NEW YORK STATE OF OPPORTUNITY. Department of Civil Service

**ANDREW M. CUOMO**
Governor
**LOLA W. BRABHAM**
Acting Commissioner

June 24, 2020

**HEALTHCARE PROGRAM ADMINISTRATIVE SERVICES ONLY (ASO)** –
DRAFT REQUEST FOR PROPOSAL

To All Interested Parties:

The New York State Department of Civil Service (Department) has issued this draft Request for Proposal (Draft RFP) for comment by the vendor community and all other interested parties. The Draft RFP is issued for informational purposes to assist the Department in developing a Final RFP for this procurement. Proposals are NOT being requested or evaluated at this time. This announcement neither constitutes a request for proposal nor invitation for bid. Any proposals received in response to this Draft RFP will be discarded without review.

The Draft RFP seeks a vendor to provide comprehensive Administrative Services Only (ASO) for the healthcare program services offered through the New York State Health Insurance Program (NYSHIP) for the Empire Plan, the Excelsior Plan, and the Student Employee Health Plan. The required components of the ASO are detailed in Section 3 of the Draft RFP, and include Hospital, Medical, and Mental Health and Substance Abuse ("MHSA") benefits. This Draft RFP defines minimum contract requirements, details response requirements, and outlines the Department's process for evaluating responses and selecting a qualified vendor.

The Department does not anticipate posting responses to any comments, questions, suggested changes, and/or feedback received; however, all input will be considered in developing the Final RFP. Additionally, the Draft RFP is subject to change when preparing the Final RFP as a result of the Department's consideration of the input received in response to the Draft RFP.

Please be advised that although no Restricted Period has been established for the review of the Draft RFP, all interested parties must be aware of the requirements of the New York State Public Officers Law (POL), particularly POL sections 73 and 74, as well as all other provisions of NYS laws, rules and regulations, and policies establishing ethical standards for current and former State employees. Failure to comply with these provisions may result in disqualification from the procurement process, civil penalties, or criminal proceedings as may be required by law. Additional information can be found in the "Plain Language Guide to the Public Officers Law and Other Related Ethics Law" issued by the NYS Joint Commission on Public Ethics.

In addition, please be advised that the provisions of Project Sunlight, a part of the Public Integrity Reform Act of 2011, applies to the draft RFP. State entities are required to report appearances by individuals or firms before State decision-makers or persons who advise decision-makers. This applies to appearances related to a procurement between covered individuals that are for the purpose of procuring a State contract, without regard to whether a governmental procurement is anticipated. For further information see the "NYS Project Sunlight Policy" located at https://projectsunlight.ny.gov/Policy.pdf

The Department invites all interested parties to thoroughly examine the Draft RFP, appendices and attachments on the accompanying procurement website (https://www.cs.ny.gov/draft-ASO-RFP/) in their entirety and to submit comments in writing via the following email address: DCSprocurement@cs.ny.gov. It should be noted that no changes will be made to Appendix A, *Standard Clauses for New York State Contracts*.

The Department requests that all comments be submitted no later than July 22, 2020 to the address listed in section 2.1 of the Draft RFP.

Additionally, the Department will host a roundtable session on July 8, 2020 to facilitate further exchange of information on this Draft RFP. If you would like to participate in the roundtable session, please complete the attached form and return as indicated in section 2.1 of the Draft RFP no later than July 7, 2020.

Thank you for your assistance in this important endeavor. The Department looks forward to receiving your considered comments on the Draft RFP.

Sincerely,

Brian Bopp

Assistant Director of Financial Administration

**NYS Department of Civil Service**
**"Healthcare Program Administrative Services Only"**

Registration for Vendor Roundtable

(Please PRINT Firm's Name Above)

Please register the following individuals for the Vendor roundtable to be held on the draft RFP on Healthcare Program Administrative Services Only. Information on the virtual meeting will be separately provided.

Please submit this form as indicated in section 2.1 of the Draft RFP.

| *(print)* Name | Email address |
|---|---|
| *(print)* Name | Email address |
| *(print)* Name | Email address |

*Please add lines as needed.*

# REQUEST FOR PROPOSALS

ENTITLED:

## "Healthcare Program Administrative Services Only (ASO)"

RELEASE DATE:

**TBD**

PROPOSAL DUE DATE:

**TBD**

**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 of this RFP and shall be in compliance with the Procurement Lobbying Law and the NYS Department of Civil Service "*Rules Governing Conduct of Competitive Procurement Process*" (refer to RFP, Section 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

Lola Brabham
Acting Commissioner
NYS Department of Civil Service

James DeWan
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) for medical program services offered through the New York State Health Insurance Program (NYSHIP) for the Empire Plan, the Excelsior Plan, and the Student Employee Health Plan (SEHP).

The RFP seeks to obtain the services of a vendor to provide comprehensive Administrative Services Only (ASO). The required components of the ASO are set forth in detail in Section 3. For purposes of this RFP, Medical Program Services (the Program) consists of Hospital, Medical, and Mental Health and Substance Abuse (MHSA) benefits. This RFP defines minimum contract requirements, details response requirements, and outlines the Department's process for evaluating responses and selecting a qualified Organization (Offeror).

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/HealthcareProgramServicesRFP/

## 1.2 Period of Performance

1. In accordance with State policy and 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). The Contract shall commence upon approval by OSC. The Contract term will commence with an implementation period which shall consist of at least 180 calendar days. The Parties agree that "time is of the essence" with regard to the completion of the implementation period.
2. "Implementation Period" is defined as the time period that commences with approval of the Contract by OSC up to but not including the Full ASO Services date. Unless otherwise agreed to in writing by the Parties, the Implementation Period shall be no less than 180 Calendar Days. The Implementation Period must be completed by December 31, 2021, unless section 1.2.4 applies. Effective January 1, 2022, the Contractor shall commence Full ASO Services. "Full ASO Services" is defined to mean the commencement of Contractor's obligation to provide all Project Services.
3. The Contract term will consist of the Implementation Period plus eight years with an option to renew for up to five years in any combination that the Department chooses. For example, if OSC approves the Contract on April 3, 2021, then the Implementation Period will commence on April 3, 2021 and end on December

31, 2021. Full ASO Services would commence January 1, 2022. The resulting Contract Term would be April 3, 2021 through December 31, 2030 (Implementation Period plus eight years from the commencement of Full ASO Services), subject to renewal for up to five years.

4. However, if OSC does not approve the Contract on or before June 30, 2021, then the Implementation Period shall end by the next December 31st after a minimum of 180 calendar days from OSC approval. For example, if OSC approves the Contract on October 15, 2021, then the Implementation Period would commence on October 15, 2021 and end on December 31, 2022. Full ASO Services would commence on January 1, 2023. The Contract Term would be October 15, 2021 through December 31, 2031 (Implementation Period plus eight years from the commencement of Full ASO Services), subject to renewal for up to five years.

## 1.3 Overview of 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 dependents. Public authorities, public benefit corporations, and other quasi-public entities, such as the NYS Thruway Authority and the Dormitory Authority, may choose to participate in NYSHIP; those that do are called Participating Employers (PEs). NYS Civil Service Law section 163 also allows local units of government such as school districts, municipal corporations, and special districts (examples include water districts, fire districts, and library districts) to participate in NYSHIP. Local government units that choose to participate in NYSHIP are called Participating Agencies (PAs).

NYSHIP is sponsored by the Council on Employee Health Insurance (Council). The Council is composed of the President of the Civil Service Commission, the Director of the Governor's Office of Employee Relations (GOER), and the Director of the Division of the Budget (DOB).

NYSHIP is currently comprised of four health insurance plans:

1. The Empire Plan provides health insurance benefits for the employees, retirees, and eligible dependents of NYS and NYSHIP PAs and PEs. It pays for covered hospital services, physicians' bills, prescription drugs, and other covered medical expenses. The Empire Plan, which became fully self-funded as of January 1, 2014, has the highest level of enrollment, with over a million covered lives of the approximate 1,241,000 NYSHIP enrollment. Presently, the Empire Plan benefit design consists of four (4) main components that are currently administered under separate contracts:

    a. Hospital Program benefits, administered by Empire BlueCross BlueShield, include coverage for hospital inpatient stays, hospice care, emergency care, skilled nursing facilities, infertility services, and the Transplants Program.

b. Medical Program benefits, administered by UnitedHealthcare Insurance Company of New York, include coverage for medical and surgical services under the Participating Provider and the Basic Medical Program. Coverage also includes specialty programs such as the Managed Physical Medicine Program and the Home Care Advocacy Program (HCAP).

c. Mental Health and Substance Abuse Program benefits, administered by Beacon Health Options, include coverage for network and non-network services.

d. Prescription Drug Program benefits, administered by CVS Caremark, include coverage for prescription drugs dispensed through retail network pharmacies, the Mail Service Pharmacy Process, and the Specialty Pharmacy Program.

2. The Excelsior Plan is a variation of the Empire Plan available to NYS 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 PEs.

4. The 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 abuse benefits, and prescription drug benefits. The Department's Employee Benefits Division administers SEHP.

All plans are offered on a calendar year basis. The Department holds the contracts with the Program administrators.

## 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 NYS, 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 NYS with the New York State Secretary of State. Such application must be approved prior to Contract Award. (For details concerning this requirement, refer to: http://www.dos.ny.gov/corps/forms_listing.html. 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 managing comprehensive group health insurance plans for, in aggregate, a minimum of five million (5,000,000) total covered lives in its full book of business,

5. As of the Proposal due date the Offeror must have experience managing a self-funded comprehensive group health insurance plan.

6. As of the commencement of the Implementation Period, the Offeror shall: retain operational, clinical account and management team staff with the appropriate experience relevant to the duties and responsibilities outlined in Section 3 of this RFP; establish appropriate minimum qualifications for individuals filling positions slated to service the Empire Plan in the future; and possess the necessary account services, enrollment, claims processing, clinical management, Clinical Referral Line (CRL), and customer service staff levels, located in facilities within the Continental United States, to service the Empire Plan.

7. 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.

8. 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 Appendices A, B and C. Such records shall include any and all financial records deemed necessary by the State to discharge its fiduciary responsibilities to Program participants and to ensure that public dollars are spent appropriately.

9. No later than 30 Calendar Days prior to commencement of the Full ASO 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 of this RFP.

10. 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)(f) requiring the Offeror to propose a financial guarantee supporting its commitment to satisfy all implementation requirements.

## 1.5 Timeline of Key Events

| EVENT | DATE |
|---|---|
| RFP Release Date | TBD |
| Deadline for Submission of Offeror Affirmation of Understanding | See below* |
| Pre-Proposal Conference | TBD (21 Calendar Days after RFP Release Date) |
| Deadline for Submission of Offeror Questions | TBD (10 Calendar Days after Pre-Proposal Conference) |
| Release Date of Official Responses to Offeror Questions | TBD (7 Calendar Days after Submission of Offeror Questions) |
| Proposal Due Date and Time | TBD (60 Calendar Days after RFP Release Date) |
| Anticipated Technical Management Interviews | TBD (35 Calendar Days after Proposal Due Date) |
| Anticipated Tentative Contract Award | TBD (45 Calendar Days after Technical Management Interviews) |
| Anticipated Implementation Period Start Date | TBD (no less than 180 Calendar Days after contract approval by OSC) |
| Full ASO Services Start Date | January 1, 2022 |

*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 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 contact information 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 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.

   Brian Bopp
   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 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 21 Calendar Days after the RFP Release Date at 10:00 a.m. in the Swan Street Building, Core 1, Room 2106, Albany, NY and/or using a virtual platform. Attendance is not mandatory but is strongly encouraged for Offerors intending to submit a Proposal. Each Offeror is requested to send no more than two (2) representatives to the Pre-Proposal Conference. If Offeror's organization plans to attend the Pre-Proposal Conference, please notify the Designated Contact identified in Section 2 of this RFP via e-mail at the address noted in Section 2 at least 24 hours before the conference with the name and affiliation of each person attending. Information regarding directions to the Empire State Plaza, available parking and security requirements, may be found at https://empirestateplaza.ny.gov/. On the date of the conference, visitors may be required to present photo identification. Prospective Offerors are advised to allow sufficient time to go through security.

## 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 (5) 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 9:00 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 of this RFP.

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

**"Submission of Errors or Omissions for the Healthcare Program Administrative Services Only (ASO) 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 (20) Business Days after the close of the review process. If additional time for the issuance of the decision is necessary, the prospective Offeror shall be

advised of the delay and of the time frame within which a decision may be reasonably expected. The Commissioner's decision will be communicated to the party in writing and shall constitute the agency's final determination in the matter.

The Department reserves the right to determine and 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/HealthcareProgramServicesRFP/.

## 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 of this RFP. Only those questions received prior to the Questions Due Date specified in Section 1 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/HealthcareProgramServicesRFP/.

