



Department of
Civil Service

**"Contractor's Technical Proposal", Mental
Health and Substance Use Disorder
Program Contract C000743**



A Caelon Behavioral Health Response to:

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

Technical Proposal

May 3, 2023

Master (USB)

Section 5: Technical Proposal

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5.1 Executive Summary

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

Commitment to Service and Partnership

Carelon Behavioral Health, Inc. (Carelon), formerly known as Beacon Health Options, Inc., is honored to be the Empire Plan's long term partner for behavioral health. Carelon's combination of scale and experience administering the Mental Health and Substance Use Disorder (MHSUD) Program has generated fiscal certainty and operational excellence, while providing a comprehensive portfolio of innovative behavioral health programs and services for Empire Plan enrollees and their dependents (members). Carelon has served the Empire Plan, Excelsior Plan, and the Student Employee Health Plan (The Empire Plan) beginning in 1992 and now under the current contract since 2014. Our commitment to behavioral health, superior service, and to keeping jobs in New York State and specifically the Capital District is steadfast.

Capacity and Proposed Approach

Carelon is committed to continuing our partnership with the Department and key stakeholders to advance recovery focused behavioral health access, continuous quality improvement, and evidence based treatment as we have done for a total of 25 years for the Empire Plan. Our collaboration with the Department and the Office of Employee Relations as well as our employment commitment and proximity in the Capital Region to support the Department is evident as we support a wide range of efforts aimed at improving behavioral health in New York.

By issuing this request for proposal, The New York State Department of Civil Service (Department) has signaled their continued investment in a behavioral health relationship that provides effective benefits management to their enrollees and their dependents. Carelon's proposal describes how we will facilitate the local delivery of person and family-centered coordinated behavioral health services that promote recovery and resiliency and foster independence within the MHSUD Program. In this next chapter of our relationship, we will focus on identifying and driving integration opportunities with physical health, pharmacy, and hospitals systems to increase whole health and wellness dimensions of members. By collaborating with providers, and furthering alignment across fiscal incentives aimed at whole health outcomes, we will engage stakeholders to continuously innovate to improve service delivery through proactive program management, data analytics, and outcomes-based reporting.

Unparalleled Industry Experience. Behavioral health is all we do, and we understand the deep connection between the mind, the body, and the environment our members live in. For more than 35 years, Carelon has provided behavioral health care management services that offer the full spectrum of behavioral health care; our value resides in an unmatched ability to integrate all available services as a single-source provider. Our programs include direct contracts with federal, state, or local governments and subcontracts

with health plans. We have an accessible network of providers available to members, with services available to those with short term or situational needs that would benefit from outpatient services to expert management services for persons facing complex behavioral health challenges. We are clinical experts with a purpose, connecting people to the right care to help them achieve tangible results. Because of this, we have earned a reputation for providing outstanding clinical quality, customized services, and quantifiable outcomes.

Today, Carelon serves more than 43 million members across the country. Our mission is to help people live their lives to the fullest potential. We are a specialty managed care organization that is singularly focused on behavioral health care, emotional well being, and recovery. We offer a nationwide specialty behavioral health network of more than 160,000 providers and facilities, as well as a large virtual care provider network across the country. Whether someone is coping with everyday stressors, relationship challenges, a child's autism diagnosis, a substance use disorder, or longer term mental health illness, Carelon's clinical knowledge makes a measurable difference in their lives.

National Thought Leader with Tenured Experience with the Empire Plan. The Department plays vital roles in the lives of the enrollee population they serve. Within the scope of the responsibilities of the Department, no part is more significant than the behavioral health needs of enrollees and their dependents. Along with the wealth of national experience that we bring, Carelon's 20+ years of experience has offered strong fiscal performance, quality customer service to providers, and care of members served. Our operations are local, with a Service Center in the Capital Region close to the Department. As such, we have deep local market knowledge and have developed relationships at both the state and local level that assist in successful program operation. Our long tenured Empire Plan leadership team will provide the same quality, responsive services for the Department and your members and we will continue to improve access and availability of behavioral health services in New York to improve whole health outcomes for all members.

Enhanced Support for Provider and Stakeholder Community. COVID 19 and the result of an interactive society shutdown has made a lasting impact. The consequences have affected vast aspects of people's lives: employment status, living situations, homeschooling, working from home, social isolation, increases in domestic and childhood violence, increasing rates of anxiety, depression—all affecting our physical, mental, and emotional well being. The long-lasting impact has caused the demand for behavioral health services to accelerate, making connecting members to care even more important.

In keeping with our values, Carelon recognized this as a responsibility and opportunity to lead, by developing new provider and stakeholder support offerings with the increase in demand for behavioral health services, especially for substance use disorder (SUD), anxiety, depression, crisis, and suicide prevention. Members identified as higher risk received proactive outreach and continued support services from Carelon clinicians while our Network team supported providers in transitioning vital administrative and behavioral health services to virtual format.

The Carelon Provider Quality Management (PQM) team had extensive training materials on telehealth and developed a series of telehealth training sessions for providers. The PQM team, in collaboration with Carelon clinical and medical subject matter experts continued to deliver several trainings in 2022 to support providers, including the following topics:

- Consequences of Catastrophes: How We Respond to Traumatic Stress
- Integrating Harm Reduction Strategies into Addiction Treatment Practice

- Equitable Youth Suicide Prevention
- An Overview of Autism Spectrum and Intervention Options

The trainings provided in 2022 reached more than 1,860 providers and were also very well received, with a 90 percent satisfaction rate and 91 percent of providers reporting they would recommend the training to other providers.

Improved Provider Network. Carelon's national provider network encompasses all levels of specialty behavioral health care so members can receive the right care at the right intensity and at the right time, in New York and across the country. We offer access to more than 160,000 providers and facilities that span all levels of care and specialties, and Carelon's continued integration with Elevance Health has resulted in network growth for Empire Plan members. However, due to the increasing demand for behavioral health services exacerbated by the pandemic, Carelon is continuously expanding our network to ensure demand can be addressed with a focus on national digital and telehealth providers to enhance access options available to members. This includes specialty services focusing on population specific expertise such as services for individuals with eating disorders, substance and opioid use disorders, and children's services.

Originally as a response to the pandemic, Carelon developed a strategic framework to expand access through digital modalities. This strategy addresses capacity issues that impact traditional care within the context of workforce challenges, developing specialty care to meet the diverse needs of members, and integrating digital services within a holistic, whole health focus.

Carelon is also committed to improving New York network access, availability, and quality for Empire Plan members and we will continue to explore network growth based on identified member need; improved provider quality through data analysis and reporting; and improved quality outcomes for members through value-based contracting models. We are focused on adding value based payment models for providers to help achieve the quadruple aim of cost effectiveness, improved outcomes, and improved member and care team experience.

In 2023, we have added approximately 44,359 providers to our national commercial network and 10,000 providers to our New York network. For Empire Plan members, nationally that is a 36 percent increase and for New York that is a 92 percent increase in the last 12 months. We will be growing our national network by an additional 100,000 throughout the next 14 months.

Carelon's Commitment to the Empire Plan

Under the new Contract, Carelon commits to the following efforts:

Local Program Management. To support the Empire Plan, Carelon will continue to deliver core administrative, clinical, peer support, claims, customer service, and provider relations functions locally. Our local office will remain in the Capital Region close to the Department to promote better coordination and integration of services. Carelon's dedicated account team will be the single point of contact and hold accountability for day to day operations.

Transparency, Collaboration, and Partnership. Our dedicated and local leadership team will be responsive to the needs of the Department, members, providers, and other stakeholders. We will ensure clear communication and transparency through robust data analysis and reporting. We will partner with you strategically, drive innovation, increase collaboration, and assure members have access to high quality services.

Commitment to Recovery and Wellness. Carelon develops systems of care that promote recovery and resiliency, weaving this approach throughout our behavioral health programs from prevention and education support to innovative care management approaches for members and their families. Therefore, our commitment as champions of hope and recovery goes beyond managing clinical care. We recognize that people with mental illness or substance use disorders benefit from working with others who have lived similar experiences and reached a significant level of recovery. Our Peer Specialists will engage and assist members and their families to connect them to services needed in the community. Our enhanced member website will offer additional member resources focused on wellness and support.

Person-Centered Whole Person Care. We developed our Clinical Model of Care to operationalize “whole person” care management. Our clinical programs are tailored around care integration and engagement, ensuring high quality care for members who oftentimes have co-occurring conditions. Our Model of Care seamlessly integrates with medical carriers and pharmacy benefit carriers to support all members based on their intensity of need. We have the expertise to serve members across the spectrum, including those with chronic and complex care needs. Carelon uses advanced predictive analytics to identify at risk sub-populations for clinical intervention. Our local clinical case managers cultivate working relationships with the Empire Plan medical and hospital carriers and other providers as necessary, and we address each individual’s needs holistically, developing a personalized care plan reflecting their goals for recovery. We will support members by connecting them with peers with lived experience who can help them navigate complex systems of care. Our clinical programs promote health equity and integrate services across behavioral health, medical, pharmacy, and social determinants of health needs.

Concierge Member Engagement and Approach to Care. Carelon delivers tailored behavioral health services to members wherever and whenever they need them. We provide high touch concierge service through our clinical referral line to engage members, listen to understand their needs, and connect them to the most appropriate services. By doing so, we more effectively and successfully transition and divert individuals from unnecessary high-cost care to more evidence based and affordable community based services. Our approach to care and utilization management is to help members receive the right care they need and connect them to the right resources to promote recovery and wellbeing.

“Exceptional service; the member was so thankful and could not believe that Leo was able to find the information he needed and he was so patient and willing to help resolve his issue.”

“I just want to say Thank You! I just had the most amazing conversation with Sheri! She is incredible! A joy! And Amazing! I am so grateful for her Customer Service!”

Multimodal Access to Services: Today’s behavioral health issues are far from simple. With increased demand to address a broad range of conditions, people need access to relevant, quality care, and they want it quickly and in a way that is most meaningful to them. In addition to our current concierge member engagement service, Carelon will implement a new member engagement website, accessible through web browser or phone in 2023. It will comply with all accessibility guidelines, and it will feature the ability to translate the website into languages other than English.

Our new innovative, unified digital member website will offer a proactive, multi-channel experience with access to clinical experts, providers, self-guided resources, digital content, and other information needed by members to improve their care journey. It will also enhance a member’s ability to search and connect to services, including through our new telehealth platform and specialty telehealth/virtual provider network.

Customized Behavioral Health Technology. We built our information technology platform from the ground up to serve the specialized needs of the behavioral health management business. Our platform integrates all core business functions, and we have continued to build a robust infrastructure fully capable of ongoing support of the contract and meeting all security requirements and service-level agreements. Carelon's enhanced capabilities support all necessary inbound and outbound file feeds, such as 834 eligibility files, accumulator, and claims files. As the incumbent, we can ensure the continued quick and accurate flow of data that reflects the customized process in place to the benefit of the Department. Carelon's IT staff offers the Department experienced professionals who are well versed in implementing and maintaining data interfaces with your systems and are accustomed to the level of service and IT capabilities required by the Department.

Carelon knows every call is important. The Carelon Telephony infrastructure has been upgraded to ensure call center efficiency and availability to meet all performance guarantees, while providing superior member service experience. Carelon has strong duplication and replication at every step, and in the event of failure of either of our telephony carriers, we can switch to a backup plan promptly. This capability ensures that Carelon can keep call center operations running whether an issue arises within Carelon or externally with a carrier.



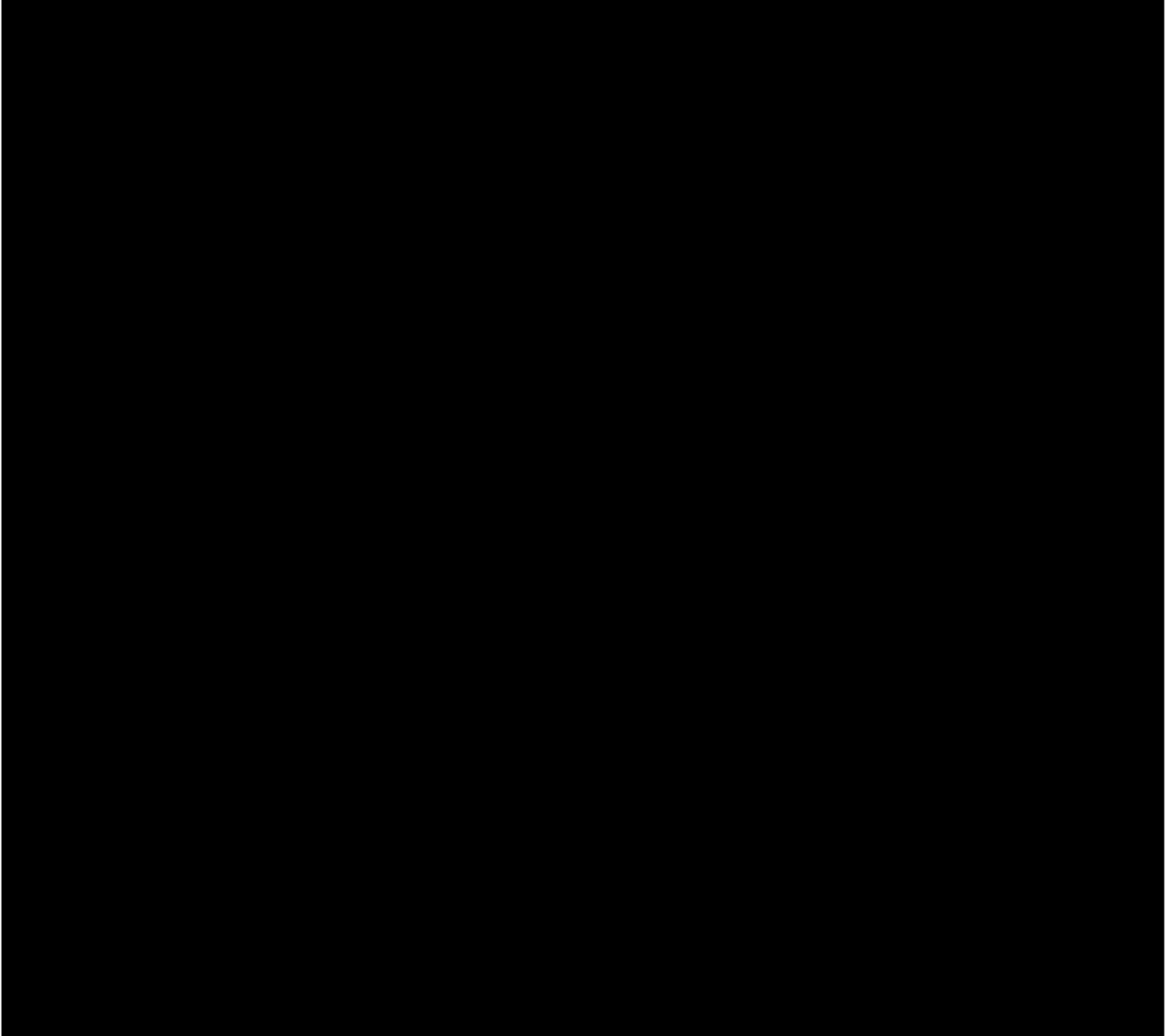
American Red Cross
Eastern New York
Region Chapter-
Sound the Alarm.

Active involvement with community organizations. Carelon is actively involved in the local community, partnering with, and supporting local organizations. We support a wide range of efforts aimed at improving behavioral health in New York and the quality of life in the community we share. We strive to be a strong partner working to give back and improve our communities.

As an example, Carelon works closely with the National Association on Mental Illness NYS (NAMI-NYS) as sponsors and participants in many of their local initiatives. We also work with the Alzheimer's Association of Northeastern NY, sponsoring their Annual Caregivers Conference.

Many of our employees live and work in the Capital Region and volunteer with local organizations as well as donate to many important causes including the Homeless and Traveler's Aid Society (HATAS) & Young Women's Christian Association (YWCA) clothing collection; the Read Across America Day Book Drive; and the Back to School Drive where Carelon employees donated school supplies for local teachers and children.

Lastly, to better support the communities we serve, Carelon sponsors a Social Determinants of Health outreach vehicle to serve residents of the state of New York. We use this vehicle to support behavioral health awareness campaigns and local events and to bring resources directly to the community where our members live, work, and play. Examples of outreach efforts include hosting food and coat drives, sponsorship for a local NAMI chapter walk, participation at local community sporting events, and delivering crisis response after a potentially traumatic event. In May 2023, Carelon will be hosting Mental Health Awareness weekend at Citi Field. The van will be on the plaza with several activation activities, and May 6 will be Mental Health Awareness Night at the ballpark.



Why Carelon

Carelon is a trusted partner with a long, successful history serving Empire Plan members. Carelon has served the Empire Plan, Excelsior Plan, and the Student Employee Health Plan beginning in 1992 and now under the current contract since 2014. Our commitment to behavioral health, superior service, proven outcomes, and to keeping jobs in New York State and specifically the Capital District has not changed. We still believe we are the best partner to manage the complexities of a rapidly evolving care delivery marketplace, address ongoing regulatory change, and support the Department in providing effective and affordable care without any member disruption. We strive to improve the wellbeing of your membership through an integrated approach to meet member's needs and we are eager to continue our partnership with the Department to deliver innovative and member-focused behavioral health programs to serve Empire Plan members.

We are passionate about behavioral health services and are committed to improving the health outcomes of members. Carelon offers a focused, mature, well managed organization in every aspect, one that enjoys high satisfaction ratings year after year from clients, providers, and members. Carelon's combination of scale and experience administering the MHSUD Program and our commitment to innovation and operational excellence provide a comprehensive portfolio of behavioral health programs and services for Empire Plan members. Our vision, our clinical expertise, and our business and technology investments have all been directed toward one goal: helping people live their lives to the fullest potential.

We are excited and grateful for the opportunity to continue our collaboration and positively impact the health and wellbeing of Empire Plan members.

5.2 Account Team

Carelon confirms that our Account Team, who currently manages the Department's MHSU Disorder Program, will continue to meet or exceed the requirements of *Section 3.1 Account Team*.

Along with the wealth of national experience that we bring, Carelon has been supporting members in the Empire Plan for a total of over 25 years. Our operations are local, with a Service Center in the Capital Region in close proximity to the Department. As such, we have deep local market knowledge and have developed relationships at both the state and local level that assist in successful program operation. Our long tenured Empire Plan leadership team will provide the same high quality, responsive services for the Department and your members, and we will continue to improve access and availability of behavioral health services in New York to ultimately improve whole health outcomes for all members.

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

() will continue to provide a highly qualified Account Team based in Latham, New York. () has completed the Biographical Sketch Form for all key personnel and provided this information as **Exhibit 2 – Biographical Sketch Form for Account Team (RFP Att. 14)**.

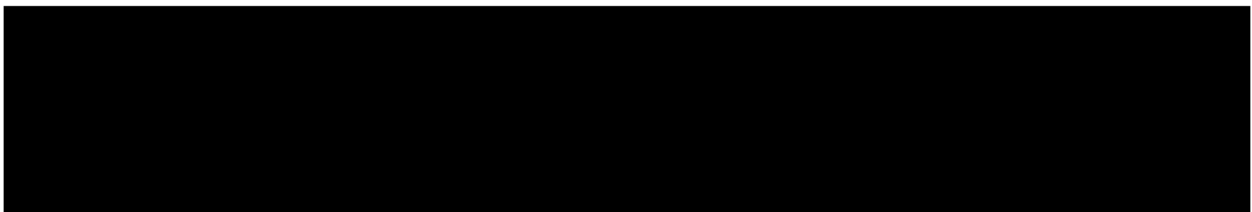
1. The name and address of the Offeror's main and branch offices, and the name of the senior officer(s) who will be responsible for this account;

Carelon's Main and Branch Offices

Carelon's headquarters (main office) is located at 200 State Street, Suite 302 Boston, MA 02109. We will continue to service the Department's MHSU Disorder Program from our Latham Service Center located at 15 Plaza Drive, Latham, NY 12110, in close proximity to the Department for your convenience.

In addition to our Latham Service Center, Carelon operates Shared Services centers in Miami, Florida; Cerritos, California; Woburn, Massachusetts; Wixom, Michigan; and a technology center in Ashburn, Virginia.

Senior Officers



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

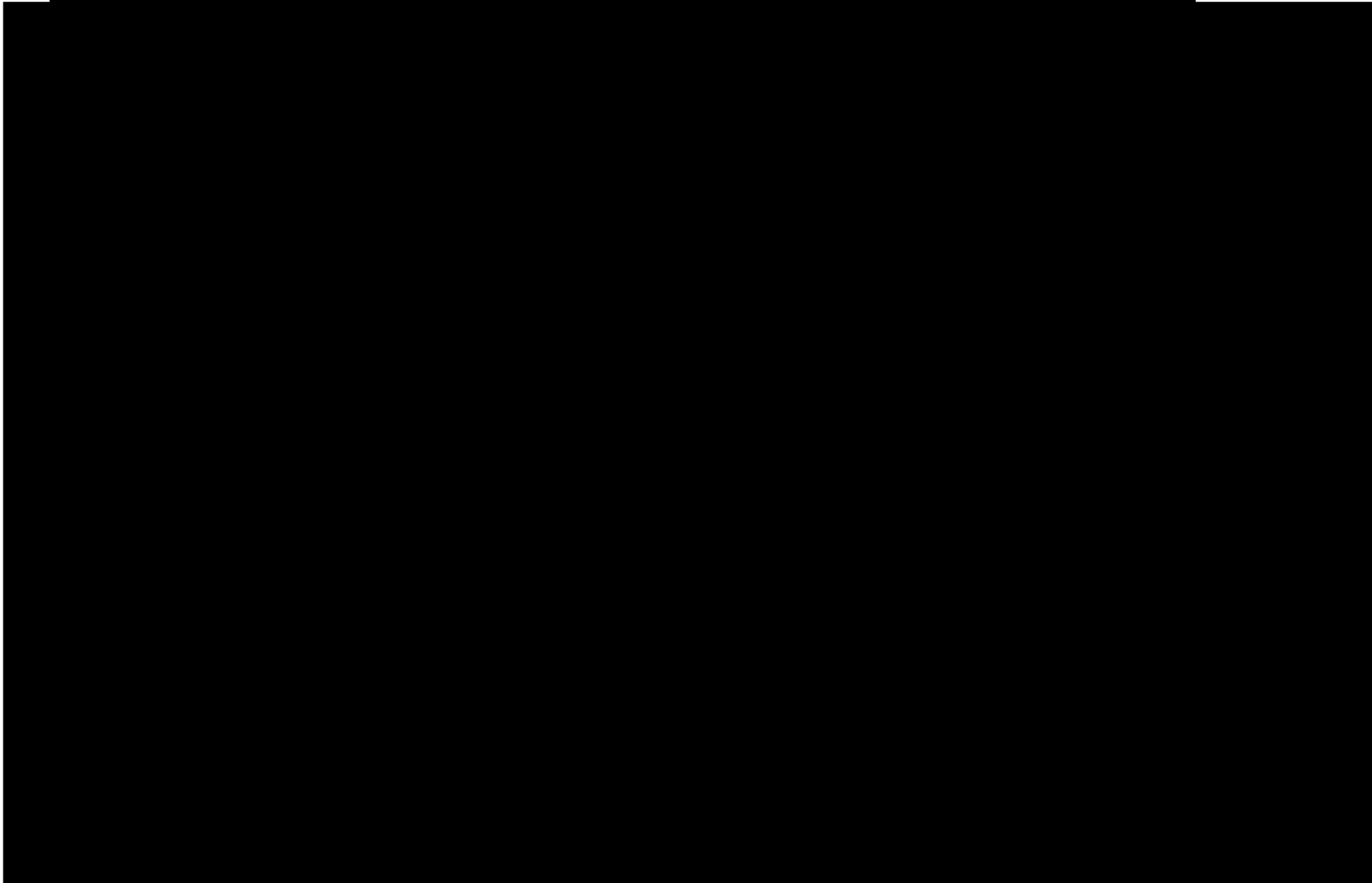
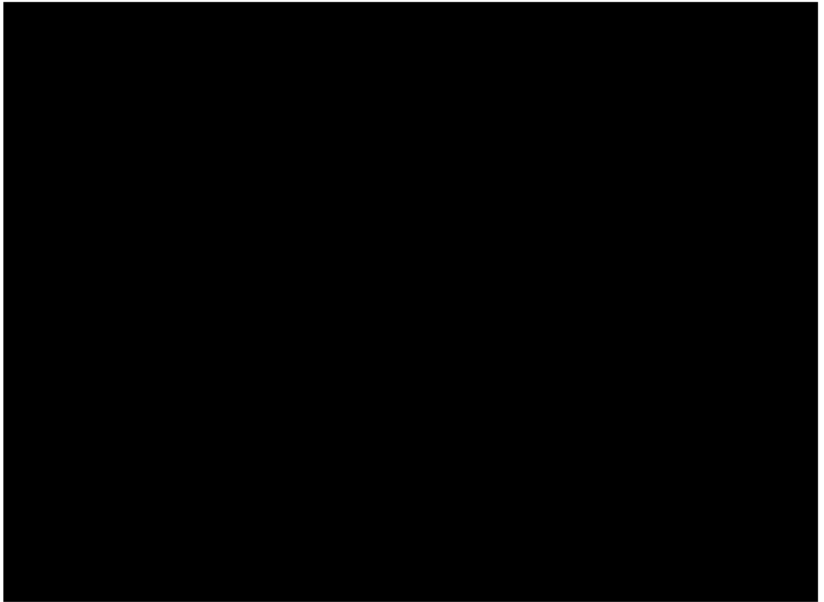
Organizational and Staffing Plan

Below, we provide our organizational and staffing plan, with the roles and responsibilities of key personnel outlined as well as their planned level of effort, anticipated duration of involvement, and their daily level of availability. This team will administer the MHSU Disorder Program.

Name and Qualifications	Roles and Responsibilities
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Name and Qualifications	Roles and Responsibilities
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Name and Qualifications	Roles and Responsibilities
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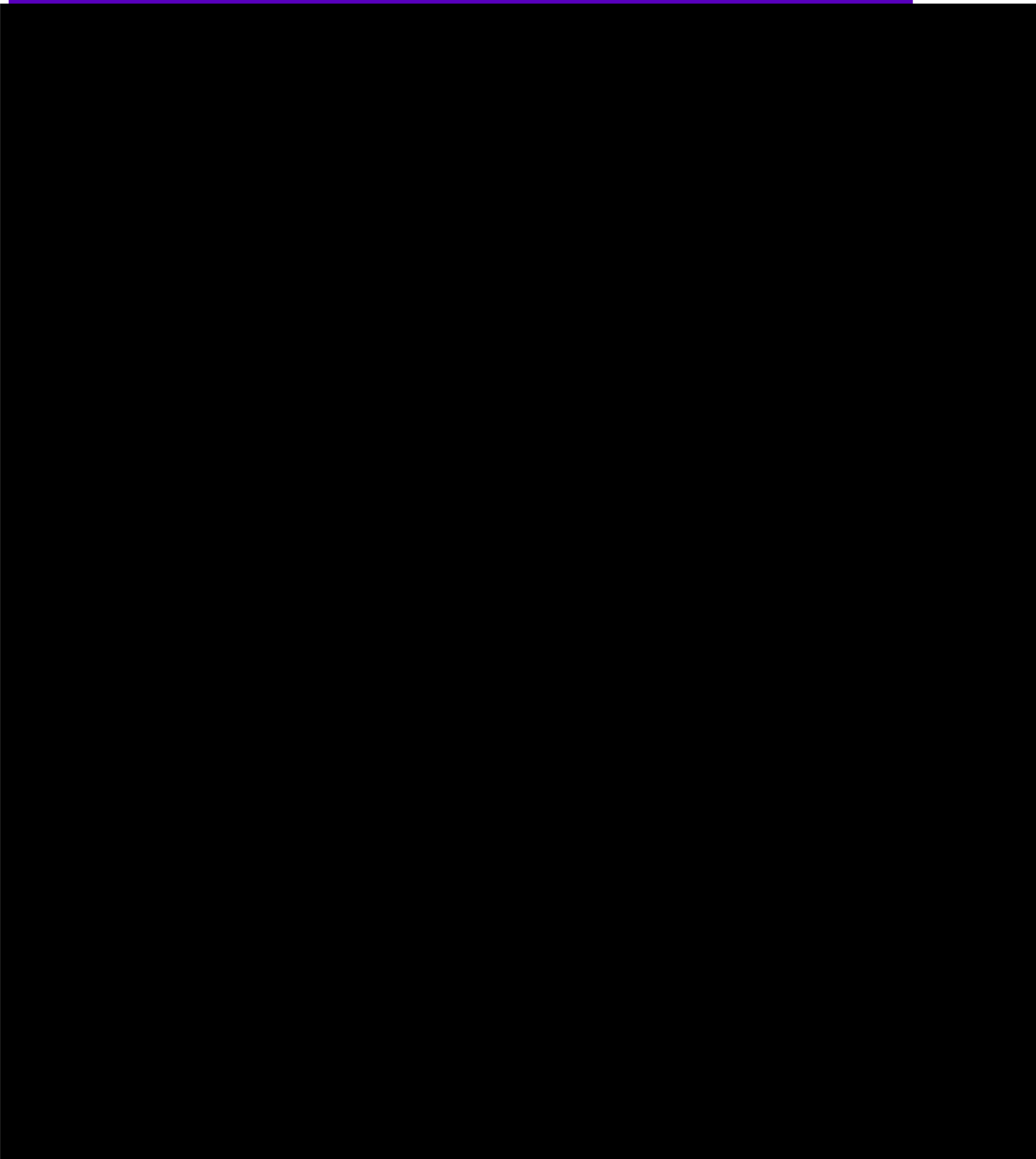
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Name and Qualifications	Roles and Responsibilities
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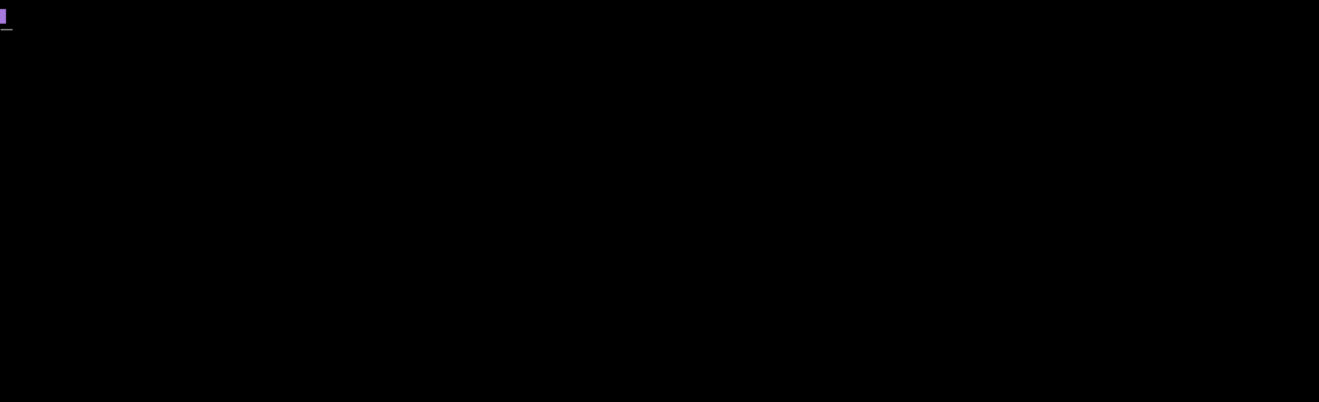
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Name and Qualifications	Roles and Responsibilities
	

Name and Qualifications	Roles and Responsibilities

Name and Qualifications	Roles and Responsibilities
	
	
	

Name and Qualifications	Roles and Responsibilities
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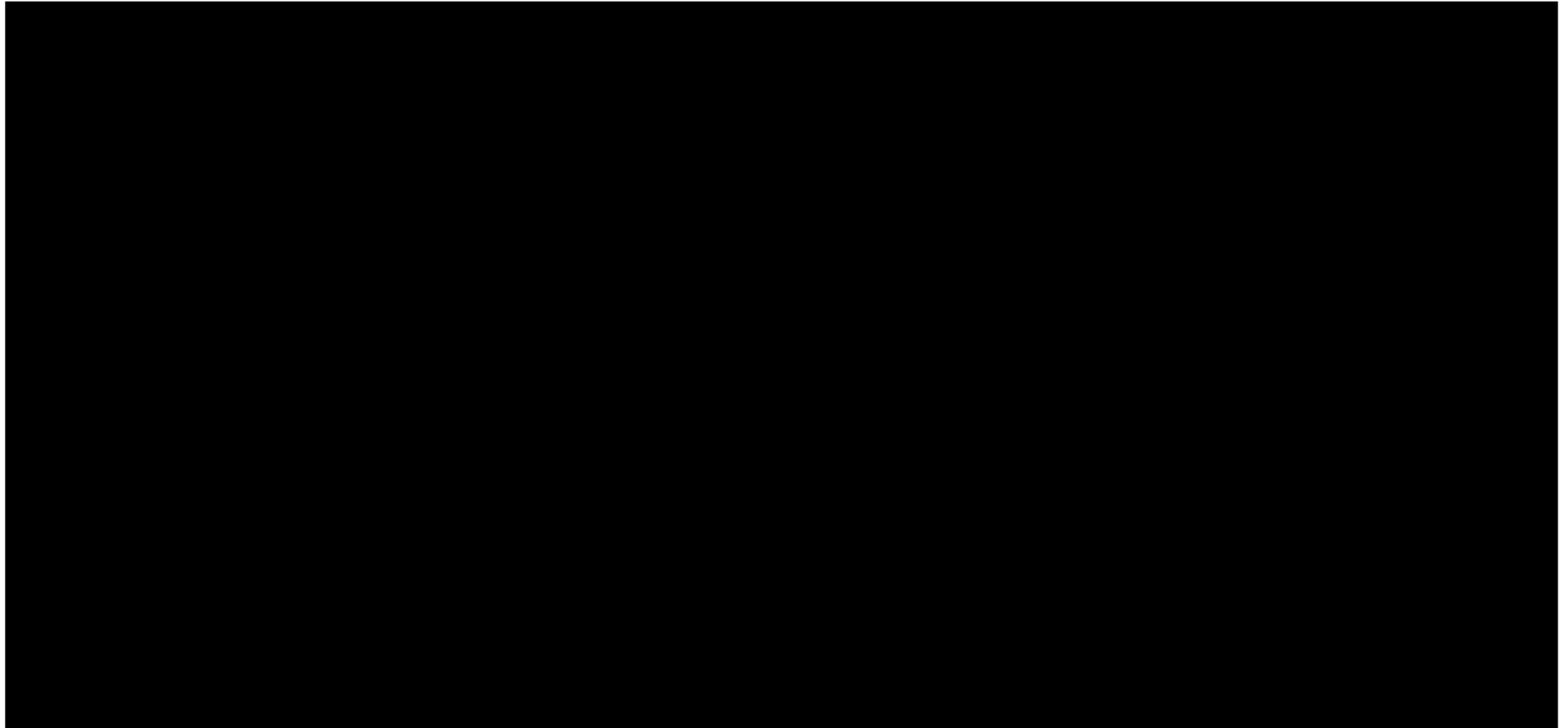
Name and Qualifications	Roles and Responsibilities

Name and Qualifications	Roles and Responsibilities

Organizational Charts

We provide our organizational charts on the next two pages detailing responsibility for functional areas necessary for the continued support of the Department's MHSU Disorder Program. The first organizational chart shows the staff and functional areas that support the current Empire Plan program. The second chart depicts the relationships between the Empire Account Team and Carelon's overall corporate structure. This structure provides direct access to and oversight by Carelon's most senior executives across all functional areas of the organization.

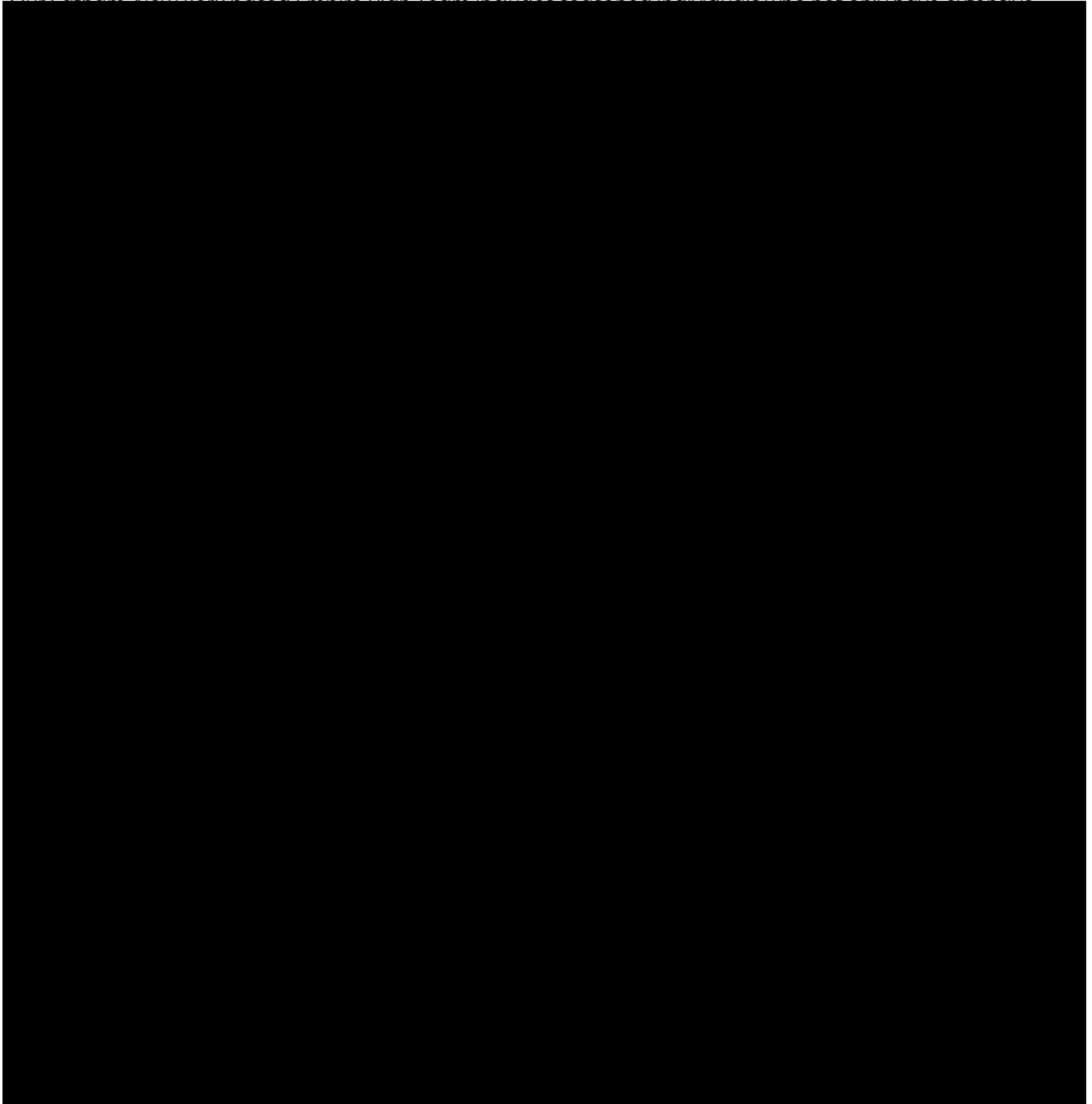




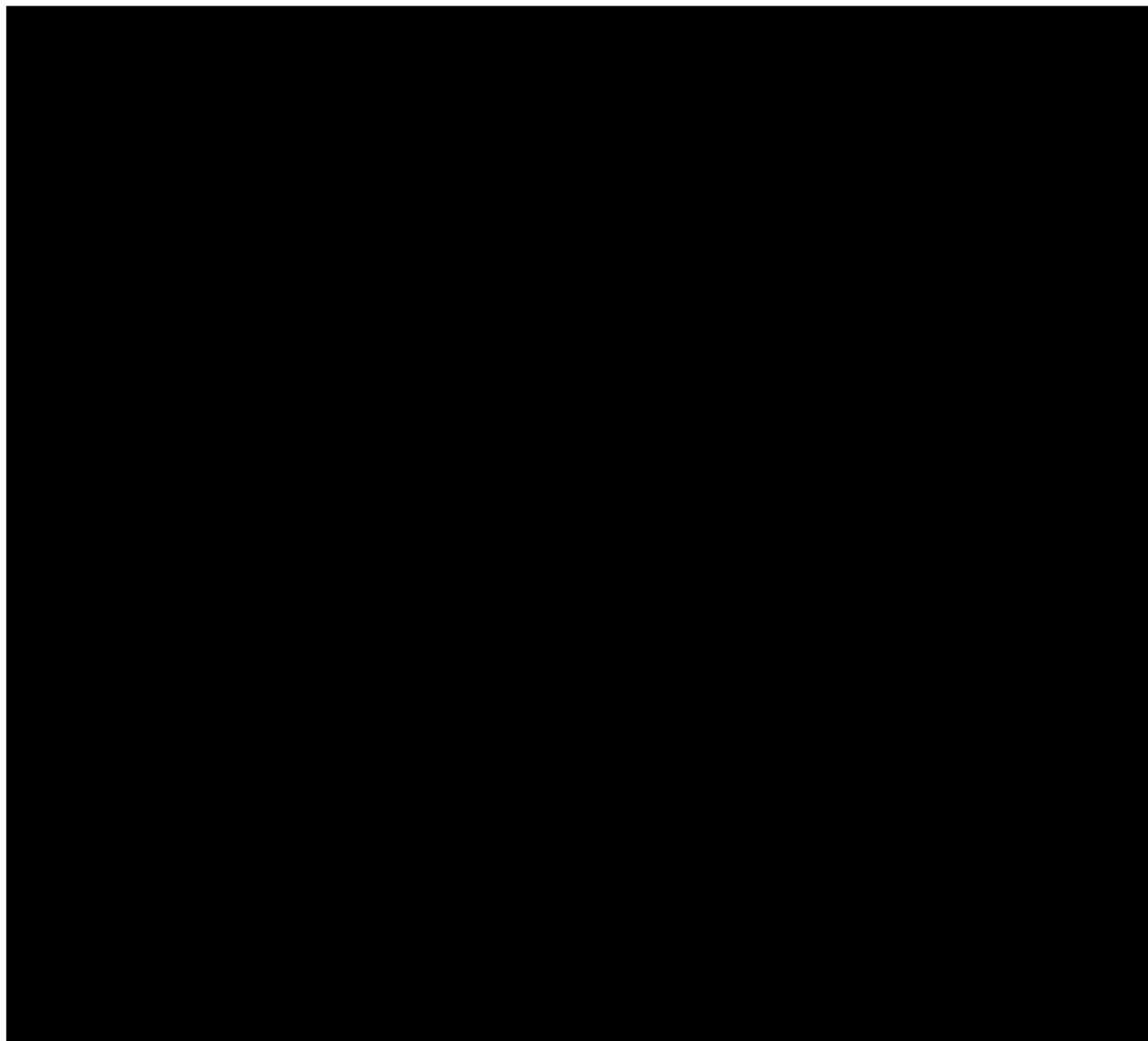
3. Reporting relationships and the responsibilities of key personnel on the Account Team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within Offeror's organization. Describe how the Account Team interfaces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

Reporting Relationships

On January 1, 2023, the Empire Plan Team includes personnel from the following organizations:







5.3 Implementation Plan

Carelon's Implementation Plan will meet all requirements of *Section 3.2 Implementation Plan*. A successful program relaunch and implementation of any new services selected by the Department is instrumental in maintaining the confidence of the Empire Plan's enrollees and their dependents (members) and encouraging utilization of MHSUD program services.

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

Implementation Plan Narrative

We are providing a description of our implementation approach and a sample plan reflective of standard activities for implementation by January 1, 2024. Fundamentally, as the incumbent, the implementation is a much less complicated affair; many of the key deliverables/milestones that a new vendor would be required to complete have already been completed, tested, and implemented.

However, we have proposed some new and refreshed innovations, programs, and providers for the new contract and provided an implementation plan that ensures activities are completed quickly with no interruptions in service.

Carelon follows a disciplined phased lifecycle for all implementations that clearly defines all of the key activities, deliverables, and milestones, and provides transparency of status and maintains control. The phases are outlined below. Please note the implementation life cycle narrative below is reflective of Carelon's standard implementation approach and methodology. Some steps and deliverables may not be applicable in this case.

Initiation Phase

Before our actual implementation process, we have several pre implementation activities that we will perform to guarantee success. During this initiation phase, we will define and finalize the delegation agreement, define the implementation governance, schedule the implementation kick-off meeting, and align resource interfaces. This phase will require the engagement and input of leadership and management level staff from the client with knowledge of the entire scope of the implementation.

Planning Phase

The planning phase is where we will focus on the design of the program and begins with detailed joint discovery meetings where we confirm all contract requirements, vet assumptions with the client, and obtain signoff on all key program requirements. Traditionally during this phase, we require decision making individuals who are knowledgeable in the overall account structure, benefit requirements, eligibility requirements, letter requirements, call center requirements, claims requirements, financial reporting, and network development.

Execution Phase

The execution phase encompasses the bulk of the implementation activity. This is where we develop our workflows, build out our application, as well as initiate benefits configuration, reporting, and data exchange activities. The 'stoplight' system is used to monitor progress and notify the leadership of issues, should they arise.

Testing and Training Phase

This vital stage in our process enables troubleshooting of any problem areas, with a Model Office/End to-End testing period to test in a “real world” environment and remediate any disruptions. Rigorous testing is key to successful efforts with critical data exchange updates, enabling a smooth transition as we move into standard operations. Staff, provider, and other key stakeholder training is also completed during this phase.

Go-live and Monitoring

During this phase, we monitor all aspects of the new operation for a minimum of 90 days to ensure success. This will include post-go live reports measuring key metrics and progress against performance standards. We will also perform a thorough audit of all contract requirements to confirm we delivered against the agreed upon standards.

Using this approach, Carelon will work with the Department to create an implementation plan to meet both current requirements as well as any new requirements and capabilities specified in the agreement.

Transition and Phased-In Services

Carelon will ensure a smooth transition from implementation to a day to day operations state. We do not view implementation as an isolated set of activities, but rather as a continuum from program development and award through post-Service Start Date operations. SME continuity is maintained throughout; the individuals that contribute to program design both participate in the implementation and support day to-day operations, including the later implementation of phased-in services. While there is a formal transition milestone, it is a natural transition to a steady state with a consistent team.

On the following page, we provide a diagram outlining the phases of our implementation process

Standard Implementation Life Cycle



Please note that the implementation life cycle diagram is reflective of Carelon's standard implementation approach and methodology. Some steps and deliverables may not be applicable in this case (dependent on additional scope items that may be required for 1/1/24.)

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.

We have provided a Sample Implementation Plan as **Exhibit 3**. This document includes timeframes for task completion, testing, and go-live. Any new requirements and capabilities have been considered and integrated into the Empire-specific implementation plan.

Please note that the implementation plan is reflective of Carelon's standard implementation approach and methodology for a new client. Some steps and deliverables may not be applicable or may depend on additional scope items required for 1/1/24. Below we describe the key activities, many of which have already been completed or are ongoing today, which ensure the smooth operation of the Empire Plan Mental Health and Substance Use Disorder Program.

Training of Call Center Staff

Carelon's call center staff, consisting of Customer Service Representatives and Referral Line Clinicians, already has expansive knowledge of the Empire Plan's program details, and they will require minimum training for the continued support of the Department's program. Our call center staff are dedicated to the Empire Plan, and we work to ensure that our well trained staff provides each member with high quality service.

We are committed to providing the training, tools, and infrastructure our employees need to provide accurate and efficient service that meets Empire Plan member expectations. Our customer service philosophy lies in our commitment to provide members and providers with the most accurate and informed benefit, eligibility, claims and authorization information in the most effective, efficient, and compassionate manner. We understand the need for and importance of the services we provide and place the customer experience at the heart of our customer service philosophy.

Our Hiring and Training Process

We are systematic and demanding in our interview process to ensure that we select empathetic and caring individuals. We recruit and thoroughly train our dedicated call center staff, as well as call center supervisory staff, to appropriately triage all types of member and provider inquiries and provide the necessary support and engagement to all call center staff. We provide a variety of learning opportunities to support employee professional skill development. This includes elective training and annual training requirements. Our goal is single call resolution for members needing information and access to services. It is our philosophy and practice to take ownership of each service request received.

All customer service staff attend behavioral health sensitivity training, which provides the groundwork for recognizing, and identifying the distinct types of calls generated to a behavioral health customer service

line. This training provides our staff with key phrases and indicators which signal when a warm or no hold transfer to a dedicated Clinical Care Manager is required.

Specialized Carelon staff deliver customer service focused training on program integrity, compliance and regulatory requirements. This focused training reinforces to staff that all inquiries are handled ethically and consistent with all applicable contractual obligations and regulatory requirements.

Customer Service Representatives undergo an intensive training program of up to six weeks that covers all aspects of the Empire Plan program prior to “going live.” The Empire Plan account-specific training includes extensive information on benefits and program design. New Customer Service Representatives will also receive training that provides them with an overall understanding of Carelon’s operations, including care management, provider relations, and claims. New staff training includes rigorous review of detailed procedures addressing patient confidentiality requirements. Customer Service Representatives are educated on the sensitivity of the information available and State, Federal, and HIPAA confidentiality requirements. Procedures clearly define what types of information may be released and to whom. In addition, staff receive training on NCQA requirements and applicable State regulations such as those governing appeals, grievances, and prompt payment of claims. In addition, new staff also receive training on how to use and access online reference tools and workflows.

An experienced trainer and experienced dedicated Empire Plan staff facilitate the training. Our remote training consists of online and interactive sessions via Teams, web based training modules, shadowing experienced representatives through service observation and practical application. The remote training mirrors the live call center, and each new hire has a fully equipped desktop and Avaya soft phone to enhance the training experience and best prepare employees to serve your members.

We take a phased-in approach to releasing trainees to the call center. During the formal training phase, they begin to handle live calls with one on one mentoring to ensure the quality of members’ experiences. Trainees are only released to the call center when they successfully complete classroom training and achieve quality assurance expectations. Call center management, quality, and training staff continue dedicated on the job mentoring for six weeks. We provide ongoing training on internal clinical policy, process changes, network updates, and customer focused workgroups. We provide additional training based on needs identified through quality or inquiry audits, workgroups, or resulting from national, procedural, or client specific change requests or updates.

New Customer Service Representative training consists of the following topics:

New Customer Service Representative Orientation Topics

• Empire Plan Benefit Design, Culture, and Service Expectations	• Handling Crisis Calls
• Performance Standards	• Explanation of Benefits
• Coordination of Benefits and Vendor Interface	• Confidentiality and HIPAA
• Certificate of Insurance	• System Security
• Member and Provider Web Portals	• Release of Minors’ PHI and Age of Majority
• Billing Codes and Fee Schedules	• Levels of Care
• Provider Licensures	• Facility Overview and Facility Accreditation
• Behavioral Health Conditions	• Department Overviews
• Code of Conduct and Integrity	• Inquiry Documentation and Management
• Sexual Harassment	• Information Systems

• Fraud and Abuse	• Quality Audit Process
• Policies and Procedures	• Prompt Payment Regulations
• Claims Processing Overview	• Single Case Agreement Process
• Medicare	• Complaints and Grievances
• Appeals	• Customer Experience and Superior Service Telephone Skills
• Behavioral Health Sensitivity	

Referral Line Clinical Training

All Referral Line Clinicians are licensed behavioral health clinicians with at least three years of clinical experience in a mental health or substance use disorder setting. Upon hire, Carelon provides comprehensive, focused training and orientation programs for all Referral Line Clinicians to ensure that they are prepared to provide high quality assessments clinically and procedurally, referrals, care management and medical necessity reviews of treatment provided at all levels of care. All full- and part time clinicians must participate in each phase of the training and orientation process. This training includes supervisory and subject matter expert presentations to staff, reading and discussion of selected articles, review of all clinical policies and procedures, clinical criteria, guidelines/protocols, and phone and computer system training. Key topics include:

- Carelon's Clinical Philosophy and Values
- Carelon's Medical Necessity Criteria
- The Empire Plan MHSU Disorder Program
- The Clinical Assessment and Referral Process
- The handling of urgent situations and crisis calls, to include:
 - Suicide Ideation
 - Safety Planning
 - Clinical Techniques for Crisis Calls
 - Non-suicide self injury
 - Handling Difficult Callers
 - Risk Rating procedures
- Engagement and Sensitivity
- Quality of Care and Complaints

Website Development

Empire Plan members will continue to have access to the customized Empire Plan website that is fully implemented today. Members can seamlessly navigate from the NYSHIP Online website to the Achieve Solutions website for the Empire Plan or can access it directly at <https://www.achievesolutions.net/empireplan>.

Our customized member website offers members a rich and diverse selection of articles, tips, and information about behavioral health issues and other life events. Members can learn about healthy living skills, disease prevention, and early intervention to make positive life decisions and improve their health.

We are also excited to share that under the new contract, Carelon will update our member engagement website for Empire Plan members to provide an enhanced experience. Our new member engagement website for Empire Plan members will contain a sophisticated online suite of behavioral health tools to enhance member convenience and optimize wellness. We will work with the Department to customize the platform, which will create one entry point to all behavioral health services, including updated access to educational content, self-help tools, and a 24/7 telehealth platform with access to virtual visits. It will include online intake and triage to help direct members to appropriate care and emergency services if needed, self-help tools and digital health solutions for care, linkages to a provider, and tailored educational content on prevalent member behavioral health concerns.

The new website can be customized to meet the needs of Empire Plan members and branded for the Empire Plan. The timeframe for implementation, testing, and finalization of the new member engagement website will be completed by the go-live date of January 1, 2024. In the interim, Empire Plan members will continue to have access to their customized Achieve Solutions website.

