Optum

Original



New York State Department of Civil Service

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

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

Thank you for the opportunity to submit our proposal for administering The Empire Plan's MHSU Disorder Program (The Plan) beginning January 1, 2024.

Three important facts about Optum emerge from the following pages:

- ***Our deep knowledge and experience with The Plan, New York State and other public sector entities***
- ***Our ability to deliver a program that meets or exceeds every requirement in the RFP***
- ***Our ability to boost Member satisfaction through exceptional customer service and a uniquely individualized approach to care results in reliability for your Members***

We know The Plan, New York State and Public Sector Business

As a former administrator of The Plan, we know your Members. We have a strong understanding of the goals of The Plan and the expectations of your leaders. This previous experience will let us confidently take the reins of your Program.

Further, Optum is steeped in New York. Our first experience providing behavioral health care services there was in 1991, when we were selected as the New York City Behavioral Health Organization as the City transitioned its public health insurance program to managed care.

Since then, our Behavioral Health services have supported every county and the 5 boroughs of New York City. Today, we serve 1.8 million Members in New York.

Immersed in the New York Legal/Regulatory Environment for 30-Plus Years

As New York health care has evolved, Optum—on behalf of our customers—has proactively monitored and complied with requirements from regulators, including the Office of Mental Health (OMH), Department of Financial Services (DFS), the New York State Office of Addiction Services and Supports (OASAS) and more.

As legislation has unfolded, we've contributed innovative thought leadership. For example, Optum behavioral health chief medical officer, Martin Rosenzweig, has actively engaged with the OMH in New York regarding clinical and operational challenges with proposed utilization review triggers. Optum also holds a seat on the OASAS committee that's tasked with defining the substance use transition measures for the 2022 NYS Quality Assurance Reporting Requirements (QARR) measure.

In 2020, our well-established Optum MH/SUD Parity and Benefits team extensively supported our New York customers when New York State released Insurance Regulation 218, expanding parity requirements.

An Added Advantage: Our Public Sector Partnerships

We work extensively with public sector customers nationwide—states, counties, cities and related entities—including EMHP of Suffolk County, whose requirements and Member population are similar to The Plan's. Optum successfully implemented Behavioral Health services for Suffolk County on January 1, 2023.

We know the complex structure and behavioral health requirements of public sector employers, including the specialized needs of educators, first responders and other public servants and mandatory personnel.

Our union experience has been especially valuable. Optum has worked successfully with union Members in every part of the country—including local unions in the New York metropolitan area. We've created specialized programs and support for their Members, such as the Optum **loveforourfrontline.com** website.

loveforourfrontline.com

Our long-time presence in New York has given us in-depth knowledge of the changing needs of groups and individuals in New York and adjacent regions.

To support frontline health care workers, police and other first responders during the pandemic, for example, Optum launched the loveforourfrontline.com online resource to provide valuable information for community connection, as well as for coping with crises and other topics, such as social unrest.

As part of our commitment to the state, Optum also takes a strong role within local advocacy organizations, such as the Northeast Business Group. Our national behavioral product director, for example, is part of the group's Path Forward committee.

Our Network: 30 Years' Strong

Our New York tenure has also helped us forge ties with local providers and build an extensive network to meet the distinct cultural and demographic needs of the state's diverse population. Today, our GeoAccess Disruption reporting shows we have strong accessibility across the state with more than 21,155 clinicians.

A notable advantage for your Members—especially with today's unprecedented demand for services—is that ***92% of providers*** in our robust New York network are accepting new patients. Further, to assure we continuously meet access standards, we base our network adequacy reporting—which determines our recruiting needs— ***only*** on providers accepting new patients.

Virtual Visits Network

Access for your Members is further augmented by our virtual visits network, a core competency and major advantage with Optum. The number of providers participating in our virtual visits network increased 1,131% from 2020 to 2022.

In New York alone, we have 13,310 licensed virtual visits providers—which can be especially important for The Plan's Members in the City, where geography can compromise access outside the 5 boroughs because of travel times exiting and/or navigating the City. In addition, we offer an express access network—with appointments within 5 days.

Flawless Delivery of Your Program

As one of the largest behavioral health organizations in the country, Optum possesses the depth, breadth and capacity to administer The Plan with scrupulous attention to detail. The client organizations listed below represent only a fraction of the total number of lives we serve every day:

- State of Tennessee Department of Finance and Administration – 293,631 employee lives
- EMHP of Suffolk County – 21,000 employee lives
- General Electric Company – 170,000 employee lives

The next table shows both the scope of our Behavioral Health services and our footprint and experience in New York.

The experience we've described with The Plan, with New York and with Public Sector clients—along with our reliability, stability and capacity and the skills and integrity of our dedicated team—will let us administer ***your plan your way.***

Dan Couser, Vice President of Empire Plan Optum Programs, already your trusted advocate, will bring continuity and comprehensive knowledge of every aspect of The Plan.

Optum Breadth and Experience

- **37 million** behavioral health program Members nationwide
- **1.8 million** behavioral health program Members in New York
- **182** behavioral health customers in New York, including 15 public sector customers
- **542** public sector customers nationwide
- **88** labor unions, including 8 labor unions in New York

Demonstrated Performance

Our operational stability, reliability and integrity are underscored by our performance guarantees and metrics:

- **93% first-call resolution**
- **99.8% claims accuracy**
- **95.6% member satisfaction**
- **93.9% of members** felt the care provided was respectful of their linguistic, cultural, racial and ethnic needs

Lending an additional level of corporate expertise and leadership is your executive sponsor, Trip Hofer, CEO of Optum Behavioral Health Solutions.

Your dedicated Optum team will include 2 medical directors, a call center, claims staff, clinical care professionals and care advocates—all fully trained on the nuances of The Plan.

Raising Member Satisfaction

Behavioral health care is not a commodity. That's why—whether our customer care team is helping with a question about benefits, or our care advocates are working with more urgent behavioral needs—***we treat each person as an individual***.

By knowing the Member better, we can help the Member better.

5.2 Account team

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

Attachment 1. Biographical Sketch Forms have been completed for all key personnel of the account team and provided with this Technical proposal.

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;**

Name of Offeror

Optum Behavioral Solutions Main Office Location
11000 Optum Circle Eden Prairie, MN 55344

Branch Office Location

13 Cornell Road, Latham, NY 12110

Branch Office Location

505 Boices Lane, Kingston, NY 12401

While this site is closing, we will be moving to a new location in the immediate area.

Senior Officers

Trip Hofer, CEO of Optum Behavioral Health Solutions, will be the senior officer within Optum and will be responsible for this account. Trip is an experienced executive with more than 20 years of experience in the health care industry. He is responsible for the overall strategy for our behavioral businesses, driving growth for our behavioral products and offerings, continuing to make sure our network supports timely access and expanding behavioral care delivery for the people we serve.

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;**

We recognize that an account the size and significance of The Plan requires ongoing attention from our experienced professionals located in the State of New York. See **Attachment 2** for an organizational chart outlining our staffing plan, including the personnel involved in administering The Plan.

In the following table, we list the key leaders, as well as the requested details about availability and involvement. These leaders will be available for strategic input and will work with The Plan and dedicated team to help guide the quality of staffing, solutioning and overall service delivery.

Table 1: Key leaders

	Role	Planned Level of Effort	Duration of Involvement	Daily Availability
Trip Hofer CEO of Optum Behavioral Health Solutions	Optum BH President and Empire Plan Executive Sponsor	As needed	Ongoing	As needed
Dan Couser Vice President, Empire Plan Optum Programs	Optum BH Executive overall responsibility for The Plan	Fully dedicated	Ongoing	Available daily
Amy Fisher VP Client Services	Executive-level staff overseeing Client Service Executives	Designated	As needed	As needed
TBD Dedicated Client Service Executive	Day-to-day account management of The Plan's needs	Fully dedicated	Ongoing	Available daily
TBD Dedicated Client Service Executive	Day-to-day account management of The Plan's needs	Fully dedicated	Ongoing	Available daily
Alicia Snow Director, Shared Services/Implementation	Executive-level staff overseeing client Implementation resources and priorities	Designated	As needed	As needed
Jan Storey Director, Implementation	Will assign/oversee dedicated implementation project manager	Designated	As needed.	As needed.
TBD Implementation Project Manager	Will provide day-to-day project oversight of the implementation of The Plan	Fully dedicated	Ongoing	Available daily
Sarah Haverkamp VP Marketing	Executive-level staff overseeing Marketing & Communications resources and priorities	Designated	As needed	As needed
Lauren Davidson Director, Marketing	Will provide management and oversight of staff creating Marketing/Communication material for The Plan	Designated	As needed	As needed

	Role	Planned Level of Effort	Duration of Involvement	Daily Availability
Russell Clark VP Data Analytics	Executive-level staff overseeing Data Analytics resources and priorities	Designated	As needed	As needed
Ty Smith Director, Data Analytics	Will assign/oversee all data analytics/reporting staff and allocate resources	Designated	As needed	As needed
TBD Data System Analyst	Will provide day-to-day support for Empire Plan data analytics and reporting needs	Fully dedicated	Ongoing	Available daily
Nancy Cantu VP Member & Provider Service	Executive-level staff overseeing Call Center/Customer Service resources and priorities	Designated	As needed	As needed
Lisa Schmidt Director, Customer Service	Will assign/oversee all call center/customer service staff and allocate resources	Designated	As needed	As needed
TBD Customer Service Staff	Will provide day-to-day customer service support for The Plan	Fully dedicated	Ongoing	Available daily
Timothy Mattson VP Enrollment/Eligibility	Executive-level staff overseeing Enrollment and Eligibility resources and priorities	Designated	As needed	As needed
Linda Kish Director, Benefits & Eligibility	Will assign/oversee all benefits and eligibility staff and allocate resources	Designated	As needed	As needed
TBD Benefit Eligibility Specialists	Will provide day-to-day benefit and eligibility support for The Plan	Fully dedicated	Ongoing	Available daily
Arnel Balingit Director, Case Installation	Will assign/oversee all case install staff and allocate resources	Designated	As needed	As needed

	Role	Planned Level of Effort	Duration of Involvement	Daily Availability
TBD Case Installation Specialists	Will provide day-to-day case installation support for The Plan	Fully dedicated	Ongoing	Available daily
Lisa Bahr VP Behavioral Claims Ops	Executive-level staff overseeing Claims payment resources and priorities	Designated	As needed	As needed
Veronica Dominguez Senior Consultant Claims Ops	Will assign/oversee all Claims staff and allocate resources	Designated	As needed	As needed
TBD Claims Processing Staff	Will provide day-to-day Claims payment support for The Plan	Fully dedicated	Ongoing	Available daily
Denise Strait VP Behavioral Claims & Appeals Ops	Executive-level staff overseeing Claims appeals resources and priorities	Designated	As needed	As needed
Jennifer Varraux Senior Director Behavioral Appeals	Will assign/oversee all Claims appeals staff and allocate resources	Designated	As needed	As needed
TBD Appeals Specialist	Will provide day-to-day Claims appeals support for The Plan	Fully dedicated	Ongoing	Available daily
Jennifer Sobiech VP, Optum Payer Ops	Executive-level staff overseeing Fraud, Waste and Abuse resources and priorities	Designated	As needed	As needed
Paul Anello Director, Fraud, Waste & Abuse	Will assign/oversee all Fraud, Waste and Abuse staff and allocate resources	Designated	As needed	As needed
Tracy Davidson VP Network Management	Executive-level staff overseeing Network Management resources and priorities	Designated	As needed	As needed
Robert Bachor Director, Network Contracting	Will assign/oversee all Network Management staff and allocate resources	Designated	As needed	As needed

	Role	Planned Level of Effort	Duration of Involvement	Daily Availability
TBD Network Staff	Will provide day-to-day Network Management support for The Plan	Fully dedicated	Ongoing	Available daily
Martin Rosenzweig Chief Medical Officer	Executive-level staff overseeing Medical policy resources and priorities	Designated	As needed	As needed
TBD Medical Directors	Will provide day-to-day Medical Policy and consultancy support for The Plan	Fully dedicated	Ongoing	Available daily
Brian Gump Director Finance & Underwriting	Executive-level staff overseeing Finance and Underwriting resources and priorities	Designated	As needed	As needed
Nathan Kring SVP, Clinical Ops/ Care Management	Executive-level staff overseeing Care Management resources and priorities	Designated	As needed	As needed
Legna Colon Director, Care Management	Will assign/oversee all BH Care Management staff and allocate resources	Designated	As needed	As needed
TBD Care Managers	Will provide day-to-day Care Management support for The Plan	Fully dedicated	Ongoing	Available daily
Glenda Maddron SVP, Clinical Ops/Utilization Management	Executive-level staff overseeing Utilization Management resources and priorities	Designated	As needed	As needed
William Johnson Director Utilization Management	Will assign/oversee all BH Utilization Management staff and allocate resources	Designated	As needed	As needed
TBD Utilization Management Specialists	Will provide day-to-day Utilization Management support for The Plan	Fully dedicated	Ongoing	Available daily

	Role	Planned Level of Effort	Duration of Involvement	Daily Availability
Catherina Sala National Accounts Manager, RR Donnelly	Will provide day-to-day printing communications and fulfillment support for The Plan	Designated	As needed	As needed

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

Leadership team

In choosing Optum as The Plan Administrator, The Plan will have the advantage of established leaders who are thoroughly knowledgeable about the program and all administrative components. Led by Dan Couser, Vice President, Empire Plan Optum Programs, and the behavioral health account management team, Dan will hold the day-to-day relationship responsibilities with all constituents as it relates to their portions of service delivery. He will have a team of client service managers dedicated to The Plan.

Trip Hofer, CEO of Optum Behavioral Health Solutions, will be the senior officer within Optum, and will be responsible for this account. The senior officer provides direct access for The Plan, OER and Union representatives to a senior leader who can field questions, respond to concerns and resolve any issues. Trip's position within the company assures the scope of authority, visibility and organizational access to successfully handle any issues that may arise and work closely with Plan decision makers.

Trip will perform the following functions:

- Serve as executive-level liaison for The Plan and provide an additional point of access to Optum
- Reach out at least quarterly to The Plan to confirm The Plan is meeting or exceeding the Department's expectations
- Make sure The Plan continues to serve the Department's strategic objectives and priorities
- Participate in an annual meeting to review high-level accomplishments of the partnership between the Department and Optum and assess any needed changes or enhancements
- Provide an immediate response to resolve any problem the Department may have that requires executive-level intervention

The Plan has direct access to executive leadership through our executive sponsor, Trip Hofer, who will ultimately oversee the account.

Leadership access is a cornerstone of our approach to account management. We achieve it by empowering our account management team to escalate issues within Optum so that appropriate staff is involved, and decisions can be made quickly.

Dan Couser has direct access to corporate department heads. He will act across all our departments to deliver smooth functionality for the program and leverage internal resources in ways that add value.

Through this team-based approach, we have a well-rounded and cohesive program that draws upon our staff's expertise throughout our company.

Account team

For The Plan, we have designed a cohesive team, which Dan Couser will coordinate daily. The dedicated account team will be based in the Albany area. Our operations team in the New York area will provide the call center, clinical services, reporting, auditing and network management responsibilities.

We will also provide a team of MHSU financial experts. All are senior Members of our finance department with dotted-line relationships to Dan Couser and the corporate finance and underwriting team. This team, led by Brian Gump, Director of Finance and Underwriting, will deliver underwriting assistance and consultation in the development of premium rates, projected aggregate claims trend analyses and detailed examinations of the program components that will impact MHSU costs. Annual premium analyses include inputs, such as trend factors, legislative mandate analyses, incurred claims reports and program design and enrollment changes.

Implementation

While this is an accelerated implementation timeline, our experience as The Plan's former MHSU vendor positions us to minimize the burden on The Plan for MHSU Disorder Program implementation. Our implementation team will be led by Jan Storey, Senior Director, Client Delivery Implementation, who will assign an Optum implementation project manager to plan and execute the implementation process. Incorporating key information gathered from the pre-implementation discussions, the project manager will work closely with Dan Couser and Optum operational staff members to define processes, identify accountabilities, anticipate any implementation bottlenecks and pinpoint The Plan's implementation priorities. Given our history providing MHSU services, we are uniquely positioned to perform an efficient, on-time implementation anticipating The Plan's needs.

Member communication support

The Plan's dedicated account management team will work with The Plan to review and provide feedback on communication materials developed and distributed by The Plan. In addition, customized materials on various topics can be prepared by Optum staff, as required, and requested by The Plan. Lauren Davidson, Director of Custom Engagement, will lead communication efforts for The Plan.

Reporting services

Comprehensive reporting will be prepared and submitted for The Plan, covering program financial status, performance guarantees, website analytics, provider monitoring and various call and clinical data. Reporting will be submitted according to a schedule defined by The Plan. Reporting efforts will be overseen by Ty Smith.

Customer services

Led by Lisa Schmidt, Director of Customer Service, dedicated customer service representatives (CSRs) who report to our New York-based office will provide answers to various questions about benefit plan design information, eligibility and claims status. They will also warm-transfer callers to the dedicated Clinical Referral Line (CRL) to speak directly to a trained, licensed clinician. Overseen by Martin Rosenzweig, MD, Chief Medical Officer, licensed clinicians will be

available to Members 24/7 so that Members get the right care in the right setting at the right time.

Enrollment management

We offer The Plan designated eligibility staff located in our New York-based, service center. In addition, the New York based eligibility analysts have access to the New York Benefits Eligibility and Accounting Systems (NYBEAS) and direct contact with The Plan eligibility staff to deliver efficient management of enrollment and eligibility. We will also cooperate with The Plan initiatives to use new technologies, processes and methods to increase enrollment maintenance efficiencies.

Claims processing

To meet all performance guarantees for claims accuracy and turnaround times, Optum will provide The Plan with a designated claims processing team, led by Denise Strait, Vice President, Behavioral Claims and Appeals Operations. The team will be trained in Plan-specific protocols and benefits, and our claims system will contain specific Plan details, including copayments, deductibles, accumulators and plan design features. Not only does our claims system have appropriate edits in place to manage clinical authorization for prior authorization and concurrent reviews, but it also integrates various functional areas—claims, customer service, eligibility and clinician/facility data—providing our claims staff with the tools necessary to provide accurate, responsive service.

Plan audit and fraud protection

Our Special Investigations Unit (SIU) pursues instances of potential claim submission errors from fraud, waste and abuse. Our investigators bring specialized understanding of behavioral health claims, which is critical due to the CPT code changes that cause provider confusion and claim errors, as well as the potential for fraud. The SIU establishes guidelines and maximizes opportunities for fraud, waste and abuse identification.

Appeal process

Led by Denise Strait, Vice President, Behavioral Claims and Appeals Operations, Optum will support The Plan with a designated appeals team. Our appeals team will provide timely determinations that always consider the circumstances around Member conditions.

Provider network

Our network team is proactive and has built an industry-leading network of providers in New York and nationwide. Led by Tracy Davidson, Vice President, Network Management, our team regularly reviews access trends confirming that we maintain a broad and diverse panel of mental health and substance use disorder clinicians available to The Plan’s Members.

Pre-certification and concurrent review

Optum clinical programs help connect Members with specialty care needs to evidence- informed treatment across the spectrum of behavioral health care. Your Members will have access to our comprehensive range of clinical programs, helping them address any mental health or substance use disorder need. Led by Martin Rosenzweig, MD, Chief Medical Officer, your dedicated team of licensed care advocates is available 24/7, supporting Members every step of the way so that they get the right care in the right setting at the right time.

Consolidated Appropriations Act (CAA)

We will support The Plan in conducting a Non-Quantitative Treatment Limitation (NQTL) comparative analysis and verifying compliance with provisions of the CAA. The Optum team is well-positioned to create a consolidated regulatory approach, whether it is in response to CAA, Transparency in Coverage or other federal or local regulations.

For The Plan, we will use the NQTL templates to provide you with required Plan-specific MHSU Disorder information and suggested comparative analysis language to support the review between the Medical/Surgical and MHSU Disorder Plans. We will engage Optum Advisory Services to conduct and document the comparative analysis of the NQTL documentation provided by the separate administrators of The Plan. Optum will partner with The Plan to provide any necessary information to respond to requests from regulators or other entity.

Disabled dependent determinations

We will develop a customized process for Disabled Dependent Determinations by our dedicated medical director that meets The Plan's specific requirements for review pertaining to dependents of Members under family coverage as well as dependents of an individual not currently enrolled in The Plan, but enrolled in other NYSHIP benefit programs.

Transition and termination of contract

We will work closely with The Plan and the new vendor to design a transition plan that will meet all requirements and enable a full transition in a timely manner. Key elements and tasks in our transition plan to confirm completion of all required duties and responsibilities include:

- Development of an approved plan
- Establishing contacts with new vendor
- Transition of program and clinical data
- Managing safe and effective transitional care for those Members who are active and ongoing treatment

Optum has experience in transitioning The Plan and will assure delivery of these services to minimize the disruption for Members and offer a successful implementation of the new Plan administrator.

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

Based on our experience with The Plan, our staffing plan (referenced in **Attachment 2**) has an organization of sufficient size with the necessary skills and experience to administer, manage and oversee all aspects of The Plan during implementation and ongoing operation. We have allocated the following staff to work on The Plan account:

- **Account Services:** Three dedicated staff members, Latham, NY
- **Enrollment:** Six designated staff members, New York-based and/or telecommute
- **Claims processing:** Approximately 38 designated staff members, New York-based and/or telecommute
- **Customer Service:** Approximately 31 dedicated staff members, New York-based
- **Network Staff:** Approximately 6 dedicated network staff, New York-based

- **Care and Clinical Management:** Approximately 52 dedicated care management staff, New York-based
- **Utilization Management:** Approximately 10 dedicated utilization management staff, New York-based

5.3 Implementation plan

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

We have reviewed and agree to the requirements in **Section 3.2** of the RFP. The following sections include details surrounding our proposed program and processes.

Our implementation of The Plan will result in a dedicated call center and a customized version of our Live and Work Well website a minimum of 30 days prior to the program implementation date and implementation of all other Plan services by the implementation date (as required by The Plan).

We have included a detailed implementation project plan in **Attachment 3**, which provides an overview and timeline identifying major tasks we will perform to implement The Plan effectively and on time. As The Plan's former administrator, we understand what is required for the successful implementation and operation of The Plan.

The Plan team will lean into the knowledge and operational expertise of functional subject matter experts from across the organization, including direct leadership involvement to support the implementation timeline. We have included a breakdown of major implementation steps next:

Implementation roles and responsibilities

To make sure the program reflects The Plan's priorities from the outset, your dedicated account management team led by Dan Couser, Vice President, Empire Plan Optum Programs, along with Jan Storey, Senior Director, Client Delivery Implementation, will engage The Plan's representatives in the implementation planning process immediately upon award. They will collaborate with the entire team throughout the contract finalization period.

The purpose of this process is to execute implementation activities required from both Optum and The Plan, respectively, and gain consensus on the implementation plan. This places minimal load on The Plan's representatives and clearly defines milestones so that The Plan's implementation requirements are methodically met. We will meet the time frame for the following activities:

- Member communication approvals and distribution
- Staff training
- Establish reporting requirements
- Determine if there are network development needs and establish recruitment schedule
- Establish a coordinated effort for transition benefits with The Plan, OER and former vendor
- Detailed testing schedule for all contractual requirements

Your Optum implementation project manager will assume overall responsibility for the planning and execution of the implementation process. Incorporating key information gathered from the pre-implementation discussions, the project manager will perform the following key functions:

- Serve as The Plan's primary contact for day-to-day implementation questions
- Develop and manage project action plans to meet milestones, identify all risks and establish a mitigation plan

- Track and report on the status of all tasks on the implementation project plan and develop corrective action plans for any issues that arise, escalating the issues as necessary
- Investigate, communicate and lead resolution of all issues presented by The Plan

The Plan's role in implementation

For a timely and successful implementation of The Plan, we respectfully request that The Plan allocate key personnel to function as primary points of contact for our implementation team. These resources are defined as follows:

- **Project Lead:** The project lead is an individual with decision-making authority and who will engage with our implementation project manager over the course of the implementation period. The primary involvement of this individual is to participate in ongoing status meetings that typically take place weekly, during which the project lead can provide Optum with feedback to help make sure the implementation is on-track from The Plan's perspective and provide input on implementation activities.
- **Supportive Roles:** Our experience shows that several individual resources should be involved in implementations (to varying degrees) to assist in implementation success. These individuals include benefits/human resources contacts, communications representatives, data and eligibility specialists, a legal team member, training team member, and vendor relations owner for carriers/vendors.

In line with The Plan's requirements, we will build 5 business days into the implementation plan for all tasks that require The Plan's review and approval.

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:

Please see **Attachment 3** for a detailed Implementation Plan.

Optum has extensive experience implementing behavioral health benefits, services and working with health plans like The Plan. Your assigned implementation project manager will manage an implementation project plan, identify needed resources, assign specific tasks within the project plan and monitor implementation activities.

