Proposal to Serve

The State of New York

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan

Technical Proposal

Redactions

April 16, 2013

Empire BlueCross BlueShield

Mental Health and Substance Abuse Program for the Empire Plan, Excelsior Plan and Student Employee Health Plan—Technical Proposal

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SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

The Department is seeking to award the Agreement to a qualified Offeror to provide Mental Health and Substance Abuse Services for The Empire Plan, Excelsior Plan, and Student Employee Health Plan Mental Health and Substance Abuse Programs (collectively referred to as the Program). The purpose of this section of the RFP is to set forth the programmatic duties and responsibilities required of the Successful Offeror selected in response to this RFP with whom the Department enters into the Agreement ("Contractor") and to pose questions concerning those duties and responsibilities for response by the Offerors. The Offeror's Technical Proposal must contain responses to all questions (i.e. Required Submissions) in the format requested. Each Offeror may submit only one Technical Proposal. The Technical Proposals will be evaluated based on the Offeror's responses to the questions contained in this section. Therefore, it is critical that Offerors fully respond to each of the questions presented in this Section IV. Evaluation of all Proposals and the selection of the Successful Offeror shall be based only upon the Offeror's Proposal regarding the duties and responsibilities set forth in the RFP, and shall not be based upon any supplemental material.

Notes Numbers, data, or statistics which may appear in the Exhibits referenced throughout this RFP are for informational purposes only and should not be used or viewed by prospective Offerors as guarantees or representations of any levels of past or future performance or participation.

The Department will accept Proposals only from qualified Offerors and will consider for evaluation and selection purposes only those Offeror Proposals that it determines to meet the Minimum Mandatory Requirements in Section III and are responsive to the duties and responsibilities set forth in Section IV of this RFP.

Please note that Offerors may not include any cost information in the Technical Proposal including exhibits or attachments. This cost information pertains to the provider fees and Administrative Fees requested in the Cost Proposal. Performance guarantee amounts are to be included in the Technical Proposal. Specific savings estimates (dollars or percentages) should not be quoted in the Technical Proposal or in any exhibits or attachments submitted with the Technical Proposal.

A. Program Administration

1. Executive Summary

The Offeror must describe its capacity to administer the Department's Mental Health and Substance Abuse Program (also hereafter collectively referred to as the "MHSA Program").

a. Required Submission

The Offeror must submit an Executive Summary that describes its capacity to administer the Department's MHSA Program. The Executive Summary must include:

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

Empire BlueCross BlueShield's (Empire BCBS) principal place of business is located at:
One Liberty Plaza
New York, NY 10006

The Empire BCBS office responsible for administering the Empire Plan Mental Health and Substance Abuse Program is located at:
11 Corporate Woods Blvd.
Albany, NY 12211

The Empire BCBS senior officer who is responsible for this account is Ethel A. Graber, VP and General Manager who reports to Brian T. Griffin, President and CEO of Empire BCBS for the New York Market.

(2) A description demonstrating its understanding of the requirements presented in the RFP, and how the Offeror can assist the Department in accomplishing its objectives;

Empire BCBS is an experienced provider of benefits to the Empire Plan, Excelsior Plan and the Student Employee Health Plan, having managed the Empire Plan Hospital Program for over 50 years. Our experience ensures that we are knowledgeable about the unique requirements and needs of both

the State and the Empire Plan. Collectively with our internal Behavioral Health Management unit, our organization can provide the Empire Plan Mental Health and Substance Abuse Program with not only the service it has come to expect from our organization, but a unique combination of capabilities, experience and strategic advantages unmatched within the healthcare industry.

Our proposal presents an offering that not only meets the requirements detailed in the Request for Proposal (RFP), but will exceed the Plan's expectations with regards to service and program administration. Our responses and assurances will confirm our understanding of the requirements and demonstrate our commitment to the Empire Plan and the State of New York. We propose to exceed your expectations and assist in accomplishing your objectives by providing the Empire Plan with:

- **A business model that is aligned with the financial interests of the Empire Plan, which offers financial protections for the State and is transparent within all business relationships relating to the Program**
- **A locally based account management team with the skills and experience to meet the needs of the State and the Program**
- **Sound underwriting, through developing and implementing a stable and realistic premium rate structure consistent with the financial interests of the Program**
- **Experience implementing a program of this size and complexity**
- **A dedicated call center able to meet all programmatic requirements, staffed with representatives that put the customer first**
- **A nationwide network that provides unmatched access and exceeds the minimum mandatory network requirements**
- **A proven approach to eligibility processing that exceeds Program requirements**

- **Provider relationships that ensure the integrity and quality of the Program**
- **The competitive position and an approach to provider contracting that achieves long term stability of the network, while maintaining competitive reimbursement rates**
- **A claims processing system with the capability to process the anticipated volume of claims timely and accurately, consistent with the Program's requirements**
- **Proven clinical management programs and processes to ensure members receive appropriate care, while controlling cost to the Program**
- **Reporting capabilities that will assist in monitoring the performance and quality of the Program**
- **An industry leading fraud and abuse program**

The Empire Plan can count on Empire BCBS to deliver benefit management services that are:

- **Competitively priced for the proposed five year period of January 1, 2014 to December 31, 2018.**
- **Aligned financially with the interests of the Empire Plan**
- **Backed by aggressive performance guarantees to demonstrate our commitment**
- **Based on a proactive network management approach that maximizes cost containment and provides superior network access**
- **Managed and staffed by qualified and experienced clinical and non-clinical staff**

These assurances, combined with our long term history of administering the Empire Plan Hospital Program, uniquely qualify us to perform the Mental Health and Substance Abuse Program services outlined in your RFP.

(3) A statement explaining previous experience managing the Mental Health and Substance Abuse Programs of other state governments or large public entities or any other organizations with over 100,000 covered lives, as well as any previous experience managing a self-funded Mental Health and Substance Abuse Program. Detail how this experience qualifies the Offeror and, if applicable, the experience of its Key Subcontractors to undertake the functions and activities required by this RFP; and

Our Behavioral Health Management unit has provided behavioral health utilization management and quality improvement programs for several large state entities including Connecticut, California and we have recently been awarded a contract for the Commonwealth of Virginia. We have served California Public Employees' Retirement System (CalPERS) PPO members (both active and retirees) since 1999. CalPERS is a multi-employer group purchaser of health benefits representing 1.2 million active and retired state and local government employees and their family members. As one of the largest purchasers of employee health benefits nationally, CalPERS is the largest purchaser of employee benefits in California.

It is our close working relationship with the CalPERS health care team that ensures we deliver a quality behavioral health utilization management program that optimizes the CalPERS benefit. Our dedicated clinical team of licensed behavioral health clinicians is trained on the specifics of the CalPERS benefit plan, philosophy and membership composition and expectations.

(4) An explanation of how the following administrative and operational components will be performed by the Offeror. Include an organizational chart explicitly detailing responsibility for the following functions;

(a) Account Team

(b) Premium Development Services

(c) Implementation

(d) Customer Service

(e) Enrollee Communication Support

(f) Enrollment Management

(g) Reporting

(h) Consulting

(i) Transition and Termination of Contract

(j) Network Management

(k) Claims Processing

(l) Clinical Management/Utilization Review

We are proposing a dedicated model which capitalizes on our existing MHSA expertise, resources and processes to meet or exceed the requirements of this RFP. For some functions we will integrate the dedicated model into our existing structure to capitalize on administrative efficiencies and best practices. Responsibilities of all key resources responsible for the NYS MHSA Program are outlined in corresponding sections of the proposal. Our approach does not require the use of any Key Subcontractors as part of our Program Team for the delivery of MHSA Program Services deemed as essential to meet the requirements of this RFP. The account team will have the authority and support of senior management to meet commitments and NYS expectations. We will capitalize on our experience of over 50 years of understanding the unique needs of NYS and our position as a leader in the health care industry to provide NYS with MHSA Program Services that achieves your financial and administrative expectations.

Empire BCBS has built exceptional technical and professional capabilities as the basis for our leadership in the health care industry. The best-in-class model we are proposing for the administration of the Empire Plan include the following:

(a) The Account Team will be responsible for ensuring that the operational, clinical, and financial resources are in place to operate the Program and

will serve as the primary contact for the Department regarding all aspects of the Program's administration.

(b) Premium development services will be the responsibility of the Account and Underwriting Teams.

(c) A cross-functional Implementation Team will be created that includes representation of leadership and subject matter experts for all of the various components of the Program. This team will develop the implementation and post-implementation plans and timelines, develop business requirements and coordinate necessary IT resources to ensure activities associated with implementation are accurate and timely.

(d) Customer Service – Customer service will occur in the NYS Dedicated Service Center, utilizing a model similar to the Hospital Program and staffed in our Albany, NY location. Certain clinical aspects of the program will capitalize on an existing model and infrastructure all located within the United States.

(e) Enrollee Communication Support will be the responsibility of the Account Team who will coordinate responses with all necessary internal areas responsible for the administration of the Program.

(f) We will capitalize on the existing process for Enrollment Management. We will use a shared eligibility file with the Hospital Program to ensure consistency.

(g) Reporting will be the responsibility of the Account Team who will coordinate with internal resources responsible for administration of the Plan. They will review and have the ability to access additional corporate resources, if required, to provide analysis and recommendations as necessary and will facilitate any ad-hoc reporting requests.

(h) Consulting will be one of the primary responsibilities of the Account Team and internal partners responsible for the Program. Empire BCBS will act in a consultative manner and keep the Department and Governor's Office of Employee Relations abreast of the latest

developments in the MHSA field and any matters that may affect the administration of the Program providing recommendations and information that will allow the State to continually make improvements to the Program, either through changes resulting from the collective bargaining process or in industry standards or practices.

(i) Transition and Termination of Contract: Empire BCBS would work cooperatively with the new Mental Health and Substance Abuse Program Contractor to facilitate a smooth transition of Empire Plan members. We will provide customer service and clinical management after the termination date of the Agreement as outlined in the proposal.

(j) Network Management: We have proposed a comprehensive nationwide network that exceeds the GeoAccess requirements. As a member of the BlueCross BlueShield Association, we can provide NYS members access to the largest network of providers nationwide, and capitalize on the provider relationships and contracts of each affiliated Blues plan, to ensure localize practice patterns are considered in the development of the network. Locally and nationwide we leverage our significant membership to provide access to the largest network of participating providers.

(k) Claims Processing: A detailed explanation of our claims processing system and corresponding processes is included in the proposal. We will utilize our CS90 claims processing system, the same system the currently processes claims for the Empire Plan Hospital Program.

(l) Clinical Management/Utilization Review: Empire BCBS's integrated solution includes all required MHSA utilization management and case management. We facilitate management and delivery of health care resources to individuals for intensive inpatient, partial hospitalization and intensive outpatient programs, residential treatment centers and outpatient services (if requested). In many respects the model we are proposing is more robust than the requirements of the RFP.

We will further discuss how all of these administrative and operational components will be performed throughout our proposal.

We have provided job titles and brief descriptions for the account management and various leadership positions throughout this proposal. An organization chart outlining the proposed Program service model is included as Appendix A. The organizational chart includes the account management team and illustrates how the team will interact with other departments responsible for the administration of the Program, as well as highlights the reporting structure providing access to senior management and resources needed to meet NYS expectations.

If the proposed organizational structure has been used in administering the program of another client, provide the client's name and include the client as a reference as required in Exhibit I.V.

We provide MHSA benefit administration for several states and large national clients using a model similar to the one proposed. Specifically, and as included as references in Exhibit I.V, we provide this service to the following clients:

- **California Public Employees Retirement System (CalPERS)**
- **Wells Fargo**
- **PepsiCo, Inc.**
- **Self Insured Schools of California**

Please refer to Exhibit I.V for our client references.

2. General Qualifications of the Offeror

The MHSA Program covers over one million lives and incurs costs in excess of $160 million annually. The Offeror/ Contractor must have the experience, reliability and integrity to ensure that each Enrollees' mental health and substance abuse care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the

MHSA Program's duties and responsibilities set forth in the RFP, ensuring full compliance with the MHSA Program Services.

a. Required Submission

The Offeror must demonstrate that it has the wherewithal to administer the MHSA Program as required by this RFP. Please provide detailed responses to the following:

(1) What experience does the Offeror have in managing/supervising a MHSA program similar to the MHSA Program described in this RFP?

We have significant experience managing complex collectively bargained benefits of government, labor and large national clients. The demographics and administrative requirements of these programs are very similar to the Empire Plan Mental Health and Substance Abuse Program and provide invaluable experience in managing a client of this size and complexity. We are currently managing the mental health and substance benefits for over 24 million members throughout our organization, including numerous National and Government clients.

The understanding and level of commitment required to manage a program of this size and complexity can only come from experience. Our experience with the California Public Employees Retirement System (CalPERS) and managing the MHSA benefits for other state programs nationwide (including the State of Connecticut and an implementation for the Commonwealth of Virginia that will be completed by the time the contract is awarded for the Empire Plan MHSA program, combined with over 50 years of experience managing the Hospital Program, uniquely qualifies us to administer the Empire Plan MHSA Program.

Empire BCBS has capitalized on the expertise of our organization for administration of the mental health and substance abuse program with our in-house, Behavioral Health Management team. The team has significant experience managing complex collectively bargained benefits of government, labor and large national clients. As outlined above, the Behavioral Health

Management team has administered the mental health and substance abuse program for CalPERS since 1999.

(2) Explain how the Offeror's account team will be prepared to actively manage the administrative, operational and clinical aspects of the MHSA Program?

Empire BCBS has a long-standing relationship administering benefits for the State of New York. The experience we have drawn from this relationship will be invaluable and directly applied to our administration of the Mental Health and Substance Abuse Program. We recognize the importance of having the State of New York as a client and are fully committed to meeting your expectations. The account team will meet deliverables, act consultatively and engage Senior Management as needed to ensure the State's expectations are met.

The operational and clinical teams will have accountability to the NYS Account Team, who will be responsible for oversight of the entire program. The Account Team will include an Operational/Clinical Account Executive who will work closely with leadership of the clinical team. All key account areas will participate in regularly scheduled meeting with the State, with the understanding that they are accountable for their various areas of operation. Providing direct access and interaction with the operational leadership creates a collaborative environment and open communication resulting in higher client satisfaction. We will outline in detail throughout the proposal our approach to actively manage all aspects of the program but some of these activities include:

- **collaborating on member mental health and substance abuse communications**
- **regular discussions to explore coverage options and their impact on costs, quality, outcomes and the overall best use of health care dollars**
- **continued review of member and provider experiences to identify opportunities for service improvement and new program development**

- **communicating performance measures**
- **fully cooperating in any program audits**
- **review of utilization trends through authorization and claims data to evaluate program performance**

We are committed to the overall satisfaction of the State of New York and have proposed the resources and administrative model that best accomplishes this goal.

(3) What internal systems or procedures will the Offeror have in place to provide financial, legal, and audit oversight of its contract with the MHSA Program?

Empire BCBS takes very seriously our responsibility for administration of the Program. We have developed a comprehensive set of controls that provide oversight of all aspects of the program, including financial, legal and audit oversight.

Legal

We have an extensive in-house legal team that is responsible for coordinating legal and regulatory compliance, litigation, public affairs, corporate communications and contract compliance. Our organization includes legal resources with a wide variety of expertise, to ensure oversight is provided for all aspects of the contract. The legal team tracks new laws and regulations and works closely with the Internal Audit, Compliance and Regulatory Oversight Departments, which are responsible for compliance.

Financial

Numerous financial controls are built into our claims processing system to ensure claim payment accuracy. This systematic payment logic consistently yields financial accuracy results exceeding 99%. A detailed explanation of the system edits and controls is included in the claims processing section of our proposal. In addition, we perform pre-payment reviews for certain claims to ensure financial accuracy.

High dollar claims are routinely reviewed pre-payment for auto-adjudicated and non-auto adjudicated claims when payments reach an established dollar threshold for professional and facility claims. Prior to these claims being finalized, they are reviewed by a lead examiner for the following:

- **Eligibility**
- **Keying accuracy**
- **Benefit limitations**
- **Contract exclusions**
- **Verification of the diagnoses and procedure codes billed**
- **Pricing accuracy**

When a claim is $50,000 or greater, it is sent to a Manager to review. If the claim is $100,000 or greater, it is sent to a Director. Any claim that is $500,000 or greater is sent to a Vice President for review and final approval of payment.

Audit

Auditing is the essential component in our claim processing quality assurance program, and we will provide a resource from our auditing area that is fully dedicated to oversee all areas, ensuring that we comply with all performance requirements of the plan and will also act as the liaison with the Department on matters relating to auditing activities. We have carefully designed our program to ensure high reliability and a high level of confidence in our auditing processes.

Auditing processes are composed of a combination of pre- and post-payment audits. Unit personnel perform audits daily, and corporate office personnel perform them monthly.

Post-Payment Audits

Three separate auditing departments within the company that are not part of the Claims Operations business unit perform post-payment audits:

- **In-line Claims Quality department**
- **Member Touchpoint Measures (MTM) Auditing department**
- **Performance Guarantee Auditing department**

In-line Claims Quality Department

Our In-line Claims Quality program offers a consistent quality review across the company.

Claims auditors have an average tenure of 15+ years claims processing experience and conduct a multi-tiered program consisting of the following in-line quality audits across the enterprise:

- **Standard Audits**

  Audits manually processed claims. A random, non-stratified, automated sample of finalized claims is selected for each processor on a weekly basis. These samples are systematically fed into the quality tracking database for the auditors to review. The auditors conduct a standard number of eight audits for each frontline claims processor, which is approximately 0.1% of the total claims processed for each processor.

- **Platform Population Audits**

  Audits the total claims population per platform to ensure claims processing and financial accuracy. A random, stratified sample is pulled and uploaded into the quality database systematically on a weekly basis. Platform population audits are primarily focused on systematically processed (auto-adjudicated) claims.

- **High Risk/Targeted Audits**

  Audits specific areas identified through our In-line Quality and MTM error trends, focusing on specific codes, claims types, providers or lines of business and pre- and post-migration/system updates.

- **End to End Provider Claims Accuracy Audits**

  An audit is conducted 30 days after a facility provider contract is updated. A random, stratified sample of all institutional claims is pulled 30 days post-facility provider contract update. The claims are audited end to end from data entry accuracy to the provider's paper contract to benefit application and overall payment accuracy.

  Auditors evaluate the claims for accuracy including, but not limited to, reviewing the original claim submitted, eligibility, benefits and pricing according to established contractual agreements, medical policy and medical review determinations.

  If a discrepancy is identified, the audit is sent electronically to the Operations Manager for review and approval through our quality database. The manager reviews the discrepancy with the associate to provide coaching and training, as needed, to improve accuracy performance.

  Auditors are audited concurrently through our Audit the Auditor program. Samples are pulled on a weekly basis for each auditor. The factors used to measure performance are audit coding, audit accuracy and overall accuracy.

  Real-time claim reporting is available at the Vice President, Director, Manager and individual level. These reports provide information on the number of claims audited, financial and processing accuracy results and root cause trending on a monthly, quarterly and year-to-date basis. Monthly partnership meetings are held with Quality and Claims Operations management teams to discuss monthly results, review trends and make recommendations to improve performance.

Blue Cross Blue Shield Association (BCBSA) Member Touchpoint Measures (MTM)

Our MTM audit team conducts post-payment reviews of claims in order to measure processing accuracy and timeliness. Audit criteria are mandated by the BCBSA MTM program. We provide semi-annual results to the BCBSA.

The MTM audit is based on statistically valid samples selected from the entire population of original and adjusted claims. The sample size is calculated at a 95% confidence level and not on a percentage of claims processed. Claims are sampled randomly via an automated process and stratified based on dollars paid. Each sample is a proration of the total sample required for the audit period. Actual performance results are compared to the expected performance results to ensure statistical integrity. Samples are designed to be statistically significant quarterly and statistically valid on a semi-annual basis.

Auditors ensure samples are selected without bias and are representative of the claim population. Sampled claims are audited in their entirety while adhering to established audit guidelines that include the verification of:

- **Patient eligibility**
- **Services rendered**
- **Data entry**
- **Electronic record integrity**
- **Benefits**
- **Payment**

MTM auditors forward discrepancies to the appropriate Operations area for review. The Operations area either accepts or refutes the audit finding. If the error is refuted, the auditor reevaluates the audit observation based on additional information provided. MTM and Operations management are included in the discussion if the auditors and Operations cannot resolve the audit observation. Follow up on any audit findings that require correction of a claim is done on a quarterly basis to ensure the corrections have been completed appropriately.

Performance Guarantee Audits

Our performance guarantee audit team conducts independent post-payment reviews of claims to measure processing accuracy. The Account Management Team reports results to clients who have entered into performance guarantee agreements with us.

Performance guarantee claim accuracy audit is based on statically valid samples selected from the entire population of original and adjusted claims. The sample size is calculated based on a 95% confidence level and not on a percentage of claims processed. Claims are sampled randomly via an automated process and stratified based on dollars paid. Each sample is a proration of the total sample required for the audit period. Actual performance results are compared to the expected performance results to ensure statistical integrity. Samples are designed to be statistically valid quarterly or semi-annually and management receives monthly reports with interim performance results.

Auditors ensure samples are selected without bias and are representative of the claim population. Sampled claims are audited in their entirety while adhering to established audit guidelines that include the verification of:

- **Patient eligibility**
- **Services rendered**
- **Data entry**
- **Electronic record integrity**
- **Benefits**
- **Payment**

Performance guarantee auditors forward discrepancies, detailing the audit observation and its final impact to the Operations area for review. The Operations area either accepts or refutes the audit finding. If the error is refuted, the auditor reevaluates the audit observation based on additional information provided. Performance guarantee and Operations area management are included in the discussion if auditors and Operations cannot resolve an audit observation. Follow up on any audit findings that require

correction of a claim is done on a quarterly basis to ensure the corrections have been completed appropriately.

Program Services

Section IV.B

SECTION IV: TECHNICAL PROPOSAL REQUIREMENTS

B. Proposed Empire Plan MHSA Program Services

In this section, the Offeror must demonstrate its capacity to provide the required services for administration of the MHSA Program.

1. Account Team

The Department expects the Contractor to have a proactive, experienced account leader and team in place who are dedicated solely to the MHSA Program and who have the authority and expertise to coordinate the appropriate resources to implement and administer the MHSA Program.

a. Duties and Responsibilities

(1) The Contractor must maintain an organization of sufficient size with staff that possesses the necessary skills and experience to administer, manage, and oversee all aspects of the MHSA Program during implementation and operation.
Confirmed.

(a) The account team must be comprised of qualified and experienced individuals who are acceptable to the Department and who are responsible for ensuring that the operational, clinical, and financial resources are in place to operate the MHSA Program in an efficient manner;
Confirmed.

(b) The Contractor must ensure that there is a process in place for the account team to gain immediate access to appropriate corporate resources and senior management necessary to meet all MHSA Program requirements and to address any issues that may arise during the performance of the Agreement.
Confirmed.

(2) The Contractor's dedicated account team must be experienced, accessible (preferably in the New York State Capital Region district) and sufficiently staffed to:

(a) provide timely responses (within 1 to 2 Business Days) to administrative and clinical concerns and inquiries posed by the Department, or other staff on behalf of the Council on Employee Health Insurance or union representatives regarding member-specific claims issues for the duration of the Agreement to the satisfaction of the Department;

Confirmed.