Network Development

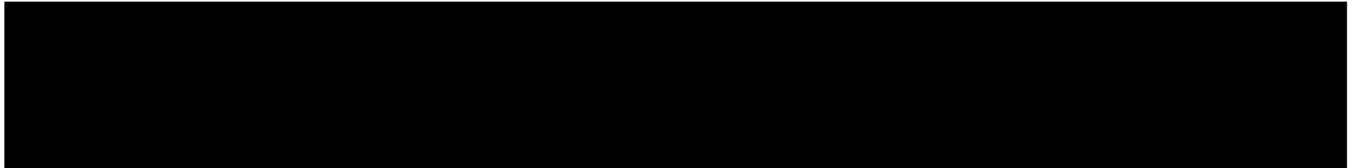
Carelon has an extensive network of providers in New York and across the country. Members have access to more than 160,000 providers and facilities across the country that span all levels of care and specialties. As the current contract holder, Carelon consistently meets GeoAccess guarantees for members. However, due to the increasing demand for behavioral health services only exacerbated by the pandemic, Carelon is committed to improving local New York network access, availability, and quality for Empire Plan members. We will continue to explore network growth based on identified member needs; improve provider quality through data analysis and reporting; and improve quality outcomes for members through value based contracting models.

While we already have a robust network of providers throughout New York, we are committed to continuing to recruit providers to our network to ensure adequate access and availability to all provider types and specialties for your members.

Sources for provider recruitment include but are not limited to:

- Access analyses that review of out-of plan requests for cultural and ethnic needs, referrals for emergency or urgent services to ensure member access to care within established standards, out of-network utilization.
- Referrals from providers who are already under contract with Carelon. Network referrals ensure the recruitment of providers who will bring not only their individual talents, but who will work cooperatively with their peers to provide clinically sound, cost effective behavioral health care services.

- Recommendations from the New York based Carelon medical director, our clinical care managers, or the clinicians working on our Clinical Referral Line based on identified member needs.
- Recommendations from the Department, the Governor's Office of Employee Relations, and the unions and members directly.



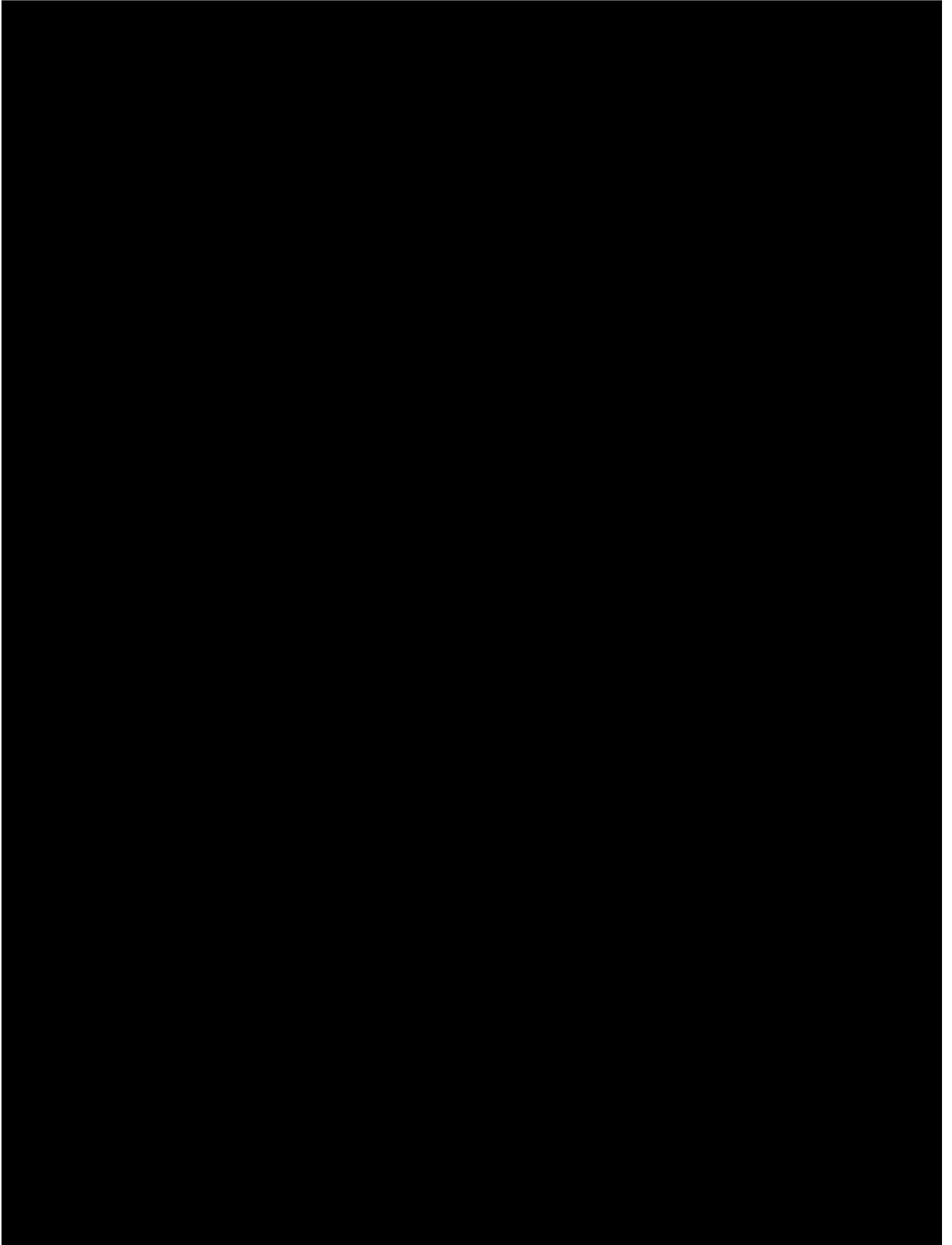
Implementation of Additional Telehealth Services

To enhance access to services in a multimodal fashion and provide the best member experience, Carelon believes having a telehealth ecosystem with multiple provider groups is critical. We have added and are in the process of adding several national telehealth providers to enhance access and availability of services to members. This includes specialty services focusing on population specific expertise such as services for individuals with eating disorders, substance and opioid use disorders, and children's services. Our experience shows that by creating this ecosystem, we ensure there is sufficient supply and short wait times for appointments. More detail on these new providers is provided in *Section 5.11 Provider Network*.

As stated above, Carelon will also be implementing a new customized member website for Empire Plan members. This website will include a 24/7 telehealth platform that links to all available telehealth providers in the network. Members can choose the solution based on their needs, register (which will include a verification of benefits) and schedule a session with the network provider of their choice in real time.

As the incumbent Mental Health and Substance Use Disorder Program administrator today, there will be no transition of benefits. This means there is no potential for disruption in care.

Should the Department require any new data feeds, the timeframe for implementation, testing, and finalization of any new data feeds would be dependent on specifications such as whether Carelon standard layouts or custom layouts are required and when we receive layouts. We will work with the Department to determine requirements and the overall timeframe for implementation should any changes be required.



5.4 Member Communication Support

Carelon's member communication support will continue to meet or exceed the requirements of *Section 3.3 Member Communication Support*. Carelon takes a holistic, multi-modal approach to communicate with members. We help members become active participants in their health care decisions. Our goal is to make members aware of the programs and services available to them, assist them in taking the necessary steps to achieve their goals, and support them in reaching and maintaining their best health. We provide outreach and tools to enhance a member's ability to prevent the onset or worsening of behavioral health issues.

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.

The Carelon legal department is available to the Empire Plan Account Team for consultation at any time necessary. They are involved during the creation of any communications related to a regulatory requirement, the Consolidated Appropriations Act (CAA) or Parity. Carelon's legal team also reviews and consults on any recommended changes to the Member Certificate of Coverage and DFS model language requirements. Carelon's Senior Corporate Counsel, Shanon Vollmer, is based out of our Latham, New York office and will be the designated staff member available to support this account with any legal questions that may arise.

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

We provide two examples of communications developed for other clients as **Exhibit 4 –Communication Samples**.

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

Carelon will continue to work with the Department to develop appropriate customized forms and letters, and to draft behavioral health content that can be used in SBCs for the MHSU Disorder Program. We will use the current process to incorporate any of the Department's feedback into the final versions. We are committed to providing the resources and experience needed for superior decision-making.

Our Account Team will work with our Marketing and Communications department led by Deanna Penn during program implementation and throughout the life of the contract to assist the Department with the development of communication materials.

The Carelon communication team works closely with your dedicated Account Team to customize collateral—including letters, tip sheets and brochures, and behavioral health content that can be used in SBCs.

- We have in house design and fulfillment staff responsible for collateral conceptualization and execution. This team works with the Account Executive from the idea phase to printing phase.
- We consider the Department's employee communications as well as MHSU Disorder Program goals when developing collaterals.
- We offer collateral in varying media formats to augment the Department's existing program.
- Our content specialists and graphic designers develop compelling collaterals that effectively describe benefits and encourage program participation.
- The Account Executive acts as the liaison to share drafts until the Department is satisfied with the customized collateral.

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

Process for Working with Our Clients to Develop Customized Communications

Carelon has nearly 40 years of experience working with large clients to produce customized communications. As part of our standard process, materials are branded with the client's logo or program name as well as the unique program phone number and member website URL.

Client Examples

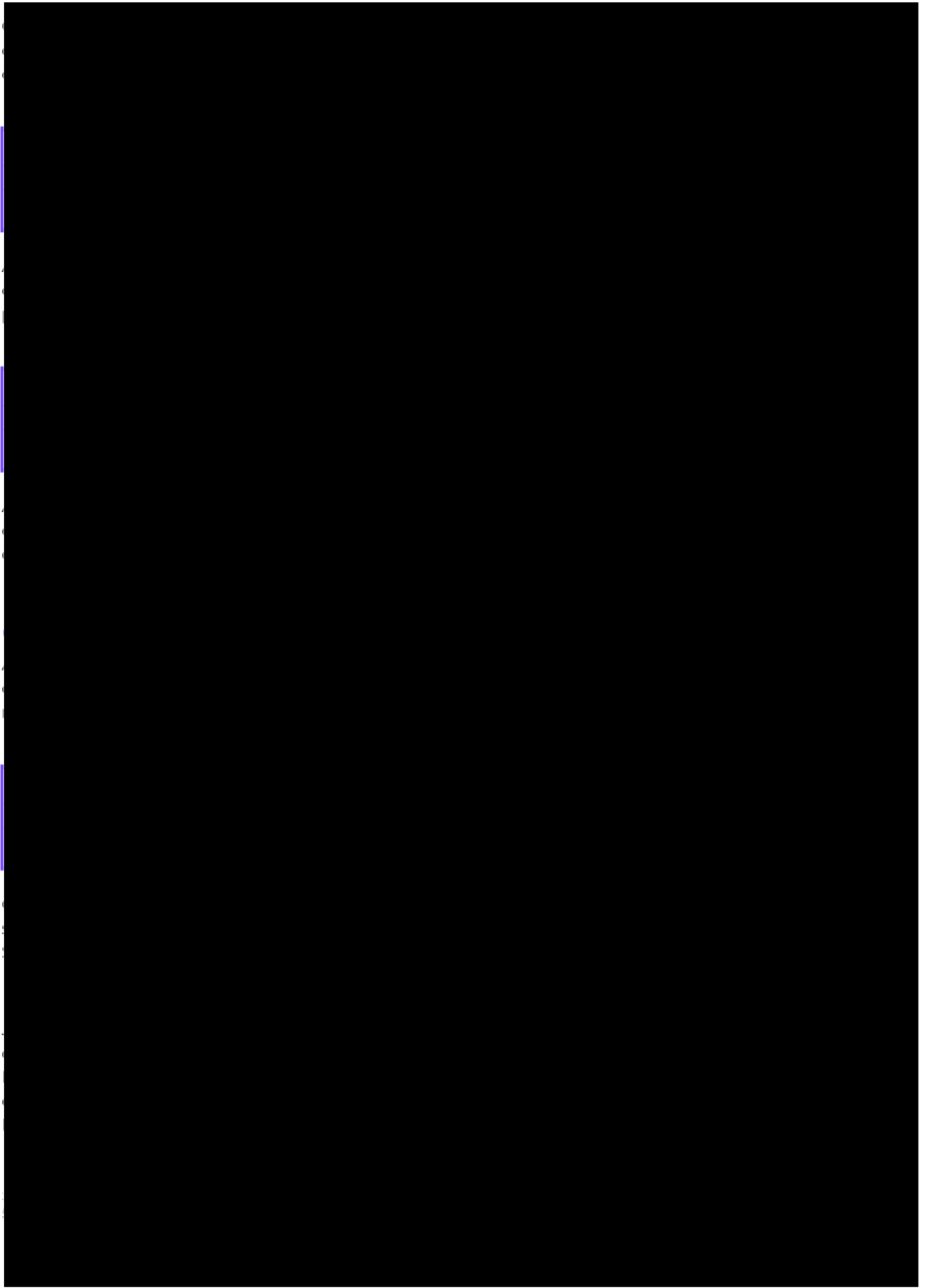
For a state client, Carelon worked with the client to educate all residents about the effective use of crisis lines (versus 911). Carelon's Marketing and Communications team developed an integrated and customized media campaign using traditional and digital media channels to drive awareness of three regional crisis lines, including what they offer and how to access them. An eight-week multi-channel awareness campaign reached over 400,000 people and served over 4.3 million ad impressions. Call volume to the Crisis Line increased in several geographic areas during the campaign.

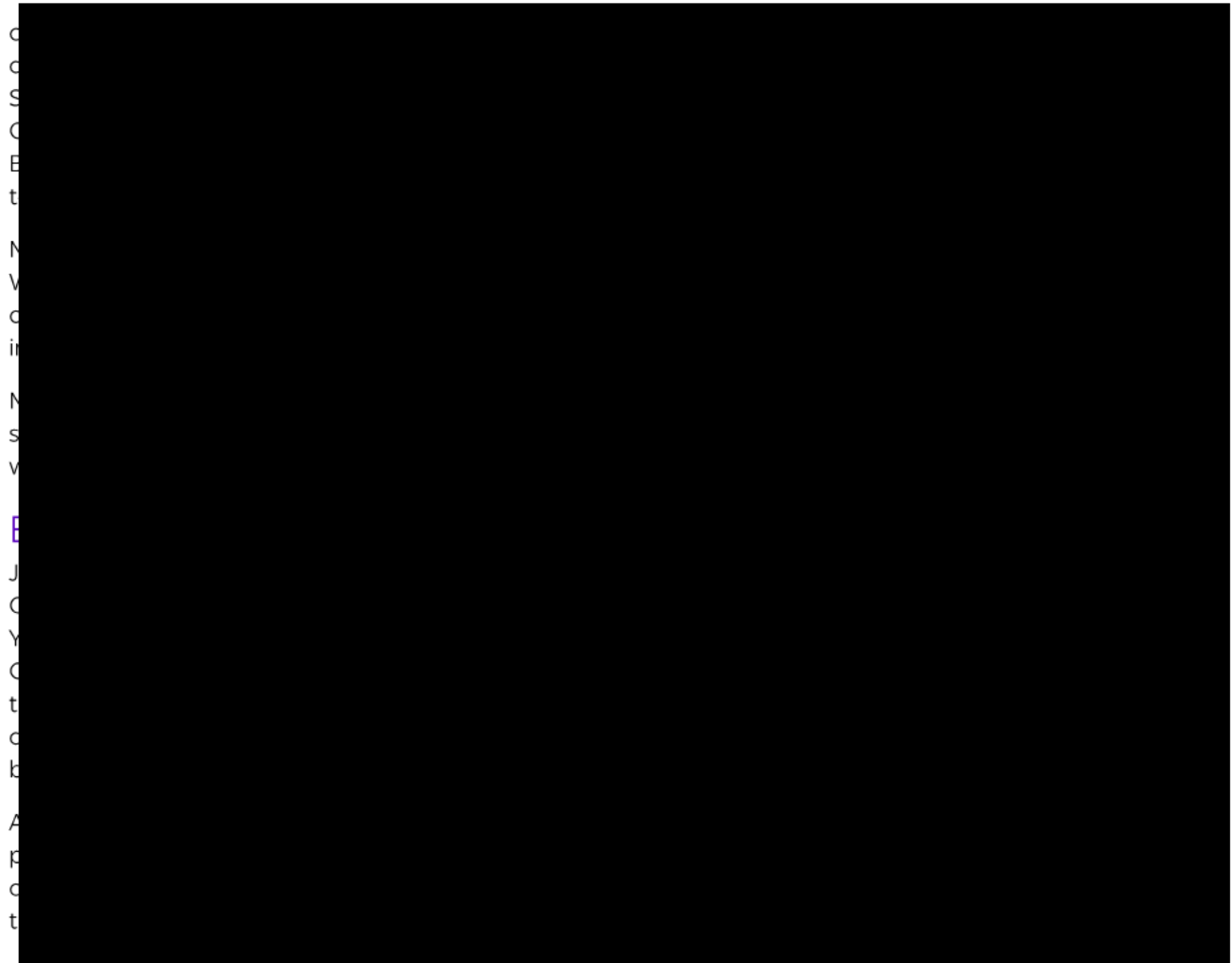
We also have experience working with our clients to tailor communications to different employee populations, such as leadership, employees in the field, employees at different office locations or working from home, and more.

We provide two examples of communications developed for other clients as **Exhibit 4 – Communication Samples**.

Our Work with the Empire Plan

For the Empire Plan, the Carelon Account Team acts as a consultant available to review and provide feedback on member communications developed by the Department. For communications created by





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

Carelon's Account Team partners closely with our Provider Data team to ensure the integrity of our provider data as accurate and complete. Both our online and printed directories use the same data source allowing Carelon to quickly produce files of our New York Network and our National Provider Network. Through an existing process, which includes collaboration with the Department's Communications staff, we are able to produce files for the printed directory with ease and accuracy. Any updates to the layout for the printed directory, including additional data fields, are accommodated without impact to the delivery date.

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

Carelon's online provider directory is available 24 hours a day, seven days a week, and 365 days a year through the Empire Plan customized website. Carelon's provider directory offers members the ability to search by what is important to them in seeking care. The Empire Plan directory search is initiated upon a member entering minimum required criteria of a location (city, state and/or zip) and optional provider name detail. The initial search results page displaying participating providers in that service region can then be further refined by the member using several methods. The member may select the distance they are willing to travel from the location criteria entered; use the filters found under "Refine Your Results" pane; and sort results by criteria such as name, distance, preferred providers, and more.

The directory is linked to our information system, which houses the provider information files. As changes are made by Carelon staff to the provider file, the Provider Search application is refreshed nightly. Our application also offers a Report Corrections button that allows the user to provide immediate feedback about suspected inaccuracy of a provider's profile (for example, address, phone number). Carelon will outreach to providers with the concerns filed under Report Corrections to verify if an update is needed. The providers profile will be flagged on the directory as "Unverified" for a period of 90 days or until the provider confirms their data, whichever occurs first.

To assist in better matching member needs to provider capabilities, Carelon is also in the process of updating our provider portal and directory to capture additional data elements to ensure we are meeting the health equity needs of members. This update will allow members to better select compatible providers by subspecialty, disability, and SOGI (sexual orientation and gender identity) among other capabilities.

Directory Update Protocol for Regular Maintenance

Carelon ensures that provider directory information is current, accurate, and consistent with the data collected during the credentialing process, including name, gender, education, training, board certification (as applicable), specialty, accepting new patients, languages spoken by the practitioner, locations, and facility accreditation status (as applicable). Carelon makes every effort to maintain accurate and up to-date information; however, changes can occur at any time. The practice locations at which the provider/facility will see members is self reported and verified during the initial credentialing process and every three years, as required by applicable state law. In accordance with Federal No Surprises Act, providers also must confirm and attest to their practice location information and specialties every 90 days. Carelon sends quarterly reminders encouraging providers to update and attest to their data to maintain compliance with federal law.

Carelon contracts with the Council for Affordable Quality Healthcare (CAQH) as the preferred single source credentialing database to collect credentialing application data. More than 93 percent of Carelon network practitioners use CAQH, which is available at no cost to providers. Carelon has a direct feed to CAQH's data that captures provider demographic changes as providers update and attest to their profile data; these changes are then ingested in Carelon's source system and fed to the provider directory. Carelon processes five data feeds from CAQH weekly to ensure our directory data remains accurate.

Adding and Removing Providers and Facilities to the Directory

The directory is linked to our information system, which houses the provider information files. As changes are made to the provider file, the Provider Search application is refreshed nightly.

Directory Audits to Ensure Accurate Information

Carelon has contracted with an outside vendor to perform directory accuracy audits. These audits include a statistically significant sample from our directories. Carelon uses a vendor, SPH Analytics or SPH (formerly Morpace Health), to complete provider directory accuracy audits. The audit frequency is scheduled for monthly. During each audit, at least 400 unique providers (facilities and practitioners) are audited, and all locations for the selected vendor are audited. This sample size ensures a 95 percent confidence level in Carelon's audits.

Data elements audited include:

- Practice/group name
- Active participation status
- Gender
- Languages spoken
- Practice address
- Telephone number
- Email address
- Website address
- Ages seen by the practice
- Office hours
- Accreditation status
- Board certification
- California NPI and California License Number
- Accepting new patients
- Programs/services offered
- Provider type, discipline, and specialty
- Cultural Competency training
- Telehealth capability
- Hospital affiliations
- Facility type and facility program/services offered
- Handicap accessibility
- Public transportation access

In addition, to allow users to report any provider directory inaccuracies, the online provider directory prominently displays the dedicated toll free number, electronic form, email address, and a hyperlink to easily report inaccuracies. Carelon documents the receipt, investigation, and outcome of each reported potential directory inaccuracy.

We are also contracting with a vendor on a Secret Shopper initiative. This will collect data on topics such as accuracy of directory contact information, whether the provider and/or provider location is accepting new patients, availability of first appointment, and types of appointments offered.

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

Carelon has experience working with the Department and hundreds of other large clients to create customized websites and web portals for benefit information. For example, Carelon has experience with developing custom home pages and configuring links to related resources for mental health and emotional wellbeing (and other areas) offered by our client's other vendor partners. We also have experience co-branding our website.

At the start of the new contract period, Empire Plan members will continue to have access to the customized Achieve Solutions website that is fully implemented today. Members can seamlessly navigate from the NYSHIP Online website to the Achieve Solutions website for the Empire Plan or can access it directly at <https://www.achievesolutions.net/empireplan>.

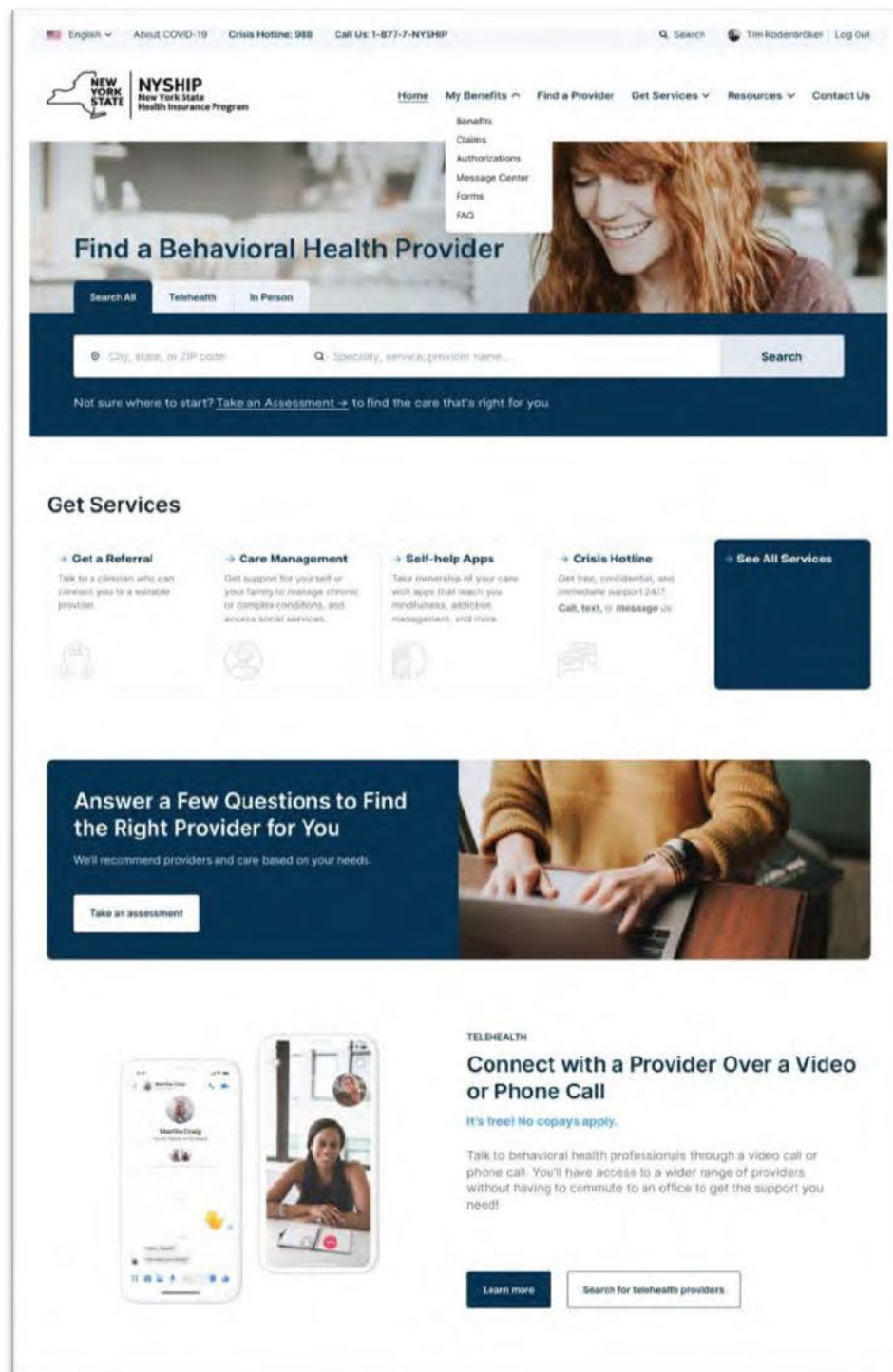
With one click on the custom website, members have access to Carelon's secure member self-service Web portal. We provide members with access to Empire Plan benefit-specific information, including the ability to:

- Check program benefits
- View eligibility
- Check authorizations
- Check claims status
- Check claims history and claim payments
- Download claims forms
- View individual or family out of pocket expenses

New Member Website

Carelon will also update our member engagement website for Empire Plan members to provide an enhanced experience. Our new member engagement website for Empire Plan members will contain a sophisticated online suite of behavioral health tools to enhance member convenience and optimize wellness.

We will work with the Department to customize the platform, which will create one entry point to all behavioral health services, including updated access to educational content, self-help tools, and a 24/7 telehealth platform with access to virtual visits. It will include online intake and triage to help direct members to appropriate care and emergency services if needed, self-help tools and digital health solutions for care, linkages to a provider, and tailored educational content on member behavioral health concerns. Mockups of the new member engagement website are provided below:



The home page will feature a prominent provider search feature, an online intake and assessment, and the ability to connect to a telehealth provider.

Recommended for You

Alcohol Use Disorder Tip Sheet

AUD is a medical condition characterized by the impaired ability to stop drinking alcohol despite adverse social, occupational or health consequences.

FACT SHEET

Substance Use Disorder Tip Sheet

Addiction is the most severe form of SUD and involves compulsively using a substance regardless of negative social, psychological and physical consequences.

FACT SHEET

Confronting the Crisis of Opioid Addiction

2 million Americans addicted to opioids, this fact sheet has the public standing at attention in a way it never has before. We have to do something – and quickly.

ARTICLE

Depression Screening Quiz

This nine-question assessment can help you to determine if you are depressed. This instrument is not a substitute for a proper evaluation by a licensed health care provider.

ASSESSMENT

Your Benefits

→ Benefits Info

Find out what is covered by your behavioral health plan, and how much services will cost.



→ Claims

Know the status of your claims, and submit claims to get reimbursed for out-of-network care.



→ Authorizations

Stay updated on the approval of services you or your provider require for coverage.



→ Message Center

Have questions or need support? Get in touch with us through the message center.



→ Forms

Download all the forms you need to manage your care.



→ FAQ

Get answers to the most common questions members have about their plans and care.



Featured Resources



FACT SHEET

Understanding Mental Illness: What to do in Crisis

Depression is a treatable, medical illness. It is important to find the treatment that works best for you. Antidepressants are commonly prescribed medications to treat depression.



ARTICLE

What Every Child Needs for Good Mental Health

Good mental health allows children to develop emotionally, socially, and intellectually, and learn new skills. These tips can help you support a child's mental health.



FACT SHEET

Confronting the Crisis of Opioid Addiction

2 million Americans addicted to opioids, this fact sheet has the public standing at attention in a way it never has before. We have to do something – and quickly.



EXTERNAL LINKS

NYSHIP Online

The website for the New York State Health Insurance Program (NYSHIP). Here you will find information on the program for active employees of State and Local Governments.

Members can find recommended content, benefits information, and featured resources.

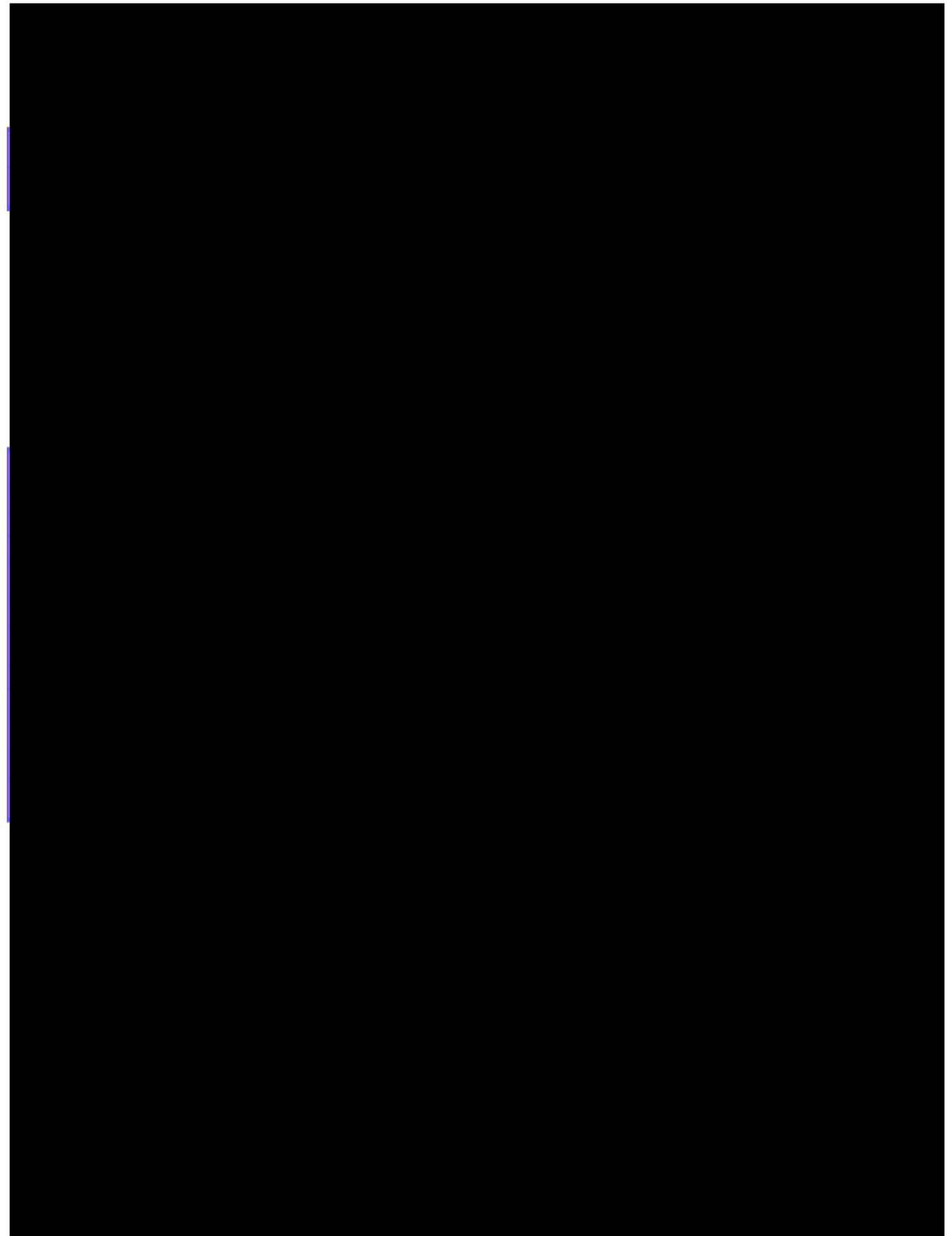
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The new website can be customized to meet the needs of Empire Plan members and branded for the Empire Plan. We can partner with you to develop a customized home page and to add links to resources, as well as provide clear reference to the NYSHIP toll-free number.

It will comply with all accessibility guidelines, and it will feature the ability to translate the website into languages other than English. The timeframe for implementation, testing, and finalization of the new member engagement website will be completed by the go live date of January 1, 2024. In the interim, Empire Plan members will continue to have access to their customized Achieve Solutions member website to ensure no disruption.

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

We have provided the requested **Exhibit 5 – Biographical Sketch Forms (RFP Att. 14)** for all staff proposed for involvement in Member Communication Support.



Our decision support system contains a comprehensive suite of standardized reports that we use for operational management (for example, behavioral health utilization) as well as client deliverables.

Our reports are categorized by functional area including:

- **Authorization** – clinical utilization, outlier management, and appeals
- **Paid claims** – utilization, fraud, and abuse, claim lags, and claims processing
- **Membership** – reports detailing enrollment including demographic data
- **Inquiry Tracking** – reports detailing customer inquiries including complaints
- **Call Center** – reports detailing call center's telephone statistics
- **Provider** – reports tracking information on our provider networks

Our reporting suite provides essential information to enable Caredon to monitor business operations. This effort translates into improved service to our clients, a better understanding of the program, and the ability to provide interventions should problems arise.

Reporting Format

We confirm that we provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word) or any format requested, as determined by the Department.

Ad-hoc Reports

Our standard reporting package routinely meets expectations and most of your reporting requirements; however, we will continue to provide ad hoc reports and other data analysis as requested. Please see **Exhibit 9 – Sample Ad Hoc Reports** for the following ad hoc reports we prepared for the Empire Plan:

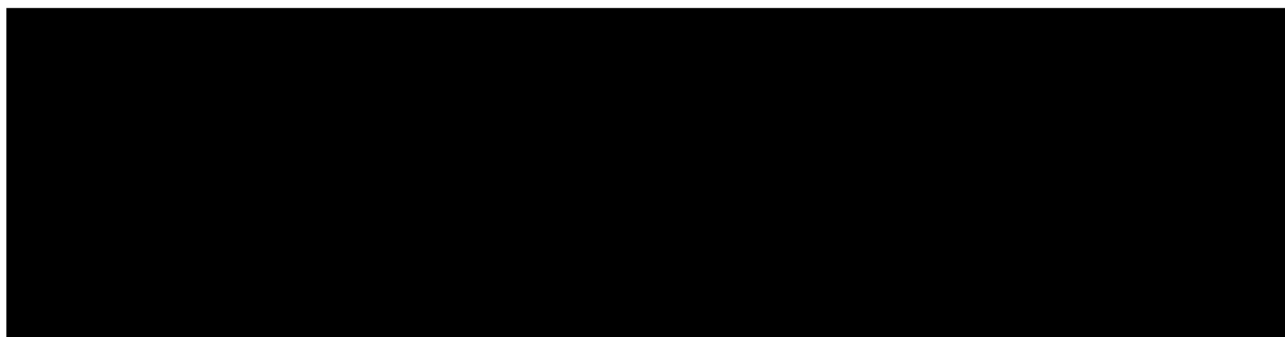
- **MHSUD Claim and Provider Data:** The Department of Civil Service requested a historical claim file with data pertaining to all claims processed, beginning January 1, 2019, through October 31, 2022, which was to include in network and out of--network claims, as well as claims where Carelon paid as Medicare Primary. In addition to that, there was also a request for data regarding MHSUD providers. The report was to include a listing of all providers treating members during the past twelve months, with provider network status to be included. The file was separated by Practitioners and Facilities.

- **Union Data Request:** The Office of Employee Relations requested a report of all claims incurred for office visits/other outpatient services that were subject to copay for Calendar Years 2019, 2020, 2021 and 2022. In addition, they requested a report of the total in-network utilization, out of network utilization, a listing of Carelon providers, including their licensure by county and zip code for those claims and utilization_for telemedicine services.

Any re runs to existing ad-hoc reports will be provided within one business day. An ad hoc report request that has a low level of effort (development time within 16 hours) will be provided within five business days. For reports with a higher level of effort, the delivery time will be mutually agreed upon with the Department based on level of effort.

The distinction between low level and higher level of effort reports is based on the time it will take to program the report. Many factors are reviewed when making the determination of level of effort, such as:

- Maturity of requirements at time of request: For instance, are detailed requirements known upfront or only at high level? If at high level, then the level of effort is considered high until detailed requirements are known at which time the level of effort is reassessed (if needed).
- Aggregate versus transactional details: If both aggregate and transactional details are to be produced, level of effort will be high.
- Breadth of history/data involved: Requests that require more than three years of data to be pulled tend to be a higher level of effort, as requests will be sourced from current and historical tables in the data warehouse.
- Existing code to leverage: If a refresh of a report is already run, the level of effort will be low.
- Addition of new data to the system: If data needs to be added to the system before the report is produced, the level of effort will be high.
- Deep dive versus snapshot requests: Snapshots level of effort is lower.
- External data to be consumed: If data is not already in Carelon's data warehouse, the level of effort will be high.



5.6 Customer Service

Carelon's customer service will continue to meet or exceed the requirements in *Section 3.5 Customer Service*. Below, we summarize our customer service efforts on behalf of the Empire Plan, and then respond directly to the RFP questions of *Section 5.6 Customer Service* on the following page.

In keeping with Carelon's commitment to help people live their lives to the fullest potential, our customer service philosophy lies in our commitment to provide Empire Plan enrollees and their dependents ('members') and providers with a strong customer service experience. We believe this includes the most accurate and informed benefit, eligibility, claims, access, and authorization information in the most effective, efficient, and compassionate manner. We understand the need for and importance of the services we provide and place the customer experience satisfaction at the heart of our customer service philosophy. In fact, our member satisfaction survey results illustrate our success:

- 96 percent of respondents said they were satisfied with the services they got from Carelon
- 92 percent of respondents reported overall satisfaction with counseling/treatment
- 95 percent of respondents said Carelon staff members were polite, courteous, and respectful
- 100 percent of respondents reported satisfaction with language assistance and 90 percent of respondents said counseling/treatment met language needs

Ensuring the quality of the member and provider experience through good customer service is important in every industry, but in none more than behavioral health care. Individuals seek out behavioral health services, often reluctantly, when they are in their most vulnerable states. How a Customer Service Representative interacts with a member can have a profound impact on their experience and willingness to continue to seek out care. Carelon is keenly aware of the critical importance of high quality customer service and has devoted considerable time and resources to assessing and improving our customer service model. For example, we are in the process of rolling out a training for call center staff on best practices for providing Gender Affirming Care and we are revising our call scripts to incorporate gender affirming language.

We know that improved customer service in behavioral health care is linked to higher member engagement, better member care, and a reduction in preventable high-cost episodes. The primary aim of our customer service process is to deliver high and consistent quality service both in terms of the constancy of the member's journey through our process and in the communication, they receive during that journey. Member satisfaction is at the heart of our strong commitment to customer service. This philosophy informs our training programs, employee development opportunities, and our telephony systems and technologies.

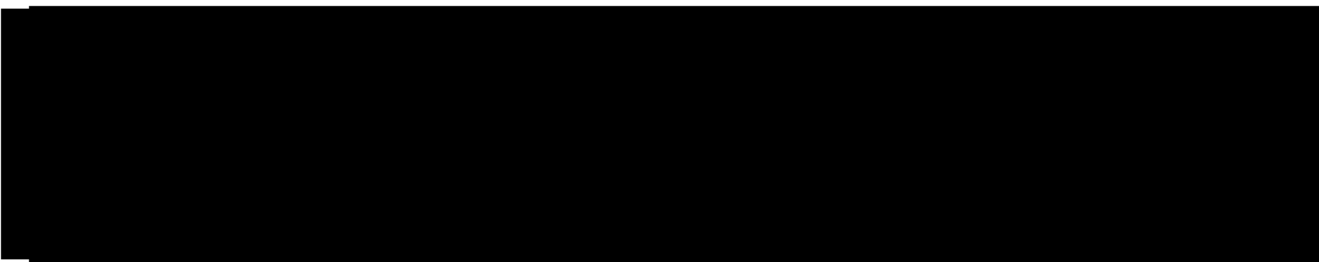
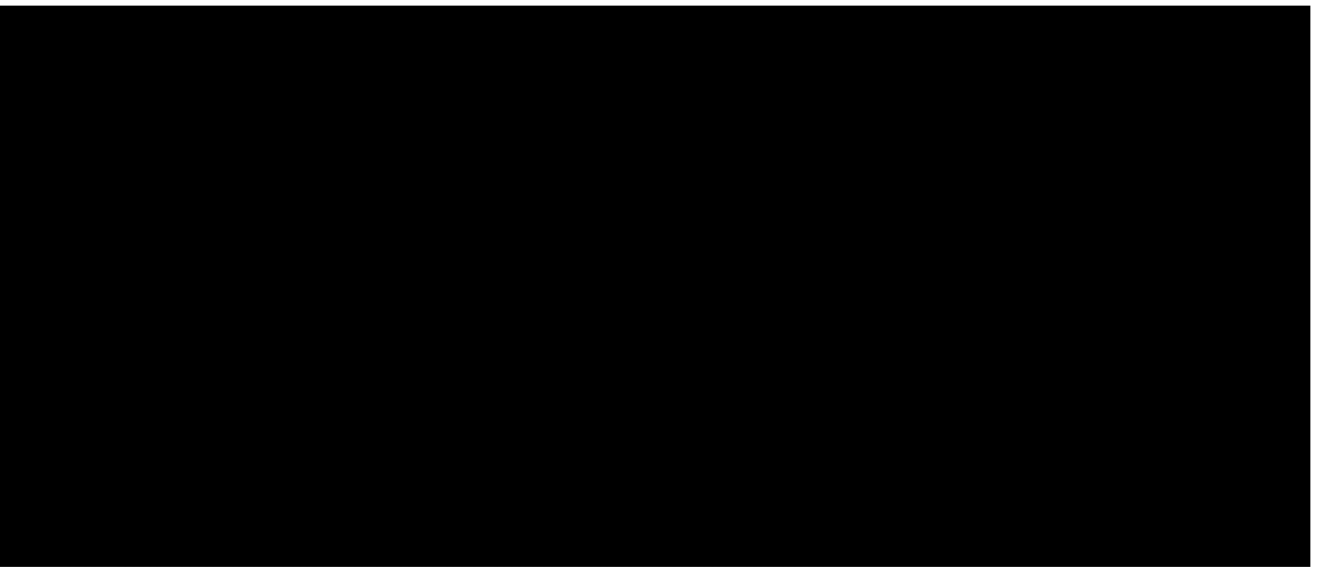
As detailed in the following sections, Carelon will continue to provide the strong core services we have provided to date, including access to all information needed for best-in-class customer service including management of the Empire Plan Consolidated Toll-Free number where members and providers access representatives who respond to questions, complaints, and inquiries regarding Plan benefits, Network Providers, clinical management programs, claim status, and appeals.

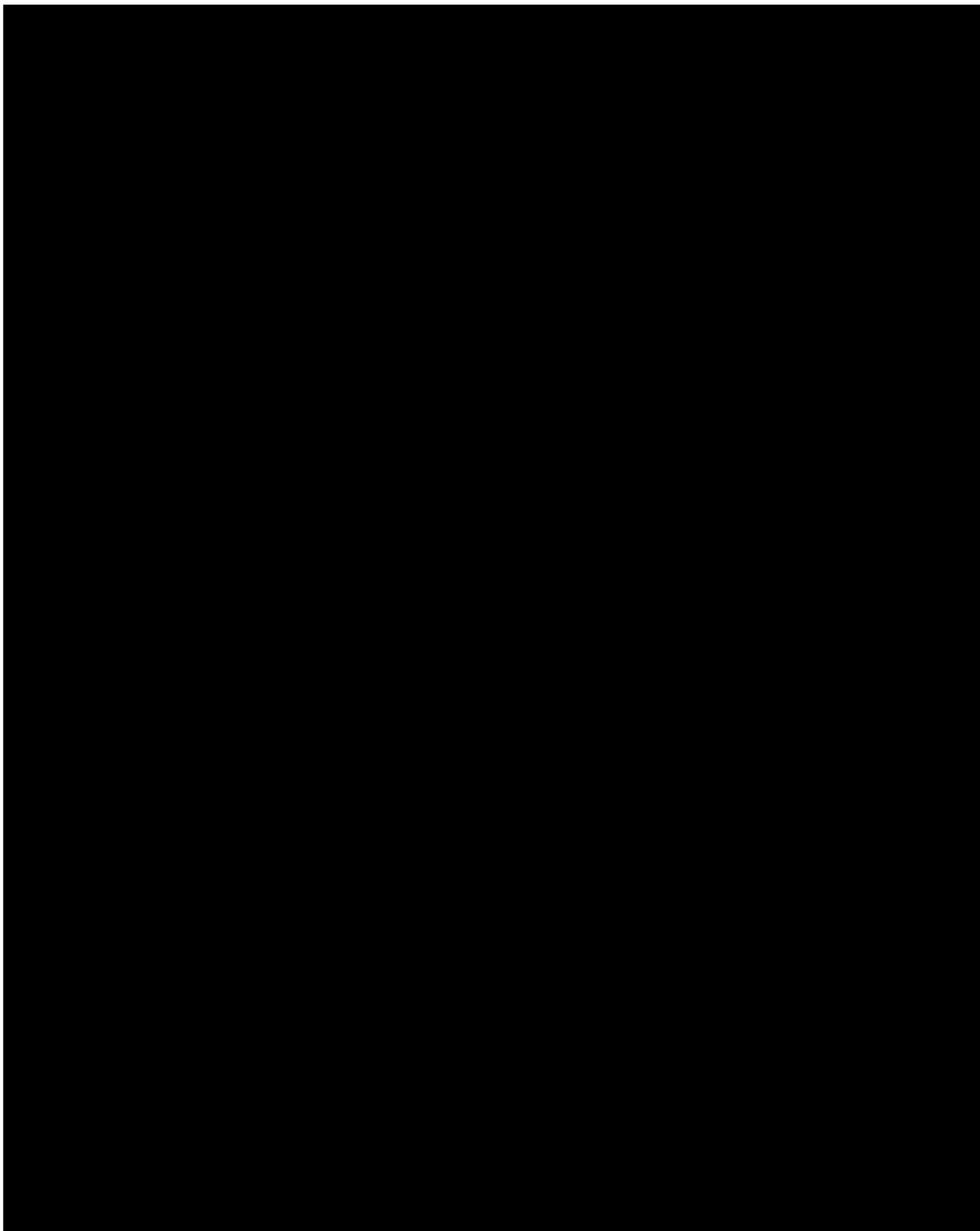
"I just had one of the best experiences I have ever had with a representative! Sheri was very knowledgeable and well spoken. She was a ray of sunshine and a wonderful representative. I am truly grateful for her!"

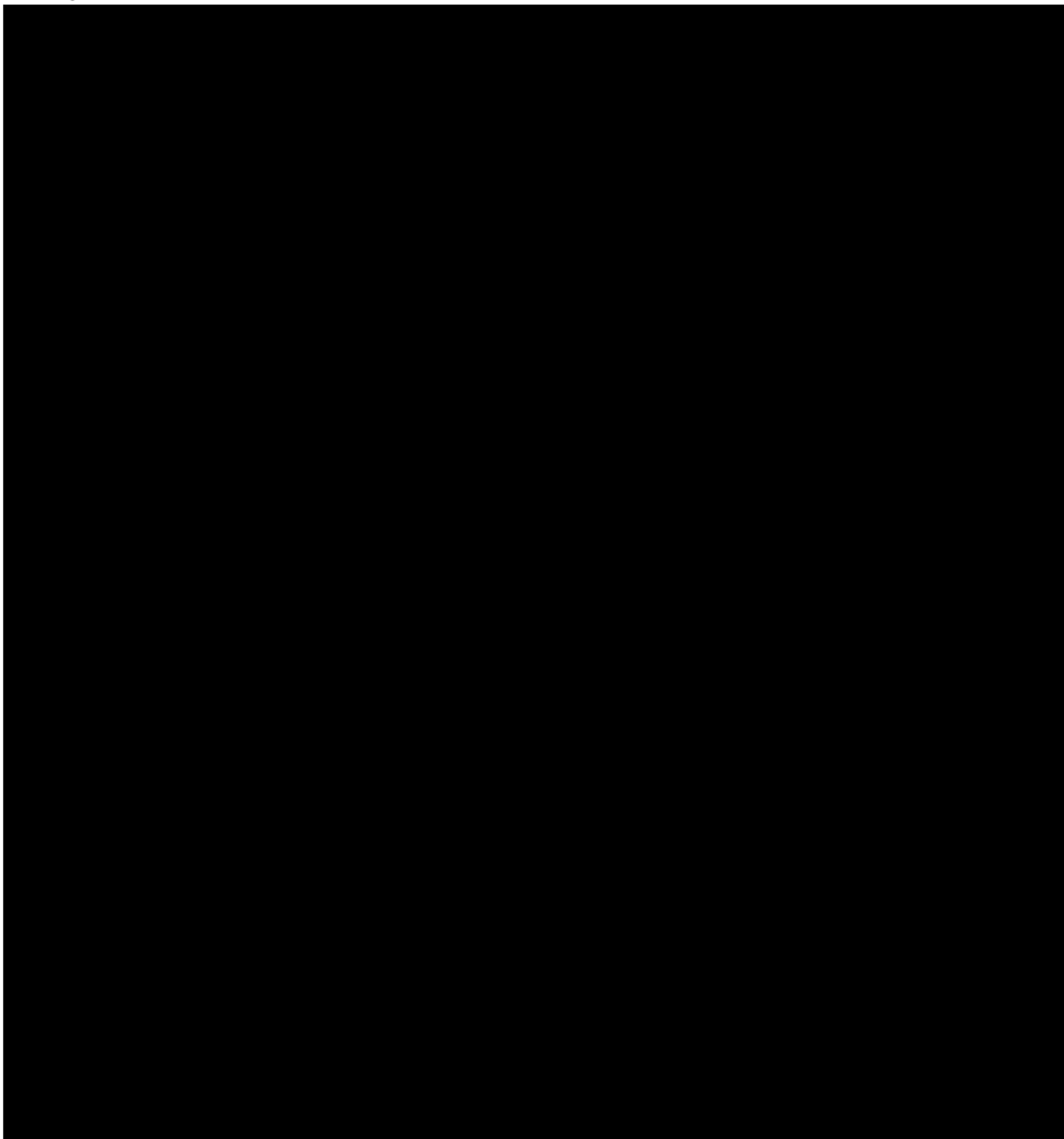
Carelon will also continue to provide members with access to information on all MHSUD benefits and services 24 hours a day, 7 days a week, 365 days a year. We will continue to maintain a fully operational dedicated Call Center, including a MHSUD Clinical Referral Line, providing all aspects of customer support with warm transfer of calls when appropriate to the MHSU Disorder Program. The Call Center will continue to be staffed by trained Customer Service Representatives (CSRs) who will use an integrated system for management of member calls. We will also continue operation of a Clinical Referral Line (CRL) available to Members 24 hours a day, 7 days a week, 365 days a year.

Currently, members can access member services such as the ability to check authorizations and view claims status, via the customized Achieve Solutions website. Moving forward, Carelon will move to a new and enhanced member engagement website, for Empire Plan members in 2023. This new member engagement website or “front door” will provide an enhanced access point to Carelon services including telehealth, be accessible by mobile devices, and offer educational and self-help resources that promote self-management and navigation.

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.

Carelon has a demonstrated commitment to overcoming the barriers to care faced by limited English-speaking members as well as those who are deaf or hearing impaired. We will take full advantage of available technology to ensure that all members have complete, prompt access to the behavioral health services they need. In fact, our member survey results show that 100 percent of respondents reported satisfaction with language assistance and 90 percent of respondents said counseling/treatment met their language needs.

Carelon ensures that members receive equitable and effective care and services based on health literacy factors and in a culturally and linguistically appropriate manner. The Carelon Cultural and Linguistic (C&L) Program has been developed following National Standards for Culturally and Linguistically Appropriate Services in Health Care, as published by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH); Health and Human Services (HHS) Final Rule that prohibits discrimination under Section 1557 of the Affordable Care Act (ACA) of 2010, The Final Rule, Nondiscrimination in Health Programs and Activities; the Federal Plain Language Guidelines, published by PlainLanguage.gov; Measuring Knowledge and Health Literacy Among Medicare Beneficiaries, published by the Centers for Medicare and Medicaid Services Office of Research; Section 1300.67.04 of Title 28 California Code of Regulations; and 2010 NCQA Multicultural Health Care Standards and Guidelines.

Carelon's Cultural and Linguistic Program includes:

- Availability of telephonic oral interpretation by staff or via a dedicated interpreter service, 24 hours a day, seven day a week including American Sign Language (ASL) referral
- Availability of Teletype (TTY) and/or relay services
- Availability of referrals to network providers for services in specified languages or cultural needs
- Translation of written materials as required or requested
- Provision of member materials in plain language
- Ability to translate member website into more than 100 languages

As part of our routine call center services, we employ bilingual staff and offer interpreter services. We have English and Spanish auto-attendant options for routing members' calls. If all Spanish speaking staff are occupied, callers are seamlessly directed to our dedicated interpreter service, which is also available 24 hours a day, seven days a week for calls to the NYSHIP toll-free phone number. Our interpreter service uses highly skilled, qualified medical interpreters who can accommodate more than 200 languages.

While our licensed clinician remains on the line with a member, the service will assist members in resolving inquiries responsively, compassionately and, most importantly, effectively. It also enables our staff to assess members with special language needs to make the most appropriate referrals to providers or community resources. In these situations, call center staff, the interpreter, and the member will hold a three-way call to complete the initial intake and assessment of the caller's needs.