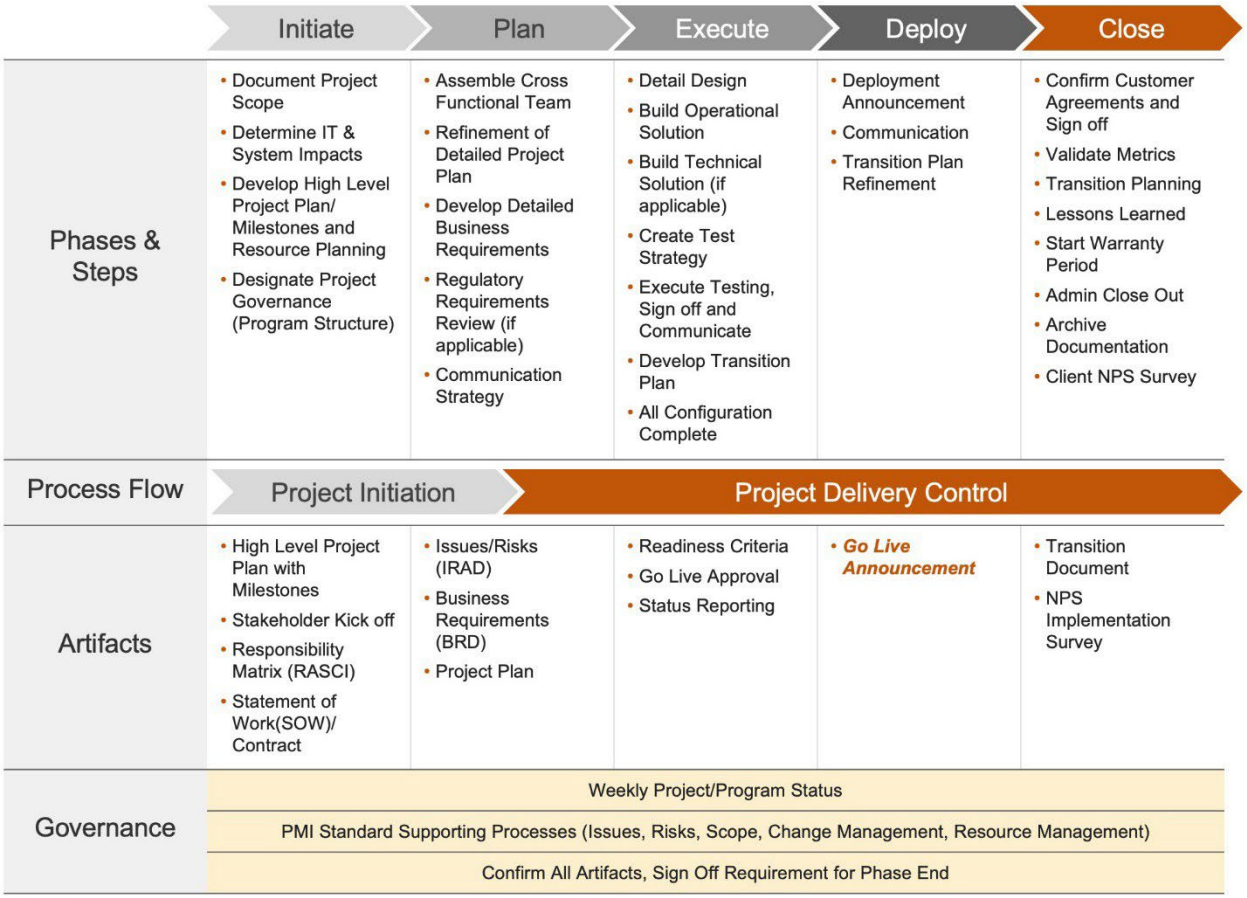


Figure 1: Implementation timeline

As illustrated in the diagram, to facilitate timely and effective program implementation, the project plan detailed in **Attachment 3** tracks critical path milestones, such as:

- Enrollment transmission and reporting requirements
- Claim, encounter, and accumulator file transmission and reporting requirements
- Banking arrangements
- Network and system preparedness
- Compliance review (as applicable)
- External integration protocols
- Account installation and setup components
- Staff training
- Member communication strategy
- Website development
- Transition of care activities
- Financial reporting and analysis

The attached Implementation Plan identifies a project timeline along with required implementation resources and assignment of specific tasks. These activities include staffing our dedicated call center based in New York, establishing The Plan's Clinical Referral Line, re-launching The Plan's fully functional, customized website, among other implementation activities. Our understanding is that finalizing specific dates could be contingent upon the execution of the agreement. If selected as The Plan's vendor, we will engage The Plan immediately upon award and throughout the contract finalization period.

The Implementation Plan incorporates key activities that include Member and provider communications, training of the dedicated call center and Clinical Referral Line staff, reporting requirements, provider network review, transition benefit planning, re-establishing eligibility feeds and claims testing.

Our implementation project manager will help provide efficient coordination of all tasks outlined on the Implementation Plan and make sure implementation activities are sensitive to the needs, objectives and timeline identified by The Plan. To keep all key stakeholders apprised of the latest implementation developments, the project manager will provide regular implementation project plan updates to The Plan and Optum staff members.

Areas for potential complication

Our experience as The Plan's former MHSU Disorder Program vendor positions us to minimize both the burden on The Plan for MHSU Disorder Program implementation, as well as limit the potential for complications.

The Plan team will lean into the knowledge and operational expertise of functional subject matter experts from across the organization including direct leadership involvement to support the implementation timeline. We anticipate the implementation timeline for a program this large and complex will require expedited decisions in the areas of:

- Member materials
- Benefit design acceptance
- Website customization review
- Staffing, training and operational tasks
- Contract finalization

a. Training of call center staff;

Our clinical learning and staff development department oversees the training of care advocates and care navigators. This department makes sure they receive training on treatment practices to collaborate with network clinicians and administer treatment for Members.

Behavioral health care advocates and care navigators are licensed professionals with a minimum of 3 years of experience post-licensure (including demonstrated experience provisioning behavioral health services).

As part of implementation, the team will:

- Conduct orientation meetings for benefit staff
- Participate in cross training with benefit staff
- Develop tracking systems for follow-up and outcomes

b. Website development;

We understand that custom development is needed. We have reviewed and assessed the requirements to implement and deliver a customized, Plan-specific website for the MHSU Disorder Program that will be complete a minimum of 30 days prior to the implementation date.

During our tenure as The Plan's vendor, our dedicated account management team worked with The Plan to enhance and customize the Member website to better meet the needs of The Plan's Members. Upon award, the Optum Web development team will be available to suggest additional enhancements for The Plan's approval.

We can enable access by Plan representatives to the Live and Work Well website with the access code "Empire" to view its capabilities and user-friendliness. We will customize the website to meet all The Plan's requirements, including branding the website with The Plan logo. All links, information and content are subject to The Plan's approval and can be removed from the site upon request.

c. Network development;

While we do meet 100% of the access requirements of the RFP, we will identify and endeavor to recruit key providers who can meet The Plan's specific needs. Our national network has grown 34% since 2022. In New York, the network has grown nearly 13.4% since 2022.

Our network management team understands the behavioral health delivery systems and is skilled in clinician and facility recruitment. They will continually identify network gaps (through provider partnerships, Member feedback and network utilization report reviews) to recruit physicians, clinicians and facilities/programs who will enhance access standards, add to the success of a transition plan or provide a specialty service. The network managers currently assigned to the program are located in New York.

To determine if inclusion of additional clinicians is appropriate, we consider the following factors:

- Number of network practitioners
- The Plan Members in service area
- Current practitioners wait lists
- Specialty information
- Population needs
- Provider experience and group affiliation

We will work closely with New York-based and accrediting bodies, such as The New York State Office of Addiction Services and Supports (OASAS), to identify programs and services that will help round out the network for The Plan. We actively recruit qualified facilities and clinicians through:

- Our clinical staff Members
- Nominations from professional organizations and other network providers
- JCAHO, COA, CARF accredited facility rosters
- American Hospital Association guidebooks
- Community-based mental health and substance use services

d. Transition of benefits; and

We emphasize continuity of care when transitioning Members who are in active, current and ongoing mental health and/or substance use treatment. Although specific transition plans are based on the Member's clinical needs, benefit plan coverage and any provisions set by The Plan, our primary focus is on avoiding Member disruption.

We will work closely with the previous vendor to establish a system that provides continuity of care for Members, including those who will be required to change providers to maintain the network level of benefits. In addition, Optum is fully compliance with the New York State Continuity of Care regulations, which allow for a 90-day transition period when a provider leaves the network while a member is undergoing a prescribed course of treatment. Based on an agreement between the 3 parties, we can assist with Member transition in the following ways:

- Receive a list of all Members currently receiving treatment from the exiting vendor (including identification of the treating provider)
- Preparing a letter for Members to advise them of their financial responsibilities if they continue to receive services from a provider outside of the new network
- Scheduling regular phone calls between the account team and the exiting vendor's designated account manager to streamline Member transition
- Facilitating communication between our clinical program managers and the corresponding individuals associated with the exiting vendor

We have detailed processes in place for transitioning Members actively receiving services. The implementation project manager will guide these efforts, which are standard components of the implementation project plan.

The process focuses on minimizing disruption and maintaining continuity of care. We will schedule meeting(s) with The Plan and existing vendor(s) for a smooth transition. These meetings will cover:

- Executing non-disclosure agreement, if applicable
- Provider recruitment needs
- Continuation of services by existing vendor until transition date occurs
- Coordination of a Member communication plan with the exiting vendor(s) about transition of program

Post-transition, the exiting vendor will be able to warm transfer to The Plan team for a smooth Member experience.

e. Eligibility feeds and testing claims processing.

Implementing eligibility

Our implementation process for eligibility feeds and testing includes the following key steps:

- Shortly after award of the business, the implementation project lead submits a request to the Technical Operations Eligibility team, triggering the assignment of an eligibility analyst to The Plan's Implementation. The analyst participates in (internal) implementation meetings as early as the business award solution debrief.
- The implementation project lead and eligibility analyst determine and define Plan eligibility based on the solution awarded and debrief discussion. These definitions are

reviewed at the prep meeting held with the assigned eligibility analyst. The meeting will serve to establish the frequency of eligibility meetings, timelines for the process, how the information will be received, and file frequency.

- Overview of eligibility approach is presented during The Plan's implementation kick-off meeting, including discussion of required data fields and file frequency.
- Eligibility meetings with external eligibility sources begin soon after the implementation kick-off meeting. Eligibility meetings typically occur weekly until the file layout and other details are agreed upon and documented. The Plan will be informed of progress as part of the ongoing implementation status meeting update.
- Eligibility analyst receives a test file from The Plan and/or The Plan's vendor(s), which will be subjected to testing.
- Eligibility analyst receives a production file from The Plan and/or The Plan's vendor(s), which will be subjected to a quality assurance review.
- The eligibility analyst provides the implementation project lead with a Load Count report from Eligibility, which is then verified for accuracy of Member counts.

It is our common practice to establish test cases within our environment to make sure all components and features are functioning as planned before the implementation date.

Our account installation team, in coordination with our eligibility and claims departments, duplicates a new or revised benefit plan in a non-production environment for testing. Any required testing will take place there, using customized claims and benefit set-up scenarios, where appropriate.

Technical integration data transfer testing

In coordination with The Plan and our internal functions, we will develop a comprehensive implementation plan, which will include the necessary testing requirements to execute a successful implementation of The Plan's requirements. Our common practice, even in situations where there is minimal configuration, is to establish test cases within our environment to validate that all components and features are functioning as planned 30 days before the effective date.

During implementation, a multi-disciplinary team representing key Optum functions that serve the account, such as eligibility, claims administration, underwriting, network management, plan administration, telecommunications, website development and clinical delivery, will verify that The Plan's benefit plans are successfully launched 30 days before the effective date.

Under the guidance and supervision of The Plan's implementation project manager, each department will test their respective systems to verify that The Plan's benefit information has been loaded successfully and is ready for live use.

Early in our partnership, your designated implementation project manager will review our testing strategy with you, including the test approaches and scenarios that have proven most effective when implementing lines of business that align with The Plan's products. We will coordinate the setup of all secure file transfer protocol (SFTP)/data file exchange scenarios.

This will include collaborating with The Plan and/or The Plan's vendor(s) to develop agreeable file names to use throughout our business relationship, organizing testing file transfer protocols and file transfer frequency for all files, such as claims files, eligibility files, reporting files and so forth.

We will set up pre-implementation test SFTP sites for testing purposes, which will be separate from post-implementation or production SFTP sites.

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

We confirm our agreement and guarantee these requirements.

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

However, an Offeror may propose higher amounts.

Attachment 4, Performance Guarantees (Attachment 6) has been completed and provided with this Technical proposal.

5.4 Member communication support

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

We have reviewed and agree to the requirements in **Section 3.3** of the RFP. The following sections include details surrounding our proposed program and processes.

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

Our Optum Legal, Compliance and Privacy teams review all Member-facing communications prior to release to clients and Members. The purpose of this review is to advise The Plan of any regulatory, legal, clinical and marketing changes advantageous to The Plan. These resources will work in conjunction with your client management team to serve as your trusted advisor to Member communication strategies.

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

In **Section A of Attachment 5**, we have included examples of Plan communications that we have customized for other clients.

Dan Couser and Lauren Davidson will deploy monthly communication strategy meetings to meet the needs of the MHSU Disorder Program managed by Optum.

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.

We will work closely with The Plan and our existing team to develop and review customized materials, including the materials outlined in **Section 3.3** of the RFP, such as claim forms, pre-certification forms and letters, explanations of benefits, appeal letters, summaries of benefits coverage (SBCs) and more.

This will go into our comprehensive communications plan, which we will customize to educate and inform Members of the benefits available with The Plan. Our account management team and dedicated marketing lead, Lauren Davidson, will work to develop appropriate communications to The Plan's Members. When a Member letter is needed to communicate changes to The Plan, Optum will compose the letter and work collaboratively with The Plan to develop the final letter.

We provide customized Member communications designed to help Members understand their benefit and fully maximize its value. Through our external material review process, we work with your account team to support your communication needs. This is a formal review and approval process of new and revised Member communication materials.

Member communication materials that go through the CRP process receive the following:

- **Legal Approval:** This review covers legal implications, accuracy of facts and information, possible ambiguity, appropriate use of terms and language, footnotes and more.
- **Clinical Approval:** This review covers accuracy of treatment information (sometimes for plan information, if applicable), consistency of information, use of current clinical terms and more.
- **Marketing Approval:** This review covers spelling/punctuation/grammar, branding, clarity of message, health literacy, diversity, inclusive language, presentation and flow of ideas

and information, consistency within the piece and with other communications, format, correct contact information and more.

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.

Optum has a long history of working with large, national clients to create customized communications campaigns utilizing our specialized marketing communications team. Over the past 3 years, Dan Couser and Lauren Davidson have worked closely with The Plan and OER to develop The Plan's customized communications on behalf of the medical plan. During this time, we have:

- **Introduced a targeted outreach strategy:** We provide targeted communications to Member groups facing potential health risks, including segmented messages based on what we know about them. We can offer timely and relevant opportunities, additional educational materials about specific conditions, or encouragement and assistance in accessing another program suited for a Member's particular condition.
- **Created data-driven engagement:** Our communications are based on insights and research, including test-and-learn findings, consumer panels, market research and behavioral economics. We have explored how Members make decisions, when they are most receptive to information and how we can build a lasting relationship that will ultimately result in improved health and well-being.
- **Delivered results with end-to-end campaign deployment:** We have demonstrated success with our customized engagement strategies that include a full range of services from planning and creative design to deployment and measurement.

For The Plan, we can build on the strengths of this experience, aligning our strategy to deliver a holistic communications program that drives awareness and engagement across Plan benefits.

We make it easy for The Plan to communicate our programs to your Members, offering a range of customizable resources and materials, as well as digital tools, which help to facilitate timely and effective Member communications. In addition, by offering a designated Director of Custom Engagement, Lauren Davidson, we can adapt quickly to The Plan's input as needs and strategies evolve.

Lauren Davidson will expand her oversight of The Plan's communications, assisting The Plan with the creation, review and presentation of relevant materials. She is already familiar with The Plan's programs, systems and culture, and will work with The Plan to customize a plan for behavioral health that aligns with your goals and objectives.

Addressing national, emerging topics and themes, Optum quickly develops and adapts communication strategies and messaging to meet the needs of Members served by this benefit. Examples of emerging topics include:

Pride 365+

Our Pride365+ public website, **pride365plus.com,** contains resources to educate and support LGBTQ+ community Members and allies. The site has customizable posters and flyers for the workplace and includes a variety of LGBTQ+ materials, such as a resource guide, terminology and pronouns, an ally guide, fact sheets and more.

We also offer communication materials designed for the mental health needs of the LGBTQ+ community. Our LGBTQ+ poster and flyer both provide information on behavioral health resources that were developed with the LBGTQ+ community in mind. Some of the resources

include the Pride365+ website and access to our cognitive behavioral therapy (CBT) self-help app.

Anti-stigma offerings

We can help The Plan empower and support the well-being of their employees and their families by increasing awareness about Mental Health and SUDs and removing stigma as a barrier to seeking behavioral health care. Our anti-stigma offerings include:

- A digital launch email letter from leadership announcing the anti-stigma program launch at their organization
- Materials/Resources that guide employees and managers on seeing the signs of depression, anxiety and substance use, how to ask questions, use the right language and more

Messaging includes how behavioral health conditions should be regarded in the same way as physical conditions. Our anti-stigma materials encourage employees to talk more openly about behavioral health conditions; show compassion toward others living with these conditions; and support friends, families and co-workers in seeking help.

As a part of these efforts, we promote recognition and respect for those with neuro-diverse conditions. Neurodiversity covers the natural and wide range of differences in brain function, how individuals process information and environment behavioral traits. Our extensive network of providers provides treatment and support for those with autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, depression, anxiety and more.

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

The Plan's current marketing leader, Lauren Davidson, Director of Custom Engagement, will expand her oversight of communications to include The Plan, assisting The Plan with the creation, review and presentation of relevant materials. She is already familiar with The Plan's programs, systems and culture, and will work with The Plan to customize a plan for behavioral health that aligns with your goals and objectives. Lauren Davidson will be supported by your Optum account management team that develops and reviews various Member publications.

Your account team will facilitate quick turnaround in developing and approving Member communications. Their experience in this area will enable them to compose Member communication materials that are written in a similar style as The Plan's and shorten the editing process for The Plan. The account team has an established process that will continue through this contract award to prioritize The Plan's correspondence and secure approval in a matter of days.

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

Confirmed.

As noted in our responses to **Question 5.4.3** and **5.4.4**, we are committed to working with The Plan to develop customized forms and letters for the programs we propose.

In **Section B** of **Attachment 5**, we have included samples of forms and letters.

In **Section A** of **Attachment 5**, we have included examples of customized communications developed for other large clients.

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

Confirmed. We will support and staff these events with staff from the account management team who are subject matter experts on The Plan's benefit design and complex customer inquiries. This includes client service managers, who will have a bachelor's degree and at least 8 years of health care experience working with clients and members directly.

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.

We update our provider directory daily, so members can see the most current information available. Multiple sources help us verify and update provider information:

- **Monthly audits of a statistically valid sample of our entire network:** Audits confirm key access-related data such as name, address, phone, license type/specialty, gender and availability status.
- **Providers' annual reviews of their directory data:** Using our provider portal, providers can attest that their data is correct or update it using our self-service capabilities. We suppress non-responsive providers from the directory.
- **Member or staff reports:** Members and our staff can use our online directory to alert our network team to outdated information.
- **Other authoritative sources:** The network team compares our network data to authoritative sources, such as state licensing agencies to verify provider information.

The Optum behavioral health team is prepared to integrate Optum MHSU provider information into The Plan's current paper directory process. Optum will deliver clean electronic provider data annually through a secure file transfer to The Plan's external vendor for printing, according to state or federal requirements. We will work with you to confirm all requirements during implementation. The Optum network team will support the quality review of directory files before they are aggregated and provided to The Plan's contractor for printing.

The same source is used for print directories and the online directory.

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

Online directory availability

Our provider search and online directory functions available through Live and Work Well are available 24/7/365. We provide online provider search capabilities that include multiple search parameters (such as specialty, location, licensure, virtual visits and more) through the Member website. Our provider database elements are updated daily to make sure Members are accessing current information.

The online directory will be available 30 calendar days prior to commencement of The Plan Start Date through a secure dedicated link that we will provide for attachment to The Plan's website. We can provide a deep link to the provider directory, which will not require Member sign-on. Our

performance standard is that the website will be available 97% of the time, as measured by total unscheduled downtime of our website accessible by U.S. participants. The website currently exceeds the standard with 99.984% availability.

How Optum maintains accurate provider information

Optum has various controls in place to make sure listed information is accurate and up to date. We update our online provider directory daily through nightly data feeds. We can add or remove providers and facilities from the directory immediately upon notification, depending on provider responsiveness. Optum works to proactively respond to these changes and provide up-to-date provider contact information through various data validation activities.

As noted in **Section 5.11.1.e**, we also use a variety of data validation activities to keep our provider directory up to date.

As noted in our response to **Section 5.15**, we will support The Plan in complying with provisions of the CAA.

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

Our web team manages more than 1,700 customized websites on Live and Work Well (our mobile-enabled Member website). They use administration tools to update/customize these websites quickly and accurately without added costs. Customizations include:

- The Plan's logo or program name at the top of each page
- Custom Spotlights in the feature area on the Welcome page
- Personalized welcome messages on the homepage (updated upon request)
- Benefits & Services capabilities link to The Plan's programs and tools
- Use of deep links from your Intranet websites to your Live and Work Well Homepage
- Suppressing or displaying content to accommodate The Plan's requirements

As part of implementation, our website, implementation and account management teams will review customization options with you and make needed updates before the go-live date. Updates, customization consultations and website demonstrations are also available post-launch, as needed and can be coordinated through Dan Couser.

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

The Biographical Sketch Forms for Member Communication Support are included as Attachment 1 of the Technical Proposal.

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respond to standard requests as well as emergent and urgent issues. Our services will be available 24/7 for emergent and urgent authorizations and crisis calls.

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

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

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

We confirm our agreement and guarantee these requirements.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than 3% of callers disconnect a call prior to the call being answered by a CSR. The forfeited amount (Standard Credit Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

We confirm our agreement and guarantee these requirements.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount (Standard Credit Amount) for each quarter in which more than 0% of incoming calls to the Offeror's telephone line are blocked by a busy signal. The forfeited amount (Standard Credit

Amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

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

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

We confirm our agreement and guarantee these requirements.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each quarter in which less than 100% of Members who call the CRL in need of life-threatening emergency care are referred to the nearest emergency room and contacted within thirty minutes by a network MHSU Provider or the CRL to assure their safety. Additionally, the Offeror must propose a forfeiture amount for each quarter in which less than 100% of Members in need of non-life- threatening emergency care are contacted within thirty minutes by a Network Provider or the CRL. The forfeited amount (Standard Credit amount) is $60,000.00 a quarter for each quarter in which this guarantee is not met. However, an Offeror may propose higher amounts.

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

5.7 Enrollment management

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

We have reviewed and agree to the requirements in **Section 3.6** of the RFP.

Our eligibility system is part of our overall proprietary information management system, specifically designed for behavioral health care. This system uses n-tier architecture comprised of a high-performance Sybase database platform, a combination Hyperion Business Intelligence and Business Objects (WEbI) front-end, and a middle tier made up of Perl and Java programs. The system fully integrates all eligibility, intake, care management, clinical network services, claims, customer service and reporting functions. The data collected through these various system modules are loaded and stored in our Data Warehouse using the Hyperion and Business Objects Suite, allowing for extremely flexible and customized reporting.

The following sections include details surrounding our proposed program and processes.

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:

As part of implementation, we will develop a testing plan that meets The Plan's standards and requirements, as detailed in **Section 3.6** of the RFP.

Testing Plan

It is our common practice, even in situations with minimal configuration, to establish test cases within our environment to make sure all components and features are functioning as planned before the implementation date.

Our account installation team, in coordination with our eligibility and claims departments, duplicates a new or revised benefit plan in a non-production environment for testing. Any required testing will take place there, using customized claims and benefit set-up scenarios, where appropriate. The AMT then reviews the analyzed test results with the customer. We have tested our claims system for standard and unusual plan designs for existing customers. When customers do not have a previously installed benefit, our business analysts and claims technical staff will work with the account installation team to perform claims testing.

Our scalable, reliable and secure n-tier applications give us the flexibility to improve elements of the system while retaining our integrated architecture. The middle tier coordinates data from our component databases and delivers it to our case management, claims and customer service applications, as well as our web portals supporting Members and clinicians.

This integrated system enables Optum to provide quality service to Members, clinicians and customers in several ways, including the following:

- **Eligibility:** We can receive eligibility data on virtually any frequency, through secure data transmission protocols that are automatically loaded into our claims and clinical platforms.
- **Care Management:** When a Member calls for assistance, CCPs, care advocates and care navigators can view all demographic, benefit and service information for that Member.

- **Claims:** The system automatically checks received claims against practitioner, eligibility, Member intake and benefit information for efficient and accurate processing. Our integrated system provides consistency of data from the initial contact with the Member to the final payment to the practitioner.
- **Customer Service:** CCPs always have access to the most current claims payment information, as well as access to benefit and clinical network data. All Optum applications access Member information from a common application service layer, preventing discrepancies among departments in viewing and updating the information.