(b) immediately notify the Department in writing of actual or anticipated events impacting MHSA Program costs and/or delivery of services to Enrollees such as but not limited to, legislation, class action settlements, and operational issues).

Confirmed.

(3) The Contractor's dedicated account team must ensure that the MHSA Program is in compliance with all legislative and statutory requirements. If the Contractor is unable to comply with any legislative or statutory requirements, the Department must be notified in writing immediately. The Contractor must work with the Department to develop accurate Summary Plan Descriptions (SPDs) and/or MHSA Program material.

Confirmed.

(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.

Confirmed.

b. <u>Required Submission</u>

(1) Provide an organizational chart and description illustrating how you propose to administer, manage, and oversee all aspects of the MHSA Program. Include the following:

(a) Reporting relationships and the responsibilities of each key position of the account management team; and how the team will interact with other departments such as the call center, clinical services, reporting, auditing, and network management within your organization. Describe how the account management team interfaces with senior management and ultimate decision makers within your organization;

An organizational chart has been provided as Appendix A. This chart reflects the dedicated model and illustrates how the Account Management team will interact with other departments within the organization to manage all aspects of the MHSA Program. The organizational model we are proposing capitalizes on our current organizational structure for the Hospital Program and integrates several operational areas into a dedicated center for the MHSA Program. The Account Management team will have oversight responsibility of this cross-functional team and all will be focused on the same goal; providing excellent service that meets or exceeds the State's expectations for administration of the MHSA Program.

Our proposed account team will be led by Ethel Graber, VP and General Manager. Ethel has current oversight responsibility for the Hospital Program and previous oversight responsibility for the Prescription Drug Program. In her role, Ethel has the authority to command the resources necessary, and the access to Senior Level Management within the

organization, to ensure the State's expectations are met and the Program runs smoothly.

Reporting to Ethel , with responsibility for the Account Management team, will be the Director for the MHSA Program. The Director will be responsible for leadership and direction of all account management activities and lead a team of dedicated resources that include an Account Executive, Account Representative, Reporting Analyst and Audit Liaison. Similar to the approach currently utilized on the Hospital Program, this model will ensure the level of service the State has become accustomed to from Empire BCBS in our management of the Hospital Program. The Account Management team will respond quickly and accurately to inquiries from and act in a consultative manner with the Department of Civil Service, the Governor's Office of Employee Relations and other New York State entities involved in the administration of the MHSA Program. The Account Management team will include:

- **<u>Ethel Graber, VP and General Manager</u> – Ethel will have oversight responsibility and assist with strategic planning and global initiatives to support the Program. Ethel has the ability to immediately engage resources as required and regular interaction with senior level management within the company to make certain the Account Management team receives the appropriate level of support to ensure the State's expectations are met.**

- **<u>Director, Account Management</u> – This position will be responsible for the leadership and direction of all management activities associated with the administration of the Program and will also have direct access to senior level management. The Director will be responsible for proactively identifying corporate initiatives that require discussion with the State, lead discussions on industry trends and for ensuring the State's overall expectations regarding the Program are met. A qualified candidate for this position will have account management**

experience as well as a clinical background. They will possess a drive for results and the "customer first" mentality vital for success in this role.

- **<u>Account Executive</u> – Reporting to the Director, the Account Executive will be responsible for ensuring all activities involved in the daily management of the Program are being performed and that the State's overall expectations regarding the Program are being met. The Account Executive serves as the central point of contact for internal and external business partners involved with administration of the Program. This person will take a proactive approach to the management of the account, as well as coordinate and lead discussions on benefit and industry information and formulate strategies to maintain member satisfaction. Although not required, a clinic background would be preferred.**

- **<u>Operational/Clinical Account Executive</u> – Reporting to the Director, the Operational/Clinical Account Executive will act as the primary liaison between the Account Team and the Clinical Management Teams to oversee day-to-day administrative functions of the Program. This position assists in responding to all types of inquiries while providing direction and oversight of clinical operations to ensure expectations are met and identify opportunities for improvement. This person will participate on inter-departmental teams to ensure the interests of the Program are represented and that policies and procedures that pertain to behavioral health administration of the Program are communicated to the Account Team in a timely and accurate manner, as well as serve as the subject matter expert for clinical discussions and utilization analysis with the State.**

- **<u>Account Representative</u> – Reporting to the Director, the Account Representative will manage the daily activities associated with the program. This position will be committed to providing complete and**

timely responses to inquiries and administrative issues brought to their attention by the Department, GOER, the unions and any other State entity. The Account Representative will have primary responsibility for review of enrollee communications and attendance at enrollment or educational meetings as requested by the Department.

- **<u>Reporting Analyst</u> – Reporting to the Director, the Reporting Analyst will have primary responsibility to ensure that monthly, quarterly and annual reports are accurate and delivered timely and act as the primary contact for the Department and GOER. The Reporting Analyst will also have responsibility for responding to all ad hoc report requests.**

- **<u>Audit Liaison</u> – Reporting to the Director, this position will be responsible for ensuring all audit activities are coordinated and executed timely. In this capacity, they will have responsibility for responses to audit inquiries from various State entities and will coordinate the implementation of recommendations associated with audit findings. They will track and monitor all aspects of audits in process and ensure the required reporting is provided to the Department.**

Additional resources that will be part of the extended Account Team will include:

- **<u>Larry Grab, Director, Behavioral Health Operations</u> – Larry is responsible for the administration of all clinical and administrative aspects of medical management services for the Program including intake, utilization management, case management and clinical quality. He will participate in the development and implementation of clinical activities that impact health care quality cost and outcomes. With responsibility for clinical operations, the Director actively participates in the identification of problems and process improvements for all**

aspects of clinical and service related functions and leads clinical and service related discussions, as necessary, with the Department and GOER.

- **<u>Steven Korn, Medical Director, Behavioral Health Services</u> – Steven is the senior behavioral healthcare practitioner directly responsible for the Program. He will provide clinical oversight, guidance, and consultation to Quality Management committee members, providers, care managers and case managers. Serving as the primary behavioral health medical resource, this position interprets existing policies and recommends new policies based on changes in the healthcare or medical arena. The Medical Director participates in the development and implementation of clinical activities that impact health care quality, cost and outcomes and assists in providing this information, as necessary, to the Department and GOER in a consultative manner.**

One of our core corporate values is "One Company, One Team." This core value is embraced and evident throughout all levels of our organization and, combined with our culture of advocacy, ensures the Account Team will have access to and the cooperation of all operational areas throughout the organization. Additionally, to provide the level of senior management accountability, as referenced in paragraph 6.3.4 of the proposed contract, Brian Griffin, President and General Manager of Empire BCBS, will continue in his oversight capacity for all Programs administered for the Empire Plan. He will provide the resources to ensure that the State's expectations are met. Reporting directly to Brian, Ethel Graber has frequent interaction and discussion regarding the administration of the Empire Plan.

We recognize the importance of our relationship with the State and understand the commitment that is required at all levels of our organization. We are committed to meeting your expectations and the requirements of the MHSA Program.

(b) Names, qualifications, and job descriptions of those individuals selected to comprise the operational and clinical account and management team for the Offeror. Complete **Exhibit I.B** of this RFP, Biographical Sketch Form, for all key members of the proposed account and management team;

The qualifications, job descriptions and names (when available) selected to comprise the operational and clinical account and management team have been provided as completed Biographical Sketch Forms (Exhibit I.B). In those instances where the individual is not named, the Biographical Sketch Forms indicate "To Be Recruited" and reflect the required qualifications of candidates considered for the positions.

(c) Where individuals are not named, include qualifications of the individuals that you would seek to fill the positions; and

In those instances where individuals of the operational and clinical account and management teams are not currently in place or named, the Biographical Sketch Forms associated with those positions have been labeled "To Be Recruited." The corresponding education, employment and experience sections of the form will outline the qualifications that will be required of any individual hired to fill the position.

(d) Where will your account services, enrollment, claims processing, clinical management, clinical referral line and customer service staff be located and approximately how many staff members will work in each functional area?

Recognizing the value of a local presence and the importance of retaining jobs in the Capital District, the Account Team, certain aspects of the Utilization Review staff, as well as the Customer Service and Claims staff, will be located in our Albany, New York office. If awarded the business,

we will conduct internal job postings and initiate an external recruitment effort to staff all aspects of the Program with the most qualified and experienced staff available. The recruitment will include the consideration of qualified candidates from the current vendor, when applicable. In order to capitalize on the functionality already in place with our industry leading Behavioral Health Resource Center, and provide economies of scale to the State, the Clinical Referral Line will be serviced in our Denver, Colorado office.

Our goal is to ensure that Empire Plan members receive the highest level of care possible. In order to meet this goal, we have staffed our MHSA Clinical Management and Clinical Referral Line (CRL) Teams with our most experienced personnel. MHSA Clinical Management services will be provided out of our locations in the Northeast, with Care Managers based in New York and Connecticut. This team has been operational since 2003 and is very experienced in providing services to large and diverse groups similar to the Empire Plan's MHSA Program. The CRL Team will be staffed with dedicated resources within our National MHSA Resource Center in Denver, Colorado. This center is available 24/7, 365 days a year. It has been operational since 2008 and currently serves over two million members. This location will also administer the voluntary Depression Management, Eating Disorders and Attention Deficit Hyperactivity Clinical Management Programs. Our CRL clinicians have expertise in addressing the needs of members in crisis as well as specific member requests. The latter includes triaging members to the most appropriate provider or providing referrals to the MHSA Clinical Care Management Program.

The organizational chart (included as Appendix A) includes the proposed staffing by each functional area.

(2) Describe how the dedicated account team will have access to larger corporate resources as well as upper level management. What tools and resources are available to the account team to manage the MHSA Program? What tools will be available to the Department to work with the account team to manage the MHSA Program?

The Account Team will be led by Ethel Graber, VP and General Manager. Ethel will have oversight responsibility for administration of both the Empire Plan Hospital and MHSA Programs. Reporting to Ethel, the Director will have overall account management responsibility for the MHSA Program. In this capacity, they will have direct access to larger corporate resources, as well as upper-level management. In instances where additional support and/or resources are required, Brian Griffin, President and General Manager of the New York Market will continue in his oversight capacity and can easily be engaged to command corporate resources as required.

The Account Team dedicated to the MHSA Program will provide the Program with the same high level of service currently provided to the Hospital Program, through the continued coordination and management of resources and personnel throughout the organization. The Account Team will have frequent interaction and oversight responsibility for the various operational areas. The tools and resources directly available to the Account Team and available to the Department include the following:

- **Account Reporting – The comprehensive monthly, quarterly and annual reporting requirements provide a solid basis for the information required to manage the Program. These reports, focusing on all aspects of the administration of the program will be accurate and delivered in a timely basis. The Account Team will have access to client specific on-line reports which will be used to manage the program and make recommendations. The Account Team will review and have the ability to access additional corporate resources, if required, to provide analysis**

and recommendations as necessary. Ad-hoc reporting is available, as necessary.

- **Operational Monitoring and Support - Real time monitoring of service operations and systems reliability is available to the Account Team through our corporate intranet. This unique monitoring capability ensures operational excellence access to real-time operational and systems statistics. Additionally, the Account Team is provided with results of internal quality assurance programs that track and review claims and customer inquiries to ensure that the MHSA Program's benefits are properly and accurately administered.**
- **Project Management Tools – One of the keys to successful management of the MHSA Program is the use and understanding of various project management tools and processes. The processes employed by the Account Team will ensure that the Department is kept abreast of all issues and new trends in the industry that may impact the Program or are impacting the Program. These tools and processes also provide a mechanism for continued communication between the State and Empire BCBS to ensure that deliverables are met and issues resolved in a timely manner. Some examples of these tools are:**
  - **Contact lists**
  - **Decisions/deliverables lists**
  - **Project management documents**
  - **Strategy documents**
  - **Account profiles**
  - **Senior management reporting**
  - **Account survey**
- **Company and Industry News – The Account Team is kept abreast of company and industry information by daily updates to our corporate**

intranet. In addition, senior leadership will share relevant information directly with the Account Team. News items, press releases, pending legislation, etc., will be communicated to the State when the information is pertinent to the Program. Additionally, when network alerts are communicated to the Account Team, they will be shared with the State along with information on potential impact to the Program.

Amended March 11, 2013

(3) List the national accreditations and levels (i.e. full, provisional, etc…) that your organization has achieved for the locations that will service the MHSA Program.

The Empire BCBS commercial HMO network has a "Commendable" accreditation from the National Committee for Quality Assurance (NCQA). The majority of our PPO network also includes these providers. The next NCQA survey is December 2014. Additionally, we have full accreditation from the Utilization Review Accreditation Commission (URAC) under their HUM 6.0 standards for our 11 Corporate Woods, Albany NY and 108 Leigus Rd., Wallingford, CT location. These will be the primary service locations for the Mental Health and Substance Abuse Program. Our next URAC review is scheduled for June 2015.

(4) Confirm you will work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. All such communications must be approved by the Department prior to their distribution.

Confirmed.

2. Premium Development Services

The Contractor must provide underwriting assistance and support to the Department in the development of premium rates chargeable to MHSA Program participants consistent with the interests and goals of the MHSA Program and the State. The Department intends to develop premium rates to be as realistic as possible, taking into account all significant elements that can affect MHSA Program costs including, but not limited to trend factors, changes in enrollment and enacted legislation. The development of premium rates that closely match the actual costs enables the plan to provide rate stability, one of the primary goals of the State, and to meet the budgetary needs of the State and local governments that participate in NYSHIP.

a. Duties and Responsibilities

The Contractor will be responsible for assisting and supporting the Department with all aspects of the premium rate development including, but not limited to:

(1) Providing a team of qualified and experienced individuals who are acceptable to the Department and who will assist and support the Department in developing premium rates consistent with the financial interests and goals of the MHSA Program and the State;

Confirmed.

(2) Developing projected aggregate claim, trend and Administrative Fee amounts for each MHSA Program Year. Analysis of all MHSA Program components impacting the MHSA Program cost shall be performed including, but not limited to claims, trend factors, Administrative Fees and changes in enrollment; and

Confirmed.

(3) Working with the Department and its contracted actuarial consultant through the annual premium renewal process to further document and explain any premium rate recommendation. This process includes presenting the premium rate recommendation to staff of the Department, Division of the Budget and GOER.

Confirmed.

b. <u>Required Submission</u>

(1) Provide the names, qualifications and job descriptions of those key individuals who will provide premium rate development services for the MHSA Program. Describe their experience in providing financial assistance and support to other large health plans. Complete Exhibit I.B of this RFP, Biographical Sketch Form, for all key staff involved in the premium rate development.

The names, qualifications, and job descriptions for key individuals of our underwriting team have been provided in Exhibit I.B.

(2) Describe the general steps that you will follow to develop the annual premium renewal recommendation for submission to the Department. Include any different steps that will be employed to develop the first year premium vs. the premium for subsequent years of the Agreement. Include a description and source of the data you will utilize, assumptions you will use and how these assumptions will be developed, as well as any resources you will utilize.

The following best describes the steps when developing the annual premium recommendation for 2014. Any differences for the subsequent years of the contract will be discussed afterwards.

<u>2014 Projected Incurred Claims</u>

Empire BCBS will develop projected incurred claims using the following methodology as well as other adjustments described below.

Data Compilation

The first step in developing 2014 projected incurred claims is to compile the complete claims data as provided by the State. We would start with utilizing claim triangles for the most current period available (e.g. August 2012 – July 2013) in the premium development (provided that this is a normative representation of 12 months of claims data and there are no known anomalies). This information is reflected in our methodology detailed below.

Projected Incurred Claims

- **Completion Factor - A completion factor will be applied based on historical book of business and/or the Program's actual runout patterns.**
- **Utilization and Cost Trend Factors - Trends will be based on the Programs actual experience as well as Empire BCBS's book of business historical and anticipated trend. The trend factors may also take into account the following:**
  - **Leveraging effect of the copays**
  - **Plan design changes**
  - **Network composition changes**
  - **Major treatment guideline changes or other factors impacting utilization pattern**
- **Demographic Adjustment - An adjustment may be made for changes in enrollment in 2014. This includes the addition of any groups known to be joining or leaving the Program in 2014.**
- **Claim payment pattern adjustment - An adjustment may be applied if it is determined that a higher or lower than normal claim lag is present in the claims experience period.**
- **Plan change adjustments - An adjustment will be made to reflect the impact that any changes to the current Program have on claim costs.**

Examples include differences in expected costs due to changes in clinical programs and plan design.

Administration Fee

Administration Fee will be the guaranteed fee(s) as proposed in the 2014 Request for Proposal.

Taxes and Assessments

Taxes and Assessments, if applicable

2014 Total Premium

The total premium recommendation for 2014 Plan Year will be based on the aggregated 2014 projected incurred claims plus administration fee(s), taxes and assessments.

Subsequent Years of Contract (2015 through 2018 Plan Years)

The main variable for determining subsequent years' premium is incurred claims. Actual claims processed by Empire BCBS will be used for developing projected incurred claims for the renewal period. Since the 2015 Renewal work up will have less than 12 months of immature claims data from Empire BCBS, we may request prior carrier runout data to help complete a full 12 month claim period and determining an appropriate completion factor.

Consistent with premium development for 2014, total premium recommendation for 2015, 2016, 2017, and 2018 is developed as the projected incurred claims for that year plus administration fee(s), taxes and assessments.

(3) Confirm your commitment to work with the Department and its contracted actuarial consultant on the annual premium renewal recommendation and your availability to present such recommendation to the Department, Division of the Budget and GOER.

Confirmed.

Note: The responses to the above three Required Submissions should be general descriptions of the financial methodology you intend to use for assisting and supporting the Department with the MHSA Program. Responses may **NOT** include any specific cost information or values relative to the development of cost/rate projections and trends for the MHSA Program; that information must be restricted to your Cost Proposal.

3. Implementation

The Contractor must ensure that the MHSA Program is fully functional by January 1, 2014. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities by December 31, 2013.

a. Duties and Responsibilities

(1) The Contractor must commence an implementation period beginning on or around October 1, 2013 following approval of the Agreement by OSC. During the implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section IV.B.3.a.2a-2e. Such implementation activities must be completed no later than December 31, 2013 so that the MHSA Program is fully operational on January 1, 2014.

Confirmed.

(2) ***Implementation and Start-up Guarantee:*** The Contractor must guarantee that all Implementation and Start-up activities will be completed no later than December 31, 2013 so that, effective January 1, 2014, the Contractor can assume full operational responsibility for the MHSA Program. For the purpose of this guarantee, the Contractor must, on January 1, 2014, have in place and operational;

(a) A contracted Provider network (including Certified Behavior Analysts) that meets or exceeds the access standards set forth in Section IV.B.10 of this RFP;

Confirmed.

(b) A fully operational call center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP;

Confirmed.

(c) A claims processing system that processes claims in accordance with the MHSA Program's plan design and benefits, as set forth in Section IV.B.11 of this RFP;

Confirmed.

(d) A claims processing system with real time access to the most updated, accurate enrollment and eligibility data provided by the Department to correctly pay claims for eligible Enrollees consistent with MHSA Program benefit design and contractual obligations; and

Confirmed.

(e) A fully functioning customized MHSA Program website with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV. B.4 of this RFP.

Confirmed.

b. Required Submission

(1) Provide an implementation plan (via a detailed narrative, diagram, and timeline) upon Agreement approval, on or around October 1, 2013 that results in the implementation of all MHSA Program services by the required date of December 31, 2013, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. Include key activities such as member and Provider communications, training of call center and clinical staff, report generation, network development, transition benefits, customized website design, eligibility feeds and claims testing.

The proposed implementation timeline provided in Appendix B outlines the specific steps Empire BCBS would undertake to ensure a smooth implementation of the MHSA Program. We would offer a consultative approach to implementation by working with the Department to ensure accuracy, precision and a seamless transition to ensure enrollee satisfaction. A narrative representation of the sample timeline is provided in the following text.

The cornerstone of the process is the collaboration between Empire BCBS and the Department. During implementation, the communication pathways are established that will set the stage for a successful relationship. The foremost goal of the implementation process is to minimize enrollee disruption by developing accurate benefit plans and a close working relationship with the Department.

After contract award, an implementation team is assigned. This team includes the Implementation Manager, who serves as the primary point of contact throughout the process; a Clinical Manager, who assists the Program in the development of various clinical programs; an Eligibility Analyst, to work with the Program on the transfer of member eligibility data; a Benefits Analyst, who coordinates the documentation and development of the benefit plans in Empire BCBS' system; and an IT Project Manager, who works closely with the Program and its existing contractor to determine the specifications for incoming transition files and outgoing MHSA claims data. The Account Team will also be fully engaged at this stage with responsibility to ensure a smooth go-live transition and effective communication throughout the implementation.

Our process follows a standard development life cycle approach with four phases: 1) requirements gathering (also known as discovery), 2) development, 3) deployment, and 4) post-installation support.

Discovery is considered the most important phase of the implementation life cycle. In this phase, a series of meetings covering all aspects of the MHSA Program will take place. During each meeting, Subject Matter Experts will lead the Program through discussions about needs, requirements and capabilities. These requirements will be documented in functional area requirements documents. Also during this process, the tracking tools used by the Implementation Manager for process control will be introduced. These tools include: an implementation guide, a regular meeting schedule to review outstanding action items, an action item list to track issue resolution, and a project plan to track milestones and task dependence. The discovery phase ends with the acknowledgement of complete requirements by Program sign-off on functional area requirements documents.

During the development phase, all required programming is completed by Empire BCBS. Implementation meetings are continued in order to maintain

control on outstanding issues and to document new action items as they arise during the development phase.

The deployment phase includes training of customer service representatives and system users as designated by the Program. This phase also includes testing of the benefit plans, eligibility transfer and all file exchanges.

During the final phase, post-implementation support, the Implementation Team will remain available to offer support following the implementation. During the first week after the go-live date, the Implementation Manager will provide updates on claims volume and claim rejection trends in order to proactively identify any systematic anomalies.

We will work with the Department, as requested, to develop enrollee communications, that can be distributed both prior to the go-live date and post-implementation.

Project Plan

Prior to scheduling a formal implementation kick-off meeting, the Account and Operational Management Teams will review the proposal, confirm plan design and program features and prepare all necessary materials for the implementation meeting. Key areas addressed at this time will include:

- **Network development, including required participation and secured contracts.**
- **Call center, where we ensure that a fully operational call center is in place to provide all aspects of customer support and services as set forth in Section IV.B.4 of the RFP.**
- **On-line claims processing system, where we ensure the on-line claims processing system is in place that processes claims in accordance with Program's plan design and benefits, as set forth in Section IV.B.11 of the RFP.**
- **Website, where we ensure a fully functioning customized Program**

website with a secure dedicated link from the Department's website that provides members with on-line access to the specific requirements, as set forth in Section IV.B.4 of this RFP.

The meeting will also focus on the following areas:

- **Member and provider communications**
- **Plan benefit design**
- **Claims administration**
- **Reporting requirements**
- **Systems testing**

A meeting will be scheduled between Empire BCBS and the Department where key aspects and milestones of the implementation process will be reviewed. We will also develop an implementation project plan that documents all program requirements, implementation milestones and deliverables and key completion dates for these items.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on or before December 31, 2013. The Offeror shall propose the forfeiture of a percentage of the 2014 Administrative Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the MHSA Program are not met is a minimum of fifty percent (50%) of the 2014 Administrative Fee (prorated on a daily basis). However, Offerors may propose higher percentages.