For December 2022 to February 2023, 1,150 calls were connected to the language line and the top three requested languages were Spanish, Mandarin and Russian.

Our TTY/TDD and relay services for members who are deaf or hearing impaired offer a confidential service that is available 24 hours a day, seven days a week. All call center staff are thoroughly trained in the use of TTY/TDD services so that callers who are deaf, hard of-hearing, or speech impaired can talk to us without an interpreter.

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

Carelon tracks the Empire Plan's call history through our Avaya telephone system. Avaya has a suite of real time and historical reports we use for trending to ensure we consistently meet telephone responsiveness performance requirements. These reports include calls received, calls handled, abandonment rate, average speed to answer, and service level handled time. This information is available by half hour intervals, day, month, quarter, and year to-date.

Avaya provides a comprehensive suite of reports including historical data for trending and real time data to ensure we consistently meet telephone responsiveness requirements. The customer service module of our proprietary information system electronically captures all call data, and it provides our staff with secure and easy access to all member and provider information. The customer service module provides immediate access to the necessary information to respond to benefit, eligibility, provider, claims, authorization, and certification related calls. Customer service staff has immediate access to all requests submitted to a support area within Carelon, including the date the request was sent, the operating area it was sent to, as well as the request type (i.e., what assistance the caller was requesting). The system module also provides our staff with real time data regarding the status of the inquiry request throughout the life of the inquiry.

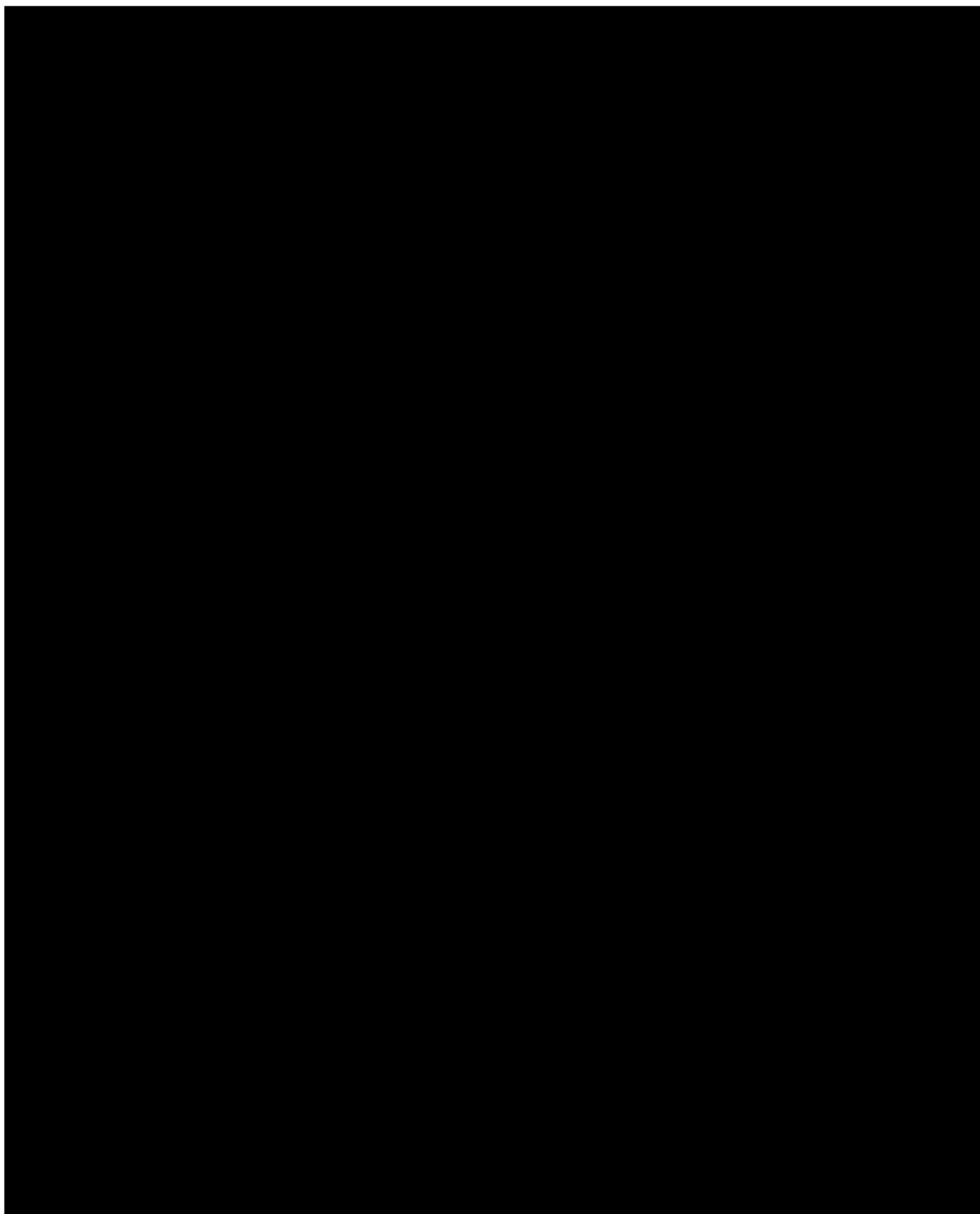
Carelon provides the Empire Plan with customized phone prompts and voice recordings. When necessary, Carelon can easily adjust phone prompts and recordings in partnership with or at the direction of the Department, as we have done historically. This is accomplished by informing your account lead of the prompt or voice recording modifications needed so that a service ticket can be entered to make the alterations in the system.

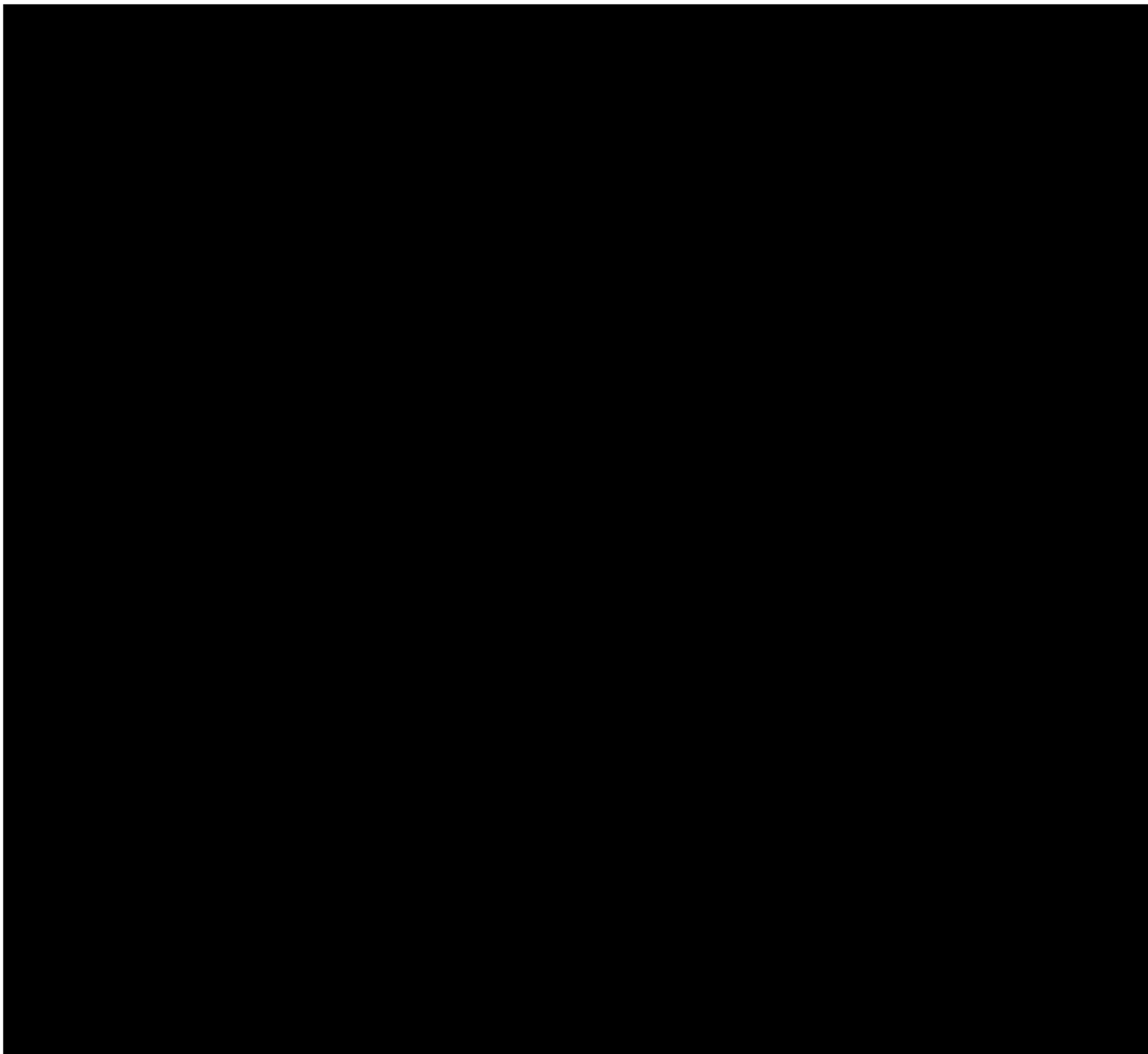
These services are all provided without additional charge to the State.

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

Carelon proposes that the Empire Plan Customer Service phone lines be open and staffed from the hours of 8:00 am to 6:00 pm EST Monday through Friday. In our experience, the majority of these types of calls are received during these hours. After hours, weekend, and holiday calls are answered by our Centralized Night Service staff, who receive the same scripts and training as the daytime staff. Our CSRs respond to inquiries regarding eligibility, benefits, claims, and for gathering and documenting demographic information.

In addition, our Clinical Referral Line staff are available 24 hours a day, seven days a week, 365 days a year to handle all clinical calls and provider referrals.





NICE Workforce Management (WFM) System

Another benefit to the Empire Plan and individuals and families served is Carelon's NICE Workforce Management System. This technology allows Carelon to enter individual call center agent information such as work hours, phone queue priorities, and Carelon's internal Avaya agent ID for each agent. This ensures call history is collected for each agent to find trends in the average number of calls they take in a day, their average call handle time, as well as which phone queues they receive most frequently among other data collection points.

In addition to agent history, the NICE WFM system also allows Carelon to build out the phone queues and expectations. For example, the Empire Plan's RFP is requesting a service level agreement (SLA) of 90 percent of all calls answered within 30 seconds. Carelon can build this into all queues and apply the SLA to the applicable queues.

Once call history is collected in the NICE system, such as call volume, average handle time of calls, and SLAs, Carelon can more accurately predict incoming call trends and handle time trends throughout each day. The algorithms in the system will allow Carelon to be able to see how many agents are required to handle the incoming volume at each interval. We also will develop operational dashboards to provide real time visibility into the Empire Plan Call Center operations to adjust staffing as needed to meet all program requirements.

Customizable Options

As described above in response to part b, our phone prompts and voice recordings are currently customized for the Empire 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.

We are committed to providing the training, tools, resources, and infrastructure our employees need to provide accurate and efficient service that meets Empire Plan member and Department expectations. Today, the Empire Plan team accesses all information necessary to address inquiries, including eligibility, benefits, authorizations, provider status, and claims via our CONNECTS platform. Customer service, clinical referral, care management, reporting, and outcomes data are all managed within this system.

Our CSRs are thoroughly trained to appropriately triage all types of inquiries. All newly hired call center personnel undergo extensive training of up to six weeks on all aspects of the Empire Plan program before they "go live" on the phones.

Highly qualified, experienced training personnel, call center management, and support staff are responsible for the initial training of new staff members. We take a phased-in approach to releasing trainees to the call center. During formal training, they begin to handle live calls with one-on-one mentoring to ensure the quality of the member experience. Call center management, quality auditors, and senior level CSRs continue dedicated on-the-job mentoring until the trainee successfully passes their quality ramp-up period.

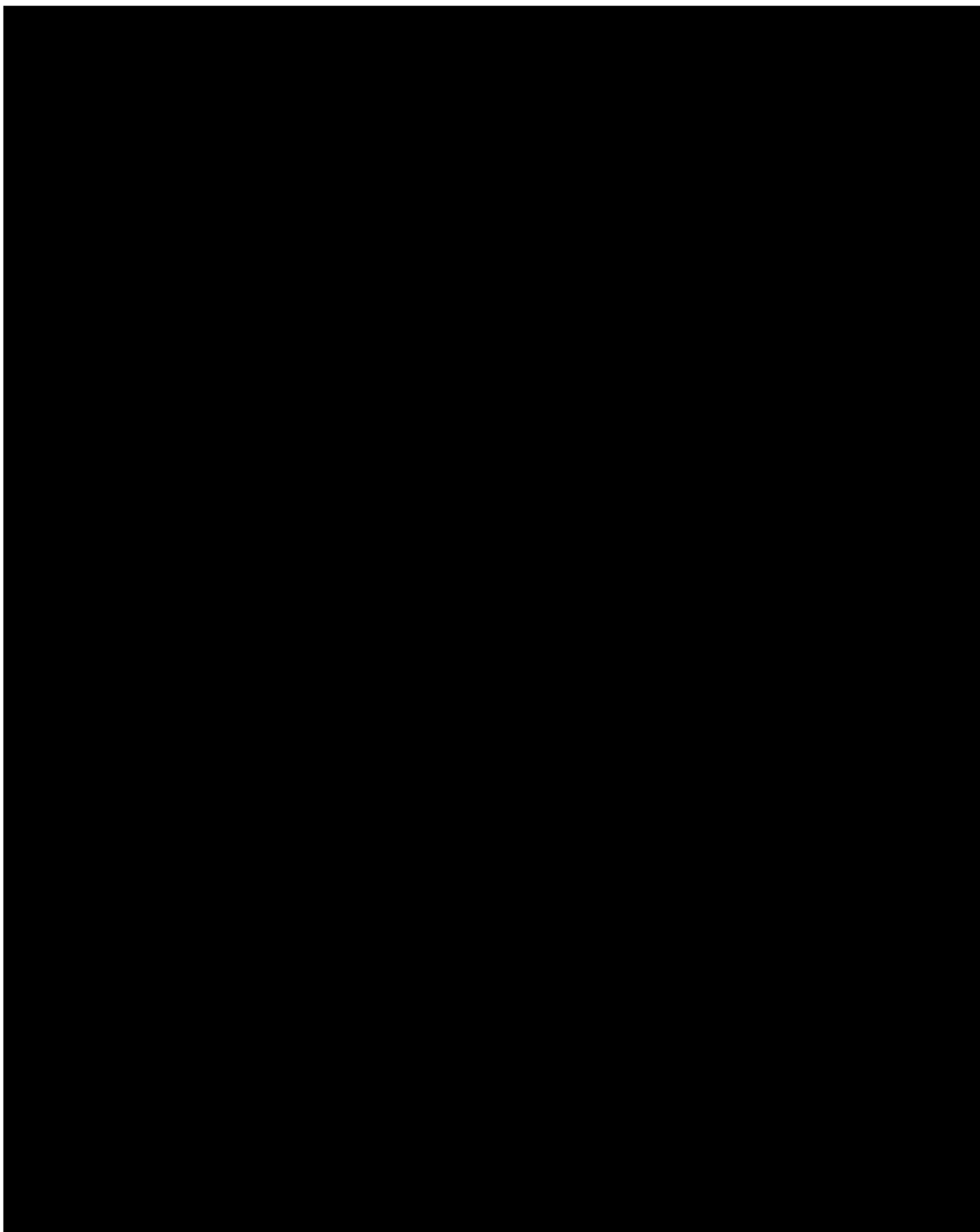
“Received a call from a member who wanted to compliment Lilas. The member indicated that she was “so helpful, patient, and a fabulous customer service representative.” The member continued to say that Lilas took her time with her and gave her the information that she needed as she gets confused sometimes when calling the insurance companies.”

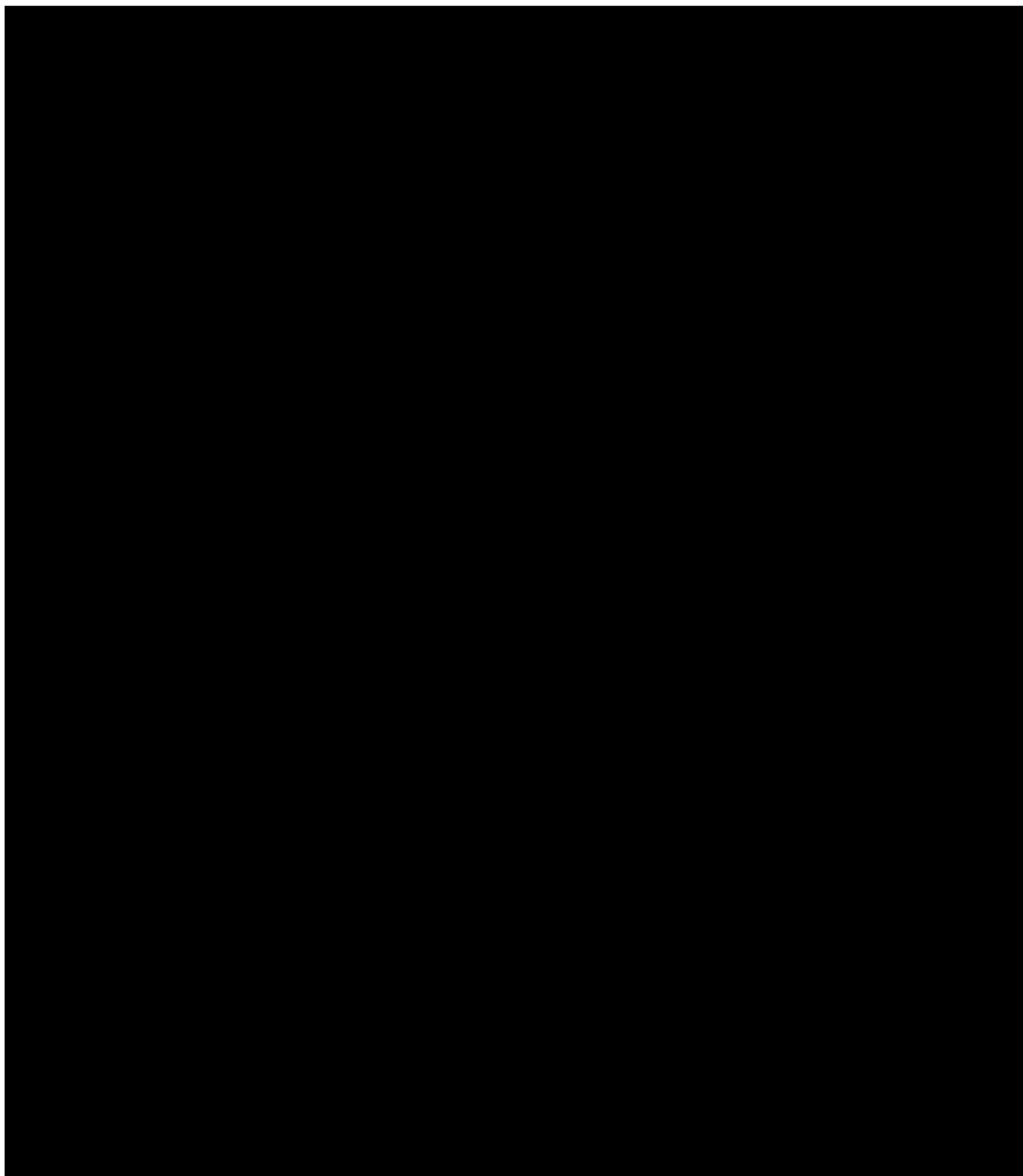
In addition to training on our customer service procedures, CSRs are taught how to recognize urgent, or crisis calls, and to implement Carelon’s standard protocol for clinical and/or crisis intervention. CSRs have real time access to Empire Plan specific benefit plan information through our central repository of all client information; this includes plan benefits, eligibility information, and additional client specific information.

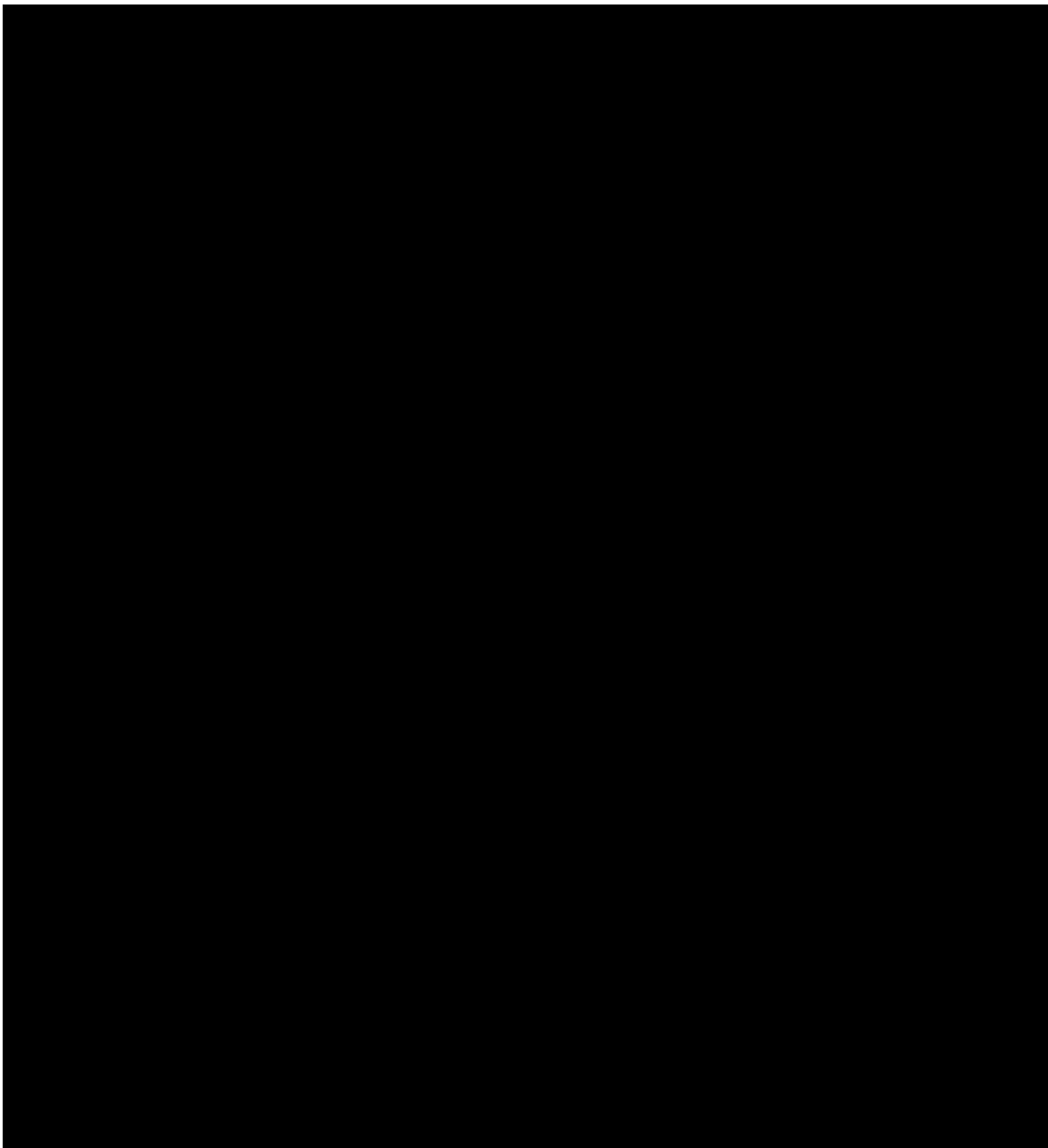
We recognize the complex nature of the inquiries received from individuals with serious behavioral health conditions. All CSRs go through clinical sensitivity training, which provides the groundwork for recognizing and identifying the diverse types of calls generated to a behavioral health line. This training provides our staff with key phrases and indicators which signal when a warm or no hold transfer to a dedicated Clinical Care Manager is required.

Additional training is provided based on needs identified through quality or inquiry audits, workgroups, or resulting from national, procedural, or client specific change requests or updates. Our internal quality monitoring processes are described in further detail below.

Internal Controls and Reviews Ensuring Quality Service







Back-up System for Primary Telephone System

The Carelon Telephony infrastructure uses two data centers, in Las Vegas, Nevada and Ashburn, Virginia. The Avaya cores are duplicated in each of these centers. Ashburn is the primary core and Las Vegas is the secondary.

All inbound and outbound calls route through the Avaya core in Ashburn. We use two carriers, Lumen and Verizon, to route inbound and outbound calls. These calls are routed over Session Initiated Protocol (SIP) trunking. Each Data Center has redundant circuits from each carrier. If a carrier circuit fails in Ashburn, it will fail over to the other carrier circuit in Ashburn. If both circuits for a given carrier fail in Ashburn, it will failover to Las Vegas. If all circuits for a given carrier fail, we can move calls to the other carrier through a web portal to ensure no disruption. This is seamless and calls are not dropped.

In addition to the carrier strategy, the Avaya cores also have failover capabilities. If the Ashburn Avaya core fails, it will automatically failover to the Las Vegas core. All these failover strategies are automatic and require no intervention from the carrier or the Telecom support team.

The Command Center can route traffic from an inbound call to any agent skill. As stated, all calls route through the core and not direct to any given call center. As an example, a call destined to Latham will route over the Ashburn core and take the Carelon internal network to route to an agent in Latham. If Latham is unavailable, the Command Center can route that call to another center or group of agents with a similar skill and/or assign another group of agents that skill.

Telecommunications Disaster Recovery

Every call is important, with duplication and replication at every point to ensure no missed calls. Our central Avaya architecture is designed to ensure resumption of call handling if the primary central Avaya telephony platform is suddenly and unexpectedly out of service.

Carelon maintains core infrastructure in two geographically diverse data centers. We have deployed a mirror image of our Avaya phone system, including peripheral services such as modular messaging and NICE Call Recording, in a hosted, premier data center in Ashburn, Virginia. This system is kept in hot-standby mode and with all system configurations automatically synchronized to the system in Las Vegas, Nevada. In the event of a catastrophic problem in Ashburn, Las Vegas can be handling all telephony requirements within 30 minutes.

Staff Training

We confirm that staff members based out of Latham, New York and Wixom, Michigan locations are trained on the Empire Plan program, and have access through our CONNECTS platform to member and provider information.

This provides a seamless service experience, with no loss of data or quality degradation. Back-up procedures are completely transparent to members and providers, who continue receiving service delivery whatever the emergency outage.

Our Business Continuity Plan encompasses telephone service recovery for all Service Centers. A telephony Business Recovery Plan (BRP) can be invoked if a call center is not able to continue to provide call handling service as normal. Every service center has its own unique BRP plan. These BRP plans are managed 24 hours a day by our National Telecommunications Group. Our geographically dispersed call centers provide backup call management services for each other. This ensures the level of service employees will receive, even when a site may be operating under BRP conditions, meets our standards and client service level

expectations. BRPs are activated by service centers when needed. To activate or de-activate a BRP plan, a service center simply calls or e mails the Technology Call Center and requests that their center be put into or taken out of Business Recovery. This process can be accommodated within minutes of notification, 24 hours, seven days a week, 365 days a year.

The activation of the Business Recovery Plan will not affect the existing protocols for delivering appropriate and necessary services to employees. In the event of a disaster that affects the service center that serves our client, our telephony system allows for look ahead routing and capabilities to send calls to different service centers without initiating business recovery. All Care Managers—regardless of the service center location—are licensed clinicians trained to quickly assess member needs and assist in getting the member to the nearest facility and/or appropriate level of care in a safe and timely manner. Further, Clinical Operations, through coordination with our Account Management team, is made aware of client disasters so that they can develop a plan that may be an additional protocol when determined beneficial for members' safety or management.

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

Feedback via Post-Call Surveys

We are committed to exceptional performance and service to your members when calling the toll free number. Consequently, we conduct post-call surveys at the conclusion of the call to collect real time customer feedback that provides an all-encompassing view of the customer experience.

Our telecommunications system provides flexible and intelligent survey flow capabilities that direct the caller to relevant questions within the survey based on the caller's response. The NICE Customer Feedback Solution provides a direct link between the post call survey and recorded customer interaction. The system design provides the tools for evaluating the customer experience, gaining insight by reviewing the recording of specific interactions, and conducting root cause analyses.

The results provide insight into caller interactions and what determines caller satisfaction and dissatisfaction. They guide us in ensuring that our business processes are compatible with members' expectations. We also use them to ensure continuous improvement by providing our member engagement, customer service, and clinical staff with the most current information about call trends.

Annual Member Survey

Satisfaction or experience surveys of members who have accessed behavioral health and other services managed by Carelon are conducted by an external vendor and reported at least annually, by the line of business, using a valid methodology. For Empire Plan members, we use a margin of error methodology for determining outreach based on utilization. Our goal is to be at no more than a 10 percent margin of error. Based on the Empire Plan utilization, the target response is 400, which was achieved during the most recent survey process. We provide a sample member survey as **Exhibit 10 –Survey Sample**.

The surveys measure member experience and satisfaction with important aspects of service, care, and outcomes including, but not limited to:

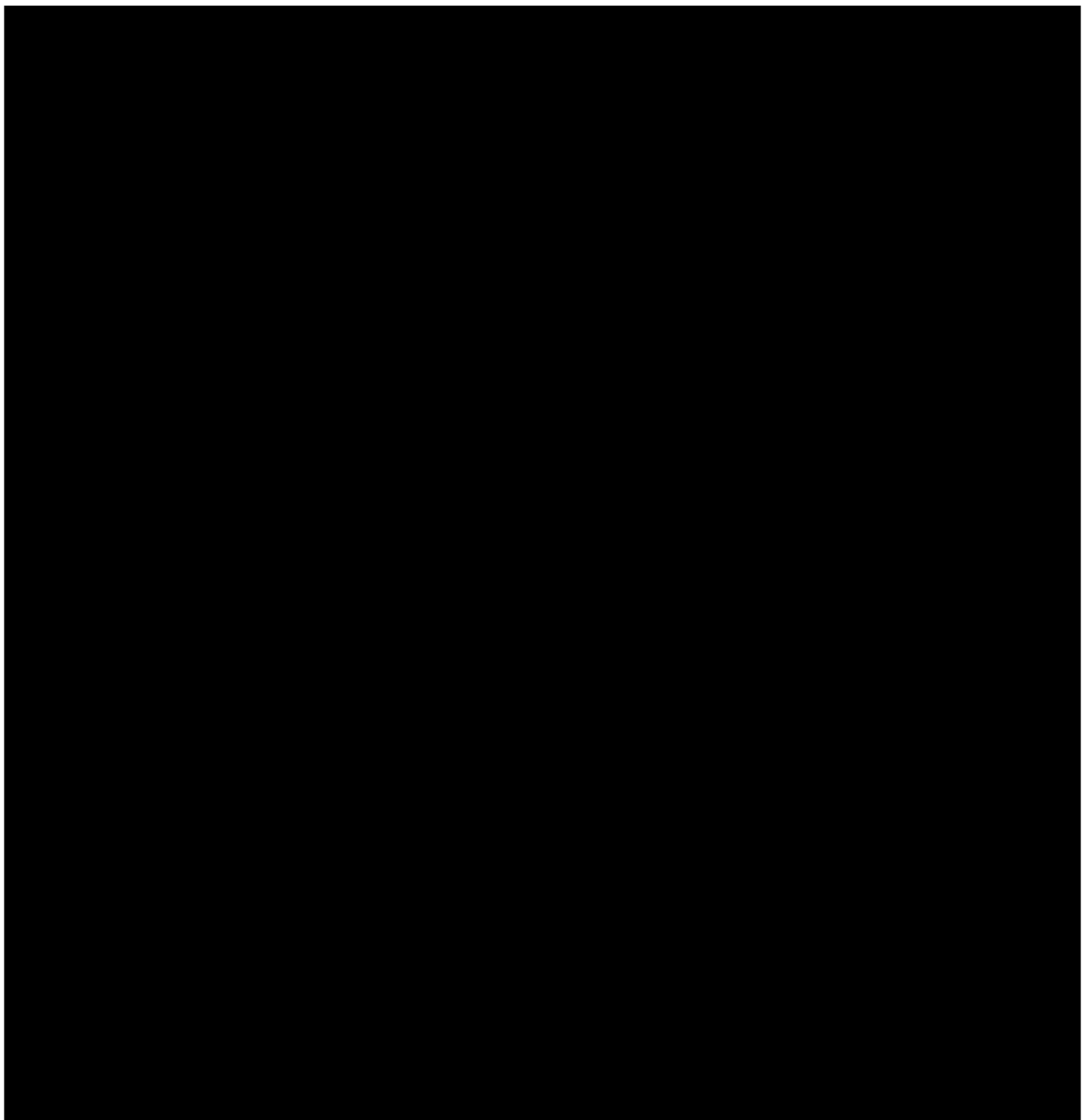
- Overall satisfaction experience with Carelon services
- Access and availability of providers and services
- Acceptability of providers and service
- Experience with utilization management and case management processes
- Perception of quality of clinical care services
- Quality of customer service
- Provider sensitivity to cultural, ethnic, gender, and linguistic needs
- Coordination of care between behavioral health providers and between behavioral health and medical care providers
- Perceptions of the outcome of care

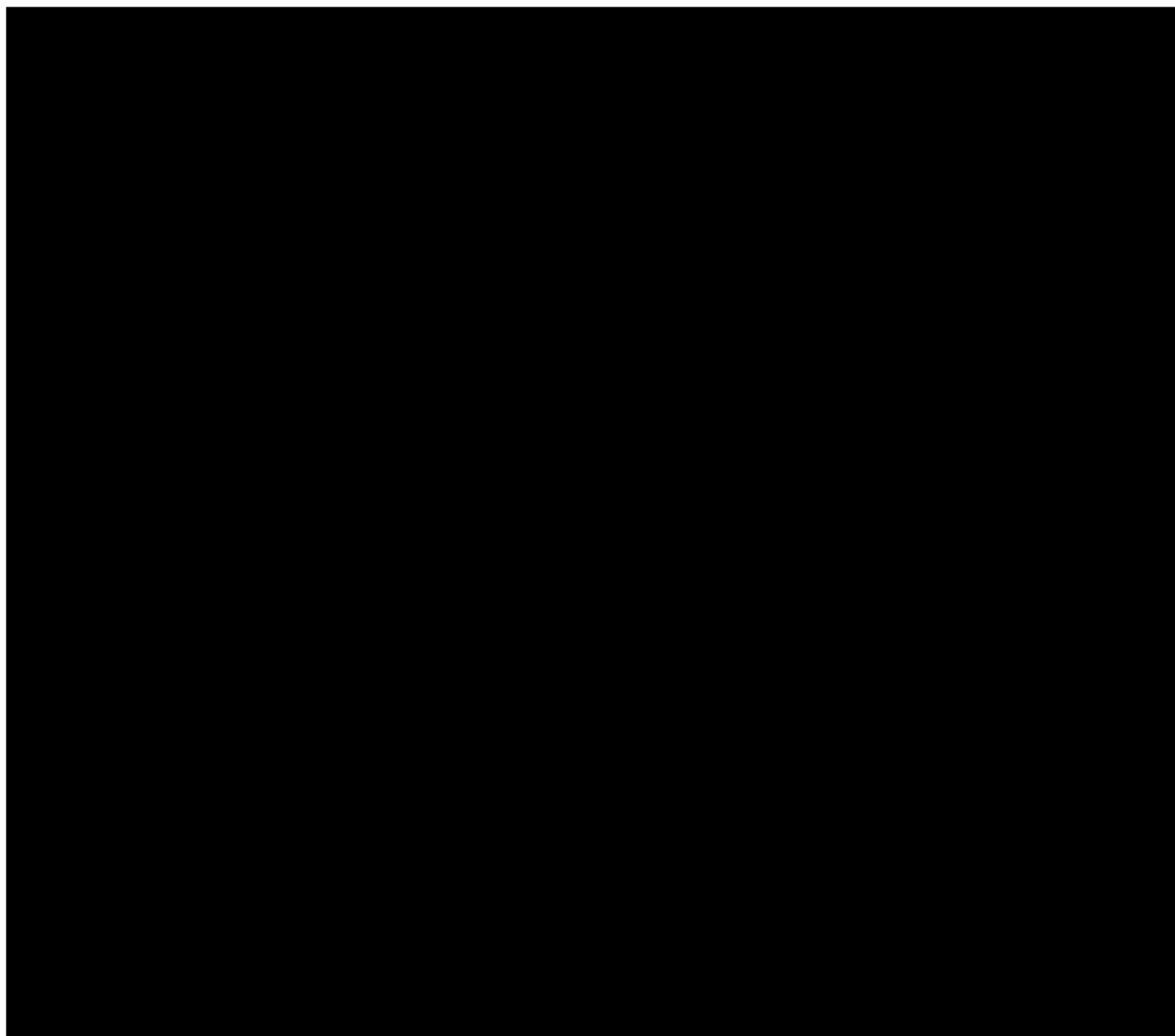
Our most recent survey results include:

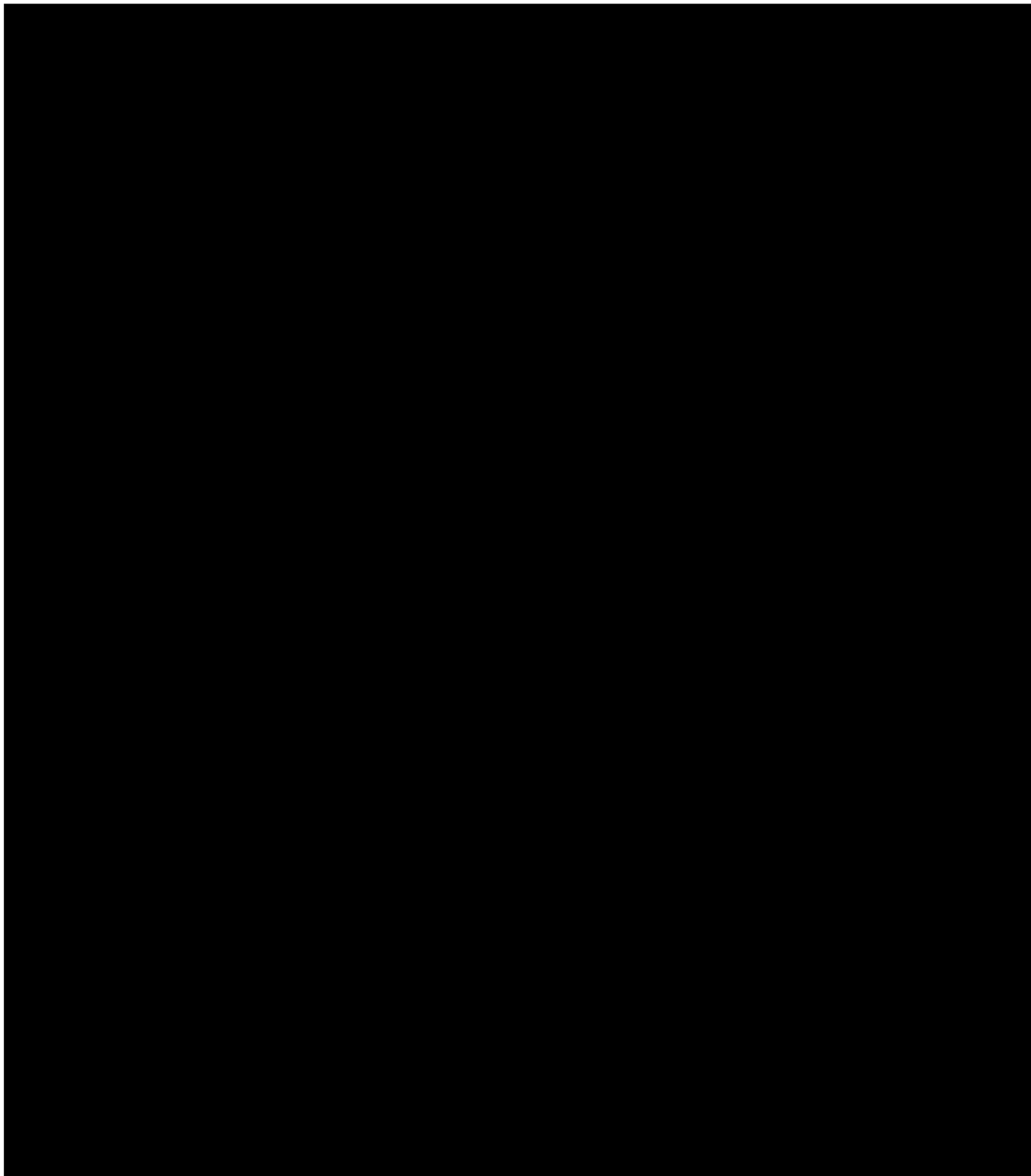
- 100 percent of respondents reported satisfaction with language assistance and 90 percent of respondents said counseling/treatment met language needs
- 92 percent of respondents reported overall satisfaction with counseling/treatment
- 96 percent of respondents said they were satisfied with the services they got from Carelon
- 95 percent of respondents said Carelon staff members were polite, courteous, and respectful

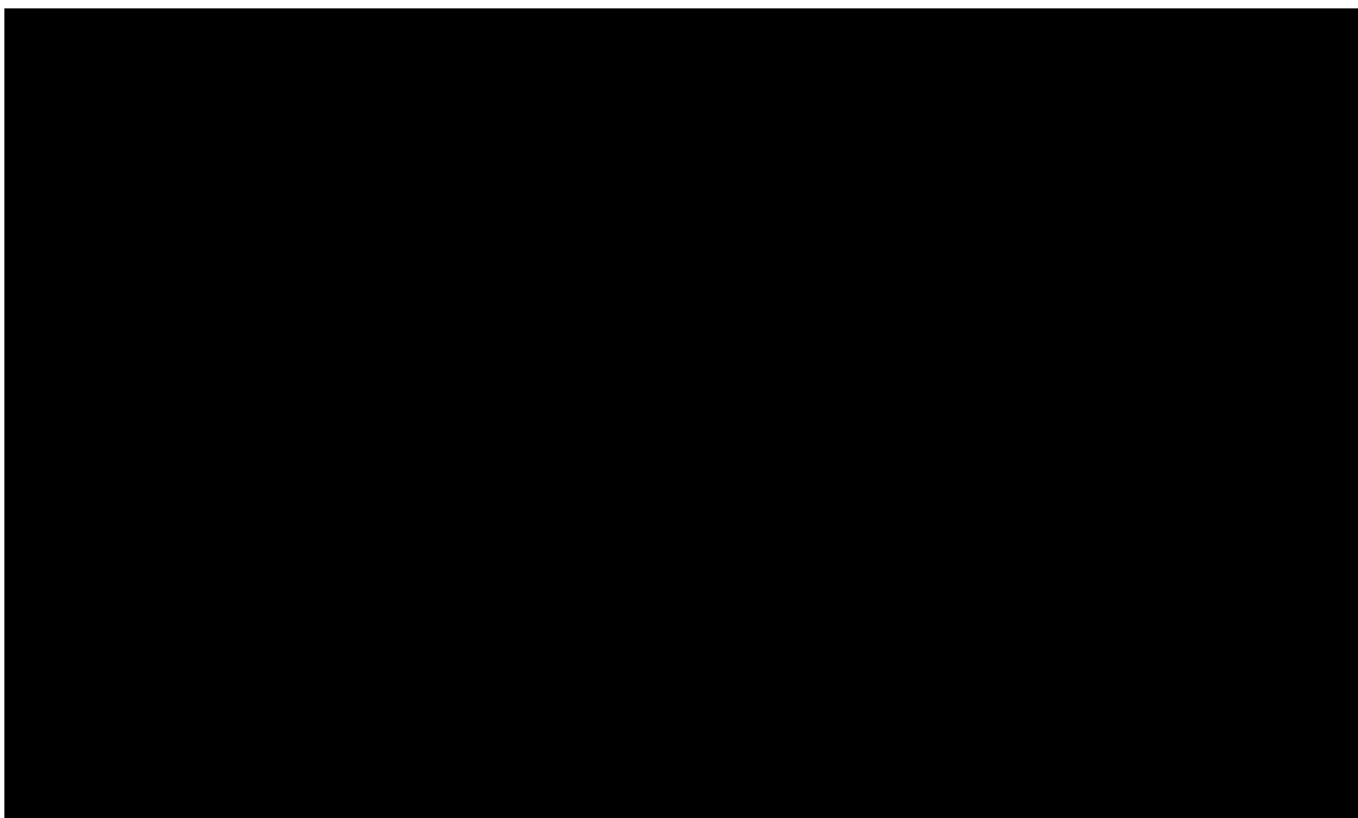
- h. Detailed information about the location(s) where call center and customer service work shall be performed. [**Note:** In accordance with New York State Labor Law section 773, the head of each State agency is required to use reasonable best efforts to ensure that all state-business-related contracts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

We will continue to service the Department's MHSU Disorder Program from our Latham Service Center at 15 Plaza Drive, Latham, NY 12110, close to the Department for your convenience.





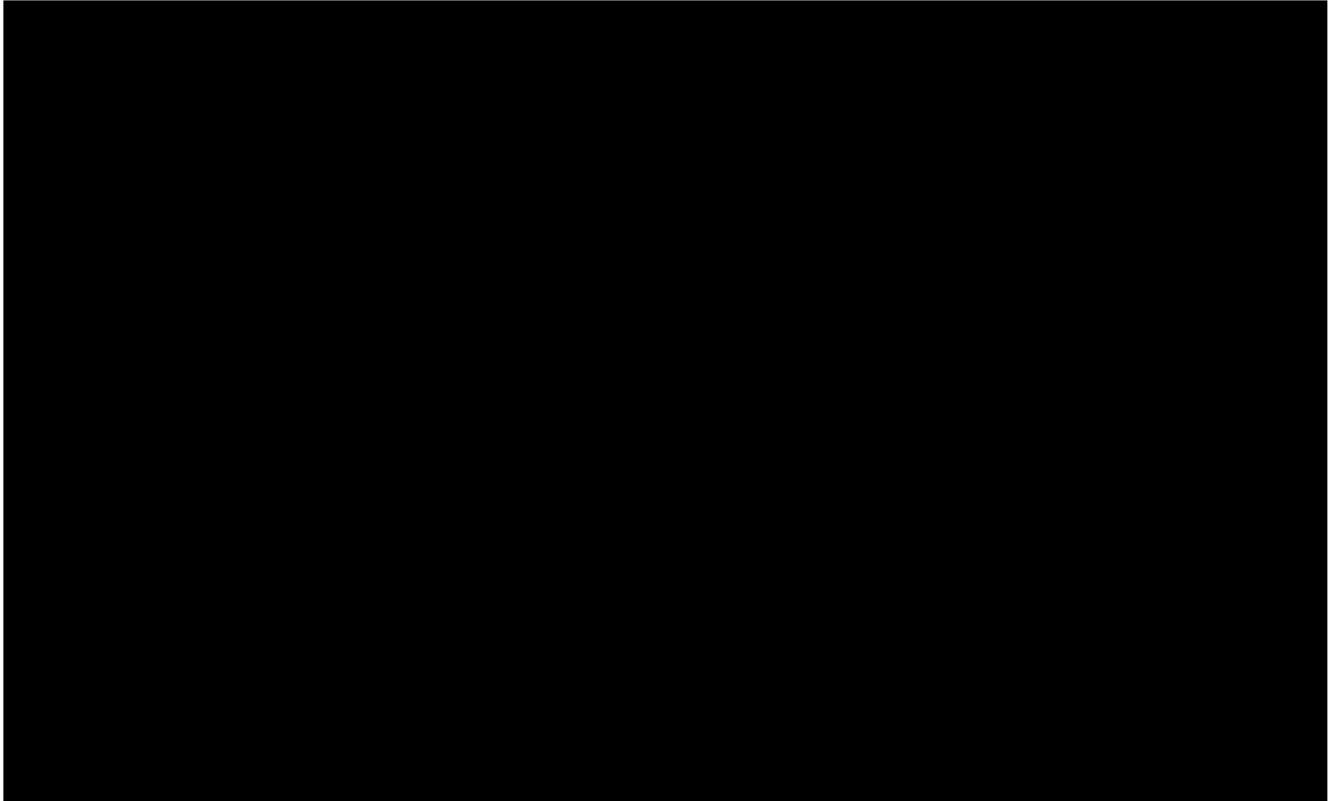


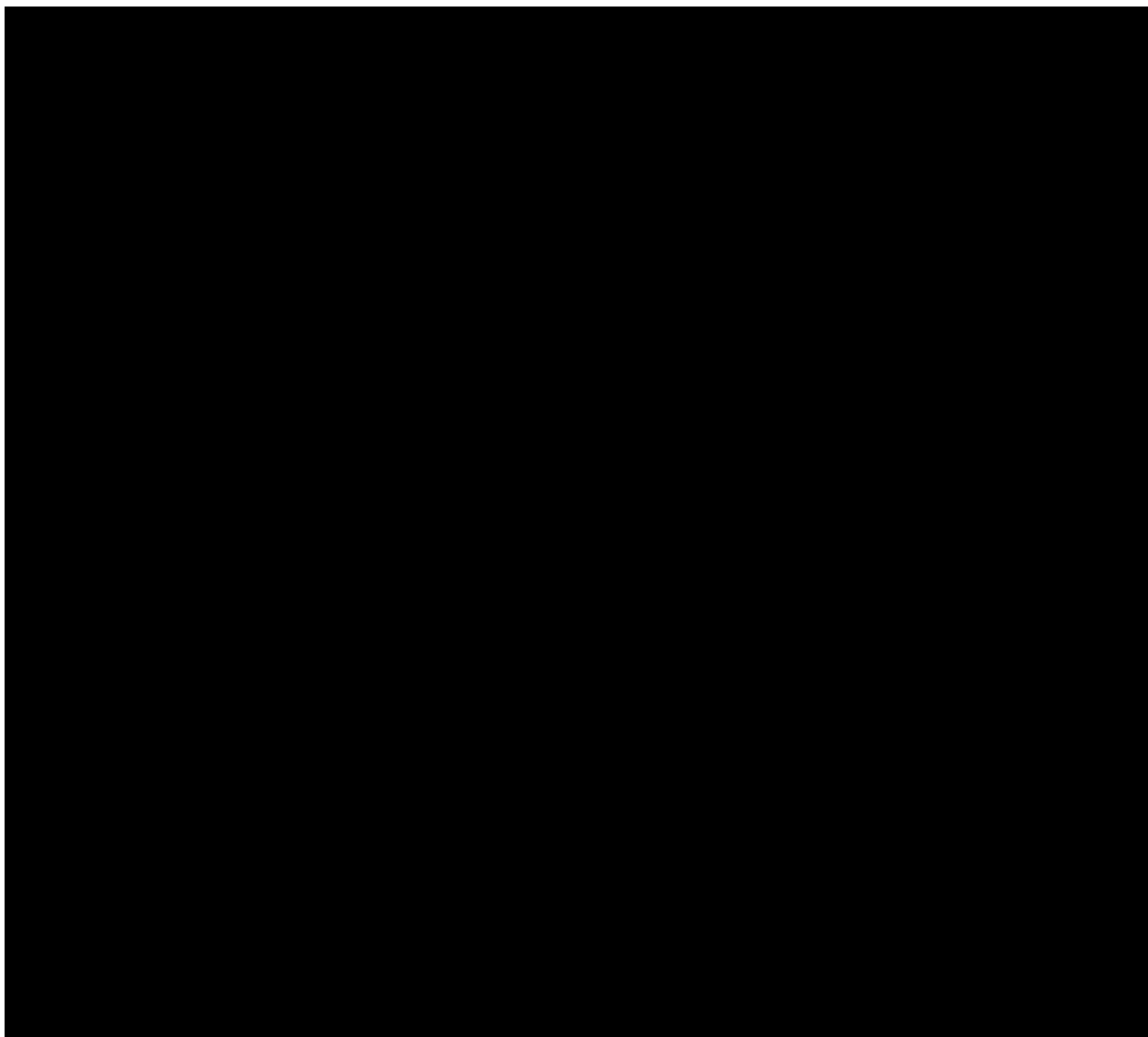


5.7 Enrollment Management

As the current MHSU Disorder vendor for the Department, Carelon's enrollment management services will continue to meet or exceed the requirements in Section 3.6 Enrollment Management.