## 6. Submission of Proposal

a. The Offeror's Proposal must be organized and separated into (3) 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 two (2) hard copy versions of each of the three (3) 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 sixteen (16) additional USB drives, eight (8) of which each contain an electronic copy of the Administrative and Technical Proposal ONLY, and eight (8) of which contain the Financial Proposal ONLY. The USB drives must conform to the technical specifications outlined in Section 2 of this RFP. Each of the sixteen electronic copies should be labeled by section and uniquely designated with a number (e.g. "TECHNICAL & ADMINISTRATIVE COPY 1", "TECHNICAL & ADMINISTRATIVE COPY 2, etc."). The eight (8) USB drives that contain the Financial Proposal should be packaged in the sealed box/envelope labeled Financial Proposal. The eight (8) USB drives that contain the Administrative and Technical Proposals should be packaged in the sealed box/envelope labeled Administrative Proposal.

v. *Top In-Network Procedure Codes by ZIP Codes – Non-Medicare Fees* (Attachment 16), *Top MHSA In Network Procedure and Revenue Codes by ZIP Codes – Non-Medicare Fees* (Attachment 17), and *Top In-Network Revenue Codes by ZIP Codes – Non-Medicare Fees* (Attachment 18) must be submitted in electronic format. Paper copies will not be accepted.

vi. Each Proposal must include a table of contents.

vii. 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.

viii. 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**
**"Healthcare Program Administrative Services Only (ASO)"**

**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(6)(b) of this RFP. To make arrangements for hand-delivery, the Offeror must notify the Designated Contact twenty-four (24) 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 to Appendix B and C* (Appendix C-1). NYS 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 Offeror has an issue or concern regarding provisions in the solicitation and is considering submission of a proposal containing a bid deviation, 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. 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, unless specifically required by the solicitation to be submitted as part of 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.

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. 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 ten (10) Business Days 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 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 Healthcare Program Administrative Services Only (ASO)"**

**OR**

**"Submission of Tentative Award Protest for Request for Proposals Healthcare Program Administrative Services Only (ASO)"**

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 (20) 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/HealthcareProgramServicesRFP/;

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, information obtained through any site visits, 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;

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 not revocable for a minimum period of three hundred sixty- five (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. Disclaimer**

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 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 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 Attachment 11 and submitting it to the Department at the time of its Proposal submission, but separately from its Proposal. If a completed 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 (3) 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 using the Redaction Function in Adobe Acrobat Professional software, version 8 or higher. Each specific portion of the Proposal documents requested to be protected from FOIL disclosure must be identified using the Adobe "Mark for Redaction" function; do not use the "Apply Redactions" function. The resulting documents must show the Offeror's requested redactions as outlined, while the content remains visible. This will allow the Department to either apply or remove requested redactions when responding to FOIL requests. The documents included on the 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 NYS 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 and Non-Collusive Bidding Certification. It also sets forth the certifications regarding compliance with the Federal Americans with Disabilities Act, compliance with the NYS Public Officers Law, certification required under NYS Procurement Lobbying Law, certification required under Executive Order No. 177 and certification required by New York State Finance Law section 139-l regarding written sexual harassment policies.

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 NYS, an Offeror for this RFP is strongly encouraged and expected to consider NYS businesses in the fulfillment of the requirements of the Contract. Such partnering may be as subcontractors, suppliers, protégés, or other supporting roles.

## SECTION 3: PROJECT SERVICES

The Department is seeking a qualified Offeror to provide comprehensive Project Services administered on an ASO basis for Hospital, Medical and MHSA benefits for the Empire Plan, Excelsior Plan and SEHP. Delivery of Project Services will impact over one million covered lives.

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

- Medical Program Services consisting of hospital, medical, and mental health and substance abuse services through a contracted nationwide provider network;
- Comprehensive administration services including customer service, claims processing and reporting;
- Coordinated ancillary services including disease management; and Centers of Excellence for cancer, infertility and transplants; and
- Clinical referral line for MHSA and a NurseLine$^{SM}$, and both services must be operational 24 hours a day, seven days a week.

### 3.1 Account Team

The Offeror must provide a knowledgeable, experienced account leader and team dedicated solely to the Empire Plan, the Excelsior Plan and the SEHP Medical Program who have the responsibility and authority to command the appropriate resources necessary to implement and deliver Project Services.

1. **Duties and Responsibilities**

    a. The Contractor's assigned 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 (2) Business Days to the satisfaction of the Department.

    b. The proposed Account Team must guarantee that the Empire Plan, the Excelsior and SEHP comply 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 the proposed Account Team immediately notify the Department of actual or anticipated events impacting Plan costs and delivery of services to Enrollees, including proposed legislative or

statutory requirements. Enrollees for purposes of this RFP are defined as the policyholder.

## 3.2 Implementation Plan

The Offeror must deliver an overall Implementation Plan and designate an Implementation Team composed of individuals knowledgeable in the requirements of a large client comparable to those of the Department. Implementation activities must be completed no later than December 31, 2021, so that Full ASO Services can commence for the Empire Plan, the Excelsior Plan, and the SEHP on January 1, 2022[1].

### 1. Duties and Responsibilities

a. The Offeror must be committed to working with the Department to analyze and document Department needs.

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

c. The Offeror must, by the commencement of Full ASO Services be operationally ready as described by, but not limited to, the following:

i. The Offeror must have a network, as contracted, that meets or exceeds the required access standards set forth in Section 3.11 of this RFP in place.

ii. The Offeror must have a fully operational, dedicated Call Center available for the use of Members and benefits administrators. As detailed in Section 3.5(1)(b), the dedicated Call Center must be open a minimum of forty-five (45) Calendar Days prior to the commencement of Full ASO Services. Members, for purposes of this RFP, are defined as all policyholders and their dependents.

iii. The Offeror must have the ability to accurately process all claims, as submitted, across all Program components.

iv. The Offeror must have clinical management programs, as described in sections 3.15 through 3.20, operational and ready to support the Program as set forth in Section 3 of this RFP.

v. The Offeror must have a fully functioning, customized Empire Plan website available for a minimum of forty-five (45) Calendar

[1] Unless the provisions of section 1.2.4 are applicable.

Days prior to the commencement of the Full ASO Services.

d. 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.

e. The Offeror shall provide a comprehensive operational readiness review, at least ninety (90) Calendar Days prior to the Full ASO Services date, which may include an onsite assessment or review of documentation, policies and procedures required to assess the Offeror's readiness in the following areas: call center scripting; IT systems connectivity; website development; and claims processing.

f. 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 December 31 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 forty-five (45) Calendar Days prior to the Full ASO Services date. The customized website must be live and operational at least forty-five (45) Calendar Days prior to the Full ASO Services 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 create, review, and distribute Plan materials in digital and hardcopy. All Member communications developed by the Offeror are subject to the Department's review and prior written approval. This includes regular standardized direct communication with Members or their Providers in connection with covered benefits 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.

Program communications materials that the Offeror will be required to create and distribute can be found in the *NYSHIP Communications Catalogue* (Attachment 25) and *NYSHIP Communications Print and Mail Volumes* (Attachment 24).

## 1. Duties and Responsibilities

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

   i. Developing language detailing the Program benefits for inclusion in various publications including but not limited to the NYSHIP *General Information Book*, *Empire Plan Certificate*, and Plan *At A Glance* documents;

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

   iii. Timely reviewing and commenting on proposed 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 Plan website to view the SBC or distribute a copy of the SBC to the Member within the federally required period; and

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

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

c. Upon the Department's request, on an "as needed" basis, the Offeror agrees to provide staff to participate in health fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. Please see *2019 Health Fair and Events* (Attachment 20) for a calendar year summary of these events. 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.

d. The Offeror shall develop the Empire Plan Participating Provider Directories on an annual basis as required by NYS Law. 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.

e. The selected Offeror must provide a 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 based on geographic location, name, or specialty. The directory must detail all Provider information as required by State and federal law. Information about all types of Providers in all geographic locations shall be accessible through this single link and search functions, including a link to Providers available through the Basic Medical Provider Discount Program. 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 Providers (a practitioner that has entered into a network agreement with the Contractor) and facilities, including if the Provider is accepting new patients. Presently, Plan Providers can be found by accessing the Department's website at http://www.cs.ny.gov. Under Benefit Programs select NYSHIP online, choose a group, choose Empire Plan Enrollee, and then Find a Provider, to access the directory.

f. The selected Offeror is required to provide Member and plan sponsor 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 (1) 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 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 Directors; and

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

g. The fully functioning, customized Program Benefits website approved and accepted by the Department must be available a minimum of forty-five (45) Calendar Days prior to commencement of the Full ASO Services 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)(f) of this RFP.

h. The Offeror must provide staff to support the communications needs of the Program. No fewer than seven staff shall be needed to work full-time with the Communications Unit of the Department's Employee Benefits Division. Health insurance benefits communications experience is preferred, but all such staff must meet the following minimum qualifications:

i. Bachelor's degree in English, Communications or related discipline;

ii. 5+ years' relevant experience managing complex projects to completion;

iii. Extensive experience with Microsoft Office Suite and Adobe Creative Suite;

iv. Strong writing, editing and proofreading skills; and

v. Ability to perform well in a fast-paced environment and produce high-quality work under tight deadlines.

i. The Offeror must employ dedicated personnel to provide technical support, including any programming, maintenance or related services, to support

the Program's websites including NYSHIP Online, the Program's portion of the Department's public website (www.cs.ny.gov/employee-benefits) and HBA Online (www.cs.ny.gov/employee-benefits/hba), the Program's secure administrative website. The Offeror shall make recommendations for website redesign and improvements that comply with State standards and accessibility guidelines.

## 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 24 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 Plan 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, access and utilization reports as specified in *Program Reporting* (Attachment 21). These reports will be delivered to the Department no later than respective due dates and are required by the Department for its use in the review, management, monitoring and analysis of the 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 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. Coordinating with the Prescription Drug Program administrator, and outside entities, including the Department's data warehouse provider, in the exchange of information to meet the Program's reporting requirements as directed by the Department, and required by applicable State and federal laws, regulations, and requirements;

v. Reporting Centers of Excellence (COE) utilization data on a quarterly basis to the Department. The Department will be notified should a provider not meet standards and facility participation will be provided annually to the Department;

vi. 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 22));

7) Reports to monitor Contract compliance; and

8) Reports surrounding new Program proposals and initiatives.

## 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 Empire Plan Consolidated Toll-Free Number shall include a prompt for the Prescription Drug Program. The average number of calls received per month in 2019 by the Hospital Program was approximately 25,300; the average number of calls received per month by the Medical Program in 2019 was approximately 100,000, including calls placed to a separate toll-free line maintained by the Medical Program administrator for Department employees to directly transfer calls; the average number of calls received per month in 2019 by the Empire Plan Nurseline$^{SM}$ was approximately 4,600; and the average number of calls received per month in 2019 for the MSHA Program was 14,300. Detailed call center statistics can be found in *Call Center Statistics* (Attachment 23). 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 an Empire Plan Consolidated Toll-Free Number, which must use the present telephone number 1-877-769-7447 (1-877-7NYSHIP) or other designated number. This consolidated number allows Members and Providers access to each of the respective components of the Plan. The Offeror shall establish a set of prompts accessible through the Empire Plan Consolidated Toll-Free Number and dedicated phone lines as required, to direct inquiries by caller type (e.g., a Member or Provider), as well as, by program type (e.g., Centers of Excellence Programs).

   b. Maintaining a fully operational dedicated Call Center, including an MHSA Clinical Referral Line, Benefits Management Program, and Prospective Procedure Review, 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 forty-five (45) Calendar Days prior to the commencement of the Full ASO Services 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 Plan. The Call Center shall be staffed by trained customer service representatives available during the required customer service hours of operation.

      i. The Offeror must maintain a dedicated Call Center staffed by

fully trained customer service representatives (CSRs) and supervisors available during Business Hours, defined as 8:00 AM to 5:00 PM, Monday through Friday, Eastern Time (ET), except State Holidays.

ii. 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.

iii. 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.

iv. Customer service staff 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.

v. The Offeror must maintain designated backup customer service staff with Plan 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.

vi. The Offeror will be responsible for performing a customer satisfaction survey at least once a year. Any survey performed must be reviewed first by the Department.

vii. The Offeror must record every call in a format acceptable to the Department and maintain at least one-year retention for recordings of both inbound and outbound calls.

viii. Calls must be able to be transferred from other third-party phone lines. The ability to provide uninterrupted access, even during a primary telephone system failure, is a requirement.

ix. The Offeror must provide support and maintenance of the telephone line 24 hours a day, 7 days a week.

x. The Offeror must guarantee the toll-free vendor establishes prompts for the Prescription Drug Program to route program-specific Member calls. The Offeror must implement capability for the Prescription Drug Program vendor to connect to the system without additional expense. The Offeror must prepare and enter into a shared service agreement with the toll-free vendor and the Prescription Drug Program vendor to address billing and maintenance issues with the provision of the Empire Plan Consolidated Toll-Free Number.

xi. The Offeror must send telephone scripting to the Department for approval.

c. Offering a separate toll-free line or method of "warm transfer" for calls received by Department customer service representatives where Plan Members have direct access to a customer service representative.

