



New York State Department of Civil Service

Optum response to Mental Health and Substance Use (MHSU) Disorder Program

Financial Proposal

Date

May 3, 2023

Contact

Dan Couser
Vice President, Empire Plan
Optum Programs
P 1-518-313-4762
E daniel.couser@optum.com

Table of Contents

Section 6: Financial Proposal	3
6.1 Program claims	3
6.2 Administrative fees	6
6.3 Assessments	7
Attachment 25. Guaranteed Average Unit Cost and Administrative Fee Quote Form	8



optum.com
11000 Optum Circle, Eden Prairie, MN 55344

Trademarks and service marks

Optum® is a registered trademark of Optum, Inc. All other trademarks, service marks, names, logos, and brands are property of their respective owners. Use of third-party trademarks, service marks, names, logos, and/or brands is for identification purposes only and does not imply endorsement, affiliation, or sponsorship.

© 2023 Optum, Inc. All Rights Reserved.

DISCLAIMER

Section 6: Financial Proposal

6.1 Program claims

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

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

Confirmed.

2. **Empire Plan Non-Network Practitioners,** the Contractor will process Empire Plan Non-Network Practitioner claims, as follows:

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

- i. The actual charge for services; or

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

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

Confirmed.

- b. Effective July 1, 2023, for certain unions: 275 percent of Centers for Medicare and Medicaid Services (CMS) rates, and will be subject to Deductible, Coinsurance and calendar year and lifetime maximums.

Confirmed.

Please refer to Attachment 30, *Benefits by Bargaining Unit* for a listing of how the Empire Plan Non-Network Practitioner benefit is administered for each group.

Confirmed.

3. **Excelsior Plan Non-Network Practitioner Benefits: 80 percent of the UCR. The UCR is the lower of billed charges or 110 percent of the Medicare allowance.**

Confirmed.

4. **SEHP Non-Network Practitioner Benefits: the Plan pays 80 percent of the allowable amount, the lower of billed charges or 110 percent of Medicare, for covered services after the Deductible is met.**

Confirmed.

5. **Non-Network Facility Benefits, the Contractor will process Non-Network Facilities claims, as follows:**

- a. **For the Empire Plan: 90 percent of billed charges. After the combined annual Coinsurance Maximum is met, the Empire Plan pays 100 percent of billed charges.**

Confirmed.

- b. **The Excelsior Plan does not provide coverage for services provided in a Non-Network facility except in an emergency or if a Network Facility is not available.**

Confirmed.

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

Confirmed.

Where a Network Provider is not available because of clinical or access considerations, the Contractor must negotiate a Single Case Agreement with a Non-Network Provider in a manner consistent with what is typically allowed for a Network Provider in the same discipline for the same service. Members will not be responsible for any payments above what they would pay for a network claim.

Confirmed.

6. **Network Pricing Guarantee: The Offeror must develop and propose one Guaranteed Average Unit Cost (GAUC) for all Network Outpatient Services and one GAUC for all Network Inpatient/Alternative Level of Care (ALOC) Services presented in the *Guaranteed Average Unit Cost and Administrative Fee Quote Form* (Attachment 25). The Contractor is required to guarantee that the Actual Average Unit Cost (AAUC) for Network Outpatient Services and Network Inpatient/ALOC Services shall not exceed the proposed GAUC. The AAUC is defined as the sum of the allowed amounts for all service codes for Network Services divided by the sum of all service units for all services codes for Network Services. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to Network Providers for Network Outpatient Services and Network Inpatient/ALOC Services for Plan primary claims only and prior to the application of Copayment and Bad Debt and Charity assessments. The Offeror must develop and propose a GAUC for Network Outpatient Services and Network Inpatient/ALOC Services, as follows:**

Confirmed. Please see our attached Attachment 25, Guaranteed Average Unit Cost and Administrative Fee Quote Form.