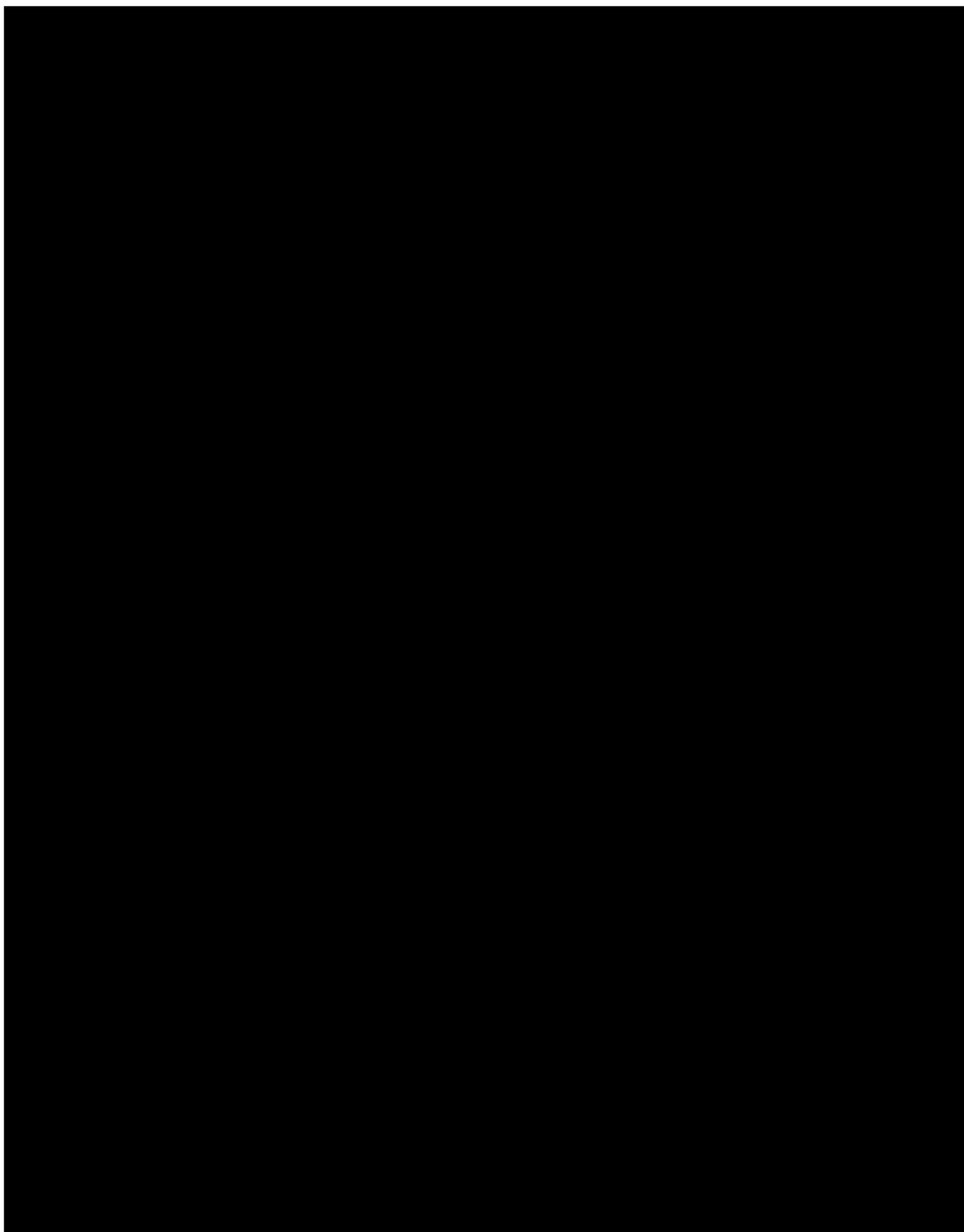
1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized to manage enrollment data as specified in Section 3.6 of this RFP, including the following:





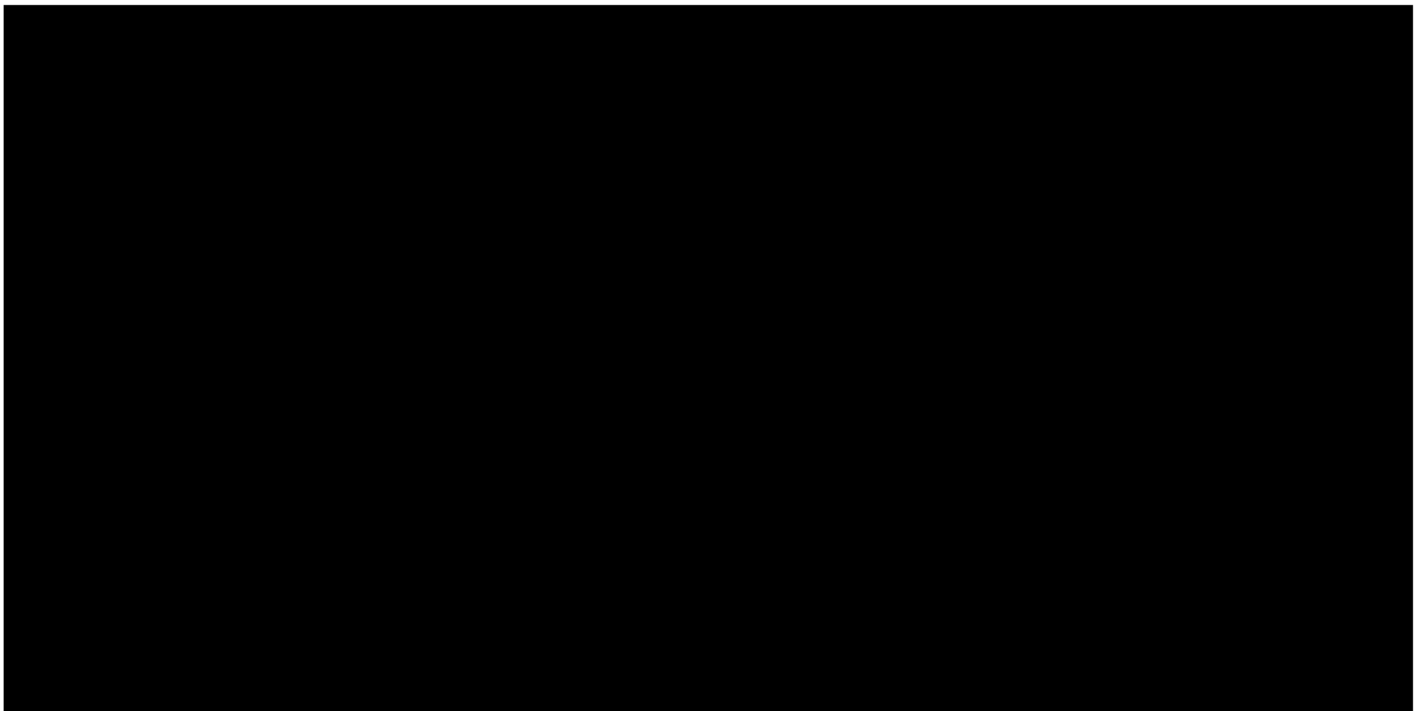
- a. Offeror's testing plan to ensure that the initial enrollment load and daily enrollment transition files for the Plan are accurately updated to Offeror's system and that such files interface correctly with Offeror's claims system. The testing plan must include:
 - i. The quality controls that are 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 the Offeror will ensure that enrollment and eligibility transactions that do not load into the Offeror's system will be manually reviewed and reported back to the Department within one Business Day.

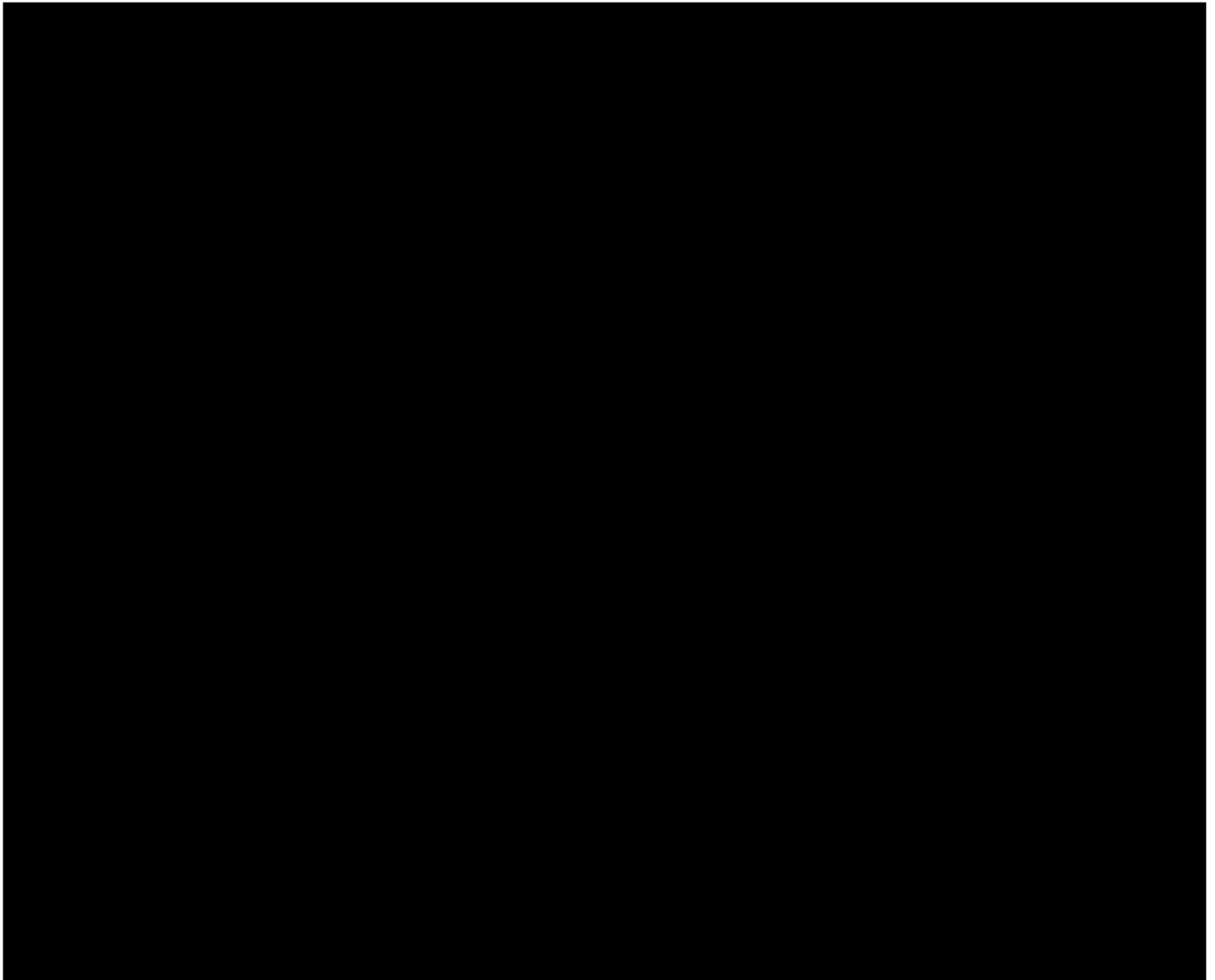
- b. Offeror's system capabilities for retrieving and maintaining enrollment information within twenty-four hours of its release by the Department as well as:
 - ii. How Offeror's system handles retroactive changes and corrections to enrollment data;
 - iii. How Offeror's enrollment system captures the information necessary to produce the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims" required in the Reporting Section of this RFP; and
 - iv. How Dependents are linked to the Enrollee in the Offeror's enrollment system and claims processing system, including a description on how Offeror's enrollment and claims processing system can administer a social security number, Employee identification number, and an alternate identification number assigned by the Department; and any special requirements to accommodate these three identification numbers.



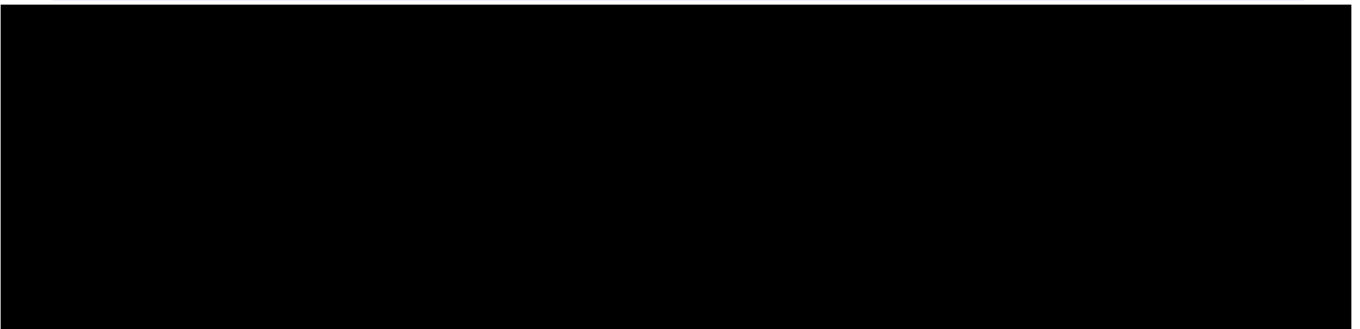


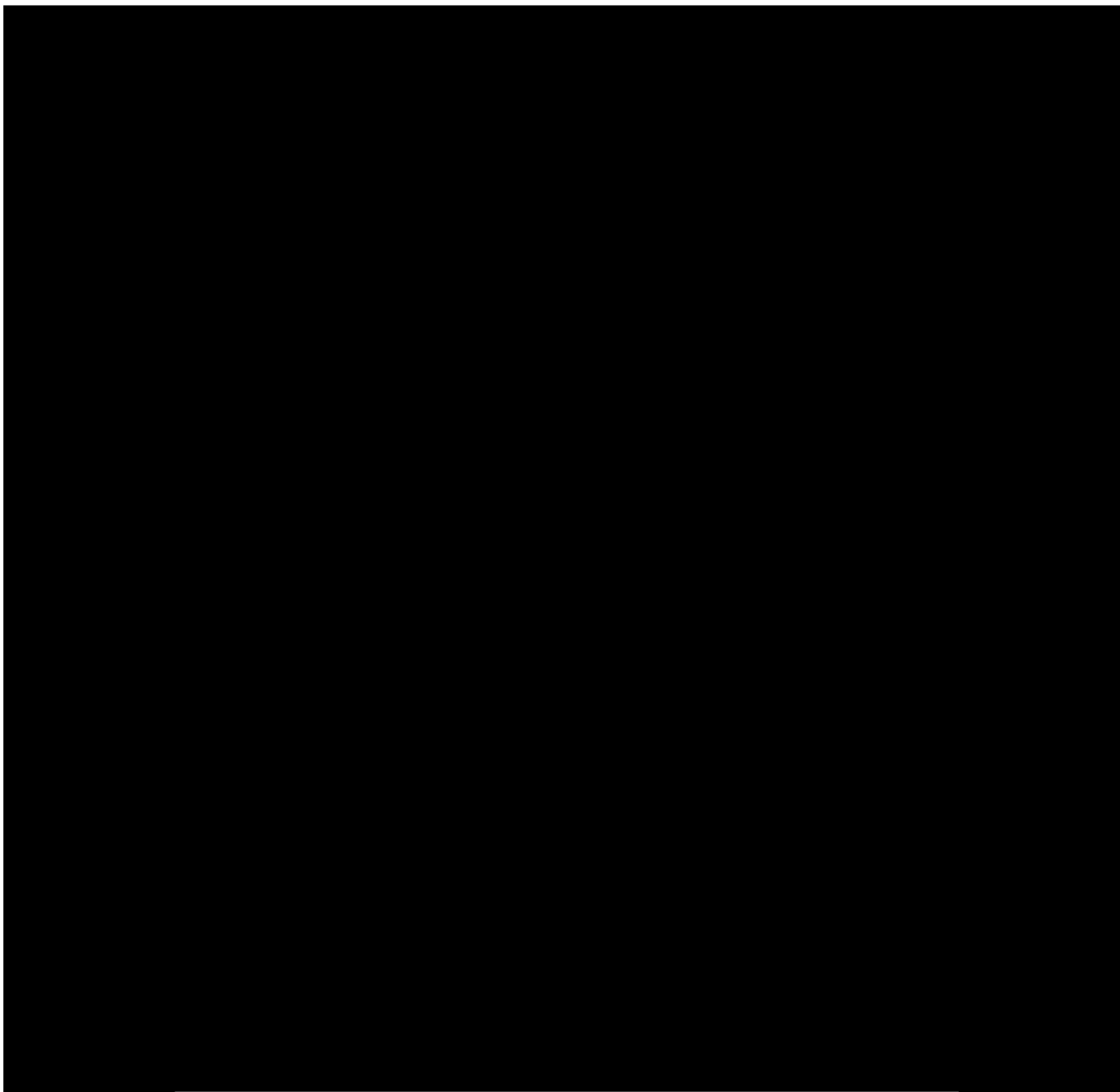
- c. How Offeror's enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

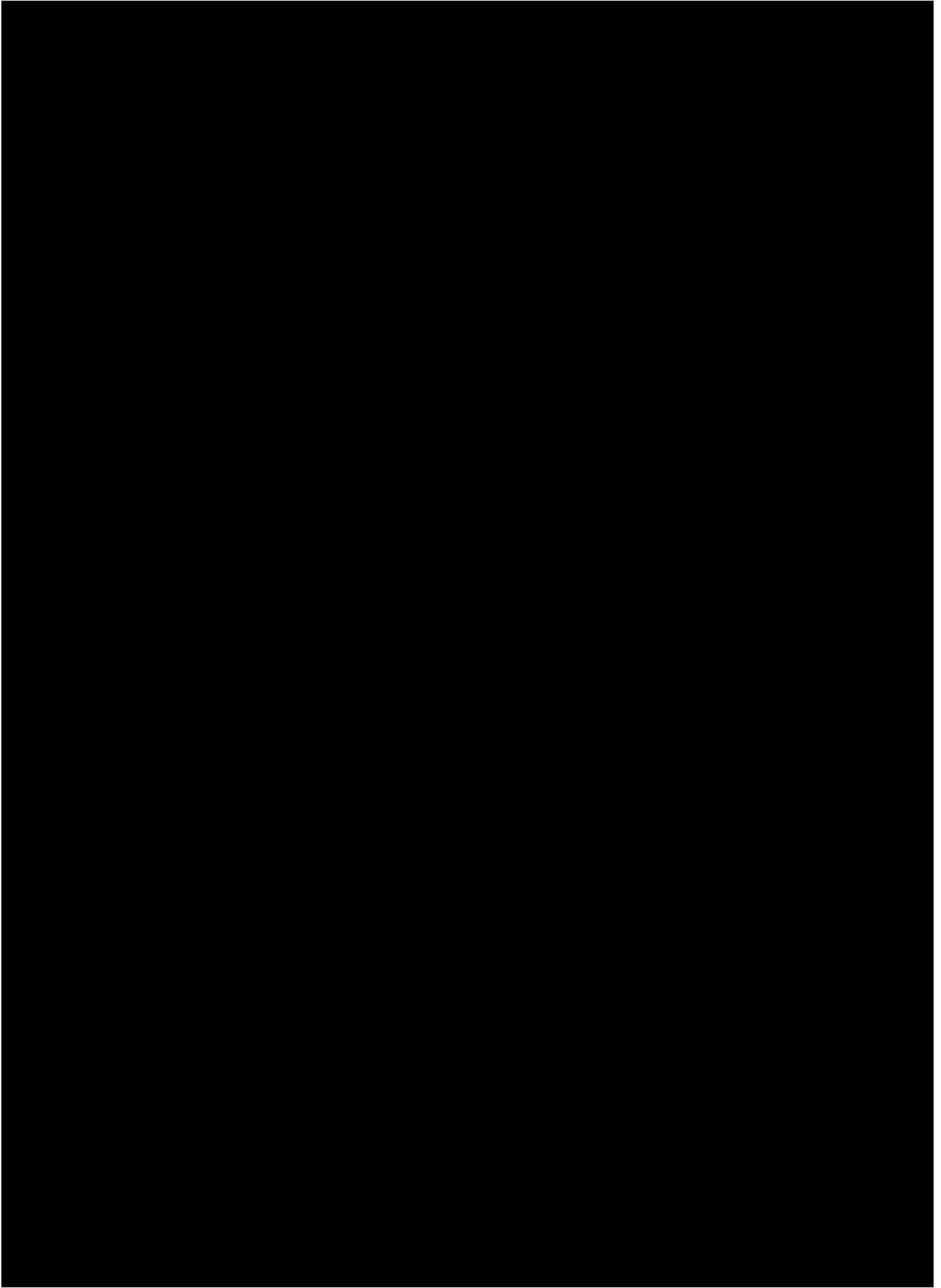


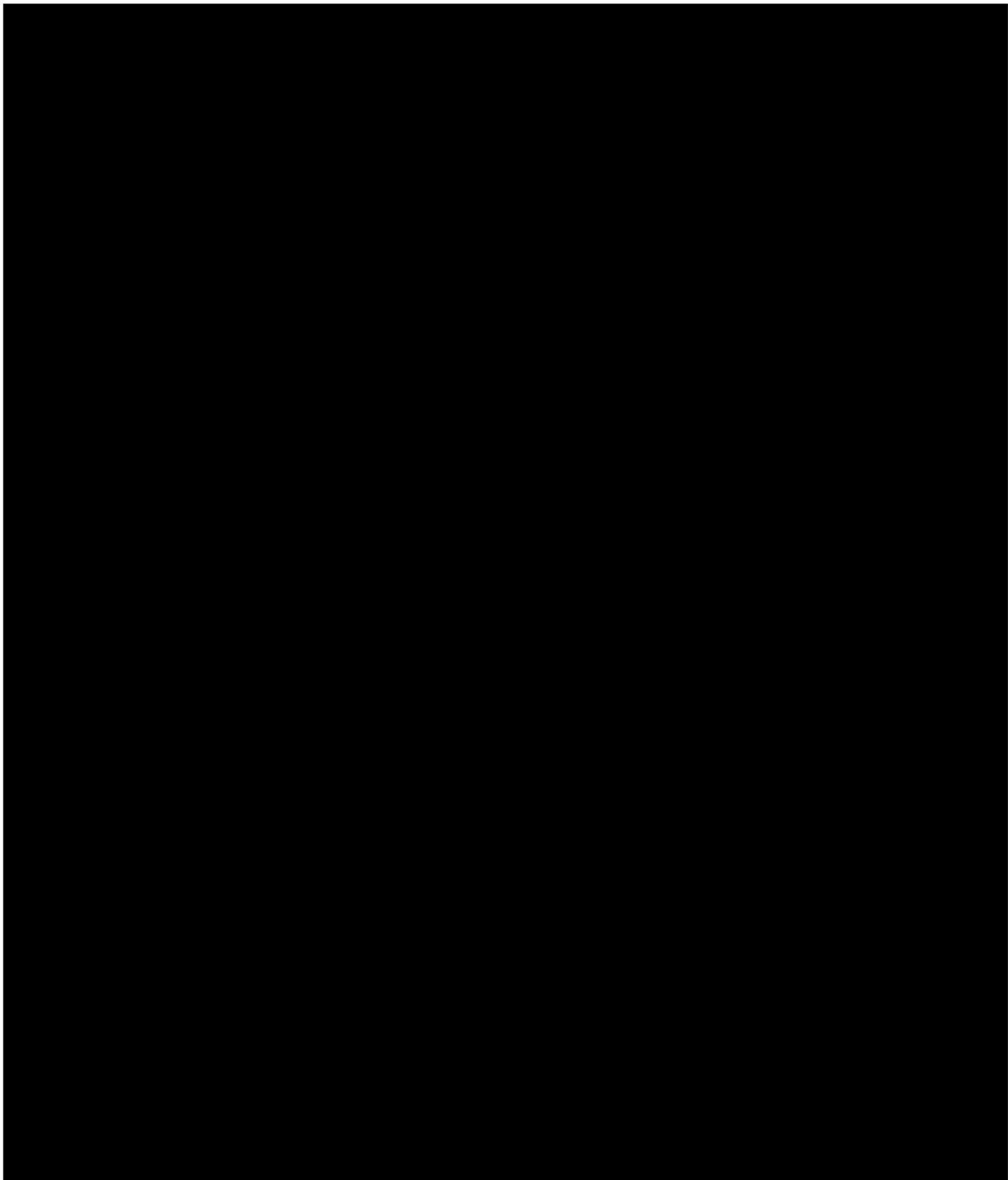


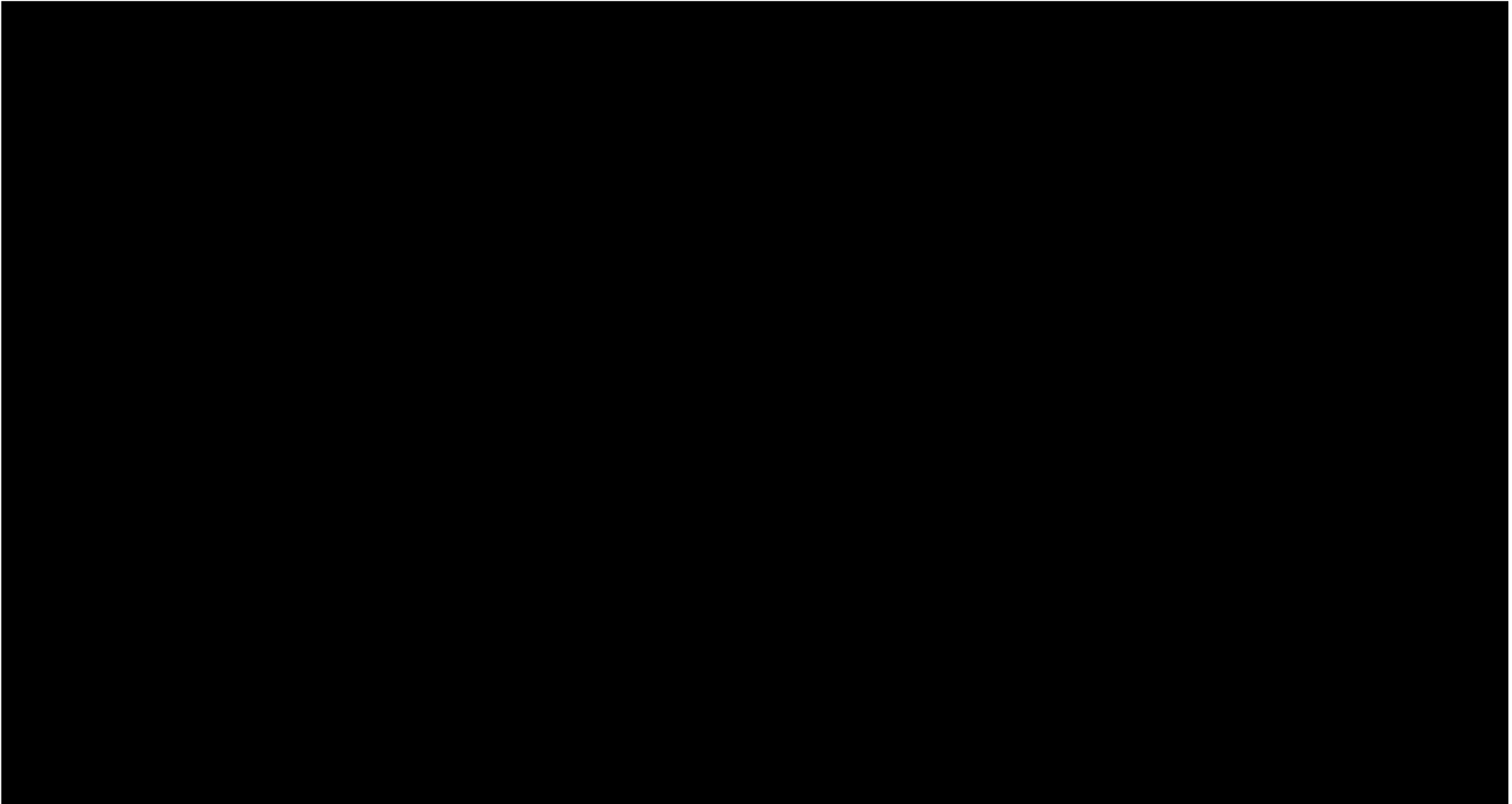
- d. Offeror's ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a QMCSO, including storing this information in Offeror's system, so that information about the Dependent is only released to the individual named in the QMCSO.

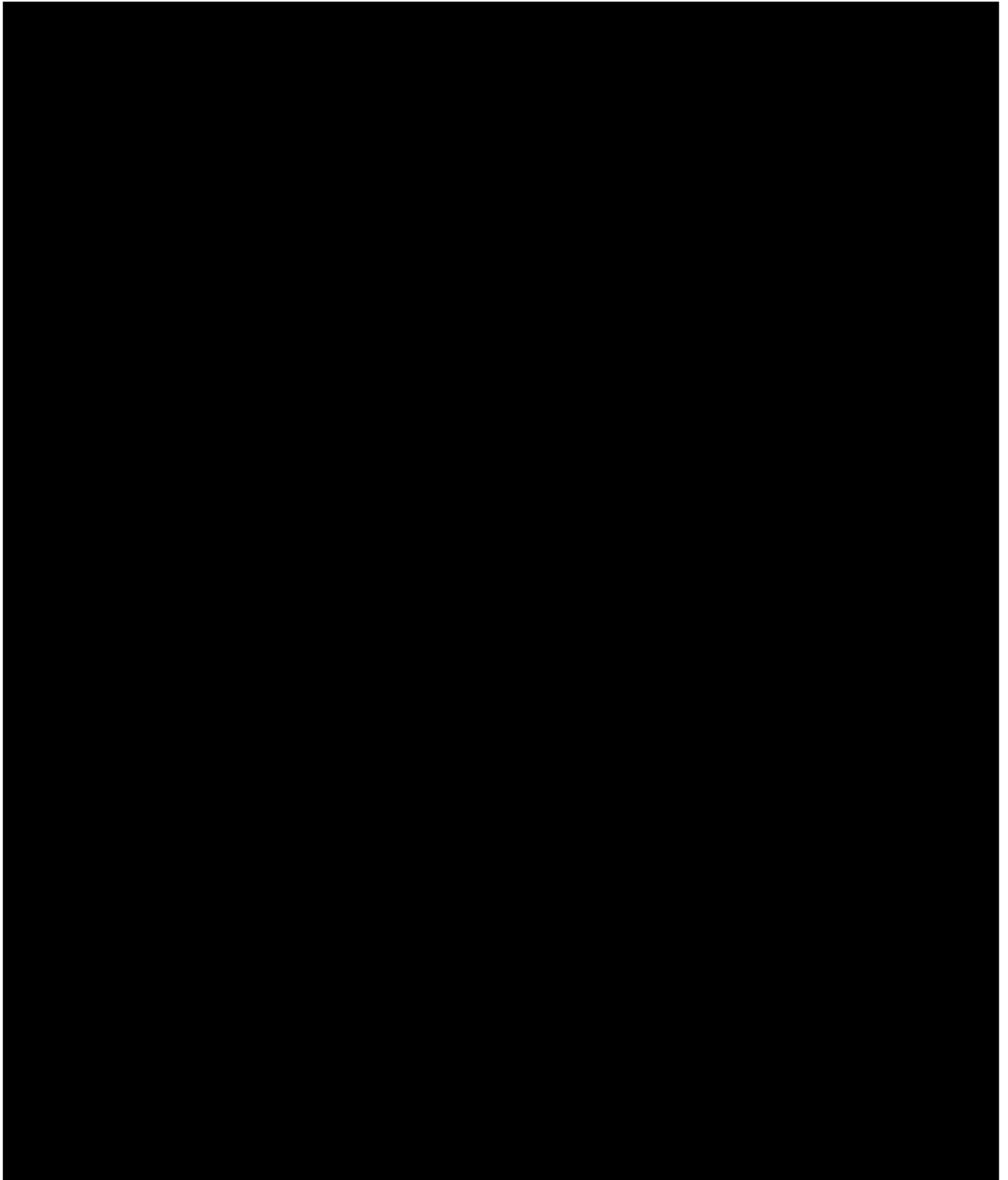


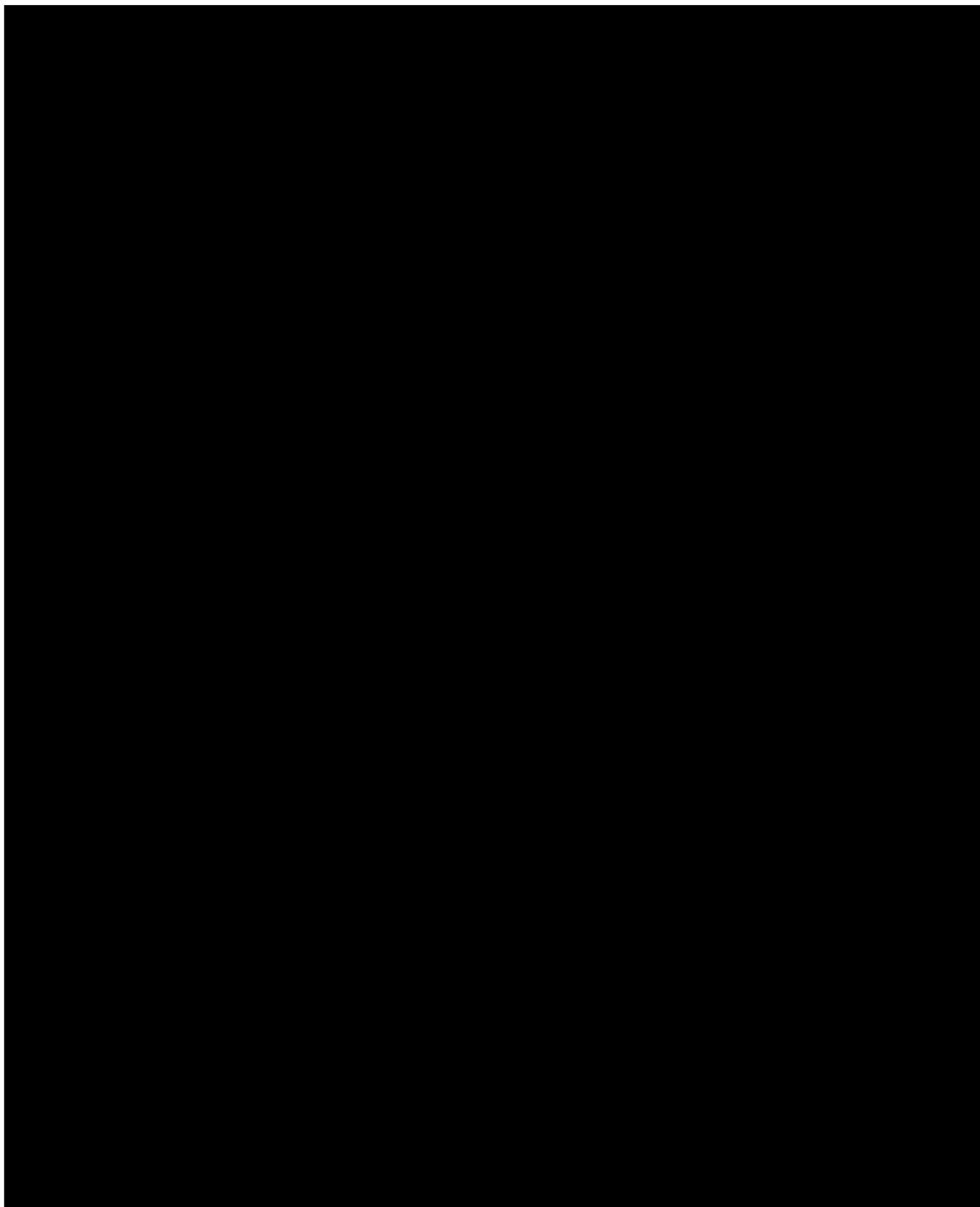






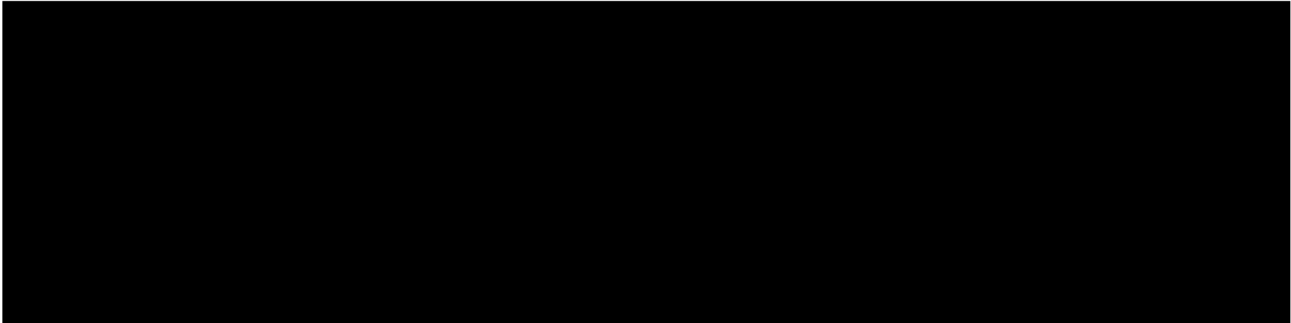




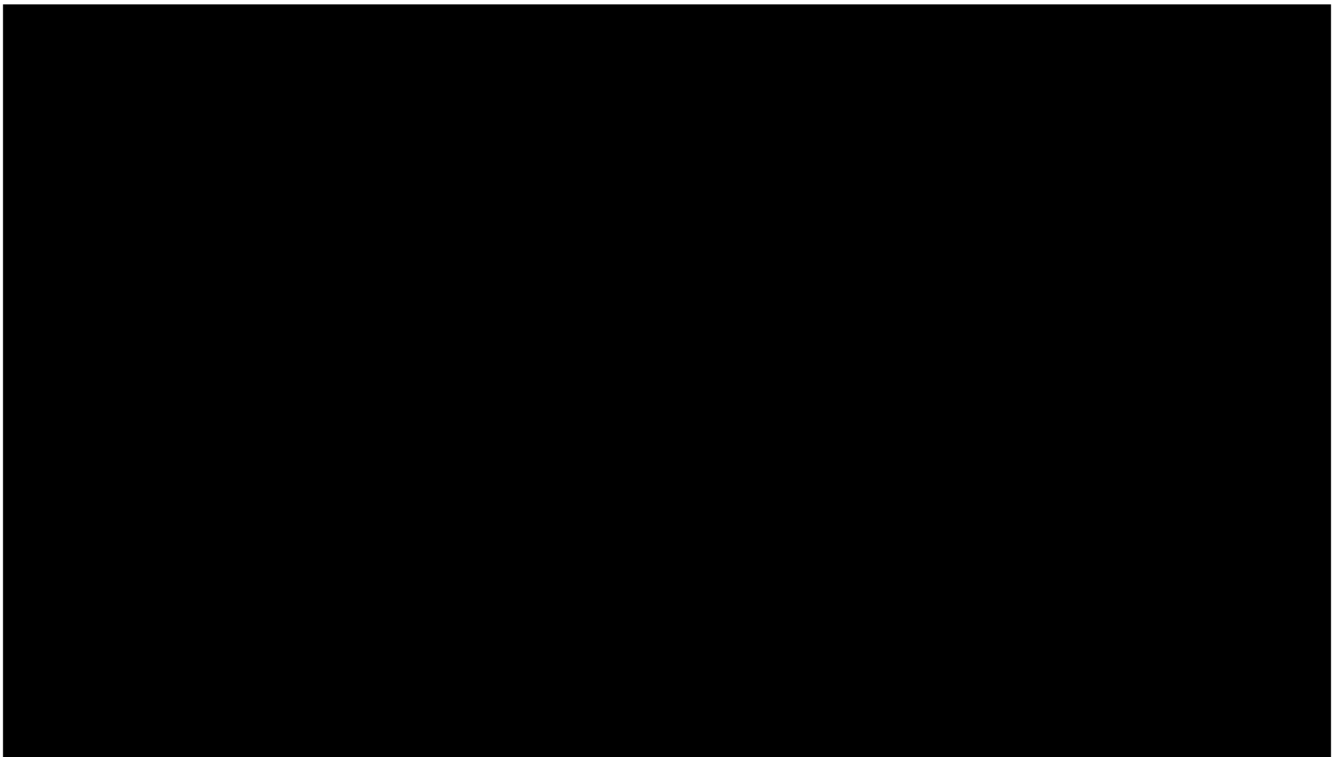


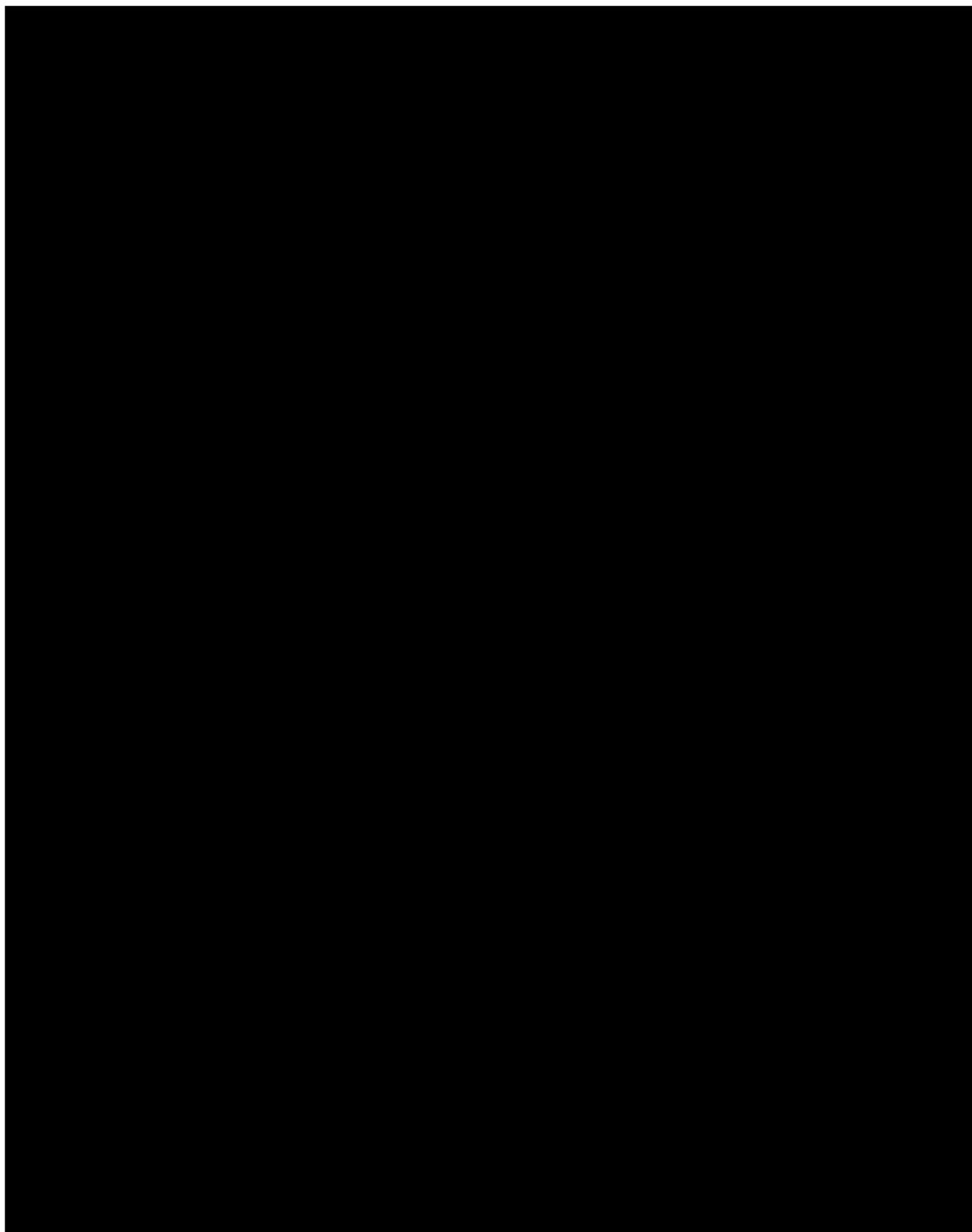


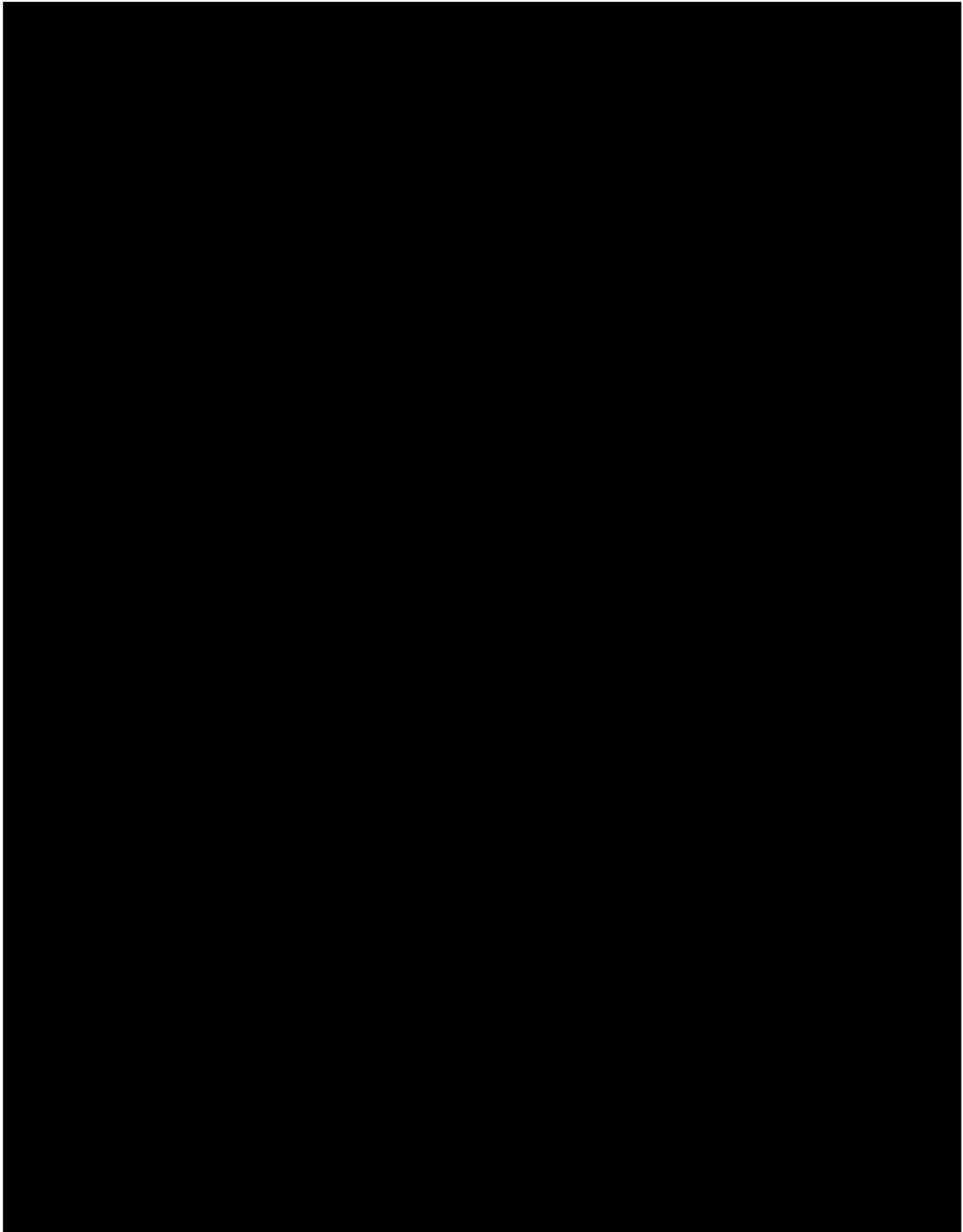
- c. Describe how Offeror's claims processing system collects overpayments from Offeror's MHSU Provider network.

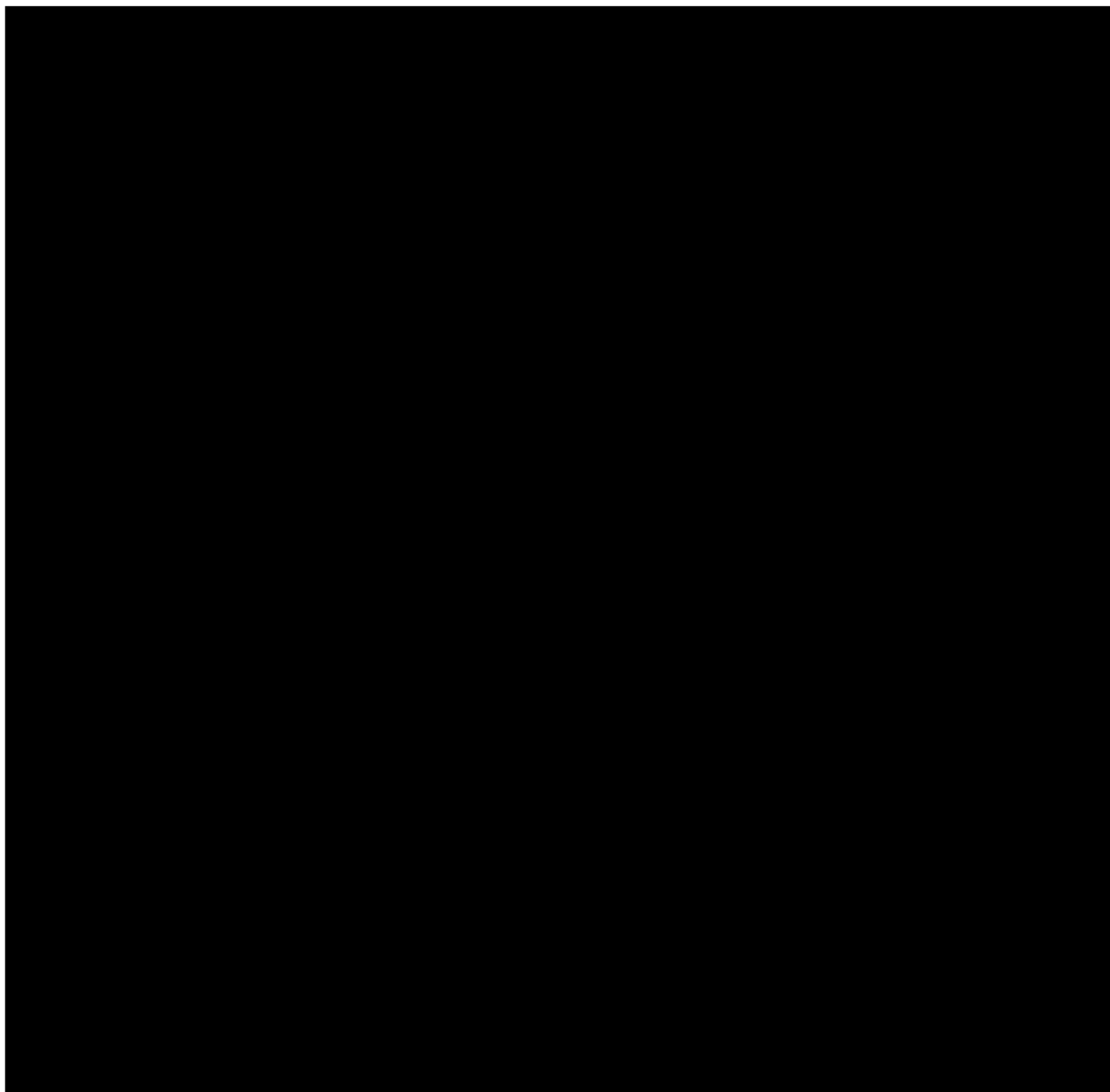


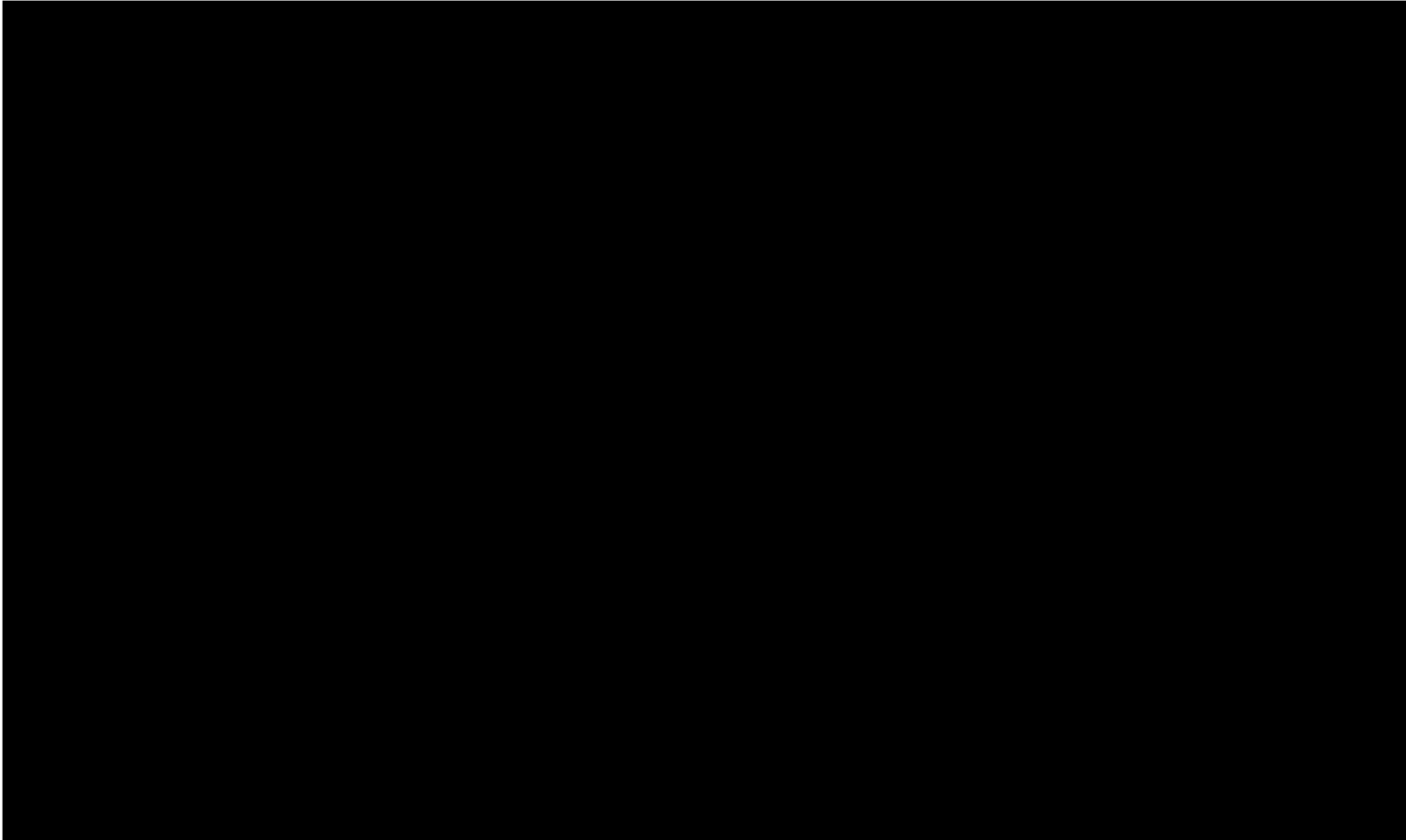
- d. Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud, and abuse, and report such information in a timely fashion to the State in accordance with a State-approved process. Confirm the MHSU Disorder Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses.