[redacted]

Amended February 20, 2013

4. Customer Service

The MHSA Program requires that the Contractor provide quality customer service to Enrollees. The MHSA Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access representatives who respond to questions, complaints and inquiries regarding MHSA Program benefits, Network Providers, claim status etc., and, when a call involves a clinical matter, refer the caller to the Contractor's Clinical Referral Line. In 2011, the customer service line received 139,072 calls and the Clinical Referral Line received 112,758 calls for a total of 251,830 calls. For the first 6 months of 2012, the customer service line received 68,652 calls and the Clinical Referral Line received 54,419 calls for a total of 123,071 calls. The Offeror/Contractor is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.I provides the number of members who have utilized the current DCS customized MHSA Program website from October 2011 through October 2012.

a. **Duties and Responsibilities**

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

(1) Providing Enrollees access to information on all MHSA benefits and services related to the MHSA Program through the Empire Plan consolidated toll-free number twenty-four (24) hours a Day, 365 Days a year;

Confirmed.

(2) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Offeror's line at their call center service site. The Contractor must sign a shared service agreement with the Empire Plan's medical carrier/third party administrator (currently UnitedHealthcare) and AT&T. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to call center service as required by this Section of the RFP;

Confirmed.

(3) Maintaining a Dedicated Call Center for the MHSA Program located in the United States that:

(a) Provides direct access to trained Clinicians who direct members to appropriate Network Providers, provide clinical MHSA information and, if requested by the caller, assist in scheduling appointments on behalf of the member, twenty-four (24) hours a Day, 365 Days a year;

Confirmed.

(b) Provides access to fully trained customer service representatives and supervisors available between the hours of 8:00AM.to 5:00PM., Monday through Friday, except for legal holidays observed by the State;

Confirmed.

(c) Meets the Contractor's proposed call center telephone guarantees set forth in Section IV.B.4b (8) of this RFP.

Confirmed.

(4) Customer service staff must use an integrated system to log and track all Enrollee calls. The system must create a record of the Enrollee contacting the call center, the call type, and all customer service actions and resolutions;

Confirmed.

(5) Customer service representatives must be trained and capable of responding to a wide range of questions, complaints and inquiries including but not limited to; MHSA Program benefits levels, status of pre-certification requests, eligibility and claim status and be able to identify calls requiring transfer to a Clinician;

Confirmed.

(6) Maintaining a designated backup customer service staff located in the United States with MHSA Program-specific training to handle any overflow when the dedicated customer service center is unable to meet the Contractor's proposed customer service performance guarantees. This back-up system would also be utilized in the event the primary customer service center becomes unavailable;

Confirmed.

(7) Maintaining and timely updating a secure online customized website accessible by Enrollees, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding; MHSA Program benefits, Network Provider locations, eligibility, Copayment information, pre-authorization information, claim status and clinically-based educational material. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior

to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal; and

Confirmed.

(8) ***Call Center Telephone Guarantees*:** The Contractor must meet or exceed the following four (4) measures of service on the toll-free customer service telephone line;

(a) ***Call Center Availability*:** The MHSA Program's service level standard requires that the Contractor's telephone line will be operational and available to Enrollees, Dependents and providers at least ninety-nine and five-tenths percent *(*99.5%) of the Contractor's Call Center Hours. The call center availability shall be reported monthly and calculated annually;

Confirmed.

(b) ***Call Center Telephone Response Time:*** The MHSA Program's service level standard requires that, at the least, ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a

customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported monthly and calculated annually;

Confirmed.

(c) ***Telephone Abandonment Rate:*** The MHSA Program's service level standard requires that the percentage of incoming calls to the Contractor's telephone line in which the caller disconnects prior to the call being answered by a customer service representative or Clinical Manager, if after hours will not exceed three percent (3%). The telephone abandonment rate shall be reported monthly and calculated annually.

Confirmed.

(d) ***Telephone Blockage Rate:*** The MHSA Program's service level standard requires that the Contractor guarantee that not more than zero percent (0%) of incoming calls to the customer service telephone line be blocked by a busy signal. The telephone blockage rate shall be reported monthly and calculated annually.

Confirmed.

b. <u>Required Submission</u>

(1) Confirm that you will provide Enrollees access to the Clinical Referral Line and MHSA Program information through a consolidated toll-free number 24 hours a day 365 Days a year, as described above.

Confirmed.

(2) Confirm you will enter into a shared service agreement with the Empire Plan medical carrier/ third party administrator, or other party designated by the Department, and AT&T. Confirm you will provide 24 hours a day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability.

Confirmed.

(3) Confirm you maintain a Dedicated Call Center for the MHSA Program located in the United States, employing a staff of Clinicians and a staff of fully trained customer service representatives (CSR's) and supervisors. Confirm that customer service representatives will be available, at a minimum, for the MHSA Program between the hours of 8:00AM to 5:00PM, Monday through Friday except for legal holidays observed by the State. If additional hours are proposed, please state. Confirm that access to Clinical Managers through the Clinical Referral Line will be 24 hours a Day, 365 Days a year.

Confirmed.

(4) Describe the information, resources and system capabilities that are available for the customer service representatives to address and resolve member inquiries. Include:

(a) Whether any Interactive Voice Response (IVR) system is proposed;

Yes. Our existing Interactive Voice Response (IVR) system is a 24/7 option for members to receive information on benefits, eligibility and the status of claims, in addition to other information about the Program. Information available via the IVR system can be customized specifically for the Program. The IVR uses speech recognition software to guide members through the available

information and has reporting capabilities to identify the frequency of use, most utilized information and call trends statistics and topics. The IVR and Call center reporting includes the necessary information to monitor performance.

(b) A sample of the IVR script and a description of customizable options, if any, you propose for the MHSA Program;

Pre-IVR routing script

"Welcome to the Empire Plan's Mental Health and Substance Abuse Program at Empire BlueCross BlueShield. If you are a Member experiencing a life-threatening emergency please press 1." (routes to BH Resource Center (Clinical Referral Line)

If you are a member, press 1. If you are a provider, press 2.

Member prompts:

- **If you are experiencing a life-threatening crisis, please press 1 now (route to BH Resource Center – live agent)**
- **If you are inquiring about your BH eligibility, benefits, claim status or to find a provider , please Press 2 (route to self serve IVR with opt out to customer service representative)**
- **For all other inquiries, including questions about Mental Health and Substance Abuse services, resources, or finding a provider, please press 3 (route to BH Resource Center – live agent)**

Provider prompts:

- **If you are a Provider calling to verify eligibility, benefits or claim status Press 4 (route to Empire Fast Check self serve with option for provider service agent after self serve)**
- **If you are a Provider calling to pre-certify care Press 5 (route to Regional UM Unit – live agent)**

Our team is experienced in customizing the IVR script and option order as we do for the Hospital Program today to meet the Department's requirements. Please refer to Appendix C for a sample of additional proposed changes to the IVR.

(c) A description of the management reports and information available from the system including the key statistics you propose to report;

Our management reports can provide telephone metrics monthly, quarterly and annually as follows:

- **Calls received**
- **Calls handled**
- **Calls abandoned**
- **Call inquiry reasons**
- **Average speed of answer**
- **Average agent handle time**
- **Percent of calls transferred**
- **Service level of calls handled within speed of answer**

We can consult with the Department to provide additional reports as needed.

(d) A description of the capabilities of your phone system to track call types, reasons and resolutions;

We use an automated call distributor (ACD) system to handle incoming calls. Through this system, calls are distributed to the staff in longest call wait order. Online tracking systems display the volume of calls received, handled and

abandoned, as well as the number of calls in queue, the number of staff on the phone, the number of staff waiting for a call, and the average speed of answer for the day.

We also maintain an inquiry tracking system, which enables us to document every member's service call, written inquiry and web inquiry, along with the reason or topic code for the member's contact. This robust system allows managers to track each call to resolution and to identify trends and report on issues to other areas of the organization so that corrective action plans can be implemented if needed.

Another aspect of our phone capabilities is the part it plays in the continuous improvement training of our customer service representatives (CSRs). Our quality call-coaching program randomly monitors inquiries and calls through the final disposition to ensure that we meet the highest service standard. A minimum of three calls per associate each month are evaluated. Our service observation capability is enhanced by the "Click2Coach" product, which records both sides of a phone conversation as well as the CSRs' computer navigation during the course of a call.

(5) Describe the training that is provided to CSR and Clinical Referral Line staff before they go "live" on the phone with Enrollees. Include:

CSR Staff Training

Initial training for CSRs involves eight weeks of classroom training, interspersed with lesson plan-specific, on-the-job training. Our corporate operations training department conducts the initial training in a classroom setting, with written evaluations conducted throughout the program. The training department works closely with operations management to ensure that all skill needs are met, resources are available, and that training is current. The training focuses on technical components but also provides a thorough understanding of the client and improved skills and culture of CSRs to advocate for members.

After the formal classroom training, the CSR is transitioned to the operational area. Directly after the formal classroom training, new hires handle three weeks of live calls in a classroom setting under the supervision of a dedicated team.

Once the new CSR is independently answering phone calls, a senior representative will monitor the interactions and be available at all times if needed. This phase is designed to increase the CSR's skills, and provides for a smooth transition from the classroom to the production environment.

CSR candidates must possess excellent computer skills, and have a minimum of a high school diploma. A college education is preferred. CSRs are hired with a target of three or more years of experience in a customer service setting. The selection process includes specific testing appropriate to the position, as well as a multi-step interview process.

Clinical Referral Line Intake Staff Training

CSR training is a multi-phased approach. The first phase is classroom-based with a dedicated behavioral health trainer delivering a formal curriculum. During this time, the CSRs follow a syllabus to learn the system/programs used, behavioral health terminology and workflows. CSRs work on practices specific to the syllabus modules and take an end-of-classroom-training evaluation to ensure they are meeting and understanding all areas of the job. This phase is usually five days in duration.

The second phase of training includes one-on-one mentoring. CSRs perform self-reviews of internal documents and listen to calls with a seasoned CSR acting as a mentor to learn call flows. During this mentoring period, the CSR begins to take calls while being live-monitored by the seasoned CSR. This typically takes an additional three to five days.

The final phase is the call coaching period, which is on-going. The Call Coach will randomly pull monthly calls and perform a calibration audit to ensure the CSR has the tools needed to answer and complete calls accurately and efficiently.

Clinical Referral Line Staff Training

Clinical Referral Line staff receives a formal orientation that includes departmental policies and procedures, IT systems training, one-on-one training with our dedicated trainer and management, in addition to weekly participation in staff meetings. Trainees learn how to manage member calls, first by listening in on seasoned clinicians and later by taking calls themselves while a trainer live-monitors each call. The senior clinician then audits the trainee's documentation.

Our Clinical Referral Line staff members have at least five years post-graduate experience in a mental health field, in addition to a current license and a master's degree. They are also knowledgeable on current legislation, court decisions and regulations in such risk management areas as:

- **Substance abuse**
- **Workplace violence**
- **American's with Disabilities Act mental health accommodation**
- **Family Medical Leave Act**

(a) A description of the internal reviews that are performed to ensure quality service is being provided to Enrollees;

All associates regularly attend ongoing training sessions, seminars and workshops, and are required to participate in 36 hours of state-approved continuing education to maintain and renew their state license every two years. They are also required to participate in annual ethics and compliance training.

CSR Staff Reviews

Additionally, as part of our ongoing CSR training program, we have developed call coaching programs and technology that effectively combines on-the-job coaching with the latest telephone technology.

Our automated call system allows supervisors and call coaches to monitor calls from any touch-tone telephone for quality assurance purposes. In addition, we utilize "Quality Monitoring" by Envision Telephony software to randomly record both sides of a customer phone conversation, as well as record the activity on the CSR's computer screen during the recorded conversation. This program allows supervisors to view all aspects of a customer's call and evaluate the CSR's entire performance. This ensures that the highest service standards are met. Our call coaching program articulates, guides, and prompts our CSRs to strive towards service excellence.

Clinical Referral Line Intake Staff Reviews

The CSR unit uses an auditing program to ensure quality service is provided. CSRs are audited by the team lead on a monthly basis. Three calls are randomly pulled and scored against an audit sheet. The audit sheet contains eight categories and 44 line items. Categories include:

- **Greeting**
- **Confidentiality**
- **Servicing communication skills**
- **Servicing actions**
- **Hold technique**
- **Call closing**
- **Accuracy**
- **Documentation**

Each category is weighted based on content, and CSRs can earn up to 100% on the entire audit sheet. For each line item, the CSR has the ability to either "meet" or "not meet" a line item. If a line item is not

met, the CSR is provided immediate feedback and re-education to ensure they will meet the line item for future calls. The audit is sent to each CSR as soon as the audit is complete to provide CSRs with up-to-date feedback and tips on how to excel in their service.

In addition to the auditing program, CSRs also meet with a call coach monthly. The call coach also randomly audits calls and provides feedback to the CSR. This ensures the CSR has all the tools they need to excel in their service.

Clinical Referral Line Staff Reviews

Clinical Referral Line staff members are audited several times each month on their interactions with enrollees through both live monitoring and recorded auditing. The staff member's documentation of enrollee calls are also audited for quality and accuracy. Clinical Referral Line staff are required to maintain a minimum high score for accuracy on their audits, and any identified issues are addressed directly by both their manager and the team lead.

(b) The first call resolution rate for the proposed call center;

Our closed first contact rate is 85% for the proposed call center. At times there are situations where we need to take further action on behalf of the member, such as reaching out to a provider or doing additional research. In these cases, we negotiate a date of resolution directly with the member, monitor the inquiry and respond back to the member upon completion.

(c) The turnover rate for customer service and Clinical Referral Line employees;

The turnover rate for Customer Service staff is as follows:

- **2011: 12.8%**
- **2012: 9.3%**

The turnover rate for Clinical Referral Line staff is as follows:

- **2011: 9.1%**
- **2012: 6.3%**

(d) Ratio of management and supervisory staff to customer service representatives; and

The ratio of management and supervisory staff to customer service representatives is 1:25.

(e) Proposed staffing levels including the logic used to arrive at the proposed staffing levels;

The proposed staffing levels include 24 Customer Service Representatives, 1 Manager, 1 Operational Expert, 1 Process Expert and 1 clerk. Staffing levels are derived based on the stated call volumes and the performance guarantees.

(6) Describe the back-up systems for your primary telephone system which would be used in the event the primary telephone system fails, is unavailable or at maximum capacity. If a back-up system is needed, explain how and in what order calls from Enrollees will be handled. Confirm that backup staff will have MHSA Program specific training. Indicate the number of times the back-up system has been utilized over the past two (2) years. Confirm that calls will be handled exclusively by your Dedicated Call Center and that the backup call center would only be used in case of system failure or call overflow;

Our Disaster recovery plan includes two Edify IVR farms in two different locations. Calls are routed to the farms from AT&T using Intelligent Call Management (ICM) to determine IVR farm availability.

Should the ICM not be available as the interface between AT&T and Edify servers, redundancy has been programmed within the AT&T network for

AT&T to "take back" the call and route it using call allocators to each of the IVR farms. With this method of delivery, the call is routed from the AT&T network directly to the IVR farm, from the IVR farm directly to Aspect switch and Agent group.

The different IVR Farm locations also provide redundancy should an entire IVR farm lose functionality. In this event, 100% of the calls would route using ICM and AT&T to the farm which is showing as available to receive incoming calls.

In the past two years we have not had to utilize the backup call routing described above. In the event that we do utilize backup systems, we will provide specific training to backup staff. This call center would only be used in cases of system failure.

(7) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop a customize website for the MHSA Program. Also, confirm that the following information, at a minimum, will be available on the website: MHSA Program benefits, Network Provider locations, eligibility, Copayment information and claim status. Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website; and

Confirmed. We will develop a customized website and, in 2014, we are enhancing our website, empireblue.com, by creating a simple and immersive member experience. Users can get easy to understand answers to everyday questions, become more aware of health care options and find resources to help them live healthier lives.

Website content is easy to understand and does not contain health care jargon or acronyms. Content can be easily crawled by search engines such as Google

and Yahoo. Our website uses images and icons to represent key personalized site content and features.

We use consistent navigational panel colors and only use the color red to indicate to users that something needs attention. In addition, each family member on the same policy is associated with a specific color, allowing each family member to easily distinguish his or her information from the others.

Our intuitive website addresses members' needs and expectations about what to do when they visit our site. When members enter our website, they see a visually appealing dashboard. Members can choose to add their own content to the page by dragging and dropping content modules onto their dashboard. The dashboard provides members with:

- **Access to membership information**
- **Information about their plans and benefits**
- **Benefit and claim status information in plain language, with ability to "drill-down"into details**

This functionality saves members time by allowing them to quickly view a brief snapshot of their most recent information within certain features and helps them manage their health care information.

Our website is customer centric and provides information in a visually engaging, simplified way, creating an experience that is relevant and useful to members. When visiting our site members see:

- **Easy and secure access to personalized member services**
- **Friendly, easy-to-understand language, meaning no insurance jargon**

Find a provider tool functionality:

- **Search for a provider by name, city and state or by ZIP code**
- **Compare providers using Zagat survey ratings The ability to print or e-mail search results**

In summary, our website is completely customizable and includes all of the information requested by the Department. We are committed to working with the Department to develop a website that meets specifications.

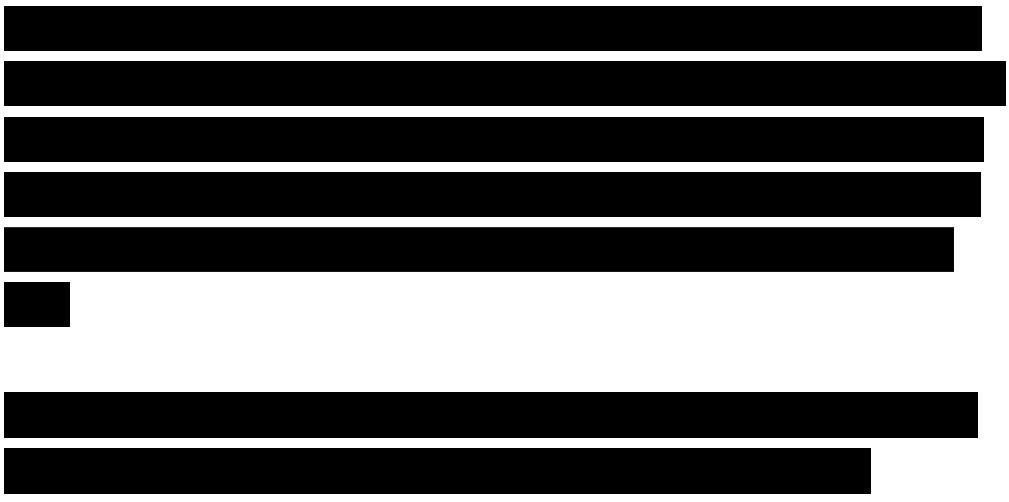
For Empire BCBS's demo website, please go to empireblue.com and use the following login credentials:

Empire ID: empirehmo1
Empire Password: pass1word

(8) ***Call Center Telephone Guarantees*:** For each of the four (4) Call Center Telephone Guarantees above, the Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fees, for failure to meet the Offeror's proposed guarantee;

(a) ***Call Center Availability:***

The Standard Credit Amount for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) that the Offeror's telephone is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours, calculated on an annual basis, is $100,000 per year. However, Offerors may propose higher or lesser amounts;



(b) ***Call Center Telephone Response Time:***

The Standard Credit Amount for each .01 to 1.0% below the standard of at the least ninety percent (90%) of incoming calls to the Offeror's telephone line that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, is $25,000 a year. However, Offerers may propose higher or lesser amounts.

[redacted]

(c) ***Telephone Abandonment Rate:***

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%), is $25,000 per year. However, Offerors may propose higher or lesser amounts.

[redacted]

(d) ***Telephone Blockage Rate:***

The Standard Credit Amount for each .01 to 1.0% of incoming calls to the Offeror's telephone line that are blocked by a busy signal, in excess of the standard of zero percent (0%), is $25,000 per year. However, Offerors may propose higher or lesser amounts.

[redacted]

5. Enrollee Communication Support

The Department regularly provides information regarding MHSA Program benefits to Enrollees through various publications, the Department's website and attendance at various meetings. The Contractor will be required to assist the Department with the creation, review and presentation of MHSA Program materials that will enhance an Enrollee's understanding of MHSA Program benefits. Please see Exhibit II.J for a summary of MHSA Program presentations that took place in the past 12 month period.

a. **Duties and Responsibilities**

(1) All Enrollee communications developed by the Contractor are subject to the Department's review and prior written approval, including but not limited to any regular standardized direct communication with Enrollees or their MHSA Providers in connection with covered benefits or the processing of Enrollee claims, either through mail, e-mail, fax or telephone. The Department, in its sole discretion, reserves the right to require any change it deems necessary.

Confirmed.

(2) The Contractor will be responsible for providing Enrollee communication support and services to the Department including, but not limited to:

(a) Developing language describing the MHSA Program for inclusion in the NYSHIP General Information Book and Empire Plan SPD, subject to the Department's review and approval;

Confirmed.

(b) Developing articles for inclusion in Empire Plan Reports and other publications on an "as needed" basis, detailing MHSA Program benefit features and/or highlighting trends in MHSA utilization;

Confirmed.

(c) Timely reviewing and commenting on proposed MHSA Program communication material developed by the Department;

Confirmed.

(d) Developing timely and accurate Summaries of Benefits Coverage (SBC), which will be consolidated with coverage information from other Program carriers/third party administrators for The Empire Plan, Student Employee Health Plan and Excelsior Plan. The Department will post the SBCs on NYSHIP Online. Upon Enrollee request, the Contractor must direct Enrollees to the NYSHIP Online website to view the SBC or distribute a copy of the SBC to the Enrollee within the federally required time period; and

Confirmed.

(e) Paying a portion of the Shared Communication Expenses, the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees. The Empire Plan's medical carrier/third party administrator will bill the Contractor on a quarterly basis for a portion of the Programs' Shared Communication Expenses. The Department agrees that these costs are not included in Administrative Fees and that the Contractor will be reimbursed for these costs as set forth in Article XV of Section VII of the RFP.

Confirmed.

(3) Upon request, subject to the approval of the Department, on an "as needed" basis, the Contractor agrees to provide staff to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. **The Contractor agrees that the costs associated with these services are included in the Offeror's Administrative Fee.**

Confirmed.

(4) The Contractor must work with the Department to develop appropriate customized forms and letters for the MHSA Programs, including but not limited to Enrollee claim forms and certification letters. All such communications must be approved by the Department, in writing, prior to distribution.

Confirmed.

b. <u>Required Submission</u>

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreement. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the MHSA Program

communications you have developed for Enrollees. Confirm your understanding that all MHSA Program communications developed by the Offeror are subject to the Department's final approval.

