care, when applicable under New York State regulations, be reviewed within twenty-four hours from the receipt of the request and the Member and MHSU Provider notified within one Business Day of the determination as calculated on a quarterly basis.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which less than 90% of requests for Pre-certification of inpatient MHSU care are reviewed within twenty-four hours from the receipt of the request and/or the Member and MHSU Provider are not notified within one Business Day of the determination. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

5.14 Consolidated Appropriations Act (CAA)

1. The Offeror must provide a narrative describing how it will conduct and document a NQTL comparative analysis and confirm the analysis will be provided upon request. This narrative should also include a summary of its planned activities to ensure compliance with other provisions of the CAA, including, but not limited to, posting machine-readable files related to claims payments, provider directory requirements, and enrollee transparency tools.

5.15 Disabled Dependent Determinations

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in disabled dependent determinations as specified in Section 3.14 of this RFP, including the following:

   a. Explanation as to whether the Offeror provides this service or a similar service for clients presently, including an example.

b. Summary on how the Offeror plans to provide disabled dependent determinations to the Department and what qualifications staff will have who perform the review.

5.16 Transition and Termination of Contract

The Offeror must provide a narrative describing in detail:

1. The process and level of customer service and clinical management that Offeror will provide in Phase One and Phase Two of the Transition Services, as specified in Section 3.15 of the RFP.

2. Transition and Termination Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee all Transition Plan requirements outlined in Section 3.15 of this RFP will be completed in the required time frames to the satisfaction of the Department.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each day or part thereof that the Transition Plan requirements are not met. The forfeited amount (Standard Credit Amount) is $1,000.00 for each day this guarantee is not met. However, an Offeror may propose higher amounts.

SECTION 6: FINANCIAL PROPOSAL

This section of the RFP sets forth the requirements for the Offeror's Financial Proposal submission and the cost structure required by the Department for Offerors to use in developing their submission. The Offeror's Financial Proposal must respond to all the following mandatory sections as set forth below in the formats as specified.

The sole compensation for the Contractor under the Contract will be payments based on the provisions set forth in this section of the RFP. During the term of the Contract, amounts paid for which it is subsequently determined that the Contractor was not entitled, if any, must be refunded to the Department. Submission of an invoice and payment thereof shall not preclude the Department from recovery or offset of payment in any case where Project Services as delivered are found to deviate from the terms and conditions of the Contract.

Evaluation of Financial Proposals will be performed in accordance with the provisions presented in Section 7.3 of the RFP.

The Financial Proposal must consist of a completed *Participating MHSU Provider Non-Medicare Fee Schedule and Administrative Fee* form (Attachment 25), which will include the Offeror's proposed per service In-Network fees that will be charged to the Program for all listed services. The Offeror will submit proposed per service In-Network fees for each of the first five years of the Contract Term.

6.1 Program Claims

Throughout the term of the Contract, the Offeror will be paid for In-Network and Out-of-Network MHSU Disorder Program claim charges on a monthly basis. Claim utilization data for Participating MHSU Providers can be found in *Empire Plan Service Counts and Net Payments by Program – All Claims* (Attachment 26). The following paragraph summarizes the benefit design for the Empire Plan, Excelsior, and SEHP. Please refer to *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 20) for further details.

1. Participating Provider Network: In accordance with Section 3.10 of the RFP, the Offeror is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSU Disorder Program's current Provider Network. The amount charged to the Program for Covered Services shall be the contracted Network Provider fee agreed to between the Offeror and the servicing Provider, less any applicable copayment and payments from other insurance coverage. This fee must be equal to or less than the contracted Network Provider fee for the Offeror's other contracted clients that are similar in size or scope to the Department.

2. Non-Network Practitioners: The Contractor will process Non-Network Practitioner claims, as follows:

    a. For the Empire Plan: 80 percent of the Usual and Customary Rate (UCR). The Empire Plan pays 100 percent of the UCR once each combined coinsurance amount exceeds the maximum for the calendar year. The Empire Plan generally utilizes the 90th percentile of FAIR Health to determine the UCR. The UCR means the lowest of:

        i. The actual charge for services; or

        ii. The usual charge for services by the Provider for the same or similar service; or

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

    b. For the Excelsior Plan: 80 percent of the UCR. The UCR is the lower of billed charges or 110 percent of the Medicare allowance.

    c. For SEHP, the Plan pays 80 percent of the allowable amount, the lower of billed charges or 110 percent of Medicare, for covered services after the deductible is met.