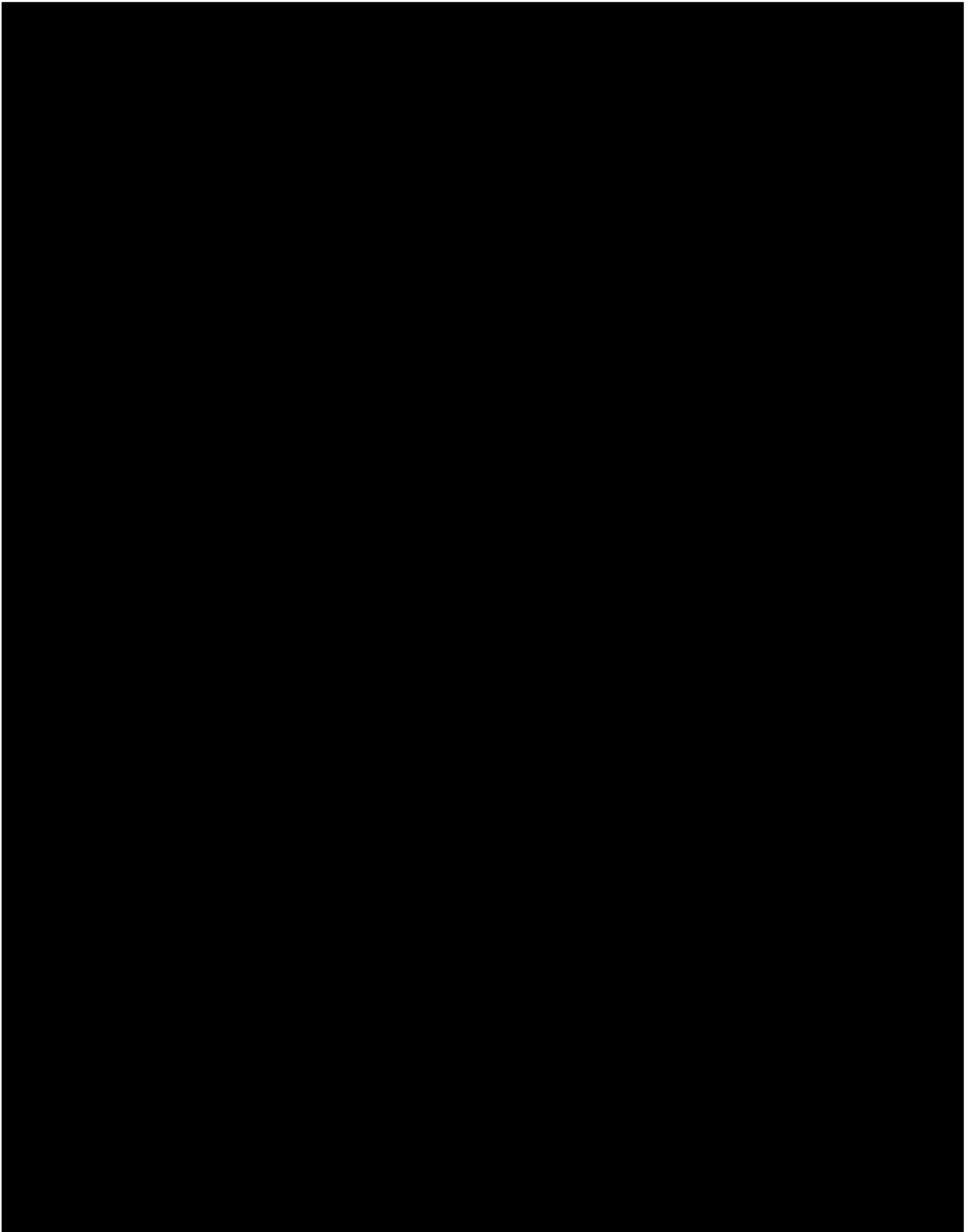


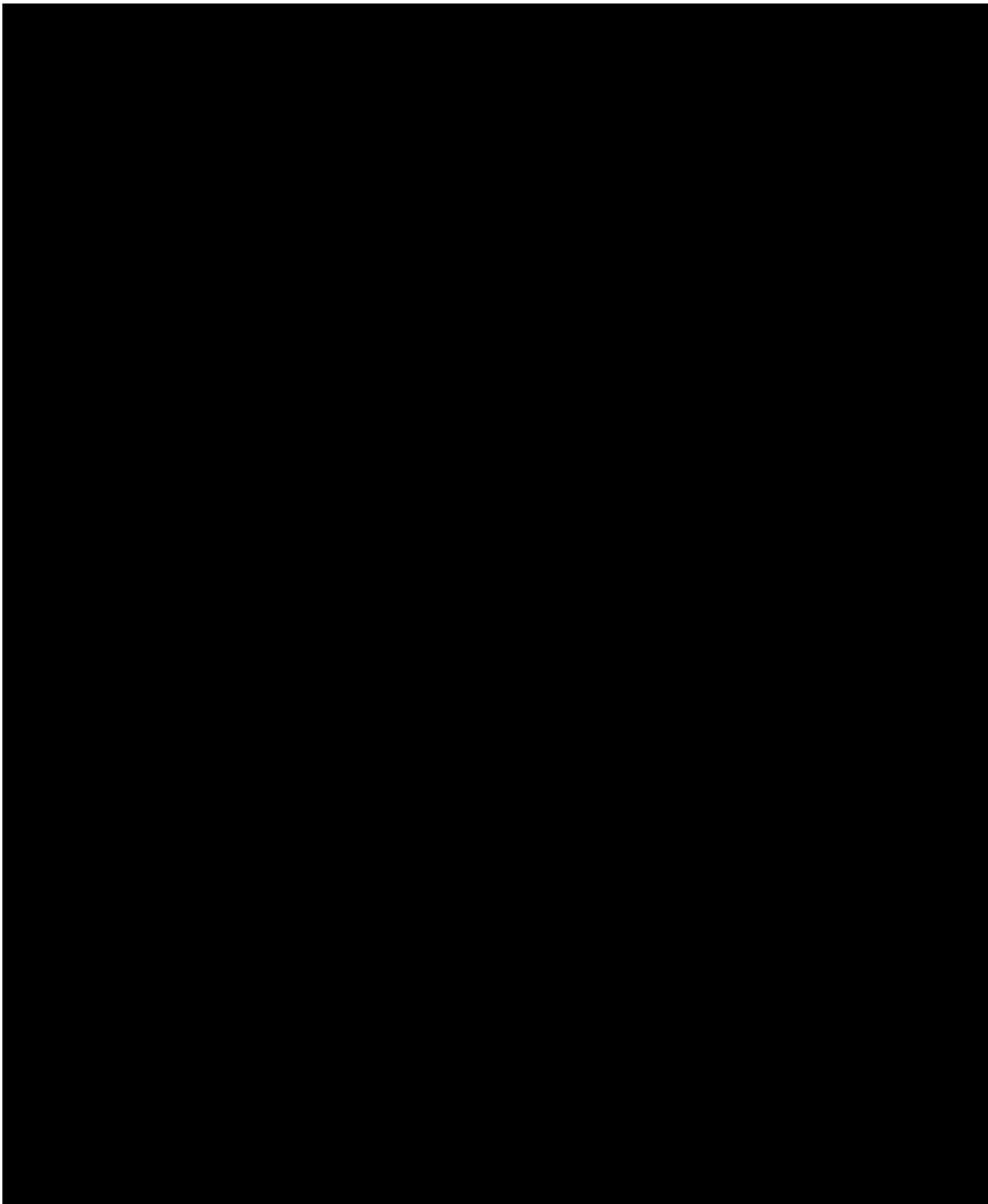






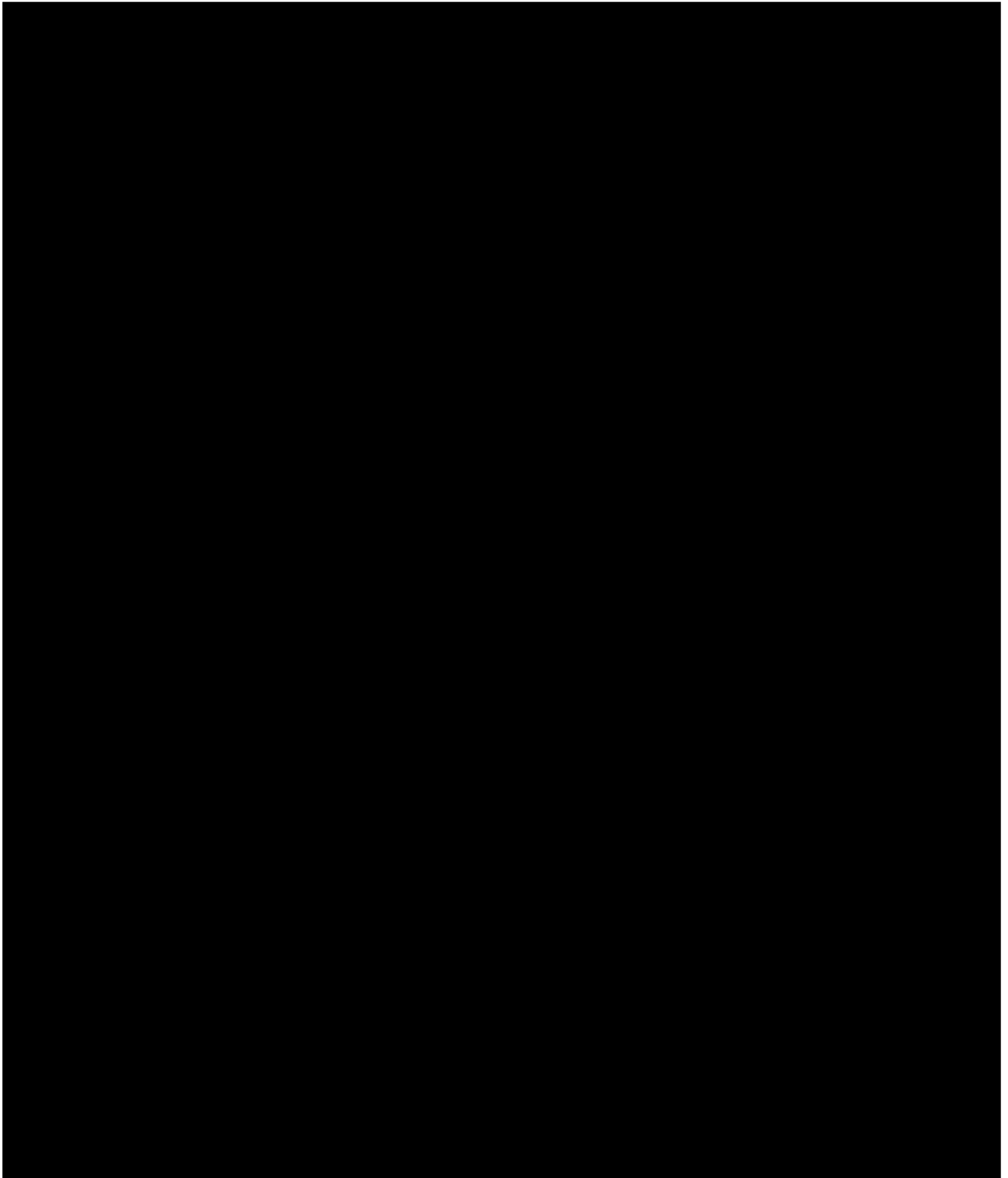






We describe the Detection, Investigation, and Resolution components of our program in detail below in *part a*.

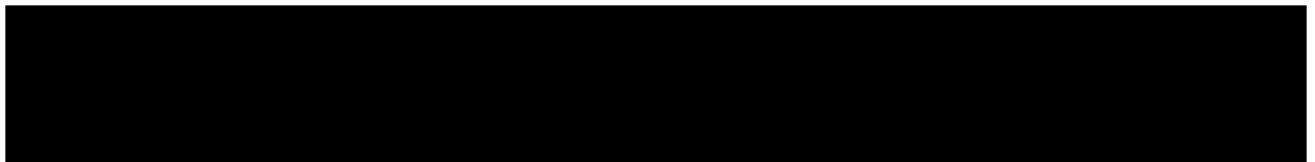
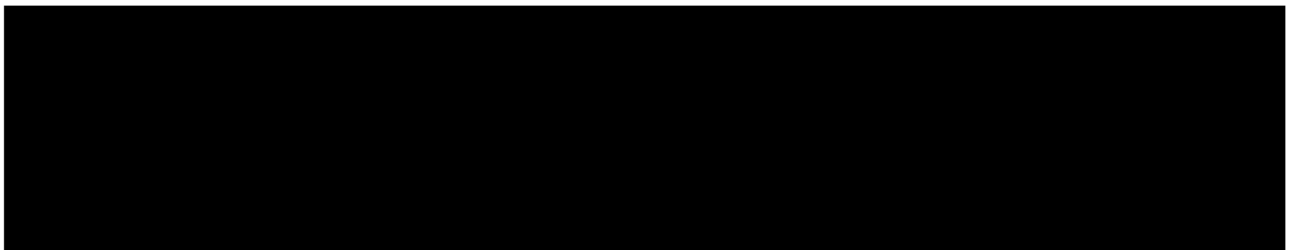
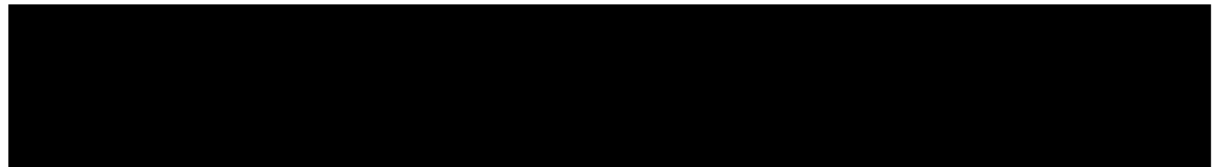
- a. Describe the audit program Offeror would conduct for the MHSU Disorder Program including a description of the criteria Offeror uses to select MHSU Providers/Facilities to audit and a description of the policy that Offeror follows when an audit detects possible fraudulent activity by a MHSU Provider,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



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

Below we provide examples of how our payment integrity algorithms and software have detected major cases of potential fraud, waste, and abuse affecting Empire Plan members.

Example One



[REDACTED]

Example Two

[REDACTED]

[REDACTED]

[REDACTED]

Example Three

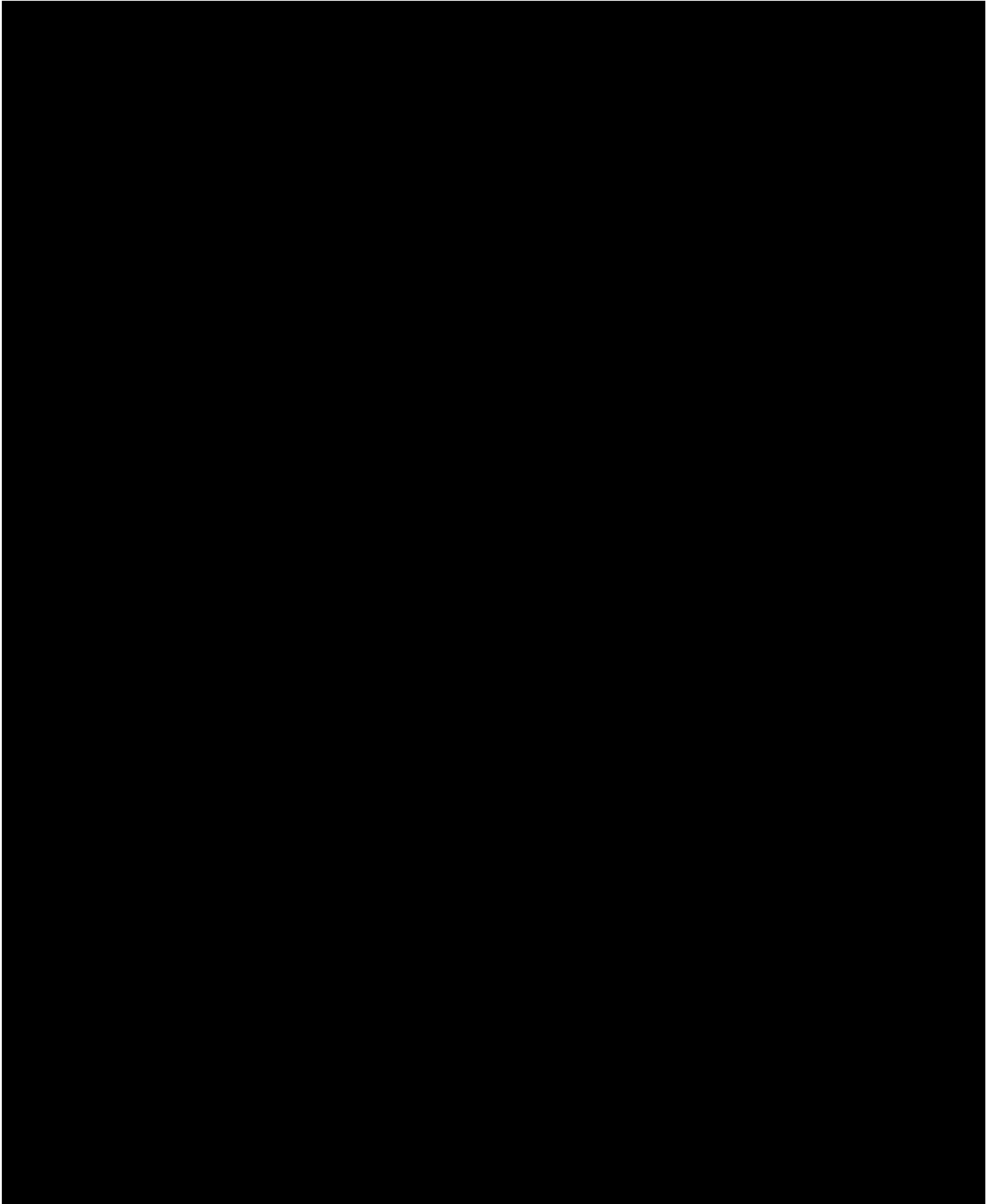
[REDACTED]

[REDACTED] monitoring the provider group's
[REDACTED]
[REDACTED]
[REDACTED] \$481k to resolve the
[REDACTED]

[REDACTED]

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

[REDACTED]

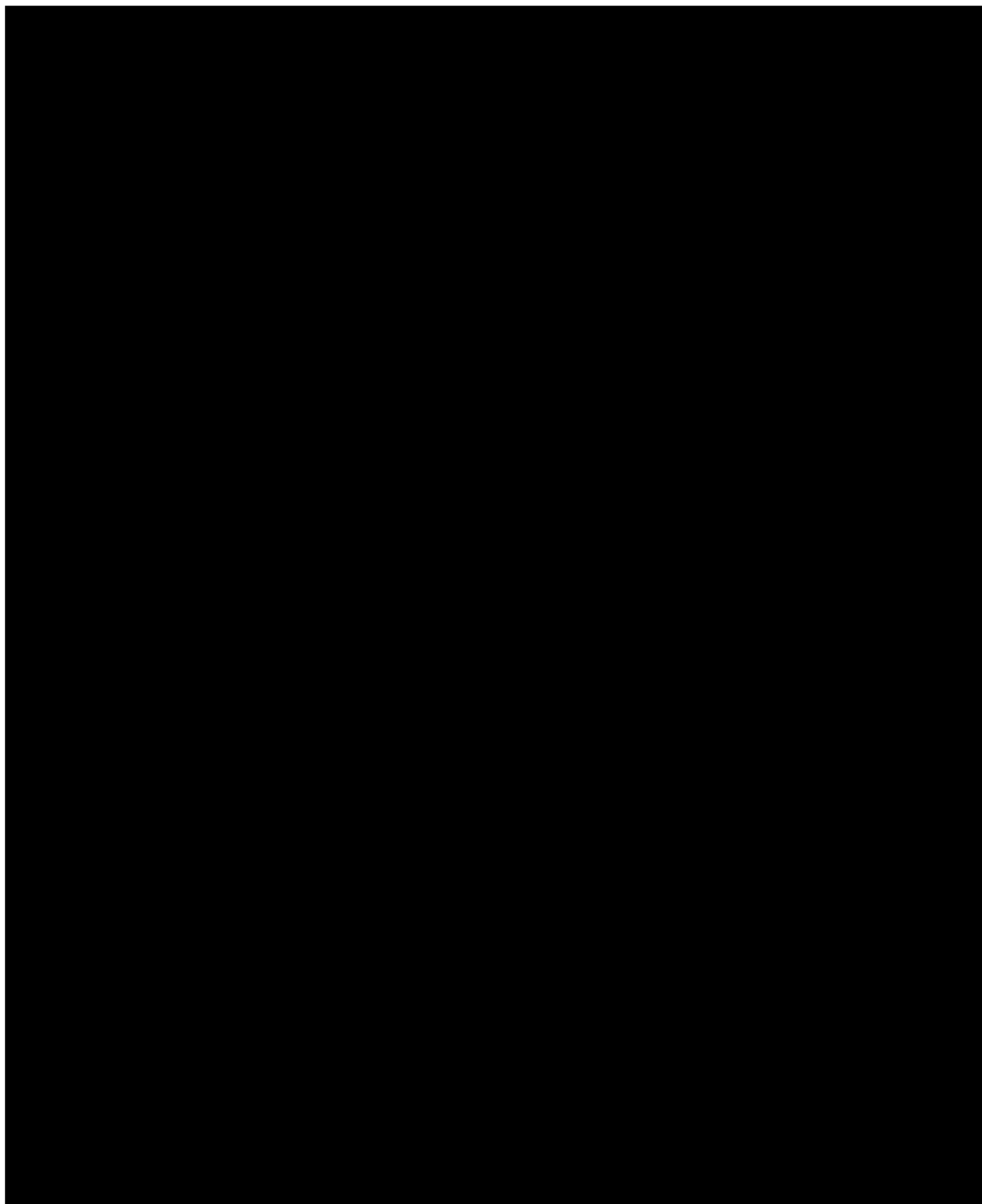


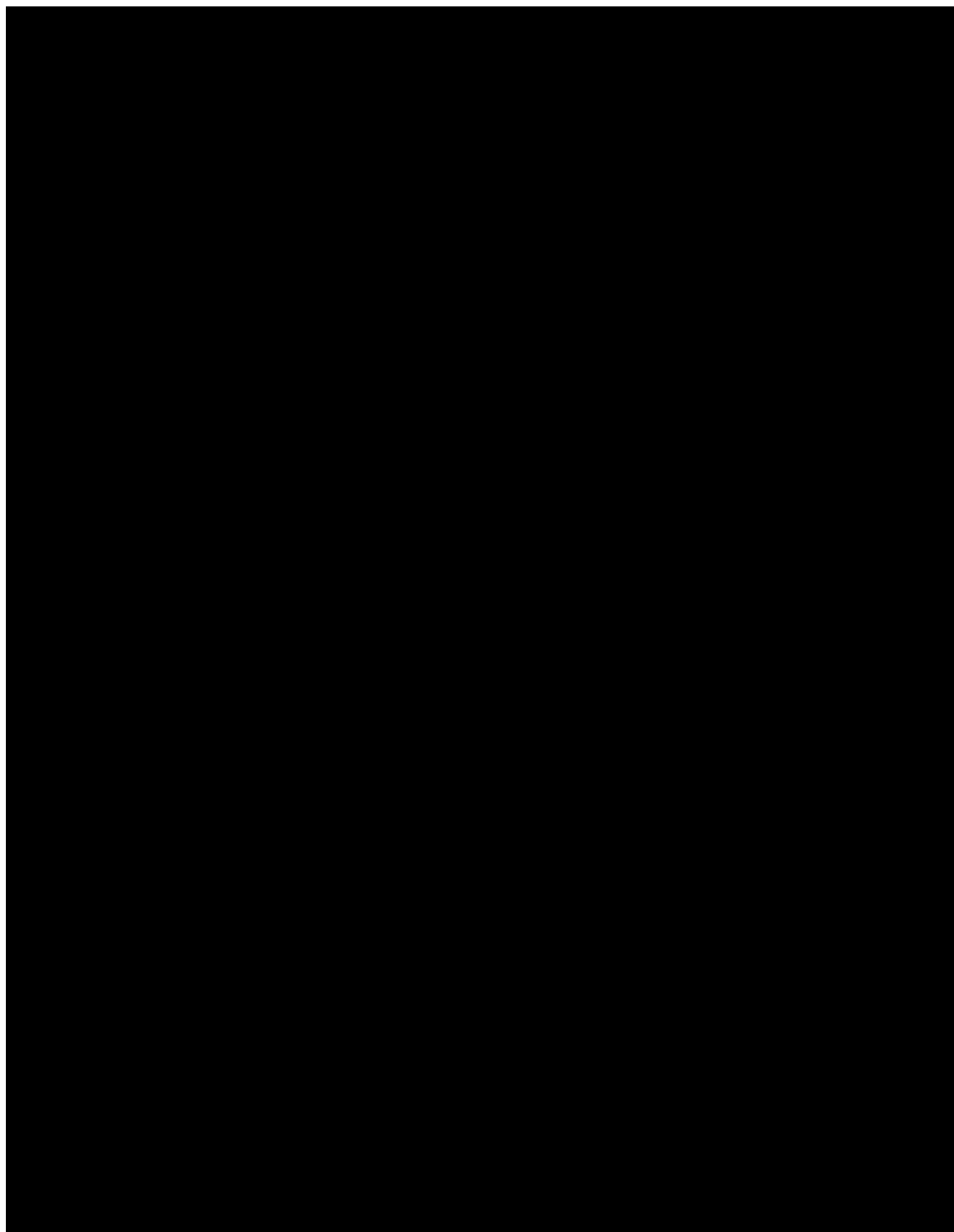


5.10 Appeal Process

Carelon's appeal process will continue to meet or exceed the requirements of *Section 3.9 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 level 1 and 2 for each program under this RFP.

For both level 1 and level 2 appeals, members and/or their authorized representatives may initiate an administrative or clinical appeal within 180 days of an adverse benefit determination.

Notification to Members of Right to Appeal

A request for appeal is not considered complete until Carelon has received, at a minimum, the name of the patient for whom a denial of authorization is being appealed, or a valid member number for the patient, and the dates for which a denial of care authorization is being appealed. Requests for an appeal of this decision, and all necessary information noted above, must be received by Carelon, within 180 days from the date of the initial adverse determination. The member, provider, or member representative may submit any additional information they would like Carelon to consider in deciding their appeal.

Carelon also notifies members of their right to appeal via a notice on every explanation of benefits (EOBs). EOBs include appeal filing procedures, including where to direct the appeal and what information to include in it. The EOB notice includes the name, address, and toll free telephone numbers of the local regulatory body and/or applicable government official appointed to investigate complaints. In addition, the notice includes the procedure for filing an expedited appeal, including where to direct the appeal and what information to include in the appeal, the timeframe for filing an expedited appeal, and the organization's timeframe for deciding the expedited appeal. Members are advised of their right to designate any person they choose, including an attorney, to be their authorized representative.

Notification of Results of Review and Appeal Decisions

Carelon has policies and procedures for communicating results of review and appeal decisions to members, practitioners, and facilities within applicable contract, accreditation, and state and federal standards and regulations. This includes:

- A. Carelon will provide notice of all determinations, favorable or adverse, to the member or member's designee and the member's health care provider verbally and in writing within the required contractual, federal, and/or regulatory timeframes.
- B. Verbal notification to the member for Inpatient, Residential, or any 24 hour care can be made by the provider upon notification by Carelon.
- C. For all other levels of care that require authorization (i.e., Partial Hospital, Intensive Outpatient, TMS, ABA), Carelon will outreach to the member, designee, and provider to verbally notify of the determination.
- D. Verbal notification to the member, designee, and provider will be clearly documented in the member record.
- E. If Carelon does not have and cannot obtain a telephone number for the member/designee, documentation will be made in the member's record.
- F. When an adverse determination is rendered, written notification to the member, or member's designee and the member's health care provider will include:
 1. A detailed clinical explanation of the member's medical condition; the medical service, treatment, or procedure in question; the basis or bases on which the determination that the service, treatment or procedure is or was not medically necessary or experimental/investigational (with specific use of

terms) was made, which shall demonstrate that member specific clinical information was considered.

2. Any additional necessary information needed by Carelon to render a decision upon appeal.
3. A statement that the criteria, guidelines, protocols, administrative rules, or any other information relevant to the adverse determination will be provided in writing, upon request, free of charge, and instructions for requesting such.
4. A statement that the medical necessity criteria can be found at www.carelonbehavioralhealth.com.
5. A concise list of available alternative providers for the recommended level of care, in the member's area, within a reasonable distance from the member's home.
6. The next level of appeal rights.

Members, providers, or member representatives have the right to appeal adverse determinations. There are two internal appeal processes available to the members, providers, or member representatives through Carelon. Members can find out more about their appeal rights by calling the Carelon Customer Service Department. An appeal can be requested in one of the following ways:

- They can send a written request to Carelon at a specified mailing address.
- They can send a fax with attention to the appeals department.
- They can call customer service to request an appeal with a toll free number, currently between 8 a.m. and 8 p.m. ET, Monday through Friday.

Carelon will notify the requestor of any information Carelon needs to decide the appeal.

Administrative Appeal Determination Process

The Director of Appeals, or designee, assumes responsibility for the processing of administrative appeals. Appeals are assigned to an appropriate subject matter expert, or committee, based on the appeal and contractual requirements.

Administrative and Clinical appeals are subject to the same standards. However, if an administrative denial is in place, it must be resolved before the clinical request can be processed. The result of this process can include three scenarios:

1. The administrative denial is upheld, and the clinical request is not processed.
2. The administrative denial is overturned; however, a clinical review is not necessary (e.g., pass through benefit, coordination of benefits, provider licensure).
3. The administrative denial is overturned, and the clinical request is processed, and a clinical determination is made.

If an administrative appeal upholds the previous denial, the appropriate appeal determination letter is sent. If an administrative appeal overturns the previous denial, a medical necessity review must be completed by the appropriate Clinical Care Manager within the appeal time frame—there is no provision to extend the time frame in this situation.

If the Clinical Care Manager cannot approve the request, the clinical data is passed on to a Peer Reviewer. The peer review must also be completed within the appeal time frame—there is no provision to extend the time frame in this situation.

If, after the administrative appeal overturns the previous denial, the medical necessity review results in full or partial denial, all standards related to medical necessity denials must be met. The appropriate clinical denial letter is sent. Administrative appeals that result in a medical necessity denial will have additional medical necessity appeal rights.

The timeframe for determination of administrative and clinical appeals begins when the appeal request is received.

Clinical Appeal Determination Process

Peer Advisors who conduct appeals are doctoral level clinical peers who hold an active, unrestricted license to practice medicine or a health profession. They are board-certified (if applicable) and are in the same profession and in a similar specialty as typically manage the medical condition, procedure, or treatment as mutually deemed appropriate. For clinical appeals, a Peer Advisor processes the appeal request as required (i.e., peer to peer conversation, or clinical peer review of the submitted documentation) and makes a determination to reverse (i.e., overturn) the original adverse determination in whole or part, or to uphold the previous adverse determination. A determination is made based on all available clinical information, including documented clinical information gathered by the utilization review (UR) clinician, any telephone reviews with the member's clinical team, and/or any additional information that may be submitted by the appellant.

When the appeal review is completed, the Peer Advisor or designee verbally informs the provider of the decision including the length of any authorization and the level of care authorized, and/or any alternatives/recommendations, which are deemed clinically appropriate. If the appeal decision for any level or type of appeal (i.e., Level 1, Level 2, retrospective, etc.) is to overturn the original denial totally or in part, the decision of that clinical appeal is implemented by the issuance of an authorization for the initial requested service consistent with the appeal determination. The provider is also informed of the procedure for the next level of appeal, if appropriate.

For Expedited Appeals, the Peer Advisor tries to reach the requesting provider for more information and discuss the case before making an appeal determination. A clinical peer review attempt must precede an appeal adverse determination with the exception of the following:

1. When the provider is not reasonably available
2. When the provider chooses not to speak with a Peer Advisor
3. When the provider has negotiated an agreement with Carelon for alternative care

Level 2 clinical appeals are conducted by a panel of two board-certified psychiatrists and a clinical manager from the Program Administrator. Panel members must not have been involved in the previous determinations of the case. In some instances, the member or designated representative may have the right to appear before the committee or communicate with the committee telephonically.

For all levels of appeal, Peer Advisors document their decision in the utilization management (UM) record, and according to Service Center standards, which include at a minimum:

1. Timeliness information and data source of review
2. Clinical criteria supporting the decision
3. Clinical rationale to support the decision
4. Identification of contact and time
5. Determination and reasons for the determination
6. Name and credentials of the clinical peer reviewers

For each appeal case completed the reviewer signs an attestation regarding their scope of licensure or certification to complete the review and current, relevant experience and/or knowledge to render a determination for the case under review.

When the appeal review is completed, the designated staff are informed of the decision.

1. If the original Adverse Determination is overturned, the designated staff notifies the member/member's authorized representative and/or provider on the day of the decision by phone and sends a letter stating that a review of the information has been completed and the initial decision has been overturned.
2. If the original Adverse Determination for authorization of payment is upheld, the Appeals Coordinator notifies the member/member's authorized representative and/or provider on the day of the decision by phone and sends a letter (final adverse determination) stating that a review of the information has been completed and the initial decision has been upheld.

Written or electronic notification is provided to the member or member's authorized representative in easily understood language and includes the following:

1. Date(s) of service in question
2. Claim amount, if applicable and available
3. Diagnosis code and meaning
4. Treatment code and meaning
5. Attending provider name
6. Title, qualifications, and specialty of individuals participating in the appeal review
7. The specific information upon which the appeal decision was based
8. The specific reason for the appeal decision, including the member's presenting condition, diagnosis, and treatment interventions including why such information does not meet the medical review criteria
9. Description of any standard used in denying the request, if applicable and available
10. Reference and inclusion of the benefit provision, guideline, protocol or criterion on which the appeal decision was based

11. Notification that the member is entitled to receive reasonable access to and copies of all documents relevant to the appeal, upon request
12. Notification that the member appeal representative and/or provider may participate in the appeal and can submit written comments, documents, or any other information relevant to the appeal
13. Appeal rights
14. External appeal instructions and application form

If there is an option for a Level II appeal, written or electronic notification of the Level I appeal determination also informs members and providers of their right to file this appeal with Carelon.

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

Our most recent results indicate that 98.5 percent of non urgent administrative and clinical level 1 and 2 appeal decisions for all programs are made within the timeframes stated below, which exceeds our current performance guarantee standard of 95.1 percent.

Level One

For non-urgent Standard Clinical and Administrative Appeals, Carelon processes the appeal as fast as the member's health requires, and within 15 calendar days of receipt of the request. Retrospective Appeal requests are processed within 30 calendar days. Where plan contracts mandate, members are eligible for a standard appeal with Carelon after an unfavorable expedited appeal determination.

Level Two

For non-urgent Standard Clinical and Administrative Appeals, Carelon processes the appeal as fast as the member's health requires, and within 15 calendar days of receipt of the request. Retrospective Appeal requests are processed within 30 calendar days. Where plan contracts mandate, members are eligible for a standard appeal with Carelon after an unfavorable expedited appeal determination.

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

Our most recent results indicate that 99 percent of urgent administrative and clinical level 1 and 2 appeal decisions for all programs under the RFP are made within the timeframes stated below, which exceeds our current performance guarantee standard of 95.1 percent

Level One

Resolution and notification for Expedited Clinical and Administrative Internal Appeals are completed as expeditiously as the member's condition requires, within two business days of receipt of necessary information to conduct the appeal, and no later than 72 hours from receipt of the appeal request. For

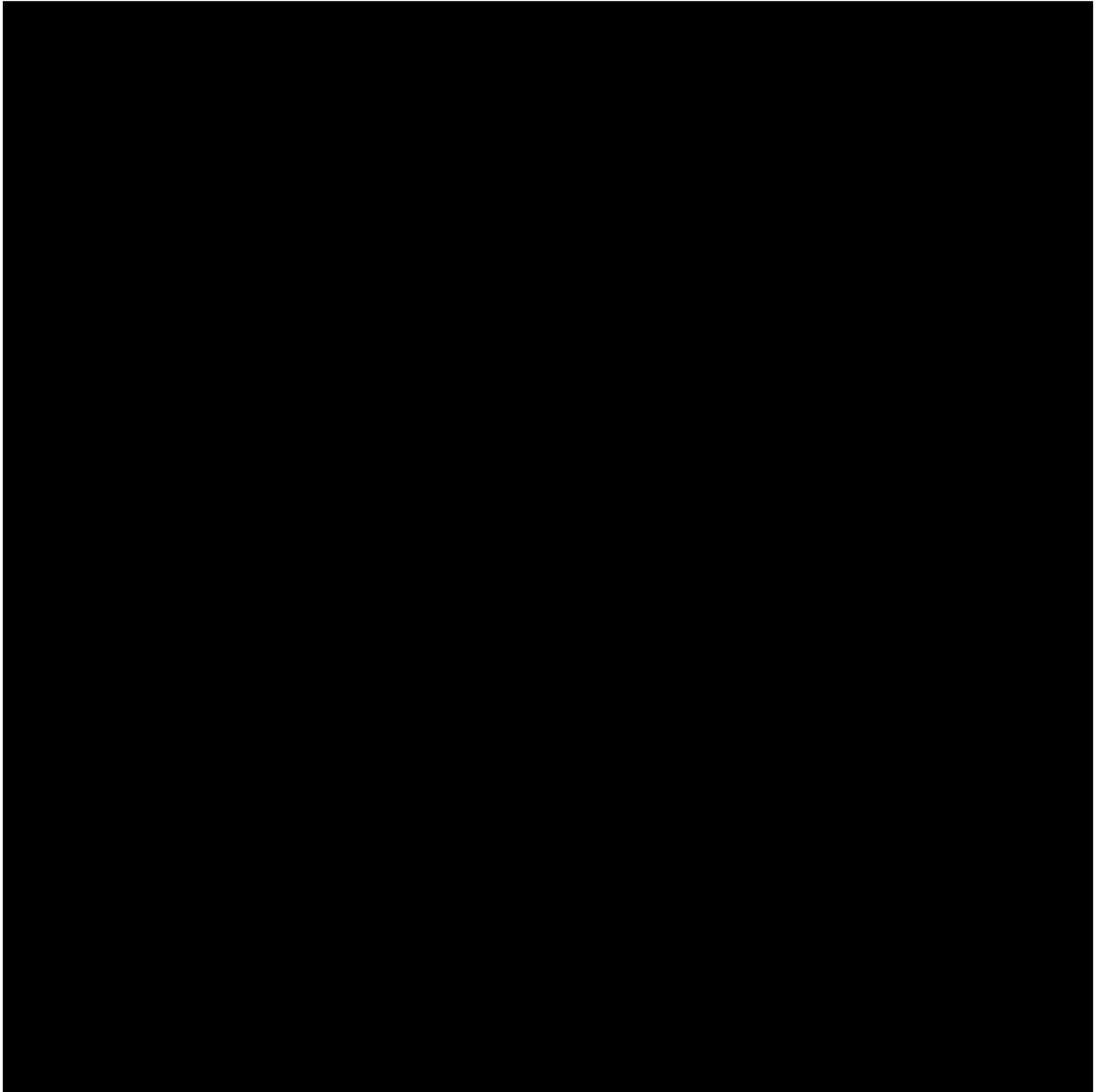
Expedited Inpatient Substance Use Disorder (SUD) Discharge Appeals, where the appeal request is received more than 24 hours prior to discharge, resolution and notification are completed within 24 hours.

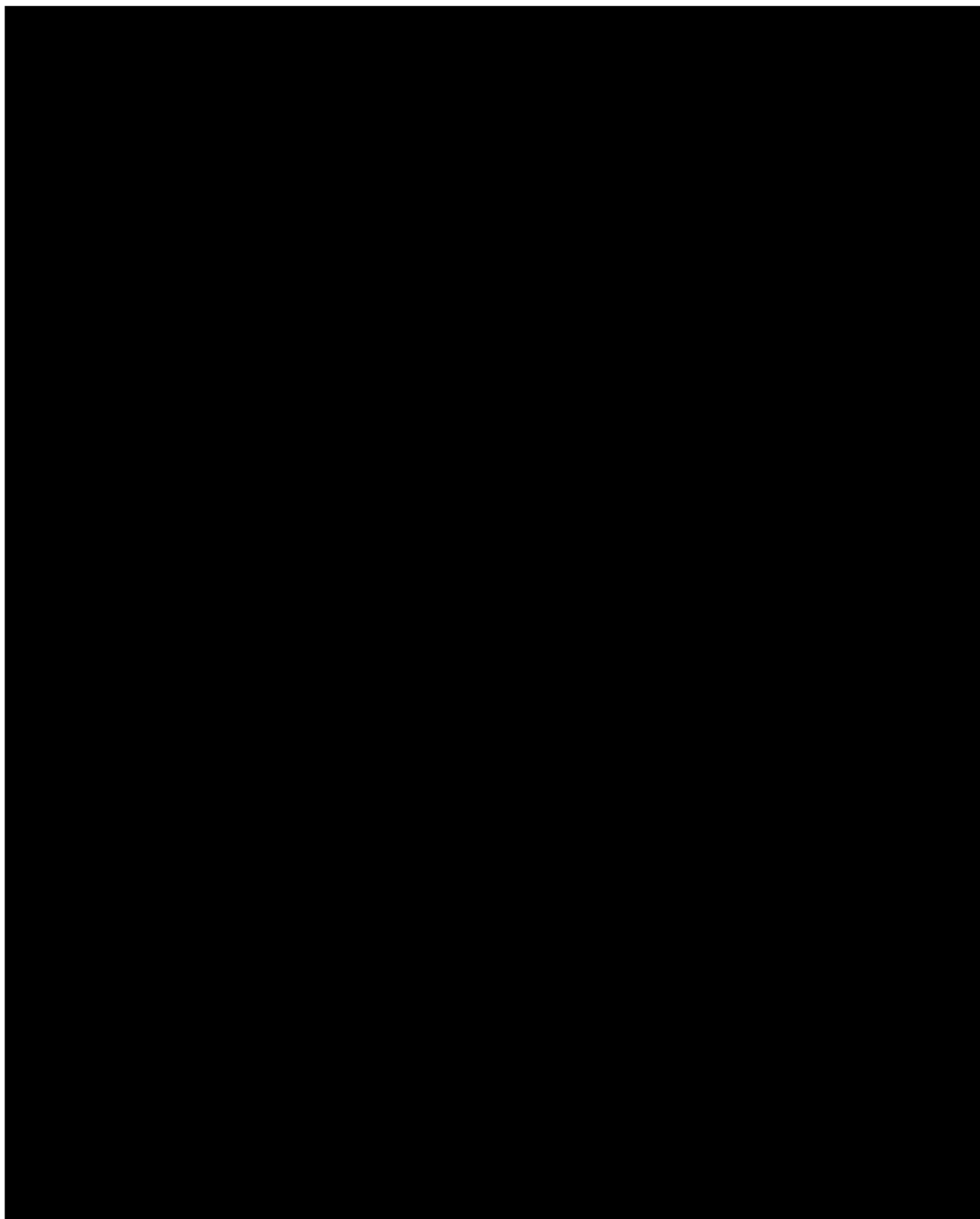
Level Two

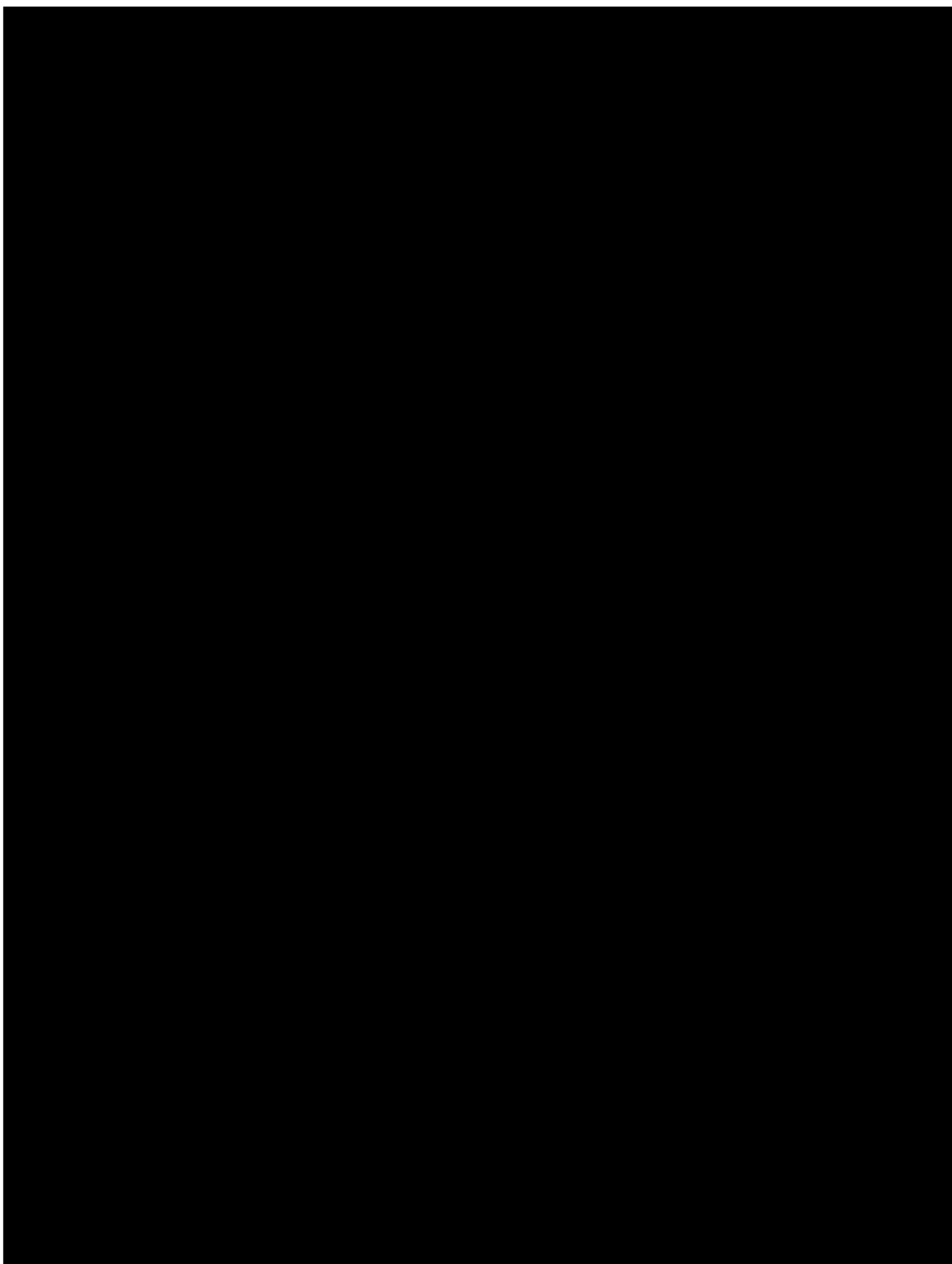
Resolution and notification for Expedited Clinical Internal Appeals, are completed as expeditiously as the member's condition requires, within two business days of receipt of necessary information to conduct the appeal, and no later than 72 hours from receipt of the appeal request. For Expedited Inpatient SUD Discharge Appeals, where the appeal request is received more than 24 hours prior to discharge, resolution and notification are completed within 24 hours.

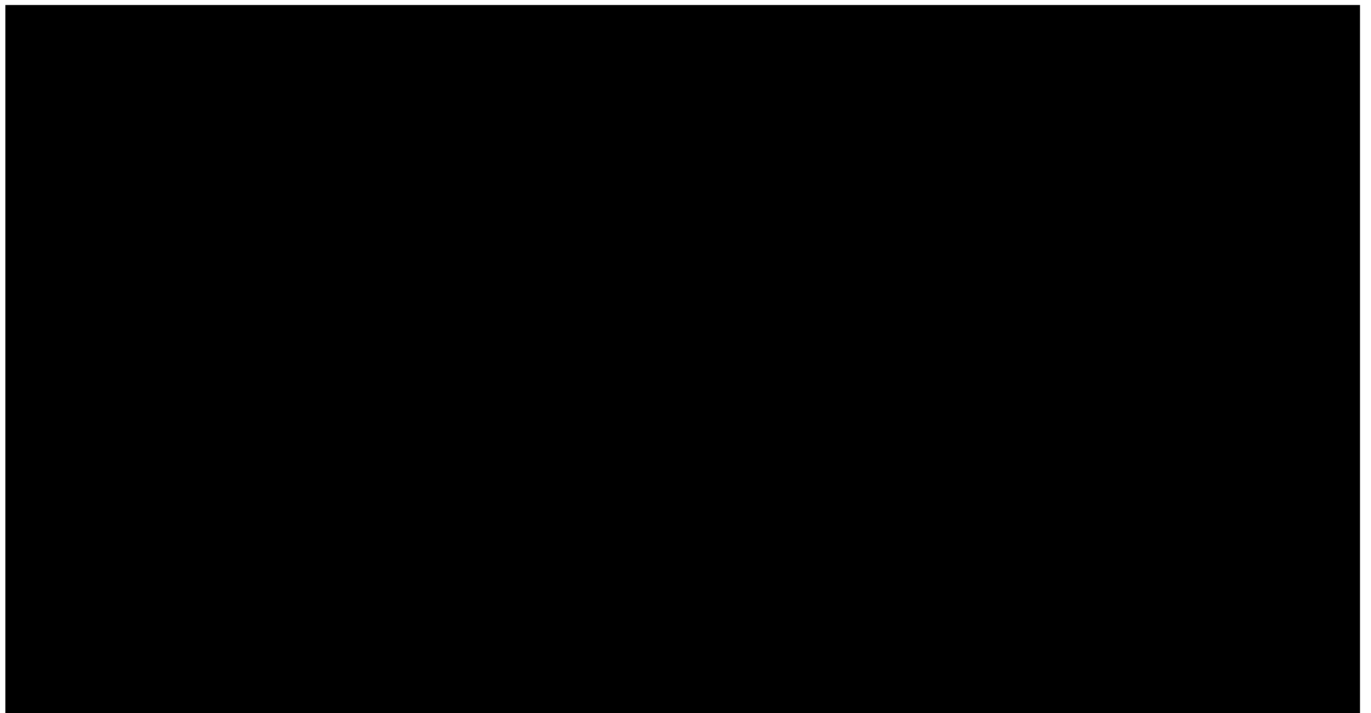
5.11 Provider Network

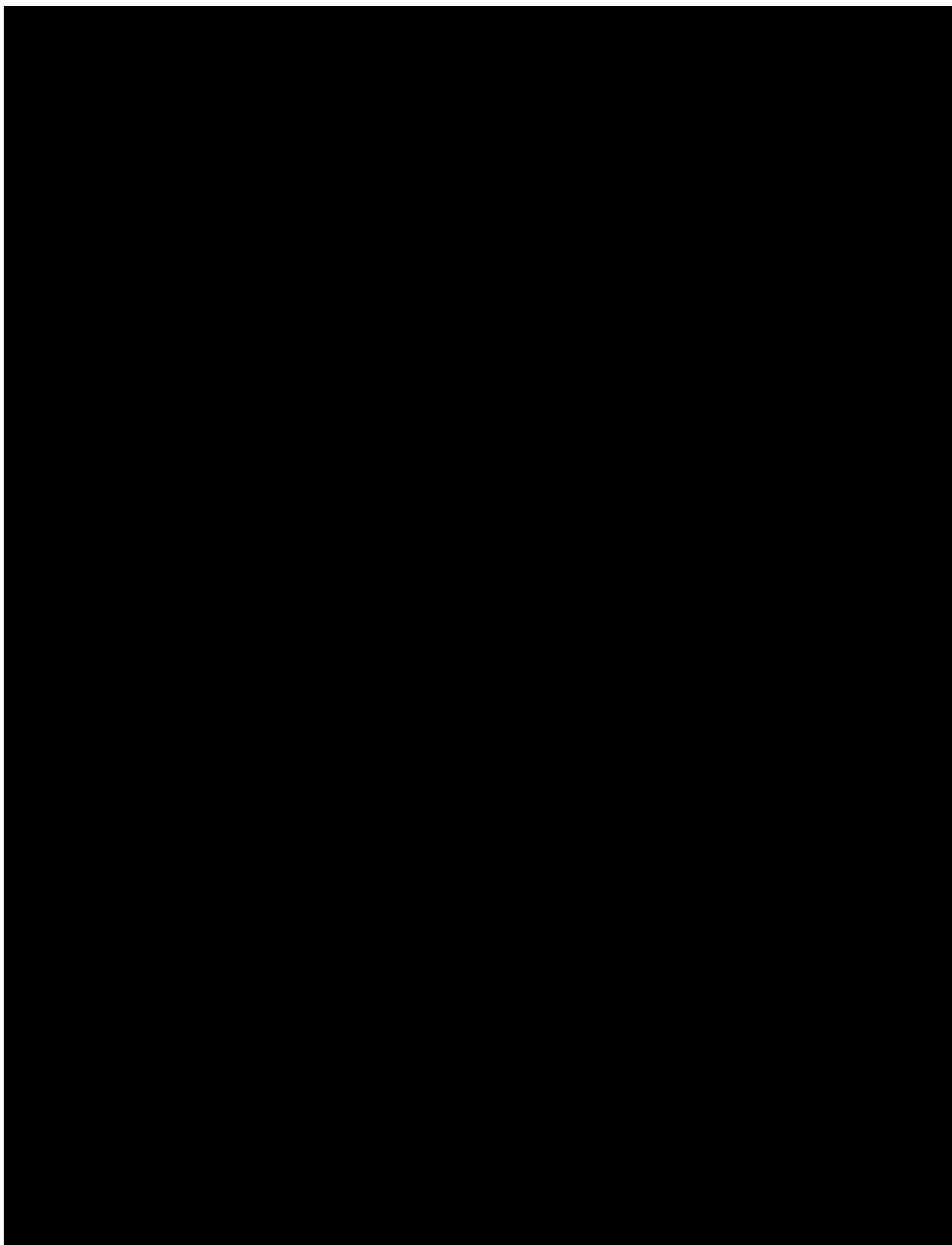
Carelon confirms that we have a participating MHSUD provider and facility network in place today that will meet or exceed the requirements of *Section 3.10 Provider Network*. Below, we provide a summary of our current and future Provider Network efforts on behalf of the Empire Plan, and then respond directly to the RFP questions of *Section 5.11 Provider Network* starting on page 124.