Confirmed, all MHSA program communications will be subject to the Department's final approval. Enrollee communications for the MHSA Program will be the responsibility of the Account Team. The Account Team will work directly with the Communications staff at the Department to coordinate one consolidated response, final draft, article, or legally approved language from all internal partners responsible for the administration of the Program. The process will mirror the current process for the Hospital Program, where one member of the Account Team acts as the Department's central point of contact. This contact will coordinate with the Operations, Clinical and Legal staff, as appropriate, to ensure a timely response with accurate, relevant and factual information about the corresponding topic.

Enrollee communications will be reviewed by staff members designated with responsibility for the Program within the various areas of the organization. When articles or proactive information about a topic is required, a content expert will be assigned within the organization. The content expert will take responsibility for the creation of the communication, while the other members of the team (i.e., Legal, Medical Director, Account Team) will have responsibility for review. This collaborative approach to the communication function develops accountability within the team and ultimately ensures the accuracy of the information.

Please refer to Appendix D for sample MHSA program communications.

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

Enrollee communications for the MHSA Program will be the responsibility of the Account Team. The Account Team will coordinate responses with designated internal subject matter experts across all aspects of administration of the Program including, but not limited to: Operations, Clinical, Legal, Marketing, Communications and Regulatory Compliance. In addition to enrollee communications requested by the Department, the Account Team will proactively identify opportunities for member education by reviewing utilization and call center trends. The Account Team will provide one consolidated response within the timeframes required based on Department guidelines.

(3) Confirm that the Offeror will pay the allocated portion of Shared Communication Expenses covering the cost of all production, distribution and mailing costs incurred to disseminate Program communication materials to Enrollees on a timely basis, and will bill the MHSA Program for reimbursement in accordance with Article XV of the Agreement.

Confirmed.

(4) Confirm that staff will be available to attend Health Benefit Fairs, select conferences, and benefit design information sessions, etc. in NYS and elsewhere in the United States. Describe the experience and qualifications of staff that will be attending these events.

Confirmed. Attendance at Health Benefit Fairs, select conferences, benefit design information sessions, etc. in NYS and elsewhere in the United States will be the responsibility of the Account Team. The Account Representative will

be a subject matter expert in the Program's benefit design and will also have a common working knowledge of benefits offered by the other Programs that comprise the Empire Plan, such as the Medical, Pharmacy and Hospital Programs.

The Account Representative will have primary responsibility for representing the Program at Health Benefit Fairs, benefit meetings, etc. The Account Executive will also be available for meetings and higher level presentations as necessary. The Account Team will be staffed with experienced representatives with clinical backgrounds, capable of leading clinical discussions.

(5) Confirm your commitment to work with the Department to develop appropriate customized forms, letters and SBCs for the MHSA Program. Provide examples of how you have worked with other large clients to produce customized communications.

Confirmed. We will collaborate with the Department, as is current practice under the Hospital Program, to develop materials to meet the Department's needs. Some examples of these customized communications include SBCs, At a Glance, Reporting On and Certificate language changes.

(6) Confirm that upon Enrollee request, the Offeror will distribute SBCs to Enrollees in a timely manner.

Confirmed.

6. <u>Enrollment Management</u>

The MHSA Program requires the Contractor to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with the Program's eligibility rules. EBD utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and

SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A through II.A4.

Note: The enrollment counts depicted in these exhibits may vary slightly due to timing differences in exhibit generation.

When a person enrolls in The Empire Plan, Excelsior Plan, or SEHP, the Department's card contractor issues an Employee Benefit Card. An Enrollee with individual coverage will receive one card containing the Enrollee's 9-digit alternate identification number and name. An Enrollee with family coverage will receive two cards containing the Enrollee's alternate identification number and name, as well as Dependents' names. This universal card is used by Enrollees and Dependents for all components of The Empire Plan. An example of The Empire Plan Employee Benefit Card is provided in Exhibit II.E. An example of the Excelsior Plan Employee Benefit Card is provided in Exhibit II.E.3. The Department will not accept an alternative approach to ID cards. It is the responsibility of the Offeror to ensure that the Provider Network accepts The Empire Plan Employee Benefit Card as evidence of coverage and is capable of submitting claims when presented with The Empire Plan Employee Benefit Card. These cards include The Empire Plan consolidated toll free number that providers may use to contact the MHSA Program if they need claim submission assistance. The Contractor should not expect any modification of the current identification card as part of implementation.

The SEHP Employee Benefit Card displays the Enrollee's 9-digit alternate identification number and name and the expiration date of coverage. The SEHP Employee Benefit Cards are issued annually by a Department contractor and have an expiration date of August 31st of each year. An example of this card is provided in Exhibit II.E.2.

a. Duties and Responsibilities

The selected Contractor will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for

whom Medicare is primary, and produce management reports and data files. The Contractor must provide enrollment management services including but not limited to:

(1) ***Initial Testing:***

(a) Performing an initial enrollment load to commence upon receipt of the enrollment file from the Department during the MHSA Program implementation. The file may be EDI Benefit Enrollment and Maintenance Transaction set 834(ANSI x.12 834 standard either 834 (4010x095A1) or 834 (005010x220)), fixed length ASCII text file, or a custom file format. The determination will be made by the Department;

Confirmed. Empire BCBS supports ANSI x12 834 Version 005010x220A1 or custom file format.

(b) Testing to determine if the enrollment file and enrollment transactions loaded correctly and that the enrollment system interfaces with the claims processing system to accurately adjudicate claims. The Contractor shall submit enrollment test files to the Department for auditing, provide the Department with secure, online access required to ensure accurate loading of the MHSA Program enrollment data, and promptly correct any identified issues to the satisfaction of the Department;

Confirmed.

(2) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will

release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.H. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

Confirmed.

(3) Ensuring the security of all enrollment information as well as the security of a HIPAA compliant computer system in order to protect the confidentiality of Enrollee data contained in the enrollment file. Any transfers of enrollment data within the Contractor's system or to external parties must be completed via a secured process;

Confirmed.

(4) Providing a back-up system or have a process in place where, if enrollment information is unavailable; Enrollees can obtain Clinical Referral Line services without interruption;

Confirmed.

(5) Cooperating fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement;

Confirmed.

(6) Maintaining a read only connection to the NYBEAS enrollment system for the purpose of providing the Contractor's staff with access to current MHSA Program enrollment information. Contractor's staff must be available to access enrollment information through NYBEAS, Monday through Friday, from 8:00 am to 5:00 pm, with the exception of NYS holidays as indicated on the Department's website;

Confirmed.

(7) Meeting the administrative requirements for National Medical Support Notices. A child covered by a Qualified Medical Child Support Order (QMCSO), or the child's custodial parent, legal guardian, or the provider of services to the child, or a NYS agency to the extent assigned the child's rights, may file claims and the Contractor must make payment for covered benefits or reimbursement directly to such party. The Contractor will be required to store this information in its system(s) so that any claim payments or any other plan communication distributed by the Contractor, including access to information on the Contractor's website would go to the person designated in the QMCSO; and

Confirmed.

(8) ***Enrollment Management Guarantee*:** The Contract must guarantee that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Contractor's enrollment system within twenty-four (24) hours of release by the Department.

Confirmed.

b. <u>Required Submission</u>

(1) Describe your testing plan to ensure that the initial enrollment loads for the MHSA Program are accurately updated to your system and that they interface correctly with your claims system.

(a) What quality controls are performed before the initial and ongoing enrollment transactions are loaded into the claims adjudication system?

Upon receipt by Empire BCBS, eligibility files are validated against HIPAA Level 1-7 edits. Files that do not contain any HIPAA errors are loaded to the system. Any incomplete or inaccurate entries are dropped from the file load and are placed on a fall-out report to be researched through NYBEAS and loaded to the system manually, as needed. Only those records that satisfy the pre-load requirements are systematically loaded. The eligibility process for the MHSA Program will follow the same process as the Hospital Program, which has a successful and proven track record.

(b) How does your system identify transactions that will not load into your enrollment system? What exceptions will cause enrollment transactions to fail to load into your enrollment system? What steps are taken to resolve the exceptions, and what is the turnaround time for the exception records to be added to your enrollment file?

Any incomplete or inaccurate transactions that will not load into the enrollment system are dropped from the file load and placed on a fall-out report to be researched through NYBEAS and loaded to the system manually. Missing or incomplete fields that do not match the programmed formatting (i.e., alpha or numeric), such as invalid birth date or invalid gender, will cause enrollment records to appear on the fall out report. Additionally, multiple transactions for the same enrollee on one report will cause the transaction to drop out for manual review. Generally, once the Department file is received, manually loaded transactions are completed (on business days) within 12 hours from the receipt of the original file.

(2) Describe your system capabilities for retrieving and maintaining enrollment information within twenty-four (24) hours of its release by the Department as well as;

A detailed process has been developed to ensure eligibility updates are loaded to the enrollment system within 24 hours of release by the Department. This existing process will be utilized, as the enrollment files will be integrated with the existing Hospital Program enrollment. This electronic data information exchange will utilize the current 834 file format and members will appear active on the claims and enrollment system within the required 24-hour turnaround.

(a) How your system maintains a history of enrollment transactions and how long enrollment history is kept online. Is there a limit to the quantity of history transactions that can be kept on-line?

Eligibility history is maintained within our eligibility system. Our system has no purge logic in place; the history remains indefinitely.

(b) How your system handles retroactive changes and corrections to enrollment data;

Retroactive change and correction transactions are handled in the same manner as outlined above in question b.1.a. A report is generated in cases of retroactive terminations. This report is reviewed to identify any claim payments made and the recovery process is initiated as appropriate.

(c) Detail how your 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;

The current Hospital Program group hierarchy allows for our enrollment system to capture the information necessary to produce the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims." The Empire BCBS enrollment system captures the following fields when loading eligibility received from the Department:

- **Agency code**
- **Agency type**
- **Dependent status**
- **Medicare primary**
- **Customer IDs**

The codes are sent by the Department on the daily enrollment file. In turn, Empire BCBS translates the codes and maps them to the eligibility system. The system is capable of collecting and maintaining Agency Code, Agency Type, COB, Medicare Part B and Customer IDs, so consequently we have the information necessary to complete the reports.

Since the Mental Health enrollment will be integrated into the Hospital enrollment, the hierarchy outlined above will also be used to provide the required reporting.

(d) Confirm your enrollment and claims processing system has the capacity to administer a social security number, Employee identification number and an alternate identification number assigned by the Department. Does your system have any special requirements to accommodate these three identification numbers? Explain how Dependents are linked to the Enrollee in the enrollment system and claims processing system;

Confirmed. Our enrollment system has the capacity to accommodate all three identification numbers. There are no special requirements to accommodate three identification numbers.

Dependents are linked to the enrollee using the employee identification number. Each dependent is assigned a dependent number that is two positions. Contract holders are assigned dependent number "00". Dependents are assigned "01-99". These numbers are assigned based on the order of the dependent records in the transaction file. Additionally, we also catch the Department's assigned dependent number.

(3) Describe how your enrollment system, data transfers, and procedure for handling enrollment data are HIPAA compliant.

Our CS90 system presently meets requirements.

Under HIPAA, a "code set" is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes. Code sets for medical data are required for data elements in the administrative and financial health care transaction standards adopted under HIPAA for diagnoses, procedures and medications.

Additionally, all data exchanges between the plan and outside entities involving electronic PHI are required to be encrypted. Access to electronic PHI is restricted on a "need to know" basis as determined by specific job function. Administrative, physical and technical processes and procedures are in place to mitigate the risks associated with the collecting, storing and processing of electronic PHI. Protection of electronic PHI includes such measures as intrusion detection and prevention, access control, security awareness training and security policies and procedures.

(4) Describe the backup system, process or policy that will be used to ensure that Enrollees receive Clinical Referral Line services in the event that enrollment information is not available.

Member information is housed on three different systems, each of which operate independently and can be accessed to verify eligibility if one of the systems is down. This process ensures members have continued service during a system outage. In addition, these systems are located at multiple sites with workflows and processes in place to contact those sites if the outage is expected to last for an extended period of time.

Dedicated staff also has access to NYBEAS, so in an extreme situation they can verify enrollment directly with the Department.

(5) Confirm you will cooperate fully with any State initiatives to use new technologies, processes, and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement.

Confirmed.

(6) Confirm that you will maintain a read only connection to the NYBEAS enrollment system, and that Offeror's staff will be available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 8:00 AM. to 5:00 PM., with the exception of NYS holidays.

Confirmed.

(7) Describe your ability to meet the administrative requirements for National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO), including storing this information in your system so that information about the Dependent is only released to the individual named in the QMCSO.

We will utilize the existing process followed under the Hospital Program to meet the administrative requirements for National Medical Support Orders and dependents covered by QMCSO. We currently utilize medical notes on CS90 to capture information based on Qualified Medical Support Orders so that EOBs, checks, etc., can be sent to an alternate address from that of the subscriber on the contract, and ensure information about the dependent is only released to the individual named on the QMSCO.

(8) ***Enrollment Management Guarantee:*** The MHSA Program service level standard requires that one hundred percent (100%) of all MHSA Program enrollment records that meet the quality standards for loading will be loaded into the Offeror's enrollment system within twenty-four (24) hours of release by the Department. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the standard.

The Standard Credit Amount for each 24 hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system is $5,000. However, Offerors may propose higher or lesser amounts.

[redacted]

7. Reporting

Reporting must be structured to provide assurances that member, network and account management service levels are being maintained and that claims are being paid and billed according to the terms of the agreements with Network Providers and the terms of the Agreement. The Contractor may on occasion be requested to provide ad-hoc reporting and analysis within very tight time frames.

Amended March 29, 2013
In order to fulfill its obligations to enrolled members and ensure contract compliance, the MHSA Program requires that the Contractor provide detailed claims data on a monthly basis, as well as specific summary reports concerning the administration of the MHSA Program in an accurate manner.

All electronic files received by the Department are first validated for compliance with the specified file structure. Files that fail to adhere to this structure are rejected in their entirety.

a. Duties and Responsibilities

The Contractor will be responsible for accurate reporting services including, but not limited to:

(1) Ensuring that all financial reports including claim reports are generated from amounts billed to the MHSA Program, and reconcile to amounts reported in the quarterly and annual financial experience;

Confirmed.

(2) Developing, in conjunction with the Department, standard electronic management, financial, and utilization reports required by the Department for its use in the review, management, monitoring and analysis of the MHSA Program. These reports must tie to the amounts billed to the MHSA Program. The final format of reports is subject to the Department review and approval;

Confirmed.

(3) Supplying reports in paper format and/or in an electronic format including but not limited to Microsoft, Access, Excel and/or Word as determined by the Department. The reports include, but are not limited to, reports and data files listed in Article XVI "Reports and Claim Files" section of this Agreement;

Confirmed.

(4) Providing Ad Hoc Reports and other data analysis at no additional cost. The exact format, frequency, and due dates for such reports shall be specified by the Department. Information required in the Ad Hoc Reports may include but is not limited to providing;

(a) Forecasting and trend analysis data
(b) Utilization data
(c) Utilization review savings
(d) Benefit design modeling analysis
(e) Reports to meet clinical program review needs
(f) Reports segregating claims experience for specific populations
(g) Reports to monitor Agreement compliance

Confirmed.

(5) Providing direct, secure access to the Contractor's claims system and any online and web-based reporting tools to authorized Department representatives;

Confirmed.

(6) ***Management Reports and Claim File Guarantees****:* The Contractor must provide accurate management reports and claim files as specified in Section IV.B.7.a.(7) of this RFP will be delivered to the Department no later than their respective due dates inclusive of the date of receipt; and

Confirmed.

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(7) ***Supplying reports in paper format and/or in a***n electronic format (Microsoft Access, Excel, Word) as determined by the Department. The primary reports and data files are listed under Annual, Quarterly and Monthly Reports and include the time frames for submittal to the Department:

Confirmed.

Annual Reports

Annual Financial Experience Report: The Contractor must submit an annual experience report of the MHSA Program's charges and credits no later than seventy-five (75) Days after the end of each Calendar Year. This statement must detail, at minimum, claims paid during the year, projected incurred claims not yet paid administration costs, performance credits, audit credits, etc. Such detail must include all charges by the Contractor to the MHSA Program;

Confirmed. Please refer to Appendix E.1.

Annual Premium Renewal Report: The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must included, but not be

limited to: paid claim amounts, projected incurred claims, trend, Administrative Fees and changes in enrollment;

Confirmed. Please refer to Appendix E.2.

Annual Summary Reporting: The Contractor must prepare and present to the Department, GOER, Division of Budget and NYS employee unions an annual report that details MHSA Program performance and industry trends. This presentation shall include, at a minimum, comparisons of the MHSA Program to book of business statistics, and other similar plan statistics. Clinical, financial and service issues are to be comprehensively addressed. The annual presentation and report is due each May after the end of each complete Calendar Year;

Confirmed. Please refer to Appendix E.3.

Annual Report of Claims and Credits Paid by Agency: The Contractor must submit a report with summary level claims and credits paid by agency. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due thirty (30) Days after the end of the Calendar Year;

Confirmed. We will provide the required report as outlined in II.F.

Quarterly Reports

Quarterly Financial Summary Reports: The Contractor must submit quarterly financial reports which present the MHSA Program's experience for the most recent quarter (based on a Calendar Year) and the experience from the beginning of the Calendar Year to the end of the quarter being reported. The quarterly reports must also include projections of;

- annual financial performance;
- assessment of MHSA Program costs;
- incurred claim triangles;
- audit recoveries;

- settlement and litigation recoveries;
- administrative expenses;
- trend statistics; and
- such other information as the Department deems necessary.

The reports are due on a quarterly basis, fifteen (15) Days after the end of the reporting period;

Confirmed. Please refer to Appendix E.4.

Quarterly Performance Guarantee Report: The Contractor must submit quarterly the MHSA Program's Performance Guarantee report that details the Contractor's compliance with all of the Contractor's proposed Performance Guarantees. The report should include the areas of: Implementation, customer service (telephone availability, telephone response time, abandonment rate and blockage rate); enrollment management, reporting, network composition, provider access, provider credentialing, financial and non financial accuracy, turnaround time for processing network and non-network claims, non-network Clinical Referral Line, emergency care Clinical Referral Line, urgent care Clinical Referral Line outpatient and inpatient Utilization Review; and inpatient and outpatient appeals. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. Documentation of compliance should be included with this report. The report is due thirty (30) Days after the end of the quarter;

Confirmed. We will provide the required report as outlined in II.F.

Quarterly Utilization Report: The Contractor must submit quarterly the MHSA Program's Quarterly Utilization Report that details MHSA care utilization by type of service for both network and non-network authorizations, by type of treatment (inpatient, outpatient, ALOC) Applied Behavioral Analysis, collective bargaining unit, age of the member, type of Dependent, and any other category as requested by the Department. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F. The report is due forty-five (45) Days after the end of the quarter;

Confirmed. We will provide the required report as outlined in II.F. In addition, please refer to Appendix E for similar reports available.

Quarterly Network Access: The Contractor must submit a measurement of the Network access (using **Exhibit I.Y.3**) based on a "snapshot" of the network taken on the last day of each quarter. The report is due thirty (30) Days after the end of the quarter;

Confirmed.

Quarterly Coordination of Benefit Report: The Contractor must submit a report that details the amount received as a result of coordinating benefits with other health plans including Medicare. The Contractor's report should identify the COB source, the Enrollee, the original claim amounts, and the amount received from the other insurance carriers or Medicare. The final format of this report will be determined by the Department in consultation with the Contractor. The report is due thirty (30) Days after the end of the quarter;

Confirmed. Please see Exhibit E.8.

Quarterly Participating Agency Claims: The Contractor must submit a quarterly report that presents summary level claim information by Participating Agency. The Contractor shall submit this report using the data elements specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the quarter;

Confirmed. We will provide the report as outlined in II.F. In addition, please refer to Exhibit E.9 for a similar report.

Quarterly Website Analytics Report: The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and

design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter;

Confirmed. Please refer to Exhibit E.10.

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Quarterly Provider Audit Report: The Contractor must submit a quarterly audit report to the Department that summarizes audits planned, initiated, in-progress and completed, as well as audit findings, recoveries and any other enforcement action by the Contractor. The report is due thirty (30) Days after the end of the quarters.

Confirmed. Please refer to Exhibit E.11.

Monthly Reports

Monthly Report of Paid Claims by Month of Incurral: The Contractor must submit a monthly report that provides summarized paid claims by month of incurral. The Contractor must submit this report using the data elements specified by the Department in Exhibit II.F unless otherwise specified by the Department. The report is due thirty (30) Days after the end of the month;

Confirmed. We will provide the report as outlined in II.F.

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MHSA Program Customer Service Monthly Reports: Each month the Contractor must submit a customer service report that measures the Contractor's customer service performance including call center availability, call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The reports are due fifteen (15) Days after the end of the month. For the first two months of the Agreement, these reports will be due on a weekly basis. After two months, the Department will re-examine the required frequency of these reports and establish due dates with the Contractor; and

Confirmed. Please refer to Exhibit E.12.

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Monthly/Periodic Reports

Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor a computerized file via secure transfer, containing detailed claim records using data elements acceptable to the Department to support the claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each month and submit a summarized report by month utilizing a format acceptable to the Department.

Confirmed.

b. Required Submission

(1) The Offeror must submit examples of the financial and utilization reports that have been listed without a specified format in the reporting requirements above as well as any other reports that the Offeror is proposing to produce for the Department to be able to analyze and manage the MHSA Program. Provide an overview of your reporting capabilities with the value you believe this will bring to the MHSA Program.

Samples of the financial and utilization reports (only those listed without a specified format in the RFP) are included as Appendix E. We have demonstrated in the past, on both the Hospital and Prescription Drug Programs, our ability to satisfy the reporting requirements of an Empire Plan Program. Many of the required reports are currently utilized on the Hospital Program. For the remaining reports, we are committed to developing the customized reports as required during the implementation of the contract.

We offer a standard client reporting package on-line that provides comprehensive information on utilization, as well as utilization management, case management and disease management information. This allows clients and the Account Management team to monitor benefit costs and the effectiveness of our managed care plans.

Our standard client reporting package includes the following features:

Online Accessibility

Our comprehensive client reporting suite is available 24/7 on-line.. The experience is entirely paperless, intuitive and flexible.

Integration

We have a holistic and practical view of information. We strive for meaningful integration of data that optimizes clients' ability to determine the right answers quickly.

Your Favorite Reports

Clients can select the reports that are most important to them and make the reports available on their home page for future use.

Next Steps

Our team of analysts has provided intuitive guides within the application to take clients to the next logical report that will answer their business questions.

Data Export Availability

Download reports to Excel and PDF with the click of a button.

Easy navigation

Navigation within the client reporting portal is easy and requires little to no training. The report library provides filtering to quickly search for any report.

In addition, we will post updates to the client reporting site when information has been refreshed or when we are showcasing a new report or enhanced functionality that may be important to our clients.

(2) Confirm that you will provide reports in the specified format (paper and/or electronic Microsoft Access, Excel, Word), as determined by the Department;

Confirmed.

(3) Confirm that you will provide direct, secure access to your claims system and any online and web-based reporting tools to the Department's offices. Include a copy of the data sharing agreement you propose for Department staff to execute in order to obtain systems access;

Confirmed. Please refer to our completed Appendix E.13 for a copy of our proposed data sharing agreement.

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(4) Confirm that your ability and willingness to provide Ad Hoc Reports and other data analysis. Provide examples of Ad Hoc reporting that you have performed for other clients.