This integration also enables us to let Members review their eligibility and benefit information, or search up-to-date online practitioner directories, on our website, Live and Work Well. Similarly, our web portal for clinicians, providerexpress.com, enables Optum network clinicians to check Member eligibility, benefits and authorizations, as well as submit claims and request certification of continued outpatient treatment.

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

When we pre-process and pre-stage the file into our common format, we identify any changes, warnings and errors. These are sent to our electronic eligibility system analyst, who reviews the statistics around adds/changes/warnings/errors and determines whether the file should be loaded to claims system. Our quality assurance department audits file load accuracy and turnaround, based on our process and any in-place performance guarantees. We also participate in required audits of our processes in alignment with the Sarbanes-Oxley Act of 2002.

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.

When we receive and load eligibility data, our system automatically produces an error report listing instances in which any required items were missing from a Member's information. We compare the total number of transactions, based on this error report, and a summary report of all individual transactions processed without errors to the total number of Members to account for all Members. Line items with missing information are sent to The Plan for correction.

We will manually update and correct errors that we can resolve internally in the eligibility repository. We load viable transactions and send line items that require resolution in the source system to The Plan to correct and return to us.

We resolve eligibility records with errors within 24 hours. If eligibility data does not pass the edit criteria, our eligibility team will reach out to The Plan's designated contact within 24 hours to rectify the issue.

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.

As noted in our response to **Question 5.7.1.a.ii**, we will manually update and correct errors that we can resolve internally in the eligibility repository. We will send errors that require resolution in the source system to The Plan to correct and return to us.

We resolve eligibility records with errors within 24 hours. If eligibility data does not pass the edit criteria, our eligibility team will reach out to The Plan's designated contact within 24 hours to rectify the issue.

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

Confirmed. Our system has the capability to retrieve and maintain enrollment information within 24 hours of its release by the department, depending on the file volume and window for batch processing.

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

Our system maintains a full history of all enrollment transactions. There are no limits to the number of historical transactions that can be kept online.

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

We can apply retroactive changes and corrections to enrollment data either automatically or manually.

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

We have reviewed and confirm our ability to meet all requirements in the Reporting Section of the RFP. We have reviewed and confirm our ability to meet all requirements in the Reporting Section of the RFP. To capture the information needed for the reports "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims" as required in the Reporting Section, we load eligibility into our Facets system, where the member eligibility will reflect for claims purposes. The reporting team connects to claims data sources on the back-end for claims data reporting. We can capture claims and eligibility stats directly from the back-end of the claim database.

As part of the implementation, we will identify the data needed to generate these reports and will develop and design the necessary processes and protocols to make sure all requirements can be met for The Plan.

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.

Dependents are linked to Members by subscriber ID, which is created based on the information provided in enrollment and claims files. This is administered through our ability to store all these data in our system, including social security numbers, employee identification numbers, alternative identification numbers assigned by the system and any special requirements to accommodate these 3 identification numbers.

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

Our enrollment system, data transfers and processes for handling enrollment data are HIPAA compliant. Optum security measures conform to federal regulations (including HIPAA) and corporate policies that define the handling and privacy of protected health information.

Our interface protocols and processes with the NYBEAS system will meet all requirements described for Enrollment in Section 3.6.

Our preferred method for eligibility transmission and connectivity is FTP via a secure online external customer gateway. Customers receive a log-on identification and a password to use to transfer files to their designated and secure location.

We use one of the following encryption methods for transmitting PHI to third-party entities outside of our organization:

- Simple Mail Transfer Protocol (SMTP) email using Cisco Registered Envelope
- We prefer PGP encryption for email submissions
- Hypertext Transfer Protocol (HTTP) with secure socket layer (SSL) using VeriSign
- Secure file transfer protocols
- File transfer protocols using industry standard encryption tools, such as PGP

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.

All QMCSO requests are submitted to the Optum compliance department for review. Responses are manually updated in our system, clearly identifying QMCSO Members so that claims and calls can be handled accordingly.

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

We confirm our agreement and guarantee these requirements.

Utilizing the Performance Guarantees form (Attachment 6), the Offeror must propose a forfeiture amount for each twenty-four-hour period or part thereof in which enrollment records that meet the quality standards for loading are not loaded in the Offeror's enrollment system after such enrollment records have been released by the Department. The forfeited amount (Standard Credit Amount) is $1,000.00 for each twenty-four-hour period or part thereof in which this guarantee is not met. However, an Offeror may propose higher amounts.

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

5.8 Claims processing

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

We have reviewed and agree to the requirements in **Section 3.7** of the RFP. The following sections include details surrounding our proposed program and processes.

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

Optum owns Facets, our claims system. It is flexible and can be set up with multiple groups with different benefit plans to meet The Plan's needs.

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

We will work closely with The Plan's benefits team to monitor benefit design changes and communicate updates to our product and quality teams, as needed. We then conduct extensive data verification and testing.

To make sure that changes to other client benefit programs do not impact The Plan, we adhere to the following change management process:

- Benefit discussion and notification
- Benefit analysis and product identification
- Peer audit of product build used to quote benefits
- Quality assurance review
- Client approval of data
- Benefit analysis and claims system build
- Peer audit of claims system
- Quality assurance review and testing

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

If we find a claim processing error, such as overpayment or underpayment of claims, we work promptly to resolve it. We identify overpayment situations through phone call contacts and internal/external audits. We then adhere to the following process:

- The claim is set up as a negative balance against the network clinician or facility's account. We recoup with overpayment by withholding payment on future claims, until we recover the total amount.
- The adjuster must determine the cause of the overpayment and apply the negative amount to the appropriate field (such as claimed, copayment, disallow–used for coverage of benefits (COB), withhold, deductible or discount).
- Collection of overpayments occurs automatically through the system, upon processing the next claim received for that clinician or facility.

- In cases of overpayments resulting from fraud and abuse by Members or providers, Optum will use reasonable efforts to recover any overpayments and credit all recoveries to The Plan.

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.

Optum has processes in place to promptly identify, research and seek recovery of claims that are deemed to be associated with fraud, waste and abuse.

Our claims system automatically verifies the following:

- Eligibility
- If the procedure is certified and covered under the benefit plan
- The clinician's tax identification number to identify any clinicians with service issues/complaints
- Coordination of benefits
- Dependent limiting age
- Whether a duplicate claim exists in the system

When the system finds a discrepancy, a claims examiner reviews the claim and determines whether to pay or deny the claim or request additional information before determination. The claims examiner can manually override a hard edit (e.g., suspected duplicate claims, claim time submission limits and internal plan maximums). Supervisors can also check authorization level categories and override edits primarily designed to prevent fraud, including the clinician and the designated payee. Our claims personnel flag a wide range of specific situations considered to indicate non-standard submissions (e.g., repetitive claims submissions, high dollar claims with no assignment, cross-outs or erasures and many more). When we detect one or more of these situations, we initiate a retrospective review of the claim in question to authenticate services and billed amounts, as well as a review of that Member's claim file history.

We also participate in an inter-company fraud control task force, convened by UnitedHealth Group, which works to align our efforts to make sure we monitor and report such activity according to State law. The task force meets regularly to discuss changes in the law, current investigations and litigation and other situations that affect our claims staff. For more on this process, see our response to **Section 5.9**.

We confirm that The Plan will only be charged for accurate claims payments of covered expenses. Optum has processes in place to identify, research and seek recovery of claims that are deemed to be associated with fraud, waste and abuse. In cases of overpayments resulting from fraud and abuse by Members or providers, Optum will use reasonable efforts to recover any overpayments and credit all recoveries to The Plan.

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

We have included a copy of our data-sharing agreement in **Attachment 7**.

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

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

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

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5.9 Plan audit and fraud protection

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

We have reviewed and agree to the requirements in **Section 3.8** of the RFP. The following sections include details surrounding our proposed program and processes.

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.

We have a dedicated unit that audits random samples of processed claims from the preceding day utilizing a specially created quality tool. The Quality Audit team then audits the claims, paying specific attention to data such as the following:

- Member eligibility
- Application of proper benefit levels
- Accuracy of data input
- Application of correct allowable amount
- Determination and accuracy of coordination of benefits
- Determination that the claim is not a duplicate submission
- Determination that services were clinically appropriate in accordance with the terms of the Member's benefits

Optum conducts a weekly pre-disbursement audit of large dollar claims to confirm accuracy of all payment information. UnitedHealth Group, our parent company, performs an additional audit on an annual basis. We also assess the performance of claims examiners, conducting monthly audits using random samples of recent claims. Performance standards are 99% dollar accuracy and procedural accuracy. If a claims examiner does not meet these standards, he or she receives additional training. In the claims examiner's subsequent monthly reviews, we perform additional audits.

We audit all high-cost claims, including those exceeding $5,000, before paying the claim. Senior claims examiners review all claims greater than $5,000 on a pre-disbursement basis. Claims examiners isolate these claims and include them on the pend or suspend report for daily review and release. These include high-cost claims with no assignment, submitted claims using non-standard procedures, altered bills, duplicate bills and other details that are suspicious or possibly indicative of fraud. Our system automatically alerts examiners of discrepancies. When the system notes a discrepancy or a possible duplicate charge, we halt processing, and a system flag alerts the claims examiner to the issue. The claims examiner reviews the apparent discrepancy and determines whether we should deny the claim, pay the claim or obtain additional information before determination.

When we detect one or more of these situations, we initiate a retrospective review of the claim in question to authenticate services and billed amounts, as well as a review of that member's claim file history.

We also participate in an inter-company fraud control task force, convened by UnitedHealth Group. The task force meets regularly to discuss changes in the law, current investigations and litigation and other situations that affect our claims staff.

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.

Our payment integrity team uses prepay flagging, internal rules and algorithms to detect suspicious claims and duplicative billing. These strategies can aid in halting payments to potentially fraudulent claims and discover various suspicious patterns that assist in identifying suspect individuals.

Recent examples of our program in action include:

- **Watchlist of Abusive Facilities:** We developed a watchlist of facilities to prevent the automatic payment of claims without investigation and approval. We noted a skyrocketing trend in ancillary charges in out-of-network substance use treatment programs related to fraudulent billing for drug screens. Our established claims coding changes and clinical rules eliminate the abuse. They also help us refer egregious instances for fraud investigation.
- **New Lab Code Protocols:** We applied new lab code protocols to reduce frequency of inappropriate urine/drug test billings, as well as new protocols to address fraudulent lab claims.
- **Duplicate Claims Detection:** Our claims system has built-in capabilities to identify duplicate claims. When we identify a previously processed claim, the system will generate an EOB indicating the duplicate.

In addition, our reimbursement policy combats excessive billing for testing services through a bundling reimbursement methodology. We reimburse the expected cost of facility-based behavioral health services using a rate for all expected components of an active treatment program. The rate incorporates payment for all dependent, ancillary, supportive and therapeutic services in payment for the primary independent program service. Optum does not make separate payments for additional ancillary services (including labs) itemized on a claim or when billed in conjunction with primary independent program service.

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.

Monitoring and recovery

Our claims system automatically verifies basic claims data. If there's a discrepancy, a claims examiner reviews the claim and determines whether to pay or deny the claim or request additional information before determination. Our system allows the claims examiner to manually override a hard edit (e.g., suspected duplicate claims, claim time submission limits and internal plan maximums). Supervisors can also override edits primarily designed to prevent fraud including the clinician, the designated payee and check authorization levels categories.

We train our claims personnel to pay attention to specific situations considered to be indicative of non-standard submission. When we detect one or more of these situations, we initiate a retrospective review of the claim in question to authenticate services and billed amounts, as well

as a review of that Member's claim file. We also participate in an inter-company fraud control task force, convened by UnitedHealth Group. The task force meets regularly to discuss changes in the law, current investigations and litigation, and other situations that impact our claims staff.

Corrective actions

We pursue disciplinary actions against network clinicians and facilities when necessary to maintain Member safety and the quality of our network. All Member complaints about clinicians/facilities are triaged by our corporate compliance team. Complaints that are administrative (such as balance billing, referring to out-of-network providers) are routed to the network services complaints team to investigate and resolve directly with the provider. Complaints related to quality of care are routed to our quality improvement (QI) team to investigate and consider whether a site audit is warranted. Our investigation includes a review of the provider's history of quality complaints, as well as any history of previous site audits performed by the network audits team.

We conduct site audits on all clinicians/facilities who receive two quality-related complaints within 12 months. A single complaint is sufficient for us to complete a site visit if the reported issue poses a substantive threat to patient safety. Using a standard site audit tool devised with NCQA guidelines in mind, a network QI specialist reviews the site for physical accessibility, physical appearance, adequacy of waiting and examining room space and availability of appointments. Audit results and any applicable corrective action plan requirements are sent to the clinician/facility after the regional peer review committee makes the final recommendations. In all cases, the clinician/facility receives a letter with the results of the audit, including a list of deficiencies identified during the review.

For site audit or treatment record reviews with scores below 85% on the audit, we require that the clinician submit a corrective action plan for our review and approval. For site audit or treatment record reviews with scores below 80%, we require submission of a written corrective action plan and participation in a re-audit within 6 months of the original audit date. We forward results to the network management and credentialing departments for inclusion in the clinician's/facility's credentialing file. For clinicians/facilities with corrective action plans, an Optum QI specialist monitors progress at least every 6 months to verify ongoing and consistent compliance with our standards.

We follow federal regulations and report providers when we have taken an adverse action related to a quality issue or any reportable issues as defined by the National Practitioner Databank (NPDB). We also simultaneously report to the provider's licensing boards. NPDB functionality enables us to send the reports to the respective licensing board.

Fraud and abuse unit

Our Special Investigation Unit (SIU) investigates both prepay and post-pay claims to recoup inappropriate payments and partner with authoritative entities to report and reduce fraud, waste, abuse and error (FWAE). The primary detection focus of the SIU are physicians and other health care entities at the provider level. SIU staff comprises various professionals, including investigators, case development analysts, certified coders, IT specialists and clinical personnel in both a prepay and post-pay space. Additionally, SIU engages external teams for additional assistance when further review is needed, aided by Optum Rx, Utilization Management and Practice Management, to name a few. SIU adheres to state and federal regulations, issuing potential fraud referrals to state agencies should the corresponding Medicaid Fraud Control Unit require.

SIU performs end-to-end FWAE detection and investigations. The process begins with evaluating allegations and tips, then validating whether a full investigation is warranted. Many outcomes can occur depending on the results of tip validation:

- The provider could be reported to the appropriate authorities in accordance with applicable law.
- The provider could be flagged so that future claims are stopped and reviewed prior to being paid.
- Medical records could be requested for further investigation.

Potential FWAE can be detected through data review and analysis. Real-time claims data is used, which allows detecting fraud more directly. This is a proven, effective addition to our well-established and effective back-end claims review. SIU investigates providers using the Provider Verification database, which verifies key licensing and demographic information. The verification process can also reveal investigative leads, in cases when abusive billing practices are found, or automated systems cannot successfully validate a provider's existence.

Providers are monitored using specialized software and tools, which examine paid claims data to identify irregular or suspicious practice patterns. Abnormalities are gathered into larger reports, and identified providers are further investigated. This data can help stop claims from being paid, flag suspicious providers, and identify potentially fraudulent behavior.

Optum is widely acknowledged as an innovator in the area of data analytics and trending analysis. New tools and processes are continually developed to prevent future losses arising from fraudulent or wasteful practices. We have a successful recovery program from both in-network and out-of-network providers, including a considerable time effort from staff and resources. Optum makes industry vigilance and cooperation with anti-fraud associations a high priority. Our SIU is highly successful in detecting, preventing and investigating potential FWAE, and in recovering improper payments.

Addressing illegal or criminal activities by a provider or facility

All situations involving suspected fraud are raised to Optum Legal for review and subsequently reported to law enforcement and/or regulatory oversight, as appropriate. Strong working relationships are maintained with various law enforcement agencies at the local, state and federal levels. These agencies rely on our partnership and collaboration in investigations, up to and including both civil and criminal prosecutions, as circumstances dictate.

Optum cannot formally declare that a provider or facility has been engaging in fraudulent or abusive activity; applicable law enforcement and the judicial system have the final say of the findings at the close of the investigation. Through collaboration with the appropriate governing body, whether visiting suspicious facilities together, producing documentation when requested, or participating in a trial, Optum can address potentially illegal or criminal claim activities from end-to-end.

5.10 Appeal process

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

We have reviewed and agree to the requirements in **Section 3.9** of the RFP. The following sections include details surrounding our proposed program and processes.

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.

Appeal process

We notify Members of their right to an appeal by including a Member Appeal Rights attachment in all communications regarding care authorization. We also notify Members verbally, when possible.

We conduct all appeal reviews (both administrative and clinical) in a manner that does not give deference to the administrative determination. Administrative reviews do not require review for medical necessity and can include instances where no prior authorization was requested or when a requested service is not covered. Administrative appeals for these denials can also include instances where a provider sends a claim in with no prior authorization.

If a Member, representative or clinician is not satisfied with an adverse benefit determination, the person may request an internal appeal review.

- Licensed clinical peer reviewers (board certified as a psychiatrist, addictionologist or are doctoral-level psychologist) practicing in the same specialty as the treating clinician conduct all clinical appeal reviews. For example, psychiatrists review and approve all medical necessity denials involving treatment by a psychiatrist. Upon receiving the appeal, the peer reviewer reviews the provided documentation, investigates appeal content, and makes a determination on evidence-informed practice. The reviewer documents their findings in the appeals database.
- In most cases, non-licensed peer reviewers will review administrative appeals.

Our internal appeal process complies with New York State requirements, as well as federal requirements, as set forth by the Department of Labor, HIPAA, Employee Retirement Income Security Act (ERISA), Patient Protection and Affordable Care Act (PPACA) and CMS (as applicable), and with the accreditation standards as set forth by NCQA and URAC.

First-level appeal review

We must receive the urgent or non-urgent appeal review requests within 180 days of the adverse determination (or as specified by state law). A different medical director than the one who issued the denial will review the appeal. The request must include a clear reason as to why the appellant believes the adverse determination was issued incorrectly.

A Member, Member representative or provider can request an urgent first-level appeal when:

- The application of non-urgent procedures and time frames could seriously jeopardize a Member's life, health or ability to regain maximum functioning.
- It is the treating clinician's opinion that the care requested is urgent.
- Failure to provide the requested care would cause the Member severe pain.

We provide a graphical depiction of the first-level appeal process in the next figure.

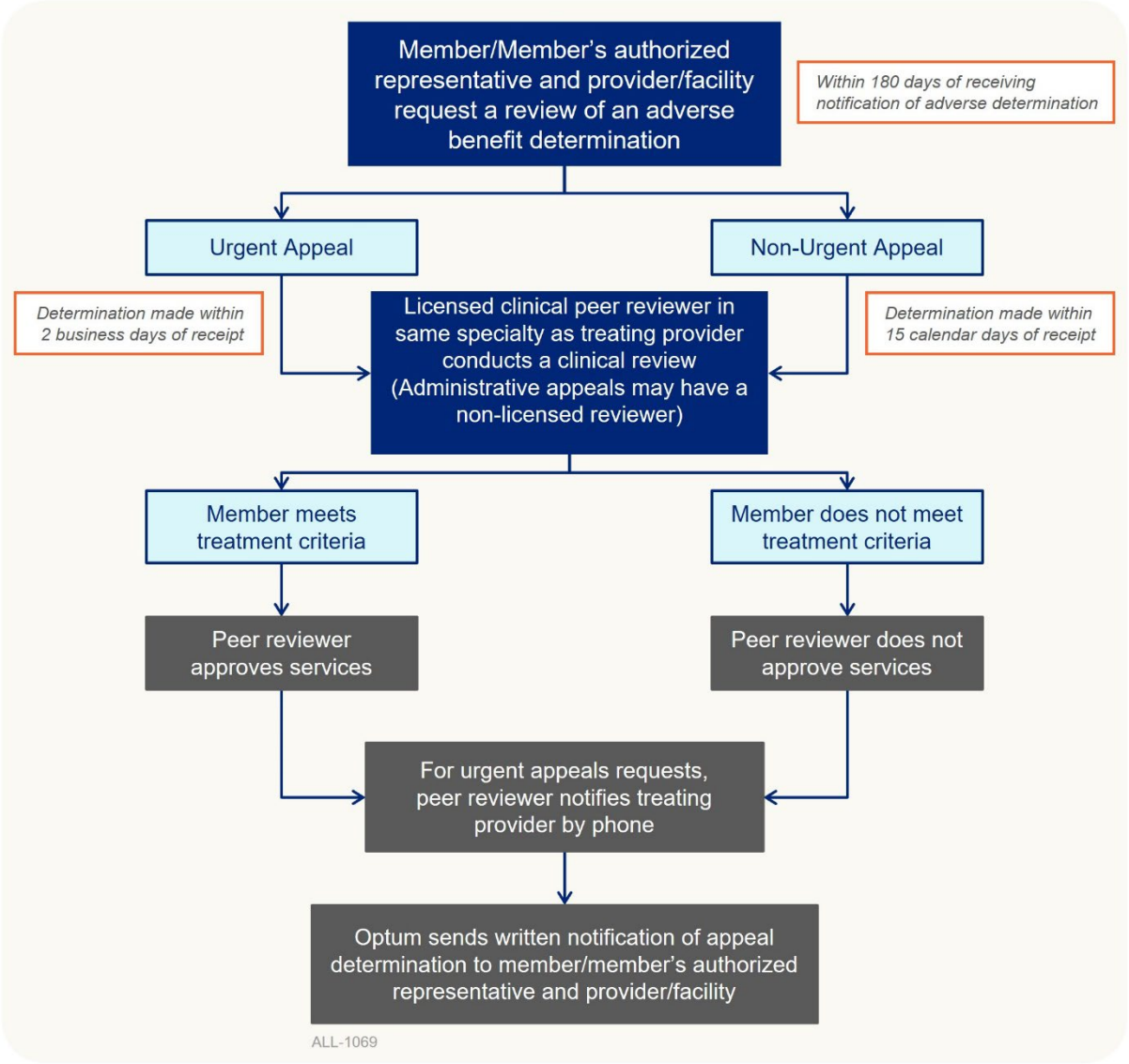


Figure 2: Process flow for appeals

We follow the same appeal process for both clinical and administrative appeals. Licensed clinical peer reviewers conduct clinical reviews and, in most cases, non-licensed peer reviewers conduct administrative reviews. To maintain the integrity of our appeal review process, we make sure that the person reviewing the appeal was not involved in the initial adverse determination nor a subordinate of the individual who issued the initial adverse determination.

First-level appeal outcome notification details

Appeal outcome notifications include:

- A statement regarding the reviewer's understanding of the facts pertinent to the case in easily understandable language
- The rationale (in easily understandable language) for the appeal decision
- Reference to the appropriate section of the Member's Certificate of Coverage or Summary Plan Description used to make a contractual or benefit determination

- An explanation of the scientific or clinical basis for the determination when the request involves the use of experimental or investigational treatment
- Reference to the evidence or documentation used as the basis for the determination, including clinical criteria such as The ASAM Criteria, Level of Care Utilization System (LOCUS), state- and contract-specific clinical criteria, and internal clinical practice guidelines
- Instructions for requesting a free copy of the relevant information used to make the determination
- A list of titles and qualifications of all parties involved in the appeal review
- A statement regarding the Member's further appeal rights

Second-level appeal review

In the State of New York, based on regulations, Optum will only conduct second-level appeal reviews for administrative appeals on HMO plans. There is currently no requirement for clinical second-level appeals for HMO plans and no requirement for second-level appeals on PPO plans.

We must receive a request for an appeal review within 180 days of the Member receiving the adverse determination letter. To maintain the integrity of our appeal review process, we make sure that the individual conducting the second-level appeal was not involved in the initial or first-level adverse determination and was not a subordinate of the individuals who issued the initial adverse determination.

Independent external appeal review

If a Member disagrees with the results of the internal appeal determination, the Member or Member's authorized representative can request an external appeal review by an external independent review organization. As per New York State law, we must receive independent external appeal review requests from members within 4 calendar months of the adverse determination letter receipt. We must receive independent external appeal review requests from providers within 60 calendar days of the adverse determination letter receipt.

A Member is eligible for an independent external appeal review when the Member is appealing a non-coverage determination that involves medical judgment, as determined by the external reviewer. This includes, but is not limited to, decisions made based on medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, or determination that a treatment is experimental or investigational. Requests for independent review can also include rescission of coverage and services covered by the Member's benefit plan. Optum medical directors not involved in any previous stage of the appeal oversee the independent external review only to verify compliance with ERISA time frames.

We select independent external reviewers who have:

- No conflict of interest with Optum
- Clinical expertise and qualifications (currently licensed and restriction-free psychiatrists and behavioral health professionals)
- Ability to conduct evidence-informed decision-making
- A record of excellent training, education and skills to produce sound, high-quality results

- Quality management processes
- Ability to protect Member identity, treatment records and case information

The independent external reviewer reviews all information used in the internal appeal process and may request additional information prior to determination. The reviewer considers and assesses sound medical evidence before making the final and binding decision.

We complete urgent external appeal reviews within 72 hours. We complete non-urgent external appeal reviews within 30 calendar days from New York State.

Formal hearing

If Optum does not approve the Member's claim and the Member has exhausted all mandatory review options, the Member has the right to file a civil action under section 502(a) of the ERIS.