3. Non-Network Facilities: The Contractor will process Non-Network Facilities claims, as follows:

    a. For the Empire Plan: 90 percent of billed charges. After the combined annual coinsurance maximum is met, the Empire Plan pays 100 percent of billed charges.

    b. The Excelsior Plan does not provide coverage for services provided in a non-network facility except in an emergency or if a network facility is not available.

    c. For SEHP: A $200 copayment is applied per person per admission. The Plan pays 80 percent of the allowable amount, the lower of billed charges or 110 percent of Medicare, after the copayment is met. The member is responsible for the balance.

    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. Members will not be responsible for any payments above what they would pay for a network claim.

4. Network Pricing Guarantee: The Offeror is required to guarantee that the Actual Average Cost Per Service (defined as actual aggregate costs divided by actual aggregate utilization for all Network Provider services paid each year) will not exceed the Average Proposed Cost Per Service (defined as proposed costs as listed in Attachment 25 divided by anticipated utilization).

    a. The Department will calculate the guarantee annually as follows:

    (Actual Average Cost Per Service – Average Proposed Cost Per Service)
    multiplied by
    Actual Paid Claim Utilization

    b. If Department determines the above calculation results in a penalty, the amount due must be remitted to the Department within thirty (30) days after the Offeror is notified.

6.2 Administrative Fees

1. The Offeror must submit a completed *Participating MHSU Provider Non-Medicare Fee Schedule and Administrative Fee* form (Attachment 25) which must include the Offeror's proposed per Enrollee per month fee for Administrative Fees charged to the MHSU Disorder Program. An Offeror's quoted Administrative Fee must include all direct and indirect costs, overhead, travel expenses, fees, and profit.

2. The Offeror will be bound by its quoted Administrative Fee, as proposed in the Offeror's Financial Proposal for the entire term of the Contract, unless amended in writing.

3. Each month, the Offeror shall calculate the total Administrative Fee payable to the Offeror by multiplying the per Enrollee per month fee by the average number Enrollees in force for the assessed month as reported by the Offeror. The average number Enrollees for the assessed month reported by the Offeror shall be based on the enrollment files and enrollment updates the Department transmits to the Offeror as set forth in Section 3.6 of this RFP.

4. The Department reserves the right to adjust the Administrative Fee charged by the Offeror based on a reconciliation of the Enrollee counts reported from the Department's NYBEAS by the Enrollee counts utilized by the Offeror to calculate the monthly Administrative Fee. The reconciliation will be performed by the Department on an annual basis using the average Enrollee count for the respective MHSU Disorder Program Year. However, the Department may perform additional reconciliations throughout a given year if the average monthly Enrollee counts utilized by the Offeror differ significantly from the Department's Enrollee counts, as reflected in NYBEAS. In addition, the Administrative Fee due

shall be adjusted on an annual basis based on penalties due to the Department or payments due from the Offeror in accordance with the *Performance Guarantees* form (Attachment 6).

6.3 Assessments

Assessments are defined as surcharges or taxes charged by federal, state, and local government entities based on claims or membership. The State will be responsible for all Assessments imposed on health insurers. The Contractor will be responsible for any future Assessments that are chargeable to the Program. The State is currently responsible for the following Assessments, which are chargeable to the health insurer as of June 2020:

1. New York Health Care Reform Act Covered Lives Assessment
2. New York Health Care Reform Act Bad, Debt and Charity Assessment
3. Massachusetts Health Safety Network Assessment
4. Massachusetts Pediatric Immunization Assessment
5. Massachusetts Child Psychiatry Access Program Assessment
6. Massachusetts Health Policy Commission Assessment
7. Michigan Health Insurance Claims Assessment
8. Maine Vaccine Assessment
9. Maine Guaranteed Access Reinsurance Association Assessment
10. New Hampshire Vaccine Assessment
11. New Hampshire Health Plan Assessment
12. Vermont Immunization Assessment
13. Connecticut Immunization Assessment
14. Connecticut DPH Assessment
15. Vermont Health Care Claims Tax
16. New Mexico Vaccine Assessment

17. Rhode Island Children's Health Account Assessment

18. Alaska Vaccine Assessment

SECTION 7: EVALUATION AND SELECTION CRITERIA

The Department seeks to contract with a single Offeror to provide and administer MHSU benefits. To this end, the Department intends to select the responsive and responsible Offeror whose Proposal offers the "Best Value" to the State, as defined in Section 7.5 of this RFP.