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

i. Call Center Response Time Guarantee: The Plan's service level standard requires that, at a minimum, ninety percent (90%) of incoming calls to the Medical, Hospital, and MHSA programs will be answered by a call center representative within sixty (60) seconds. Please note that this guarantee is separate from the Clinical Referral Line guarantees in Section 5.5(16) of this RFP. 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;

ii. Availability Guarantee**:** The Plan'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 ninety-nine and five-tenths (99.5%) of the Offeror's required up-time (24 hours a day, 7 days a week, of which the hours between 8:00 AM to 5:00 PM, Monday through Friday must be staffed by in-person operators per section 3.5(1)(b)(i)). The telephone line availability shall be reported monthly and calculated quarterly;

iii. First Call Resolution Guarantee**:** The Plan's service level standard requires that 95% of all customer service calls are resolved with one call. The Offeror will report first call resolution

statistics monthly. First Call Resolution is defined as the ability to resolve a customer's issues, questions or needs the first time a customer calls with no follow-up required.

iv. Open Inquiry Closure Guarantee**:** The Plan's service level standard requires that 90% of open inquiries are resolved within two (2) Business Days and 98% within (5) five Business Days. The Offeror will report open inquiry closures statistics monthly.

v. Telephone Abandonment Rate Guarantee: The Plan'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 three percent (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.

vi. Telephone Blockage Rate Guarantee**:** The Plan's service level standard requires that not more than three percent (3%) 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.

e. The Offeror must provide access to a Nurseline$^{SM}$ for Medical Services that allows Members to contact a Registered Nurse (RN) 24 hours a day, 7 days a week, at no additional cost to the Department. Members call the Empire Plan Consolidated Toll-Free Number to access the service and receive health information, education, and support services to help individuals choose the most appropriate treatment at the right time. The Offeror must provide a staff of RNs with a thorough understanding of Plan benefits and requirements. Staff should have the ability to direct Members to Participating Providers and make referrals to appropriate Plan Programs. Peak calls times as reflected by current utilization are between 9:00 AM and 4:00 PM ET, Monday through Friday. Members must also receive information, such as an annual postcard reminder, that the Nurseline$^{SM}$ is an available benefit.

f. Members are strongly encouraged to seek clinical referrals prior to receiving MHSA 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. The CRL is staffed by clinicians, 24 hours a day, 7 days a week, who determine the medical appropriateness of MHSA care and direct Members to the most appropriate Network Provider and level of care.

The CRL is a menu option within the MHSA portion of the Empire Plan Consolidated Toll-Free Number. For purposes of the MHSA Program, a Clinician is a: Psychiatrist; Psychologist; licensed and registered clinical social worker with at least three (3) years of post-degree experience who qualifies for the New York State Board for Social Work "R" designation; Licensed Marriage and Family Therapists; Licensed Mental Health Counselor; 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 MHSA care needs and direct the Member to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate a Clinician's assessment of the callers, MHSA 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 a Non-Network Facility for treatment and the Offeror is notified in advance of the admission, the Offeror must provide the Member, or other Health Insurance Portability and Accountability Act (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 a Non-Network Facility when the initial determination of medical necessity occurs;

iv. Preparing and sending communications to notify Members and/or their Providers of the outcome of their Pre-certification or prior authorization request and notifying them in writing of the date through which MHSA Project 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, and managing the Member's care if transferred to rehabilitative care;

vii. Upon denial of Pre-certification for Inpatient care, the Offeror is required to provide 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 (24) 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

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

1) Non-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 which meets the Member's clinical needs, a referral will be made to an appropriate MHSA Non-Network Provider or program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases.

2) Emergency CRL Guarantee: One hundred percent (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 (30) minutes to assure their safety. Additionally, one

hundred percent (100%) of Members in need of non-life-threatening emergency care shall be contacted by a Network Provider or re-contacted by the CRL Clinician within thirty (30) minutes of the Member's call to the CRL.

3) Urgent Care CRL Guarantee: At least ninety-nine percent (99%) of Members in need of urgent care will be contacted by the Offeror to ensure that the Network Provider contacted the Member within forty-eight (48) hours of the Member's call to the CRL.

## 3.6 Enrollment Management

The Offeror must be able to administer the Department NYSHIP's Member eligibility definitions and provisions. The Plan requires the Offeror to ensure the timely addition of enrollment data as well as cancelation of benefits in accordance with the Plan's eligibility rules. The Offeror shall use a Department-provided enrollment system in performing its services. The Department reserves the right to change or modify the enrollment system at any time.

Currently, the Department utilizes a web-based enrollment system for the administration of employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, the Excelsior and SEHP Members. Enrollment information is outlined in *Enrollment by Month* (Attachment 27) *Total Empire Plan and SEHP 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 Plan 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 (24) 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 (24) 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 (24) hour period. The Offeror must be capable of loading all enrollment files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 standard 005010x220 transaction set in the format specified by the Department. The latest transaction format is contained in *NYBEAS Enrollment Record Layout - Transaction Set Header* (Attachment 30). 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 (see *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 Clinical

Referral Line 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 Plan enrollment information. Offeror's staff must be available to access enrollment information through the Department-provided enrolment system, Monday through Friday, from 8:00 am to 5:00 pm, 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), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the 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 NYS including, but not limited to, health benefits administrators for NYS agencies, PEs, and PAs;

x. Agreeing to the State-defined Eligibility Periods;

xi. Administering insurance coverage for any employee and their 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 subscribers to join the plan, change coverage, or add eligible dependents; and

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

b. The Offeror is required to:

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

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

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

iv. Maintain 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 (1) Business Day of discovery;

v. Report to the Department data changes of name, date of birth, gender, or Health Insurance Claim Number (HICN) from the federal Centers for Medicare and Medicaid Services so that the Department can update its system as appropriate to report these changes on the eligibility enrollment file; and

vi. Report 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.

c. Enrollment Management Guarantee: The Offeror must guarantee one hundred percent of all Plan enrollment records that meet the quality standard for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department.

## 3.7 Claims Processing

The Offeror must process all claims submitted under the Plan, 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, Plan provisions and negotiated agreements with Providers. The Offeror must coordinate benefits in order to prevent an overpayment and to avoid duplicate benefit payments so that total payment under the Plan is not more than the Plan'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 31).

To be covered, Member-submitted claims are required to be submitted to the Offeror no later than one hundred twenty (120) days after the end of the calendar year in which the service was rendered, or one hundred twenty (120) days after another plan processes the claim, unless it was not reasonably possible for the Member to meet this deadline. The Plan count of claims can be found in *Empire Plan Number of Paid Services and Claims* (Attachment 26) of this RFP.

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 Plan'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, prior authorization, concurrent review and benefit maximums. Any customizations made by the Offeror to their system during the term of the Contract to accurately process claims for the Plan shall not be charged to the Department;

        iii. Payment of claims based on a definition of medical necessity. Please refer to the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31);

        iv. 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;

        v. Maintaining claims histories for 24 months online and archiving older claim histories for a minimum of six (6) years and the balance of the calendar year in which they were made with procedures to retrieve and load claim records easily;

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

vii. 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., Disease Management) and the Department's Decision Support System 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;

viii. 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;

ix. 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 Plan the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Member in instances where a claim is paid in error due to Offeror error, or due to fraud or abuse, without additional administrative charge to the Plan. 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 Plan upon receipt;

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

xi. Providing Members with hardcopy Explanation of Benefits (EOBs) in accordance with New York State Insurance Law §3234. 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 claims via the Offeror's Program Benefits website. At a minimum, EOBs will include the following information:

1) Type of service;

2) Date of service;

3) Amount billed;

4) Amount plan paid;

5) Amount Enrollee owes;

6) Copayment, Deductible and Coinsurance responsibility;

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

8) Summary of Managed Physical Medicine Deductible;

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

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

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

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

13) Telephone number to call if Enrollee has questions about claims.

xii. When the Plan is secondary to any other plan, the Offeror shall reduce 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; and

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

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

i. Claims Payment Accuracy Guarantee: The Plan's service level

standard requires that claims payment accuracy is achieved for a minimum of ninety-seven percent (97%) 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 ninety-five percent (95%) confidence level with precision of +/- three percent (3%).

ii. Claims Processing Guarantee – fourteen (14) Day Turnaround Time: The Plan's service level standard requires that a minimum of ninety-two percent (92%) of submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror are processed within fourteen (14) Calendar Days from 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 a payment/statement is sent to the Member.

iii. Claims Processing Guarantee – thirty (30) Calendar Days Turnaround Time: The Plan's service level standard requires that a minimum of ninety-nine percent (99%) of submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror are processed within thirty (30) days from 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 a payment/statement is sent to the Member.

iv. Claims Data Submission Guarantee: The Offeror must submit a file including all processed claims to the Department's Decision Support System (DSS) vendor no later than twelve (12) Calendar Days following the end of each calendar month.

## 3.8 Plan Audit and Fraud Protection

The protection of the Plan 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 NYS Insurance Law, provides a framework and sets forth certain requirements related to fraud and fraud prevention. 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, 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 Plan'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 (7) Business Days of receipt of such allegations or identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the 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 consistent with the requirements of Appendices A, B and 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 (15) 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 agreed upon audit findings that are the responsibility of the Offeror within thirty (30) 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 (30) days of receipt. Remittances shall be credited to the subsequent Administrative Fee invoice.

## 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 Plan provides Members with two internal appeal levels and an external appeal process. In 2019, the Medical Program received over 10,000 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 Plan's appeal process, see information found within the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31)

1. **Duties and Responsibilities**

    a. 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. 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. Establish two levels of internal administrative appeals, as defined by New York State Insurance Law section 4900 et seq, for urgent and non-urgent appeals, strictly adhering to notification guidelines established as follows:

        i. A level two (2) appeal for administrative matters. Administrative matters will be performed by an employee of the Offeror that has the requisite authority to resolve Member appeals and did **not** review the initial appeal.

    d. Establish two levels of internal clinical appeals, as defined by New York State Insurance Law section 4900 et seq, for urgent and non-urgent, as follows:

        i. A level 2 clinical appeal must be conducted by the Plan's Medical Director or designated Physician for medical/facility appeals, and panel of two board-certified psychiatrists and a Clinical Manager for MHSA appeals. Reviewers must not have been involved in the previous determinations of the case.

## 3.10 Medicare Coordination and Secondary Payment

The Department requires that the Offeror coordinate and comply with the requirements of the Centers for Medicare and Medicaid Services (CMS); this includes complying with

Medicare Crossover and all Medicare Secondary Payor Mandatory Reporting and data matching established and required by CMS. Medicare Crossover is defined as the process by which Medicare, as a primary insurance carrier for some Members, automatically forwards Medicare Part B claims to the Offeror for processing. The Department also receives demand summary notices from Medicare for claims that Medicare believes were paid in error. In 2019, the Department received 295 demand summaries totaling over $4.5 million, and in 2018, the Department received 217 notices totaling over $104.7 million.

The Offeror shall also be required to provide the appropriate benefit level to Members diagnosed with end-stage renal disease (ESRD) and adjudicate claims as per Medicare Secondary Payor Rules and regulations. Information about Medicare and ESRD as related to the Plan can be found in the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31).

**1. <u>Duties and Responsibilities</u>**

a. The Offeror shall have in place a contract to provide Medicare Crossover and will participate in Medicare Crossover by accepting electronic claims data files from Medicare for Members that have Medicare as primary coverage.

b. The Offeror shall properly identify and process all Medicare claims for consideration of secondary Plan coverage. Inaccurate or unclear claim submissions shall be rejected and a request for clarification shall be sent to the sender.

c. The Offeror shall automatically enroll Members into Medicare Crossover in the state where the Member resides unless the Member opts out by contacting the Offeror.

d. The Offeror shall properly adjust claims for those Members required to enroll in Medicare Part B but have not done so. The Offeror shall not pay any portion of claims that Medicare Part B would have paid if the Member was enrolled when required, and shall determine the amount Medicare would have paid for a specific service if the Member is not enrolled in Medicare Part B or uses a provider who is not covered under Medicare

e. The Offeror shall propose a notification system to alert the Department to those members who have not yet enrolled in Medicare Part B but appear to be required to do so.

f. Upon direction from the Department, in certain cases, Members will be "held harmless" for their failure to enroll timely into Medicare Part B. The Offeror shall adjust claims and transmit proper payment to Providers as directed by the Department.

g. The Offeror shall manage demand notice requests from CMS. Once Medicare initiates a demand, the first priority is given to Treasury demand notices, and then the priority moves to notices with the earliest payment due date. The Offeror must research all notices forwarded by the Department, and either submit defenses for those claims that have already been paid or submit payment for charges due. The Offeror shall adhere to Department policy on payment of demand notices.

h. The Offeror shall request lien releases from Medicare on behalf of the Department.

i. The Offeror shall identify Members with ESRD and accurately pay claims for those Members.

j. The Offeror shall notate Member files to reflect the date when Medicare will be primary for the Member and then notify the Department of Members identified and confirmed as ESRD.

## 3.11 Provider Network

Provider Network means the Offeror's credentialed and contracted network of practitioners and network facilities. The selected Offeror must have in place a comprehensive, nationwide Provider Network to allow access to a broad network both within New York State where most Plan Enrollees reside and throughout the United States. In addition, the Department expects the Offeror to maintain industry standards in the health care delivery system to make quality care available while providing cost containment measures. The Plans currently monitor key quality and utilization metrics, supports value-based contracting, and participates in regional healthcare initiatives.