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

Our turnaround times for non-urgent administrative appeals and non-urgent clinical appeals are the same. We base our turnaround times on the urgency of the need, not on the type of appeal. Non-urgent appeals for services not rendered (pre-service, where the Member is waiting) have shorter turnaround times than non-urgent appeals when services have already been rendered.

- For **non-urgent appeals for services that have not yet been rendered**, the appropriate peer reviewer (licensed reviewer for clinical appeals and most likely non-licensed for administrative appeals) makes an appeal determination and notifies the provider, the Member and/or the representative of the outcome in writing within 15 calendar days of request receipt. This turnaround time is less than the State of New York's requirement of 30 days.
- For **non-urgent appeals for services that have been rendered**, the appropriate peer reviewer (licensed reviewer for clinical appeals and most likely non-licensed for administrative appeals) makes an appeal determination and notifies the provider, the Member and/or representative in writing within 30 calendar days of request receipt.

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

Our turnaround times for urgent administrative appeals and urgent clinical appeals are the same. We base our turnaround times on the urgency of the need, not on the type of appeal. Urgent appeals for services not rendered (pre-service, where the Member is waiting) have shorter turnaround times than urgent appeals when services have already been rendered.

When making an urgent appeal determination, the peer reviewer (licensed reviewer for clinical appeals and most likely non-licensed for administrative appeals) considers the seriousness of the Member's condition.

Per State of New York regulations, we will provide a written notification of the urgent appeal review determination within 2 business days of the receipt of necessary information. We notify the provider by phone and send written notification of the appeal outcome to the clinician, the Member and/or the representative.

For inpatient substance abuse, we will provide written notification of the urgent appeal review determination within 24 hours of receipt of the appeal.

5.11 Provider network

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 is required to 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 located within the pre-defined access standards.

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

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

Confirmed. We have completed and enclosed in the USB the **Attachment 10**, MHSU Provider Network reports for MHSU Facilities and MHSU Practitioners (Attachment 23) in Excel, as instructed in the Attachment 23 instructions.

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.

Confirmed. We have completed and enclosed the full **Attachment 11**, GeoAccess Network and GeoAccess Accessibility Summaries reports with our proposal. The GeoAccess Network report is available on USB, as instructed.

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.

Confirmed. **Attachment 12**, the Proposed Provider Network Summary Worksheet (Attachment 32) has been completed and enclosed with our proposal.

5.12 Center of excellence for substance use disorders

The Offeror must provide a narrative describing, in detail, the proposed Center of Excellence for Substance Use Disorders the Offeror is proposing to administer as specified in Section 3.11 of this RFP, including a detailed description of how the program operates.

Our COE approach: Focus on treatment effectiveness

Our Center of Excellence model for SUD is the Optum Platinum program. The program identifies top-performing network programs—by geographic region—that demonstrate the best treatment outcomes. Performance is measured by the program's use of evidence-informed medicine practices and on their superior outcomes.

We developed the Platinum program based on our experience that patients do better in treatment facilities close to home, rather than destination-treatment centers with unproven quality measures and high costs. We re-tier these facilities annually.

Our Platinum programs provide members with an all-inclusive, in-network continuum of care, based on levels of care defined by American Society of Addiction Medicine (ASAM). These include:

- Acute inpatient
- Residential treatment centers
- Partial hospitalization programs
- Intensive outpatient programs (evening outpatient and weekend programs)
- Outpatient programs, including opioid treatment programs

Telephonic assessment prior to treatment placement

Telephonic assessment by our licensed care advocates occurs prior to treatment placement and can be initiated in various ways:

- ***When Members call our toll-free number or our Substance Use Disorder Helpline***
- ***When providers call or submit an online request for authorization for SUD facility-based care***.
- ***When we outreach to a Member based on our data analytics that identify SUD gaps in care***

To guide our decisions on the most effective treatment setting for Members, we use ASAM guidelines. For New York, we use the LOCADTR tool.

ATLAS: Helping Members Understand Their Needs and Find Providers

We also provide the Shatterproof ATLAS SUD Assessment, available through our Live and Work Well website to help members learn more about services available to them.

The tool includes our entire behavioral health network in New York, including our Platinum program facilities and quality information.

Members answer a 13-question assessment created by ASAM and receive personalized, ***high-quality addiction treatment options*** based on science. Options can be filtered and sorted by location, services and insurance/payment options. In addition, ATLAS displays a range of facility details that are specific to treating addiction (e.g., fast access to treatment, personalized evaluations, access to medications for opioid or alcohol use disorder).

ATLAS is free and confidential for families to use, and it's currently live in 6 states—including New York—with plans to expand nationally through 2023 and into 2024.

Before treatment placement, we also use our Facility Benefit Inquiry process, which reduces the use of out-of-state, out-of-network residential/destination facilities. With this process, when an out-of-network facility calls to inquire about benefits, we will not provide benefit information without first speaking to the Member to discuss their clinical needs.

Managing the care of Members for the first 90 days of treatment, including relapse or readmission needs

In accordance with New York's requirement disallowing utilization review for the first 28 days of treatment, our behavioral health care advocates monitor Members in treatment, rather than actively managing their care.

After the initial 28 days, our care advocates collaborate with providers to review Members' treatment histories and identify barriers, adherence issues, psychosocial or other support challenges and precipitants. They close gaps, facilitate clinician interactions and co-develop discharge plans as the Member steps down to less intensive levels of care.

All clinical review activities rely on clinical criteria including the LOCADTR, *ASAM*, Level of Care Utilization System for Psychiatric and Addiction Services {LOCUS}, American Psychological Association *2019 Psychological and Neuropsychological Testing Billing and Coding Guide*, state- and contract-specific clinical criteria, and internal clinical practices guidelines), state- and contract-specific clinical criteria, and internal clinical practices guidelines.

Identifying relapse or readmission needs

For Members at high risk of relapse or readmission based on our analytics, we assign a licensed care navigator during discharge planning to support the Member's recovery process. This reduces the chance of readmission within the 30 days following discharge. Care navigators call Members within 3 business days post-discharge to confirm they have an outpatient appointment scheduled with a clinician and to identify community resources. This helps improve continuity of care and treatment adherence to ultimately prevent future readmissions.

Detoxification; Intermediate Levels of Care; room and board; transfer back to the community and family; virtual family program; and digital supports

Detoxification

In lieu of detoxification for opioid use disorder (OUD), medications for opioid use disorder (MOUD) is the gold standard that combines FDA-approved medication with counseling, therapy and recovery supports to deliver improved outcomes and protect Members from accidental overdose. Our 2022 data consistently shows better treatment outcomes in addition to lower total cost of care for members using MOUD for OUD services and MAUD for AUD services versus those who did not.

Medically supervised withdrawal management (detoxification) may be clinically appropriate for Members using CNS depressants where withdrawal may pose a health risk. Optum offers withdrawal management services in all facility levels of care from acute inpatient hospital based through ambulatory services in outpatient settings.

Residential treatment centers; partial hospitalization programs; intensive outpatient program

Our network represents a full range of alternatives to inpatient/hospital-based treatment for both mental health conditions and SUDs. These include residential treatment centers, partial hospitalization programs and intensive outpatient programs, as listed previously.

Room and board

Our contracts with hospitals and residential treatment programs are inclusive of room and board.

Care coordination for transfer back to the community

Optum care advocates work with facility discharge planners to assure Members discharged from facility-based care have timely and appropriate follow-up care, community resource support and care coordination between treatment providers.

Virtual family program and other digital supports

We offer various digital engagement tools and treatment programs to help Members with SUDs. These include a Children's Program, a Virtual Family Program, an online Twelve-Step Program, on-demand webinars, chat rooms and daily messages to support living in recovery and self-paces online educational programs to increase SUD awareness and reduce stigma.

Travel/lodging and meals allowance

Optum will administer the travel and lodging (T&L) benefit and meals allowance for Members in our COE-level, top-quality facilities, which are located nationwide. Across the country, we have 129 locations, with 16 in the Northeast, including 11 in New York and one in Connecticut.

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5.16 Disabled dependent determinations

1. The Offeror must provide a narrative describing in detail the proposed processes that will be utilized in disabled dependent determinations as specified in Section 3.15 of this RFP, including the following:

We are fully prepared to deliver a tailored solution to meet The Plan's exact needs for Disabled Dependent Determinations—both for dependents under the Enrollee's family coverage and for those enrolled in other NYSHIP benefit programs.

Our dedicated staffing and structure for The Plan will accommodate the projected volume of reviews in alignment with all guidelines, Duties and Responsibilities outlined in Section 3.15 of the Proposal.

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

Although we do not currently provide this service specifically as outlined in Section 3.15, we look forward to developing a comprehensive process and protocols for The Plan that will meet your precise needs.

We have included a high-level description of our standard dependent eligibility review process and staffing, below.

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

As noted, we will customize the process below to meet The Plan's specific requirements as described in Section 3.15.

To provide disabled dependent determinations regarding continuation of a dependent's eligibility under the plan beyond Age 26 and for dependents of employees on the basis of disability, our process is as follows:

- In cases where an employee/retiree's child eligibility to remain a dependent under the terms of the plan for continuation of coverage beyond age 26, our Case Managers would review and make a recommendation.
- Optum medical directors would assess the recommendation and review all medical records furnished by the dependent's health care providers or parents, along with any records Optum has regarding the dependent, in order to make the determination decision.
- Optum provides the plan with a medical assessment of the nature and extent of mental impairment and disability, and a recommendation for continued coverage for use by the plan or his/her designee in determining whether the child continues to be eligible to remain enrolled under the terms of the plan.

Our care advocates and case managers providing recommendations have extensive experience, clinical skills and active involvement in decisions about patient care. This gives them credibility with treating clinicians, resulting in a high level of cooperation and productive interaction. Care advocates and case managers must have the following:

- A master's-level or higher clinical degree with independent, unrestricted licensure (such as licensed professional counselors or social workers, psychologists or psychiatric nurses)

- At least 3 years of direct clinical experience (post-licensure preferred) with emphasis on acute psychiatric and substance use disorders (SUDs), inpatient and/or residential/day treatment experience (variable experience strongly preferred)
- In-depth experience in the full range of treatment settings
- Complete knowledge of available treatment modalities and their relative effectiveness

Our staff performing determinations are our behavioral health medical directors with an unrestricted license to practice medicine; completion of an accredited psychiatric residency program; Certification by the American Board of Psychiatry and Neurology; and a minimum of 5 years of post-licensure experience, which may include experience in an organized health care setting and supervisory responsibility.

5.17 Transition and termination of contract

The Offeror must provide a narrative describing in detail:

1. **The process and level of customer service and clinical management that Offeror will provide in Phase One and Phase Two of the Transition Services, as specified in Section 3.16 of the RFP.**

We have reviewed and agree to the requirements in **Section 3.16** of the RFP.

We will provide uninterrupted access to our program and associated services throughout the course of the account. We will continue all contractual obligations and all activities necessary to complete the processing and settlement of all open claims, per The Plan's requirements. If The Plan decides to terminate our contract, we will work closely with you and the new vendor to meet all transition needs and enable full and timely transition.

Throughout the transition period, we will continue to provide administrative services. In consultation with The Plan, we will process enrollment updates and maintain phone lines and adequate staffing levels to serve your Members. In addition, we can respond to any state audit requests in a timely manner, fully cooperate with audit findings and perform timely reviews. We will remit reimbursement that is owed to The Plan consistent with RFP requirements.

Phase 1: We agree to fulfill Phase 1 activities within 6 months of the end date, as detailed in **Section 3.16**. Upon contract termination, we will support The Plan in completing a full, seamless and timely transition to the new vendor. Our standard processes and procedures include:

- **Coordinating with The Plan and New Vendor:** We begin by establishing communication with the new vendor, working to understand their benefit plan design, network and information technology structure. We also obtain their Member services phone number and initiate dialogue between our relevant department heads and their corresponding staff, laying the groundwork for future success.
- **Establishing Continuity of Care:** After establishing a plan, the account management team will notify our behavioral health departments to begin a continuity of care plan. For inpatient/intermediate cases, we will identify the step-down policy the group wishes to use (for example, standard transition at stepdown, hard stop and handoff at the end date of the service period). Before the transition date, we will run transition-of-care Member reports for the vendor clinical contact. We will also work to transfer program and clinical data to The Plan and the new vendor. When a confidentiality agreement is approved by all 3 parties, we can start transferring clinical information to the new vendor to maintain continuity of care for Members in treatment at the time of program transition.
- **Communicating with Members:** Members will receive notification from The Plan of the benefit transition with contact information, transition policy and a description of the new benefits. They also receive information on how to access services during the transition period.
- **Honoring Contractual Requirements:** We use a standardized process to make sure we honor all contractual requirements relative to the termination, including the confirmation of all systems and staff and a final reconciliation of the performance guarantees for the previous year.

Phase 2: We agree to fulfill Phase 2 activities beginning at 12:01 a.m. on the first day after the end date, according to the requirements detailed in **Section 3.16**. Proceeding from the work performed during Phase 1, we will continue processing claims until all claims incurred as of the

end date have been settled, according to the requirements set forth by The Plan. We will also continue to provide access to any online claims processing data and reporting systems and will provide sufficient staff resources to address any audit or reporting needs in a timely manner.

2. Transition and Termination Guarantee: In this part of its Technical Proposal, the Offeror must state its agreement and guarantee that all Transition Plan requirements outlined in Section 3.16 of this RFP will be completed in the required time frames to the satisfaction of the Department.

We confirm our agreement and guarantee these requirements.

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

Attachment 4, Performance Guarantees (Attachment 6**)** has been completed and provided with this Technical proposal.

Attachment 4. Performance Guarantees (Attachment 6)

Please see the following pages for our Attachment 6, Performance Guarantees.

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Attachment 5. Communications Samples

Please see the following pages for our Communication Samples.

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Optum

Behavioral Health

Communications and Engagement Samples

Prepared for The Empire Plan

April 2023



Section A

Behavioral Health communications samples
as customized for other clients

Rebranding to destigmatize behavioral health

OPPORTUNITY:

Create a new brand cohesive creative theme for a large public sector client that makes behavioral health more approachable and showcases the breadth of services.

INSIGHT:

There is often a stigma around behavioral health services. Members may perceive this as a benefit for “someone else” or only for those with acute or extreme mental health concerns. Because of this, other program benefits are overlooked.

APPROACH:

A new program name and brand were created to de-stigmatize behavioral health benefits and increase utilization. Our multi-channel approach was designed to reach the full population — and specific segments — with multiple and ongoing touch points, driving improved program engagement.



+62% higher engagement than book of business

2x more engagement than previous vendor

Monthly member touchpoints in addition to segmented outreach

Timely and relevant communications to drive engagement

Optum

OPPORTUNITY:

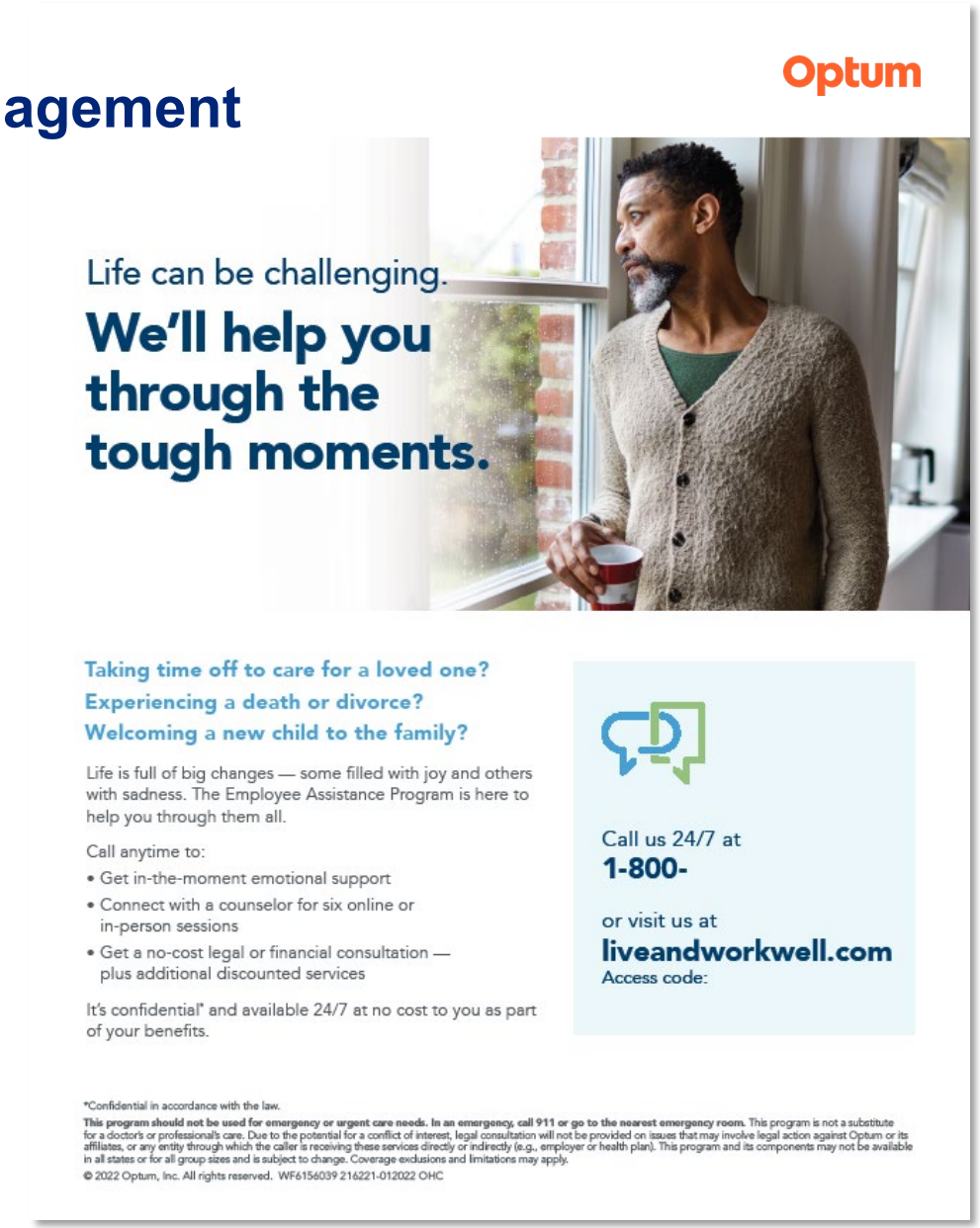
Promote mental health services to members who are taking a leave of absence from their work.

INSIGHT:

Employees requesting leave of absence are commonly going through a challenging life event, whether it's welcoming a new baby or helping a sick family member. It's a good time to remind them they are not alone and are have support through their health plan if needed.

APPROACH:

5 custom digital flyers were developed to be sent to members when they take a leave of absence. The versions were customized to help the message resonate for members and included birth/adoption, death of a family member, marriage, divorce, and general leave.



Connecting with members on issues relevant to them

OPPORTUNITY:

Promote awareness and utilization of behavioral health benefits for employees of a large healthcare client with thousands of front-line healthcare workers who experienced mental and behavioral challenges following the COVID-19 pandemic.

INSIGHT:

Healthcare workers experienced caregiver burnout as they spent more time caring for others and not enough time taking care of their own needs.

APPROACH:

A direct mail campaign was developed using a “coffee break” them to help add brevity to otherwise emotionally-heavy topic. The mailer outlined resources available to members across acuity levels ranging from digital self-care to those who wanted to connecting with a mental health provider.

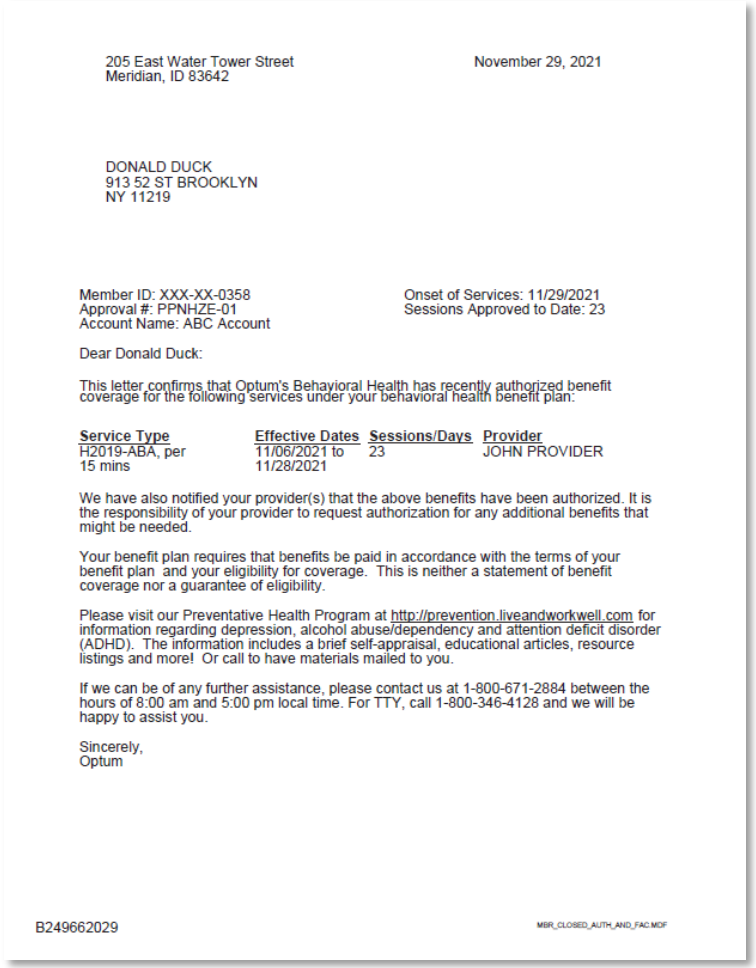




Section B

Sample forms and letters

Sample forms and letters



205 East Water Tower Street
Meridian, ID 83642

November 29, 2021

DONALD DUCK
913 52 ST BROOKLYN
NY 11219

Member ID: XXX-XX-0358
Approval #: PPNHZE-01
Account Name: ABC Account

Onset of Services: 11/29/2021
Sessions Approved to Date: 23

Dear Donald Duck:

This letter confirms that Optum's Behavioral Health has recently authorized benefit coverage for the following services under your behavioral health benefit plan:

Service Type	Effective Dates	Sessions/Days	Provider
H2019-ABA, per 15 mins	11/06/2021 to 11/28/2021	23	JOHN PROVIDER

We have also notified your provider(s) that the above benefits have been authorized. It is the responsibility of your provider to request authorization for any additional benefits that might be needed.

Your benefit plan requires that benefits be paid in accordance with the terms of your benefit plan and your eligibility for coverage. This is neither a statement of benefit coverage nor a guarantee of eligibility.

Please visit our Preventative Health Program at http://prevention.liveandworkwell.com for information regarding depression, alcohol abuse/dependency and attention deficit disorder (ADHD). The information includes a brief self-appraisal, educational articles, resource listings and more! Or call to have materials mailed to you.

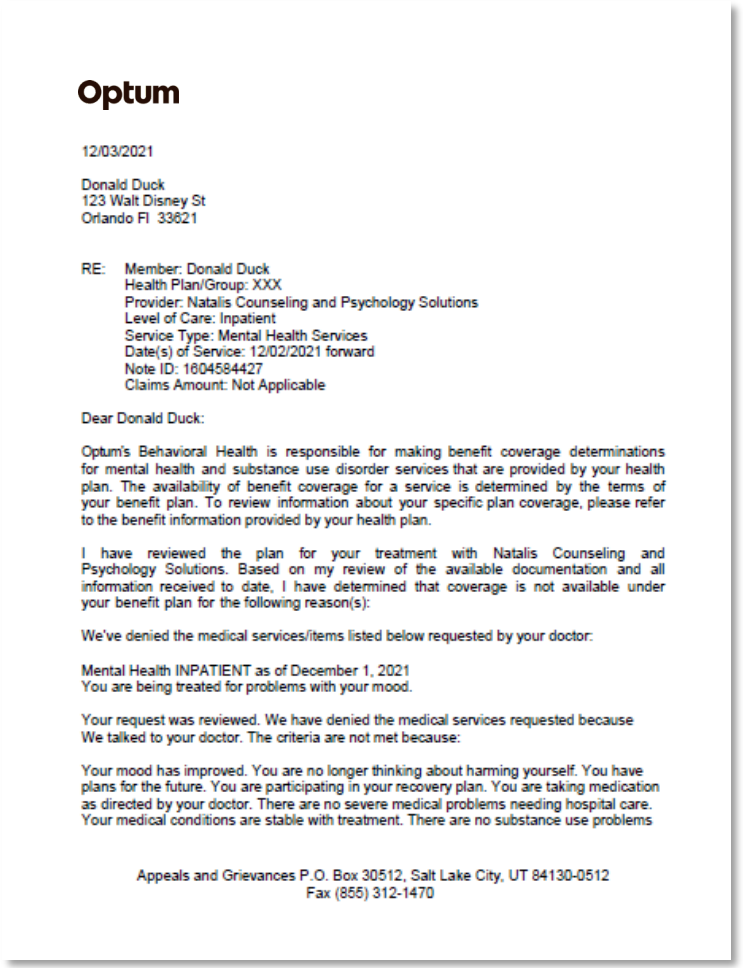
If we can be of any further assistance, please contact us at 1-800-671-2884 between the hours of 8:00 am and 5:00 pm local time. For TTY, call 1-800-346-4128 and we will be happy to assist you.