Confirmed.

(5) ***Management Reports and Claim File Guarantees*****:** The MHSA Program's service level standard requires that accurate management reports and claims files will be delivered to the Department no later than their respective due dates. For the management reports and claim files listed in Section IV.B.7.a. (7) of this RFP,

the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this standard.

The Standard Credit Amount for each management report or claim file that is not received by its respective due date is $1,000 per report per each Business Day. However, Offerors may propose higher or lesser amounts.

[redacted]

[redacted]

8. Consulting

The Department requires the Contractor to be an expert in the MHSA industry, thus, the Department requires the Contractor to provide the Department with up-to-date developments in the MHSA industry and may be requested by the Department to provide advice and recommendations related to such developments. The Department expects the Contractor to proactively provide advice and recommendations that are related to the clinical quality and cost management of the MHSA Program. Such recommendations must, at a minimum include preliminary analysis of financial, therapeutic and Enrollee impact of proposed and contemplated benefit design changes.

a. Duties and Responsibilities

The Contractor will be responsible for providing advice and recommendations regarding the MHSA Program. Such responsibility shall include, but not be limited to:

(1) Informing the Department in a timely manner concerning such matters as cost containment strategies, technological improvements, Provider best practices and State/Federal legislation (e.g., Federal parity legislation, etc.) that may affect the MHSA Program. The Contractor must also make available to the Department one or more members of the clinical or account management team to discuss the implications of new trends and developments. The Department is not under any obligation to act on such advice or recommendation; and

Confirmed.

(2) Assisting the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. Recommendations must include a preliminary analysis of all associated costs, a clinical evaluation, and the anticipated impact of proposed MHSA Program modifications and contemplated benefit design changes on Enrollees.

In the event of a design change and should the Offeror request any change in compensation, any such change will be processed in accordance with Section V of this RFP.

Confirmed.

b. <u>Required Submission</u>

(1) What resources do you utilize to ensure the MHSA Program is kept abreast of the latest developments in the MHSA field? How do you propose to communicate trends, pending legislation and industry information to the MHSA Program?

Empire BCBS will take a proactive approach to the administration and management of the MHSA Program, similar to the approach currently used on the Hospital Program and previously used on the Prescription Drug

Program. One of the primary responsibilities of the Account Team and all internal partners responsible for the Program will be to act in a consultative manner and keep the Department and the Governor's Office of Employee Relations (GOER) abreast of the latest developments in the MHSA field. Key to this process will be a dedicated Operational/Clinical Account Executive, who will also oversee all clinical aspects of our services. In addition, we will provide the Department with information about any company or industry trends and changes that may impact the administration of the Program. We view our relationship with the Department as a partnership, with the goal of providing Empire Plan enrollees with the best coverage and service possible. A key component of this goal is to provide recommendations and information that will allow the Department to continually make improvements to the Program, either through changes resulting from collective bargaining or changes in industry standards or practices. Our collective Clinical and Account Teams are directly responsible for providing the Department with the necessary information to make these important Program decisions.

Our team will consist of experienced account management and clinical staff focused on providing expert consultation to the Program. The team will continually gather and analyze industry information from such sources as the internet and newspapers to ensure the Program is aware of all current trends, pending legislation and other relevant information. In addition the Account Team will work closely with internal and external counsel to identify pending legislation and communicate this proactively to the Department. Our teams use email, our corporate intranet and industry articles and websites to immediately identify and communicate trends and information to the Program. These tools ensure that we are current on the developments in the MHSA field that may impact the Program and that we are making timely recommendations based on this information.

Frequent print information is critical to the management of the Program, but face-to-face meetings, where relevant events and developments within the industry are communicated in an environment conducive to constructive

dialogue between Empire BCBS, the Department and GOER prove to be the most effective form of consultation. These meetings will be scheduled both on an as-needed basis and as standing meetings throughout the year, to provide continual Program updates to the Department and GOER.

(2) Please confirm you will assist the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State.

Confirmed.

9. <u>Transition and Termination of Agreement</u>

The Contractor shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their MHSA benefits and associated customer services through the final termination of the Agreement . This includes, but is not limited to: ensuring Enrollees can continue to receive services from Network Provider, the processing of all claims; verification of enrollment; providing sufficient staffing to ensure members continue to receive good customer service and clinical management service even after the termination date of the Agreement; and developing a strategy for addressing the treatment needs of those members in treatment with Providers that are not in the successor contractor's network. It is also imperative that the MHSA Program continue to have dialogue with key personnel of the Contractor's dedicated account team, maintain access to online systems and receive data/reports and other information regarding the MHSA Program after the termination date of the Agreement. In addition, the Contractor and the successor contractor shall fully cooperate with the Department to create and establish a transition plan in a timely manner.

a. Duties and Responsibilities

(1) The Contractor must commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program;

Confirmed.

(2) The Contractor must, within one hundred twenty (120) Days prior to the end of the Agreement, or within forty-five (45) Days of notification of termination, if the Agreement is terminated prior to the end of its term, provide the Department with a detailed written transition plan, which outlines, at a minimum, the tasks, milestones and deliverables associated with:

Confirmed.

(a) Transition of MHSA Program data, including but not limited to a minimum of one year of historical Enrollee claim data including providers' telephone numbers, names, addresses, zip codes and tax identification numbers, detailed COB data, report formats, pre-certification/prior authorization, approved - through dates, disability determination approved-through dates, any exceptions that have been entered into the adjudication system on behalf of the Enrollee, as well as other data the successor contractor may request and the Department approves during implementation of the MHSA Program in the format acceptable to the Department. The transition or pre-certification/prior authorization files should include but not be limited to the following;

(i) Providing a test file to the successor contractor in advance of the implementation date to allow the successor contractor to address any potential formatting issues;

Confirmed. However, in lieu of tax identification numbers, we will provide National Provider Identifiers (NPI).

(ii) Providing one or more pre-production files at least four 4 weeks prior to implementation that contains pre-certification/prior authorization approved - through dates and one year of claims history as specified by the Department working in conjunction with the successor contractor;

Confirmed.

(iii) Providing a second production file to the successor contractor by the close of business January 2nd (or 2 days after the Agreement terminates) that contains all pre-certification/prior authorization approved – through dates specified by the Department working in conjunction with the successor contractor.

Confirmed.

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

Confirmed.

(4) Within fifteen (15) Business Days from the Contractor's receipt of the required changes, the Contractor shall incorporate said changes into the Transition Plan and submit such revised Transition Plan to the Department;

Confirmed.

(5) The Contractor shall be responsible for transitioning the MHSA Program in accordance with the approved Transition Plan;

Confirmed.

(6) To ensure that the transition to a successor contractor provides Enrollees with uninterrupted access to MHSA benefits and associated customer services, and to enable the Department to effectively manage the Agreement, the Contractor must provide the following obligations and deliverables to the MHSA Program through the final financial settlement of the Agreement, including but not limited to:

(a) Provide all Contractor-provided services associated with claims incurred on or before the scheduled termination date of the Agreement, including but not limited to paying network claims, manual submit claims including but not limited to: Medicaid, out-of-network claims, foreign claims, in-network claims, COB claims, and Medicare, reimbursing late filed claims if warranted, repaying or recovering monies on behalf of the MHSA Program for Medicare claims, retaining NYBEAS access and continuing to provide updates on pending litigation and settlements that the Contractor or the NYS Attorney General's Office has/may file on behalf of the MHSA Program. In addition, the Contractor must continue to provide the Department access to any online claims processing data and history and online reporting systems through the final settlement dates, unless the Department notifies the Contractor that access may be ended at an earlier date;

Confirmed.

(b) Complete all reports required in Section IV.B.7.a.(7) of this RFP;

Confirmed.

(c) Provide the MHSA Program with sufficient staffing in order to address State audit requests and reports in a timely manner;

Confirmed.

(d) Agree to fully cooperate with all Department and/or OSC audits consistent with the requirements of Article XXIII of the Agreement and Appendices A and B;

Confirmed.

(e) Perform timely reviews and responses to audit findings submitted by the Department and the Comptroller's audit unit in accordance with the requirements set forth in Article XXIII "Audit Authority", Section VII, Contract Provisions and Appendices A and B; and

Confirmed.

(f) Remit reimbursement due the MHSA Program within fifteen (15) days upon final audit determination consistent with the process specified in Article XXIII, "Audit Authority" and Article – "Payments/credits) to/from the Contractor" of Section VII, Contract Provisions and Appendices A and B.

Confirmed.

(7) The Contractor must receive and apply enrollment updates, keep dedicated phone lines open with adequate available staffing to provide customer service at the same levels provided prior to termination of the Agreement, adjust phone scripts, and transfer calls to the successor contractor's lines during the transition period;

Confirmed.

(8) The Contractor must work cooperatively with the successor contractor and the Department to develop an approach to ensure a smooth transition for members who must change Providers to maintain the network level of benefits;

Confirmed.

(9) The Contractor must prepare, on a case by case basis, a plan to extend and manage the care of high risk Enrollees who are nearing the end of a course of treatment beyond the transition period;

Confirmed.

(10) The Contractor must continue to clinically manage and pay for Covered Services for Enrollees determined to be Totally Disabled on the last day of the Contract, for ninety (90) Days or until the disability ends, whichever occurs first;

Confirmed.

(11) The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined on or before December 31, 2018 until the earlier of the step down of care or midnight on the 90th day subsequent to December 31, 2018; and

Confirmed.

(12) The Contractor must agree that, if the Contractor does not meet the Transition Plan requirements in the time frame stated above, the Contractor **will permanently forfeit 100%** of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

Confirmed.

b. <u>Required Submission</u>

(1) Confirm that the Contractor will commit to fully cooperate with the successor contractor to ensure the timely, smooth transfer of information necessary to administer the MHSA Program.

Confirmed.

(2) Provide an outline of the key elements and tasks that would be included in your Transition Plan to ensure that all the required duties and responsibilities are completed if you were the incumbent contractor. Include a brief explanation on how you would accomplish this with the successor contractor.

Upon termination notification, Empire BCBS will prepare a transition plan that meets the Program requirements as defined above and will include the following key elements and tasks:

- **Administer run-out claims incurred prior to contract termination**
- **Transfer all applicable MHSA records to the Program's new Contractor, including the following (including test files and pre-production files):**
  - **A defined claims history file**
  - **Available COB data**
  - **The format of reports and all run out reports for incurred data prior to the contract termination**
  - **Prior authorization files**
  - **Appeal data and exceptions**
- **An approach to provide call center and enrollment support, as well as transferring members to the new contractor**
- **Transition plans for high-risk members**

We reserve the right to exclude certain financial data elements, as necessary, when the data is deemed proprietary and confidential in nature.

(3) Please detail the level of customer service and clinical management that you will provide after the termination date of the Agreement resulting from this RFP.

Empire BCBS will work cooperatively with the new Contractor to facilitate a smooth transition of Empire Plan members. We will provide the following level of customer service and clinical management after the termination date of the Agreement resulting from this RFP:

- **Customer Service support for all claims incurred prior to the contract termination date.**
- **Clinical support for pre-certifications (benefit authorizations) requested before the termination of the contract. We will also provide the new Contractor an open authorization file, including those members in active treatment at the inpatient level of care and all members in active case management. We would also remain available to assist with any enrollee issues as result of the transition.**
- **Account Team will be available after the contract termination to provide reporting for incurred claims prior to the contract termination and to assist with other transition-related tasks.**

(4) Confirm the Contractor will, if the Contractor does not meet the Transition Plan requirements in the time frame stated above, **permanently forfeit 100%** of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirement(s) to the date the Transition Plan requirement(s) are completed to the satisfaction of the Department.

Confirmed.

10. Network Management

Empire Plan Enrollees reside throughout the United States and are guaranteed access to Network Providers under the design of the MHSA Program. The Contractor must have a comprehensive, nationwide Provider Network in place to allow adequate access for Enrollees to obtain all covered MHSA services through the Provider Network. Through this RFP, the Department MHSA Program is seeking a Provider Network that delivers cost-effective clinically appropriate MHSA services, while meeting the minimum guarantees for Network Provider access.

Provider Network

The current MHSA Program includes a nationwide Provider Network through which Enrollees can obtain all covered MHSA Program services. The Offeror must propose and the Contractor must provide a MHSA Provider Network that meets or exceeds the MHSA Program's minimum access guarantees at the time of proposal submission that is credentialed and contracted for participation in the MHSA Program's Provider Network commencing on January 1, 2014. The Contractor may choose to enter into MHSA Program-specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's proposed provider Network File upon the submission date of their Proposal.

a. Duties and Responsibilities

(1) The Contractor must maintain a credentialed and contracted MHSA Provider Network that meets or exceeds the MHSA Program's minimum access standards throughout the term of the Agreement.

Confirmed. Empire BCBS reviews a practitioner's malpractice information, current licensure and training certifications and any applicable DEA certifications during our internal credentialing process for MHSA providers. Additionally, Empire BCBS has contracted with Beacon Health Strategies,

LLC to manage and build a network for Applied Behavioral Analyst practitioners. Beacon Health Strategies follows NCQA standards and has retained a designation of FULL NCQA Accredited.

(2) The MHSA Program requires that the Contractor have available to Enrollees on January 1, 2014 its proposed MHSA Provider Network in accordance with the requirements set forth in Section IV.B.3.a.(2)(a) guaranteeing effective implementation of their proposed Provider Network.

Confirmed.

(3) The Contractor shall offer participation in its MHSA Provider Network to any Provider who meets the Contractor's credentialing criteria upon the Department's request where such inclusion is deemed necessary by the Department to meet the needs of Enrollees even if not otherwise necessary to meet the minimum access guarantees outlined below.

Confirmed.

(4) In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed and registered Clinical Social Workers (CSW) (in NYS social workers must have an "R" number issued by the State Education Department), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis).

Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied;

Confirmed.

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(5) ***Network Composition Guarantee:*** The Contractor must guarantee that throughout the five-year term of the Agreement, at the least, ninety percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on **Exhibit I.Y.2**; will be maintained. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee; and,

Confirmed.

(6) ***Network Provider Access Guarantee:*** The Contractor must guarantee that, throughout the term of the Agreement, the Contractor's MHSA Provider Network meets or exceeds the Department's minimum access guarantees as follows;

a) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Facility within five (5) miles;

b) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Facility within fifteen (15) miles;

c) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Facility within forty (40) miles;

d) Ninety-five percent (95%) of Enrollees in urban areas will have at least one (1) Network Practitioner within three (3) miles;

e) Ninety-five percent (95%) of Enrollees in suburban areas will have at least one (1) Network Practitioner within fifteen (15) miles; and,

f) Ninety-five percent (95%) of Enrollees in rural areas will have at least one (1) Network Practitioner within forty (40) miles.

Note: In calculating whether the Offeror meets the minimum access guarantees, all Enrollees must be counted; no enrollee may be excluded even if a Provider is not located within the minimum access area.

Confirmed.

Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two Provider types: Network Facility (Inpatient and ALOC) and Network Practitioner types (Psychiatrist; Psychologist; Licensed Clinical Social Worker) for a total of six separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home (zip code) to the nearest MHSA Provider Network Provider location.

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Urban, suburban and rural are based on US Census Department classifications, as determined by GeoAccess. Offerors may guarantee better access than the minimums, but the guarantee must follow the same structure as the above minimum (i.e., access guarantees for each two Provider groups for each of the six (6) Provider type/area combinations based on the entire MHSA Program population).

b. Required Submission

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding Certified Behavior Analysts, Licensed Mental Health Counselors and Licensed Marriage and Family Therapists) that meet or exceed the minimum set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

% of Enrollees with Access to Network Facilities	Enrollee Location	Access Guarantee – 1 Network Facility at least within
[redacted]		

% of Enrollees with Access to Network Practitioners	Enrollee Location	Access Guarantee – 1 Network Practitioner at least within
[redacted]		

Please refer to Exhibit I.Y.3.

(2) Propose access standards for Certified Behavior Analysts in the MHSA Program's Provider Network. The access standard must be provided in terms of actual distance from Enrollees' residences.

% of Enrollees with Access to Certified Behavior Analysts	Enrollee Location	1 Certified Behavior Analyst at least within
[redacted]	[redacted]	[redacted]

These results are based on patients who are younger than 19 years of age, which is the population who would be utilizing these services. Certified Behavior Analysts providers are fairly new to the New York market and recruitment is ongoing. As with the rest of our provider network, it is open to any willing practitioner that meets our credentialing criteria. For our network, Empire BCBS has engaged Autism Services Group (a Beacon Health Strategies Company) who have brought their experience in other areas with selecting appropriate providers and delivering these services to the New York market.

Autism Services Group (ASG) utilizes a tiered service delivery model which relies upon Board Certified Behavior Analyst (BCBA) to design and supervise a treatment program delivered by a Paraprofessional (also known as an ABA Aide). The tiered services delivery model is a common practice in ABA treatment. A Paraprofessional, under the supervision of a BCBA, directly provides applied behavior analysis according to the treatment plan designed by a BCBA for the individual diagnosed with ASD. The use of carefully trained and well-supervised Paraprofessionals permits sufficient expertise to be delivered for each case at the level needed to reach treatment goals.

The tiered service delivery model is the most common way ABA therapy is delivered nationally due to its clinical effectiveness and practical use of resources for treatment of individuals diagnosed with ASD. The tiered service delivery model enables health plans and insurers build and maintain adequate provider networks. Leveraging a tiered service model enables ABA to be delivered to families/members in hard to access areas and deliver medically necessary ABA treatment in a way that manages costs. The tiered service model has been proven effective in remote/rural areas as BCBAs are

often not readily available therefore creating limited access and availability to ABA services.

Commitment to Network Adequacy

Autism Services Group is committed to providing services to families and individuals diagnosed with ASD. ASG will address potential obstacles and geographical challenges as they arise. In regards to geography, since the services provided are specialized and require specific training and qualifications, ASG will continue to leverage the tiered service delivery model. In areas where BCBAs may not be available, ASG will aggressively focus on Paraprofessionals who have met or exceeded the education and experience requirements as defined by State regulators and supported by ASG.

ASG will use a telemedicine approach that meets the Health Insurance Portability and Privacy Act (HIPAA) and Personal Privacy Information Act (PIPA). ASG will use available technology in servicing requests for ABA therapy from families/members. The use of technology will make it possible to bring these qualified, highly specialized providers to families and provide the level of care necessary for treatment.

(3) Complete **Exhibit I.Y.4**, entitled "Comparison of MHSA Program Providers and the Offeror's Proposed Provider Network." Identify whether each of the MHSA Program's Providers will or will not participate in the Offeror's proposed Provider Network in accordance with the instructions provided in **Exhibit I.Y.4**. The file containing the MHSA Program's Providers can be obtained by meeting the requirements specified in Section III.G of this RFP.

Confirmed. We are committed to working with the Department to perform a comparison of MHSA providers based on National Provider Identifier (NPI), which will provide more accurate results. Matching by Tax Identification Numbers may result in false negatives.

(4) Please confirm that if selected, you will provide an updated **Exhibits I.Y.2, I.Y.3** and **I.Y.4** on December 1, 2013 confirming that the Offeror's proposed Provider Network will be implemented as required on January 1, 2014. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Provider Network along with a detailed explanation for all deviations.

Confirmed.

(5) Describe the types of Providers, inpatient facilities and Alternative Levels Of Care (ALOC) included in your proposed Provider Network. Include a listing of programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) which are included in the Provider Network.

Empire BCBS' MHSA Provider Network includes a variety of facility providers including acute care medical institutions that provide behavioral health services, free-standing psychiatric and substance abuse facilities, and free-standing agencies and clinics and professional providers. Our practitioner network includes Psychiatrists, Psychologists, Psychiatric Nurse Practitioners and Licensed Clinical Social Workers. Our providers are contracted for various levels of care, including acute inpatient psychiatric and detoxification services, inpatient substance abuse rehabilitation, residential detoxification and rehabilitation, partial hospitalization, intensive outpatient, ambulatory detoxification and traditional outpatient services. Network facility providers must pass our credentialing criteria, which includes State of New York licensure (including OASAS licensure for substance abuse services) along with JCAHO and CARF accreditation, as required. (Please see the Provider Credentialing section for further information.) Empire BCBS' Provider Network is open to eligible MHSA providers and we continually expand our Provider Network. Network Providers outside of Empire BCBS' operating area and located in another

Blues' Plans' area, must comply with local Plan credentialing and contracting requirements. Our Provider Network provides access to OASAS-certified evidence-based programs, some of which are listed below:

All Stars
Brief Alcohol Screening and Intervention for College Students (BASICS)
Children in the Middle
Class Action
Families And Schools Together (FAST)
Guiding Good Choices (GGC)
Incredible Years
Keep A Clear Mind (KACM)
LifeSkills Training (LST)
Project ALERT
Project SUCCESS
Project Toward No Drug Abuse (TND)
Protecting You/Protecting Me
Reconnecting Youth (RY)
Strengthening Families Program (SFP)
Strengthening Families Program: For Parents and Youth 10-14
Teen Intervene
Too Good For Drugs (TGFD)
Too Good for Violence

(6) Describe the approaches you would use to solicit additional Providers to enhance your proposed Provider Network for Facilities, OASAS Programs and Practitioners or to fulfill a request to add a specific Provider.

Empire BCBS' Provider Engagement and Contracting Team works with the various areas within our company that receive recommendations from members, accounts and providers regarding providers interested in joining the network. We will also conduct periodic recruitment activities including reviews and solicitation of specific provider license-types in targeted areas to achieve the most robust network possible, ensuring access and availability for services to our members. These solicitations will include telephonic outreach and recruitment mailings. We will also work with other BlueCross

and BlueShield plans on a national basis to recruit providers practicing outside Empire BCBS' operating area.

We will assess out-of-network providers and conduct recruitment activities based on non-network utilization and specific provider license types to achieve the most robust network.

(7) Members may have successful therapy plans with current Network Providers that are not in the Offeror's Network. For key Providers (i.e., those who provide services for a significant number of Members or who are in an underserved area), what criteria would be used to determine which to recruit?

Empire BCBS, along with each of the BlueCross and BlueShield plans, systematically reviews its provider network to identify and fill any access needs. While our GeoAccess results indicate that we have few gaps in our network, we use member feedback, internal claims reports, and client requests to identify underserved areas and initiate recruitment efforts where a need has been identified. We are willing to recruit these key network providers as well as any other providers interested in participating in our network and who meet our credentialing requirements.

We are strongly committed to recruiting providers to ensure Empire Plan members' care needs are being met.

(8) Describe your strategy for maintaining the MHSA Program's Network throughout the term of the Agreement resulting from the RFP.

We are a strong proponent of value-based provider contracting and our long-term strategy includes partnering with providers and hospital systems to:

- **Secure optimal discounts and contracting terms**
- **Implement additional accountability standards and incentive initiatives**
- **Eliminate unnecessary costs**
- **Negotiate long-term contracts to ensure discount stability and to minimize provider disruption**

Our goal is to build the strongest relationships possible with providers nationwide that result in cost-effectiveness and enhanced consumer awareness. With the largest membership among national carriers, we are able to leverage our significant market share to negotiate the most competitive discounts.