### 1. Duties and Responsibilities

a. The Offeror's proposed MHSA 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 Mental Health Counselors, Licensed Marriage and Family Therapists, Physician Assistants, Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Addiction Services and Supports (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers

throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Contract are fully satisfied.

b. 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 Enrollee accessibility.

c. Network Access Guarantees. From the first day of the month following the commencement of Full ASO Services and throughout the term of the Contract, the Offeror's Provider Network must meet or exceed the Department's minimum access standards as follows. Facilities and Providers must be contracted for participation to commence Full ASO Services. [**Note:** In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no Enrollee may be excluded even if a Provider is not located within the minimum access area.] Urban, Suburban and Rural classifications are based on United States Census Department classifications.

    i. **URBAN AREAS**: Ninety percent (90%) of Enrollees will have at least:

        1) two (2) Chiropractors within three (3) miles;

        2) two (2) Occupational Therapists within three (3) miles;

        3) two (2) Physical Therapists within three (3) miles;

        4) two (2) Primary Care Physicians within five (5) miles; primary care physician is defined as a Family Practitioner, General Practitioner, and a Doctor of Internal Medicine;

        5) two (2) Pediatricians within five (5) miles;

        6) two (2) Obstetricians/Gynecologists within five (5) miles;

        7) two (2) Specialty Physicians within five (5) miles as applied to each separate category: Allergy, Anesthesia, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, Hematology/Oncology, Neurology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pulmonary Medicine, Radiology, Rheumatology, and Urology;

        8) one (1) Hospital within five (5) miles;

9) two (2) Psychiatrists within three (3) miles;

10) two (2) Psychologists within three (3) miles;

11) two (2) Substance Abuse Counselors within three (3) miles;

12) two (2) Psychiatric Residential Facilities within five (5) miles;

13) two (2) Substance Abuse Facilities within five (5) miles;

14) two (2) Licensed Social Workers within three (3) miles; and

15) two (2) All Other Master's Level Counselors within three (3) miles.

ii. **SUBURBAN AREAS:** Ninety percent of Enrollees will have at least:

1) two (2) Chiropractors within eight (8) miles;

2) two (2) Occupational Therapists within eight (8) miles;

3) two (2) Physical Therapists within eight (8) miles;

4) two (2) Primary Care Physicians within eight (8) miles; primary care physician is defined as a Family Practitioner, General Practitioner, and a Doctor of Internal Medicine;

5) two (2) Pediatricians within eight (8) miles;

6) two (2) Obstetricians/Gynecologists within eight (8) miles;

7) two (2) Specialty Physicians within eight (8) miles as applied to each separate category: Allergy, Anesthesia, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, Hematology/Oncology, Neurology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pulmonary Medicine, Radiology, Rheumatology, and Urology;

8) one (1) Hospital within ten (10) miles;

9) two (2) Psychiatrists within ten (10) miles;

10) two (2) Psychologists within ten (10) miles;

11) two (2) Substance Abuse Counselors within ten (10) miles;

12) two (2) Psychiatric Residential Facilities within fifteen (15) miles;

13) two (2) Substance Abuse Facilities within fifteen (15) miles;

14) two (2) Licensed Social Workers within ten (10) miles; and

15) two (2) All Other Master's Level Counselors within ten (10) miles.

iii. **RURAL AREAS:** Ninety percent (90%) of Enrollees will have at least:

1) one (1) Chiropractor within forty (40) miles;

2) one (1) Occupational Therapist within forty (40) miles;

3) one (1) Physical Therapist within forty (40) miles;

4) one (1) Primary Care Physician within twenty-five (25) miles; primary care physician is defined as a Family Practitioner, General Practitioner, and a Doctor of Internal Medicine;

5) one (1) Pediatrician within twenty-five (25) miles;

6) one (1) Obstetrician/Gynecologist within twenty-five (25) miles;

7) one (1) Specialty Physician within forty (40) miles as applied to each separate category: Allergy, Anesthesia, Cardiology, Dermatology, Emergency Medicine, Gastroenterology, General Surgery, Hematology/Oncology, Neurology, Ophthalmology, Orthopedic Surgery, Otolaryngology, Pulmonary Medicine, Radiology, Rheumatology, and Urology;

8) one (1) Hospital within thirty (30) miles;

9) one (1) Psychiatrist within forty (40) miles;

10) one (1) Psychologist within forty (40) miles;

11) one (1) Substance Abuse Counselor within forty (40) miles;

12) one (1) Psychiatric Residential Facility within forty (40) miles;

13) one (1) Substance Abuse Facility within forty (40) miles;

14) one (1) Licensed Social Worker within forty (40) miles; and

15) one (1) All Other Master's Level Counselor within forty (40) miles.

d. The Offeror may choose to enter into Plan specific contracts that are contingent on award and/or utilize existing agreements that can be made applicable to the Plan to meet the requirement that the Offeror has executed contracts with all the Network Providers included in the Offeror's proposed Provider Network on the Full ASO Services date.

e. The Offeror must support Plan activities within all current regional health initiatives. These include:

i. Adirondack Medical Home Demonstration, which is a collaboration of regional Providers and commercial health plans. The Empire Plan is the third-largest health plan participating in this regional collaboration, with over 15,000 attributed Members. Plan contracts with Adirondack providers allow for a base monthly per member per month payment to support advanced primary care activities, with additional payments earned when certain quality measures are met.

ii. Regional Oversight Management Committees (ROMC), are committees established through NYSDOH leadership in Western New York, Capital Region/Hudson Valley and New York City. The goal is to facilitate provider transition to the delivery of advanced primary care, especially for smaller medical practices seeking support as they work to make the

transition. Medical practices participating in the Capital Region/Hudson Valley and New York City ROMC as Plan contracted Providers are able to earn additional revenue on a per member per month basis when certain quality metrics are achieved.

iii. North Country Innovation Pilot (NCIP) – the NCIP is a pilot in development exploring an all-payer, risk-based total cost of care payment model for hospitals in a six-region county in the Adirondack Region of New York State. The Department and the current Hospital and Medical Program administrators have participated in preliminary discussion around NCIP.

f. The Offeror will be responsible for contracting with practitioners and facilities, as defined by the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31) and credentialing according to Offeror guidelines and all applicable State and Federal law, rules, and regulations. Practitioners are defined as Providers legally licensed to perform a covered medical service. Contracts with Providers must be written to obtain competitive reimbursement rates while ensuring that Plan access and quality guarantees are met. Such contracting services must include, but are not limited to:

i. Negotiating single case agreements with Non-Network Providers when the Offeror determines that it is clinically appropriate or to address guaranteed access issues;

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

iii. Notifying the Department within one (1) Business Day from the time Offeror received notice, in writing, if there is a substantial change to either the number, composition or terms of the Provider contracts utilized by the Plan, even if access standards are still met; and

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

g. The Offeror shall monitor and maintain the following utilization metrics for Plan primary Members: Inpatient Hospital Utilization (admissions per 1,000), Avoidable Emergency Room Visits (avoidable admissions per

1,000), and Inpatient Readmissions (All-Cause, readmissions per 1,000). The thresholds that the Offeror will be expected to maintain on an annual basis will be based on historical utilization and established by the Department, in consultation with the Department's DSS vendor. The Offeror will be expected to report these values quarterly and document an action plan should performance fall under the prescribed annual benchmarked values. The performance guarantee associated with these measures pertains to the second year of the Contract and all subsequent years; reporting is required the first contract year.

The Offeror shall establish a value-based payment program that promotes quality care versus fee-for-service payments and will work to include Network Providers that the Offeror determines have the capacity to participate in value-based payment agreements. The Offeror, in consultation with the Department, will determine the scope of the value-based payment programs.

As a commitment to quality care, the Offeror will monitor and report to the Department all New York State Advanced Primary Care Core Measures and is expected to use a subset of these measures in value-based payment agreements with providers. A full list of these core measures is included as *New York State Advanced Primary Care Core Measure* (Attachment 34). The New York State Advanced Primary Care Core Measures are established through a steering committee facilitated by the New York State Department of Health and are subject to change.

The Offeror shall establish value-based contracts (VBC) that include at least fifty percent of Plan primary members that can be attributed to a primary care provider. The Offeror will be expected to meet the following goals: at least 40% of attributed Plan membership by the end of the second year of the Contract will receive care from a provider with a VBC; at least 45% of attributed Plan membership by the end of the third year of the Contract will receive care from a provider with a VBC; at least 50% of attributed Plan membership by the end of the fourth year of the Contract will receive care from a provider with a VBC; and at least 50% of attributed Plan membership for all subsequent years the Contract is in place will receive care from a provider with a VBC.

h. The Offeror shall establish a tiered MHSA Provider Network and provide incentives including, but not limited to, financial, administrative, and continuing professional education to enhance Provider performance and clinical outcomes.

i. 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 provider possesses a particular subspecialty that is clinically appropriate or to address access issues.

j. The Offeror must ensure that Plan Network 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 National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC) certification for credentials verification. Credentials shall be provided to the Department upon request.

k. Quality Assurance Guarantee: The Offeror must guarantee, effective the second year of the Contract, that a minimum of two out of three utilization metrics must be met annually against the Department's established benchmark for Plan primary members. These measures are:

    i. Inpatient Hospital Utilization (admissions per 1,000);

    ii. Avoidable Emergency Room Visits (avoidable readmissions per 1,000); and

    iii. Inpatient Readmissions (All-Cause) (avoidable readmissions per 1,000)

l. Value-Based Contracting Guarantee: The Offeror must guarantee Plan primary Members that can be attributed to a primary care provider will receive care from a provider with a VBC. The guarantees are as follows:

    i. at the end of the second year of the Contract, at least forty percent (40%) of attributed Plan Members will receive care from a provider with a VBC;

    ii. at the end of the third year of the Contract, at least forty-five percent (45%) of attributed Plan Members will receive care from a provider with a VBC;

    iii. at the end of the fourth year and all subsequent years of the Contract, at least fifty percent (50%) of attributed Plan Members will receive care from a provider with a VBC.

## 3.12 Out of Network Access

The Offeror must administer a program where Members who use certain out of Network Providers may be eligible for a discount. This must include hospital and medical services. Once a Member's out of network deductible is met, cost-share will be based

on the lower of the Offeror's discounted fee schedule or the FAIR Health Inc. database Reasonable and Customary rate. Providers who accept the discounted fee schedule must agree not to balance bill the Plan Member.

**1. Duties and Responsibilities**

a. The Offeror will establish hospital and medical providers that will accept a discounted rate and not balance bill for out of network services.

b. Providers will be visible in the Online Participating Provider Directory and regularly updated.

## 3.13 Ancillary Networks

The Plan currently includes several ancillary network programs designed to provide medical services and supplies to Members as well as managing treatment. These ancillary programs as detailed in the RFP must be provided by the Offeror. These programs are: Home Care Advocacy Program, Prosthetic and Orthotic Network, Managed Physical Medicine Program (MPMP), and the Centers of Excellence for Transplants, Infertility, and Cancer treatment.

### Home Care Advocacy Program

The Plan presently has a program entitled "Home Care Advocacy Program (HCAP)" that offers medically necessary skilled nursing care services, diabetic supplies, durable medical equipment, and certain medical supplies to Members through a provider network. SEHP members are subject to certain limitations. Covered services received from a Network Provider are paid in full (no copayment required) if received from a Network Provider. The Program guarantees access to the network level of benefits for Plan Members. Members are directed to call HCAP for prior authorization to ensure network coverage. In 2019, the Medical Program administrator received 22,919 requests for authorization. Out of Network benefit levels apply to Members who do not receive authorization from HCAP or do not use an HCAP network approved Provider. Medicare-primary Members living or visiting an area that participates in the Medicare Durable Medical Equipment, Prosthetics, and Orthotics Supply (DMEPOS) program must utilize a Medicare-approved supplier in order to receive a paid-in-full benefit.

**1. Duties and Responsibilities**

a. The Offeror shall provide a nationwide network where Members can receive a paid-full-benefit, after prior authorization, when determined Medically Necessary, from nationally credentialed and contracted home care vendors to supply: durable medical equipment and supplies, diabetic and ostomy supplies, enteral formulas, skilled nursing services, home infusion therapy, and other home health care services that are covered

when the care arranged takes the place of hospitalization or care in a skilled nursing facility. Other services include home health aides, physical, occupational, and speech therapy, prescription drugs, and laboratory services. All Program services will be supplied in accordance with the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31).

b. The Offeror shall ensure that Providers can deliver equipment and supplies to the Member's home when necessary.

c. The Offeror must utilize those vendors for infusion services that are contracted with the Empire Plan Prescription Drug Program.

## The Prosthetic and Orthotic Network

The Prosthetic and Orthotic Network provides access to Plan members for coverage of functionally necessary prosthetic and orthotic devices from certified Prosthetic and Orthotic Providers. Empire and Excelsior Plan Members receive a paid-in-full benefit (no copayment) for prostheses and orthotic devices received from a Participating Prosthetic and Orthotic Provider. Basic Medical benefits are considered for devices obtained through Non-Participating Providers. Orthotic devices used to support, align, prevent, or correct deformities or to improve the function of the foot are covered only when medically necessary and custom made.

Access to participating Prosthetic and Orthotic Providers must be available to all Plan members, such as through a contracted national vendor, with an emphasis on providing a robust network in New York State where most Members live.

### 1. Duties and Responsibilities

a. The Offeror shall provide a network of certified Prosthetic and Orthotic Providers, with a focus on access in New York State.

b. The majority of Providers in the Offeror's network shall be certified by the American Board for Certification in Orthotics and Prosthetics & Pedorthics.

## The Managed Physical Medicine Program

The Managed Physical Medicine Program (MPMP) provides Members with access to a network of Participating Providers for chiropractic treatment, occupational and physical therapy. Members, including Medicare primary members, must follow requirements. Network benefits are guaranteed under the MPMP when Plan requirements are followed. If a Provider is not available within a Member's geographic area according to access standards as stated in Section 3.11 of this RFP, the Offeror attempts to negotiate a reduced fee with an available Provider and the Enrollee only pays the applicable copayment. If a Member receives services

from a Non-Network Provider when the MPMP has not made arrangements for the Member to receive services from the Provider, out-of-network benefits apply. There is no prior authorization requirement for the MPMP. However, care must be managed to ensure medically necessary services are rendered. Care management may include review of provider treatment plans. Excelsior and SEHP members have certain benefit limits and treatment exclusions.