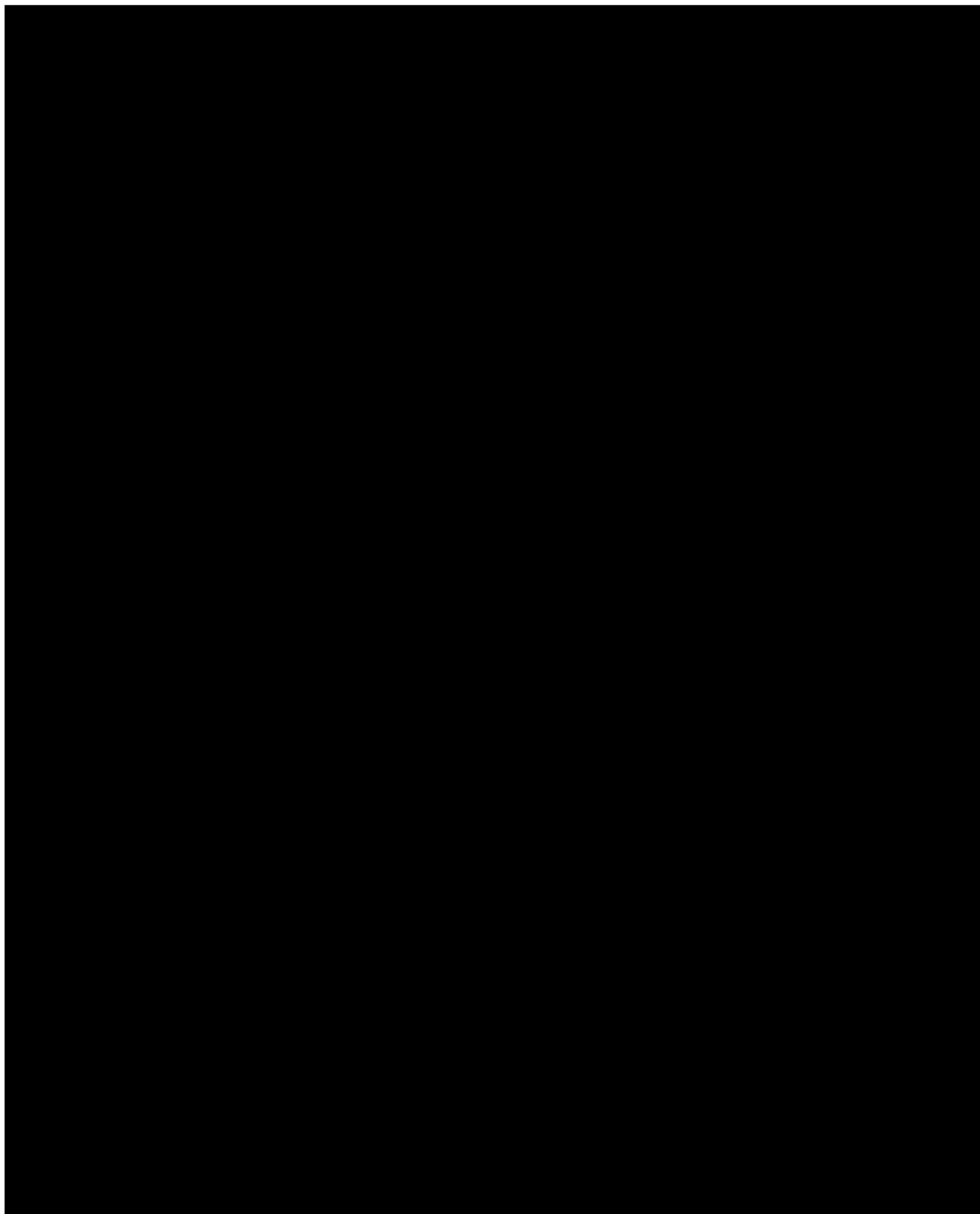


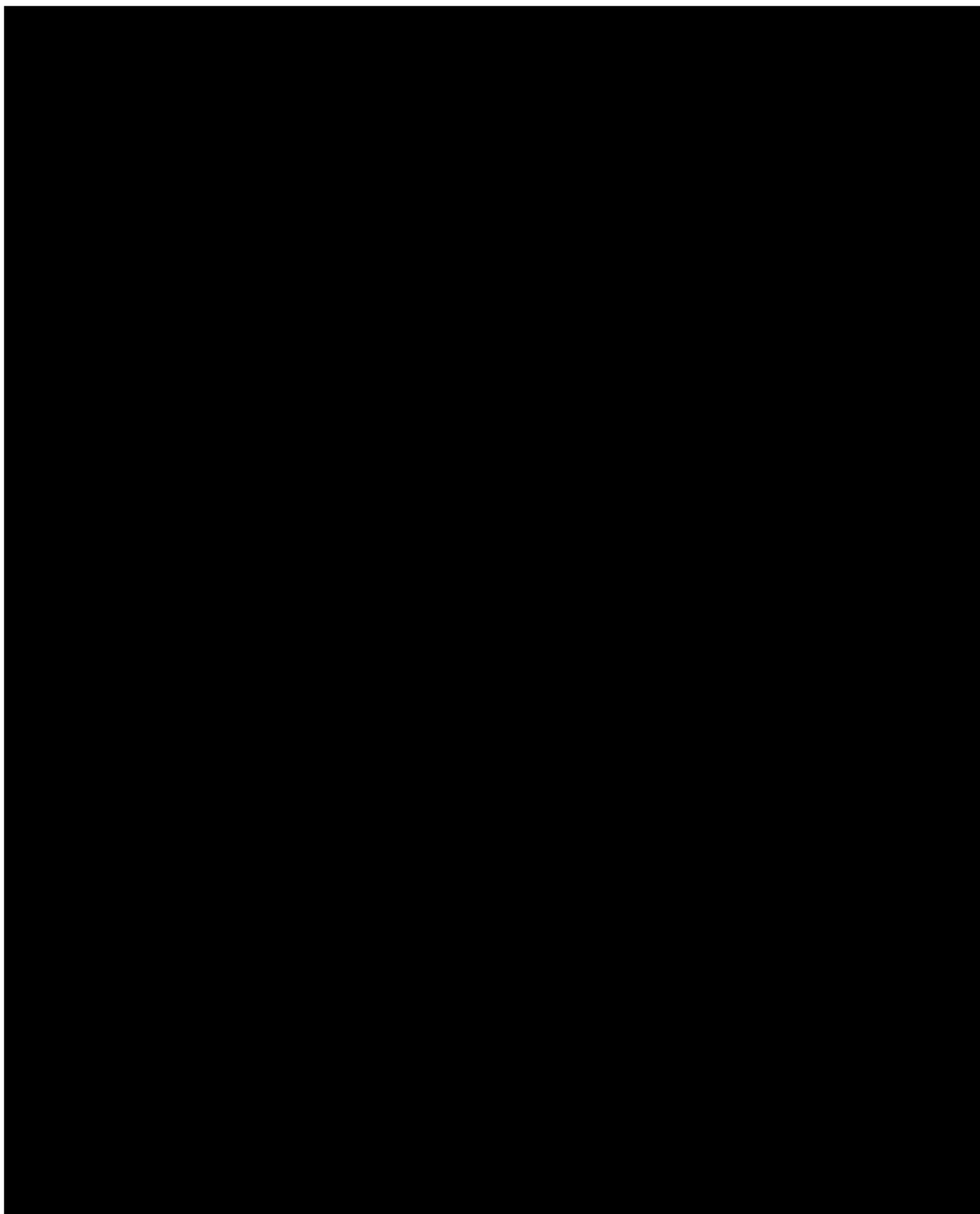


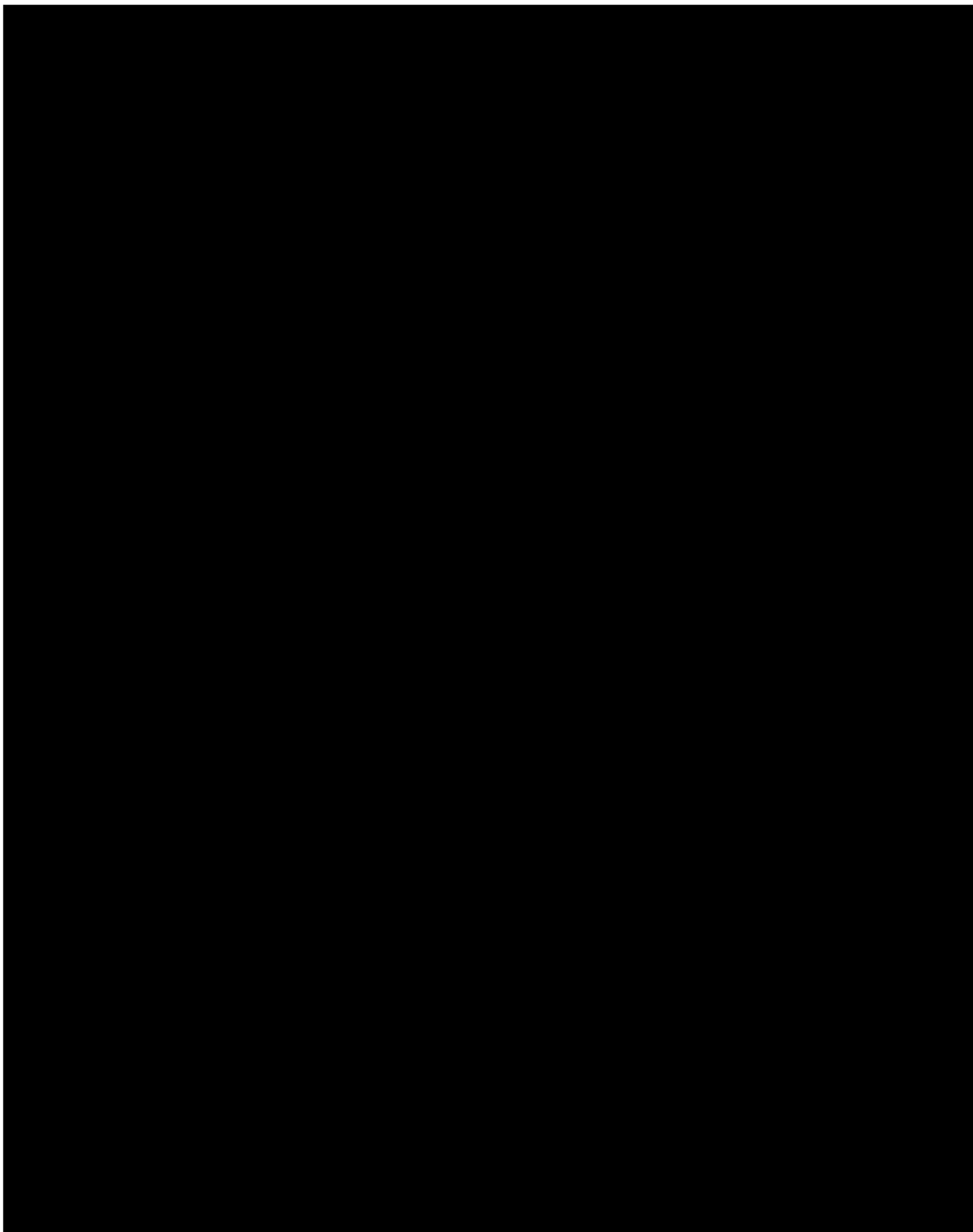


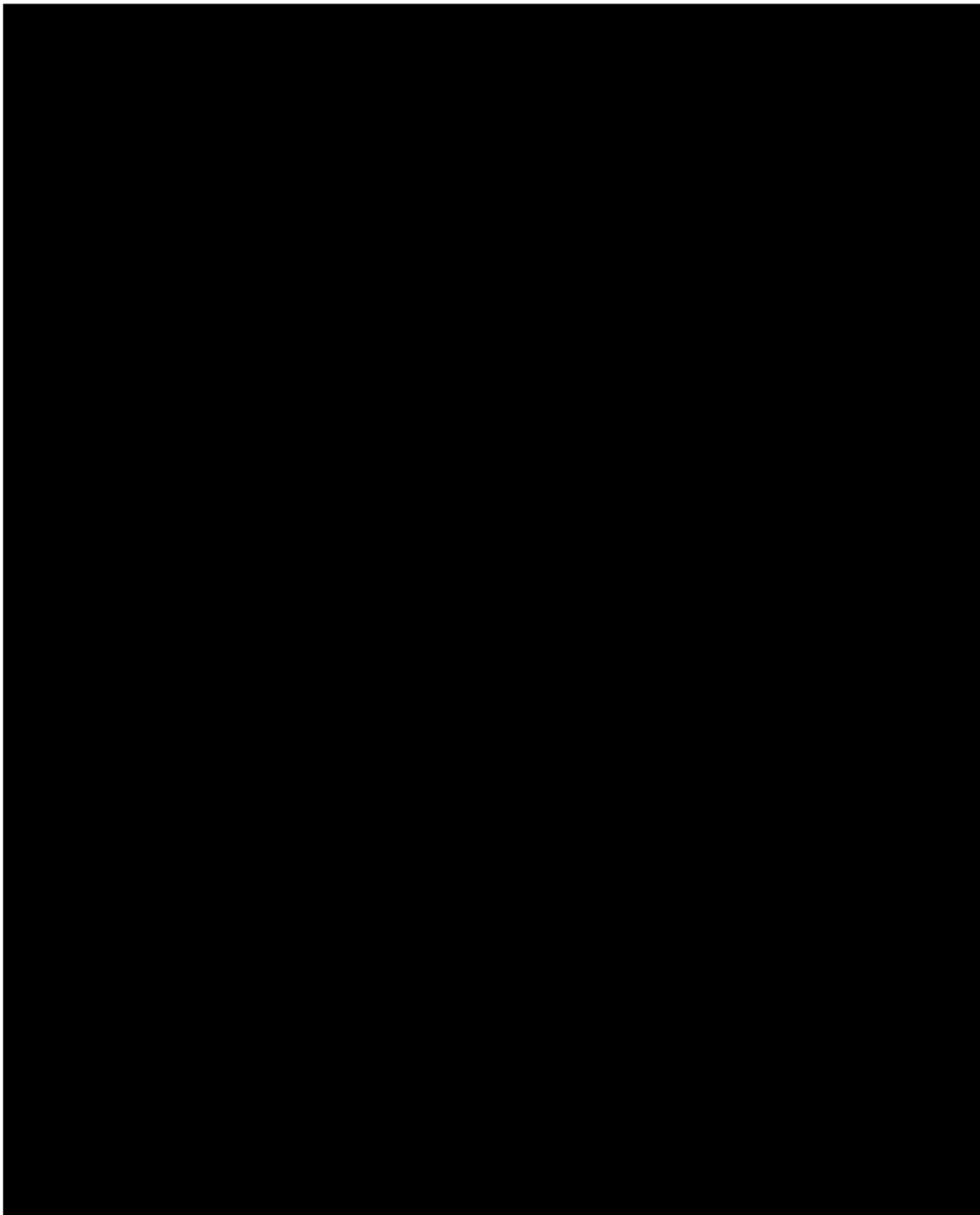


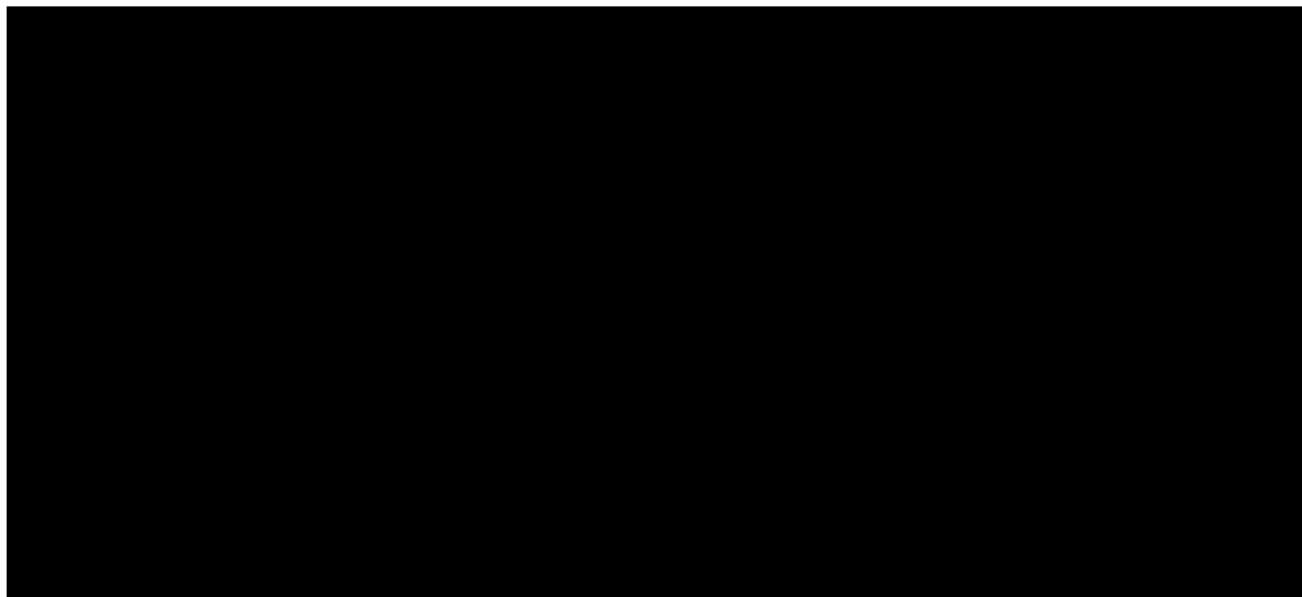
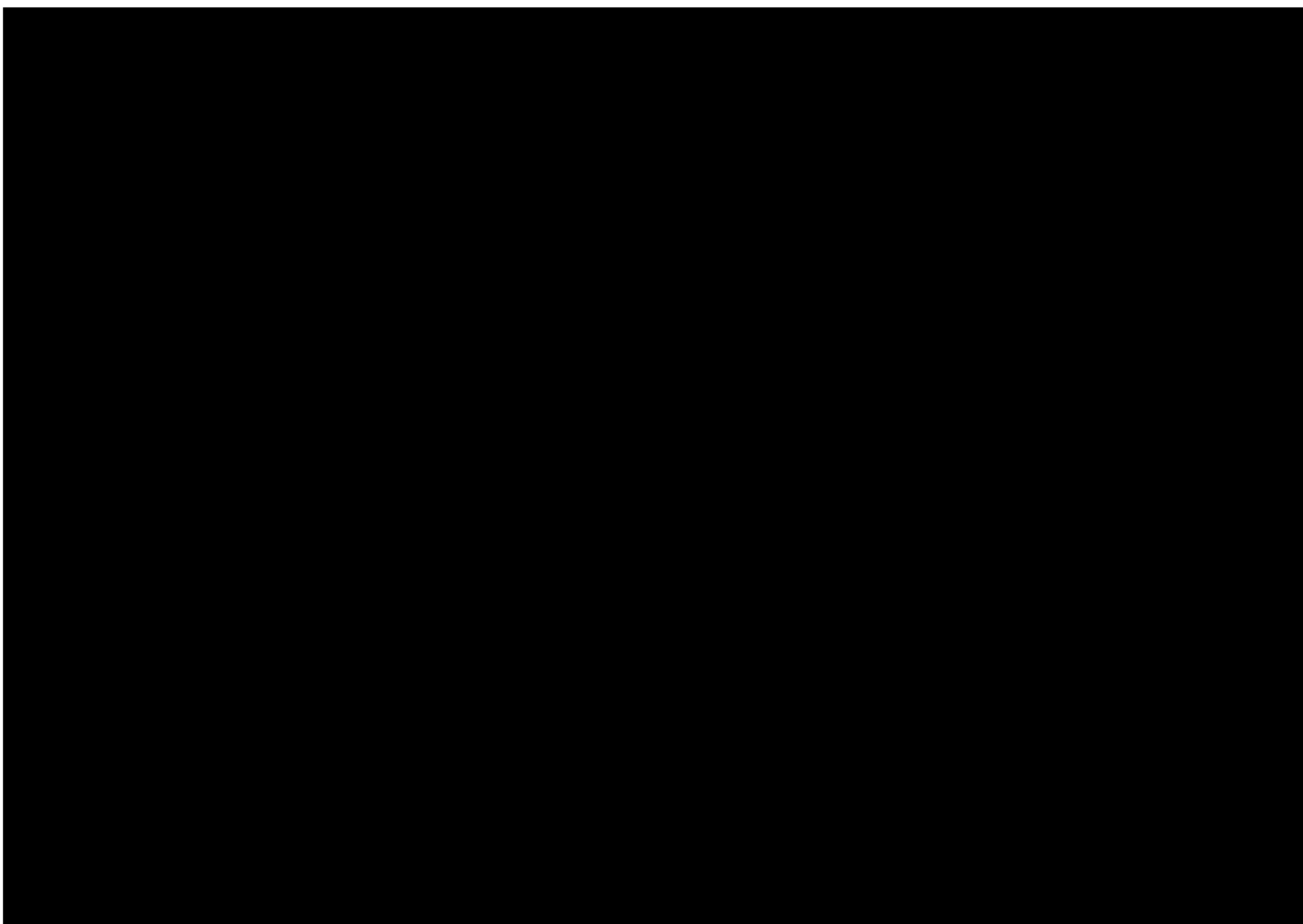


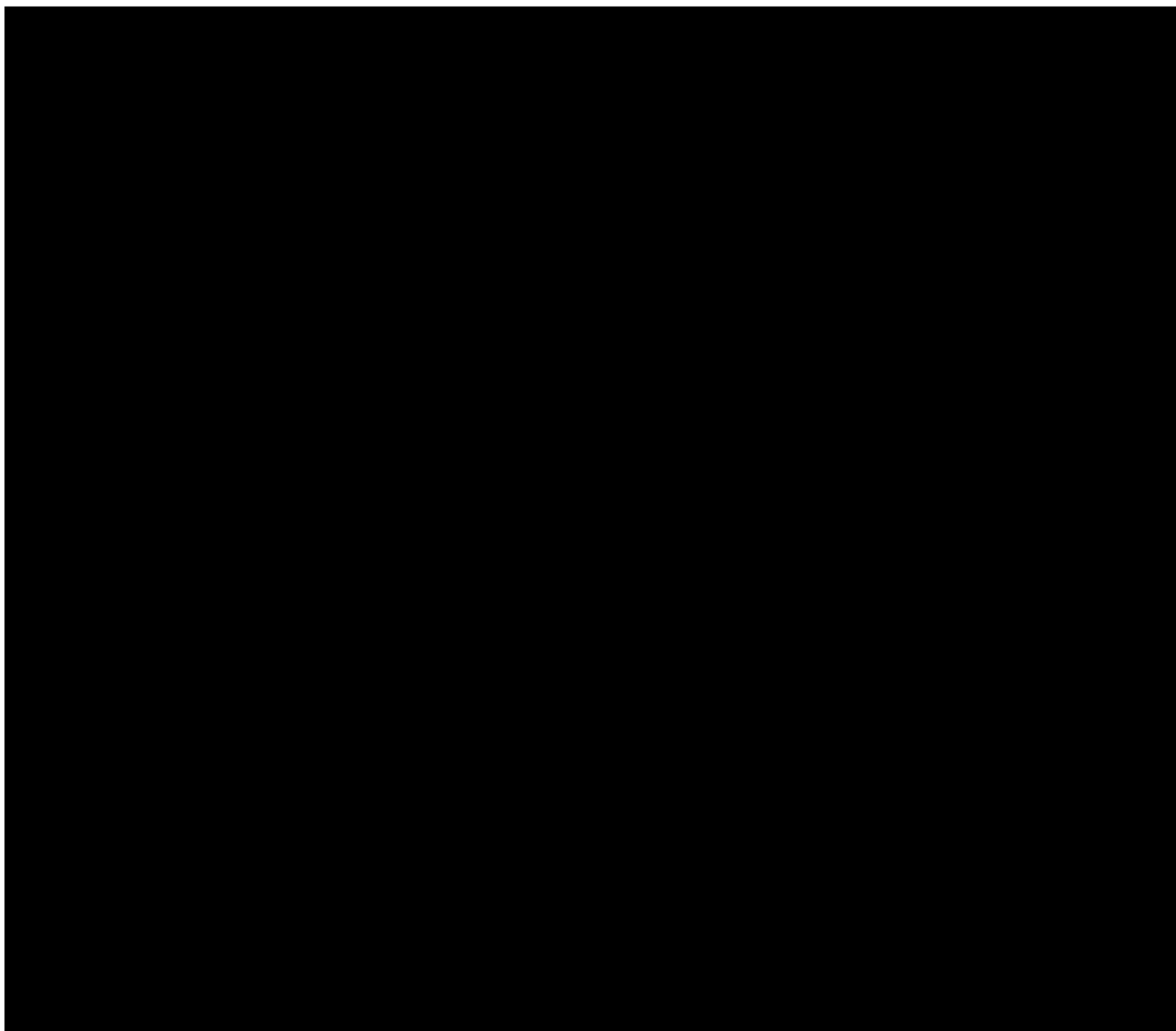


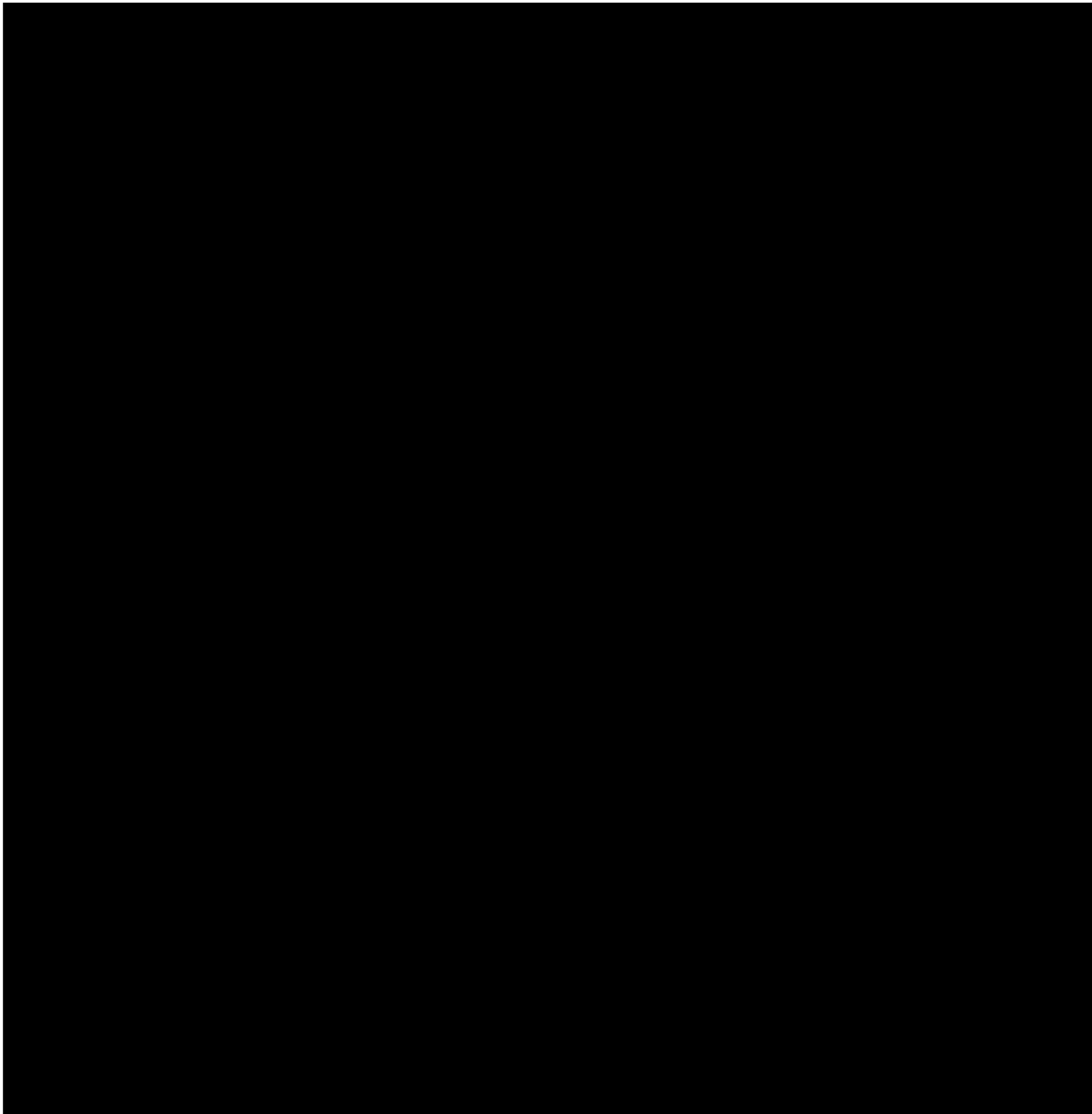


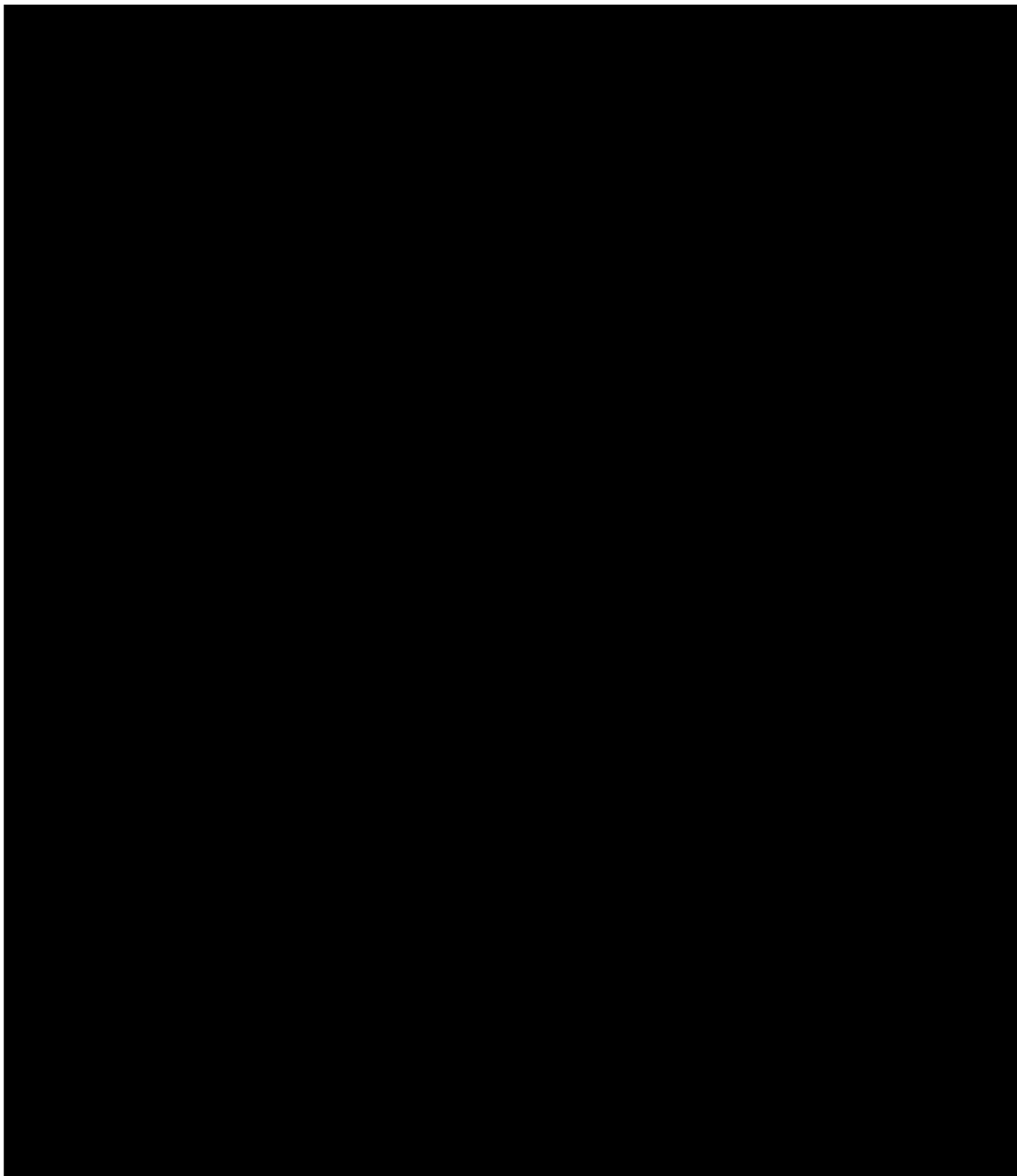












At least thirty calendar Days prior to the commencement of Full MHSU Disorder Project Services, and throughout the term of the Contract, the Offeror must possess a Participating MHSU Provider/Facility network that meets or exceeds the accessibility standards set forth in Section 3.10 of this RFP. To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

An Offeror will need to obtain sensitive information from the Department. Upon receipt of a completed, notarized *Confidentiality and Non-Disclosure Agreement* (Attachment 11), the Department shall provide the Offeror with *Enrollment by ZIP Code and Geo Access Network Report File* (Attachment 22) and *Utilized Provider File* (Attachment 34). The confidentiality and non-disclosure agreement must be submitted by an Offeror requiring access to Enrollment by ZIP Code and Geo Access Network Report File (Attachment 22) and Utilized Provider File (Attachment 34).

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

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

Carelon has completed the requested analyses as detailed below in part a to d.

In addition, Carelon's continued integration with Elevance Health will result in additional network growth for Empire Plan members. Our partnership with Elevance Health will help create additional capacity of clinicians/facilities to enhance member access across the United States.

- a. Submit their proposed Provider network using the *Offeror's Proposed Provider Network Files* form (Attachment 23). An Offeror is required to submit its proposed MHSU Provider network in two separate files: one for MHSU Facilities; and one for MHSU Practitioners. Additionally, Offerors must provide the *Offeror's Proposed Network Summary Worksheet* (Attachment 32) detailing the percentage of enrollees that will have network access to the required Provider and Facility types outlined in Section 3.10.l.

We provide the requested MHSU Facilities file as **Exhibit 11a Provider Listing - Facilities (RFP Att. 23)**, and the requested MHSU Practitioners file as **Exhibit 11b Provider Listing Practitioners (RFP Att. 23)** on USB.

We provide the requested **Exhibit 12 - Provider Network Summary Worksheet (RFP Att. 32)**.

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

We provide as **Exhibit 13a GeoAccess Summaries**, in both searchable PDF on USB and in hard copy, as well as **Exhibit 13b GeoAccess Complete Reports**, our complete Geo network reports, in a searchable PDF format as requested on a clearly labelled USB drive.

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

We provide the requested information as **Exhibit 12 - Provider Network Summary Worksheet (RFP Att. 32)**.

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

We provide the requested **Exhibit 14 - Provider Comparison (RFP Att. 33 and 34)** on a clearly labeled USB.

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

Access to an available provider network of behavioral health providers and facilities with a variety of clinical specialties and intensity is critical when assessing the success of a superior behavioral health system of care. As a foundation to equitable, whole person focused care, Carelon understands that access standards must consider MHSU Provider availability, especially as the COVID 19 pandemic exacerbated mental health concerns and has resulted in increased demand for services.

Carelon strives to ensure when access is sought, access is achieved. Carelon makes every effort to maintain accurate and up to date information; however, behavioral health availability in any community shifts constantly and changes can occur at any time. As such, Carelon uses multiple methods to update and relay availability:

- Carelon ensures provider availability is known to members via the mental health and substance use disorder online provider directory for the Empire Plan. Carelon ensures information is current, accurate, and consistent with the data collected during the credentialing/recredentialing process, including the provider's name, gender, education, training, Board certification (as applicable), specialty, accepting new patients, languages spoken by the practitioner, race and ethnicity, locations, and facility accreditation status (as applicable).
- Providers are able to self report changes to their provider profile through the Council for Affordable Quality Healthcare (CAQH), Carelon's web portal, or by directly contacting Carelon.
- Network providers are also prompted quarterly to update their practice data, including notification if they are not accepting new patients, via ongoing relationship with the Alliance Partners team for strategic providers.
- Carelon also collects data from multiple other sources to ensure the availability of providers is accurately recorded. Feedback is obtained by sources outside the more formal provider network management processes, such as seeking feedback from members and clinical care and utilization managers.

To improve member experience in getting their first appointment, Carelon is launching a digital audit with a focus on Directory Optimization and Accuracy in New York in quarter two of 2023. Providers will have the opportunity to accept new Carelon members into their practices based on participation in and feedback obtained during the audit survey and advise if they are looking to grow their practice at a given location.

We are also contracting with a vendor on a Secret Shopper initiative. This will collect data on topics such as accuracy of directory contact information, whether the provider and/or provider location is accepting new patients, availability of first appointment, and types of appointments offered.

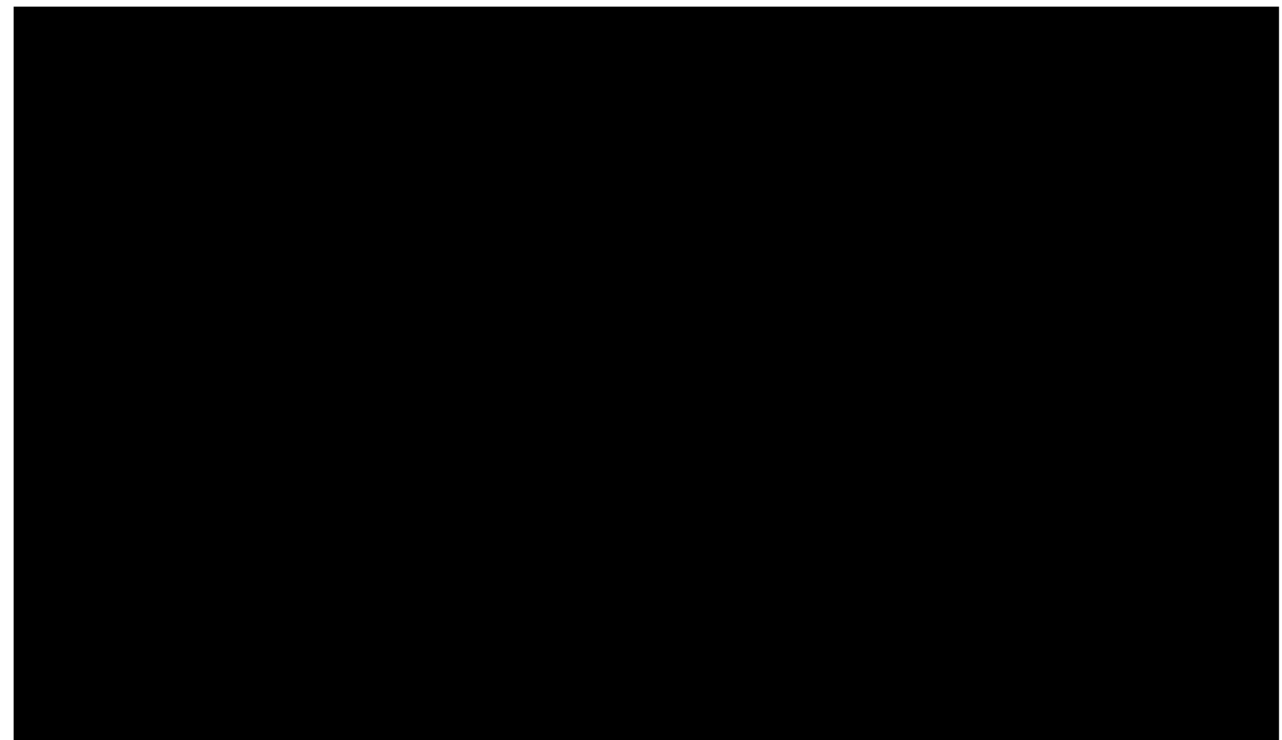
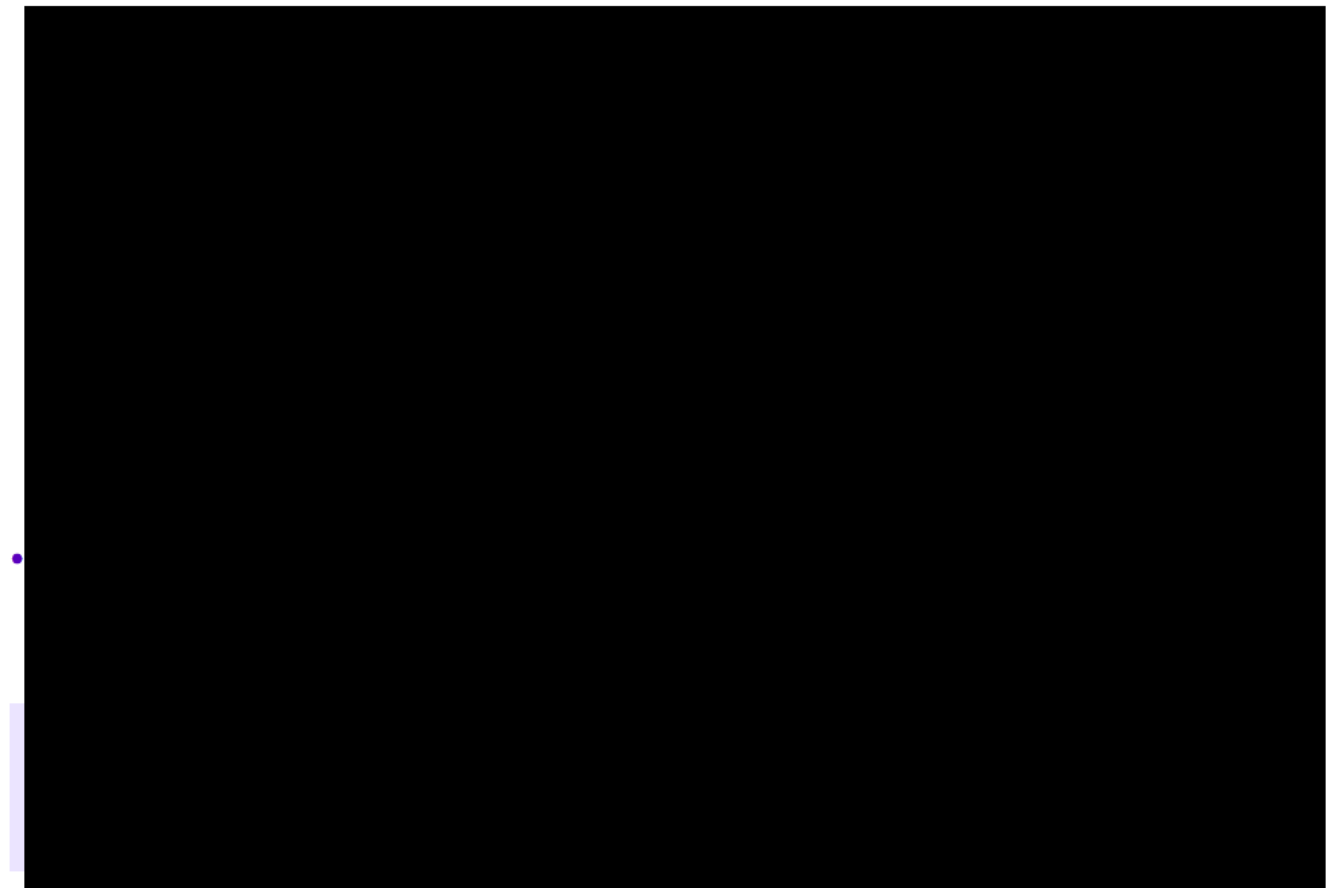
Carelon establishes an expectation to notify us should a provider no longer be open to accepting new patients. This includes a contractual obligation with providers that does not allow providers to limit the cases they accept; rather, we do allow a provider to "close" their practice to new referrals for a limited time if he/she believes the practice is at capacity. This limitation is made when the request is received by written notice and the practice is then monitored to assure duration is limited and the practice reopened to new referrals as soon as possible.

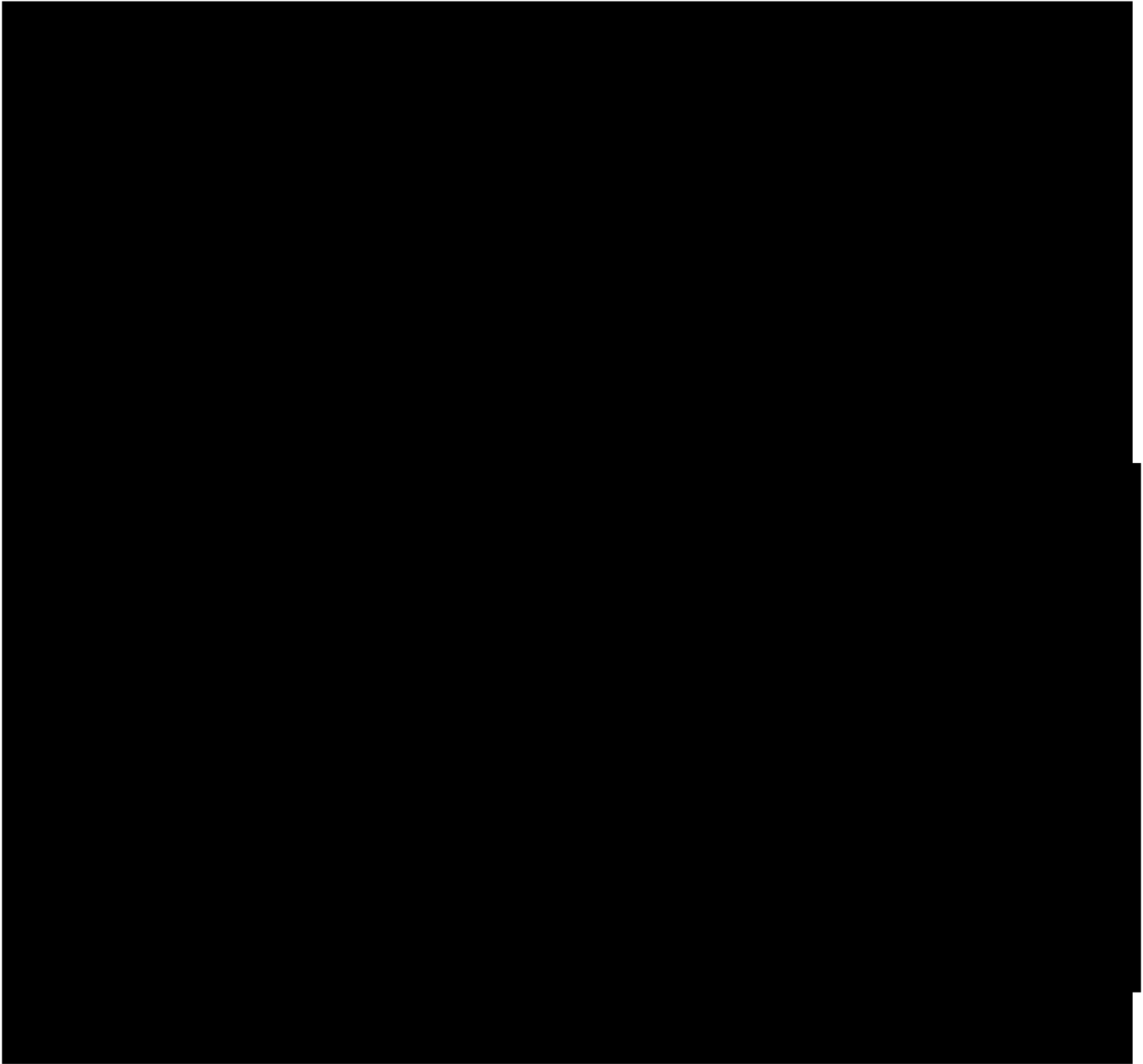
However, we know that more needs to be done to ensure that Empire Plan members have true access and availability of services based on their specific identified needs. Carelon also monitors provider availability in the following ways:

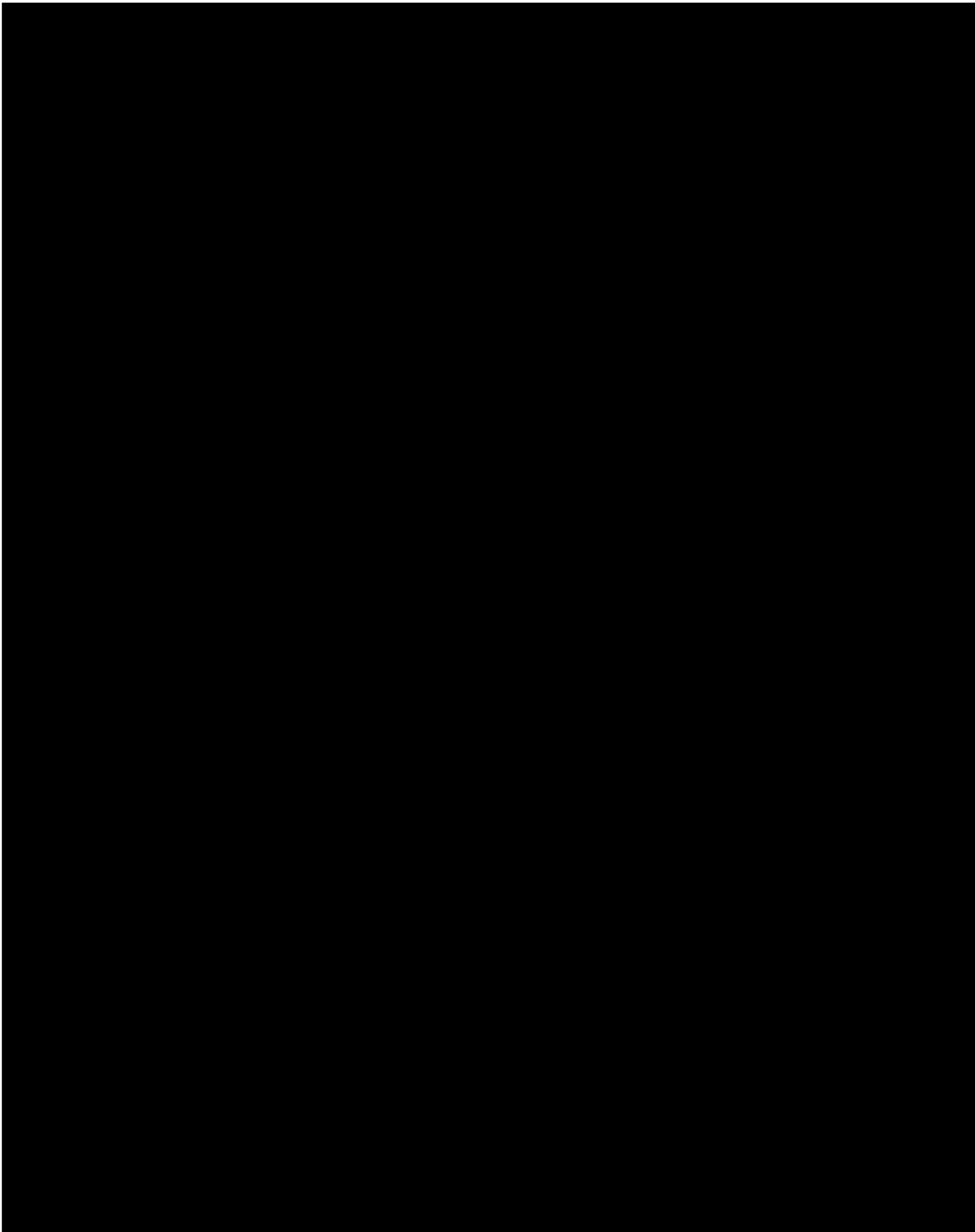
- **A directory audit initiative:** This ongoing monthly audit is designed to measure the accuracy of the information in the provider database that Carelon uses to make clinical referrals. The audit includes validating providers' practice status regarding accepting new members. One of the questions asked is if the provider is accepting Carelon Members, and Carelon is scored on that measure. The team utilizes the CMS (Centers for Medicare Services) methodology to score our overall provider directory.
- **Provider Access and Availability Surveys:** Carelon Provider Relations conducts annual surveys of our New York market to confirm provider's availability. This is reserved to remind our CAQH providers to attest to access. For non CAQH providers, it serves as another avenue to solicit and receive access details.
- **Use of CAQH Data:** Over 93 percent of Carelon network providers use CAQH, and we use CAQH data feeds to receive information from providers as to their contact information and appointment availability. We capture CAQH attestation five days a week and process all demographic changes so the information in our network remains current. In addition, CAQH has a substantial provider outreach program to prompt providers to confirm their data elements every 90 days and to attest or update their information every 120 days. If a provider does not attest to their CAQH profile at least every six months, then a Carelon Provider Relations Representative reaches out to the provider to ensure they are still in practice and taking new members. For those Providers who are not utilizing CAQH, Carelon initiated a campaign to encourage CAQH participation to receive their access more systematically, in addition to meeting other regulatory requirements as part of the No Surprises Act.
- **Provider Portal:** Through an update to Carelon's online provider portal, Carelon will have enhanced capability to push reminders to providers to validate their information.