[**Note**: Access to technical proposals will be made available to representatives of NYS employee unions for review. Representatives of NYS employee unions may participate in Management Interviews and Site visits, if applicable.].

7.1 Administrative Proposal Evaluation

Proposals determined by the Department to satisfy the submission requirements set forth in Section 4 of this RFP will be evaluated by an evaluation team composed of staff from the Department. An Offeror's Proposal shall not be considered for award until the Offeror submits a *Formal Offer Letter* (Attachment 3) and an *Offeror Attestations Form* (Attachment 13).

7.2 Technical Proposal Evaluation

The evaluation of the Offeror's Technical Proposal will be based on that Offeror's written Technical Proposal and responses to clarifying questions (if any) and, as deemed necessary by the Department, Technical Management Interviews conducted to amplify and/or clarify information in the Offeror's Technical Proposal.

1. Technical Score Ratings

The Technical Proposal of any Offeror meeting the requirements set forth in Section 7.1 of this RFP will be evaluated by the Department and representatives from other State agencies. Each Offeror's Technical Proposal will be evaluated based on the following rating scale and criteria as applied to each response as required in Section 5 of this RFP. A rating of "excellent" equates to a score of 5 for each evaluated 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 high-quality services and is proactive and innovative.

b. Good (4)

The Offeror exceeds the criteria. The services described indicate that the Offeror will exceed the requirements of the RFP. 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 requirements of the RFP.

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.

2. Performance Guarantee Ratings

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.

A rating of "excellent" equates to a score of 4 for each evaluated service level standard. Each reduction in the ratings results in a reduction in the score such that a rating of "poor" equates to a score of 1. An Offeror may propose performance guarantees that exceed the MHSU Disorder Program's service level standards presented in this RFP. Proposed Performance Guarantees are contained within the *Performance Guarantees* form (Attachment 6) and will be evaluated using the following criteria:

a. Excellent (4)

i. The Offeror's proposed performance guarantee exceeds the MHSU Disorder Program's service level standard contained within this RFP; and

ii. The Offeror's proposed credit amount is 125% or more of the Standard Credit Amount stated within this RFP.

b. Good (3)

i. The Offeror's proposed performance guarantee equals the MHSU Disorder Program's service level standard contained within this RFP, and the Offeror's proposed credit amount is 125% or more of the Standard Credit Amount stated within this RFP; or

ii. The Offeror's proposed performance guarantee exceeds the MHSU Disorder Program's service level standard contained within this RFP; and the Offeror's proposed credit amount is greater than 100% but less than 125% of the Standard Credit Amount stated within this RFP.

c. Meets Criteria (2)

i. The Offeror's proposed performance guarantee equals or exceeds the MHSU Disorder Program's service level standard contained within this RFP; and

ii. The Offeror's proposed credit amount equals the Standard Credit Amount stated within this RFP.

d. Poor (1)

i. The Offeror's proposed performance guarantee is below the MHSU Disorder Program's service level standard contained within this RFP regardless of the credit amount proposed by the Offeror; or

ii. The Offeror's proposed credit amount is less than 100% or less of the Standard Credit Amount stated within this RFP regardless of the level of performance the Offeror pledges.

3. Allocation of Technical Score Points

The scores referenced above shall be applied to weighted point values associated with each evaluated Submission response. The relative point value for each section of the Technical Proposal is as follows:

Section	Title	% of Technical Score
5.3	Implementation Plan	2%
5.4	Member Communication Support	2%
5.5	Reporting Services	1%
5.6	Customer Service	15%

5.7	Enrollment Management	10%
5.8	Claims Processing	10%
5.9	Plan Audit and Fraud Protection	2%
5.10	Appeal Process	1%
5.11	Provider Network	50%
5.12	Other Clinical Management Programs	2%
5.13	Pre-Certification and Concurrent Review for Mental Health and Substance Use Disorder Services	1%
5.14	Consolidated Appropriations Act	2%
5.15	Disabled Dependent Determinations	1%
5.16	Transition and Termination of Contract	1%
Total		**100.0%**

4. Technical Proposal Scoring

The Technical Proposal evaluation will be based on 700 total available points. The average score of all evaluators for each section of the Technical Proposal will be applied against the weights depicted in the chart above.