Sincerely,
Optum

B249662029

MBR_CLOSED_AUTH_AND_FAC.MDF

Authorization letter



Optum

12/03/2021

Donald Duck
123 Walt Disney St
Orlando Fl 33621

RE: Member: Donald Duck
Health Plan/Group: XXX
Provider: Natalis Counseling and Psychology Solutions
Level of Care: Inpatient
Service Type: Mental Health Services
Date(s) of Service: 12/02/2021 forward
Note ID: 1604584427
Claims Amount: Not Applicable

Dear Donald Duck:

Optum's Behavioral Health is responsible for making benefit coverage determinations for mental health and substance use disorder services that are provided by your health plan. The availability of benefit coverage for a service is determined by the terms of your benefit plan. To review information about your specific plan coverage, please refer to the benefit information provided by your health plan.

I have reviewed the plan for your treatment with Natalis Counseling and Psychology Solutions. Based on my review of the available documentation and all information received to date, I have determined that coverage is not available under your benefit plan for the following reason(s):

We've denied the medical services/items listed below requested by your doctor:

Mental Health INPATIENT as of December 1, 2021
You are being treated for problems with your mood.

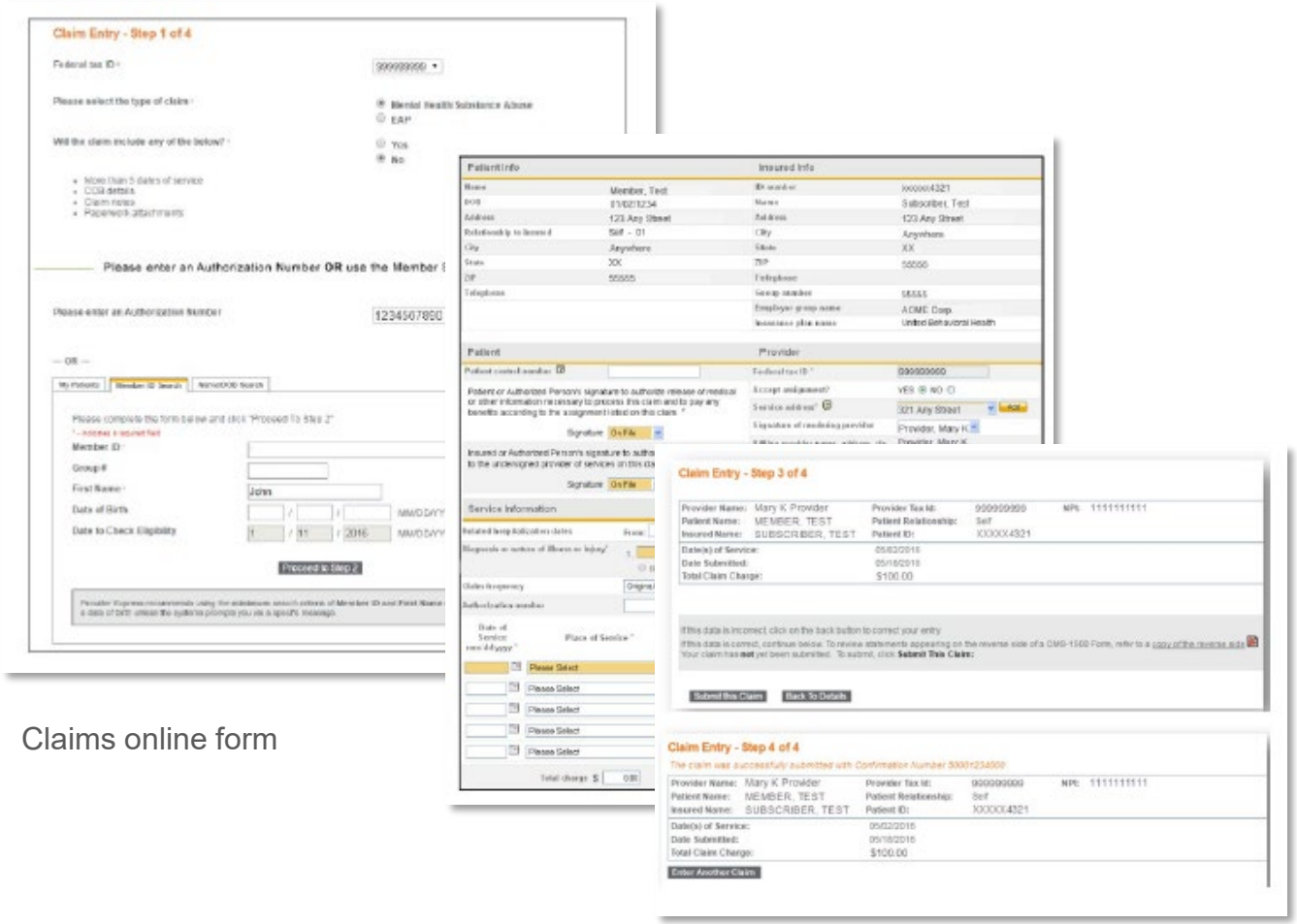
Your request was reviewed. We have denied the medical services requested because We talked to your doctor. The criteria are not met because:

Your mood has improved. You are no longer thinking about harming yourself. You have plans for the future. You are participating in your recovery plan. You are taking medication as directed by your doctor. There are no severe medical problems needing hospital care. Your medical conditions are stable with treatment. There are no substance use problems

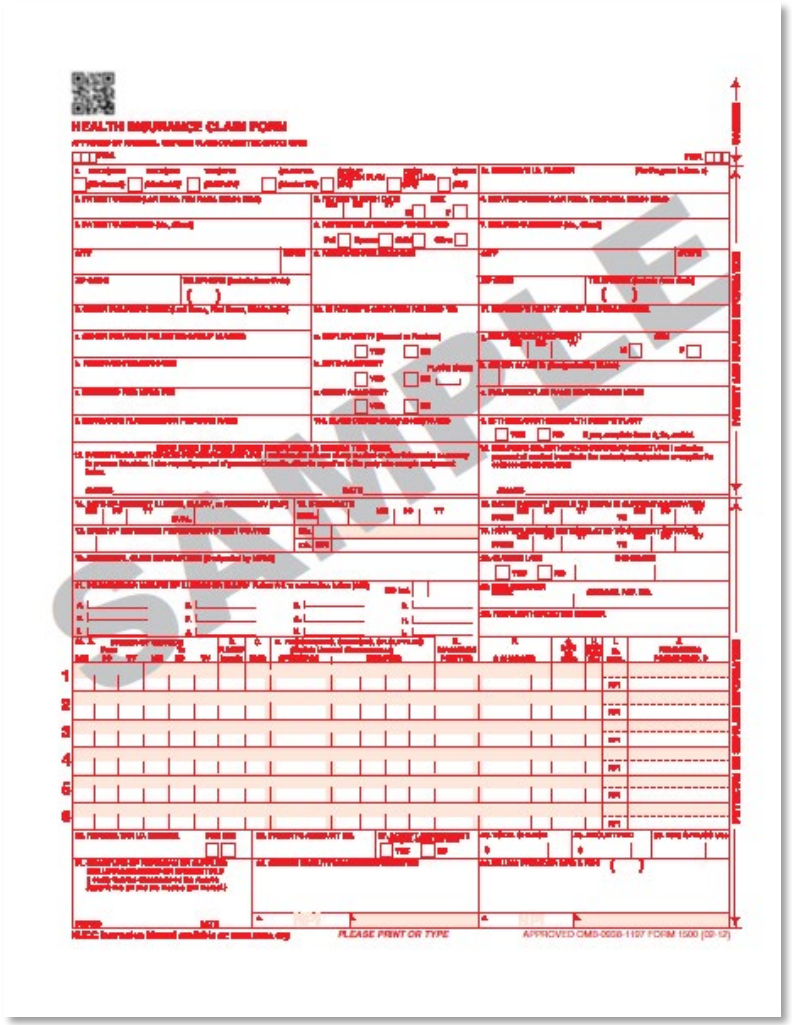
Appeals and Grievances P.O. Box 30512, Salt Lake City, UT 84130-0512
Fax (855) 312-1470

Denial letter

Sample forms and letters



Claims online form



Claims paper form



Optum is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions. All other brand or product names are the property of their respective owners. Because we are continuously improving our products and services, Optum reserves the right to change specifications without prior notice. Optum is an equal opportunity employer.

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Attachment 6. Financial and Utilization Reporting

Please see the following pages for our Reporting Samples.

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Attachment 7. Optum Data Sharing Agreement

Please see the following pages for our Sample NDA.

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Mutual Non-Disclosure Agreement

This MUTUAL NON-DISCLOSURE AGREEMENT (this "Agreement") between Optum Entity ("Optum") and Primary Counterparty ("Company") is effective as of the date last signed below ("Effective Date"). The parties to this Agreement and/or their Affiliates desire to share certain information in the course of contemplating or implementing a business relationship (the "Purpose") that is confidential, non-public or proprietary. The parties agree as follows:

1. Definitions.

(a) "Affiliate" or "Affiliates" means any entity controlled by, controlling, or under common control with a party.

(b) "Confidential Information" means any and all information that is of a confidential or proprietary nature of the Disclosing Party or its Affiliates, or of a third party to whom Disclosing Party owes a duty of confidentiality, that is received or accessed by the Receiving Party, its Affiliates, or their directors, officers, employees, agents, contractors or advisors ("Representatives," which are included in the definition of "Receiving Party") on, after, or within thirty (30) days prior to the Effective Date whether disclosed or accessed orally or in writing, electronic or other form, whether marked, designated or otherwise identified as "confidential," including, without limitation, information clearly designated as confidential at the time of disclosure, or under the circumstances surrounding disclosure, Receiving Party knows, or ought to reasonably know, is confidential, including but not limited to information regarding pricing, assets, business plans, proposals, standard operating procedures, unpublished patent applications, Trade Secrets, data, processes, methods, formulae, agreements, customers, products, sales, patients, providers, vendors and finances, technology, source and object code, data marts and data warehouses, algorithms, systems and architecture, methods of database creation, translation, standardization, and enhancement, health data analysis techniques, health data reporting and profiling methods and formats, the Purpose, and any copies, notes, derivatives and summaries that the Receiving Party derives, in whole or in part, from any Confidential Information of the Disclosing Party. The fact that discussions or negotiations regarding the Purpose have occurred, or are occurring, is also considered Confidential Information.

(c) "Disclosing Party" means each party that provides or whose Affiliates provide, directly or indirectly, Confidential Information to Receiving Party.

(d) "Trade Secret" or "Trade Secrets" means information that derives economic value, actual or potential, from not being generally known to or readily ascertainable by other persons who can obtain economic value from its disclosure or use and is the subject of efforts by the Disclosing Party that are reasonable under the circumstances to maintain its secrecy.

(e) "Receiving Party" means each party that receives or whose Affiliates receive, directly or indirectly, or access Confidential Information of the Disclosing Party.

2. Confidentiality Obligations. Receiving Party will: (i) hold Confidential Information in confidence, and secure and protect it as confidential and proprietary utilizing no less than the degree of care Receiving Party uses to protect its own similar confidential information but in no case less than a reasonable degree of care; (ii) disclose Confidential Information only to Representatives with a legitimate need to know the Confidential Information in connection with the Purpose, and who are bound in writing by confidentiality obligations at least as strict as those set forth herein; (iii) use Disclosing Party's Confidential Information only as required in connection with the Purpose; and (iv) not reverse engineer, disassemble, decompile or create derivative works using Disclosing Party's Confidential Information. The Receiving Party is and will remain solely and completely liable and responsible for any breach of this Agreement by the Receiving Party, its Representatives, or its Affiliates and will promptly notify the Disclosing Party if it becomes aware of any such breach and use reasonable efforts to minimize the damage from the breach.

The obligations under this Agreement last until the Confidential Information becomes available to the public other than through breach of this Agreement, or longer as provided by applicable law.

3. Information Not Covered By This Agreement. This Agreement imposes no obligation on Receiving Party with respect to Confidential Information that: (i) at the time of disclosure is, or thereafter becomes, generally available to and known by the public through no fault of Receiving Party; (ii) was rightfully in the possession of Receiving Party prior to receiving it pursuant to this Agreement; (iii) at the time of disclosure is, or thereafter becomes, lawfully available from a third party source not subject to a duty of confidentiality to Disclosing Party; or (iv) was or is independently developed without reference to, or use of, any of Disclosing Party's Confidential Information.

4. Compelled Disclosures. If Receiving Party is required by applicable law or regulation or obligated by valid legal process to disclose any of Disclosing Party's Confidential Information, Receiving Party will provide Disclosing Party with prompt notice of the requirement or obligation. Receiving Party will reasonably cooperate in efforts by Disclosing Party to seek an appropriate protective order or other remedy and will consult with Disclosing Party about taking steps to resist or narrow the scope of the requirement or obligation. If a protective order or other remedy is not obtained, Receiving Party will disclose only that portion of the Confidential Information that Receiving Party is legally required to disclose and will exercise reasonable efforts to obtain assurances that the recipient will hold the Confidential Information in confidence.

5. Return of Information. Receiving Party will use commercially reasonable efforts to return or destroy all of Disclosing Party's Confidential Information upon the earlier of Disclosing Party's written request or termination of this Agreement. If applicable, Receiving Party shall certify the destruction of Disclosing Party's Confidential Information in writing to Disclosing Party. Notwithstanding the foregoing, electronic copies of Confidential Information stored in computer system backups that cannot reasonably be isolated for deletion from the backup and that are retrievable only by using special tools need not be returned or destroyed provided that access to the system backup is restricted and the Confidential Information is held in confidence for so long as Receiving Party's obligations under this Agreement continue. Receiving Party may retain one (1) copy of Confidential Information for the sole purpose of complying with regulatory requirements or verifying Receiving Party's compliance with its obligations under this Agreement, provided that the copy is retained in secure storage and held in confidence for so long as Receiving Party's obligations under this Agreement continue.

6. No License Granted. All Confidential Information of Disclosing Party and all rights, title, interest, and ownership therein is and shall remain the sole and exclusive property of the Disclosing Party. Nothing in this Agreement shall constitute an express or implied transfer, conveyance, grant or license, or otherwise confer any right, title, interest, license or option in or to the Disclosing Party's Confidential Information, except the limited right granted to Receiving Party under this Agreement to review the Confidential Information solely in connection with the Purpose. Nothing in this Agreement obligates either party to disclose information to the other party.

7. Disclaimers. Confidential Information is provided "AS IS" without any warranties, express or implied, of any kind. Disclosing Party will have no liability relating to or resulting from any use of Confidential Information or any errors or omissions in the Confidential Information.

8. Remedies. Each party agrees that the other party may suffer irreparable harm for which monetary damages would not be a sufficient remedy for any breach or threatened breach of this Agreement by Receiving Party. Therefore, in addition to all other remedies available at law or in equity, the Disclosing Party is entitled to seek specific performance and injunctive or other equitable relief as a remedy for any breach or threatened breach of this Agreement. The parties waive any requirement for securing or posting any bond or showing actual monetary damages in connection with the claim.

9. Term and Termination. This Agreement shall be effective on the Effective Date. Either party may terminate this Agreement by giving sixty (60) days advance written notice of termination to the other party. Termination of this Agreement will not affect the parties' duties to abide by all terms of this Agreement with respect to Confidential

Information disclosed under this Agreement prior to such termination.

10. Governing Law. This Agreement will be governed by the laws of the State of Delaware without reference to its conflict of law principles.

11. Miscellaneous. This Agreement binds and benefits the parties and their respective successors and assigns. A party's failure or delay to exercise any right, power, or privilege under this Agreement will not operate as a waiver, nor will any single or partial exercise preclude the exercise or further exercise of any other right, power, or privilege under this Agreement. This Agreement may be amended, or its requirements waived, only by a writing signed by the parties. This Agreement may be executed by electronic signatures or in one or more counterparts, each of which will be deemed an original, and all of which, together, will constitute one agreement. This Agreement constitutes the entire agreement between the parties with respect to its subject matter. Any provision of this Agreement that a court of competent jurisdiction determines is invalid will be ineffective only to the extent of the determination without invalidating or affecting the enforceability of the remaining provisions of this Agreement.

IN WITNESS HEREOF, the parties have signed this Agreement through their duly authorized representatives.

Optum Entity	**Primary Counterparty**
Signature:	Signature:
Print Name:	Print Name:
Title:	Title:
Date:	Date:
Agreement Number: Agreement Number	

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Attachment 8. Ad Hoc Reporting Sample

Please see the following pages for our Sample Ad Hoc Reports.

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Optum

Behavioral Health

April 6, 2022

2021 Annual Review



AGENDA

01 Welcome & Program Updates

02 Behavioral Health Trends

03 Behavioral Health Innovations

04 Closing Remarks & Follow-ups

Behavioral Health
Annual Trends & Utilization

Behavioral Health Executive Summary



Utilization

- Utilization of Behavioral Health benefits continues to increase, and is up 12%
- Increase is across demographics (employees and dependents ↑ 10% each) and across diagnostic categories



PMPM

- $21.96 PMPM, down from $23.58
- PMPM *decrease* driven by lower high cost claims, for both Substance Use (↓ 57%) and Mental Health (↓ 42%)



Virtual Care

- 26.6% of claims were paid for virtual care, down from 33.6%
- % of claimants using virtual care is growing, ↑ 13% to 73.3%

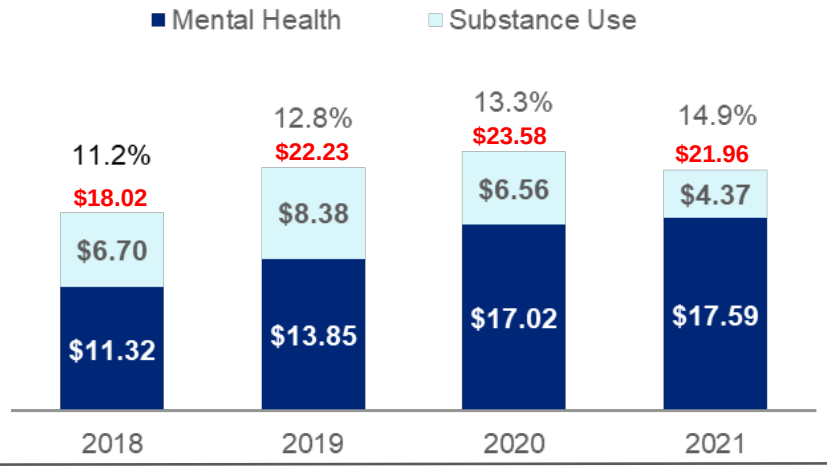
15% % of members with a Behavioral Health claim

-7% Decrease in PMPM

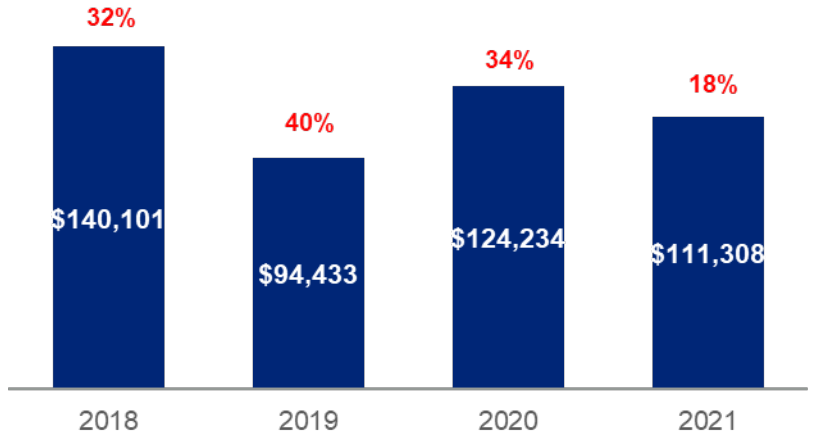
27% % of claims paid for care received virtually

Historical Trends

PMPM Breakout

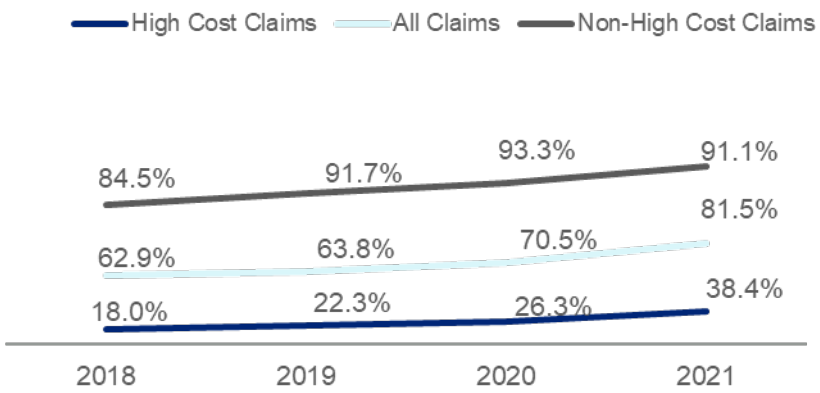


Average Paid per High Cost Claimant



% → % of behavioral health claims

% of Claims $ Paid to In-Network Providers



Trends

- ***Behavioral Health PMPM*** → While the utilization rate has increased, the PMPM is the lowest in 3 years, driven by lower Substance Use paid claims
- ***Substance Use PMPM*** → High cost claimants decreased from 9 to 4, and paid claims for high cost claims decreased $500k
- ***High Cost Claims (avg.)*** → Fewer claimants and higher in-network utilization both Substance Use and Mental Health lowered the average paid
- ***In-Network Utilization*** → Claims paid to in-network providers has steadily increased since 2018, with the exception of Non-High Cost claims, which decreased from 93.3% to 91.1% in 2021.