- a. **Based on incurred claims for each Plan Year that are paid as of June 30th of the following year, the Contractor shall calculate the AAUC for the Network Inpatient Services and Outpatient Services categories. Such Network Services shall include all services/days paid at the Network benefit level including services/days rendered by Non-Network**

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

Confirmed.

- b. The Contractor acknowledges that the GAUC for the Inpatient Services set forth in the *Guaranteed Average Unit Cost and Administrative Fee Quote Form* (Attachment 25) may incorporate the inpatient professional service component pertaining to global reimbursement arrangements. Amounts actually paid and reported to the Department for Inpatient Services will include the inpatient professional service component of global arrangements. Any adjustments in the calculation of the AAUC shall be at the sole discretion of the Department.

Confirmed.

- c. If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee, as follows: For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in the *Guaranteed Average Unit Cost and Administrative Fee Quote Form* (Attachment 25), the Contractor shall pay the Department a performance credit equal to 1.5% of the Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charged to the MHSU Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year. For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in the *Guaranteed Average Unit Cost and Administrative Fee Quote Form* (Attachment 25), the Contractor shall pay the Department a performance credit equal to 1.5% of the Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charge to the MHSU Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

Confirmed.

- d. Offerors may propose a different Inpatient and Outpatient GAUC for each of the five years of the Contract. However, these amounts should be fixed and cannot be tied to any index or variable inflation rate. Any changes requested by the Offeror throughout the term of agreement are at the sole discretion of the Department and are subject to approval by the Office of the Attorney General and the Office of the State Comptroller.

Confirmed.

- e. For purposes of both the development of the GAUC and AAUC, claims processed as secondary to the Plan shall be excluded from the calculations and network pricing guarantees. In addition, the GAUC and AAUC shall not include any fees or assessments.

Confirmed.

6.2 Administrative fees

1. **The Offeror must submit a completed *Guaranteed Average Unit Cost and Administrative Fee Quote Form* (Attachment 25) which must include the Offeror's proposed per Enrollee per month fee for Administrative Fees charged to the MHSU Disorder Program. An Offeror's quoted Administrative Fee must include all direct and indirect costs, overhead, travel expenses, fees, and profit.**

Confirmed.

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

Confirmed.

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

Confirmed.

4. **The Department reserves the right to adjust the Administrative Fee charged by the Offeror based on a reconciliation of the Enrollee counts reported from the Department's NYBEAS by the Enrollee counts utilized by the Offeror to calculate the monthly Administrative Fee. The reconciliation will be performed by the Department on an annual basis using the average Enrollee count for the respective MHSU Disorder Program Year. However, the Department may perform additional reconciliations throughout a given year if the average monthly Enrollee counts utilized by the Offeror differ significantly from the Department's Enrollee counts, as reflected in NYBEAS. In addition, the Administrative Fee due shall be adjusted on an annual basis based on penalties due to the Department or payments due from the Offeror in accordance with the *Performance Guarantees* form (Attachment 6).**

Confirmed.

6.3 Assessments

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

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

Confirmed.

Attachment 25. Guaranteed Average Unit Cost and Administrative Fee Quote Form

Please see the following pages for our Guaranteed Average Unit Cost and Administrative Fee Quote Form (Attachment 25).

ATTACHMENT 25



Department of
Civil Service

**Guaranteed Average Unit Cost and
Administrative Fee Quote Form- RFP
entitled: "Mental Health Substance Use
(MHSU) Disorder Program"**

	Year 1	Year 2	Year 3	Year 4	Year 5
Inpatient GAUC					

Instructions: Offeror is to provide their total Guaranteed Average Unit Cost for both Inpatient and Outpatient services for plan primary claims. Quoted amounts can change for each year.

Fee Quote

Basis

Monthly Administrative Fee Quote(1)

Per Enrollee Per Month

(1) The Offeror's quoted fee will be for the duration of the contract as set forth in 6.2.2 of the RFP.