7.3 Financial Proposal Evaluation

The Financial Proposal of any Offeror meeting requirements set forth in Section 4 of this RFP will be evaluated by the Department. [**Note:** Aggregate utilization is available in *Empire Plan Service Counts and Net Payments by Program – All Claims* (Attachment 26)].

1. Financial Proposal Scoring

a. The Department will calculate a Total Projected Cost for each Offeror as the sum of (i); and (ii) as follows:

i. The Total Projected Participating Provider Network Claims Cost, which shall be calculated by the Department by:

1) Using the *Utilized Provider Files* (Attachment 34) to identify the Offeror's proposed Participating Provider, and

2) For each identified Participating Provider, multiplying the Offeror's quoted fees for each type of service, as presented by the Offeror on the *MHSU Provider Fee Schedule and Administrative Fee* form (Attachment 25), by the normalized utilization projected by the Department for the specific Participating Providers over the five-year period.

ii. The Total Projected Non-Network Claims Cost, which shall be calculated by the Department by:

1) Using the *Utilized Provider Files* (Attachment 34) to identify the Offeror's proposed Non-Network Practitioners and Facilities; and

2) For each identified Non-Network Practitioner and Facility, multiplying the Non-network cost for each type of service, as reflected in the *Non-Network Estimated Cost per Unit by Service* form (Attachment 36) by the normalized utilization projected by the Department for the specific Non-Network Practitioner or Facility over the five-year period. For those practitioners not identified in the *Utilized Provider Files* (Attachment 34), the Department will use as a proxy the projected utilization of the Non-Network Practitioners or Facilities in the same or similar geographic location.

iii. The Total Projected Administrative Costs, which shall be calculated by the Department by multiplying the Monthly Administrative Fee quoted by the Offeror on the *Participating MHSU Provider Fee Schedule and Administrative Fee* form (Attachment 25) by the projected MHSU Disorder Program enrollment.

b. The Offeror's Proposal with the lowest Total Projected Cost will be awarded 300 points. A Financial Proposal score for each remaining Offeror will be determined based on the following formula:

<u>Cost Score of Evaluated Proposal</u> =

300 * Lowest Evaluated Cost

divided by

Total Cost of Proposal being evaluated

7.4 Total Combined Score

The Total Combined Score assigned to each Offeror will be the sum of the Offeror's Technical Score and Financial Score.

7.5 Best Value Determination

Best Value means that the proposal that optimizes quality, cost, and efficiency among responsive and responsible bidders shall be selected for award (State Finance Law, Article 11, Section 163). Best Value will be determined by a weighted point system, with 70 percent allocated to the Technical Proposal and 30 percent allocated to the Financial Proposal. The Department shall select and enter into negotiations for the purpose of executing a Contract with the responsive and responsible Offeror that has obtained the highest Total Combined Score, inclusive of both cost and technical. If two offers' Total Combined Scores are tied, the award shall go to the bidder with the highest cost score (lowest price), as calculated pursuant to Section 7.3 of this RFP.

SECTION 8: ADDITIONAL PROVISIONS

The Offeror that is determined to provide the Best Value to the Department shall be notified of its conditional award of Contract subject to the successful development of a Contract. The resulting Contract shall incorporate the requirements set forth in the RFP. Additional terms and conditions not already addressed in the RFP are set forth below.

1. Work in The Continental United States of America

All work performed by Contractor personnel under this Contract must be performed within the Continental United States of America.

2. Entire Contract

The resulting Contract, including all appendices, constitutes the entire Contract between the parties hereto and no statement, promise, condition, understanding, inducement, or representation, oral or written, expressed or implied, which is not contained herein shall be binding or valid and the Contract shall not be changed, modified, or altered in any manner except by an instrument in writing executed by both parties hereto, except as otherwise provided herein. The Contract is subject to amendment(s) only upon mutual consent of the Parties, reduced to writing and approved by OSC and subject to the termination provisions contained herein.