Behavioral Health Trends

Utilization of Behavioral Health Benefits increased 12% to 14.9%, while the PMPM decreased 7% to $21.96, driven by a 50% increase in Outpatient paid claims and 36% increase in Mental Health paid claims

Accessing Care

14.9% of members had a Behavioral Health claim

12.8% | 13.3% | 8.8%

73.3% of claimants had a virtual care claim, and averaged **8.5** visits/claimant

N/A | 64.7%, 8.2 | N/A

5 claimants have used Talkspace and averaged **7.0** sessions/claimant

N/A | 11; 2.9 | N/A

60 members registered for Sanvello (**153** since inception)

N/A | 93 | N/A

In-network utilization: **90.9%** of claimants, **81.5%** of paid claims

Claimants: 88.9% | 89.8% | 85.6%

Paid claims: 63.8% | 70.5% | 73.7%

PMPM Breakouts

Behavioral Health

$21.96 -7%
149.2 Claimants/1000 +12%

PMPM: $22.23 | $23.58 | $15.90
Claimants/1000: 128.4 | 133.5 | 88.1

Mental Health

$17.59 +3%
143.8 Claimants/1000 +11%

PMPM: $13.85 | $17.03 | $12.46
Claimants/1000: 123.5 | 129.5 | 84.7

Substance Use

$4.37 -33%
5.4 Claimants/1000 +39%

PMPM: $8.38 | $6.56 | $3.44
Claimants/1000: 4.8 | 3.9 | 3.4

2019 data | 2020 data | Norm data

Cost Drivers

Outpatient Services — **$12.36**
Claimants/1000 ▲ 12.3%

$8.40 | $10.54 | $7.29

Dependents — **$9.78**
High cost claims ▼ $1.76

$12.35 | $11.40 | $8.28

Depression — **$5.72**
Allowed Days/Inpatient ▲ 46%

$4.81 | $4.63 | $4.00

Catastrophic Claims — **$3.98**
Substance Use ▼ $2.91

$8.94 | $8.03 | $4.70

ABA Therapy — **$1.07**
Average Hours/Claimant ▼ 40%

$1.73 | $1.35 | $1.04

Behavioral Health Breakout

Behavioral Health

Mental Health

Paid PMPM ↑ 3% from $17.02 to $17.59
High Cost claims ↓ $1.14 to $1.74

80% of Behavioral Spend
Prior → 72%

93% of claims paid in-network
Prior → 91%

10% of PMPM is high cost claims
Prior → 17%

96% of Behavioral claimants
Prior → 97%

Substance Use

Paid PMPM ↓ 33% from $6.56 to $4.37
High Cost claims ↓ $2.91 to $2.24

20% of Behavioral Spend
Prior → 28%

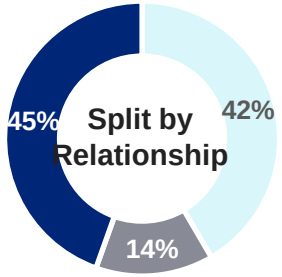
34% of claims paid in-network
Prior → 18%

51% of PMPM is high cost claims
Prior → 79%

5% of Behavioral claimants
Prior → 4%

Diagnostic Trends

Dependents drive claims costs at 45%



42%
Employees
36% | 42% | 33%

Depression
PMPM ↑ 29%

Trauma
PMPM ↑ 34%

Substance Use
PMPM ↓ 55%

14%
Spouses
9% | 10% | 15%

Substance Use
PMPM ↑ 22%

Depression
PMPM ↑ 63%

Bipolar
PMPM ↑ 200%

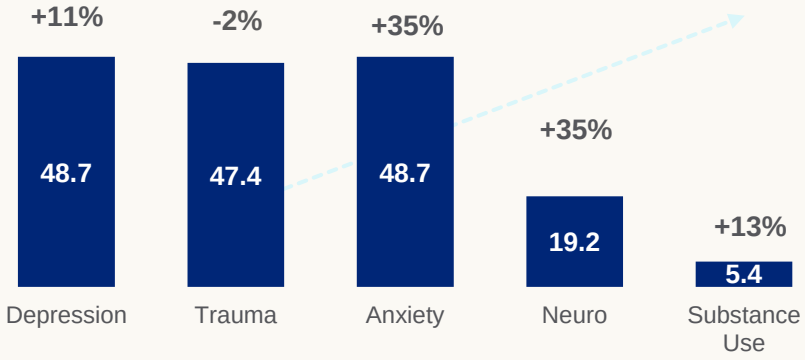
45%
Dependents
56% | 48% | 52%

Depression
PMPM ↑ 9%

Neurodevelopmental
PMPM ↓ 12%

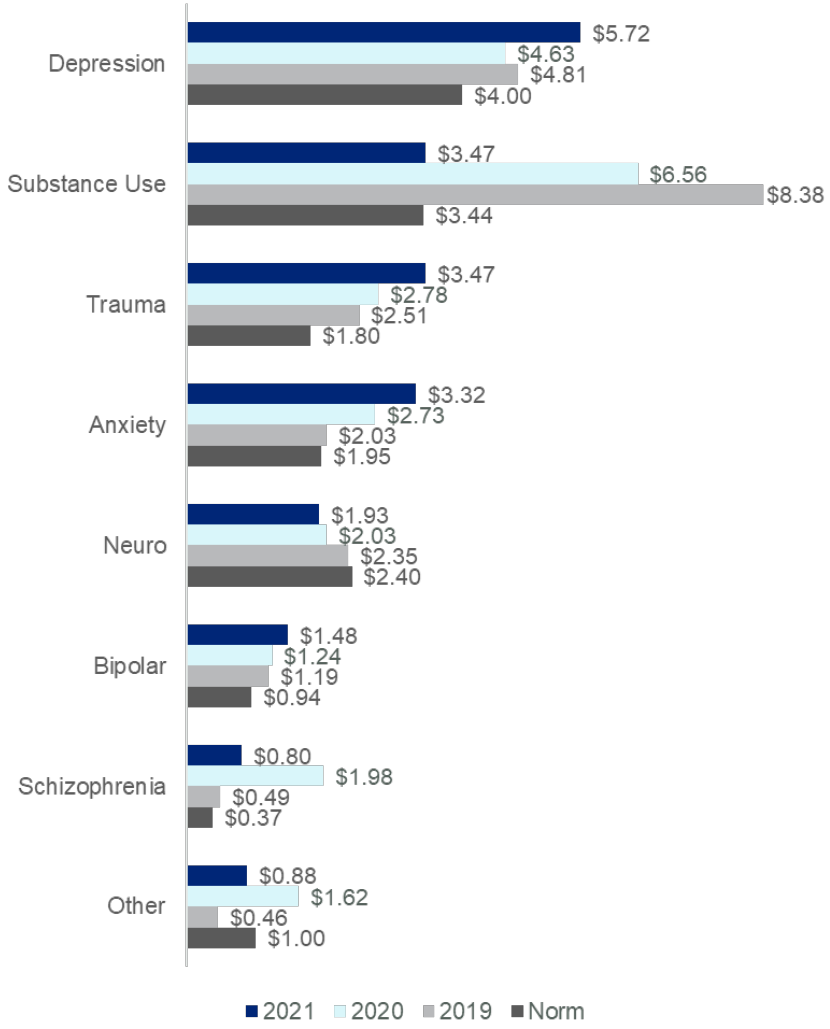
Substance Use
PMPM ↓ 12%

Claimants/1000 has increased across most diagnostic categories, since 2019 . . .



45%
Claimants that are Employees
45% | 42% | 44%

Diagnostic Categories by PMPM



ABA Trends

Claimants

Autism	ABA Therapy
2.3 Claimants/1000	**0.9** Claimants/1000
1.6 | 2.1	0.6 | 0.9 | 0.8
32 Claimants	**12** Claimants
23 | 29 | N/A	9 | 12 | N/A

Financials

Autism	ABA Therapy
$1.16 PMPM	**$1.07** PMPM
$1.75 | $1.39	$1.73 | $1.35 | $1.04
$6,072 Avg paid/claimant	**$14,896** Avg paid/claimant
$12.8k | $8.2k	$32.4k | $19.1k | $16.4k

Key Metrics

14.1
Avg weekly hours authorized
19.8 | 8.1 | 15.0

10
Active authorizations
6 new authorizations
4 have ended services

191.3
Avg hours per claimant
477.7 | 266.8 | 354.1

11
Accessed care virtually
N/A | 8 | N/A

Age Breakouts

	Under 7	7-12	13+
Claimants	6	5	1
Paid Claims	42%	55%	3%
claimants	6 | 6	2 | 5	1 | 1
paid claims	88% | 61%	12% | 26%	0.0% | 13%

Norm is CY2020, paid through February 2021

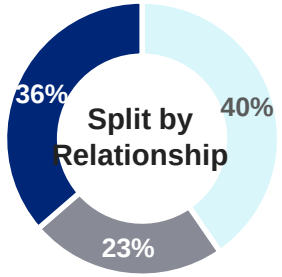
$195k
Autism paid claims
$179k → ABA Therapy
92% of Autism paid claims
5% of Behavioral paid claims
99%, 8% | 96%, 6%

100%
ABA Therapy in-network utilization
100% | 100%

1
ABA Therapy claimants had paid claimants >$50k
3 | 1

Substance Use Trends

Employees drive claims costs at 40%



40% Employees	23% Spouses	36% Dependents
41% | 60% | 45%	2% | 13% | 22%	57% | 27% | 33%
Claimants: 29 | 36	Claimants: 9 | 18	Claimants: 19 | 21
Alcohol 61% of claimants 50% of PMPM	Alcohol 61% of claimants 79% of PMPM	Alcohol 38% of claimants 64% of PMPM
2019: 67%. 50% 2020: 52%, 66%	2019: 36%, 61% 2020: 44%, 71%	2019: 33%, 20% 2020: 37%, 55%

Alcohol is the most prevalent and top cost Substance Use type

Alcohol

$2.71 PMPM
$2.74 | $4.15 | $1.98

12% of paid claims*
13% | 18%

50% of paid claims are for high cost claimants
85% | 75%

Opioids

$0.70 PMPM
$3.49 | $1.70 | $0.72

7% of paid claims*
16% | 3%

53% of paid claims are for high cost claimants
92% | 81%

Where members are going
($10k in paid claims for facility-based care)

14 Members stayed in XX

4 went to non-network providers
- XXXXX

10 went to in-network providers
- XXXXX

7 Members went outside of XX

5 went to ***non-network*** providers
- 2 went to 7 facilities in CA
- 2 went to 5 facilities in FL
- 1 went to 1 facility in MA
- 1 went to 1 facility in TX

3 went to ***in-network*** providers
- 2 went to 2 facilities in FL
- 1 went to 1 facility in MD

Optum

*behavioral health paid claims

High Cost Claims ($50k)

$111,308
Average paid per claimant
- Mental Health → $58.3k
  $45.2k | $54.5k
- Substance Use → $94.1k
  $99.4k | $97.3k

54.5%
Claims paid to in-network providers
- Mental Health → 65.7%
  94.7% | 57.7%
- Substance Use → 17.2%
  3.0% | 8.7%

$469k ($2.80 PMPM)
3 claimants with paid claims >$100k
2 dual diagnosis, 1 mental health

Prior: 6 claimants, $994k, $5.84 PMPM
3 substance use, 2 dual diagnosis, 1 mental health

Utilization

0.43
Claimants/1000
1.1 | 0.78 | 0.56

6
Unique Claimants
16 | 11 | N/A

Financials

$3.98
PMPM
$8.94 | $8.03 | $4.70

$111,308
Avg Paid/Claimant
$94.4k | $124.2k | $101.6k

18.1%
of Paid Claims
40.2% | 34.1% | 29.6%

54.5%
Paid In-Network
22.3% | 45.2% | 46.0%

Demographics

Employee
2 Claimants $1.30 PMPM
Claimants: 4 | 6
PMPM: $2.52 | $3.37 | $0.94

Spouse
1 Claimant $0.44 PMPM
Claimants: 0 | 1
PMPM: $0.00 | $0.66 | $0.54

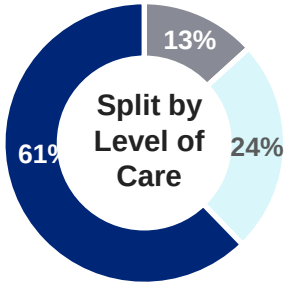
Dependent
3 Claimants $2.25 PMPM
Claimants: 12 | 4
PMPM: $6.42 | $4.01 | $3.23

Diagnostic Mix

Diagnosis	Prior	Current	Change
Substance Use	$5.15	$2.24	-56.5%
Depression	$0.22	$0.64	190.9%
Schizophrenia	$1.55	$0.63	-59.4%
Neurodevelopmental	$0.44	$0.41	-6.8%
Anxiety	$0.00	$0.05	100.0%
Eating Disorders	$0.62	$0.00	-100.0%
All Others	$0.05	$0.01	-81.7%

Level of Care

Office-based paid claims have increased from 42% to 61% of Behavioral Health paid claims since 2019



13% Inpatient
14% | 10% | 14%

- Depression PMPM ↑ 55%
- Bipolar PMPM ↑ 17%
- Substance Use PMPM ↓ 6%

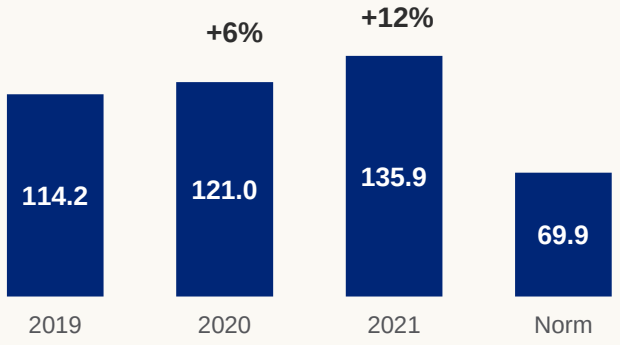
24% Intermediate
41% | 39% | 30%

- Substance Use PMPM ↓ 40%
- Depression PMPM ↑ 16%
- Schizophrenia PMPM ↓ 74%

61% Office-based
42% | 48% | 53%

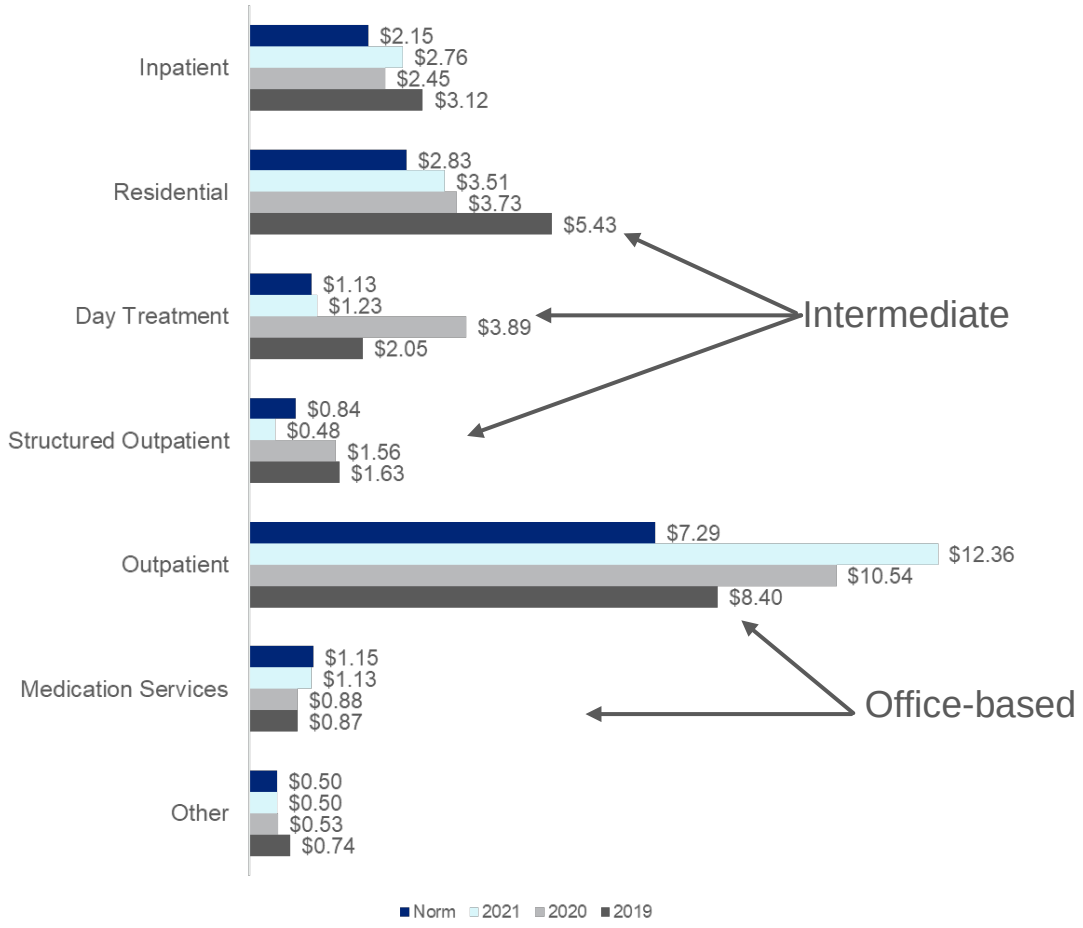
- Depression PMPM ↑ 17%
- Trauma PMPM ↑ 23%
- Anxiety PMPM ↑ 26%

Claimants/1000 has steady increased for Outpatient Services since 2019 . . .



56%
of paid claims are for Outpatient Services
38% | 45%

Level of Care by PMPM



Virtual Care

Financial and Utilization Trends

Data reflects virtual care at all levels of care

1,529
Member accessing Virtual Care
Prior: 1,224

73.3%
% of claimants accessing virtual care
Prior: 64.7%

8.4
Average Virtual Care visits per Claimant
Prior: 8.2

8.8
Average Outpatient Visits per Claimant (w/o ABA)
Prior: $7.92

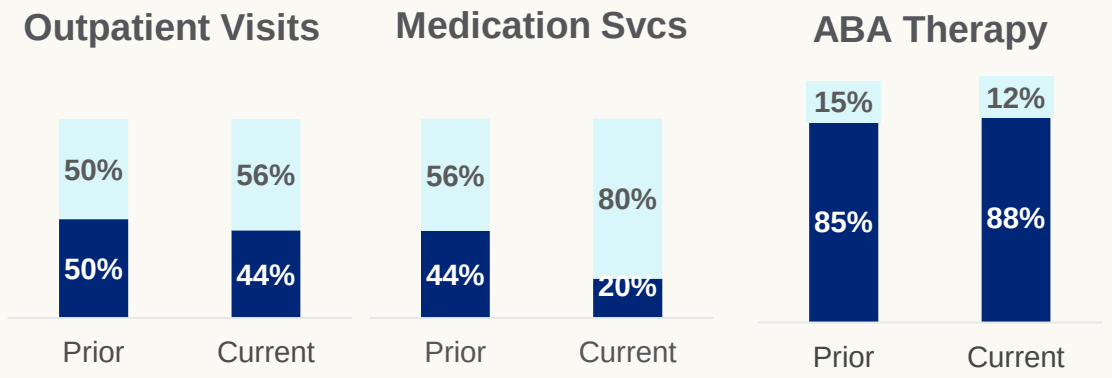
$5.83
Virtual Care PMPM
Prior: $7.92

26.6%
% of Behavioral Health paid claims
Prior: 33.6%

Average Outpatient Visits per Claimant	Virtual		Face-to-Face	
	FC	Norm	FC	Norm
Overall	8.9	10.1	8.1	9.4
Continuously enrolled	9.0	10.3	8.3	9.6
Newly enrolled	8.0	8.0	6.2	7.7
Claims prior to COVID-19	11.7	13.7	10.7	13.9
No claims prior to COVID-19	7.6	8.5	6.9	7.7

Norm → direct ASO accounts

Claims incurred CY 2021, paid through 01/31/2022



Based on allowed units

Sanvello Utilization (since inception)

Members Enrolled
153
Member signed up for Sanvello Premium

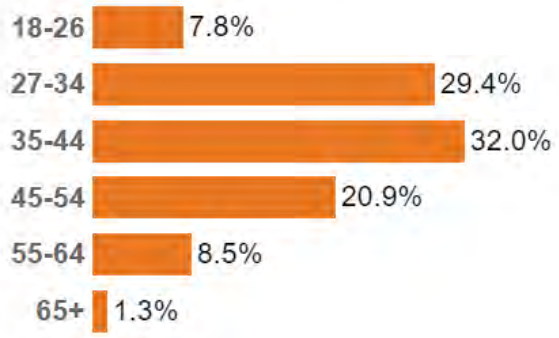
Members in a Guided Journey
57
Member completed at least one Guided Journey module

Members Using Tools
136
Member completed at least one Off-Journey activity

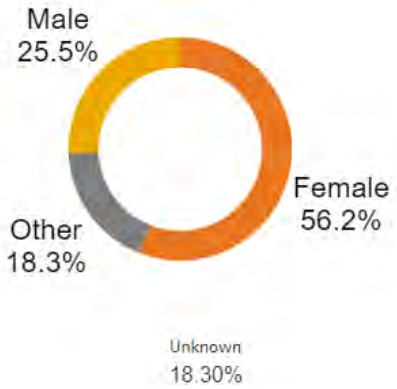
Members Using Assessments
132
Member completed at least one assessment

Member Demographics

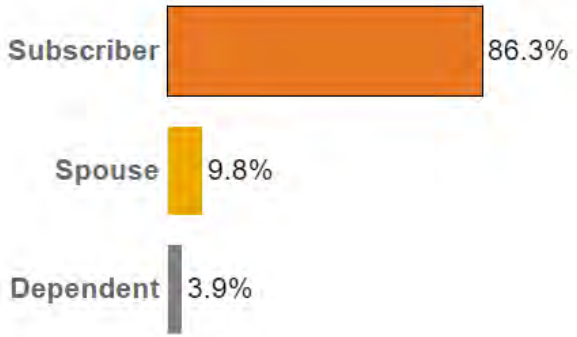
Member Age
Average member age is 40 years



Gender



Relationship



Outcomes

Members Completing DASS-21 Screenings
47

% with Improvement Depression
38%

% with Improvement Anxiety
49%

% with Improvement Stress
57%

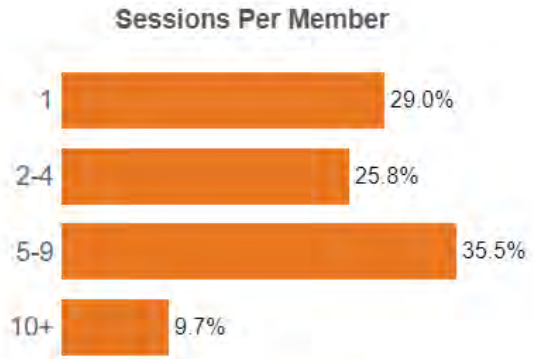
Talk Space Utilization (EAP and Behavioral Health, since inception)

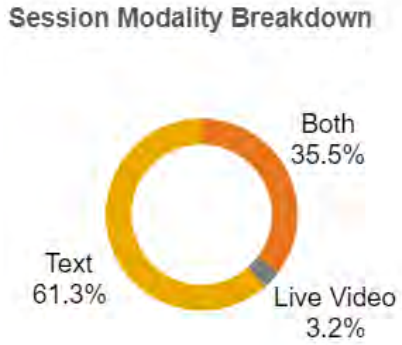
Members Using Talkspace

37

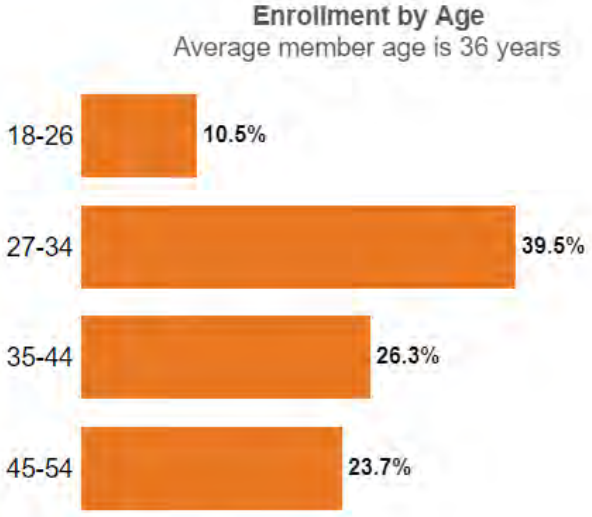
Total Sessions

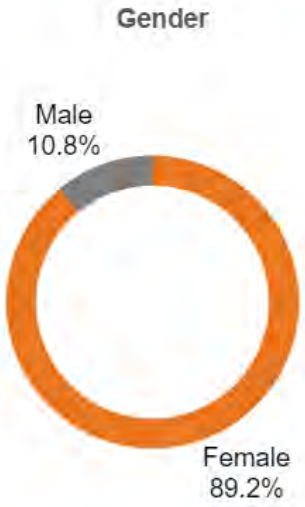
164

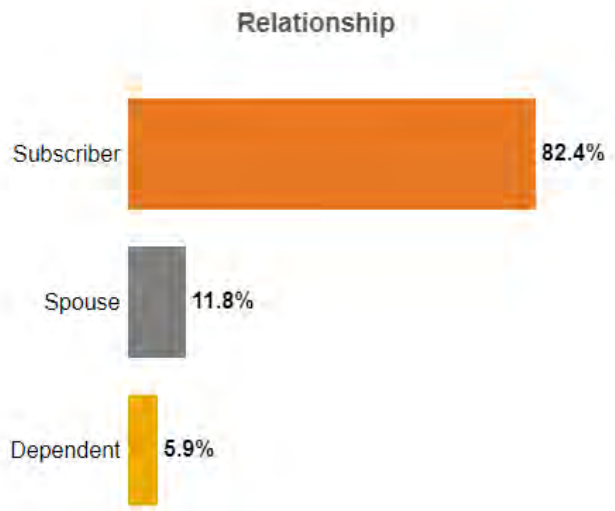




Member Demographics







Outcomes

Members Completing GAD-7 Screenings (Anxiety)

16

% with Improvement

50%

XXX Network Expansion Highlights

Growth by Provider Type
March 2022 over March 2021



Provider Counts
as of March 30, 2022

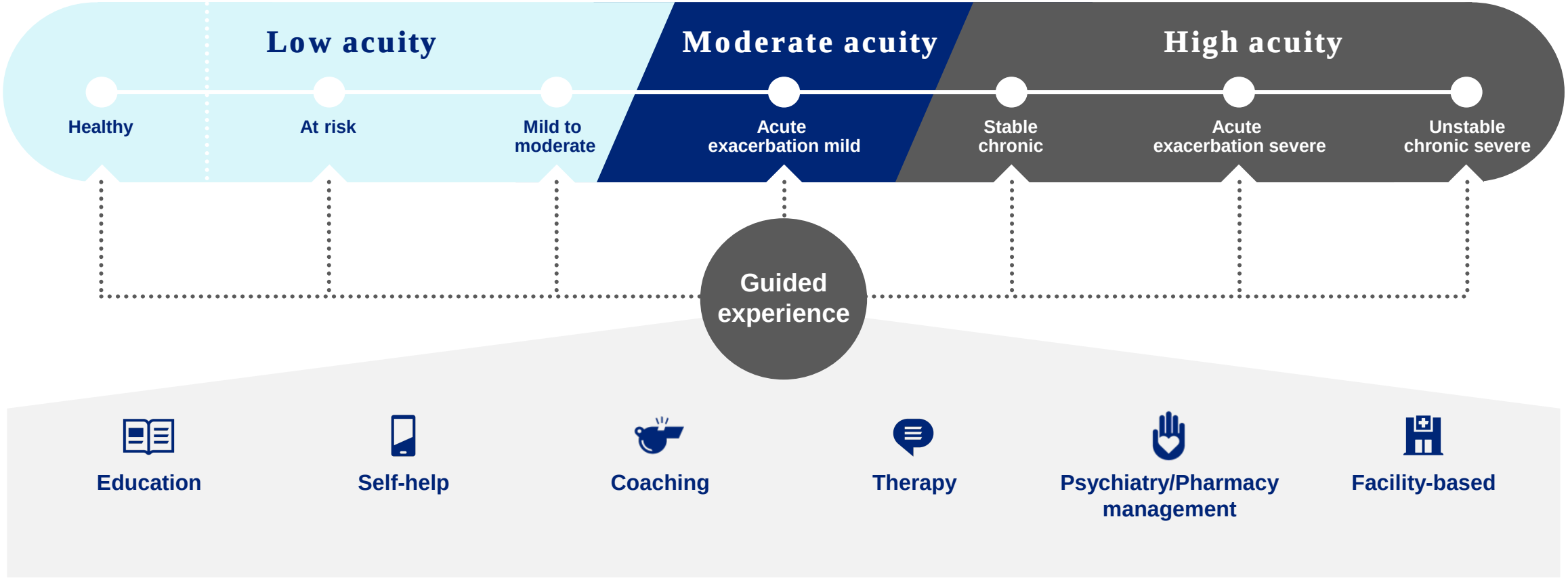
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Key Provider Additions