Additionally, discount savings are a function of both network utilization and provider contract rates. We strongly differentiate ourselves in rural areas, where our network breadth and depth promote higher levels of in-network utilization, and also allow for competitive contracting among rural network providers. The MHSA Program will be combined with our other MHSA membership to further strengthen our already strong negotiating position.

(9) How do you monitor whether Network Providers are accepting new patients into their practices? Do your proposed access standards take into account Provider availability? If yes, how?

The current number of providers with closed panels is negligible and is approximately less than one percent of the entire MHSA Network . We track

whether Network Providers are accepting new patients through an indicator on our provider files and perform an annual survey sampling of our network to track providers taking in new patients, the wait times for appointments, etc. Our network agreements require providers to retain a set number of members before they close their panels. In order for a panel to be closed, providers must submit a written request to close their panels once that threshold is met.

Consequently, there is no impact on provider availability.

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(10) ***Network Composition Guarantee:*** The MHSA Program's service level standard requires that at the least ninety percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

The Standard Credit Amount for each .01 to 1.0% below the MHSA Program's service level standard requiring that at least ninety-percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner,

*Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist) listed on **Exhibit I.Y.2** will be maintained is $25,000 per year. However, Offerors may propose higher or lesser amounts.*

[redacted]

(11)***Network Provider Access Guarantees:*** You must guarantee that throughout the term of the Agreement resulting from this RFP, Enrollees living in urban, suburban and rural areas will have access, as proposed by the Offeror, to a Network Provider. The Offeror must propose an access guarantee that meets or exceeds the minimum access guarantees set forth in the "Provider Network" Section of this RFP. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet the guarantee.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Network Facility Access for Urban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

[redacted]

[redacted]

[redacted]

Measurement of compliance with each access guarantee will be based on a "snapshot" of the Provider Network taken on the last day of each quarter within the current plan year. The results must be provided in the format contained in **Exhibit I.Y.3**. The report is due thirty (30) Days after the end of the quarter.

Confirmed.

Provider Credentialing

The Contractor must ensure that MHSA Network Providers meet the licensing standards required by the state in which they operate. MHSA Network Providers are also required to meet the credentialing criteria established by the Contractor. These criteria should be designed to ensure quality MHSA care.

a. Duties and Responsibilities

(1) The Contractor must assure its MHSA Provider Network is credentialed in accordance with all applicable federal and state laws, rules and regulations.

Confirmed. Empire BCBS and its vendor credential the Provider Network. Similar guidelines may exist throughout BlueCross and BlueShield plans that are not under our organization's umbrella.

(2) The Contractor must establish credentialing criteria for Network Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the MHSA Provider Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.

Confirmed. Empire BCBS credentialing criteria follow state regulations. Items such as hours of operation and appointment availability are tracked by the Plan's Quality Improvement department following National Committee for Quality Assurance (NCQA) standards.

(3) The Contractor must credential MHSA Network Providers in a timely manner and shall have an effective process by which to confirm MHSA Network Providers continuing compliance with credentialing standards.

Confirmed.

(4) The Contractor must maintain a Provider Relations staff presence within New York State.

Confirmed.

(5) The Contractor must maintain credentialing records and make them available for review by the Department upon request.

Confirmed. In compliance with state and federal regulations, we will make de-identified records of credentialed providers available for review upon request.

(6) ***Provider Credentialing Guarantee:*** The Contractor must guarantee that within sixty (60) Days of receipt of a completed MHSA Provider application to join the Program's network, the review, including credentialing, will be completed and the Provider notified of the determination.

Empire BCBS will meet this requirement within our New York service area and within WellPoint's 13 other plans. We will work with other remaining BlueCross and BlueShield plans towards meeting this requirement.

b. Required Submission

(1) Confirm that you will utilize a credentialing verification organization or establish credentialing criteria for Practitioners and Facilities, including ALOC, for the purpose of ensuring quality of the Network, including, but not limited to, years of experience, level of education/certification, licensure, quality of care, practice patterns, malpractice insurance coverage, hours of operation and availability of appointments.

Confirmed.

(2) Describe the Offeror's process to ensure that Network Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?
Empire BCBS ensures that all Network Providers meet applicable state requirements and comply with state and federal laws, rules and regulations by administering the credentialing process. As part of the credentialing process, most BlueCross and BlueShield Plans screen managed care providers against established credentialing standards which meet the credentialing standards of the NCQA.

Network Providers who participate in the credentialing process are evaluated for professional conduct and competence based on evaluation of the following credentialing information:

- **License**
- **Education**
- **Residency training**
- **Training and certification**
- **Malpractice experience**
- **Work history**
- **Current or historical sanctions by licensing agencies as well as those reported to the National Practitioner Data Bank (NPDB)**
- **History of sanctions recorded by other governmental bodies (OIG, OPM)**
- **Drug Enforcement Administration (DEA) registration (when required)**
- **Signed attestation regarding other issues of professional conduct and competence**

Credentialed Practitioners are recredentialed every three years. Criteria are outlined in the following grid. In addition, all credentialed providers are subject to ongoing monitoring for sanctions against their license and interim adverse actions are reviewed when this information is made available.

Similar credentialing guidelines may exist within the BlueCross and BlueShield Plans that are not under our organization's umbrella.

Selection is based on the successful completion of the credentialing criteria, geographic and/or specialty need and any state mandates.

Typical guidelines are illustrated below.

	Primary Physician		Specialty Physician		Other	
Criteria	**Credentialing**	**Recredentialing**	**Credentialing**	**Recredentialing**	**Credentialing**	**Recredentialing**
Graduation from an accredited college or university program	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Valid state license, Review of any action taken against license	✓	✓	✓	✓	✓	✓
Board certification (specify)	**✓Board Cert.**	**✓ Board Cert.**	**✓ Board Cert.**	**✓ Board Cert.**	**✓ Board Cert. If applicable**	**✓ Board Cert. If applicable**
DEA license	✓ **If applicable**	✓ **If applicable**	✓ **If applicable**	✓ **If applicable**	✓ **If applicable**	✓ **If applicable**
Malpractice coverage	✓	✓	✓	✓	✓	✓
Malpractice history	✓	✓	✓	✓	✓	✓
Evaluation of previous work history	✓	✓	✓	✓	✓	✓
Ability to perform required functions	**Practitioners must attest that they have no reason to believe they pose a risk to patients or that they are unable to perform the essential functions required by their practice.**					
Detailed history of substance use	**Practitioners must attest that they are free of any substance use that would impair their ability to practice and to perform their functions with skill and safety.**					
Detailed history of conviction of fraud or felony	**Practitioners must provide detailed history of conviction of fraud/felony and attest to accuracy of the information.**					

(3) Describe your approach for credentialing Network Providers.

(a) Specify if you utilize an external credentialing verification organization. When was this process last completed? What is your process for confirming continuing compliance with credentialing standards? How often do you conduct a complete review?

We do not use an external credentialing verification organization. We credential network providers in-house.

(b) What steps do you take between credentialing periods to ensure that Network Providers that are officially sanctioned, disciplined, or had their licenses revoked are removed from the Provider Network as soon as possible? What steps, if any, do you take to advise members when a Provider has been removed from the Provider network? Under what circumstance would you notify the Department of the removal of a Network Provider?

Our Credentialing Department performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. **Office of the Inspector General ("OIG")**
2. **Federal Medicare/Medicaid Reports**
3. **Office of Personnel Management ("OPM")**
4. **State licensing boards/agencies**
5. **Covered individual/customer services departments**
6. **Clinical Quality Management Department (including data regarding**

complaints of both a clinical and non clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)

7. Other internal company Departments

8. Any other verified information received from appropriate sources When a Provider has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the Chair of Empire BCBS' Credentialing Committee, review by Empire BCBS Medical Director, referral to the Credentialing Committee, or termination. Empire BCBS' Credentialing Departments will report providers to the appropriate authorities as required by law.

(4) How does Provider Relations staff keep abreast of Provider practices, attitudes, and concerns in New York State and other areas? Do you have Provider Relations staff that is located in NYS? How do you support a strong information infrastructure for your Network Providers?

All Empire BCBS Provider Relations Staff are encouraged to attend relevant conferences and other educational seminars that will assist them in performing their job responsibilities. In addition, we have a communication process in place that ensures information on key State activities is passed to the appropriate areas within the organization.

The Provider Relations staff will also conduct site visits and meetings, as required, at provider offices or facility locations. We conduct an annual Provider Satisfaction Survey unique to MHSA providers. This tool provides the opportunity to evaluate providers attitudes and concerns. Process improvements are implemented based on survey results.

Empire BCBS employs Provider Relations staff located in New York, New York. These individuals work with the professional providers and free-standing facilities and agencies on network participation, rate reviews, provider issues/concerns around claim submissions, recredentialing and

other operational functions. They are assisted by the Contracting Team and their support staff who manage the relationship with the medical institutions that are contracted for MHSA services. The Team is available to network providers to respond to issues, questions and concerns. They have access to appropriate areas of the organization to ensure provider concerns are resolved.

Providers have access to a wide variety of information available online.In addition to the website, providers also receive a bi-monthly newsletter which includes information relative to updates in clinical practice guidelines, as well as industry information.

(5) How do you help your Network Providers achieve patient-centered care? How do you help Network Providers improve their diagnosis and assessment abilities to ensure that the care they provide is based upon the best available scientific knowledge? How do you ensure that your Network Providers collaborate with other clinicians to ensure an appropriate exchange of Enrollee information and coordination of care?

There are various ways that our MHSA Clinical Team works with providers to achieve the best care and ensure that best clinical practices are followed. As noted previously, we communicate regularly with providers via a bimonthly newsletter. Updates to our Medical Necessity Criteria (MNC) and the adoption of Clinical Practice Guidelines (CPGs) are included, as well as instructions on where they can be found on the Empire BCBS website, and all providers are encouraged to review them. In addition, there is a MHSA Provider Advisory Committee made up of representative network providers from each of the license-types included in the New York network. Prior to implementing changes in MNC or adopting a CPG, they are brought to the provider committee for comment and review. Minimal clinical policy change occurs without soliciting involvement from local provider representatives.

Empire BCBS also provides numerous tools to assist Network Providers with diagnosis and treatment of members. Providers may access CPGs for a variety of disorders, including ADHD, depression, substance use disorders, bipolar disorder and postpartum depression. All CPGs are based upon current scientific literature and are reviewed annually to ensure they include the most current scientific guidance. Our provider website also offers tools to facilitate coordination of care between MHSA and primary care providers, including a brief form summarizing the member's clinical information and a letter designed for use with PCPs. Empire BCBS communicates changes and new or updated resources through our bi-monthly Provider Newsletter which includes a section for Behavioral Health, through telephone communications when discussing cases and through other mailings both paper or electronic.

Our Behavioral Care Managers work with facilities from the date of the first review to ensure coordination of care and that a comprehensive aftercare plan is being developed. Our Outreach Coordinators are available to identify network providers and levels of care should the facility need assistance. Coordination of care in outpatient settings is also encouraged; it is also one of the measures on the Provider Satisfaction Survey that is tracked. The survey offers an opportunity for suggestions or comments about improvements or barriers to this activity. We also supply our providers with a sample template letter that can be used between professional providers regarding coordination of care for a member in treatment. The template is available online.

(6) Confirm that you will maintain credentialing records and make them available for review by the Department upon request.

Confirmed. In compliance with state and federal regulations, we will make de-identified records of credentialed providers available for review upon request.

(7) ***Provider Credentialing Guarantee:*** The MHSA Program's service level standard requires that at least within sixty (60) Days of receipt of a completed Provider application to join the MHSA Program's Network, the review, including credentialing, will be completed and the Practitioner, ALOC Program or Facility notified of the determination. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The Standard Credit Amount for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the provider is not completed within sixty (60) Days is $1,500. However, Offerors may propose higher or lesser amounts.

[redacted]

Provider Contracting

Contracts with Providers must be written to utilize the MHSA Program's market strength to obtain competitive reimbursement rates with high quality Providers while also

ensuring MHSA Program access guarantees are met. Contracting staff should keep abreast of current market conditions and have the wherewithal to adjust contracts with Providers that reflect the best interests of the MHSA Program. The Contractor must ensure that all Network Providers contractually agree and comply with the MHSA Program's requirements and benefit design. Contracts must be consistent with and support proposed access guarantees to ensure long-term stability of the Provider network. The Contactor may choose to enter into MHSA Program specific Provider contracts that are contingent on award and/or utilize existing Provider agreements that can be made applicable to the MHSA Program to meet the MHSA Program's requirement that the Contractor have executed contracts with all the Network Providers included in the Contractor's Proposed Provider Network File upon the submission date of its proposal.

a. <u>Duties and Responsibilities</u>

The Contractor will be responsible for providing Provider contracting services including but not limited to:

(1) Negotiating pricing arrangements that utilize the MHSA Program's size to optimize the Provider fee schedule;

Confirmed.

(2) Ensuring that all MHSA Network Providers contractually agree to and comply with all of the MHSA Program's requirements and benefit design specifications;

Confirmed.

(3) Ensuring that MHSA Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program Copayments;

Confirmed.

(4) Notifying the Department in writing within one (1) Business Day of any substantial change to the number, composition or terms of the Provider contracts utilized by the MHSA Program;

Confirmed.

(5) Negotiating Single Case Agreements with Non-Network Providers on a case-by-case basis when the Contractor determines that it is clinically appropriate or to address guaranteed access issues;

Confirmed.

(6) Negotiating agreements on a case-by-case basis, with prior approval from the Department, with Licensed Marriage and Family Therapists (LMFTs) and Licensed Mental Health Counselors (LMHCs) when an LMFT or LMHC possess a particular subspecialty that is clinically appropriate or to address guaranteed access issues; and

Confirmed.

(7) Establishing a tiered MHSA Provider Network and incentives including but not limited to financial, administrative and continuing professional education to enhance Provider performance and clinical outcomes.

Confirmed.

b. Required Submission

(1) Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.). Specify if Providers are reimbursed at varying levels of the Provider fee schedule for the same covered service.

The majority of MHSA intensive services are contracted at a per-diem arrangement. Intensive services include inpatient, residential, partial hospital and intensive outpatient levels of care. Professional, clinic and traditional outpatient services are at a per-visit arrangement. The contracted rates for intensive levels of care renew periodically, as these services tend to be part of larger facilities and institutions with multi-year agreements with rate escalators. The professional fee schedule is reviewed annually, both for reimbursement rates and CPT code change updates. Empire BCBS is committed to maintaining a competitive MHSA professional fee schedule and ensuring that reimbursement negotiations do not negatively impact our members' access to network providers. Our commitment to manage and maintain strong, ongoing relationships with providers minimizes the need for retroactive settlements. Our Contracting Team will work with network providers to ensure that any active negotiations continue and appropriate rate extensions are in place, should negotiations go beyond a renewal date. Providers are reimbursed at varying levels of the provider fee schedule for the same covered service based on geography, licensure and specialty.

(2) Confirm that your agreements with Network Providers require their compliance with all the MHSA Program's requirements and benefit design specifications. Provide a copy of the Offeror's proposed Provider contract for both Facilities and Practitioners.

Confirmed. In Appendix F, we have provided for your review the latest version of our contract templates. Upon renewal, contract versions are reviewed with each provider type to ensure that our network is contracted with the most current version. The templates differ based on the type of provider and representative of contracts for:

- **Facility Agreement with behavioral health services**
- **Practitioner Behavioral Health agreement**
- **Behavioral Health Freestanding Facility/Hospital Agreement**

The time period for facility contracts varies; however, three years would be considered standard. Empire BCBS' professional provider agreements do not expire; however, negotiated rates may require renewal.

(3) Confirm that Network Providers accept as payment-in-full, the Contractor's contractual reimbursement for all claims for covered services, subject to the applicable MHSA Program copayments.

Confirmed.

(4) Confirm that you will, without delay, notify the Department in writing of any substantial changes to the number, composition or terms of Provider contracts utilized by the MHSA Program.

Confirmed.

(5) Complete the following chart listing reasons for voluntary Provider Network terminations:

Facilities/ALOCs/Practitioners	2012	2011	2010
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

[redacted]

(6) Describe the circumstances under which the Offeror will negotiate a single case agreement with a Non-Network Provider. Estimate the frequency with which you would expect to authorize network level benefits for non-network inpatient and outpatient services received under the MHSA Program.

Empire BCBS has an extensive network of providers nationally, that encompasses a wide range of specialties, language fluency, and levels of care. In rare instances, it is necessary to look outside the network to ensure that appropriate treatment is provided. These situations occur in approximately one percent or fewer cases, and generally involve members with rare disorders in whose treatment few providers are trained. There is also an occasional need to provide single case agreements in some rural areas, where more common specialists may be unavailable. Lastly, some members with severe psychiatric illness may have difficulty transitioning to a new provider when their current provider either leaves the network or when the member's new insurance does not include the provider in the network. In those instances, a plan is developed with the member's provider to gradually transition the member to a participating provider.

Non-network authorizations considered for single-case agreements are reviewed by the Behavioral Health Clinical Director for approval. The following criteria are used to assist in rendering the final decision:

1) **No network provider with the appropriate expertise needed to treat the member is available within 30 miles of the member's residence**
2) **The member requires emergency treatment**
3) **When the member transitions from one insurance carrier to another and the existing provider is not a member of the new network, and when clinical circumstances make transition of care clinically inappropriate.**

We are confident that our provider network will meet the needs of the Program's members, and non-network authorizations will be necessary only for remote member locations or specific skills.

(7) Describe the tiering criteria and incentives you propose for the MHSA Program.

Empire BCBS has recently reviewed opportunities to tier its MHSA provider network based upon provider efficiency, volume and quality. First tier providers are those who have demonstrated efficient and effective treatment, and who have no history of member complaints. First tier providers also include providers with longer lengths of treatment who specialize in harder to treat disorders, such as eating disorders and autism.

Second tier providers are those who generally provide treatment of longer duration for the same member population and who have no history of member complaints. These providers' length of treatment is one standard deviation or more above the mean for those providing the same type of care.

Third tier providers are those who consistently require much longer period of treatment to address the most common psychiatric and substance use disorders, or providers who have generated member dissatisfaction. Third tier providers' length of treatment runs two standard deviations or more above the average length of treatment. As an incentive, we will exempt top-tier practitioners from the medical management requirements and allow them to self-manage. They will be monitored with semi-annual claims reporting.

Provider Audit and Quality Assurance

The Contractor must support a high quality and cost-effective MHSA Program. The protection of MHSA Program assets must be a top priority of the Contractor. The Contractor must have a strong audit presence throughout its organization. The Contractor

shall be responsible for the oversight and audit of Providers that provide MHSA services to MHSA Program Enrollees.

The Contractor must support and encourage quality MHSA care through the following audit and quality assurance duties and responsibilities:

a. Duties and Responsibilities

(1) The Contractor must have a staffed and trained audit unit employing a comprehensive Provider audit program that includes but is not limited to:

(a) Conducting routine and targeted on-site audits of Network Providers. Providers that deviate significantly from normal patterns in terms of cost, CPT coding or utilization are to be identified and targeted for on-site and desk audits in accordance with established selection and screening criteria. On-site audits must also be conducted upon request by the Department and/or OSC, or when information is received by the Contractor that indicates a pattern of conduct by a Provider that is not consistent with the MHSA Program's design and objectives. Any modifications to the proposed audit program must receive written prior approval by the State;

Empire BCBS will add MHSA Program claims to its systematic and well-established CPT® Correct Coding Initiatives for Evaluation and Management upcoding program which is operated through EquiClaim, a preferred Empire BCBS vendor. This program identifies outliers in E/M billing, educates those outliers, and provides outliers an opportunity to explain why their billing practices are outside peer norms. Identified outliers who do not have a clinical basis for their outlier status are tracked for potential change in billing conduct and those who do not change are referred to the Special Investigations Unit for action. Empire BCBS has additional audit programs as outlined below that may or may not apply to the MHSA network. Beyond those established programs, Empire BCBS will engage a preferred vendor with an established MHSA

audit program to assist in audits. At present, Empire BCBS is researching vendors in the MHSA space to select as a preferred vendor.

(b) Providing reports to the Department detailing audits planned, audits initiated, audits in progress, audits completed, audit findings, audit recoveries, and any other enforcement action by the Contractor. The Contractor must inform the Department in writing of any allegation or other indication of potential fraud and/or abuse identified within seven (7) Business Days of receipt of such allegations or identification of such potential fraud and/or abuse. The Department must be fully informed of all fraud and/or abuse investigations impacting the MHSA Program upon commencement, regardless of whether the individual fraud and/or abuse investigation has a material financial impact to the State;

Empire BCBS will provide reports as required. Empire BCBS will report an allegation of potential fraud and/or abuse within seven business days of receipt. However, Empire BCBS suggests that, in light of the expertise of its fraud team, which includes a former federal prosecutor and two former Federal Bureau of Investigation supervisory special agents, that Empire BCBS report only allegations that meet the threshold of constituting "reasonable suspicion" of fraud or abuse, as opposed to any such allegation.

(c) Maintaining the capability and contractual right of the Contractor to effectively audit the MHSA Program's Provider Network, including the use of statistical sampling audit techniques and the extrapolation of errors;

Empire BCBS's provider contracts maintain the capability and contractual rights to audit and our techniques include the use of statistical sampling. While Empire BCBS's auditing policies do not support extrapolation of errors, if it can be reasonably determined that a particular finding appears to be affecting the broader population, our

actions may include, but are not limited to: provider education, settlement agreement on recoverable dollars, adjustment to future rate increases or, in cases of suspected fraud, reporting to our Special Investigations Unit for further investigation.

(d) Remitting 100% of Provider and Enrollee audit recoveries to the Department as applicable within thirty (30) Days of receipt consistent with the process specified in Section X.V, "Payments/ (credits) to/from the Contractor," of the Agreement resulting from this RFP; and

Confirmed, subject to the provisions outlined in the extraneous terms of Section V.

(e) Utilizing the auditing tools and performance measures proposed by the Contractor to identify fraud and abuse by Network Providers and/or Enrollees.

Confirmed.

(2) The Contractor must conduct a comprehensive quality assurance program which includes, but is not limited to:

(a) Monitoring the quality of care provided by Network Providers;

(b) Monitoring technical competency and customer service skills of Network Provider staff;

(c) Network Provider profiling;

(d) Peer review procedures;

(e) Outcome and Quality Measurement analysis; and

(f) Maintaining an ongoing training and education program that will be offered to Network Providers.

Confirmed.

b. Required Submission

(1) Describe the Provider audit program you would conduct for the MHSA Program including a description of the criteria you use to select Providers for audit and a description of the policy that you follow when a Provider audit detects possible fraudulent activity by the Provider or an Enrollee. Include all types of audits performed and offered by your organization.

Our Provider Audit Team oversees preferred vendors who provide comprehensive audit activities. The following audits are currently conducted, most of which would not be applicable to a behavioral health network:

- **HBA/DRG**
- **Credit balance**
- **CPT® Correct Coding Initiatives to include but not limited to Evaluation and Management and Modifiers**
- **Ancillary, including high cost drug, DME, home health, implant, pre-admission testing, and DRG readmit**
- **Implant Audits, including but not limited to invoice cost, add-pay, line item review, medical policy.**

As noted above, Empire BCBS would immediately include providers in the MHSA Program network in its CPT® Correct Coding Initiatives Program and audit all such providers to identify outliers. Outliers who could not explain their billing behavior and who did not change their billing would be referred to Empire BCBS's SIU, which is described more fully below.