**1. Duties and Responsibilities**

a. The Offeror shall provide a nationwide network of chiropractors, physical therapists and occupational therapists.

b. The Offeror will negotiate with a Non-Network Provider to provide Member services in an area where there are no Network Providers according to access standards.

c. The Offeror shall maintain a separate out-of-network deductible for MPMP services for Empire Plan members and SEHP members.

d. The Offeror will maintain a process to ensure treatment rendered is medically necessary.

**Centers of Excellence (COE) for Transplants, Infertility, and Cancer**

The Plan offers a Centers of Excellence Program (COE) for Transplants, Infertility, and Cancer. SEHP Members are excluded from all COE programs. Plan primary and Medicare primary Members are eligible to enroll in all programs. Travel, meal, and lodging benefits must be provided when a Member receives pre-authorization for benefits and needs to travel over 100 miles to receive services at a COE. COE network benefits will not apply if a Member does not follow Program requirements. No copayments apply for services received at the Center; however, copayments or deductibles will apply for ancillary services received outside of the Center, such as laboratory work and prescription drugs. See the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31) for additional details regarding the Program and the COE Travel Allowance.

The COE for Transplants offers access to a national network of Transplant Providers with a proven record of success. The following types of transplants are covered: bone marrow, cord blood stem cell, heart, heart-lung, kidney, liver, lung, pancreas, pancreas after kidney, peripheral stem cell, and simultaneous kidney/ pancreas. This list may change. The Transplant Program also includes a case management component through a registered nurse from the time the Member is listed for a transplant until up to twelve (12) months after the transplant is received.

The COE for Infertility offers access to highly qualified infertility treatment centers, most of which are located within New York State. The Offeror who is awarded a

Contract as a result of this RFP shall select Centers based on several criteria, including but not limited to: volume of in vitro fertilization cases, success rates of live births per retrieval, the range of services, credentials of personnel at the centers (including doctors and registered nurses), patient access, and outcome data. Qualified Infertility Procedures are subject to a lifetime maximum of $50,000, per covered person, including the allowance for travel.

The COE for Cancer Services offers access to a national network of leading cancer treatment centers. Members receive nurse consultations and assistance locating COE Centers. Routine follow-up care that is provided at a Center is covered.

**1**. **Duties and Responsibilities**

a. The Offeror must establish a COE network for Transplants, Infertility, and Cancer Programs that provide a paid-in-full benefit, including all Facility and Provider fees.

b. The Offeror must reimburse the Member for any covered travel, meals, and lodging when the COE facility is more than 100 miles from the Member's home.

c. The Offeror must track and cap all qualified and pre-authorized Infertility Program services at a $50,000 lifetime maximum, per covered individual. This lifetime maximum includes all Facility and Provider fees and travel allowances per Program requirements; the lifetime maximum does not include costs for the first three cycles of IVF and services necessary for those cycles. These costs are paid separately and do not accumulate towards the $50,000 lifetime maximum.

d. The Offeror must establish the ability for an eligible Plan Member to connect to any of the COE Programs, to receive information and enroll in the Program, using a prompt through the current Empire Plan Consolidated Toll-Free Number.

e. The Offeror must review COE outcome data relative to quality and success rates to ensure Providers and Facilities are meeting acceptable standards as set by the Offeror for participation. Utilization data shall be reported quarterly to the Department and a broader report outlining quality, and facility participation will be provided annually to the Department.

## 3.14 Medical Case Management (MCM)

Medical Case Management (MCM) is a voluntary program for Empire Plan Members to help coordinate covered services for catastrophic and/or complex cases. MCM staff identify these cases through claims information or referrals from sources such as

hospital discharge planners. If an eligible Member agrees to participate, MCM staff will work with the Member's medical provider to identify treatment options and resources that may be available.

**1**. **Duties and Responsibilities**

a. The Offeror must provide access through the Empire Plan Consolidated Toll-Free Number to connect Members to the appropriate customer service staff for the MCM program. Staff shall be available Monday through Friday, 8:00 a.m. to 5:00 p.m. ET (except for legal holidays observed by the State) to accept Member calls for the program. The Offeror shall also provide voice mail that allows Members to leave messages 24 hours a day. Voice mail shall be responded to within one (1) Business Day.

b. The MCM must include methods and procedures, including a methodology to identify catastrophic and/or complex medical cases appropriate for MCM. This will include policies for contacting prospective MCM candidates, informing them of the availability of assistance through MCM, and obtaining authorization for those who choose to participate in MCM.

## 3.15 Voluntary Specialist Consultation Evaluation Program

As part of the Plan's Benefits Management Program, the collectively bargained Voluntary Specialist Consultation Evaluation Program offers Members the opportunity to receive a second opinion for any covered scheduled procedure. Upon request, Offeror staff will provide a Member with a list of up to three Physicians whose specialty is similar to the Physician scheduled to perform the procedure. After the Member has determined which of the referring Physicians they prefer to see for the evaluation, the Offeror's Program staff shall schedule a consultation with the selected provider. The consultant evaluation is provided at no cost to the Member. However, if the specialist from whom the Member received the consultation performs the procedure, the Member shall be responsible for the cost of the consultation. In 2019, the Medical Program Administrator received 73 requests; the majority were for orthopedic surgeons.

**1. Duties and Responsibilities**

a. The Offeror shall provide access through the Empire Plan Consolidated Toll-Free Number to connect Members to the appropriate customer service staff for the Program. Staff shall be available Monday through Friday, 8:00 a.m. to 5:00 p.m. ET (except for legal holidays observed by the State) to accept Member calls for the program. The Offeror shall also provide voice mail that allows Members to leave messages 24 hours a day.

## 3.16 Predetermination and Pre-certification of Benefits

Predetermination of benefits is the process in which the Offeror reviews the treatment plan and estimates the benefits for covered services before services are rendered. Plan Members or their Provider may request a predetermination of benefits before any medical service, procedure, supply or pharmaceutical product is ordered, performed or rendered to ensure coverage and/or to estimate cost. The number of predeterminations requested by Members in 2019 for Medical Program services totaled over 13,000.

Clinical decisions relative to predetermination of benefits shall be reviewed by a licensed physician or credentialed health care professional who is in the same profession or similar specialty as the Provider who typically manages the Member's care.

Pre-certification is required to ensure the medical necessity for certain benefits, including, Intensive Outpatient Program for Mental Health/Structured Outpatient Program for Substance Use Disorder, Outpatient 23 Hour Bed Mental Health/Substance Use Disorder, 72 Hour Bed Mental Health/Substance Use Disorder, Outpatient Detoxification, Transcranial Magnetic Stimulation, Electroconvulsive Therapy - Inpatient & Outpatient; Applied Behavioral Analysis; Group Home; Halfway House; Residential Treatment Centers Mental Health/Substance Use Disorder and Partial Hospitalization Mental Health/Substance Use Disorder. In addition, Members must obtain pre-certification before a scheduled (nonemergency) hospital admission, before a maternity hospital admission, skilled nursing facility admission or within 48 hours or as soon as reasonably possible after an urgent or emergency hospital admission. If the Member or their Provider does not call and the Plan does not certify the hospitalization, the Member is responsible for the entire cost of care if medical necessity criteria is not met. If the hospitalization/care was medically necessary and the Member or their Provider did not call, a $200 penalty is assessed. This penalty does not apply to inpatient MHSA services that were not pre-certified.

The Prospective Procedure Review (PPR) requires prior notification by Plan primary Members for the following elective (non-emergency) diagnostic tests: Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emissions Tomography (PET) Scans, and Nuclear Medicine procedures. Notification is waived if the test is done on an emergency basis or as an inpatient in a hospital. The purpose of PPR is to promote medically necessary imaging services and also to control Plan costs for historically over-utilized procedures through a clinical review process. Upon notification from the Member or their physician, the Offeror or their program administrator performs a clinical review for appropriateness and Medical Necessity for the service(s). If adequate information is not provided so that the Offeror or administrator can determine Medical Necessity, additional information from or discussion with the Physician will be requested. If the service(s) requested is determined to be appropriate and Medically Necessary, the service(s) will be approved and covered in accordance with Plan provisions.

If the program administrator is not notified, and a clinical review confirms that the procedure was not Medically Necessary, the Member is responsible for the full charges. Penalties apply if the Plan's prior notification requirements are not met (no call was made) and a review confirms the procedure was Medically Necessary but not an emergency. In 2019 the current administrator received 226,754 requests. Additional information on the PPR can be found in the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31).

**1. <u>Duties and Responsibilities</u>**

a. The Offeror must have the capacity to pre-certify Plan required services, testing, and hospital admissions.

b. The Offeror must have the capacity to provide a prior notification program that is consistent with Plan requirements.

c. At least ninety percent (90%) of requests for Pre-certification of inpatient care must be reviewed within twenty-four (24) hours from the receipt of the request and the Member and Provider notified within one (1) Business Day of the determination as reported and calculated on an annual basis.

e. The Offeror must follow-up in writing once a determination is made. This notice will be mailed to the Member and transmitted to the provider within twenty-four (24) hours from the time of the determination.

f. The Offeror must provide an adequate staff of utilization review coordinators and Clinicians trained to perform a PPR determination as set forth in Section 3.13.

g. The Empire Plan Consolidated Toll-Free Number must include a prompt that connects a caller attempting to comply with PPR notification requirements. At a minimum, customer service representatives will be available during regular Business Hours, 8:00 a.m. to 5:00 p.m. Monday through Friday, ET (except for legal holidays observed by the State). Voice mail shall be available 24 hours a day with call backs within one (1) Business Day for emergency and urgent situations.

h. The Offeror must link PPR authorizations and penalty assessments to the claims payment system for processing.

i. <u>Predetermination of Benefits Notification Guarantee</u>: The Offeror must process a minimum of ninety percent (90%) of pre-determination of benefits requests within ten (10) Calendar Days of receipt.

## <u>3.17 Disease Management</u>

The Plan includes a comprehensive Disease Management Program for Plan Primary Members, excluding SEHP, for the following conditions: Coronary Artery Disease (CAD), Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, Attention Deficit Hyperactivity Disorder (ADHD), Depression, and Eating Disorders. The Plan also includes a Kidney Resources Services Program to identify Plan Primary Members who have kidney disease and may benefit from education or outreach.

Potential candidates are identified through medical, pharmacy, hospital and MHSA claim data, as well as by self-referrals. Member participation and inclusion in disease management is completely voluntary. Identified Plan Primary Members who may benefit from disease management are invited to participate in the program either by mail or telephone depending on an assigned risk level. Medicare primary Members are not initially eligible but may continue within the program if they become Medicare prime during the course of their participation. Please see *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31) for detailed information on Plan Member participation.

**1. Duties and Responsibilities**

a. The Offeror must provide a voluntary, integrated Disease Management Program that manages chronic illnesses including Coronary Artery Disease, Asthma, Diabetes, Chronic Obstructive Pulmonary Disease, Heart Failure, Chronic Kidney Disease, Attention Deficit Hyperactivity Disorder, Depression, and Eating Disorders.

## 3.18 Benefits Management Program

The Benefits Management Program pre-certifies inpatient medical admissions and certain procedures, assists with discharge planning and provides inpatient and outpatient medical case management. The Program helps to protect the Member and allows the Plan to cover essential treatment for patients by coordinating care and avoiding unnecessary services. In order to receive maximum benefits under the Plan, Plan Primary Members must follow the Benefits Management Program requirements, including obtaining Pre-certification for certain services.

**1. Duties and Responsibilities**

a. The Offeror must have a process and clinical staff in place to handle preadmission certifications by phone:

i. Before a scheduled (nonemergency) hospital admission, skilled nursing facility admission/transfer, or transplant surgery.

ii. Before a maternity hospital admission. Members are to call as soon as pregnancy is certain.

iii. Within 48 hours, or as soon as reasonably possible, after an emergency or urgent hospital admission.

b. The Offeror must have the ability to assess a penalty to the Member if specified services are deemed medically necessary but are not pre-certified.

c. The Offeror must deny services if it is deemed not medically necessary and not pre-certified.

## 3.19 Concurrent Review for Mental Health and Substance Abuse Services

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 31) includes information relative to Concurrent Review.

### 1. Duties and Responsibilities

a. To safeguard Member health and ensure adherence with the Plan's benefit design and requirements of Mental Health Parity, 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 which 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 (5) years of clinical experience who renders Medical Necessity decisions.

b. For Members admitted to Non-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 ninety percent (90%) of requests for Pre-certification of inpatient care be reviewed within twenty-four (24) hours from the receipt of the request and the Member and Provider notified within one (1) Business Day of the determination as reported and calculated on an annual basis.

## 3.20 Disabled Dependent Determinations

The Offeror shall be responsible for making Disabled Dependent Determinations for dependents with a medical (physical) disability and mental health and substance abuse-related disability. 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 60 applications per month. However, the number will vary. An application form, *PS-451 Statement of Disability* (Attachment 32) 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:

- "Expected"- the case will typically be reviewed again within six (6) to eighteen (18) months unless the Offeror determines a need for a more frequent review.

- "Possible" - the case will typically be reviewed again no sooner than three (3) years unless the Offeror determines a need for more frequent review.

- "Not expected"- the case will typically be reviewed again in no sooner than seven (7) 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 (Part D) 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 (7) 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 (3) Business Days of the clinical determination, advising of the recommendation. The Department will formally advise the Enrollee of the determination in writing.