3. Use and Disclosure of Protected Health Information

a. The Offeror acknowledges that the Offeror is a "Business Associate" as that term is defined in the HIPAA implementing regulations at 45 CFR 160.103, of the Department as a consequence of the Offeror's provision of Project Services on behalf of the Department within the context of the Offeror's performance under the resulting Contract and that the Offeror's provision of Project Services will involve the disclosure to the Offeror of individually identifiable health information from the Department or other service providers on behalf of the Department, as well as the Offeror's disclosure to the Department of individually identifiable health information as a consequence of the Project Services performed under the resulting Contract. As such, the Offeror, as a Business Associate, will be required to comply with the provisions of this Section.

b. For purposes of this Section, 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 the resulting Contract, PHI may be received by the Offeror from the Department or may be created or received by the Offeror on behalf of the Department in the Offeror's capacity as a Business Associate. All PHI received or created by the Offeror in the Offeror's capacity as a Business Associate and as a consequence of its performance under the resulting Contract is referred to herein collectively as "Department's PHI".

c. The Offeror 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 Offeror further acknowledges that the Department has designated NYSHIP and the Empire Plan as an Organized Health Care Arrangement (OHCA), respectively. The Offeror further acknowledges that (i) the Offeror is a HIPAA "Business Associate" of the group health plans identified herein as "covered entities" as a consequence of the Offeror's provision of certain services to and/or on behalf of the Department as administrator of the "covered entities" within the context of the Offeror's performance under the resulting Contract, and that the Offeror's provision of such services may involve the disclosure to the Offeror of individually identifiable health information from the Department or from other parties on behalf of the Department, and also may involve the Offeror's disclosure to the Department of individually identifiable health information as a consequence of the services performed under the resulting Contract; and (ii) Contactor is a "covered entity" under HIPAA in connection with its provision of certain services under the resulting Contract. To the extent Offeror acts as a HIPAA "Business Associate" of the group health plans identified as "covered entities", the Offeror shall adhere to the requirements as set forth herein. Offeror is responsible to obtain from Members and Enrollees all consents and/or authorizations, if any, required for Offeror to perform the services hereunder and for the use and disclosure of information, including the Department's PHI, as permitted under the resulting Contract.

d. Permitted Uses and Disclosures of the Department's PHI: The Offeror may create, receive, maintain, access, transmit, use and/or disclose the Department's PHI solely in accordance with the terms of the resulting Contract. In addition, the Offeror may use and/or disclose the Department's PHI to provide data aggregation services relating to the health care operations of the Department. Further, the Offeror may use and disclose the Department's PHI for the proper management and

administration of the Offeror if such use is necessary for the Offeror's proper management and administration or to carry out the Offeror's legal responsibilities, or if such disclosure is required by law or the Offeror 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 Offeror of any instances of which it is aware in which the confidentiality of the information has been breached. Additionally, the Offeror may use and/or disclose the Department's PHI, as appropriate: (i) for treatment, payment and health care operations as described in 45 CFR Section 164.506(c)(2), (3) or (4); and (ii) to de-identify the information or create a limited data set in accordance with 45 CFR §164.514, which de-identified information or limited data set may, consistent with this section, be used and disclosed by Offeror only as agreed to in writing by the Department and permitted by law.

e. Nondisclosure of the Department's PHI: The Offeror shall not create, receive, maintain, access, transmit, use, or further disclose the Department's PHI otherwise than as permitted or required by the resulting Contract or as otherwise required by law. The Offeror shall limit its uses and disclosures of PHI when practicable 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.

f. Safeguards: The Offeror shall use appropriate, documented safeguards to prevent the use or disclosure of the Department's PHI otherwise than as provided for in the resulting Contract. The Offeror shall maintain a comprehensive written information security program that includes administrative, technical, and physical safeguards that satisfy the standards set forth in the HIPPA Security Rule at 45 CFR §§ 164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 CFR § 164.316, appropriate to the size and complexity of the Offeror'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, accesses, or that it transmits on behalf of the Department pursuant to the resulting Contract to the same extent that such electronic PHI would have to be safeguarded if created, received, maintained, accessed or transmitted by a group health plan identified herein.