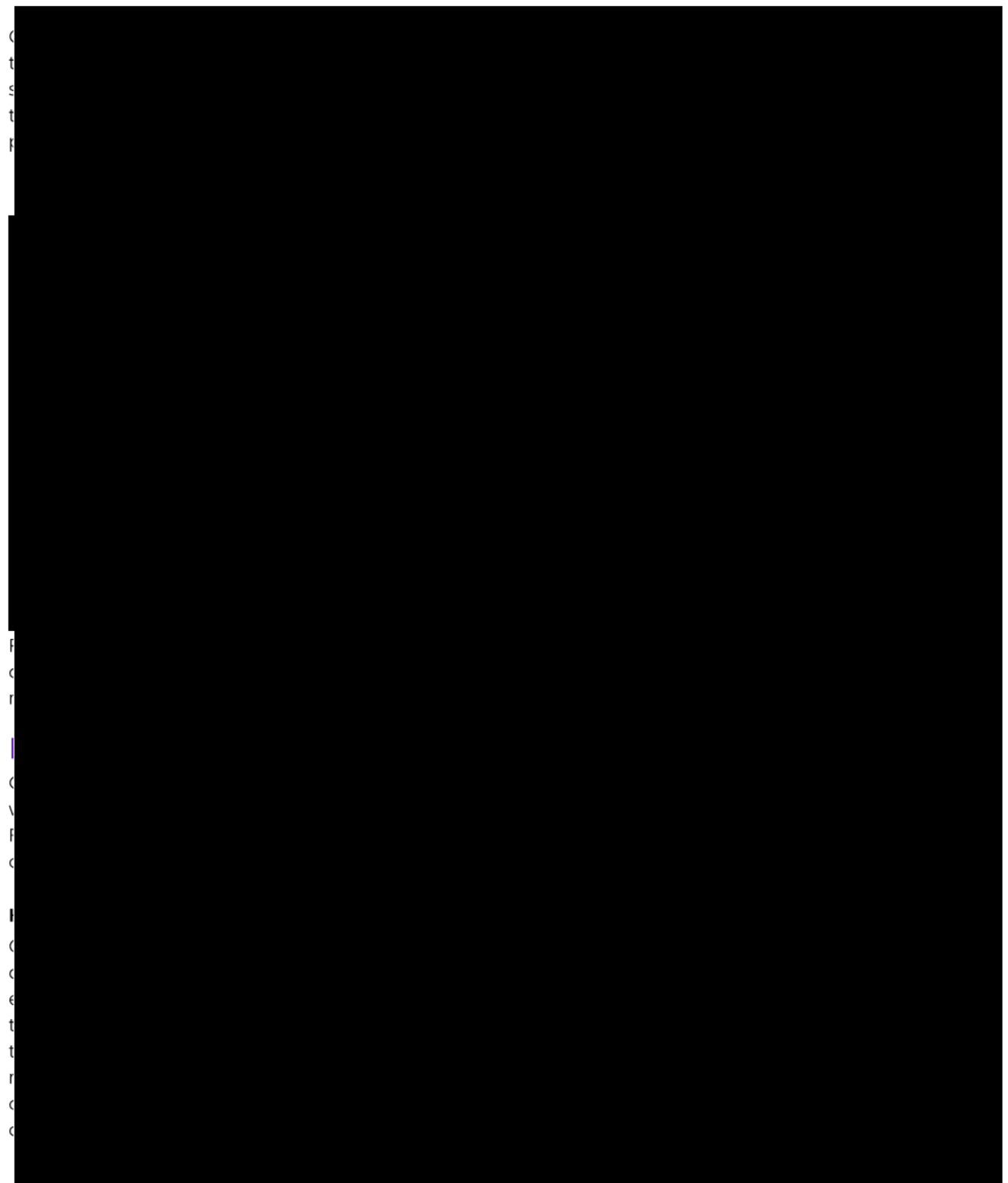
We also carefully evaluate and document the capacity of network providers to ensure members receive the benefits to which they are entitled according to established, reasonable access performance standards. The methods used to conduct the evaluation are described below:

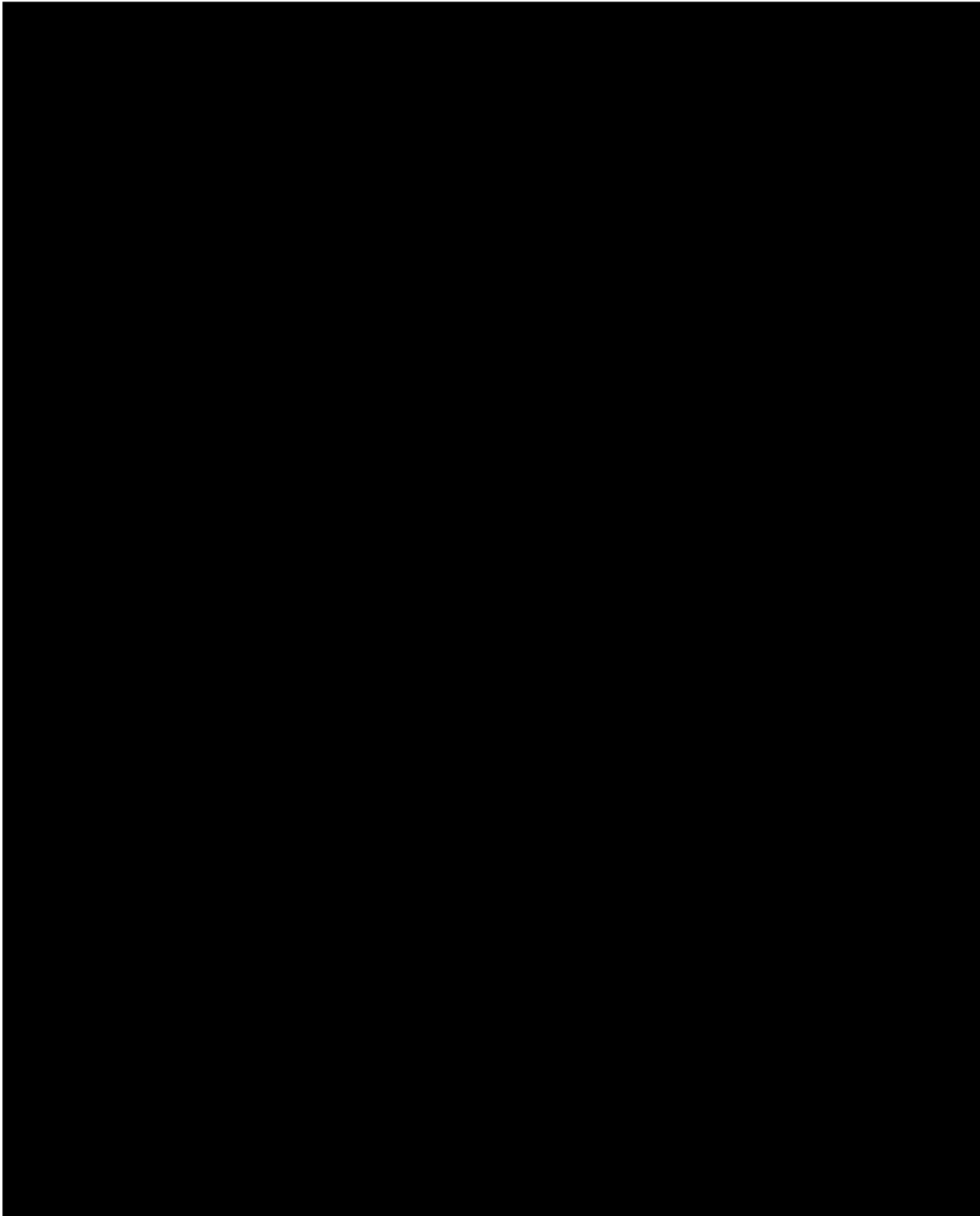
- **Credentialing Process**—Our extensive credentialing process includes an assessment of a provider's capacity to accept additional members. Because our network is driven primarily by member referral, providers are not accepted into the network unless they can accept additional members. We do not contract with providers who have full practices or waiting lists. Our credentialing and recredentialing processes provide information about caseload and availability, which provide the opportunity to assess capacity both at the point of entry to the network and at the point of recredentialing.
- **Network Monitoring**—In addition to evaluating provider capacity during initial credentialing, we also monitor the network continuously to ensure members receive the services and treatment they need promptly and according to established performance standards. This is accomplished via three methods:
 15. **Member Feedback:** First, we listen carefully to members by having a no wrong door approach across our organization. From clinical and customer service teams to provider relations and network contracting, we take feedback about provider access and availability however it may be supplied. Information indicating that a provider is unable to provide members with treatment according to established protocols is included in the provider's file and our provider directory is then











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

Carelon maintains a robust network that exceeds access standards. Carelon's continued integration with Elevance Health will enhance our existing network and help fortify access for the Empire Plan membership in New York State and nationwide.

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

We are committed to continuously improving access to quality behavioral health care for the Empire Plan members we serve. Along with continued recruitment efforts to increase the availability of in person services, we will offer access to additional national telehealth provider groups under the new Contract. This allows members who want telehealth services or the ability to message providers to do so without reducing the availability of our "brick and mortar" providers, many of whom are currently offering both in person and telehealth services.

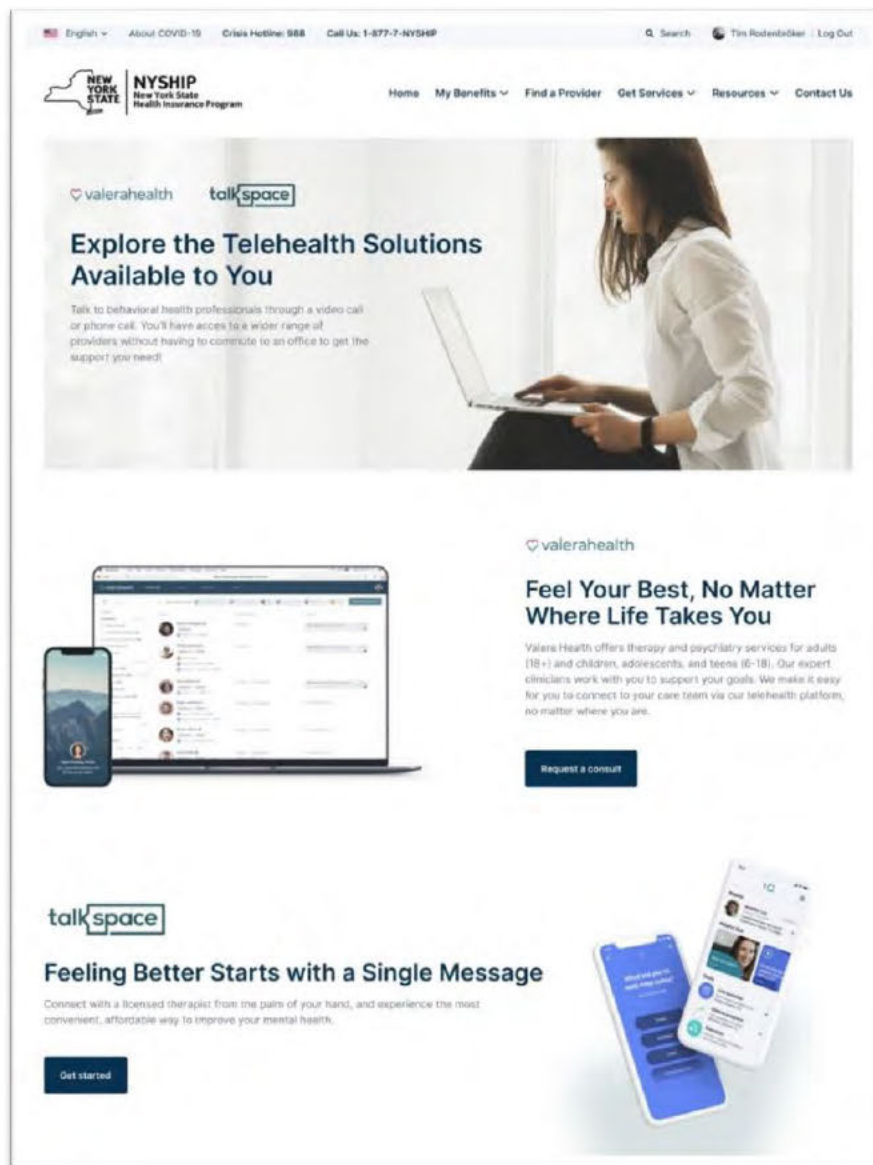
Carelon is also seeking to enhance our applications, with collaboration from CAQH, to capture the service modalities that practitioners offer. As the ability to report on this information becomes available, we will enhance search capabilities on our online provider directory to improve members' search experience as they seek telehealth or in person appointments.

Expanding member choice allows members seeking access to behavioral health services to choose a treatment modality that meets their needs, in a manner that eases access to care and meets the member where they are at. Accordingly, our telehealth ecosystem offers a range of treatment modalities and delivery options, including self-navigated digital tools, medication management, and psychotherapy delivered both synchronously and asynchronously, for a wide range of conditions including mental health and substance use. In doing so, we are removing certain barriers to accessing care by improving convenience, alleviating the cost and burden of travel to get care, and bypassing stigma barriers and confidentiality concerns that may discourage members from seeking in-person care.

Telehealth Platform

Carelon is creating a customized member portal with a Telehealth platform for Empire Plan members. This portal will include all important resources for behavioral health. Within the platform, there will be a button for telehealth services. When the member taps this button, they will be taken to a telehealth homepage which will prominently display and provide content regarding the national contracted telehealth solutions and "preferred provider network for telehealth services." It will describe that this preferred network is a co-pay free option. Empire Plan members can choose the solution that best fits their needs based on service or provider. For telehealth, they will then be able to schedule a session with the network provider of their choice.

Below, we show a mockup of what this landing page will look like for Empire Plan members:

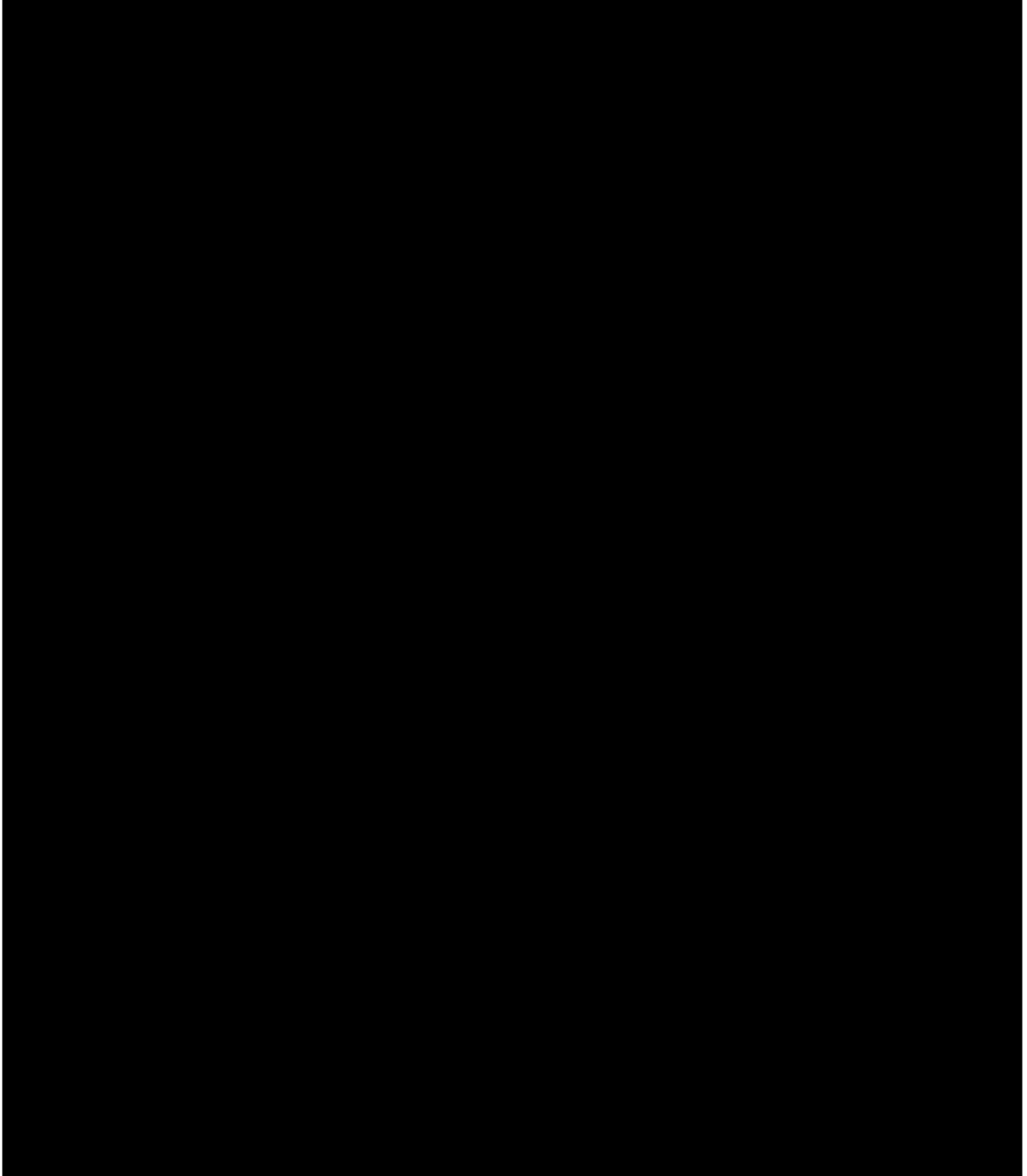


Building a Telehealth Ecosystem

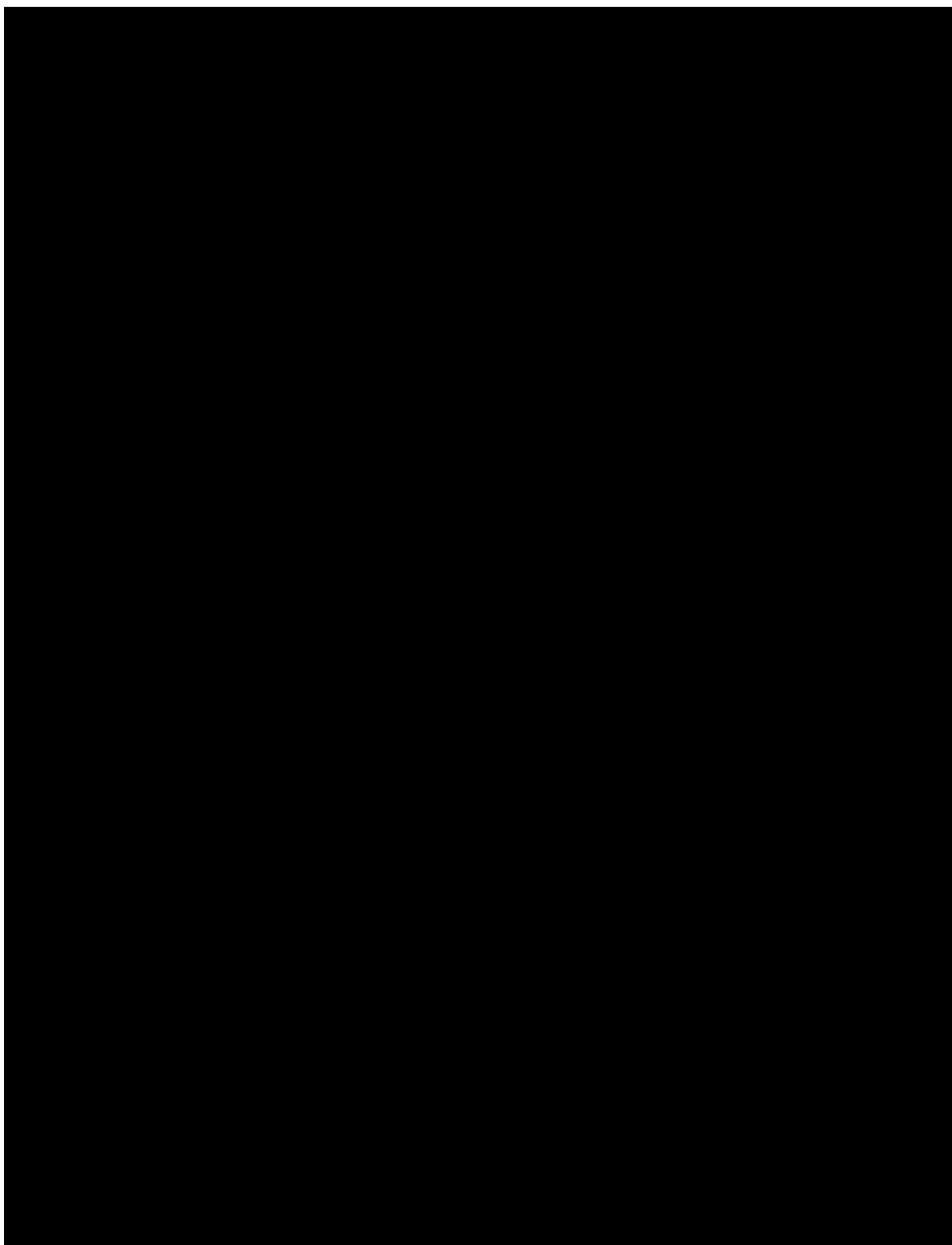
Along with the telehealth platform described above, to meet access needs and provide the best member experience, Carelon believes having a telehealth ecosystem with multiple provider groups is critical. We have added and are in the process of adding several national telehealth groups to our network. Our experience shows that by creating this ecosystem, it allows us to ensure there is a sufficient supply of providers resulting in shorter wait times for appointments.

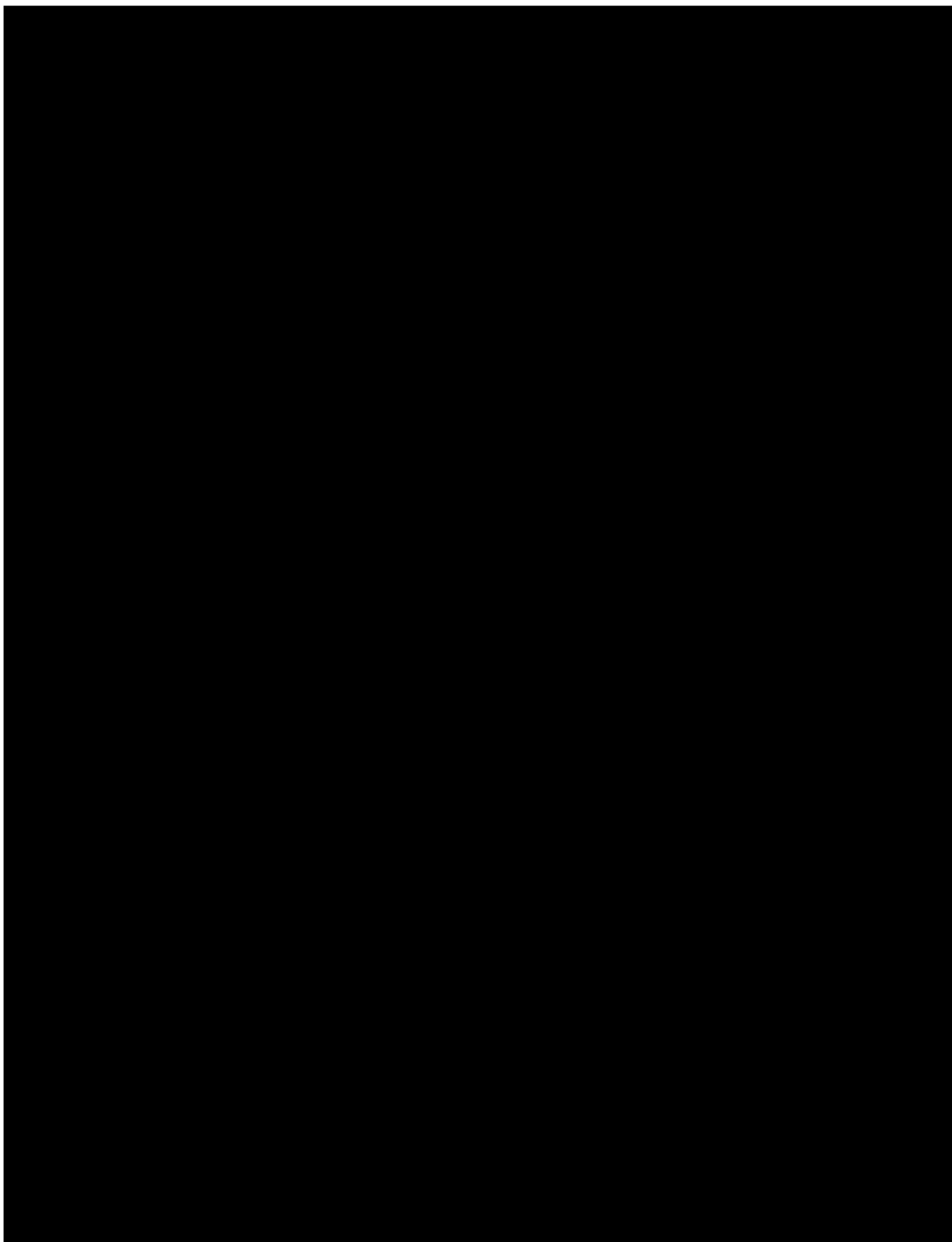
To provide more choices for Empire Plan members, our Medical Director and Clinical team are working closely with Carelon's Digital Product Development team to evaluate additional telehealth provider groups who treat subspecialties such as substance use, eating disorders, Obsessive Compulsive Disorders, and

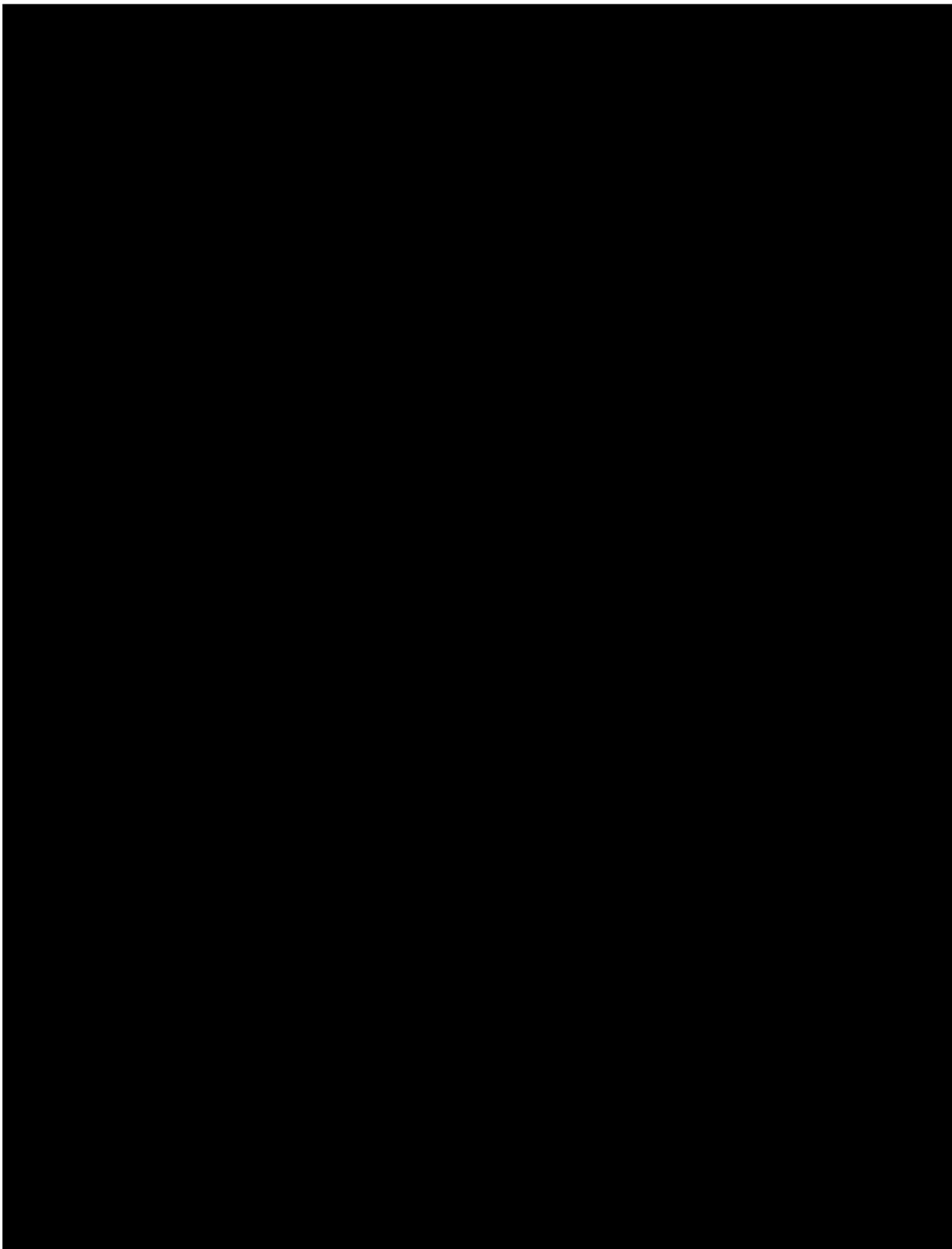
others. Some of those national telehealth groups are listed below, along with a description of any specialized services they offer.

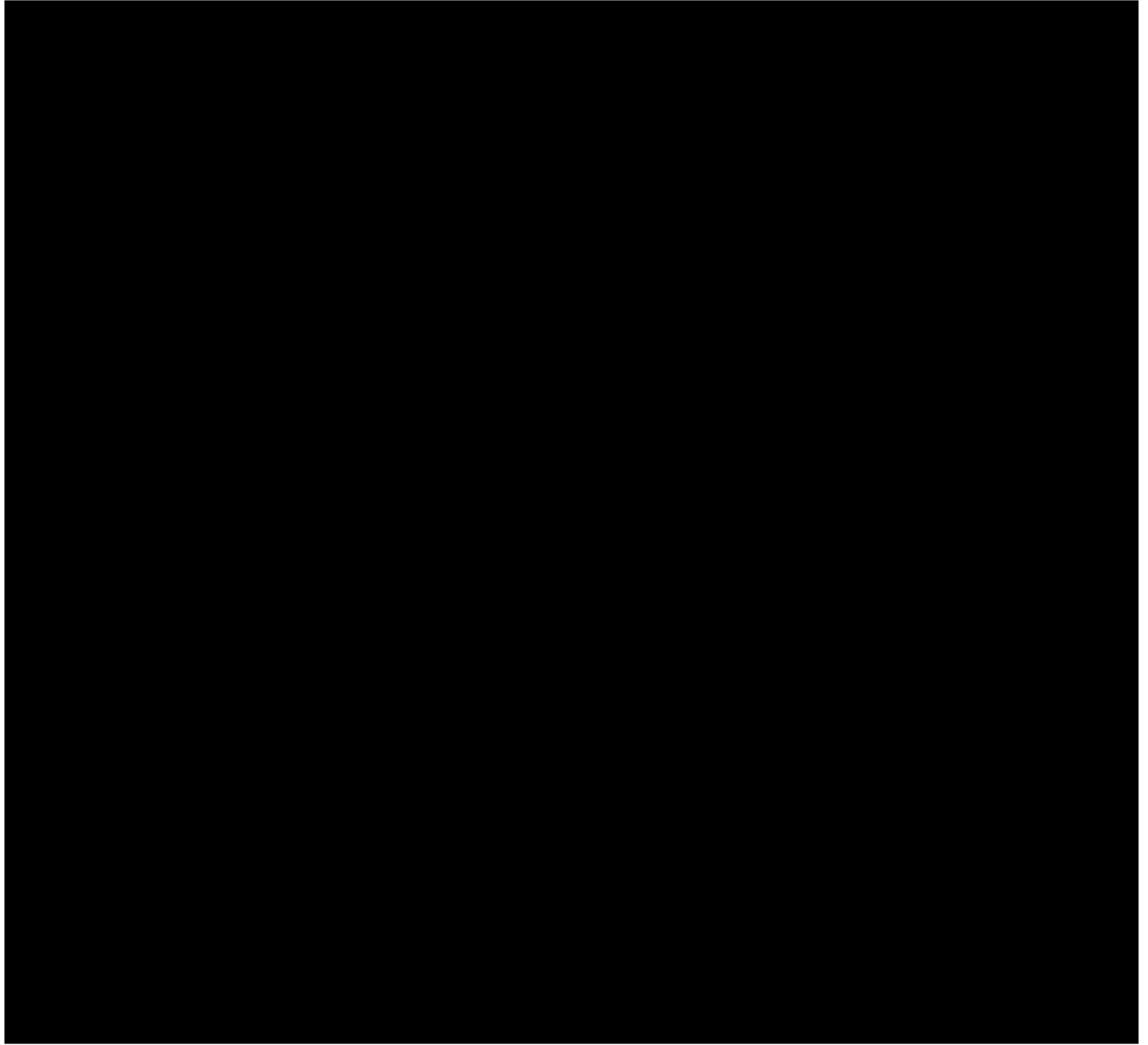


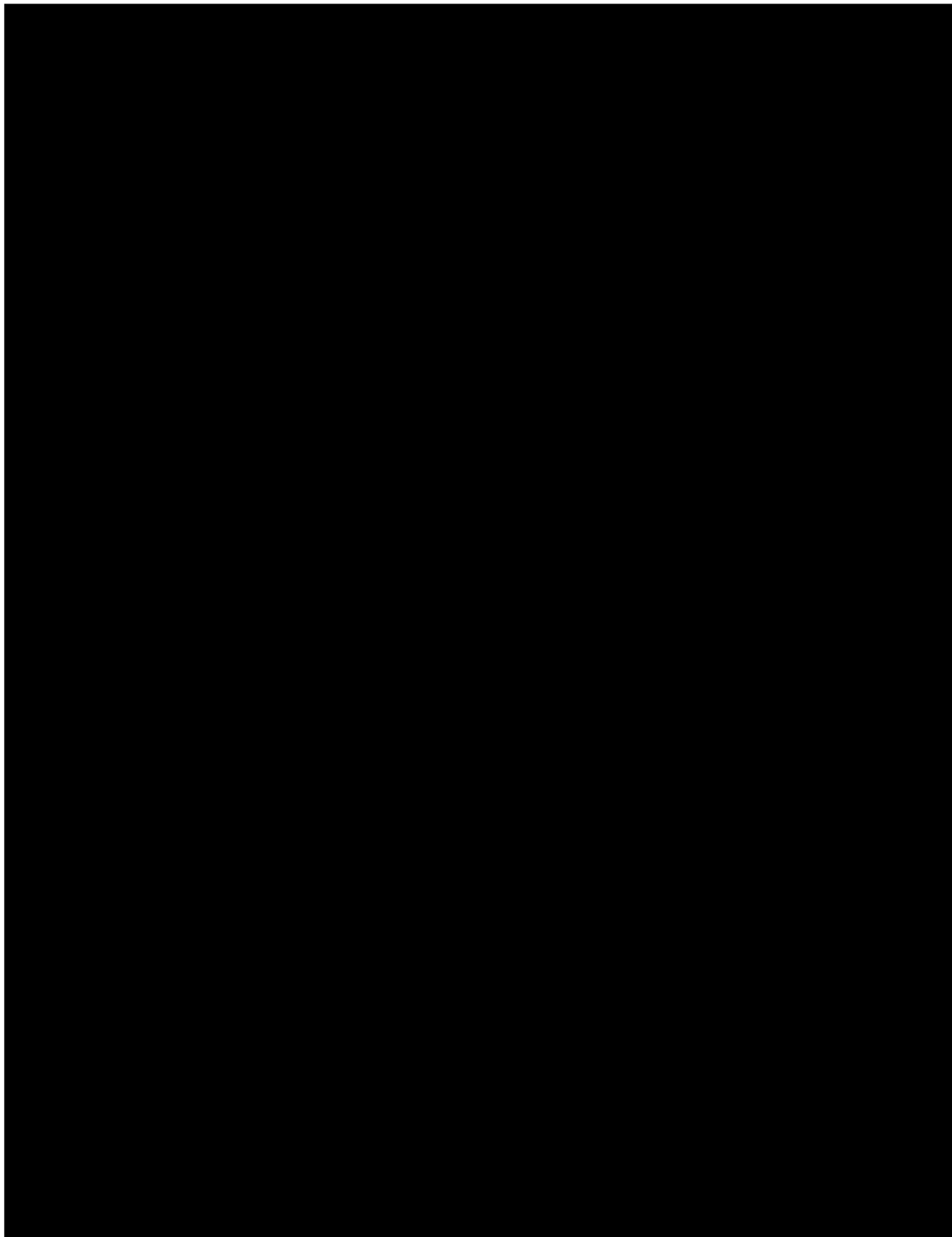


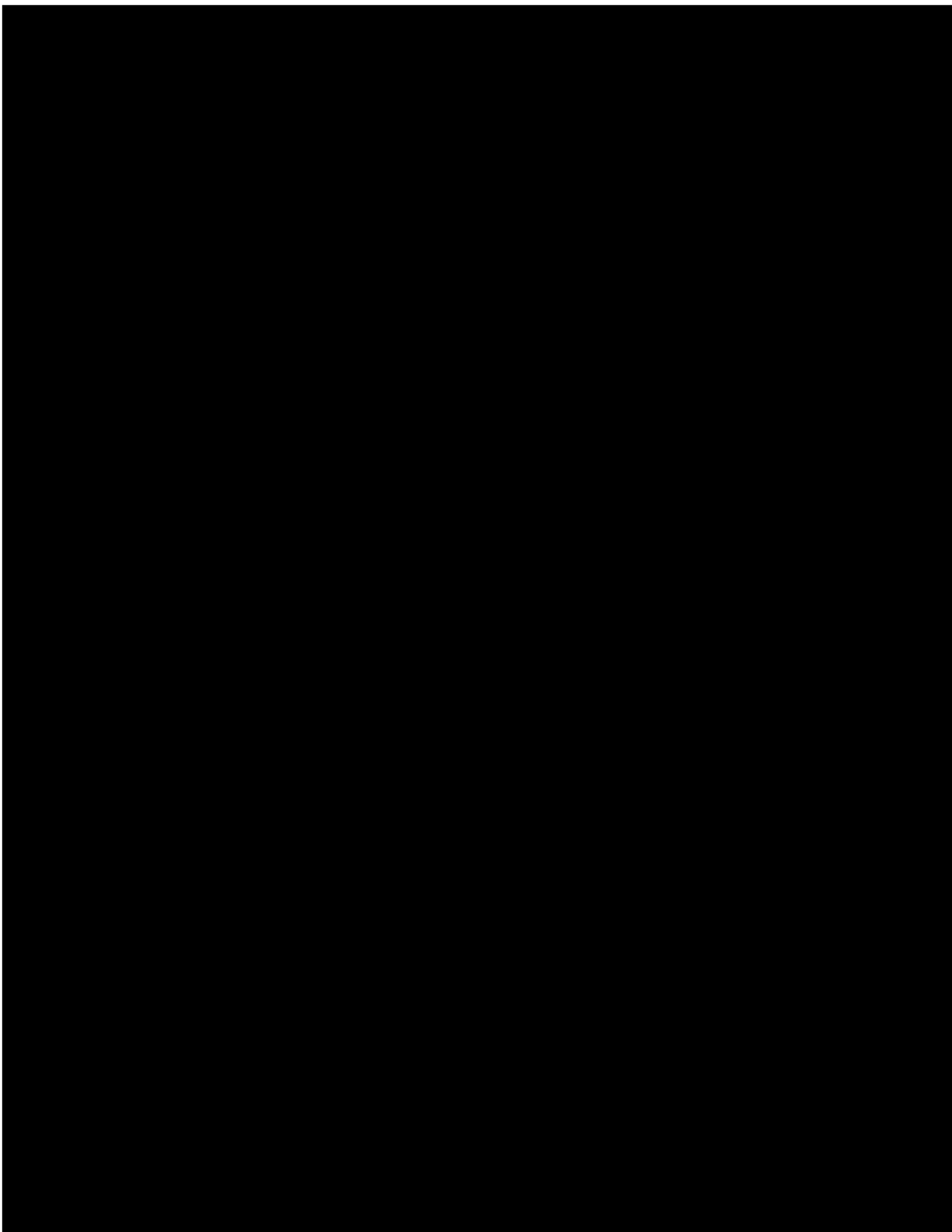


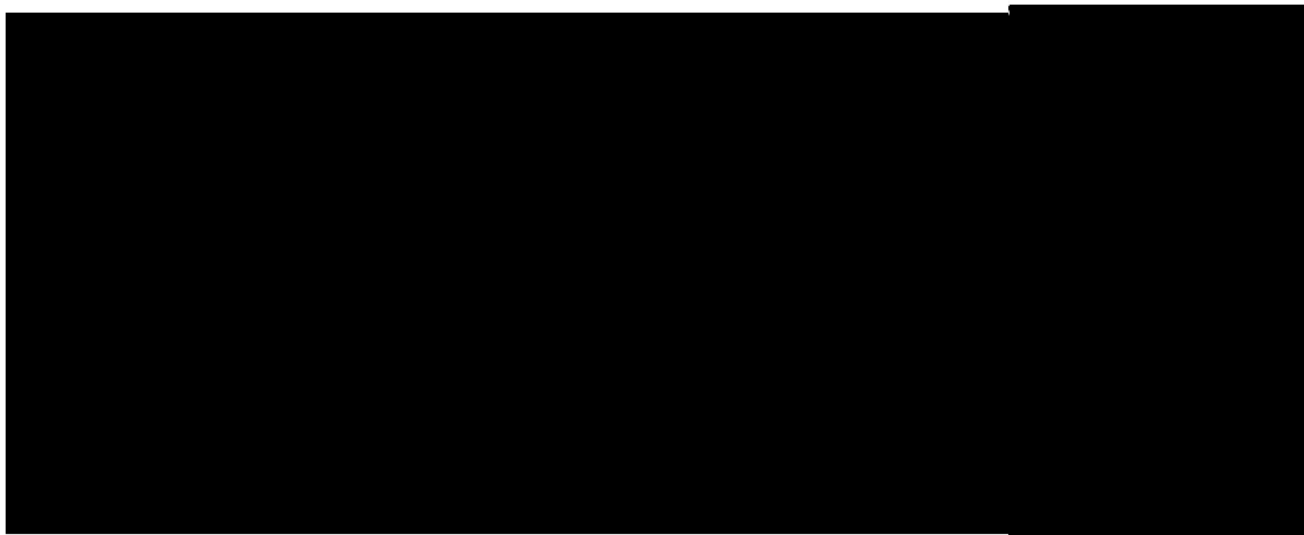


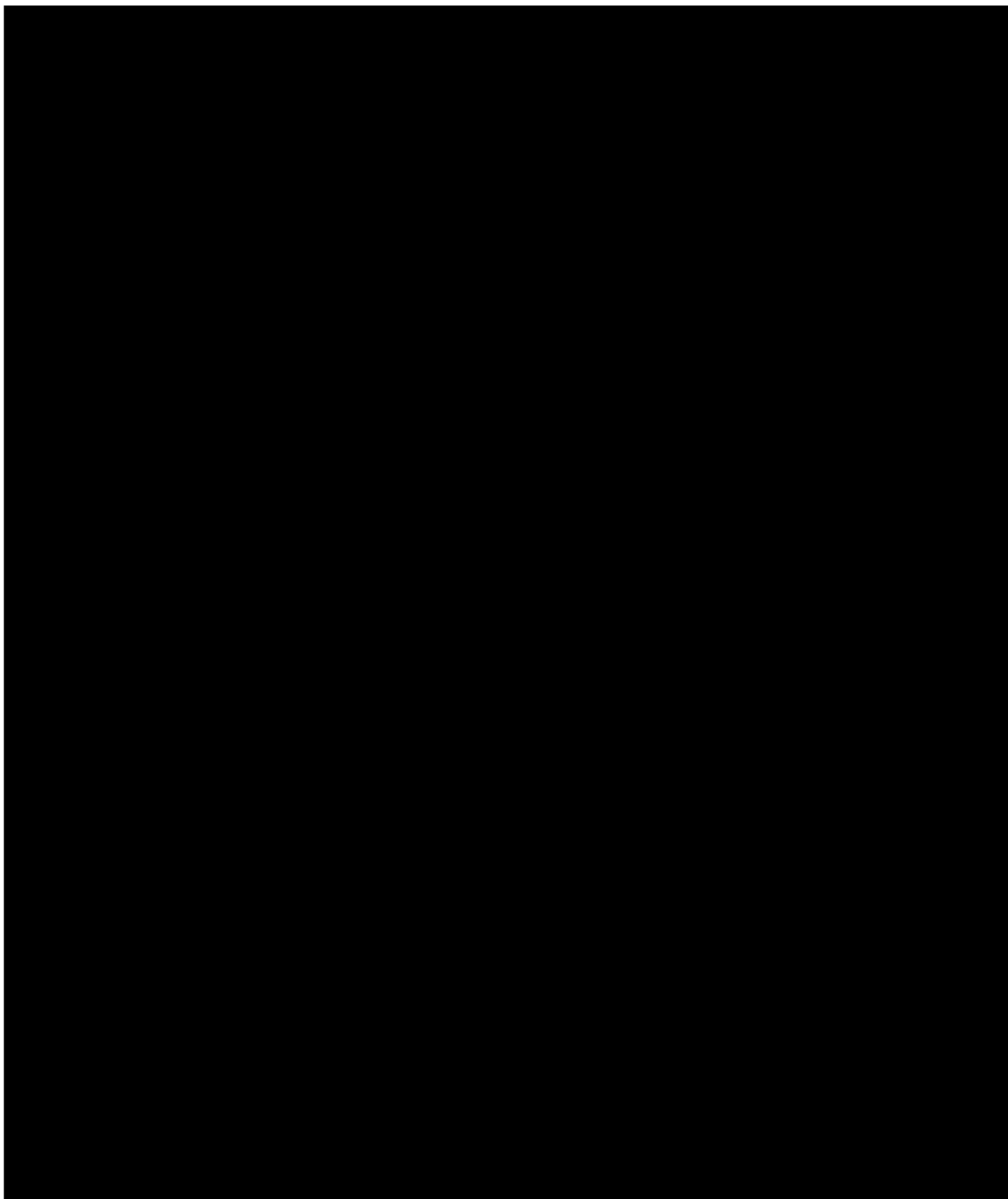


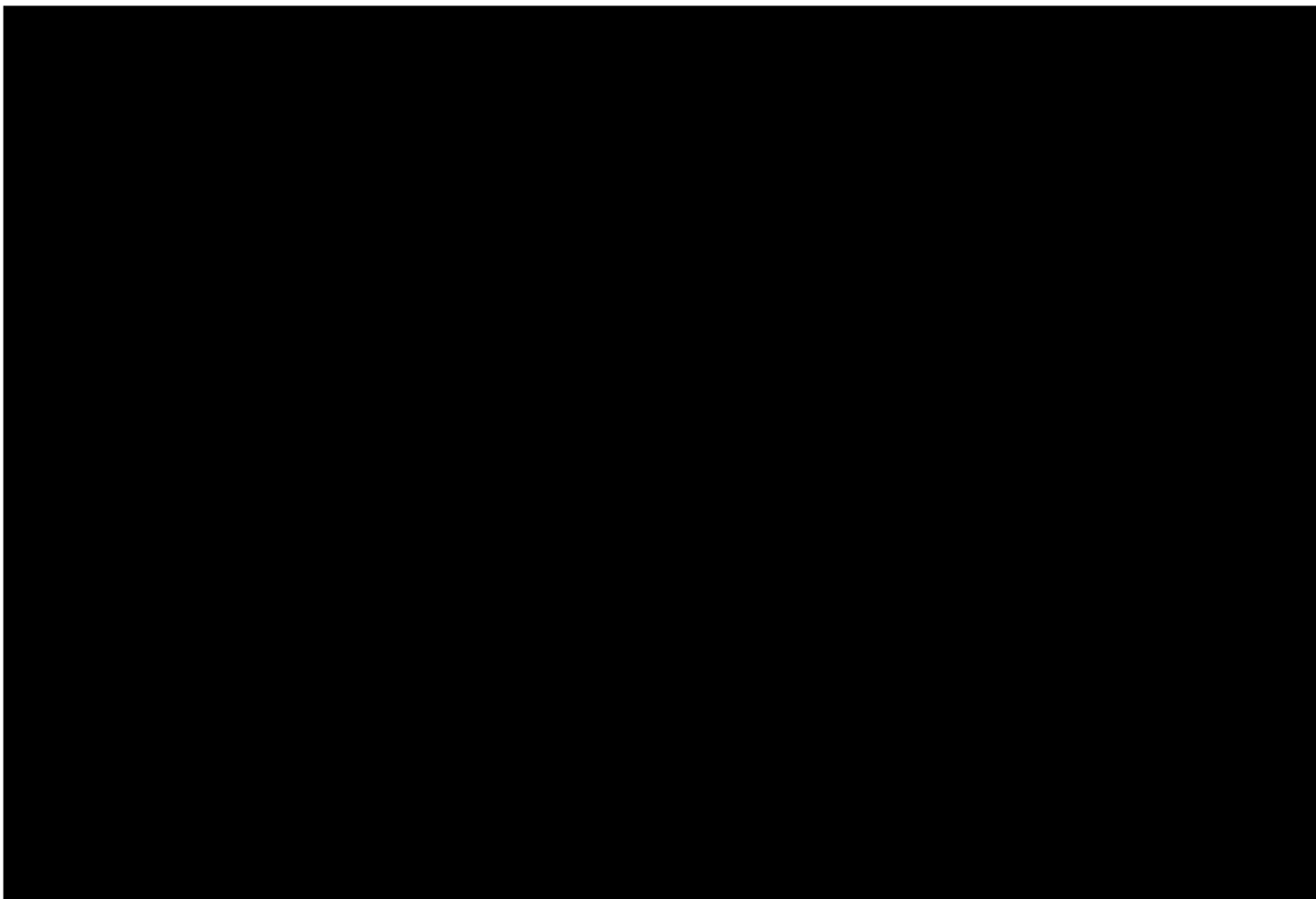


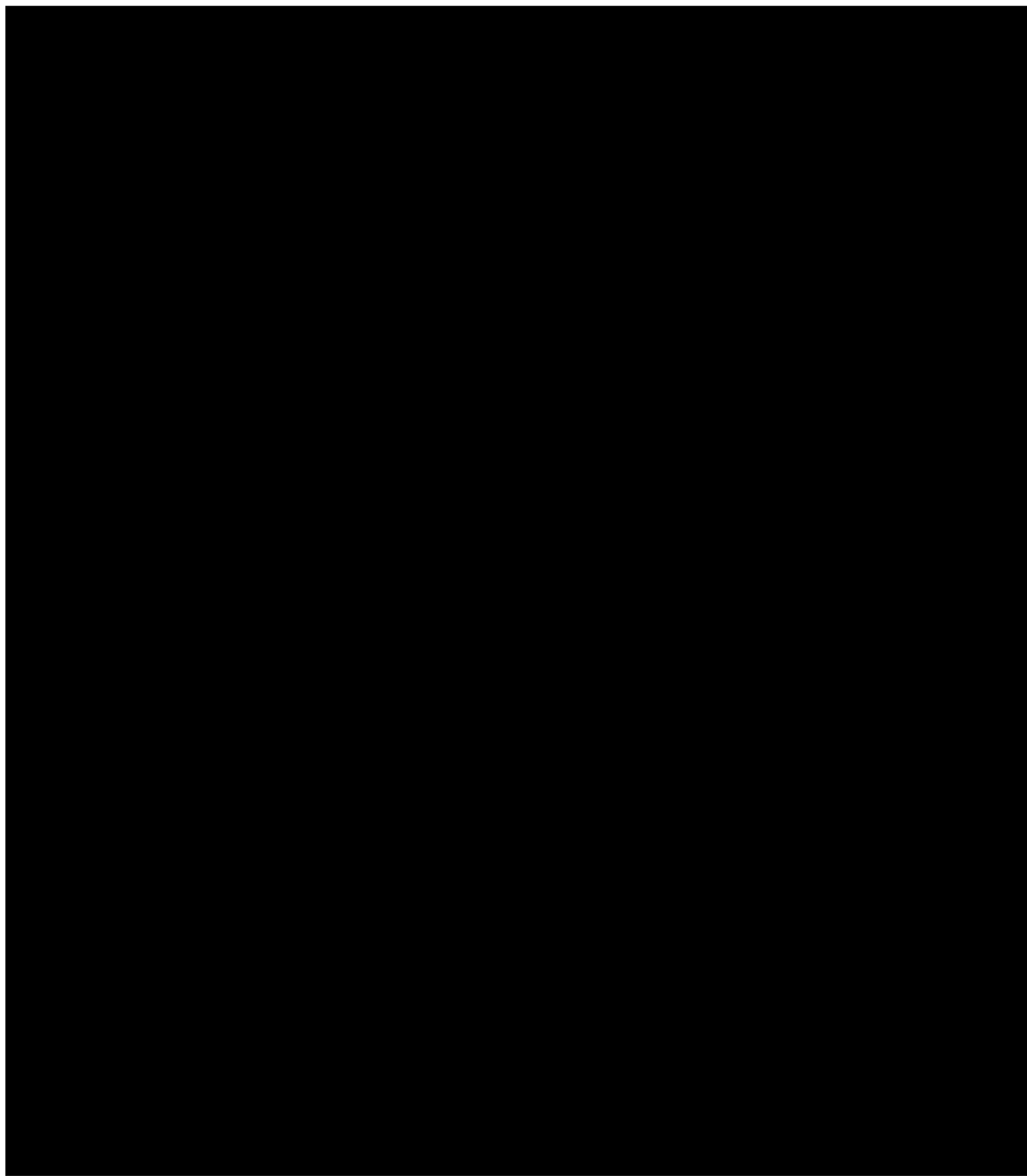


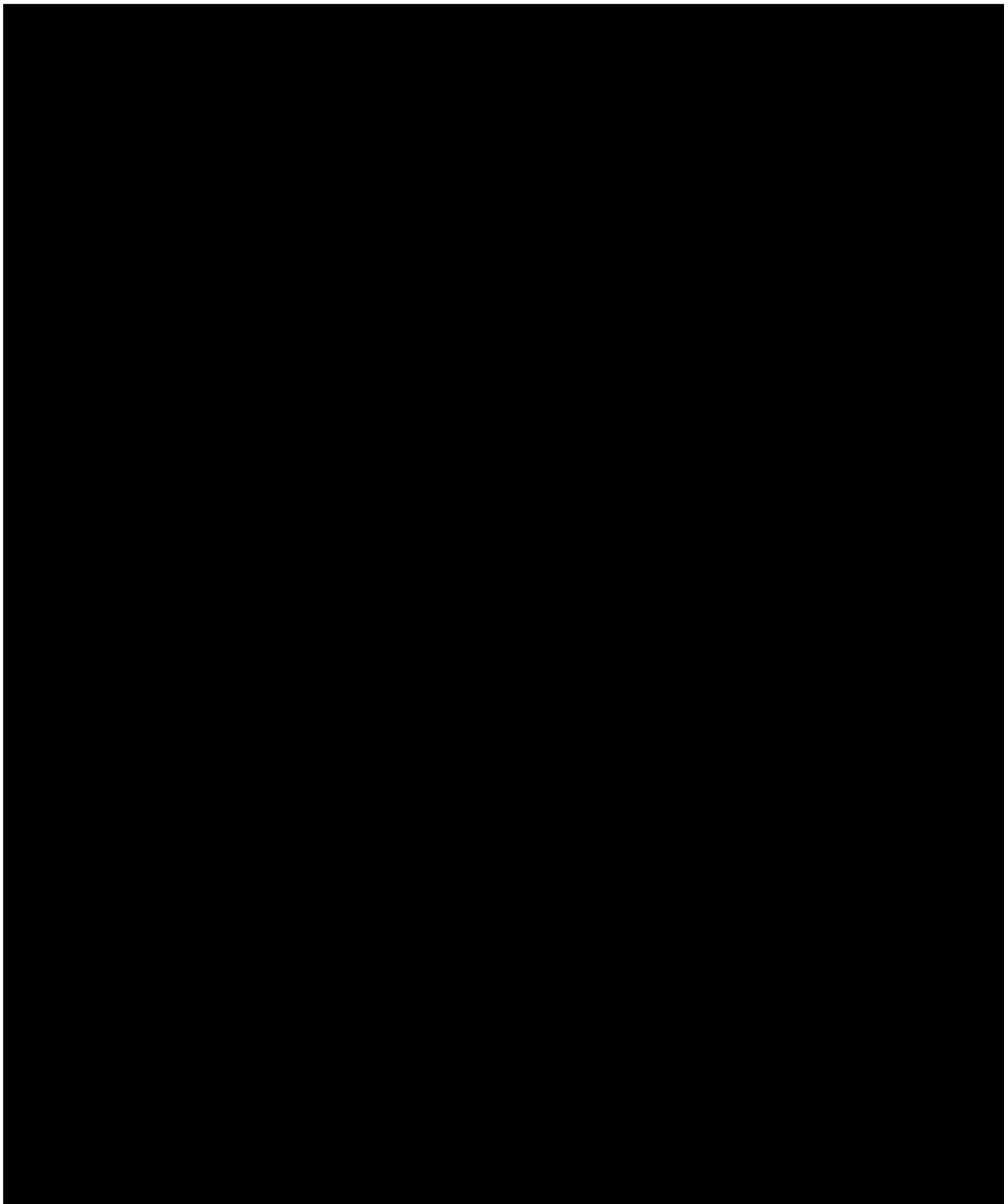


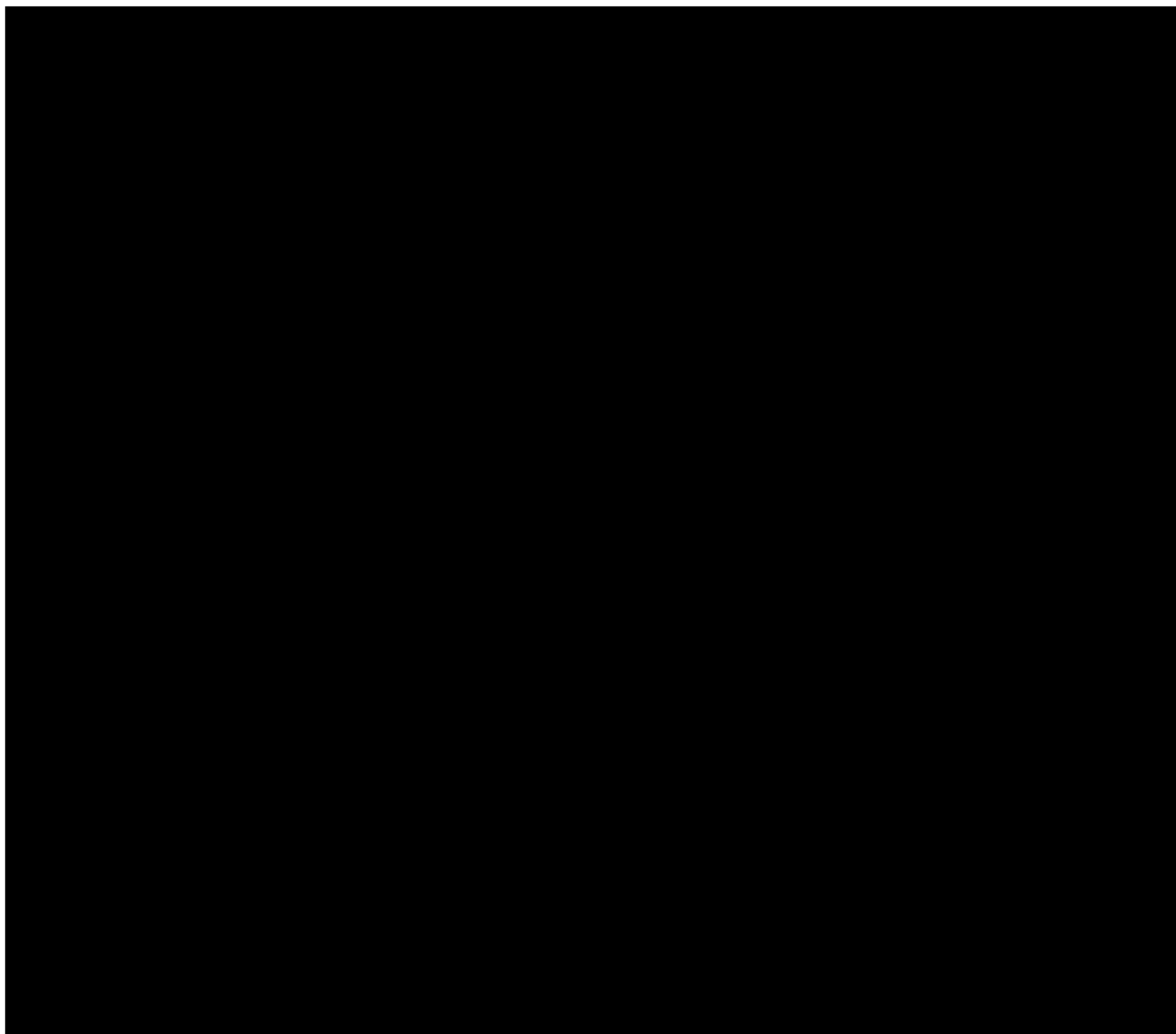












5.14 Pre-Certification and Concurrent Review for Mental Health and Substance Use Disorder Services

Carelon's pre-certification and concurrent review for MHSU Disorder services will continue to meet or exceed the requirements of *Section 3.12 Pre-Certification and Concurrent Review for Mental Health and Substance Use Disorder Services*. Carelon closely monitors all state and Federal regulations and mandates to ensure full compliance.