XXXXXXX

Innovation / Opportunities

Behavioral Solutions Across the Continuum



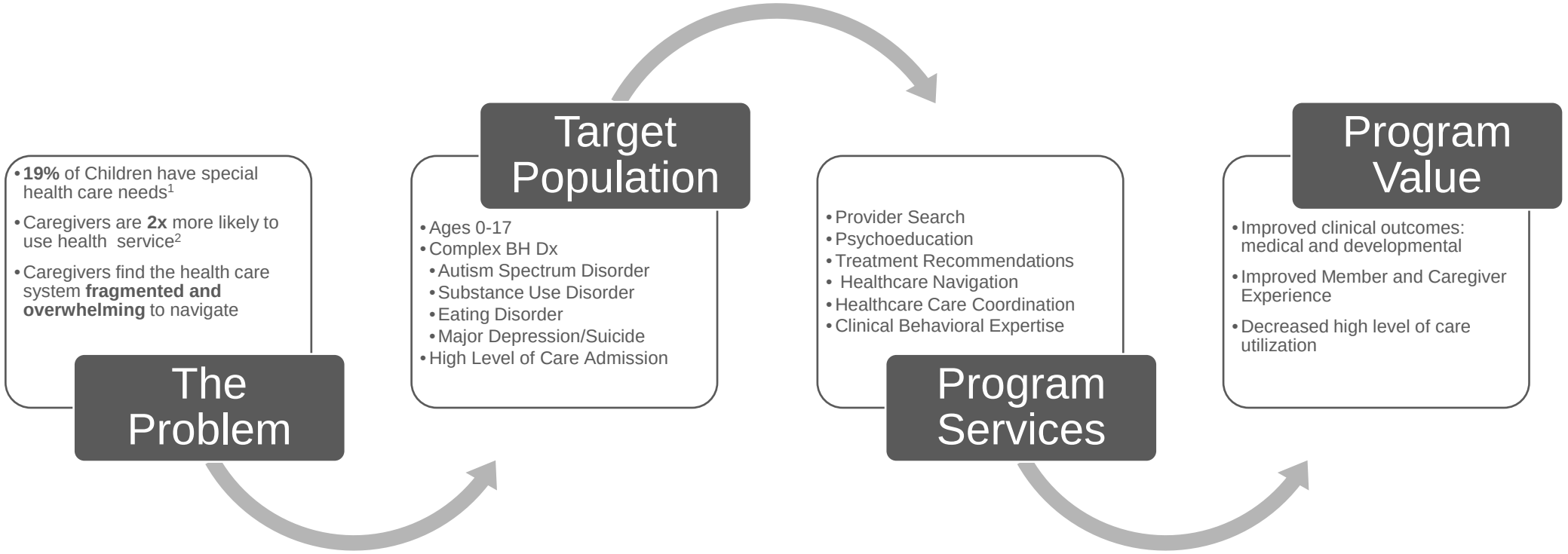
Partnership Opportunities

1 Child Caregiver Support

2 Virtual Behavioral Coaching

Family Support Program

Family Support Program (FSP) provides tailored education, support, referrals and provider/specialist searches so caregivers can make educated and confident decisions for their child and their family



Child Caregiver Support

Child Caregiver Support Digital Platform



Personal Profile

Recommended content is personalized based on child's profile setup



Consultative Support

3 annual hours of BCBA support available 24/7 virtually or telephonically.



Planning and Progress

Progress tracking against plan and/or child's milestones

Checklists and resources can be printed

Key Differentiators

- 2,000+ videos that include caregiver and child facing for all grade levels
- Solution provides 24/7 virtual access to Board-Certified Behavioral Analysis and a robust e-learning and education system
- Fast and easy client implementation
- User does not need to meet eligibility or diagnosis criteria to gain access to Rethink
- Ability to engage individuals earlier before claim recognition or diagnosis
- BCBAs specialize in Individualized Education Program (IEP) support/expertise*

BCBA

A board-certified behavior analyst (BCBA) is a healthcare professional who studies the behavior of children and adults and creates plans to improve or change problematic behaviors. They often work with people who have developmental disabilities, brain injuries or emotional control, social or behavioral issues.

The Rethink BCBA's previously worked in the school systems as district BCBAs – very experienced but cannot virtually participate in actual school meetings with parents and usually can't replace an attorney. They review the IEP and help parents understand gaps and agenda items for their meetings.

Virtual Behavioral Coaching

Providing evidence-based support for those managing stress, anxiety or depression

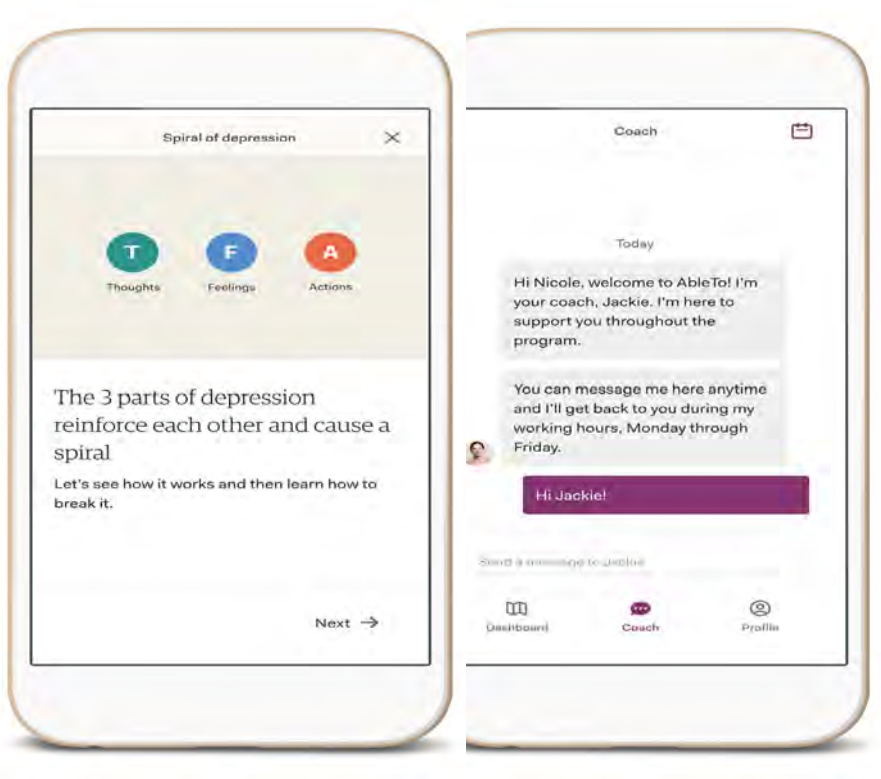
The self-paced virtual behavioral coaching program offers:

Structured tools and activities

- Weekly cognitive behavioral therapy (CBT) delivered through a series of progressive modules
- 24/7 access via smartphone, tablet or computer
- Ongoing access to resiliency tools

Dedicated coach support

- Trained in motivational interviewing, coaches focus on individual goals
- Unlimited 1-on-1 coaching via text, phone and video



This is AbleTo's Digital+ program.*
* AbleTo is majority owned by OptumHealth Holdings, LLC, a UnitedHealthcare affiliate.

Improving Network Diversification through Cultural Competency

Goal:

Our goal is to raise cultural sensitivity within the XXX provider network to better serve our membership at large.

We will start by providing training around how to serve some of our most underserved and/or members who distrust the health care system. We'll build out a more comprehensive training program over time.

The idea is to start the journey, not consider this completion or a checkmark.

Today



Unconscious Bias Training as Foundation

7 out of 10 Black Americans say they're treated unfairly by the health care system and **55%** say they distrust it.

Oct 2020

8% of all LGBTQ people, 22% of transgender people, and 14% of those who have experienced discrimination in the past year – avoided or postponed medical care because of discrimination from health care staff.

Specialized Training Deep Dives



Specialized training to better serve the African American Community

Specialized training to better serve the LGBTQ+ Community



End Goal

Offer evidence-based comprehensive cultural competency training to all internal and network behavioral health specialists to advance health equity for all members, expanding upon the 2021 efforts

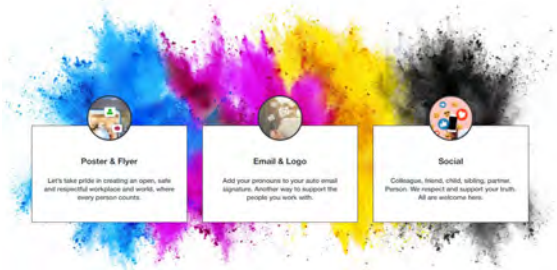
Supporting our LGBTQ+ Members and Communities

Supporting our LGBTQ+ members and communities 365 days a year: [pride365plus.com](), [Sophia's Story]()

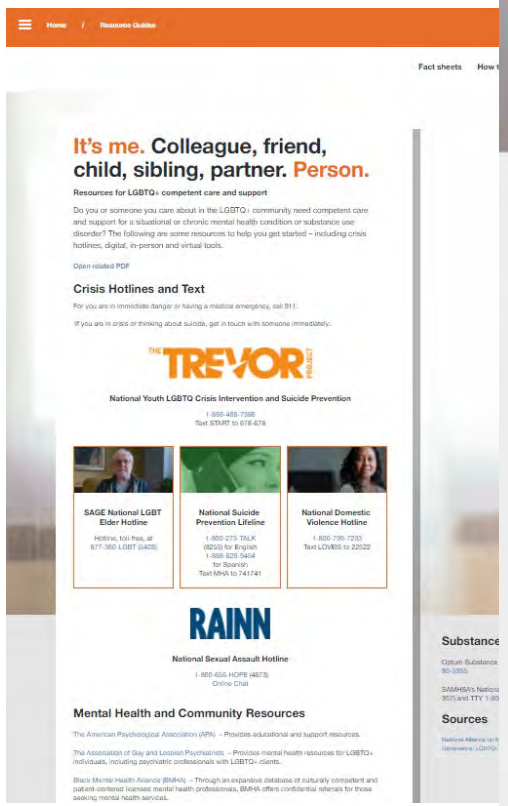


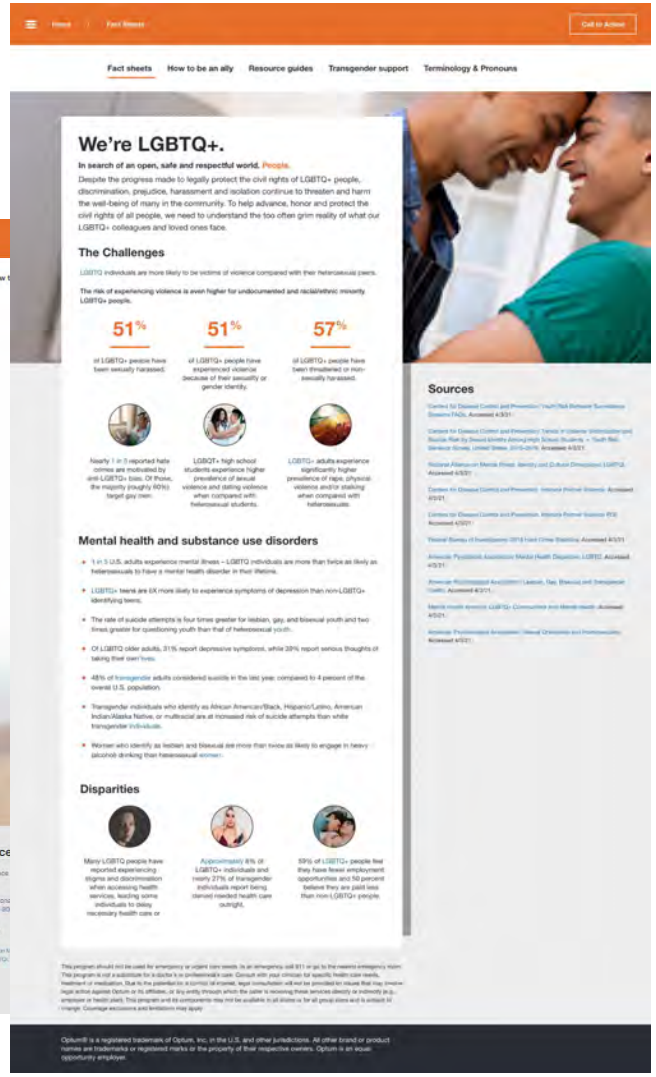
Pride 365+ Toolkit Materials



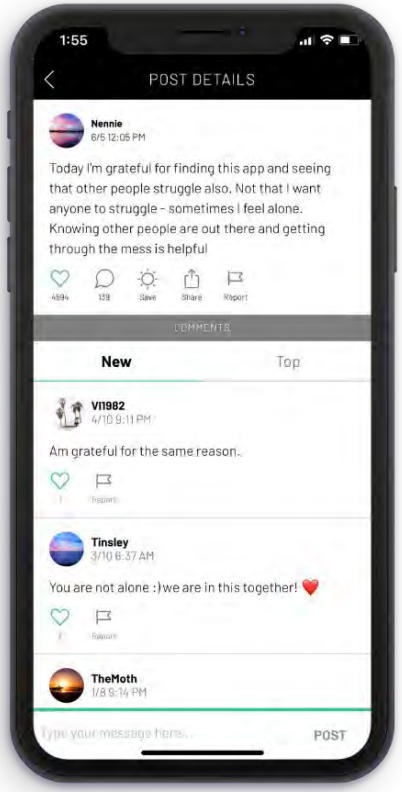


Pride365+





Sanvello PRIDE Community [https://sanvello.app.link/PRIDE365]()





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Attachment 9. Behavioral Health Member Satisfaction Survey

Please see the following pages for our Satisfaction Survey results.

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100758 BH CNPS – Q1 2022

OBJECTIVES

1. Establish a benchmark measure for NPS and other secondary loyalty measures
2. Identify key levers to improve member experience and retention
3. Measure member satisfaction on key drivers of positive experience
4. Identify strengths and weaknesses
5. Identify product, process, or service improvements to enhance member satisfaction

SAMPLE CRITERIA

Sample includes members who meet the following criteria

- Have had a date of service within the past 90 days
- Coverage/eligibility has not expired as of the date sample is pulled
- Has a valid birth date and ZIP code for authentication purposes
- Has a valid phone from either Linx, EDW, or Pacific East
- Minors = 2-12
- Adults = 18-80

Records flagged as Expansion Member

- Out-of-network
- Denied claim
- In-patient/structured/residential/day treatment

Exclusions

- Designated customers/accounts
- Do Not Call list
- UHG employees
- Those with institutional/non-private phones
- Ages 12-17, less than age 2, greater than age 80

INTRODUCTION

IF BEH_MBR_STS=ADULT: Hello, may I please speak with [Insert FirstName, LastName from Sample]?
IF BEH_MBR_STS=YOUTH: Hello may I please speak with the parent or guardian of [Insert FirstName, LastName from Sample]?

IF BUSINESS_MARKET_CODE≠C&S

I'm [Insert Interviewer Name] from Burke, a research company, conducting a survey regarding your experience with your ***[IF BEH_MBR_STS=YOUTH: child's]*** health plan, ***[BEH _INTRO_NAME].*** I want to assure you that I have not been given any of your [***IF BEH_MBR_STS=YOUTH: child's]*** personal health information.

This survey should take about 10-12 minutes to complete and your answers will be kept confidential. Are you willing to continue with this survey at this time?

NSPW

1	Continue	
2	Continue with Language Line	
3	Refused	THANK AND TERM
4	No Such Person	THANK AND TERM
5	Name on sample can't speak on phone	THANK AND TERM
7	Respondent prefers caregiver to complete survey on their behalf	
8	Refused to take the survey because of COVID-19 concerns	THANK AND TERM
9	Refused as no longer employed or covered by insurance	THANK AND TERM

Programmer Note: If #2 Language Line selected, only show questions in the Screener, the Loyalty Section & D7/D8 before closing survey. Questions noted with * are Language Line questions.

IF NSPW=7 (Caregiver)
Throughout the survey, please answer all questions based on their experience at their last visit.

PROGRAMMER SET

1	Cell Phone
2	Landline

IF CELL PHONE RECORD, CONTINUE WITH CP1. OTHERWISE, SKIP TO AUTHENTICATION QUESTION

***CP1**

It appears that you are on your cellphone. Can you safely continue our call? For example, you're not currently driving.

DO NOT READ LIST

01	Yes/safe	
02	No	Set up call back time and confirm call back number
98	Refuse	Thank and term
99	Don't Know	Thank and term

AUTHENTICATION

***Auth2**

IF BEH_MBR_STS=YOUTH
For your protection and privacy, I want to make sure I am speaking with the right person. Can you please provide your first and last name? Also, can you provide your full address and your child's date of birth (month, day and year)?

IF BEH_MBR_STS=ADULT
For your protection and privacy, I want to make sure I am speaking with the right person. Can you please provide your full address and date of birth (month, day and year)?

Interviewer: Respondent must provide information. Do not read information to them. If respondent is unwilling to provide this, thank and terminate. If values are incorrect, thank and terminate.

DO NOT ALLOW INTERVIEWER TO EDIT FIELDS

IF BEH_MBR_STS=YOUTH, PIPE IN:

- *PARENT_1_FIRST_NAME*
- *PARENT_1_LAST_NAME*
- *PARENT_1_ADDRESS_1*
- *PARENT_1_ADDRESS_2*
- *PARENT_1_CITY*
- *PARENT_1_STATE*
- *PARENT_1_ZIP*
- *PARENT_2_FIRST_NAME*
- *PARENT_2_LAST_NAME*
- *PARENT_2_ADDRESS_1*
- *PARENT_2_ADDRESS_2*
- *PARENT_2_CITY*
- *PARENT_2_STATE*
- *PARENT_2_ZIP*
- *DATE_OF_BIRTH*

IF BEH_MBR_STT=ADULT, PIPE IN:

- *MEMBER_ADDRESS_1*
- *MEMBER_ADDRESS_2*
- *MEMBER_CITY*
- *STATE*
- *ZIP*
- *DATE_OF_BIRTH*

1 Information verified. CONTINUE
2 Info incorrect THANK AND TERM
98 Refuse THANK AND TERM

SCREENING

IF NON-C&S
This survey will focus on mental health and substance use services, known as behavioral health services that ***[BEH_ENTITY_NAME]*** provides. ***[IF ENTITY_MATCH = 0: Going forward I will refer to them as BEH_SHORT_ENTITY_NAME].***

IF NEEDED: If a respondent asks about Behavioral Health Services: Behavioral Health Services can include services like counseling or therapy, substance-use services, and medications for behavioral health issues such as anxiety and depression.
IF NEEDED:** If a respondent asks if answers are linked directly to them say: "Your responses will help ***[BEH_SHORT_ENTITY_NAME/BEH_ENTITY_NAME] better understand areas for improvement based on your responses. In order to analyze the results, your responses are tied to the services you received."

Interacted with Behavioral Health
IF BEH_MBR_STS=ADULT, USE "Have you". IF BEH_MBR_STS=CHILD, USE "Has your child, (Child's Name)".
***S1f**
[Have you/Has your child, (Child's Name)] received behavioral health services ***{Don't Show If BH_PILOT_IND = Yes AND [BH_OON_FLAG = YES OR BH_DENIED_FLAG = YES]: through [BEH_SHORT_ENTITY_NAME/BEH_ENTITY_NAME]}*** in the past 90 days?

DO NOT READ LIST
1 Yes
2 No Thank and term

98	Refuse	Thank and term
99	Don't Know	Thank and term

LOYALTY SECTION

IF BUSINESS_MARKET_CODE≠C&S
*I am going to start out by asking you a few questions about your overall experience with ***[BEH_SHORT_ENTITY_NAME / BEH_ENTITY_NAME]***.
*Your feedback may be recorded to make sure we are doing a good job. There will be opportunities to provide comments. Please wait to say your comments until those questions.

Overall Satisfaction

IF BUSINESS_MARKET_CODE≠C&S. TERM IF 98, 99.
***RRP3**
On a scale of 0 to 10, where 0 is very dissatisfied and 10 is very satisfied, how would you rate your overall satisfaction with ***[BEH_SHORT_ENTITY_NAME /BEH_ENTITY_NAME]***?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99. Thank and Term if "Refuse" or "Don't Know" is selected.
_____ Range (0-10, Refuse = 98, Don't Know = 99)

Likely to Recommend

IF BUSINESS_MARKET_CODE≠C&S. TERM IF 98, 99.
***RRP4**
How likely are you to recommend ***[BEH_SHORT_ENTITY_NAME /BEH_ENTITY_NAME]*** to others on a scale of 0 to 10, where 0 is not at all likely and 10 is extremely likely?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.
_____ Range (0-10, Refuse = 98, Don't Know = 99)

PROGRAMMER SET
NPS1 (Based off of RRP4)

Promoter	RRP4 = 9,10
Passive	RRP4 = 7,8
Detractor	RRP4 = 0,1,2,3,4,5,6

PROGRAMMER SET
NPS2 (Based off of NPS1)

_1	Promoter
_0	Passive
Negative1	Detractor

Likelihood to Recommend Open End

IF BUSINESS_MARKET_CODE≠C&S AND IF PROMOTER
***RRP4c**
Can you tell me a few things that you think ***ENTITY*** does well in regards to your Behavioral Health services?
(Open End)

IF BUSINESS_MARKET_CODE≠C&S AND IF PASSIVE OR DETRACTOR
***Q20**
What one suggestion would you make to improve your Behavioral Health experience with ***ENTITY***?
(Open End)

Likelihood of Using Again In The Future

IF BUSINESS_MARKET_CODE≠C&S

***Q135**

Please use a scale from 0 to 10 where 0 means you would definitely not use the service again and 10 means you would definitely use the service again. How likely is it that you would use this service if the need were to arise again and you had a choice?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

CORE ATTRIBUTE SECTION

IF BUSINESS_MARKET_CODE≠C&S
On a scale of 0 to 10, where 0 means Very Dissatisfied and 10 means Very Satisfied, how would you rate your satisfaction with the services *[you/your child]* received from *[BEH_SHORT_ENTITY_NAME/ BEH_ENTITY_NAME]* on...?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.
Interviewer: Please read question text. Read scale initially and as needed throughout attributes.

IF NEEDED: If a respondent asks about alternatives to Behavioral Health Services:
Alternatives to behavioral health services or treatment could include services from resources in your community, referrals to other professionals, educational materials, etc.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

ASK IF BUSINESS_MARKET_CODE≠C&S. RANDOMIZE ATTRIBUTES.
Q5a Showing they care about ***[your/your child's]*** behavioral health needs
Q7a Making it simple to understand
[your/your child's] behavioral health benefits
Q11 Understanding you, your situation and your needs
BH38 Your plan providing coverage for the behavioral health services ***[you need/your child needs]***

SEGMENT SPECIFIC QUESTIONS – OPTUM BEHAVIORAL HEALTH

IF BUSINESS_MARKET_CODE≠C&S
For the following questions, we are going to ask you about your most recent experience with support from ***[BEH_SHORT_ENTITY_NAME/ BEH_ENTITY_NAME]*** when accessing behavioral health services.

Optum Behavioral Health Interaction

IF BUSINESS_MARKET_CODE≠C&S

BH41

Did you communicate with ***[BEH_SHORT_ENTITY_NAME/ BEH_ENTITY_NAME]*** regarding behavioral health services in the last 90 days through..?

READ LIST. SELECT ALL THAT APPLY.

1	A phone call	
2	The website	
3	None of the above	DO NOT READ; MARK IF CALL OR WEBSITE NOT SELECTED
98	Refuse	DO NOT READ
99	Don't Know	DO NOT READ

Had an authorization

BH42

In the past 90 days, have you received an authorization for services? DO NOT READ LIST

1	Yes
2	No
98	Refuse
99	Don't Know

Experience with Finding Clinician, Getting Referrals or Authorizations

IF BUSINESS_MARKET_CODE≠C&S

When thinking about the support you received from ***[BEH_SHORT_ENTITY_NAME/ BEH_ENTITY_NAME]***, how would you rate your experience on a scale of 0 to 10, where 0 is Very Dissatisfied and 10 is Very Satisfied, on…?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

Ask IF BH41=1 or 2 OR BH42=1
BH2b
The helpfulness of the information and resources you received
Ask IF BH41=1 OR BH42=1
BH3b
Having your calls answered in a reasonable time
Ask IF BH41=1 or 2 OR BH42=1
BH4b
The helpfulness of the staff
Ask IF BH41 =1 or 2
BH43
The accuracy of any provider information you received
Ask IF BH42=1
BH5b
The process of getting authorizations

Received Claim Support

IF BUSINESS_MARKET_CODE≠C&S
BH44
In the past 90 days, have you called into customer service or used the website for a behavioral health claim question?
DO NOT READ LIST 1 Yes 2 No 98 Refuse 99 Don't Know

Help Received on Claim

ASK IF BH44=YES AND BUSINESS_MARKET_CODE≠C&S
BH29b
On a scale of 0 to 10, please rate your overall satisfaction with the claims process.
Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99. If needed, remind respondent that 0 means Very Dissatisfied and 10 means Very Satisfied. _____ Range (0-10, Refuse = 98, Don't Know = 99)

IF BUSINESS_MARKET_CODE≠C&S
For the following questions, we are going to ask you about your most recent experiences with getting an appointment with a behavioral health clinician.