g. Breach Notification: In addition to the Disclosure of Breach requirements specified in Appendix B, the following provisions shall apply:

    i. Reporting: The Offeror shall report to the Department any breach of unsecured PHI, including any use or disclosure of the

Department's PHI otherwise than as provided for by the resulting Contract, of which the Offeror becomes aware. An acquisition, access, transmission, use or disclosure of the Department's PHI that is unsecured in a manner not permitted by HIPAA or the resulting Contract is presumed to be a breach unless the Offeror demonstrates that there is a low probability that Department's PHI has been compromised based on the Offeror's risk assessment of at least the following factors: (i) the nature and extent of Department's PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used Department's PHI or to whom the disclosure was made; (iii) whether Department's PHI was actually acquired or viewed; and (iv) the extent to which the risk to Department's PHI has been mitigated.

ii. Required Information: In addition to the information required in Appendix B, paragraph 40, Disclosure of Breach, the Offeror shall provide the following information to the Department within in the time period identified in Appendix B, Disclosure of Breach, except when, despite all reasonable efforts by the Offeror to obtain the information required, circumstances beyond the control of the Offeror necessitate additional time. Under such circumstances, the Offeror 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:

1) the date of the breach incident;

2) the date of the discovery of the breach;

3) a brief description of what happened;

4) a description of the types of unsecured PHI that were involved;

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

6) a brief description of what the Offeror is doing to investigate the breach, to mitigate harm to individuals and to protect against any further breaches; and

7) any other details necessary to complete an assessment of the risk of harm to the individual.

iii. The Offeror will be responsible to provide 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 of the United States Department of Health and Human Services and the media, as required by 45 CFR Part 164.

iv. The Offeror 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.

v. The Offeror shall mitigate, to the extent practicable, any harmful effects from any use or disclosure of PHI by the Offeror not permitted by the resulting Contract.

h. Associate's Agents: The Offeror shall require all of its agents or Subcontractors to whom it provides the Department's PHI, whether received from the Department or created or received by the Offeror on behalf of the Department, to agree, by way of written contract or other written arrangement, to the same restrictions and conditions on the access, use, and disclosure of PHI that apply to the Offeror with respect to the Department's PHI under the resulting Contract.

i. Availability of Information to the Department: The Offeror shall make available to the Department such information and documentation as the Department may require regarding any disclosures of PHI by the Offeror to fulfill the Department's obligations to provide access to, provide a copy of, and to account for disclosures of the Department's PHI in accordance with HIPAA and its implementing regulations. The Offeror shall provide such information and documentation within a reasonable amount of time of its receipt of the request from the Department. The Offeror must provide the Department with access to the Department's PHI in the form and format requested, if it is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by the Parties, provided, however, that if the Department's PHI that is the subject of the request for access is maintained in one or more designated record sets electronically and if requested by the Department, the Offeror must provide the Department with access to the requested PHI in a readable electronic form and format.

j. Amendment of the Department's PHI: The Offeror 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 Offeror shall, as directed by the Department, incorporate any amendments to the Department PHI into copies of such Department PHI maintained by the Offeror.

k. Internal Practices: The Offeror 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 Offeror 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.

i. Termination: This Contract may be terminated by the Department at the Department's discretion if the Department determines that the Offeror, as a Business Associate, has violated a material term of this Section. Data return and destruction upon contract termination is governed by Information Security Requirements, Appendix C.

l. Indemnification: Notwithstanding the provisions in Appendix B, the Offeror agrees to indemnify, defend and hold harmless the State and the Department and its 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 section, Use and Disclosure of Protected Health Information, or from any acts or omissions related to this section by the Offeror or its employees, officers, subcontractors, agents or other members of its workforce, without limitations. Accordingly, the Offeror 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 Offeror's acts or omissions hereunder. The Offeror's obligation to indemnify any Indemnified Party shall survive the expiration or termination of this Contract. This section is not subject to the limitation of liability provisions of the Contract.

m. Miscellaneous:

    i. Survival: The respective rights and obligations of Business Associate and the "covered entities" identified herein under HIPAA and as set forth in this Section, USE AND DISCLOSURE

OF PROTECTED HEALTH INFORMATION, shall survive termination of the resulting Contract.

ii. 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, as of their respective compliance dates.

iii. Interpretation: Any ambiguity in the resulting Contract shall be resolved to permit covered entities to comply with HIPAA.