## 3.21 Waiver of Premium

The Offeror shall assist the Department in making waiver of premium determinations. To qualify for a waiver of premium, an Enrollee must be totally disabled as a result of sickness or injury and must apply for a waiver. An application form, *PS-452 Application for Waiver of Premium* (Attachment 33), is sent to the Offeror after the Enrollee, their employing agency, and their physician have completed their portions of the form. Once the Offeror has made their determination, it must be documented and transmitted to the Department. The Department makes the final decision to grant a waiver.

**1**. **Duties and Responsibilities**

a. The Offeror must establish a process to review the medical questions on the PS-452 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 (7) 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 (3) Business Days of the clinical determination, advising of the recommendation. The Department will formally advise the Enrollee of the determination in writing.

## 3.22 Transition and Termination of Contract

To ensure that the transition to a successor entity provides Members with uninterrupted access to all Plan benefits and associated customer services, the Contractor is required to provide Contractor-related obligations and deliverables to the 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 (Transition Services). These duties are described below. 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 3.22, 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.

The transition process shall be governed as follows:

1. Length of Transition Period

    a. 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.

    b. Phase Two – Phase Two of the Transition Period will commence at 12:01am 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).

    c. The Department reserves the right to amend the length of Phase One or Two Transition Period upon thirty (30) days prior written notice to the Contractor.

2. No Interruption in Service

    a. 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.

b. 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.

3. Transition Plan

a. Within thirty (30) Calendar Days of receipt of a notice of termination of the Contract or six (6) 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.

b. Within fifteen (15) Business Days from receipt of the Contractor's proposed Transition Plan, the Department shall either approve the Transition Plan or notify the Contractor, in writing, of the changes required to the Transition Plan to make it acceptable to the Department.

c. Within fifteen (15) 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.

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

i. Transitioning of the Healthcare Program Services data. 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:

1) Providers' names, addresses, zip codes, telephone numbers and tax identification numbers;

2) Detailed coordination of benefits (COB) data;

3) High volume provider data;

4) Report formats;

5) Pre-certification/prior authorization approved through dates;

6) Disability determination approved-through dates;

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

8) Any other data the successor entity may need.

ii. All such data transfers must be approved by the Department and provided in a format acceptable to the Department.

iii. The transitioning of the Plan data shall at a minimum include:

1) Providing a test file to the Department or a successor entity at least 20 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.

2) Providing one or more pre-production files at least twelve (12) 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.

3) Providing a production file six (6) weeks prior to the successor entity's Implementation Date. The Department will notify the Contractor of the successor entity's Implementation Date.

4) Providing a second production file to the successor entity by the close of business three (3) days prior to the End Date.

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

v. 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.

vi. 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.

4. Transition Services

a. "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.

b. 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 Plan as necessary to ensure Members are provided with uninterrupted access to benefits and associated customer services.

c. Phase One of the Transition Services shall include:

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

1) 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 health care facilities that are part of a health plan's network of providers with which the Contractor has negotiated a discount;

2) reimbursing late-filed claims if warranted;

3) repaying or recovering monies on behalf of the Plan for Medicare claims;

4) retaining NYBEAS access; and

5) continuing to provide updates on pending litigation and settlements that the Offeror or the NYS Attorney General's Office has/may file on behalf of the Plan.

ii. 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;

iii. Completing all reports required under Section 3.4 of this RFP;

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

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

vi. 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;

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

viii. Receiving and applying enrollment updates and verifying enrollment;

ix. 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;

x. 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;

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

xii. Notify Members currently in care with a Network Provider, per NYS 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.

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

i. Process all Open Claims to final settlement;

1) 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 health care facilities that are part of a health plan's network of providers with which the Contractor has negotiated a discount;

2) reimbursing late-filed claims if warranted;

3) repaying or recovering monies on behalf of the Plan for Medicare claims;

4) retaining NYBEAS access; and

5) continuing to provide updates on pending litigation and settlements that the Offeror or the NYS Attorney General's Office has/may file on behalf of the Plan.

ii. 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 submitted by the Department, unless the Department notifies the Offeror that access may be ended at an earlier date;

iii. Completing of all reports required under Section 3.4 of this RFP;

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

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

vi. 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;

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

viii. Receiving and applying enrollment updates;

ix. 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, and transferring calls to the successor Contractor's lines during this period;

x. 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

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

5. Compensation for Transition Services

a. 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. As indicated below in subsection (c), the Department shall retain the final monthly Administrative Fees payment from the Contractor until completion of all Transition Plan requirements.

b. Phase Two:

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

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

c. Retainage:

To ensure Contractor meets all the Transition Plan obligations in the time frames stated above, the Department shall withhold from payment to the Contractor the final monthly Administrative Fees payment due. The final monthly Administrative Fees payment will be released to the Contractor upon completion of all Transition Plan requirements to the Department's satisfaction. The Department in its discretion may release partial sums of the withheld Administrative Fee where the Contractor has made good faith efforts to complete the Transition plan requirements.

6. 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.

7. 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.

8. <u>Transition and Termination Guarantee</u>

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, and Appendices A, B, C and 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. Subcontractors or Affiliates is defined as those contractors with whom the Offeror subcontracts to provide Project Services and incorporates as part of the Offeror's Project Management Team. For purposes of reporting in the *Subcontractors or Affiliates* form (Attachment 9), Subcontractors include all vendors who will provide $100,000 or more in Project Services over the term of the

Contract that results from this RFP, as well as 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. For each Subcontractor identified, the Offeror must complete and submit the *Subcontractors or Affiliates* form 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 in Attachment 9 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./vendors/index.htm.

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 (5) 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. 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). 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. You may also find useful information on their website: http://www.wcb.ny.gov.

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

To the extent that the Offeror is proposing the use of 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

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 the New York State Department of Financial Services 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 paragraph 12. Specific Coverages and Limits below.

        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 paragraph 11 below. 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: 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.

2. **Primary Coverage**

All liability insurance policies 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. 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.

3. **Breach for Lack of Proof of Coverage**

The failure to comply with the requirements of this Attachment 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.

**4. 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.

**5. 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(11), 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.

**6. Waiver of Subrogation**

For all liability policies, 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 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.

**7. Additional Insured**

The Offeror shall cause to be included in each of the liability policies required below coverage for on-going and completed operations naming as additional insureds (via ISO coverage forms CG 20 10 04 13 or 20 38 04 13 and CG 20 37 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 11 below. 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 Attachment had the Contractor obtained such insurance policies.

**8**. **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.

**9**. **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 (5) Business Days of receipt of any notice of cancellation or non-renewal 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.

**10. 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.

**11. 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:

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

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

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

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

e. 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.

**12. <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, products-completed operations, 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).
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 – $5,000,000

ii. General Aggregate – $6,000,000

iii. Products/Completed Operations – $6,000,000

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

v. Medical Expense – $5,000

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;

vi. Products/completed operations for a term of no less than 1 year, commencing upon acceptance of the work, as required by the Contract;

The CGL policy, and any umbrella/excess policies used to meet the "Each Occurrence" limits specified above, must be endorsed to be primary with respect to the coverage afforded the Additional Insureds, and such policy(ies) shall be primary to, and non-contributing with, any other insurance maintained by the Department. Any other insurance maintained by the Department shall be excess of and shall not contribute with the Contractor's or Subcontractor's insurance, regardless of the "Other Insurance" clause contained in either party's policy(ies) of insurance, if applicable.

b. Business Automobile Liability Insurance

The Offeror shall maintain Business Automobile Liability Insurance in the amount of at least $2,000,000 each occurrence, covering liability arising out of any automobile 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 $50,000,000 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.

i. Such insurance shall include coverage of all professionals and technical personnel whose actions could be considered "professional services" arising out of the scope of services as additional named insureds.

ii. If coverage is written on a claims-made policy, the Offeror 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 any Contract resulting from this Solicitation is completed. Written proof of this extended reporting period must be provided to the Department upon request.

iii. The policy shall cover professional misconduct or lack of ordinary skill for those positions defined in the Scope of Services of any Contract resulting from this Solicitation.

d. Technology Errors & Omissions Insurance

The Offeror shall maintain, during the term of any Contract, Technology Errors and Omissions Insurance in the amount of at least $50,000,000 each occurrence, for claims for damages arising from computer-related services including, but not limited to, the following: consulting, data processing, programming, system integration, hardware or software development, installation, distribution or maintenance, systems analysis or design, training, staffing or other support services, any electronic equipment, computer software developed, manufactured, distributed, licensed, marketed or sold. The policy shall include coverage for third party fidelity including cyber theft if coverage is not met in a Data Breach and Privacy/Cyber Liability policy.

If the policy is written on a claims-made basis, the Offeror must provide to the Department proof that the policy provides the option to purchase an Extended Reporting Period (tail coverage) providing coverage for no less than one (1) year after work is completed in the event that coverage is

canceled or not renewed. This requirement applies to both primary and excess liability policies, as applicable.

e. 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 $100,000,000 each occurrence, 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.

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. Cyber theft of customer's property, including but not limited to money and securities

# 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 Plan, which covers over one million lives and incurs claims costs of over $6 billion 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 five million (5,000,000) covered lives. In determining covered lives, the Offeror should count all lives (i.e., an employee, a spouse, and two (2) eligible dependents counts as four (4) covered lives).

## 5.2 Account Team

The Offeror must complete the *Biographical Sketch Form* (Attachment 14) for all key personnel including subcontractor provided key staff, if any, of the proposed Account Team. Where individuals are not named, include qualifications of the individuals that you would seek to 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 Empire Plan, 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.

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 December 31 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 forty-five (45) Calendar Days prior to the Full ASO Services Date. The customized website must be live and operational at least forty-five (45) Calendar Days prior to the Full ASO Services 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 $200,000.00 a day for each Calendar Day the guarantee is not met. However, an Offeror may propose higher or lower 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 Offeror has developed for other clients.

3. Describe the Offeror's approach to developing appropriate customized forms, letters, and SBCs for the Plan, 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 100,000 or more covered lives.

5. Describe how the Offeror proposes to maintain an updated file of nationwide 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.

6. 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 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.

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

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

## 5.5 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 allow the Prescription Drug Vendor to connect to the Empire Plan Consolidated Toll-Free Number, transfer calls, and, at a minimum, 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 AM and 5:00 PM, ET, Monday through Friday, except for legal holidays observed by the State.

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

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 Plan specific training. Indicate the number of times a backup system has been utilized over the past two (2) 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. Please provide a sample of a survey Offeror used for a large client and advise of the typical response rate for a large client.

h. Describe the Offeror's proposed staffing for administering a Nurseline$^{SM}$ service for the Plan. Detail the Offeror's proposed staffing levels and minimum staff qualifications.

i. Describe the Offeror's experience administering a similar Nurseline$^{SM}$ program for a large client.

j. Describe what criteria the Offeror uses to measure effectiveness of the Nurseline$^{SM}$ Program.

k. Provide a representative sample of Member communication materials for any existing Nurseline[SM] service that the Offeror administers. Also, provide samples of Member communication materials designed to increase awareness and utilization of the program.

l. Describe in detail how Offeror proposes to pre-certify MHSA services including:

i. An overview of Offeror's CRL and proposed Pre-certification process as well as the criteria Offeror uses to identify the services that the Plan should consider for Pre-certification

ii. Offeror's proposed CRL staffing and qualifications of each level of Clinician rendering authorizations and denials of care. Indicate whether Offeror presently manages a clinical referral line and if clinical management staff will be dedicated to the Plan or will also service other customers of the Offeror as well.

iii. For the calendar year 2019, the percentage of covered lives in its commercial large group plans who called the CRL and who received a referral at a different level of care from the one initially requested.

iv. The steps that will be taken to meet the needs of Members who require a Provider with subspecialties, especially those who require pediatric, adolescent, or geriatric mental health services.

v. How the Offeror will meet the ongoing therapy needs of those Members whose first language is not English; who are hearing impaired; or who request a Provider with a particular ethnic background.

vi. How urgent and emergency cases will be identified and who on the clinical management team will be responsible for making such determinations. Describe the procedures that will be followed for ensuring that Members receive appropriate care in urgent and emergency situations.

vii. The procedures followed in cases where a Network Provider is contacted directly by a Member seeking treatment.

viii. The steps Offeror will take to encourage the use of the Empire Plan Consolidated Toll-Free Number for the CRL to minimize self-referrals to Providers, as well as steps Offeror will take to encourage the use of Network Providers. Specify the location where CRL and other clinical management services for the Program will be provided. Explain how Offeror will ensure that

CRL and clinical management staff are aware of MHSA community resources.

ix. The methods Offeror uses to measure the effectiveness and efficiency of the CRL and Pre-certification services. *(Do not include any reference to specific monetary savings.)*

x. How Offeror will transition Members with existing Pre-certifications with a Network Provider into Offeror's system. Confirm Offeror will load one or more files of Pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.

xi. The guidelines Offeror uses to determine length of stay including whether these guidelines have been peer-reviewed.

m. The steps the Offeror will take to Pre-certify MHSA inpatient hospital admissions for alcohol detox and manage the Member's care if transferred to rehab.

n. The steps the Offeror will take to ensure that upon denial of MHSA Pre-certification for Inpatient care, the Offeror will provide the Member with facility options where the Member may receive the precertified lower level of care. Also, confirm the Offeror will notify the chosen facility of the Pre-certification of the lower level of care and will follow-up with the Member and the selected facility within twenty-four (24) hours to confirm that the lower level of care has commenced.

o. Detailed information about the location(s) where call center and customer service work shall be performed. 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 six program service level standards:

a. <u>Call Center Response Time Guarantee</u>: Ninety percent (90%) of incoming calls to the Empire Plan Consolidated Toll-Free Number must be answered by a CSR within sixty (60) 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 sixty seconds falls below ninety percent

(90%) of all incoming calls. The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

b. Availability Guarantee: The Empire Plan Consolidated Toll-Free Number must be operational and available to members and providers equal to or better than ninety-nine and five-tenths (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 Empire Plan Consolidated Toll-Free Number is not operational and available to members and providers ninety-nine and five-tenths (99.5%) percent of the time. The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

c. First Call Resolution Guarantee: No less than ninety-five percent (95%) of all customer service inquiries shall be resolved with one call.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must, propose a forfeiture amount (Standard Credit Amount) for each quarter in which less than ninety-five percent (95%) of all customer service inquiries are not resolved with the Member's initial call. The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

d. Open Inquiry Closure Guarantee: A minimum of ninety percent (90%) of open inquiries shall be resolved within two (2) Business Days, and a minimum of ninety-eight percent (98%) of open inquiries shall be resolved within five (5) Business Days.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which at least ninety percent (90%) of open inquiries are resolved within two (2) Business Days, and/or for each quarter in which at least ninety-eight percent (98%) of open inquiries are resolved within five (5) Business Days. The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter in which either of these guarantees are not met. However, an Offeror may propose higher or lower amounts.

e. Telephone Abandonment Rate Guarantee: No more than three percent (3%) of callers to the Offeror's Empire Plan Consolidated Toll-Free

Number will disconnect a call prior to the call being answered by a customer service representative.