Satisfaction with Time to Appointment

IF BUSINESS_MARKET_CODE≠C&S
BH7b
On a scale of 0 to 10, rate your satisfaction with the amount of time it took to get an appointment with a behavioral health clinician.
Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99. If needed, remind Respondent that 0 means Very Dissatisfied and 10 means Very Satisfied.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

Time to Get Appointment when Urgent Need

IF BUSINESS_MARKET_CODE≠C&S

BH9

When ***[you/your child]*** needed to see someone right away, how soon was an appointment available? Within…

READ LIST.

1 1 Day or Less
2 2 Days
3 3-4 Days
4 5 or More Days
97 Not Applicable Do Not Read
98 Refuse Do Not Read
99 Don't Know Do Not Read

Time to Get Appointment when Non Urgent Need

IF BUSINESS_MARKET_CODE≠C&S

BH10

When *[your/your child's]* need for counseling or treatment was NOT urgent, how soon was an appointment available? Within…

READ LIST.

1 5 Days or Less
2 6-10 Days
3 11-15 Days
4 16 or More Days
97 Not Applicable Do Not Read
98 Refuse Do Not Read
99 Don't Know Do Not Read

Experience with Behavioral Health Clinicians

IF BUSINESS_MARKET_CODE≠C&S

On a scale of 0 to 10, where 0 is Very Dissatisfied and 10 is Very Satisfied, please rate your experience finding a behavioral health clinician, on …

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

IF BUSINESS_MARKET_CODE≠C&S

BH47

Finding a clinician who was a good fit for ***[you/your child]***

ASK ONLY IF BUSINESS_MARKET_CODE≠C&S

BH12b

Locating a network clinician whose office was convenient to your home or office

IF BUSINESS_MARKET_CODE≠C&S

BH13b

Finding care that was respectful of your language, cultural and ethnic needs

IF BUSINESS_MARKET_CODE≠C&S

BH14b

The overall experience of finding an available clinician

Overall Satisfaction with BH Clinician

IF BUSINESS_MARKET_CODE≠C&S

BH45

Now, please think about ***[your/your child's]*** experience with behavioral health counseling or treatment in the past 90 days. Using a scale of 0 to 10, please rate your Overall experience with ***[your/their]*** behavioral health clinician.

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99. If needed, remind Respondent that 0 means Very Dissatisfied and 10 means Very Satisfied.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

IF BUSINESS_MARKET_CODE≠C&S

Using a scale of 0 to 10, please rate your experience, on…?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99. If needed, remind Respondent that 0 means Very Dissatisfied and 10 means Very Satisfied.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

IF BUSINESS_MARKET_CODE≠C&S

BH15b

The communication among ***[your/your child's]*** behavioral health clinician, medical primary care physician, and other clinicians involved in ***[your/their]*** care was sufficient

IF BUSINESS_MARKET_CODE≠C&S

BH16b

Receiving treatment from your clinicians that helped ***[you/your child]*** better manage ***[your/their]*** problems

IF BUSINESS_MARKET_CODE≠C&S AND TELEHEALTH FLAG IN SAMPLE IS "YES".

BH63 On a scale of 0 to 10, where 0 is very dissatisfied and 10 is very satisfied, how would you rate *[your/your child's]* overall satisfaction with *[your/their]* most recent remote or video visit with a provider?

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

IF BUSINESS_MARKET_CODE≠C&S AND BEH_MBR_STS=ADULT

There are many tools available to support Behavioral Health needs. For each of the following, please tell me how interested you would be in using this as part of your treatment plan if it were available through your insurance plan. Please use 10 for Very interested and 0 for Not at all interested. If you are already using the tool, please use 10 for Will definitely continue using and 0 for Will definitely not continue using.

BH64_1 Self-help solutions, like education and guidance on the Live and Work Well website
BH64_2 Digital or app-based solutions that provide therapy and meditation strategies, like Sanvello
BH64_3 Coaching, like AbleTo or an in-the-moment emotional support line

Interviewer: Put answer on scale of 0 to 10 in box. If "Refuse", enter 98. If "Don't Know", enter 99.

_____ Range (0-10, Refuse = 98, Don't Know = 99)

DEMOGRAPHICS

Automark Age based on date of birth.

D1 Age

1 UNDER 18
2 18-24
3 25-34
4 35-44
5 45-54
6 55-64
7 65-74
8 75-84
9 85-94
10 95 OR OLDER

OPTUM FOLLOW UP

ASK IF RRP4 = 0-6 AND IF BUSINESS_MARKET_CODE≠C&S
***D7**
[BEH_SHORT_ENTITY_NAME/ BEH_ENTITY_NAME] may want to follow-up with some respondents to gain more insights into the results of this survey. Would it be okay to share your contact information with them?

1. Yes
2. No

ASK IF D7 = 1
Programming note: Pipe in phone number from sample
***D8**
Can we make sure we have your right phone number?

_____ Enter Phone Number in xxx-xxx-xxxx

CLOSING

IF BUSINESS_MARKET_CODE≠C&S
Those are all the questions that I have for you today. On behalf of ***[BEH_SHORT_ENTITY_NAME/ BEH_ENTITY_NAME]*** I want to thank you for your participation; your input is very much appreciated.

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Attachment 10. MHSU Provider Network Reports for MHSU Facilities and MHSU Practitioners (Attachment 23)

Please see our USB for our MHSU Provider Network Reports for MHSU Facilities and MHSU Practitioners.

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Attachment 11. GeoAccess Network and GeoAccess Accessibility Summaries

Please see our Geo network reports (in electronic searchable PDF only) and the GeoAccess Accessibility Summaries (in both searchable PDF and hard copy).

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Geo Network Reports

Please see our USB for our Geo network reports (in electronic searchable PDF only).

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GeoAccess Accessibility Summaries

Please see the following pages for our GeoAccess Accessibility Summaries (in both searchable PDF and hard copy).

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Attachment 12. Provider Network Summary Worksheet (Attachment 32)

Please see the following pages for our Provider Network Summary Worksheet (Attachment 32).

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Instructions:

(A) Include facility or practitioner type based on the following specifications and categorizations from Attachment 23:

1) Psychiatrists should only include Licensed Psychiatrists (PSYI)

2) Psychologists should only include Licensed Psychologists (PSYCH)

3) Master's Level Clinicians can include Licensed Clinical Social Workers with and without a "R" designation in New York and Master's level clinicians with the highest level of licensure in other states (MLC)

4) Inpatient, ALOC, and Outpatient Clinic Groups - Mental Health should include facilities that provide facility-based Mental Health Services (MHF, MHSAF, MH - OCG)

5) Inpatient, ALOC, and Outpatient Clinic Groups - Substance Abuse should include facilities that provide facility-based Substance Abuse services (SAF, MHSAF, SA - OCG)

6) Facilities providing Services for both Mental Health and Substance Use should be included in both "Inpatient, ALOC, and Outpatient Clinic Groups - Mental Health" and "Inpatient, ALOC, and Outpatient Clinic Groups - Substance Abuse"

7) Provider types PA, RNCS, RNP, CBA, ABAA, ABA, and MHSUP should not be included in the summary worksheet

(B) The Total number of enrollees with access and without access should be calculated as weighted average with each of the provider categories weighted equally. For example, the number of enrollees with and without access to Psychiatrists should be divided by five.

(C) The Offeror's proposed MHSU provider network access %'s must equal the Program's minimum mandatory access requirements, set forth in Section 3.10 of this RFP, for each of the three categories in order for their proposal to be evaluated.

Note: All Enrollees must be counted in calculating whether the Offeror meets the MHSU provider Network access pre-requisites. No Enrollee may be excluded even if there is no provider located within the minimum mandatory access requirements.

Attachment 13. Comparison of Utilized Provider File and Offeror's Proposed Provider Network (Attachment 33)

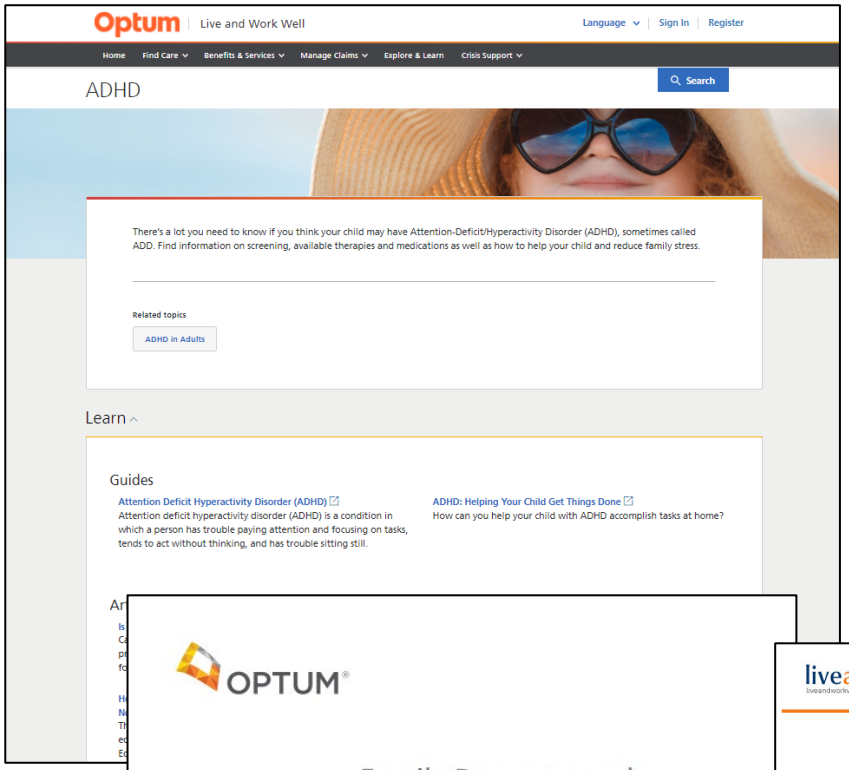
Please see the following pages for our Comparison of Utilized Provider File and Offeror's Proposed Provider Network.

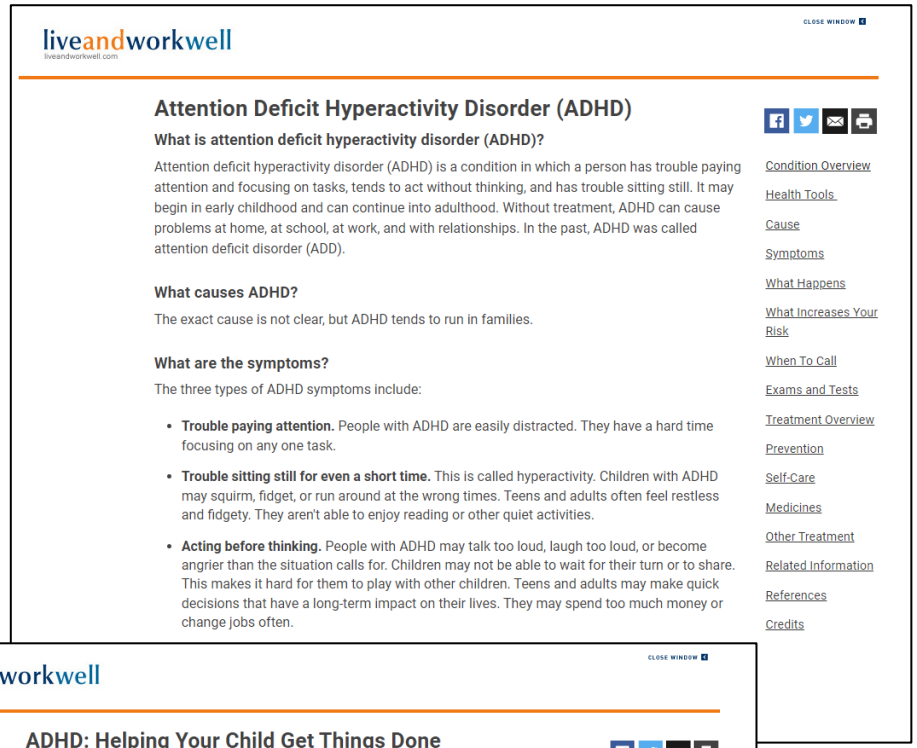
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Attachment 14. ADHD Resources Example

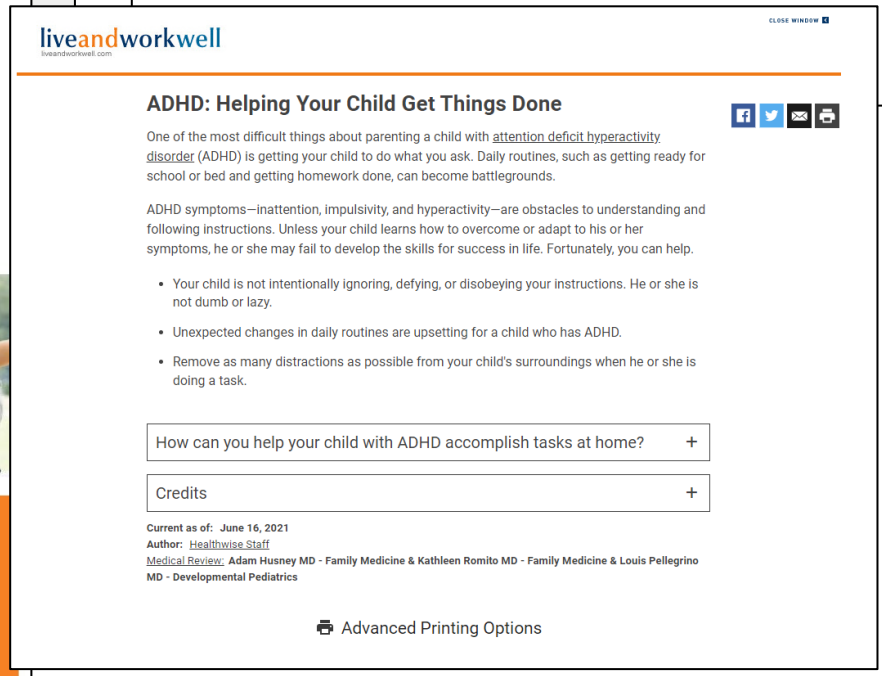
Please see the following pages for our ADHD Resources Example.

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Optum | Live and Work Well
Language | Sign In | Register
Home Find Care Benefits & Services Manage Claims Explore & Learn Crisis Support
ADHD
Search
There's a lot you need to know if you think your child may have Attention-Deficit/Hyperactivity Disorder (ADHD), sometimes called ADD. Find information on screening, available therapies and medications as well as how to help your child and reduce family stress.
Related topics
ADHD in Adults
Learn
Guides
Attention Deficit Hyperactivity Disorder (ADHD)
Attention deficit hyperactivity disorder (ADHD) is a condition in which a person has trouble paying attention and focusing on tasks, tends to act without thinking, and has trouble sitting still.
ADHD: Helping Your Child Get Things Done
How can you help your child with ADHD accomplish tasks at home?


liveandworkwell
liveandworkwell.com
CLOSE WINDOW
Attention Deficit Hyperactivity Disorder (ADHD)
What is attention deficit hyperactivity disorder (ADHD)?
Attention deficit hyperactivity disorder (ADHD) is a condition in which a person has trouble paying attention and focusing on tasks, tends to act without thinking, and has trouble sitting still. It may begin in early childhood and can continue into adulthood. Without treatment, ADHD can cause problems at home, at school, at work, and with relationships. In the past, ADHD was called attention deficit disorder (ADD).
What causes ADHD?
The exact cause is not clear, but ADHD tends to run in families.
What are the symptoms?
The three types of ADHD symptoms include:
Trouble paying attention. People with ADHD are easily distracted. They have a hard time focusing on any one task.
Trouble sitting still for even a short time. This is called hyperactivity. Children with ADHD may squirm, fidget, or run around at the wrong times. Teens and adults often feel restless and fidgety. They aren't able to enjoy reading or other quiet activities.
Acting before thinking. People with ADHD may talk too loud, laugh too loud, or become angrier than the situation calls for. Children may not be able to wait for their turn or to share. This makes it hard for them to play with other children. Teens and adults may make quick decisions that have a long-term impact on their lives. They may spend too much money or change jobs often.
Condition Overview
Health Tools
Cause
Symptoms
What Happens
What Increases Your Risk
When To Call
Exams and Tests
Treatment Overview
Prevention
Self-Care
Medicines
Other Treatment
Related Information
References
Credits


OPTUM
Family Recovery and Resiliency Tools
Some of the best tools available for your well-being.


liveandworkwell
liveandworkwell.com
CLOSE WINDOW
ADHD: Helping Your Child Get Things Done
One of the most difficult things about parenting a child with attention deficit hyperactivity disorder (ADHD) is getting your child to do what you ask. Daily routines, such as getting ready for school or bed and getting homework done, can become battlegrounds.
ADHD symptoms—inattention, impulsivity, and hyperactivity—are obstacles to understanding and following instructions. Unless your child learns how to overcome or adapt to his or her symptoms, he or she may fail to develop the skills for success in life. Fortunately, you can help.
Your child is not intentionally ignoring, defying, or disobeying your instructions. He or she is not dumb or lazy.
Unexpected changes in daily routines are upsetting for a child who has ADHD.
Remove as many distractions as possible from your child's surroundings when he or she is doing a task.
How can you help your child with ADHD accomplish tasks at home? +
Credits +
Current as of: June 16, 2021
Author: Healthwise Staff
Medical Review: Adam Husney MD - Family Medicine & Kathleen Romito MD - Family Medicine & Louis Pellegrino MD - Developmental Pediatrics
Advanced Printing Options

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Attachment 15. Depression Example

Please see the following pages for our Depression Example.

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I'm feeling concerned

Learn about depression and finding the right care.

Depression is a mental health disease which is not your fault. It's nothing to be ashamed of or embarrassed about. No one should ever hesitate to seek help. And fortunately, there are several paths one can take towards getting treatment — and feeling better.

Tell your primary care provider (PCP) or nurse practitioner that you think you might have depression. Have a thorough checkup to rule out any medical condition that could be causing or mimicking your depression symptoms. Once a medical condition is ruled out, depression is commonly diagnosed with a depression quiz. This quiz is known as the PHQ-9. This list of questions helps identify depression and whether the depression is minor, moderate, or severe.

The depression treatment recommended for you will be based on many factors. These may include your age, health history and your personal preferences. Your PHQ-9 score will also be a factor. Recommended treatments may range from:

- Reassurance and supportive counseling and instructions to call if depression gets worse
- "Watchful waiting" for a month or more, with the addition of medication or counseling if there's no improvement
- A prescription for antidepressant medication combined with counseling

TYPES OF COUNSELING

There are different kinds of mental health professionals who are trained to work with people with depression, whatever the severity. These providers have different titles and levels of expertise, but they can all provide the therapy you need to help you reach your goals. The therapy they offer is called psychotherapy. You may have heard it called "talk therapy." Psychotherapy can help you deal with your feelings and behaviors and suggest ways to cope. Your PCP or nurse practitioner may refer you to a psychotherapist, or you might look for one on your own. In any case, it's helpful to understand your provider options.

- **Psychologists** — Psychologists have a Ph.D. (Doctor of Philosophy) or Psy.D. (Doctor of Psychology) degree. They are also licensed by the state they practice in. They are trained to diagnose and evaluate a person's mental health through testing and talking to the patient and to treat them accordingly.
- **Counselors, clinicians, and therapists** — These professionals have obtained their master's degree. They might also be licensed in their state as a Licensed Professional Counselor (LPC), a Licensed Marriage and Family Therapist (LMFT) or a Licensed Clinical Alcohol and Drug Abuse Counselor (LCADAC). These providers provide psychotherapy aimed at helping improve your symptoms so you feel better.

- **Clinical social workers** — Clinical social workers include Licensed Independent Clinical Social Workers (LICSW), Licensed Clinical Social Workers (LCSW), and ACSW (Academy of Certified Social Worker). All are trained to assess a person's mental health and provide psychotherapy using various therapeutic techniques.
- **Online therapy (Virtual Visits)** — Some therapists are providing services over the internet so you can talk to a therapist from your computer, in the privacy of your own home. This is a convenient, comfortable, and easily accessible option for many people. Be certain that the therapist you talk to is licensed in your state and complies with all privacy (HIPAA) laws.

The therapists listed above can't prescribe medication. But they might suggest it as something that could help you. They may encourage you to see a doctor to discuss whether antidepressant medications are right for you. If so, schedule an appointment as soon as you can.

IF YOU NEED MEDICATION

Medications for depression can be prescribed by your primary care physician, a nurse practitioner or a psychiatrist. Psychiatrists are physicians that specialize in mental health and have gone through medical school with additional training in the field of psychiatry. Because they are licensed physicians, they are able to prescribe medications. They have deep knowledge about antidepressants, how they work, dosing, and prescribing what might work for you. Your PCP might refer you to a psychiatrist because of this specialized expertise. Psychiatrists can also provide psychotherapy in addition to prescribing medications.

Some psychiatrists are now practicing telepsychiatry. This is a visit with a psychiatrist that is conducted via computer, much like telepsychology. You can check our virtual visit providers to find a psychiatrist who can see you online.

BUT HOW DO I FIND THESE PEOPLE?

There are many ways to find therapists and psychiatrists:

- Search our in-network provider database on Live and Work Well
- Ask your primary care provider or another health provider
- Contact a local university's psychology department
- Call a community mental health clinic
- Visit online resources such as the American Psychological Association or the American Psychiatric Association
- Ask family or friends for a referral

Sources

The MacArthur Initiative on Depression and Primary Carelaunchpdf icon. https://www.nami.org/Learn-More/Treatment/Types-of-Mental-Health-Professionalslaunch. http://www.apa.org/helpcenter/online-therapy.aspxlaunch. www.psychiatry.org/patients-families/psychotherapylaunch.

For more information, call your Optum Behavioral Health Plan at XXX-XXX-XXXX.

Available 24 hours a day, seven days a week.

#pledge2Bstigmafree

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This program is not a substitute for a doctor's or professional's care. Consult with your clinician for specific health care needs, treatment or medication. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

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Attachment 16. Eating Disorder Example

Please see the following pages for our Eating Disorder Example.

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I'm feeling concerned

Caring for someone with an eating disorder and taking care of yourself, too.

Eating disorders are conditions that cause a person to have unhealthy thoughts, feelings and behaviors related to food and body image. Some people with eating disorders severely restrict their food intake (anorexia nervosa) while others eat excessively (binge eating disorder or compulsive overeating). They may also vomit, take laxatives or exercise excessively to try to prevent weight gain after binge eating (bulimia nervosa).

IT'S A COMPLEX SITUATION

Serious and life-threatening, these disorders often create turmoil within a family even before a diagnosis is made. While receiving an eating disorder diagnosis may offer a moment of relief for families who feel that treatment can finally begin, it can also compound feelings of guilt for not having acted sooner, fear for their loved one's future, and anxiety about facing long-term caregiver responsibilities and expensive medical bills.

SUPPORTING YOUR FAMILY IS IMPORTANT WORK

Helping a loved one who has an eating disorder is important work. They are very lucky to have you in their life. The most important thing you can do is reflect confidence and hope. People do recover. Children build resiliency and move forward into a full life. Your support will mean a great deal to help people move into that positive future.

WHERE DO YOU START?

Understanding eating disorders can give you more confidence in your role as a caregiver or as part of your loved one's support system. Start by arming yourself with information. Ask questions at doctor's visits. Consider joining a support group or seek information from trusted sources, like the National Institute of Mental Health.

TAKE CARE OF YOURSELF

Sometimes people get overly focused on the loved one with an eating disorder and forget to take care of themselves. If you're a caregiver, you won't be a good one if you're physically or emotionally spent. Try these tips to be at your best:

- **Do things you enjoy each day.** Caregiving is not your entire life. Spend time doing what makes you happy.
- **Lead a healthy lifestyle.** Get enough sleep, eat balanced meals and get enough exercise. And don't neglect your own doctor visits.
- **Manage stress.** Learn how to manage your stress with activities, such as journal writing or yoga and meditation, which use breathing exercises as a focal point.
- **Learn to say "no."** Caregiving is hard work. Be careful about taking on additional responsibilities. Make lists for yourself and tackle only what you can reasonably handle in a day.
- **Reach out to others.** Make time for other family members or friends. Be sure to talk about things besides caregiving. If someone offers help, accept it. Look for an eating disorder support group in your area.

For more information, call your Optum Behavioral Health Plan at XXX-XXX-XXXX.

Available 24 hours a day, seven days a week.



#pledge2Bstigmafree

This program should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. This program is not a substitute for a doctor's or professional's care. Consult with your clinician for specific health care needs, treatment or medication. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against Optum or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

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