Our local team of dedicated clinical and medical director professionals will continue to ensure that Empire Plan enrollees and their dependents ('members') connect to the right treatment at the right time enabling them to live their life to the fullest potential. We have a macro-management clinical philosophy and approach, basing our view on the 'big picture,' and directing outcomes, efficiencies, and applying our resources for maximum impact.

We achieve outstanding results by focusing on promoting evidence-based care to your members by working closely with trusted, high performance facilities identified through ongoing performance and outcome management. We partner with our providers to offer training and education on new treatment modalities that are supported by (clinical thought leaders. Through network design and reimbursement strategies, we incentivize providers who deliver evidence based care, employ reporting tools that capture clinical and social measures of member health, and commit to appointment availability for members identified as needing urgent behavioral health care. We aim to reduce the administrative burden on providers by focusing on facility management and the intensive treatment and care management of outlier members.

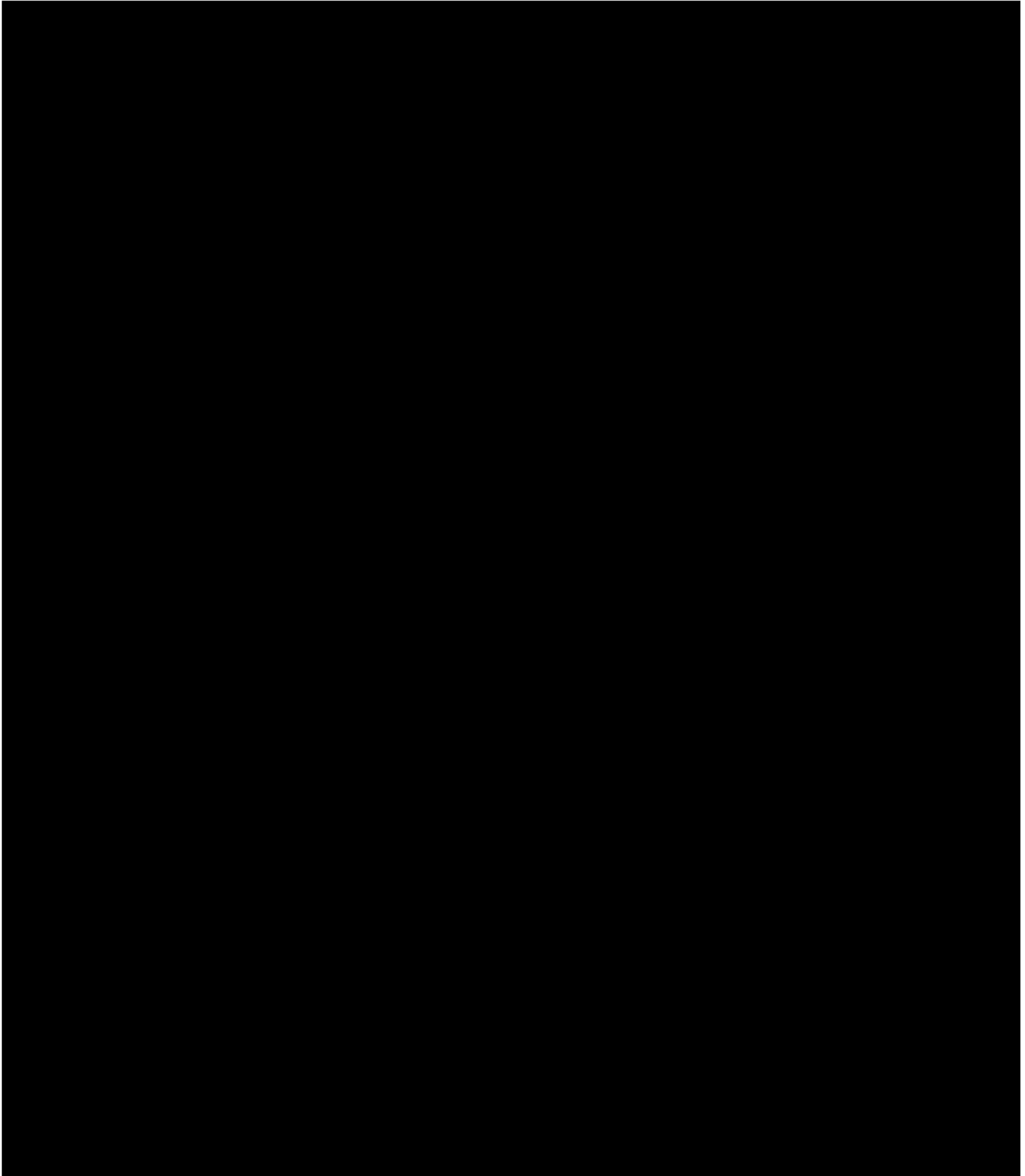
1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in for Pre-certification of benefits and concurrent review for MHSU services in accordance with New York State regulations as specified in Section 3.13 of this RFP, including the following:

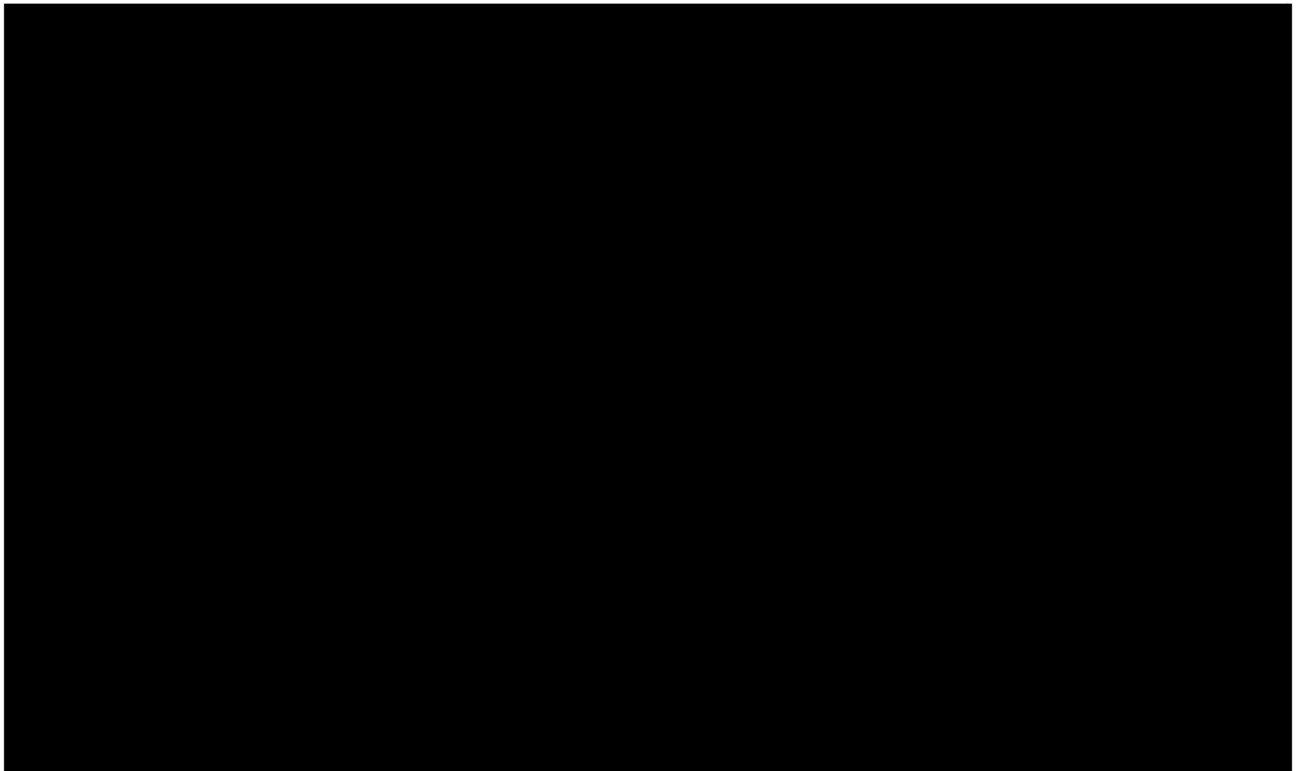
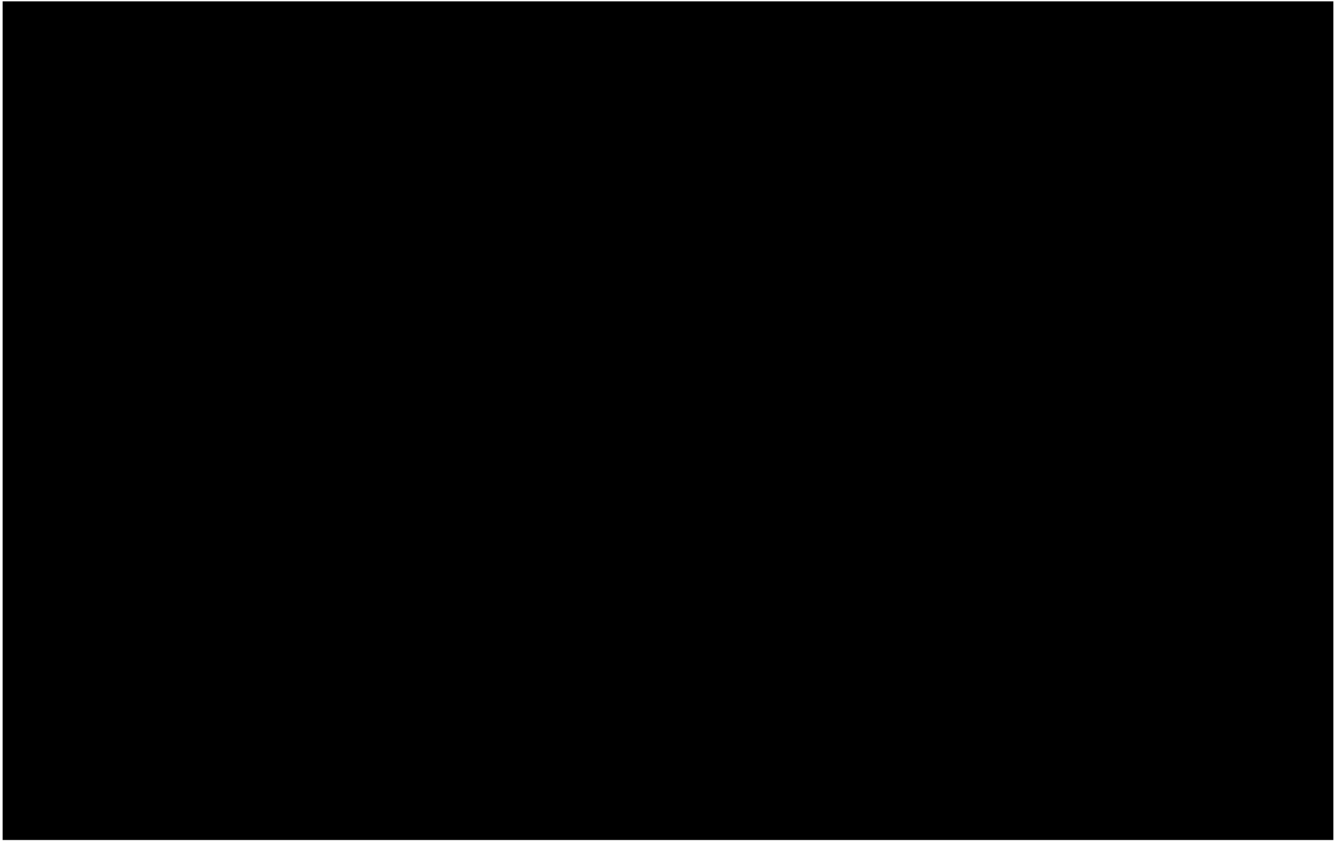
Our commitment to high quality, affordable health care for members is demonstrated through our accreditation status. **NCQA has awarded Carelon Full Accreditation under the Managed Behavioral Health Organization (MBHO) standards.** Accreditation is granted for three years to those plans that have excellent programs for continuous quality improvement and that meet NCQA's rigorous standards. NCQA MBHO Accreditation standards are intended to help organizations achieve the highest level of performance possible, reduce patient risk for untoward outcomes, and create an environment of continuous improvement. Carelon is a quality driven organization with the framework in place to continually assess and improve the clinical care and services we provide.

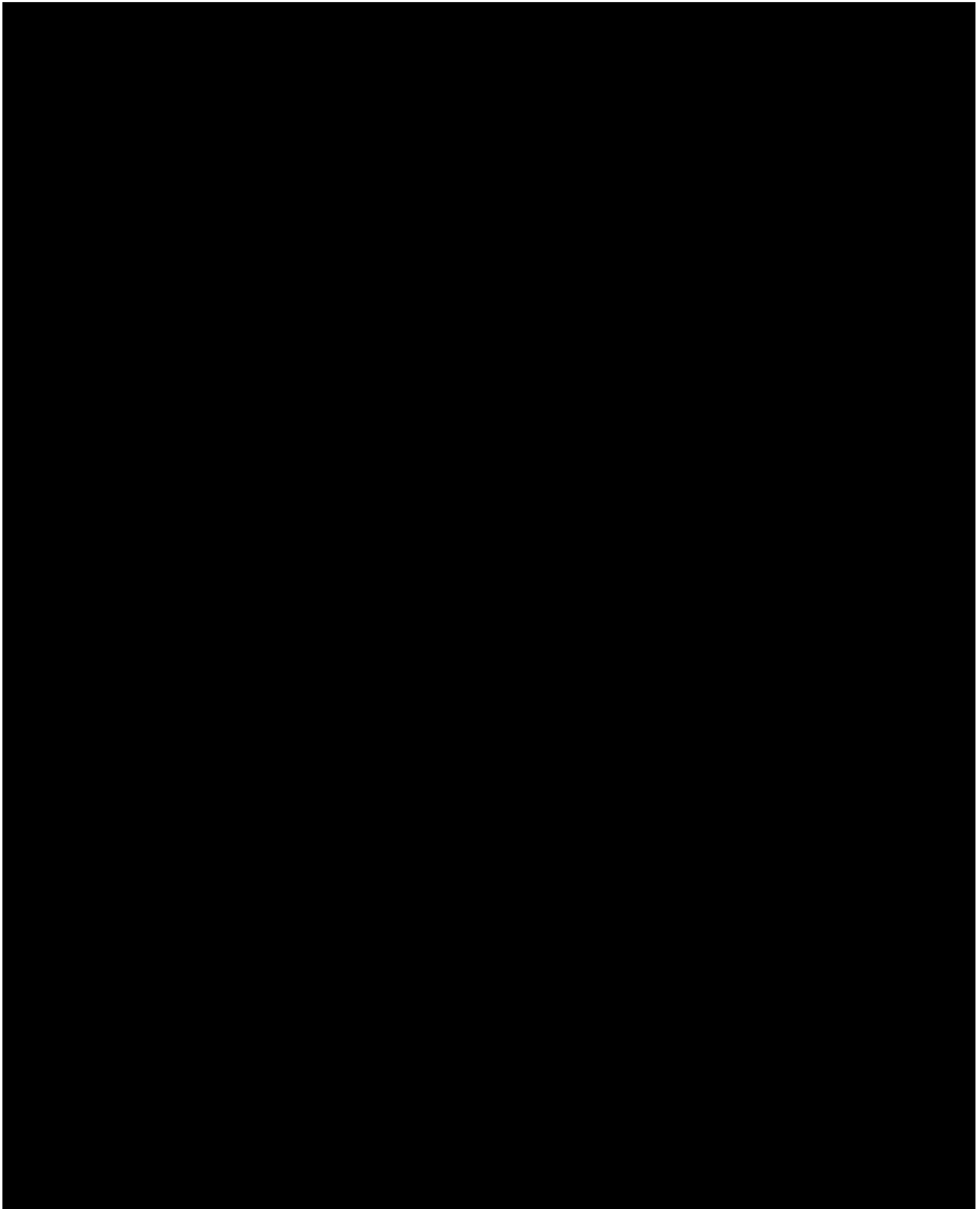
Qualified, trained, and appropriately licensed staff conduct all clinical reviews. The UM process ensures that appropriate care is delivered to members according to InterQual criteria, the NYS Guiding Principles, LOCADTR or ASAM criteria (dependent on primary presenting diagnosis) in the context of an individualized treatment plan. When a request for services is received, the Care Manager discusses the clinical needs of the member with the person requesting services.

Carelon will continue to use processes for pre-certification of benefits and concurrent review for MHSU services in accordance with New York State regulations as specified in *Section 3.12* of this RFP.

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







Intensive Case Management of High-Risk Members

Data shows in 2022 that members engaged in ICM services were 11 percent less likely to readmit to substance use treatment within 90 days of discharge from substance use treatment than those not engaged in ICM.

Carelon's Case Management program, also known as Intensive Case Management (ICM) and/or Complex Case Management, serves members with the most complex care needs. These members are assessed to be at the highest risk within the population for negative clinical outcomes related to mental health/substance use disorder and co-occurring medical issues. The primary goals of the Case Management program are to help individuals maintain or improve community tenure, regain optimal health, improve life functioning, and promote resiliency and recovery. Carelon's Case Management program works closely with medical and/or health plan staff to create an integrated model, which meets the member's whole health needs. Currently, Carelon does not have access to a member's complete medical and pharmacy claims data. The Department's approval for access to complete medical and pharmacy claims data exchanges would enable Carelon to expand on identifying, stratifying, and proactively outreaching to members—enhancing the impact of our ICM services.

Carelon provides comprehensive case management programs and services to address a broad range of member needs. Carelon is committed to offering clinical expertise, operational excellence, and innovation within all programs. Carelon's Case Management program offers a clinically appropriate and cost-effective solution, advocating healthy behaviors and proactively managing wellness and disease for members most in need.

In looking at our predictive modeling data, of those predicted to utilize higher levels of care, there were no inpatient admissions for those engaged in ICM. This shows the positive impact that engaging in ICM can have on members and improving their quality of life and reducing the utilization of inpatient, higher levels of care.

Carelon case management programs align with industry-leading definitions and criteria. For example, the Case Management Society of America's 2016 definition of Case Management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost-effective outcomes."

"Good morning. I received an appointment from Mindful Care for next Tuesday. Thank you so much for assisting me with this. I was lost and worried I wouldn't find someone before my meds ran out."

Interventions include assessments, referrals, appointment reminders, care coordination, wellness education, and overall monitoring of treatment engagement. Intensive Case Managers assist members in linking to community resources and supports such as Alcoholics Anonymous / Narcotics Anonymous, National Alliance on Mental Illness (NAMI), Depression and Bi Polar Support Alliance, Project Hope, Findhelp.org to address social determinants of health resource needs, PRIDE Center, domestic violence resources, Single Point of Access (SPOA), On Track and educational support resources.

Where applicable, Carelon's case management programs meet the National Committee for Quality Assurance (NCQA) definition for Complex Case Management: "the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of

resources and who need help navigating the system to facilitate the appropriate delivery of care and services.”

The case management program is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes (Case Management Society of America 2016). Adults and children at clinical risk because of behavioral health, psychosocial, and/or co occurring problems are enrolled into the ICM program. An individual’s behavioral health condition is evaluated, and a case management plan is developed in collaboration with the member and, when possible, the member’s providers, primary care physician (PCP), family members and/or caregivers, and other relevant contacts. Case Management plans are designed to meet the member’s individual needs. Case management facilitates appropriate and quality care for members. Carelon’s case management program identifies members who have complex care needs and who could benefit from advocacy on their behalf.

Carelon’s current offering of case management services is robust and includes dedicated Case Managers who assist members with a broad range of needs, including those with unique, specialized needs, such as first responders. In addition, through collaboration with an eating disorder program, there is focus on ensuring linkage to appropriate services for those with eating disorders. Lastly, the Center of Excellence for SUD program with Hazelden Betty Ford that is being implemented will have ICM at the forefront, playing an active role in coordinating care for those most in need of substance use treatment.

Case management interventions are generally telephonic, though they may also include face to face field-based interventions. Field based Case Managers work directly with members in their community in facilities or in provider offices to review medical and treatment records, develop care plans, and engage members in their care. The ability to meet the members where they are and offer an initial face to face meeting yields a higher engagement rate for case management services. While members are receiving services in a higher level of care, the ability to connect with their Case Manager, who will continue to follow up with them post discharge, helps develop an initial level of comfort. This also encourages open communication, fosters a positive relationship with the facility, and supports linkage to appropriate aftercare that meets the member’s needs. Once the member is discharged, the Case Manager continues outreaching telephonically, confirms attendance at aftercare appointments and works on mutually agreeable goals. Field based Case Managers follow strict protocols to identify themselves when working with members and others in the community.

Carelon views the integration of behavioral health with the physical health and hospital plans as an essential activity to target the health care needs of members with active behavioral health and physical health conditions to ensure they are holistically addressed. When we advocate for our members in partnership with other carriers, we can prioritize care for co occurring conditions and identify a primary point of contact to coordinate the member’s care. This coordination ensures interventions are aligned and that the member is clear on the care plan and goals. Carelon can also collaborate with the medical and hospital carriers to conduct rounds on cases where several specialties are required to treat the member. This approach helps to reduce inpatient readmissions and emergency department utilization and improves whole health outcomes for members.

Carelon works with United Health Care (UHC), the current medical carrier for Empire Plan members. When UHC is speaking with a member and they feel additional behavioral health support is needed, they can connect the member with a Carelon Case Manager or with the clinical referral line (CRL) for more immediate support. If, after speaking with a CRL clinician, the member requests or it is believed the member

would benefit from ongoing intensive case management, the CRL clinician can refer the member to ICM for continued coordination and outreach. The CRL clinician can offer assessment, education, support, and referrals as needed during the initial contact. Ongoing support would be provided by ICM. ICM will then follow up with members on a mutually agreeable schedule, create and work on goals and address any barriers to treatment adherence.

Another integrated process occurs when a member is admitted to a medically managed detox in a medical facility. Carelon processes the authorization request and if medical necessity criteria is met, enters an authorization into our system. A unique code is entered into the authorization to indicate Carelon does not pay the claim on this authorization because of the type of detox facility in which treatment is being rendered. Daily, a report is sent to management and reviewed for accuracy and then sent via a password protected email to select staff at Empire BCBS notifying them of the authorizations entered the prior day.

Clinical indicators trigger an evaluation for case management services. The Case Manager ensures integrated service delivery through ongoing communication with the provider(s) involved in the case, establishing linkages to family service agencies, community services organizations, the court system, schools, legal systems, external case management providers, and other appropriate resources.

Access, Referral, and Case Finding

CM Referral Sources

Case Managers receive or identify a referral to the CM program consistent with established referral criteria and processes, from any of the following sources:

- The clinical rounding processes, retrospective chart reviews, or other reviews
- Medical/health plan staff through coordinated care programs or other activities, including jointly developed identification criteria or population health/disease management programs
- Internal Carelon referral sources, including clinical management staff reviewing cases with a provider for authorization and discharge planning
- Direct requests from providers or state agencies
- Claims data, including behavioral health discharge data, readmission data, as well as medical data (Should the Department approve access to medical and pharmacy claims data, we would be able to enhance our stratification of members to ensure population health management)
- Member or family self referral
- Predictive modeling or other internal data mining
- Hospital discharge coordinators

CM Program Inclusion Criteria

Clinical leadership provides referral criteria for all clinical teams, accounting for any local market specific need and regulatory, accreditation, or contract-specific requirements. Carelon's Data Analytics team provides an analysis of program data and outcomes to further inform the overall referral criteria as well as the identification of potential referrals via data mining. Predictive modeling and identification of members for case management may vary across the Regions.

Outlined below are general criteria that members may meet for inclusion in programs:

- Member demonstrates behavioral symptoms consistent with a DSM or ICD diagnosis, which requires and can reasonably be expected to respond to case management intervention. Member requires assistance in obtaining and coordinating treatment, rehabilitation, and/or social services.
- Member has a combination of severe, persistent psychiatric clinical symptoms and lack of family or social support, with an inadequate outpatient treatment relationship, which places the member at risk of requiring acute behavioral health services.
- Members have had multiple inpatient admissions, for example, more than one inpatient admission within the past six months for primary behavioral health issues or co occurring behavioral/medical health conditions.
- Member has had multiple emergency department (ED) visits, for example, more than one ED admission in the past six months with psychiatric complaints and no evidence of ongoing treatment support after the last ED discharge to resolve issues precipitating the need for acute care.
- Member has complex co occurring behavioral and medical health conditions, including but not limited to diabetes, heart disease, obesity, HIV/AIDS, pregnancy at risk for or diagnosed with postpartum depression or psychosis, requiring significant coordination between behavioral and medical treatment providers.
- Significant suicidal or homicidal risks including recent history (within the past six months) of serious life-threatening attempts requiring medical treatment for which care management is indicated to ensure ongoing treatment support and to promote member safety.
- Member has a history of multiple SUD treatment episodes – including a lack of follow up with referrals or discontinued treatment.
- There is currently, or a history of, repeated high risk behaviors, for example, inability to care for self, hospitalization, and/or present harm to self or others including, but not limited to, running away from treatment facilities, repeated non compliance with treatment or medications, engaging in repeated self injurious behaviors, or involvement with protective services agencies.
- Special potentially vulnerable population segments (with no evidence of ongoing treatment support to resolve potential issues associated with their condition) may also benefit from case management. These may include:
 - Pregnant women with SUD
 - All children under age 18 with a higher level of care admission
 - Special Needs Population (SNP) – as defined per health plan agreements, beyond the criteria for chronic health issues defined above (for example HIV/AIDS)
 - Child or adolescent with a parent having a history of behavioral health disorders, which may be putting the child at risk
- Complex psychiatric cases including those with multiple state/provider agency involvement requiring coordination of care between specialty providers (such as eating disorder cases)

- Members with high cost behavioral health and/or combined medical and behavioral health utilization patterns.
- Member has a newly diagnosed and/or unstable high risk behavioral health condition as evidenced by a recent (past six months) admission to inpatient/higher level of care or a new diagnosis, and no indication of ongoing treatment or supportive services after the discharge or the indication of a new diagnosis.
- Multiple family members are receiving acute behavioral health treatment services at the same time.
- Medical case coordination/integrated care – members with significant health issues including chronic pain and a coexisting disorder with possible behavioral health concerns are referred for screening and service coordination as needed.

Carelon understands the stress of having a child in behavioral health treatment and the impact it can have on parents and the family. As a specialty support within our intensive case management program, our Parent/Family Concierge case management services are designed to provide additional supports to parents and caregivers when a child is in treatment. Through this support system, a behavioral health clinician from our intensive case management team will contact parents/guardians within 48 hours of their child's admission to help them understand what lies ahead, including:

While the child is in treatment

- What's involved in a mental health substance use disorder (MHSUD) inpatient admission
- Why it's important to go to and take part in family therapy
- Encouraging parents to communicate with their child's doctor about the hospital stay
- Planning for discharge

Doctor to Doctor peer review and decision, as needed

- How the peer to-peer process works
- Medical necessity criteria for care requests
- What the peer to peer decision means
- When care is approved, timing of the next review
- Appeal rights and how to ask for an appeal

Coming home

- Scheduling outpatient appointments
- Connecting with resources nearby
- Knowing what to do in case of a setback
- Why it's important to continue family therapy

Referral Screening

Referrals are screened by the case management team or other designated staff to evaluate the member's needs and appropriateness for the program. CM staff completing clinical assessments must be licensed clinicians practicing within the scope of their licensure or certification and with at least three years of relevant clinical experience. Information considered in the screening assessment includes:

- Case records in the utilization management or medical management system
- Program criteria qualifications
- Coordination with medical and behavioral Case Managers or providers familiar with the member's condition
- Any other available data

Engagement

If the member meets criteria and is an appropriate candidate for the Case Management program, the Case Manager or designee:

- Contacts the member to explain the program, obtain member agreement for involvement in the program, and secure appropriate HIPAA releases.
- If applicable, arranges to speak to the member while the member is receiving care on an inpatient or another acute setting, and, if possible, identifies appropriate sharing of information to all appropriate entities to ensure collaboration and communication. If that is not possible, the Case Manager will make every effort to confirm contact information with the facility to best contact member post discharge.
- Mails a description of the program to the member.
- Contacts providers who are actively involved with member care as appropriate, explains the program, and solicits the provider's active participation.

Assessment

The Case Manager will complete a comprehensive clinical assessment on all members who meet criteria and agree to participate in the Case Management program. This assessment may include, but is not limited to the following:

- Evidence based assessment tools, including evaluation for co occurring conditions (mental health, medical, SUD)
- Psychosocial strengths and needs
- Member's stated needs and preferences
- Member's health status
- Safety and risk issues
- Condition-specific issues related to a member's health

- Clinical history and medications (including the safety of current medications)
- Current treatment plan and participation
- Activities of daily living
- Mental health status and cognitive functioning
- Social determinants of health
- Life planning activities
- Cultural and linguistic needs
- Visual and hearing needs
- Caregiver resources and involvement
- Available benefits
- Availability of community resources and use of resources

Case Managers gather the above information to determine the members' needs and the best available resources to assist them. The purpose of the assessment is to:

- Identify problems that place members at risk for adverse outcomes
- Identify barriers to adherence with prescribed treatment regimens
- Assess the level of risk based upon history and current clinical data
- Determine realistic, achievable, and individualized goals
- Promote applicable screening programs and tools as available
- Develop a member centric care plan (consistent with risk and identified goals)
- Identify and coordinate appropriate resources in support of the care plan

Stratification

Cases are prioritized and stratified for the intensity of intervention. Stratification is based on the total risk acuity score determined from the assessment considering the clinical assessment of need. This assessment incorporates a review of clinical records and telephonic and/or face to face outreach with the members, associated care providers and Case Managers as needed. Staffing and caseloads match the program needs to ensure members who meet established criteria obtain case management services.

Detailed below, this initial placement rating assists our clinicians to determine the most appropriate level of ICM and intervention contact schedule. As additional assessments occur during ongoing care management contact, the assigned tier status is reviewed and modified. The frequency, duration, and type of intervention are generally based on risk level but are decided by a member's need.

Acuity Range	ICM Tier Level	Description
1 – 6	Tier 1 – Integrated Care/Medical Coordination (lowest level of intervention)	- Aimed at ensuring behavioral health needs are addressed as part of an overall treatment plan - Cases opened 30 days on average - One to three contacts within 30 days to triage clinical needs, provide resources, and follow-up as needed to confirm status. - A formalized care plan is not required for Tier 1 members. - Primary objectives for Tier 1 ICM are service connection, education, and efficient coordination of medical and behavioral health services.
7 – 13	Tier 2 – Intensive Case Management Moderate (medium level intervention)	- Short term care management that addresses barriers and access to care, treatment adherence - Goals achieved within 90 days on average - Weekly or biweekly in the first month, and then monthly until care plan is met. Activities include assessment, education, care planning, monitoring, and coordination, of all medical and behavioral health services
14+	Tier 3 – Intensive Case Management Acute (highest level of intervention)	- Targets members with complex needs, high risk clinical factors, multiple psychosocial stressors - ICM interventions to prevent hospitalization and/or exacerbation of symptoms - The highest tier of ICM - aligned with National Committee for Quality Assurance (NCQA) standards - Goals achieved in 180 to 270 days on average - Multiple contacts per week or weekly as needed in the first period of engagement. - Acute management period may last up to 30 to 60 days to stabilize and engage members in ongoing treatment. - Members are re evaluated for a transition to Tier 2 ongoing care management when acute care plan goals are met.

Care Planning and Progress Monitoring

After completing the assessment goals, the Case Manager—in collaboration with the members, caregivers, and providers—creates an individualized member-centric plan of care/recovery plan. The care plan considers the member and caregivers' goals, preferences and desired level of involvement as well as identifying barriers to meeting goals or adhering with the plan.

The care plan identifies measurable short- and long term goals, barriers to meeting them, the resources needed for the member to achieve them, and clear objectives and timeline for completion. Goals will address acute and immediate needs and identify what is needed for the member to maintain optimal functioning. When possible, the Case Manager engages the member, family, and natural support to ensure goals are realistic and achievable. To that end, the Case Manager regularly evaluates the goals for ongoing effectiveness. This process allows the Case Manager to determine whether the care plan is appropriate for the member's needs or if it requires modification and updates. The Case Manager revises the care plan with member input to reflect treatment progress, barriers, new priorities, and changing health status.

"I don't think I could honestly put into words the amazing job Carly did. She was soothing, reassuring, and I thank God she called because she was a light in the forest."

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

We will continue to ensure that Empire Plan members receive the most appropriate, least restrictive treatments and support to meet their identified clinical needs and increase community tenure. We are attentive to each member's holistic life situation, including medical illness, social needs, strengths/weaknesses, and resources available for promoting recovery. Our objective is to efficiently ensure access to all medically necessary care and support transitions to less restrictive services as clinically appropriate.

Measuring Member Satisfaction

In keeping with Carelon's commitment to help people live their lives to the fullest potential, Carelon is committed to a member experience that includes access to effective, efficient, and compassionate Customer Service and Clinical experts. We measure the quality of the member experience through:

- **Member Satisfaction Survey Results:** Carelon conducts a member experience survey to identify areas for improvement as a key component of our Quality Management Program. We will use the results of our surveys to improve service delivery. Carelon's Quality Management Department contracts with an independent research and survey firm to objectively measure client, member, and provider experiences and attitudes towards Carelon's services each year.

This survey provides Carelon with information regarding many aspects of the member's experience with Carelon as well as with our provider network. The survey asks about the Clinical Referral Line referral process and the member's experience with scheduling an appointment with a participating provider. We use the information received from the survey to educate providers about helping them continuously improve their performance in meeting the treatment needs of members. In 2022, 95 percent of respondents said Carelon staff members were polite, courteous, and respectful and 96 percent of

respondents said they were satisfied with the services they got from Carelon. In addition, 92 percent of survey respondents reported overall satisfaction with counseling/treatment.

- **Annual Cultural and Linguistic Needs and Preference Analysis:** An annual Cultural and Linguistic Needs and Preference Analysis is conducted by the Carelon Quality Department with support from the Network Department. These reports assess member needs through data collection on ethnic, racial, and linguistic needs of members from the U.S. Census and enrollment data, complaint, and member experience survey. Cultural, ethnic, racial, and linguistic characteristics of network providers are also assessed to evaluate whether they meet members' needs. The member and provider data are compared to established performance goals and previous measurements, when available. Based on the analyses, achievements are noted, opportunities for improvement identified, and interventions implemented to improve the quality of care and service to our diverse member populations. The evaluation of the overall effectiveness of cultural and linguistic may be included in the Quality program evaluations, integrated work plans, or in a separate document.

In response to our member satisfaction survey, 100 percent of respondents reported satisfaction with language assistance and 90 percent of respondents said counseling/treatment met language needs.

Measuring Network Quality

One way in which Carelon is looking to further enhance service effectiveness is through the creation of a Centers of Excellence (COE) program for Substance Use Disorder with Hazelden Betty Ford. At this COE, Empire Plan members will be identified for admission into one of their highly respected substance use treatment centers and obtain various levels of care, depending on need, within one facility. Through collaboration with their team and the Carelon behavioral health team, members will receive a high quality continuum of care with measurable outcomes. Carelon will remain integrally involved through care coordination and assistance with discharge planning while minimizing the administration burden of traditional UM activities.

Carelon measures the effectiveness of MHSU services delivered by our network providers through the additional activities described below:

- **Reporting:** Our reporting package includes management reports, utilization reports, and financial reports that are comprehensive and robust, and are provided on a monthly, quarterly, and annual basis as required by the Department. Some also contain commentary from our Carelon Team regarding performance of the Mental Health and Substance Use Program. Our reporting suite provides essential information to enable Carelon and the Department to monitor operations and the effectiveness of MHSU services. Examples of the type of information captured include:
 - Major diagnostic groupings (allows for summarization and enterprise reporting)
 - Membership information (enables accurate per 1,000 and other per member per month [PMPM] calculations)
 - Book of business utilization statistics and trends
 - Readmission rates
 - Authorizations
 - Average lengths of stay

- Penetration rates of membership
 - Outlier management
 - Appeals
 - Claims processing and paid claims
 - Fraud and abuse
 - Service utilization statistics
- **Provider Quality Performance Data:** Carelon maintains an automated database that tracks claims-based performance data on all contracted network providers with members in outpatient treatment. As a recertification tool, the standard performance report covers three years. We also designed it to capture relevant events between recertification cycles. As a quality improvement tool, key performance indicators identify patterns of care. We designed the indicators to support national and regional comparative analyses. We perform analysis on individual providers or in aggregate across provider and/or member groups. This system of analysis provides Carelon with monitored data that ensures quality services with positive clinical outcomes. We use the data to evaluate the successes and weaknesses of service delivery, determine the need for training, and examine the need for new clinical protocols. It also satisfies national accreditation and quality assurance reporting requirements for provider credentialing, utilization management, and quality of care activities.

As part of our continuous quality improvement process, this measurement system allows Carelon to assess objectively the outcomes of care and to identify best practices for targeted populations. The database includes a wealth of information. Measures currently reported track both utilization and quality of care activities. Each performance indicator reported has a specific measure, a performance standard, and a performance improvement strategy.

- **Tracking and Investigating Complaints:** Carelon measures the effectiveness of MHSU service providers and facilities by tracking and investigating any quality of service or quality of care complaints initiated by members, providers, or Carelon clinical staff.
- **Provider Quality Manager Interactions with Providers:** Our Provider Quality Managers (PQMs) work with a select set of high volume “strategic providers,” sharing over 20 metrics, tracking provider performance over time, and in comparison, to similar providers in their state; see **Exhibit 18 – Sample Provider Quality Report** for a sample report shared with providers. PQMs share utilization and quality metrics for inpatient and higher levels of care include readmission rates, length of stay, timely successful transitions of care quality-of-service issues, admissions to each facility, and admissions to lower levels of care, such as step downs.

Carelon employs PQMs who excel at building collaborative relationships with providers to drive provider performance year-over-year through data review. A PQM is a licensed clinician responsible for monitoring provider performance, helping to ensure continuous improvements to clinical quality and efficiency outcomes.

The goal of our Provider Quality Management Program is to drive improved quality care and cost effectiveness through expert consultation and education of our provider, supported by aggregate data. In New York, our PQM team helped strategic inpatient providers improve key performance indicators, increasing follow-up rates by as much as 23 percent.

- **Facility Readmission Tracking:** Carelon uses facility readmission tracking to assess the effectiveness of appropriate precertification assessment, and sound discharge planning (from time of admission) to ensure successful transitions of care. The dashboard provides both facility and member specific detail which allows targeted outreach when needed to facilities and members.
- **Provider Treatment Record Review:** Carelon assesses in-network provider adherence to clinical practice guidelines and evidence based care through our treatment record review process. These reviews are a vital component of our overall member safety program and ensure that members are receiving safe, high-quality care.

Measuring the Effectiveness of the Carelon Clinical Team

Carelon also believes it is important to measure the effectiveness of our dedicated Latham-based Clinical team. We do that by performing the following quality assurance processes:

- **Call Tracking:** All dedicated Clinical team calls are tracked by type of call. These include emergency, urgent, and routine referrals. All emergency and urgent calls are audited to ensure the service standards are met, and results are reported to the quality management and utilization management committee.
- **Quality Management Audits:** Our Clinical & Quality Management teams conduct monthly audits of precertification and continued stay reviews completed by our dedicated Clinical Care Managers and Peer Advisors. The audit tool evaluates whether medical necessity criteria were met for admission; whether the level of care approved was the most appropriate, least restrictive level of care based on the member's clinical needs; whether all determination timeliness standards were met, and care protocols are evidence based. Dedicated Clinical Care Managers are evaluated at least monthly, and more frequently for new employees. The audits are used as a tool in the orientation and training of new clinicians; quality assurance in maintaining performance standards with regards to professionalism, collection of critical clinical information and appropriate application of criteria; a routine part of performance evaluations; and, as a follow-up on complaints received. During the telephone audit, the quality auditor listens to calls and evaluates the interaction in six areas – opening, triage, assessment, treatment planning, hold and transfer techniques, closure, comprehensive service, and resolution.
- **Inter-rater Reliability Tool:** Carelon uses an Annual Inter Rater Reliability (IRR) tool, administered to all Clinical and Medical staff who are involved in making medical necessity criteria determinations. The IRR tests for consistent application and adherence to medical necessity criteria. Competency on this tool is a passing score of 90 percent or above. This tool assists in determining that our precertification and continued stay review processes are effective and reliable across clinicians and consistent from the provider standpoint.

5.15 Consolidated Appropriations Act (CAA)

Carelon will comply with the requirements of *Section 3.14 Consolidated Appropriations Act*.

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

Non-Quantitative Treatment Limitations (NQTL) Comparative Analysis

Carelon, along with our parent company Elevance Health, Inc., is a leader in Mental Health Parity. Recognizing its importance and ongoing efforts in the health care industry to meet new rules regarding Mental Health Parity and Addiction Equity Act (MHPAEA) and Consolidated Appropriations Act (CAA), we have developed an internal structure to ensure we can effectively assist our clients regarding parity questions and analyses. Carelon has a team dedicated to mental health parity, including Account Management, legal, clinical and other subject matter experts to support the Empire Plan in its efforts to demonstrate mental health parity compliance.

As the administrator of the Empire Plan's mental health and substance use disorder (MH/SUD) benefits, Carelon will provide a written description of its MH/SUD protocols to assist the Empire Plan with compliance obligations, including non quantitative treatment limitations (NQTL) as required by the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Consolidated Appropriations Act. Carelon will provide assistance to help the Empire Plan to demonstrate Empire's compliance with MHPAEA disclosure requirements (e.g., utilization management). In accordance with the most recent guidance FAQ, US Dept. of Labor Self Compliance tool, Carelon has developed a tool that encourages a step-wise approach to the analysis. Carelon will provide information needed to complete the steps and provide guidance as well as work with the other Empire Plan carriers to complete the tool to enable the Plan to arrive at a CAA compliant comparative analysis showing that all NQTLs are applied no more stringently on the behavioral health side than on the medical side.

As a managed behavioral health organization, Carelon does not establish the benefit coverage plan designs for its contracted client plans. As a result, the Empire Plan has the responsibility for the financial testing and actuarial certification relating to quantitative treatment limitations (QTLs) applicable to MH/SUD benefits to ensure they meet MHPAEA's standard and are no more restrictive than the predominant financial requirements and QTLs applied to substantially all the medical and surgical benefits.

Carelon will provide information requested by the Empire Plan to assist with its annual analysis of quantitative treatment limitations, however, there may be a charge for more frequent requests or customized reports. Whether there is any additional charge would depend on the scope and frequency of the analysis and would need to be discussed and mutually agreed upon. Any fees for Mental Health Parity analyses are included in our pricing outline.

Compliance with Transparency in Coverage and Consolidated Appropriations Act

Carelon is prepared to support client compliance with the Transparency in Coverage (TiC) and Consolidated Appropriation Act (CAA) No Surprise Billing Act in the following ways:

Payer Machine Readable Files (MRF)

As required by the Transparency in Coverage Rules, Carelon will create machine readable files that contain negotiated rates and historical payments for in network and out of-network providers. These files can be used to help create the payer cost transparency tools as currently required by law in 2023 and 2024.

Continuity of Care

Carelon has policies and procedures to provide limited continued coverage at network rates for members with complex care situations when providers change network status or Fully Insured groups terminate. This includes notifying the members of the potential for network coverage for up to 90 days from the date of provider termination.

Provider Network Directories

Carelon is in the process of revising our provider data processes and policies to comply with the CAA. This includes verification of certain components of provider data every 90 days with a two business day required turnaround for updates received by providers and developing a provider directory suppression policy.

Prohibition on Gag Clauses

Carelon notified our providers of the change in regulatory requirements which ban gag clauses in contracts between providers and health plans related to price or quality data.

CAA Surprise Billing Dispute Resolution Process

The September 30, 2021, interim rule establishes the federal independent dispute resolution (IDR) process that out of-network (OON) providers, facilities, plans, and issuers in the group and individual markets may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation. While we anticipate a low volume of inquiries related to this area, Carelon has a process to support our New York clients as required by contract. To date, we have had no IDR cases for the Empire Plan since the regulation went into effect.

If additional support not mentioned above is required, Carelon requests that this be discussed as additional fees may apply.

5.17 Transition and Termination of Contract

Carelon understands and will comply with the requirements of 3.16 *Transition and Termination of Contract* to ensure that any transition to a successor entity results in uninterrupted member access to benefits and customer service.

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 3.16 of the RFP.

Carelon confirms that we will fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSUD Program. We will have a project schedule that is very comprehensive and will supply the necessary information to ensure a seamless process and not disrupt member treatment.

We recognize the importance of continuity of care and are committed to completing all outgoing transition tasks with great sensitivity. We will implement a detailed transition plan that includes written communication to enrollees and their dependents ('members') to reduce confusion and disruption in care. We will take all necessary precautions to ensure continuity of services for members receiving treatment during the transition. We will also maintain engagement and help motivate them to continue their care during this critical time.

Our highest priority is to ensure that the transition process safeguards the continuity and quality of care that your members receive, avoids disruption, and minimizes as well as mitigates transition risks on behalf of the Empire Plan. To this degree, we will commit to not only providing the required data to the successful contractor, but we will provide them with the necessary knowledge transfer and support that will offer them a more thorough understanding of the data we supply (e.g., members in care, Intensive Case Management cases, coordination of benefit data, paid claims history).

Phase One

During Phase One, as we approach our contract's termination, we will continue to fulfill all requirements and provide all necessary and essential information to the new vendor. In addition, we will ensure that the new vendor and our care management team are communicating on a daily (or other designated period) basis to smoothly transition members in treatment to the next level of care necessary.

When we receive a notice for transition, we will immediately initiate the process. Our overall approach includes the following functional steps:

- **Administrative:** Identify our internal team leads and schedule recurring meetings with the Department.
- **Claims:** Determine what claims data needs to be sent and to whom, what information needs to be forwarded, and what steps are needed to resolve financial questions. We will also ensure that all queues are worked to completion and develop scripts for staff members resolving claims.
- **Clinical:** Review authorizations for ongoing care beyond the termination date, establish care coordination meetings for complex or special needs cases, furnish pending and open authorization data to the new vendor, and determine staffing needs for run-out period.

- **Appeals:** Develop a plan for managing appeals during transition, determine appeals workflow, and implement a process for handling appeals through the run out period.
- **Communications:** Determine disposition of member and provider communications materials.
- **Customer service:** Develop question and answer scripts for call center staff, develop client member communications as directed by the Department, record auto attendant message about account transition on the customer service line, and plan for final termination of that phone number, when appropriate.
- **Finance:** Determine run out period. Close bank accounts, as appropriate.
- **Network:** Field provider inquiries about transition.
- **Quality management:** Establish workflows for complaints and grievances received after contract end date, coordinate the transfer of information for those in the Clinical Management Programs.
- **Reporting:** Establish final reporting requirements and timeframes, forward appropriate data to new vendor, and to the Department as required.

The goal of a comprehensive transition plan is to minimize the potential disruption in member care and ensure that the appropriate information is shared with all parties involved. It is with this spirit of cooperation that Carelon would enter such a process to ensure an effective and seamless closure and transition of services through a well-developed and executed turnover plan.

Phase Two

During Phase Two, we will provide the highest level of dedicated customer service and clinical management for an agreed to period after the contract's termination. Carelon's primary goal during any transition is to ensure member care is not disrupted. We have developed a standard transition project plan that we have used successfully to transition services to a new organization in those instances when a contract is awarded to a different vendor. Our plan emphasizes ensuring a smooth transition of services to members in our care.

For example, if a member is receiving inpatient treatment on the effective date of the transition, we would recommend that we continue to handle the case until he/she moves to a different level of care. This ensures continuity of benefits for the members. We would propose to meet with the new vendor and provide clinical information, in addition to the usual standard authorization reports that are provided. By providing additional clinical details, the new vendor will be better able to understand the treatment plans of the members and their ongoing needs. The new vendor would then commence utilization and care management of the case at the point inpatient treatment has ended.