Utilizing the *Performance Guarantees form* (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than three percent (3%) of callers disconnect a call prior to the call being answered by a customer service representative. The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

f. Telephone Blockage Rate Guarantee: No more than three percent (3%) of incoming calls to the Offeror's Empire Plan Consolidated Toll-Free Number 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 three percent (3%) of incoming calls to the Offeror's telephone line are blocked by a busy signal.The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower 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. Non-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 which meets the Member's clinical needs, a referral shall be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than ninety percent (90%) of cases where Members are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available. The forfeited amount (Standard Credit amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

b. Emergency CRL Guarantee: One hundred percent (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 (30)

minutes to assure their safety. Additionally, one hundred percent (100%) of Members in need of non-life-threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL.

Utilizing the *Performance Guarantees* form (Attachment 6) the Offeror must propose a forfeiture amount for each quarter in which less than one hundred percent (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 (30) minutes by a Network Provider or the CRL to assure their safety. Additionally, the Offeror must propose a forfeiture amount for each quarter in which less than one hundred percent (100%) of Members in need of non-life-threatening emergency care are contacted within thirty (30) minutes by a Network Provider or the CRL.

The forfeited amount (Standard Credit amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

c. Urgent Care CRL Guarantee: At least ninety-nine percent (99%) of Members who call the CRL in need of urgent care shall be contacted by the Offeror to ensure that the Network Provider contacted the Member within 48 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 ninety-nine percent (99%) of cases when a Member calls the CRL and requires urgent care, contact will be made by the Offeror to ensure that the Network Provider contacted the Member within forty-eight (48) hours of the call to the CRL. The forfeited amount (Standard Credit amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

## 5.6 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 will the Offeror 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 (1) Business Day?

b. Offeror's system capabilities for retrieving and maintaining enrollment information within twenty-four (24) 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. Detail 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. Explain 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 Qualified Medical Child Support Order (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 one hundred percent (100%) of all Plan enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department.

   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 $10,000 for each twenty-four-hour period or part thereof in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

## 5.7 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 Plan, and the quality assurance program to guarantee that changes to other client benefit programs do not impact the Plan.

   c. Describe how Offeror's claims processing system collects overpayments from Offeror's 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 Plan 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 five program service level standards:

a. Claims Payment Accuracy Guarantee: Claims payment accuracy must be achieved for a minimum of ninety-seven percent (97%) 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 ninety-seven percent (97%) 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 $5,000,000.00 for each year this guarantee is not met. However, an Offeror may propose higher or lower amounts.

b. Claims Processing Guarantee – 14 Day Turnaround Time: No less than ninety-two percent (92%) of submitted claims received by the Offeror that require no additional information in order to be correctly processed shall be processed within fourteen (14) Days from 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.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than ninety-two percent (92%) of claims that require no additional information in order to be correctly processed, are not processed within fourteen (14) Days from 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 $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

c. Claims Processing Guarantee – 30 Day Turnaround Time: No less than ninety-nine percent (99%) of submitted claims received by the Offeror that require no additional information in order to be correctly processed shall be processed within thirty (30) Days from 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.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than ninety-nine percent (99%) of claims that require no additional information in order to be correctly processed, are not processed within thirty (30) Days from 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 $1,200,000.00 a quarter for

each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

d. Claims Data Submission Guarantee: Within twelve (12) Calendar Days following the end of each calendar month, the file including all processed claims shall be submitted to the Department's DSS vendor.

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each day, after twelve (12) Calendar Days following the end of each calendar month that the file including all processed claims is not submitted to the Department's DSS vendor, as calculated on a quarterly basis. The forfeited amount (Standard Credit Amount) is $10,000.00 for each day this guarantee is not met. However, an Offeror may propose higher or lower amounts.

## 5.8 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 Plan including a description of the criteria Offeror uses to select Providers/facilities to audit and a description of the policy that Offeror follows when an audit detects possible fraudulent activity by a 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 Provider 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 Provider and confirm Offeror will pursue litigation on the Department's behalf when necessary.

## 5.9 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 both 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.

## 5.10 Medicare Coordination and Secondary Payment

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in Medicare coordination and secondary payment as specified in Section 3.10 of this RFP, including the following:

    a. A notification system to alert the Department to those Members who have not enrolled in Medicare Part B but appear to be required to do such.

    b. How the Offeror determines the amount Medicare would have paid for a specific service if the Member is not enrolled in Medicare Part B or uses a provider that has opted out of Medicare.

    c. The Offeror's experience handling Medicare demand notices and lien releases on behalf of a large client.

    d. The process the Offeror will use to identify, monitor, and track when ESRD Members become eligible for Medicare during their (up to) 30-month coordination of benefits period.

    e. The Offeror's experience with other large insurance plans that have a similar benefit provision with an extended coordination period for ESRD Members. If the Offeror has experience with ESRD coordination, describe the Offeror's policies and procedures.

    f. The reporting the Offeror will provide on a regularly scheduled basis of ESRD Members who have been identified and are being tracked, as well as, notification when their coordination period to Medicare Primacy is close or has occurred.

## 5.11 Provider Network

At least 30 Calendar Days prior to the commencement of Full ASO Services, and throughout the term of the Contract, the Offeror must possess a Participating Provider/Facility Network that meets or exceeds the accessibility standards set forth in Section 3.11(1)(c) 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 37).

An Offeror will need to obtain sensitive information from the Department. Upon receipt of a completed, notarized *Confidentiality and Non-Disclosure Agreement* (Attachment 19), the Department shall provide the Offeror with Attachment 37, containing the NYBEAS enrollment file that will ensure that all Offerors perform their analyses consistently.

The Offeror may execute custom Plan 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 Provider contracts, to the Department upon request to demonstrate satisfaction of this requirement. No Enrollee may be excluded from the Offeror's GeoNetwork analysis, even if no Provider is located within the pre-defined access standards.

1. To fulfill the requirements of this Section and Section 3.11 of the RFP, the Offeror must:

    a. Submit their proposed Provider Network using the *Offeror's Proposed Provider Network Files* form (Attachment 38) in the format specified by Attachment 38 of this RFP. An Offeror is required to submit its proposed provider network in four (4) separate files in the format specified in Attachment 38: one for Hospitals; one for Medical Practitioners; one for MHSA Facilities; and one for MHSA Practitioners.

    b. Perform a GeoAccess analysis, per provider type, based on the Access Standards as referenced in Section 3.11(1)(c). The Offeror should submit the complete GeoNetworks reports in a searchable PDF and the GeoAccess Accessibility Summaries in 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 GeoNetworks or QuestAnalytics software and GeoAccess or Quest Analytics System Data should be used to create these reports.

    c. Submit *Offeror's Proposed Network Summary Worksheet* (Attachment 35), which indicates fulfillment of Urban, Suburban and Rural Network Access requirements as outlined in 3.11(1)(c).

d. Complete and submit *Comparison of Plan Providers and the Offeror's Proposed Provider Network*, (Attachment 36). Identify whether each of the Plan's current Providers will or will not participate in the Offeror's proposed Provider Network in accordance with the instructions provided in Attachment 36.

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

f. Describe how the Offeror proposes to provide a nationwide network of chiropractors, physical therapists and occupational therapists and guarantee network benefits for Members seeking access to Providers.

g. 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. Do not include specific cost information.

h. Describe actions Offeror will take to monitor and maintain the following utilization measures for Plan primary Members: Inpatient Hospital Utilization; Avoidable Emergency Room Visits; and Inpatient Readmissions (All-Cause).

i. Summarize Offeror's experience or participation related to regional health demonstration projects or pilots.

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 ninety percent (90%) of urban Enrollees with access to two (2) In-Network Providers per provider type within the geographic limits outlined in Section 3.11(1)(c)(i).

      Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a single forfeiture amount for each quarter in which less than ninety percent (90%) of urban Enrollees do not have 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 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

$1,200,000.00 for any provider type, calculated quarterly. An Offeror may propose a higher or lower amount.

b. Network Access Suburban Areas Guarantee: The Offeror's network cannot provide less than ninety percent (90%) of suburban Enrollees with access to two (2) In-Network Providers per provider type within the geographic limits outlined in Section 3.11(1)(c)(ii).

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must, propose a single forfeiture amount for each quarter in which less than ninety percent (90%) of suburban Enrollees do not have 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 provider type in Suburban Areas. The quoted access standard is not an overall aggregate of provider access in Suburban Areas. The forfeited amount (Standard Credit Amount) is $1,200,000.00 for any provider type, calculated quarterly. An Offeror may propose a higher or lower amount.

c. Network Access Rural Areas Guarantee: The Offeror's network cannot provide less than ninety percent (90%) of rural Enrollees with access to one (1) In-Network Providers per provider type within the geographic limits outlined in Section 3.11(1)(c)(iii).

   Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must, propose a single forfeiture amount for each quarter in which less than ninety percent (90%) of rural Enrollees do not have 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 provider type in Rural Areas. The quoted access standard is not an overall aggregate of provider access in Rural Areas. The forfeited amount (Standard Credit Amount) is $1,200,000.00 for any provider type, calculated quarterly. An Offeror may propose a higher or lower amount.

3. In this part of its Technical Proposal, the Offeror must state its agreement and guarantee for the following Program Service level standards:

   a. Quality Assurance Guarantee: This Guarantee will be effective starting the second year of the Contract. The thresholds that the Offeror will be expected to maintain on an annual basis will be established by the first year Inpatient Hospital admissions per 1,000 members, Avoidable Emergency Room Visits per 1,000 members, and Inpatient Readmissions per 1,000 members.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount should the Offeror's number of admissions, readmissions or Emergency Room visits per 1,000 members exceed one-hundred three percent (103%) of the established benchmark for any two out of the three utilization measures applicable to Empire Plan primary members in any calendar year. The three measures are Inpatient Hospital Utilization, Avoidable Emergency Room Visits, and Inpatient Readmissions (All-Cause). The forfeited amount (Standard Credit Amount) is one-half of one percent of the Annual Administrative Fee. However, an Offeror may propose a higher or lower amount. In addition, an Offeror will be eligible for an incentive payment of one-half of one percent of the Annual Administrative Fee should the Offeror's number of admissions, readmissions or Emergency Room visits per 1,000 members fall below ninety-seven (97%) of the established benchmark for any two out of the three utilization measures applicable to Empire Plan primary members in any calendar year.

b. Value-Based Contracting Guarantee:

At least forty percent (40%) of Plan primary members, defined as those members that can be attributed to a primary care provider, must receive care from a provider that has a value-based contract by the end of the second year of the Contract.

At least forty-five percent (45%) of Plan primary members, defined as those members that can be attributed to a primary care provider, must receive care from a provider that has a value-based contract by the end of the third year of the Contract.

At least fifty percent (50%) of Plan primary members, defined as those members that can be attributed to a primary care provider, must receive care from a provider that has a value-based contract by the end of the fourth year and for all subsequent years of the Contract.

Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each calendar year that the Offeror does not meet the established value-based contracting goal. The forfeited amount (Standard Credit Amount) is $5,000,000.00 per year. However, an Offeror may propose a higher or lower amount.

## 5.12 Out of Network Access

The Offeror must describe the program proposed to provide discounts to Members that use out of network hospital and medical providers. Include Offeror's experience in offering this program or a similar program to other large employers.

## 5.13 Ancillary Networks

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in managing the ancillary networks specified in Section 3.13 of this RFP, including the following:

    a. Describe how the Offeror proposes to provide a nationwide network of suppliers and providers so Members can access network benefits when calling HCAP for paid in full Plan benefits.

    b. Propose limited prior authorization criteria. [**Note**: Prior authorization is currently required for Empire Plan primary Members when an HCAP service or item costs over one-thousand dollars ($1,000.00). The Department reserves the right to approve such criteria.]

    c. Describe plans to monitor HCAP utilization or implement cost controls.

    d. Describe how the Offeror proposes to monitor HCAP and evaluate its Network Providers for quality of care/service.

    e. Describe how the Offeror proposes to provide a network of Prosthetic and Orthotic Providers.

    f. Describe how the Offeror proposes to manage care under the Managed Physical Medicine Program to best ensure care rendered is medically necessary.

    g. Describe how the Offeror will implement and administer separate COE programs as defined in Section 3.13 of the RFP. This narrative must include a description of how the Offeror currently administers centers of excellence programs for transplants, infertility, and/or cancer patients, or a program(s) similar to the State's current COE programs; and how long each program has been administered.

    h. Provide the top ten (10) utilized facilities for each of the listed COE Programs.