In addition to our current audit and SIU activities, as noted above, Empire BCBS will engage a preferred vendor partner to focus on MHSA provider audits (the selection process is currently under review).

(2) Describe the corrective action and the monitoring that takes place when you find that a Provider is billing incorrectly or otherwise acting against the interests of your clients. Please indicate whether you have a fraud and abuse unit within your organization and its role in the Provider audit program. In the extreme case of potentially illegal activity, what procedures do you have in place to address illegal or criminal activities by the Provider?

As discussed above, Empire BCBS has a comprehensive Fraud and Abuse Team that works with our Provider Audit Team. To enhance the effectiveness and collaborative efforts of those two units, the units report up to the same executive leader.

Should a provider bill Empire BCBS incorrectly, which results in an overpaid claim, the overpayment will be collected and when appropriate, the provider will be educated. In cases where a pattern of incorrect billing is discovered, the option of an individual claims review may be put in place to prevent overpayments. In general, the method and/or resources used for corrective action depend on the scope and severity of the identified issue. Corrective actions include:

- **Provider Letter – Upon review by the Director of the Special Investigations Unit (SIU) (and, in cases seeking reimbursement of greater than $75,000, the Staff Vice President), a certified letter is sent to the provider documenting the findings and the need for improvement, with response requested. The letter may include education and/or request for recoveries, in accordance with state statutes and regulations. Further action is based on the provider's response or lack thereof.**

- **Flagged Provider Review – When billing issues are egregious, or the provider fails to comply despite intervention, then the provider may be placed on flagged provider review for further monitoring and evaluation. Flagged provider review uses system edits to prevent automatic payment of claims and requires a medical reviewer evaluation.**
- **Recoveries – Recoveries are sought through either direct reimbursement by the provider to the SIU, or, if in accord with a contractual relationship between Empire BCBS and the provider, through a recovery process as described in the contract.**
- **Termination – Failure to comply with program policy and procedures or any violation of the contract could result in termination.**
- **Referral to law enforcement – SIU may refer matters to law enforcement for action. As a result of SIU's active involvement with law enforcement, it has a wide network for referral.**

(3) Provide a copy of the audit language and fraud and abuse language that is contained in your standard contract(s) for Network Providers.

[redacted]

[redacted]

(4) Confirm that the Offeror will remit 100% of Provider and Enrollee audit recoveries to the Department within thirty (30) Days of receipt consistent with the process specified in Section V, "Payments/ (credits) to/from the Contractor" and Appendix B of Section VII.

Confirmed, subject to the provisions outlined in the extraneous terms of Section V

(5) Describe the Offeror's proposed auditing tools and performance measures for identifying fraud and abuse by Network Providers and/or Enrollees.

Empire BCBS maintains a fully-staffed Fraud and Abuse Team to identify and deter fraudulent activity and to act upon allegations of fraud and abuse. The Special Investigations Unit (SIU), which consists of about 70 investigators and analysts across the enterprise, detects abuse (as well as outright fraud) through a number of means, categorized in general as follows: internal data mining, internal and external referrals, and outreach. SIU's internal data mining is conducted through VIPS-STARS, a commercial query tool providing analysts and investigators access to 36 months of claims paid data.

The data mining efforts are spearheaded by the Fraud and Abuse Team's Data Mining Solutions (DMS) team and the Clinical Investigations Unit (CIU). DMS is expert at obtaining data across the entire enterprise. DMS runs about 130 fraud, waste and abuse queries, including, for instance, queries to identify sudden spikes in claims payments by member and by provider. CIU is a team with clinical expertise that data mines for clinical aberrancies in coding and in care. The Fraud and Abuse Team's identification efforts will be enhanced in 2013, as it implements a new, gold standard identification tool.

The SIU investigates cases that are referred by internal associates and by external sources. Employees from other departments, especially claims processing and customer service, play a crucial role in uncovering fraud. They are trained annually to enhance their ability to identify potential fraud. Our medical management team and its medical directors are likewise trained annually and identify cases that they refer to the SIU. In addition to internal referrals, the SIU receives external referrals through its fraud hotline and through its significant contacts with law enforcement, as described briefly below.

The SIU does significant outreach to learn of current schemes and issues in the industry. Empire BCBS and our parent company, Wellpoint, is one of the insurers that has since the outset of the effort, been participating in the Federal Private Fraud Prevention Partnership announced by the White House in mid-2012. It is a corporate member of the National Healthcare Antifraud Association (NHCAA) and is, in fact, a very active member of that organization, with one of its SIU Directors serving as the NHCAA Chair in 2013. Further, it is part of the BlueCross BlueShield National Antifraud Association Board.

On a local level, it participates in task forces with various law enforcement and prosecutive agencies, frequently acting as the host for such meetings. It interacts regularly with regulators and law enforcement. In addition to these general efforts, the Fraud and Abuse Team has specific initiatives it undertakes to identify and combat fraud and abuse.

For several years, the SIU has run an initiative called "Operation Pillbox," in which physicians whose patterns of prescribing schedule II narcotics are inconsistent with patient medical conditions are identified and disclosed to law enforcement. The SIU won a "Best of Blue" award for this program. It likewise won a "Best of Blue" award for its initiative to identify DMEs and laboratories that bill in a manner that appears inconsistent with its physical inventory or capabilities. When such providers are identified, they are stopped from billing before claims are paid. In other instances, the SIU will seek recoveries from identified providers and track provider billing behavior to ensure appropriate billing after an SIU intervention. In cases of actual fraud, the SIU will refer cases to law enforcement partners.

Currently, the SIU tracks savings based on recoveries and change in behavior. The SIU savings exceeds benchmark standards. Empire BCBS suggests determining appropriate expected savings based on expected claims costs.

11. Claims Processing

The Contractor must process all claims submitted under the MHSA Program according to the benefit design, including Network Provider claims and manual submit claims including but not limited to Medicaid, out-of-network claims, foreign claims, in-network manual claims and COB including Medicare primary claims. The claims processing system shall include controls to identify questionable claims, prevent inappropriate payments, and ensure accurate reimbursement of claims in accordance with the benefit design MHSA Program provisions and negotiated, agreements with Providers. All MHSA Program provisions for benefit design and other utilization or clinical management programs must be adhered to for all claims.

Enrollee Submitted Claims are required to be submitted to the Contractor no later than one hundred twenty (120) Days after the end of the Calendar Year in which the MHSA service was rendered, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The MHSA Program count of claims can be found in Exhibit II.G3 of this RFP.

a. Duties and Responsibilities

(1) The Contractor must provide all aspects of claims processing. Such responsibility shall include but not be limited to:

(a) Maintaining a claims processing center located in the United States staffed by fully trained claims processors and supervisors;

Confirmed.

(b) Verifying that the MHSA Program's benefit design has been loaded into the system appropriately to adjudicate and calculate cost sharing and other edits correctly;

Confirmed.

(c) Accurate and timely processing of all claims submitted under the MHSA Program in accordance with all applicable laws as well as the benefit design applicable to the Enrollee including Copayment, Deductible, Coinsurance, annual maximums and coinsurance maximums, at the time the claim was incurred as specified to the Contractor by the Department;

Confirmed.

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(d) Developing and maintaining claim payment procedures, guidelines, and system edits that guarantee accuracy of claim payments for covered expenses only, utilizing all edits as proposed by the Contractor and approved by the Department. The Contractor's system must ensure that payments are made only for authorized services;

Confirmed.

(e) Maintaining claims histories for twenty-four (24) months online and archiving older claim histories for the balance of the calendar year in which they were made and for six (6) additional years thereafter, per Appendix A, with procedures to easily retrieve and load claim records;

Confirmed.

(f) Maintaining the security of the claim files and ensuring HIPAA compliance;

Confirmed.

(g) Adjusting all attributes of claim records processed in error crediting the MHSA Program for the amount of the claim processed in error;

Confirmed.

(h) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department;

Confirmed.

(i) Maintaining a back-up system and disaster recovery system for processing claims in the event that the primary claims payment system fails or is not accessible;

Confirmed.

(j) Maintaining a claims processing system capable of integrating and enforcing the various clinical management and utilization review components of the MHSA Program; including pre-certification, prior authorization, concurrent review and benefit maximums;

Confirmed.

(k) Developing and securely routing a MHSA daily claims file that reports claims incurred to date which have been applied to the shared Deductible and Coinsurance Maximums between the Empire Plan Hospital Program, Medical Program and MHSA Program;

Confirmed.

(l) Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports shared Deductible and Coinsurance Maximums;

Confirmed.

(m) Participating in Medicare Crossover by entering into an agreement with the Empire Plan medical carrier /third party administrator to accept electronic claims data record files from the medical carrier/third party administrator for Empire Plan Enrollees that have Medicare as their primary coverage. Claims data will only be sent to the Contractor for possible Empire Plan mental health and substance abuse outpatient claims which also involve Medicare coverage. The claims information sent from the medical carrier/third party administrator will include claims filed with the Center for Medicare and Medicaid Services (CMS) that should be considered by the Contractor for secondary coverage. The Empire Plan medical carrier/third party administrator will sort out any claims for benefits that are for mental health or substance abuse services and electronically forward the claim to the Contractor for consideration;
Confirmed.

(n) Pursuing collection of up-to-date coordination of benefit information that is integrated into the claims processing edits and pursuing collection of any money due the MHSA Program from other payers or Enrollees who have primary MHSA coverage through another carrier;

Confirmed.

(o) Analyzing and monitoring claim submissions to promptly identify errors, fraud and/or abuse and reporting to the State such information in a timely fashion in accordance with a State approved process. The Contractor will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Contractor error, without additional administrative charge to the MHSA Program. The Contractor shall report fraud and abuse to the appropriate authorities. In cases of overpayments resulting from errors only found to be the responsibility of the State, or due to fraud and abuse the Contractor shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the MHSA Programs upon receipt; however, the Contractor is not responsible to credit amounts that are not recovered;

Confirmed.

(p) Establishing a process through which Providers can verify eligibility of Enrollees and Dependents during Call Center Hours;

Confirmed.

(q) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit. The Department agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Section V.C of this RFP; and

Confirmed.

(r) Updating the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

Confirmed.

(2) ***Financial Accuracy Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the MHSA Program's financial accuracy be maintained for a minimum of ninety-nine percent (99%) of all claims processed and paid each Plan year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

Confirmed.

(3) ***Non-Financial Accuracy Guarantee***

The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no

errors by the total number of claims reviewed. Non-financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code, as well as incorrect application of Deductibles and/or Coinsurance amounts to the shared accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%);

Confirmed.

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(5) ***Turnaround Time for Non-Network Claims Adjudication Guarantee:*** The Offeror must meet or exceed the following performance guarantee. The MHSA Program's service level standard requires that, at the least, ninety-nine and five-tenths percent (99.5%) of enrollee-submitted claims that are received in the Offeror's designated post office box, and require no additional information in order to be properly adjudicated, will be turned around within eighteen (18) Business Days or twenty-four (24) Days of receipt. Turnaround time is measured from the date the Enrollee-submitted claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent.

Confirmed.

b. Required Submission

(1) Provide a flow chart and step-by-step description of your proposed claims processing methodology for adjudicating Non-Network and Network claims. Provide a description of the comprehensive edits you propose to ensure proper claim adjudication.

Claims are filtered prior to entering the claims engine with edits performed by Electronic Data Interchange (EDI) for electronic claim submissions or the front end data entry vendor for paper receipts to ensure all common elements necessary for any claim submission are present. Claims with defects or missing required elements are returned to the provider.

A high level claim processing workflow has been included in Appendix G outlining the entire process. Additionally, Appendix G contains a flowchart of the claims processing logic; a description of the corresponding steps is in the following text.

In addition, please refer to question 2 for further detail on our system edits.

(2) Describe your claims processing system platform including any backup system utilized. Describe your disaster recovery plan and how Enrollee disruption will be kept to a minimum during a system failure.

Automated Inquiry Data Entry (AIDE), Transaction Validation, and Membership Eligibility

Medical claims are processed through CS90, Empire BCBS' comprehensive business system for membership, claims, financial, and benefits administration of medical and hospital claims. "Clean claims" are received into CS90 and pass through a multi-stage editing process. Initially, a simple validation occurs to ensure the member is enrolled and the provider on the claim is both valid and recognized. Matching of care,

authorization/approval (e.g., Medical Note) matching occurs in this step as well. Any defect will result in a claim suspension requiring manual intervention before the claim is allowed to continue through the processing logic. Typically, these edits are fairly simple and only require minor changes. Other than minor patient name issues and authorization edits, most corrections occur on paper claims rather than those submitted electronically.

Plan Adjudication Specification Method (PLASM)

All members, as well as covered dependents, are assigned to group numbers on our CS90 eligibility and claims system. Specific contract numbers are assigned to these groups. All contractual benefit detail is loaded to these contract numbers and each is very specific and unique. PLASM has every revenue code, CPT4 code, or service assigned to a benefit category. The contract numbers have any covered benefit category assigned to them which further distinguish how the benefit is to be applied, e.g., in/out of network, penalties for failure to precertify the service, cost sharing, etc. Authorizations matched to the claim are now used to reference claims history and authorization limitations. Visit maximums, as well as maximum dollars, are included and referenced in this process with PLASM's ability to interrogate claim history.

While over 85% of all claims are adjudicated on the first pass, i.e., requiring no manual intervention, claims that require further investigation are suspended. Currently, there are over 2,000 different edits in place. Duplicate checking, authorization matching, and medical policy editing are the most common.

Edits may be general and apply to a broad spectrum of contracts and products or can be specific to a particular group. Of the 2,000 current edits previously mentioned, the goal is to be as specific as possible to target a limited population of claims meeting well-defined conditions. In addition to suspending the claim for specific edits, the logic within CS90 will allow the

operations area to assign these edits to processors based on the complexity of the edit, contract and claim type. This logic allows for ensuring that each edit can be routed to the appropriate processor.

PLASM's steps to ensure contract compliance are as follows:

- **Initial Step – contains contract-specific information, establishing the contractual allowance (i.e., pricing) and setting the approved units.**
- **Rule Step – contains Plan-wide policies applied to all or most contracts. Can hold or modify the approved units or allow line level denials.**
- **Cover Step – contractual restrictions are applied in this step. Approved units can be held or modified, which is the last step where approved units can be changed. Following this step, only dollar values can be changed. Visit maximum reductions are taken in the Cover Step.**
- **Deduct Step – contractual deductions are applied here, and any reduction in dollars here and beyond are patient liability. An example is Managed Care penalty applied for failure to preauthorize a required service.**
- **Copay – contractual co-payment or co-insurance, based on the benefit design, is calculated and applied in this step.**
- **Maximum Step – contractual maximum dollar amounts when applicable are applied in this step.**

Claims are adjudicated by the systematic progression through these PLASM steps. Once completed, the reimbursement levels and payment determination has been established. CS90 and the PLASM claims processing logic is also the enrollment database and claims processing engine used in the successful and accurate claims administration of the Empire Plan Hospital Program.

Incoming mail services, correspondence indexing, and data entry for paper claims is outsourced to Xerox, with which we've had a contractual relationship for approximately 14 years. The current contract extends our relationship through 2016; however, there are no plans to change this arrangement once the current contract expires.

Empire BCBS' data file back-up policy includes daily back-up of data and removal of CS90 files twice a year to an offsite storage facility. Claims are retained for seven years; however, after 18 months of history, claim data is purged to another database. This database is readily accessible and simply uses a different transaction key to access. With extensive back-up capabilities for both the data processing system and the telecommunications network, we will assure the protection of the Program's data and ongoing processing support in the event of a service interruption.

For data systems, we employ an enterprise network intelligent routing and self-healing system via a Sonet Ring. This system can diagnose a delay or stoppage in information and automatically reroute data to other backup systems in other locations with no data loss. Our business continuity plan was tested on September 11, 2001, when we lost our corporate headquarters and all resident support systems at the World Trade Center. The loss of this facility displaced approximately one-third of our employees and eliminated two service systems. Despite these devastating losses, we suffered no loss in service. This can be attributed to the redundancy and business continuity systems that were in place.

(3) Confirm that all aspects of claims processing are located only in the United States staffed by fully trained claims processors and supervisors.

Confirmed.

(4) Describe the capabilities of your claims processing system to integrate each of the following required MHSA Program components:

(a) Prior authorization for inpatient services, psychological testing and electro-convulsive treatment and concurrent review of outpatient services;

The claims engine can read history and identify related services by benefit category. Visit thresholds can easily be established and tracked to administer a 10 visit "pass-through" approach to outpatient services.

As additional visits or inpatient days are approved and added to an authorization, the information is passed to the claims engine. The claim will use the updated information on the authorization and allow only the number of approved days or visits.

All case information entered into our care management application, CareConnect is passed electronically through a nightly batch feed to our claims processing system. For example, all procedures requiring precertification are linked to the claims processing system. As the claim is processed, if the precertification failed to occur, the claim adjudicates based on suspension logic. The claims processing system is coded to pay claims based on medical management decisions. Without precertification, the claim is denied and/or penalty is applied.

(b) Eligibility verification;

The member is enrolled into CS90, the same system used to adjudicate claims. All dependents are loaded to the member's contract and accessed under the member's employee identification number, alternate identification number or social security number. This information is also fed to our care management application, CareConnect, to enable

loading of authorizations at the patient level. Eligibility can be verified through the provider IVR and on the secure provider portal.

(c) Customized edits for variations in benefits required various employee groups;

The requirement above is a very common occurrence. As noted above, the contract number is used in PLASM to establish the benefit design. Each group (and specific benefit design when necessary) is assigned a unique contract number. This customization allows for the appropriate processing of benefit variations. This is evidenced by our proven track record on the Empire Plan Hospital Program and our ability to customize benefits for various entities that comprise the Program.

(d) Historic look up capability for claims and clinical information; and

Inquiry access to CS90 is available to all claims, service, and case managers. This includes enrollment, claim history, group information, and authorization information necessary to process the claim or handle any member or provider inquiry. Clinical detail regarding prior authorizations is maintained in our CareConnect application. Claims remain active on CS90 for 18 months, based on the last transaction date of the claims. After this time, the data is purged to another database that is readily accessible, but uses a different transaction key to process and access. Claims history is ultimately retained for seven years in total.

(e) Multi-level cost sharing (Deductibles, Co-insurance, Co-payments).

Member claim history is integrated on every claim that is adjudicated to aggregate cost share dollars to apply the appropriate amounts. Cost sharing amounts are calculated/determined in the PLASM processing logic.

(5) Confirm that you will develop and securely route a daily claims file of shared accumulator amounts to the Empire Plan medical carrier/third party administrator and hospital carrier.

Confirmed. We are accustomed to working with many third parties for the loading of daily claim files.

(6) Confirm that you will timely load the daily claims files of shared accumulator amounts received from the Empire Plan medical carrier/third party administrator and hospital carrier.

Confirmed. We are accustomed to working with many third parties for the loading of daily claim files.

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

The benefit design is coded using contract numbers and is specific to the Program. Changes to the benefit design must be requested by the Program and initiated internally through the Program's Account Team. Benefit changes initiated by other client's would not impact the Program.

When a change is requested for the Program, the Account Team will coordinate the request with the necessary internal areas. The appropriate documentation is provided to the Requirements Analyst. Working with the Account Team, the requirements are determined and a system change request is initiated. Following initial review the change request is authorized and forwarded to the PLASM developers who create the technical design of the change. The benefit coding is then updated, tested and forwarded to the test region where the PLASM tester performs detailed regression testing. If the output passes this stage of testing, it is sent to the business owner for user acceptance testing. Following successful completion of all phases of testing the change is implemented and the various benefit reference information sources are updated (e.g., call center on line benefits, the portals, IVR speak-out, etc.).

(8) Confirm that you participate in Medicare Crossover and provide details of your experience with Medicare Crossover.

Confirmed. Empire BCBS participates in Medicare Crossover. Medicare crossover claims are received from the Coordination of Benefits Contractor (COBC). We began receiving the claims from the COBC in 2006. We currently provide Medicare Crossover to all clients including the State of New York (Hospital Program).

(9) Describe your procedures for the collection, storage and investigation of COB information other than Medicare.

We maintain a coordination of benefits (COB) data file. To assist the claims examiners in identifying other coverage, our claims processing systems access membership files, prior claims history and a separate COB database. This database currently contains over 500,000 detailed records on other carriers' coverage of our members. Our COB files identify the other insurance carrier

name (if provided), primary cardholder, level of coverage, and dependents covered.

We currently employ a retrospective process (pay and pursue), and questionnaires are generated when a claim is received and no COB information is on file.

We maintain the following COB information online:

- **Name of person with other coverage**
- **Employer, if any**
- **Date of birth**
- **Name and address of employer/group that offers other coverage**
- **Name and address of insurance company**
- **ID number, effective date of other coverage and kind of coverage**
- **Employment status of person with other coverage – (active or retired)**

Our claims examiners access the COB database through interfacing logic in place between this database and the claims processing system. This interface utilizes the following criteria:

- **Patient sex/relationship**
- **Positive record on the COB database**
- **Notation of alternate coverage on the enrollment file**
- **Prior claim rejected for COB reasons**

Additionally, our proactive alert feature on our website, empireblue.com, allows members to supply online the information required to process claims. Members can fill out a COB questionnaire online, print a copy, or request that the form be mailed to them. Once the online questionnaire is completed, the submitted information automatically searches for any suspended claims. These claims are then processed within seconds.

If COB information is on file and a claim is received without a voucher, the claim will be denied regardless of the dollar amount of the claim. When we identify a potential COB situation, we contact the other carrier or the participant, the provider, or the employer to determine primary and secondary liability. We have no threshold levels on the pursuit of claims when COB information does exist.

COB information is requested annually from members upon receipt of the first claim received, if no COB information is on file. The claims system continues to scan the COB database every time we process a claim. Additionally, if during the year a claim is received with a COB indicator, we send out an inquiry and update our records. If there is evidence of a primary carrier, the claim will be denied and the member is advised to submit to the claim primary carrier.

(10) Explain how your claims processing system collects overpayments from your Provider network.

When provider overpayments are identified, a refund is requested. The claim is adjusted upon receipt of the funds. Currently refunds are solicited on amounts of $30.00 or more.

We will make a reasonable attempt to recover our overpayment through claim recoupments 45 days after the original solicitation. If we do not think we can recoup the funds in this manner, we will send a follow up letter 35 days after the initial request. If funds are not recovered by this point, the case is sent to our business partner to recover the funds.

For network providers, we attempt to recover overpayments by requesting a refund for the amount due from the provider. Amounts refunded will reflect within the system so that utilization reporting and accumulators are updated. We can also recoup overpayments automatically on future payments with proper notification to the overpaid provider. For

underpayments, the claims staff corrects the claim and forwards the amount balance to the provider.

Amended March 29, 2013

(11) Describe how your adjudication system feeds the reporting system, including how claims backlogs are captured and reported.

CS90, Empire BCBS's single-site processing system, provides a centralized database that utilizes one system to store and process all transactions and information, and it provides a real-time link between our member services, claims, eligibility, utilization review/medical management, and network management areas.

For client reporting, data is refreshed monthly and reports are available 25 calendar days after the end of previous month.