## 5.14 Medical Case Management (MCM)

The Offeror must describe the criteria the Offeror proposes for identifying Members for participation in the program.

## 5.15 Predetermination and Pre-certification of Benefits

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in the predetermination and pre-certification of benefits as specified in Section 3.16 of this RFP, including the following:

    a. Describe the process and procedure the Offeror proposes to use for making predeterminations of benefits including what information will be required of the Member and how this information can be submitted (i.e. facsimile, telephone, electronically).

    b. 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 for Pre-certification of benefits, or if these will be separate functioning units. Describe how the Medical Director of the Plan will be involved in the predetermination and Pre-certification process.

2. Predetermination of Benefits Notification Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that a minimum of ninety percent (90%) of predetermination of benefits requests will be processed within 10 Calendar Days of receipt.

    Utilizing the *Performance Guarantees* form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than ninety percent (90%) of predetermination of benefits requests are processed within ten (10) Calendar Days of receipt. The forfeited amount (Standard Credit amount) is $1,200,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

## 5.16 Disease Management Program

The Offeror must provide a narrative describing its proposed Disease Management Program based on the specifications in Section 3.17 of this RFP.

## 5.17 Concurrent Review for Mental Health and Substance Abuse Services

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in concurrent review for mental health and substance abuse services as specified in Section 3.19 of this RFP, including the following:

a. Detail the full scope of the concurrent Utilization Review (UR) program that Offeror is proposing to utilize for MHSA 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.

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

2. Inpatient Treatment UR Guarantee: In this part of its Technical Proposal the Offeror must state its agreement and guarantee that at least ninety percent (90%) of requests for Pre-certification of inpatient MHSA care be reviewed within twenty-four (24) hours from the receipt of the request and the Member and Provider notified within one (1) 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 MHSA care are reviewed within twenty-four (24) hours from the receipt of the request and/or the Member and Provider are not notified within one (1) Business Day of the determination. The forfeited amount (Standard Credit Amount) is $1,200,000.00 a quarter for each quarter that in which this guarantee is not met. However, an Offeror may propose higher or lower amounts.

## 5.18 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 3.20 of this RFP, including the following:

    a. Explain if the Offeror provides this service or a similar service for clients presently. If so, please provide an example.

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

## 5.18 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 3.22 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 3.22 of this RFP will be completed in the required times 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 $10,000.00 for each day this guarantee is not met. However, an Offeror may propose higher or lower 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 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 the following:

## 6.1 Program Claims

Throughout the term of the Contract, the Offeror will be paid for estimated In-Network and Out-of-Network claim charges prospectively on a monthly basis for claims that will be incurred during a given month. The first prospective payment will be made within the first week of January 2022[2] and the monthly amount will be reassessed prior to the beginning of each calendar year. The estimated payment will be based on projected annual claims prorated in equal monthly installments. Estimated payments will be reconciled to actual costs on an annual basis, in February following the end of the calendar year in which the costs incurred. During the Transition Period, payments will be made for actual expenditures as claims are closed. Accordingly, there will not be any prospective payments during the Transition Period.

1. For purposes of this RFP, a Program Claim is defined as a payment by the Department to the Offeror as reimbursement for Medical, Hospital or Mental Health and Substance Abuse Services. The Health Insurance industry classifies services based on Revenue Codes or Procedure Codes. Revenue Codes are four-digit numeric identifiers of where a patient received treatment or the service/item the patient received. Procedure Codes are five-digit numeric or alphanumeric identifiers of medical, surgical, and diagnostic procedures utilized by physicians, or entities such as health insurance companies.

2. Using the electronic spreadsheet available at https://www.cs.ny.gov/HealthcareProgramServicesRFP/ the Offeror must

[2] Unless the provisions of section 1.2.4 are applicable.

complete the *Top In-Network Procedure Codes by ZIP Codes – Non-Medicare Fees* (Attachment 16), *Top MHSA In-Network Procedure and Revenue Codes by ZIP Codes – Non-Medicare Fees* (Attachment 17), and *Top In-Network Revenue Codes by ZIP Codes – Non-Medicare Fees* (Attachment 18), which must include the Offeror's proposed per service In-Network fees that will be charged to the Program for all listed services. The spreadsheets are categorized by tabs that reference service delivery locations by three-digit ZIP Codes for Hospital and MHSA Services; and by three-digit ZIP Codes of Enrollees' addresses for Medical services. The Offeror must complete all applicable tabs. The Offeror will submit proposed per service In-Network fees for each of the first five years of the Contract Term. Reimbursement rates for subsequent years will be based on the United States medical component of the Consumer Price Index (CPI).

3. In accordance with Section 3.11(1)(f) of the RFP, the Offeror must contract with In-Network Providers. The amount charged to the Program for covered services shall be the contracted In-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 In-Network provider fee for the Offeror's other contracted clients.

4. Unless otherwise specified in the *Empire Plan Certificates, Excelsior Plan and SEHP At A Glance* (Attachment 31), the Offeror will process Out-of-Network claims using Reasonable and Customary charges based on the 90$^{th}$ percentile of charges for each service performed, as determined by current Fair Health values. Reasonable and Customary means the lowest of:

    a. The actual charge for services; or

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

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

5. Network Pricing Guarantee: The Offeror is required to guarantee that the Actual Average Cost Per Service (defined as actual costs divided by actual 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 Attachments 16 through 18 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. Out-of-Network Guarantee: The Offeror must guarantee that the aggregate amount paid for all Out-of-Network provider services during the calendar year will not exceed 15% of the total amount paid for all services during the calendar year. This review will be conducted by the Department no sooner than June 30th of each calendar year.

   a. The Department shall calculate the guarantee as follows:

      Total amount paid for all services by Out-of-Network Providers during a calendar year

      divided by

      Total amount paid for all services during the same calendar year

   b. Any amounts paid for Out-of-Network Provider services in excess of 15% of the total amount paid for all services in a calendar year must be remitted to the Department within thirty (30) days after the Offeror is notified in writing by the Department.

## 6.2 Administrative Fees

The Offeror will be reimbursed for Administrative Fees on a monthly basis based on the Offeror's annual Administrative Fees proposed on *Administrative Fees Form* (Attachment 15), prorated in equal monthly installments.

1. Administrative Fees are costs charged by the Offeror for the management and delivery of all required Project Services, including but not limited to, the services set forth in *Administrative Fees Form* (Attachment 15). Administrative Fees are exclusive of all Program Claim charges.

2. The Offeror must submit a completed *Administrative Fees Form* (Attachment 15) which must include the Offeror's proposed fee for Personal Service Costs and Non-Personal Service (NPS) Costs. Personal Service Costs are the various forms of compensation for personnel, including fringe benefits. Non-Personal Service Costs are generally those for supplies/materials, contractual services, travel, utilities, and equipment. The Offeror should refer to chapter IV.4(B) of the New York State Guide to Financial Operations (GFO) at https://www.osc.state.ny.us/agencies/guide/MyWebHelp/ for instructions on how to categorize various NPS costs into the major classes of expenditures.

3. The Offeror will submit proposed annual Administrative Fees for each of the first five years of the Contract Term. Reimbursement rates for subsequent years will be based on the All Items category in the United States Consumer Price Index (CPI).

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

## 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 all other Assessments chargeable to the Program.

## SECTION 7: EVALUATION AND SELECTION CRITERIA

The Department seeks to contract with a single Offeror to provide and administer Hospital, Medical, and MHSA benefits. To this end, the Department intends to select the responsive and responsible Offeror whose Proposal offers the "Best Value". Best Value will be determined by a weighted point system, with 25 percent allocated to the Technical Proposal and 75 percent allocated to the Financial Proposal.

### 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 be removed from the evaluation process and not be considered for award if the Offeror does not submit a *Formal Offer Letter* (Attachment 3) and an *Offeror Attestations Form* (Attachment 13) or should it be determined that the Offeror did not satisfy the requirements specified in Section 4 of this RFP, despite any attestation made regarding the requirements. If the Offeror's proposal meets these requirements, it will be advanced for technical proposal evaluation.

### 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, oral presentation(s) and/or site visits 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 5 for each evaluated Service Level Standard. Each reduction in the ratings results in a one-point reduction in the score such that a rating of "poor" equates to a score of 1. An Offeror may propose performance guarantees that exceed the Program's service level standards presented in this RFP. Proposed Performance Guarantees are contained within Attachment 6 and will be evaluated using the following criteria:

a. Excellent (5)

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

ii. The Offeror's proposed credit amount is one hundred and twenty-five percent (125%) or more of the Standard Credit Amount stated within this RFP.

b. Good (4)

i. The Offeror's proposed performance guarantee equals the Program's service level standard contained within this RFP, and the Offeror's proposed credit amount is one hundred and twenty-five percent (125%) or more of the Standard Credit Amount stated within this RFP; or

ii. The Offeror's proposed performance guarantee exceeds the Program's service level standard contained within this RFP; and the Offeror's proposed credit amount is greater than one hundred percent (100%) but less than one hundred and twenty-five percent (125%) of the Standard Credit Amount stated within this RFP.

c. Meets Criteria (3)

i. The Offeror's proposed performance guarantee equals or exceeds the 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. Fair (2)

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

ii. The Offeror's proposed credit amount is greater than fifty percent (50%) but less than one hundred percent (100%) of the Standard Credit Amount stated within this RFP.

e. Poor (1)

i. The Offeror's proposed performance guarantee is below the 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 fifty percent (50%) 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 | Customer Service | 10% |
| 5.6 | Enrollment Management | 10% |
| 5.7 | Claims Processing | 10% |
| 5.8 | Plan Audit and Fraud Protection | 2% |
| 5.9 | Appeal Process | 1% |
| 5.10 | Medicare Coordination and Secondary Payment | 1% |
| 5.11 | Provider Network | 51% |
| 5.12 | Out of Network Access | 4% |
| 5.13 | Ancillary Networks | 1% |
| 5.14 | Medical Case Management (MCM) | 1% |
| 5.15 | Predetermination and Pre-certification of Benefits | 1% |
| 5.16 | Concurrent Review for Mental Health and Substance Abuse Services | 2% |
| 5.17 | Disabled Dependent Determinations | 1% |
| 5.18 | Transition and Termination of Contract | 1% |
| **Total** | | **100.0%** |

4. Technical Proposal Scoring

The Technical Proposal evaluation will be based on 250 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. The Offeror with the highest technical score will receive 250 points. All other Offerors are awarded points in a proportional manner as follows:

Technical Score of Evaluated Proposal =

250 * Technical Proposal Score

divided by

Highest Evaluated Technical Proposal Score

## 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 the electronic spreadsheets located at https://www.cs.ny.gov/HealthcareProgramServicesRFP/.

### 1. Financial Proposal Scoring

a. The Department will calculate a Total Projected Cost for each Offeror as the sum of the Offeror's quoted:

   i. Proposed In-Network Fees from *Top In-Network Procedure Codes by ZIP Codes – Non-Medicare Fees* form (Attachment 16) for years one through five per ZIP Code for each Procedure Code listed multiplied by estimated annual utilization by ZIP Code;

   ii. Proposed In-Network Fees from *Top MHSA In-Network Procedure and Revenue Codes by ZIP Codes –Non-Medicare Fees* form (Attachment 17) for years one through five per ZIP Code for each Procedure Code listed multiplied by estimated annual utilization by ZIP Code;

   iii. Proposed In-Network Fees from *Top In Network Revenue Codes by ZIP Codes – Non Medicare Fees* form (Attachment 18) for years one through five per ZIP Code for each Revenue Code listed multiplied by estimated annual utilization by ZIP Code; and

   iv. Proposed Administrative Fees from *Administrative Fees Form* (Attachment 15).

b. The Offeror's Proposal with the lowest Total Projected Cost will be awarded 750 points. A Financial Proposal score for each remaining Offeror will be determined based on the following formula:

   Cost Score of Evaluated Proposal =

750 * 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

The Department shall select and enter into negotiations for the purpose of executing a Contract with the responsive and responsible Offeror that has accumulated the highest Total Combined Score. If an Offeror's Total Combined Score is equal to or less than one (1) point below the highest Total Combined Score, that Offeror's proposal will be determined to be substantially equivalent to the Offeror holding the highest Total Combined Score.

Among any Offeror proposals with the same or substantially equivalent Total Combined Scores, the Department shall select the Offeror with the highest Financial Proposal Score, as calculated pursuant to Section 7.3 of this RFP, to enter into negotiations for the purpose of executing a Contract.

## SECTION 8: LEGAL TERMS AND CONDITIONS

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

   This 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 the Office of the State Comptroller of the State of New York 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. 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 have or will be obtained from Enrollees and or Members.

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 Section 4, below, 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 C.F.R §§164.308, 164.310, and 164.312, along with corresponding policies and procedures, as required by 45 C.F.R. § 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, 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.

l. Termination

    i. 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. Date return and destruction upon contract termination is governed by Information Security Requirements, Appendix C.

m. 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 Contract or from any acts or omissions related to this Contract 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.

n. 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.