(12) Confirm the Offeror will adjust all attributes of claim records processed in error and credit the MHSA Program for all costs associated with the claim processed in error.

Confirmed.

(13) 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 MHSA Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged an Administrative Fee only for Final Paid Claims. Confirm the Offeror will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Offeror error. In cases of overpayments resulting from errors only found to be the responsibility of the Department and

for fraud and abuse, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Program upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

Confirmed. Edits and notifications built into our system currently include the following:

- **Patient's gender or age is inconsistent with the procedure code**
- **Diagnosis code and procedure code are inconsistent**
- **Patient's gender or age is inconsistent with the diagnosis code**
- **Valid date of service**
- **Valid procedure code**
- **Valid diagnosis code**
- **Pre-certification is necessary for claim payment**
- **Appropriateness review is necessary for procedure**
- **Service is not usually considered medically necessary**
- **Claim is a possible candidate for audit**
- **Client-specific ICD-9 and CPT "flags"**
- **Unbundling and upcoding of services**
- **Claimant is a candidate for disease management**
- **Claimant is a candidate for case management**

In an effort to help achieve claims standardization across the enterprise, our parent company, Wellpoint, has a contract with McKesson Health Solutions for their industry-leading automated claims auditing software program, ClaimsXten.

ClaimsXten is a system of checks and balances in which claims are reviewed to ensure adherence to industry standards for coding. In addition, ClaimsXten provides considerable flexibility to manage our reimbursement policies by line of business. This level of specificity helps to improve first-pass and auto-adjudication rates, limit re-work and lower administrative costs.

Moreover, as discussed in other parts of this proposal, our parent company maintains a comprehensive Fraud and Abuse Department consisting of approximately 70 investigators and analysts. Based on its findings, the Fraud and Abuse Team makes edit recommendations that can be incorporated into ClaimsXten.

Pre-payment Audits

High dollar claims audits are routinely performed pre-payment for auto-adjudicated and non-auto adjudicated claims when payments reach an established dollar threshold for professional and facility claims. Prior to these claims being finalized, they are reviewed by a lead examiner for the following:

- **Eligibility**
- **Keying accuracy**
- **Benefit limitations**
- **Contract exclusions**
- **Verification of the diagnoses and procedure codes billed**
- **Pricing accuracy**

When a claim is $50,000 or greater, it is sent to a Manager to review. If the claim is $100,000 or greater, it is sent to a director. Any claim that is $500,000 or greater is sent to a Vice President for review and final approval and payment.

Overpayment

In the event we overpay claims for a particular party, we will pursue recovery of the overpayment and will credit the Department at the time the overpayments are adjusted.

Overpayments are identified in various ways, including: customer service interactions, claim department audits, BlueCross BlueShield Association Member Touch Point audits, internal data mining queries, overpayment identification by vendors, and voluntary receipts.

Uncollected overpayments are pursued via telephone contacts, letters and collection agency action.

When overpayment funds are received, the member's claims history is adjusted to correct the payment. Overpayments are managed by our Financial Operations Department. Contract terms specify our responsibilities with regard to the recovery process.

Post-payment Audits

Three separate auditing departments within the company that are not part of the Claims Operations business unit perform post-payment audits:

- **In-line Claims Quality department**
- **Member Touchpoint Measures (MTM) Auditing department**
- **Performance Guarantee Auditing department**
- **In-line Claims Quality Department**

Our In-line Claims Quality program offers a consistent quality review across the company.

Claims auditors have an average tenure of 15+ years claims processing experience and conduct a multi-tiered program consisting of the following in-line quality audits across the enterprise:

- **Standard Audits**

  Audits manually processed claims. A random, non-stratified, automated sample of finalized claims is selected for each processor on a weekly basis. These samples are systematically fed into the quality tracking database for the auditors to review. The auditors conduct a standard number of eight audits for frontline claims processors, which is approximately 0.1% of the total claims processed for each processor.

- **Platform Population Audits**

  Audits the total claims population per platform to ensure claims processing and financial accuracy. A random, stratified sample is pulled and uploaded into the quality database systematically on a weekly basis. Platform population audits are primarily focused on systematically processed (auto-adjudicated) claims.

- **High Risk/Targeted Audits**

  Audits specific areas identified through our In-line Quality and MTM error trends, focusing on specific codes, claims types, providers or lines of business and pre- and post-migration/system updates.

- **End to End Provider Claims Accuracy Audits**

  An audit is conducted 30 days after a facility provider contract is updated. A random, stratified sample of all institutional claims is pulled 30 days post-facility provider contract update. The claims are audited end to end from data entry accuracy to the provider's paper contract to benefit application and overall payment accuracy.

Auditors evaluate the claims for accuracy including, but not limited to, reviewing the original claim submitted, eligibility, benefits and pricing according to established contractual agreements, medical policy and medical review determinations.

If a discrepancy is identified, the audit is sent electronically to the Operations manager for review and approval through our quality database. The manager reviews the discrepancy with the associate to provide coaching and training, as needed, to improve accuracy performance.

Auditors are audited concurrently through our Audit the Auditor program. Samples are pulled on a weekly basis for each auditor. The factors used to measure performance are audit coding, audit accuracy and overall accuracy.

Real-time claim reporting is available at the Vice President, Director, Manager and individual level. These reports provide information on the number of claims audited, financial and processing accuracy results and root cause trending on a monthly, quarterly and year-to-date basis. Monthly partnership meetings are held with Quality and Claims Operations Management Teams to discuss monthly results, review trends and make recommendations to improve performance.

BlueCross BlueShield Association (BCBSA) Member Touchpoint Measures (MTM)

Our MTM audit team conducts post-payment reviews of medical and hospital claims in order to measure processing accuracy and timeliness. Audit criteria are mandated by the BCBSA MTM program. We provide semi-annual results to the BCBSA.

The MTM audit is based on statistically valid samples selected from the entire population of original and adjusted claims. The sample size is calculated at a 95% confidence level and not on a percentage of claims processed. Claims are sampled randomly via an automated process and stratified based on dollars paid. Each sample is a proration of the total sample required for the audit period. Actual performance results are compared to the expected performance results to ensure statistical integrity. Samples are designed to be statistically significant quarterly and statistically valid on a semi-annual basis.

Auditors ensure samples are selected without bias and are representative of the claim population. Sampled claims are audited in their entirety while adhering to established audit guidelines that include the verification of:

- **Patient eligibility**
- **Services rendered**
- **Data entry**
- **Electronic record integrity**
- **Benefits**
- **Payment**

MTM auditors forward discrepancies to the appropriate Operations area for review. The Operations area either accepts or refutes the audit finding. If the error is refuted, the auditor reevaluates the audit observation based on additional information provided. MTM and Operations Management are included in the discussion if the auditors and Operations cannot resolve the audit observation. Follow up on any audit findings that require correction of a claim is done on a quarterly basis to ensure the corrections have been completed appropriately.

<u>Performance Guarantee Audits</u>

Our performance guarantee audit team conducts independent post-payment reviews of medical and hospital claims to measure processing accuracy. Account Management reports results to clients who have entered into performance guarantee agreements with us.

Performance guarantee claim accuracy audit is based on statically valid samples selected from the entire population of original and adjusted claims. The sample size is calculated based on a 95% confidence level and not on a percentage of claims processed. Claims are sampled randomly via an automated process and stratified based on dollars paid. Each sample is a proration of the total sample required for the audit period. Actual

performance results are compared to the expected performance results to ensure statistical integrity. Samples are designed to be statistically valid quarterly or semi-annually and management receives monthly reports with interim performance results.

Auditors ensure samples are selected without bias and are representative of the claim population. Sampled claims are audited in their entirety while adhering to established audit guidelines that include the verification of:

- **Patient eligibility**
- **Services rendered**
- **Data entry**
- **Electronic record integrity**
- **Benefits**
- **Payment**

Performance guarantee auditors forward discrepancies, detailing the audit observation and its final impact to the Operations area for review. Operations either accepts or refutes the audit finding. If the error is refuted, the auditor reevaluates the audit observation based on additional information provided. Performance Guarantee and Operations Management are included in the discussion if auditors and Operations cannot resolve an audit observation. Follow up on any audit findings that require correction of a claim is done on a quarterly basis to ensure the corrections have been completed appropriately.

(14) Confirm that the Offeror will update the claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

Confirmed.

(15) ***Financial Accuracy Guarantee:*** The MHSA Program's service level standard requires that the MHSA Program's financial accuracy be achieved for a minimum of ninety-nine percent (99%) of all claims processed and paid each year. Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) the Offeror's financial accuracy rate of all claims processed and paid each year is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

(16) ***Non-Financial Accuracy Guarantee:*** The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-five percent (95 %) of all claims processed and paid during the first year of the Agreement. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Results shall be determined

based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during the first contract year is $10,000 per year and for each .01 to 1.0% below ninety-seven percent (97 %) of the Offeror's non-financial accuracy rate of all claims processed and paid during years two through five of the Agreement is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

(17) ***Turnaround Time for Non-Network Claims Adjudication Guarantee:*** The MHSA Program's service level standard requires that a minimum of ninety-nine and five -tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing

agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine and five-tenths percent (99.5%) of Enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent is $6,000 per each quarter. However, the Offeror may propose higher or lesser amounts.

[redacted]

12. Clinical Management

Quality Clinical Management techniques help to control costs and ensure that Enrollees are receiving safe, effective treatment in the least restrictive setting. The Department requires the Contractor to provide clinical management that is MHSA parity compliant through three Utilization Review (UR) methods that are currently used for the medical component of the Empire Plan: Pre-certification, Concurrent review and Retrospective review. The Contractor must, at a minimum, provide UR as described further in this Section; however, Offerors are not prevented from offering other value oriented UR methods, provided that they are parity compliant and implementation is at the sole discretion of the Department.

Both inpatient hospital and MHSA admissions are subject to pre-certification, except in Emergencies, concurrent review and retrospective review. Recurring outpatient therapy visits under the medical program, such as physical therapy, occupational therapy and chiropractic care, are certified based on clinical assessment of the member by the provider. The determination occurs after there has been a clinical assessment by the provider and the clinical assessment can occur after one or more visits. Services rendered by ”tier 1” in-network providers for physical therapy, occupational therapy and chiropractic services do not need to be certified. The following are the options related to when a Provider is expected to seek authorization for these services:

1. No contact at all
2. Prior to the first contact
3. After the first contact
4. After the tenth visit

Under the MHSA Program, recurring outpatient therapy visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit.

For the period January 1, 2011 through December 31, 2011 clinical management of the MHSA Program resulted in authorization of approximately 1,117,000 outpatient visits and the certification of nearly 4,300 inpatient and alternate level of care admissions.

Pre-Certification of Care

The MHSA Program is designed to strongly encourage members to seek clinical referral prior to receiving MHSA services. This is accomplished through the use of a Clinical Referral Line (CRL). The CRL is staffed by clinicians who determine the medical appropriateness of MHSA care and direct members to the most appropriate Network Provider and level of care. Also, the pre-certification process includes procedures to determine medical necessity in advance of non-emergent inpatient admissions and for out-patient benefits for "recurrent therapy visits". "Recurrent Therapy Visits" are defined as treatment modalities or services that are dependent on the provider and patient interaction during the patient encounter as the major form of treatment, reoccur on a regular basis, and the total number of which are determined by a specific treatment plan based on the patient's clinical presentation. The current Contractor requires pre-certification for ECT, psychological testing and Applied Behavioral Analysis (effective January 1, 2013).

a. Duties and Responsibilities

To ensure that the resources available to the MHSA Program are utilized for appropriate, medically necessary care, the Contractor is required to perform pre-certification of care which includes, at a minimum:

(1) Use of a voluntary Clinical Referral Line (CRL) located in the United States to evaluate Enrollees MHSA care needs and direct Enrollees to the most appropriate, cost-effective Providers and levels of care. The CRL must be structured to facilitate Clinicians' assessment of the caller's MHSA treatment needs and to provide suitable, timely referrals especially in emergency or urgent situations or for care that requires inpatient admission;
Confirmed.

(2) Use of alternate procedures to precertify care when the Enrollee fails to call the CRL, as follows:

(a) When an Enrollee contacts a Network Provider directly for treatment without calling the CRL, the Contractor is ultimately responsible for ensuring that Enrollees receive the Network level of benefits and obtaining all necessary authorizations for treatments for Network outpatient services for "Recurrent Therapy Visits" and Network inpatient care, when an Enrollee contacts a Network Provider directly for treatment without calling the CRL;

Confirmed.

(b) When an Enrollee contacts a Network Provider directly and the Network Provider is not the appropriate Provider to treat that Enrollee, the Contractor is responsible for ensuring that its Network Providers take responsibility for assisting the member in obtaining an appropriate referral; and

Confirmed.

(c) When an Enrollee contacts a Non-Network Facility for treatment and the Contractor is notified in advance of the admission, the Contractor must provide the Enrollee or other HIPAA authorized representative of the Enrollee, with a written determination of medical necessity of care in advance of the inpatient admission, where feasible.

Confirmed.

(3) Timely written notification to the Enrollee, or other HIPAA authorized representative of the Enrollee, of the potential financial consequence of remaining in a Non-Network Facility when the initial determination of medical necessity occurs;

Confirmed.

(4) Preparing and sending communications to notify Enrollees and/or their Providers of the outcome of their pre-certification or prior authorization request and notifying them in writing of the date through which MHSA Program services are approved;

Confirmed.

(5) Promptly loading into the clinical management and/or claims processing system approved authorizations determined by the Contractor;

Confirmed.

(6) Pre-certifying inpatient hospital admissions for alcohol detox, advising the facility to send the claim to the Hospital Program carrier/third party administrator and managing the Enrollee's care if transferred to rehab;

Confirmed.

(7) Loading into the Contractor's clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received; and

Confirmed.

(8) Clinical Referral Line Guarantees: The Contractor must meet or exceed the following three (3) performance guarantees as follows:

(a) ***Non-Network CRL Guarantee*:** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate MHSA Non-Network Provider or

program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases.

Confirmed.

(b) ***Emergency Care CRL Guarantee*:** The Program's service level standard requires one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within (thirty) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non life-threatening emergency care shall be contacted by a Network Provider or recontacted by the CRL clinician within thirty (30) minutes of the Enrollee's call to the CRL.

Confirmed. Empire BCBS confirms we will follow up with 100% of Enrollees who call the Clinical Referral Line within 30 minutes after referring them to emergency care services. The suggested protocol outlined by NYS for a Network Provider or Clinical Referral Line clinician to contact Enrollees that were in need of a non life-threatening emergency care within 30 minutes of the call is exceeded by our MHSA Program. Empire BCBS's MHSA Program immediately connects Enrollees who contact the Clinical Referral Line with a non-life threatening emergency to an on-site licensed MHSA clinician on our team, and that clinician manages the crisis *as the member calls in*, and makes an appropriate clinical decision based on the member's presentation. There is no need for a call back or outreach within 30 minutes, as our program protocol does not allow the member to disconnect until the situation is resolved or a solid care plan is in-place. After a care plan is put in place, a MHSA clinician continues to track the member throughout the incident. The timeline of follow-up is dependent upon the situation; however, our protocol is to follow-up with the Enrollee within 24 hours after their initial non-emergency needs are met

to assess on-going assistance and help them however clinically appropriate.

In summary, our proposal to exceed the *Emergency Care CRL Guarantee* is as follows:

Empire BCBS's MHSA Program immediately connects Enrollees who contact the Clinical Referral Line with a non-life threatening emergency to an on-site licensed MHSA clinician on our team, and that clinician manages the crisis as the member calls in, and makes an appropriate clinical decision based on the member's presentation.

Amended March 11, 2013

(c) ***Urgent Care CRL Guarantee:*** The Program's service level standard requires that, at the least, ninety-nine percent (99%) of Enrollees in need of urgent care be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the Enrollee's call to the CRL.

Confirmed.

b. <u>Required Submission</u>

(1) Describe in detail how you propose to precertify services including;

(a) An overview of your Clinical Referral Line (CRL) and proposed precertification process as well as the criteria you use to identify the services that the Program should consider for pre-certification or prior authorization.

<u>Clinical Referral Line Overview</u>

The Clinical Referral Line is the gateway to MHSA Program services and information. Trained MHSA customer care representatives guide Enrollees to the most appropriate resource available. Licensed MHSA clinicians handle complex issues and provide specialized crisis support for urgent services or emergencies. In an urgent or emergency situation, the

Clinical Referral Line clinician works directly with the Enrollee to immediately manage and resolve the issue as clinically appropriate.

The Clinical Referral Line offers a robust protocol for Enrollees in-crisis. When the Enrollee with a non life-threatening crisis contacts the Clinical Referral Line, a licensed clinician manages the call to develop an appropriate clinical solution. Interventions range from providing support and structure, to dispatching emergency authorities to transport the Enrollee to a face-to-face emergency evaluation. If our recommendation is an emergency evaluation, the clinician will follow-up with the Enrollee within 30 minutes to ensure they have arrived at the facility to be assessed.

If the Enrollee has a relationship with a network provider, the clinician will involve that clinician in the treatment plan as appropriate.

If the Enrollee is not currently in treatment, the MHSA clinician will help find appropriate support for a face-to-face appointment within 48 hours.

<u>Precertification Process</u>

MHSA clinicians review certification requests for intensive care services according to established standards and protocols for the collection and evaluation of clinical information. All reviews are conducted within established timeframes by appropriate licensed healthcare professionals using adopted clinical criteria under the supervision of the NYS MHSA medical director. The NYS MHSA medical director is responsible for oversight of clinical decision-making. Additional regional and national medical directors also participate in the selection and evaluation of clinical criteria, clinical practice guidelines and review referred critical incidents/sentinel events with clinical quality/safety quality concerns.

Treatment in care settings require authorization prior to admission, and are subject to continued stay review. The care settings include the following:

- **Acute inpatient**
- **Residential treatment**
- **Partial hospital**
- **Intensive outpatient**
- **Group homes**
- **Halfway houses**

Prior authorization is not required for the first ten outpatient visits per calendar year. Upon the eleventh visit, prior authorization is required via submission of an outpatient treatment report.

Emergent conditions requiring immediate hospitalization to stabilize the emergency condition are certified under prudent layperson regulations and are eligible for continued stay review on a concurrent basis.

Participating facilities are expected to contact the Clinical Referral Line immediately, including upon an emergency admission. The process is as follows:

1) If the situation is a life-threatening emergency and the Enrollee is not already in an emergency room, he/she is referred to the nearest emergency room.

2) If the Enrollee is not yet discharged at the time of notification, continued stay is reviewed on a concurrent basis.

All admission reviews are conducted telephonically by MHSA care managers. Clinical criteria are used to evaluate the proposed treatment

plan to determine if the requested services are customary for the diagnosis and provided at the most appropriate level of care. Cases where clinical indications are unclear or where medical necessity is not met are referred to a clinical peer reviewer for further assessment. Providers and Enrollees are verbally notified of review decisions within established timeframes. Written confirmation letters of all determinations are mailed and/or faxed to providers and Enrollees.

(b) Your proposed Clinical Referral Line staffing and qualifications of each level of clinician rendering authorizations and denials of care. Will clinical management staff be dedicated to the Program or will they service other customers as well?

Empire BCBS will staff the Clinical Referral Line with dedicated clinicians who determine the medical appropriateness of MHSA care and direct Enrollees to the most appropriate network provider and level of care. The dedicated MHSA clinical team will provide the following services:

- **Manage utilization for the NYS membership once they enter into treatment with a provider.**
- **Work with providers, facilities and professionals to determine medical necessity through pre-certification and concurrent review.**
- **Assist providers in triaging Enrollees to the most appropriate level of care at the point of entry or at the time of discharge of a higher level of care.**
- **Provide referrals to MHSA Case Management or to one of the specific MHSA Disease Management programs as appropriate.**
- **Provide referrals to Enrollees with MHSA cases requiring a medical disease management program or medical case management.**

The Clinical Referral Line, including the dedicated MHSA clinical utilization management team, will be comprised of 27 licensed MHSA

clinicians. A licensed clinician, as required in this offering, will be available 24/7 for emergent and non-emergent member issues, as well as to conduct utilization management services.

Calls requiring clinical interpretation are handled by licensed care managers, who are registered nurses or other licensed master's level clinicians and are assessed for urgency according to MHSA protocols. Referrals are made to appropriate care settings based on MHSA written clinical criteria. Referral and triage activities are supervised by the manager of Utilization Management Services. All clinical decisions regarding the authorization of the Enrollee's benefits are made under the supervision of the manager of Utilization Management Services.

Denial and appeal decisions are made by medical doctors. In the case of outpatient treatment provided by a Ph.D. level or below (master's level) and psychological testing, a licensed psychologist can render the decision.

(c) For the calendar year 2012, the percentage of Enrollees who called the CRL and who received a referral at a different level of care from the one initially requested.

While our reporting does not specifically track this type of information, our experience is that less than 10% of Enrollees who call require a level of care different from the one initially requested.

(d) A description of your proposed precertification program including the type of services subject to precertification, staffing levels, the timeline for completion, clinical information requested, and the number of cases reviewed, approved and declined for a client similar to the Program (for the most recent calendar year). Provide a sample of any pre-certification forms used by the Offeror.

The precertification review process applies to all levels of care. Below is a brief description of more commonly used levels of care. All of descriptions below are general, and subject to medical necessity criteria and contract benefit coverage.

Acute Inpatient

When an Enrollee presents in crisis with acute symptoms and severe deterioration in functioning (such as imminent risk of harm to self or others, acute psychotic symptoms or grave disability) stemming from diagnosable MHSA condition, the appropriate intervention may include an admission to an inpatient environment. This is the most restrictive and intensive setting, and provides 24 hours/day, 7 days/week skilled nursing care, daily medical care, availability of psychiatrists and other physicians 24 hours/day, intensive multidisciplinary assessment and treatment. Structured interventions are available throughout the day and evening, and discharge planning begins on admission. Where appropriate and available, a 23-hour observation unit/bed may be used for Enrollees who may present with a psychiatric emergency, but their symptoms may resolve quickly with intensive treatment. Therefore, further evaluation is needed before an inpatient admission is recommended. During such time, the member can be assessed, initially treated and stabilized, support systems mobilized and the Enrollee triaged to a different level of care if clinically indicated.

We review inpatient admissions at the time of admission to appropriately evaluate the Enrollee's case. This review helps to ensure Enrollees receive the most effective treatment available. Licensed clinicians conduct concurrent reviews based on approved medical necessity criteria and must ensure the Enrollee is receiving all necessary services at the appropriate intensity.

Residential Treatment

Residential treatment is a non-hospital 24-hour level of care. This level of care offers an organized set of services (diagnostic, medical management and monitoring), and therapeutic services (social, psychosocial, clinical, educational and rehabilitative). Direct nursing supervision and an individually planned regimen of care are included as part of residential treatment. The level and frequency of psychiatric and nursing services will vary by sub-type of residential program (substance abuse, child/adolescent, eating disorders).

Addressing treatment issues through a therapeutic setting is a unique aspect of treatment in this level of care. This level of care requires at least weekly individual psychiatric sessions, plus medical necessity criteria defined individual and family therapy.

Partial Hospital

Partial hospital is an intensive structured setting providing six to eight hours of therapeutic services per day (a half day partial, if included by contract, consists of four to five hours) in a program that is available at least five days per week. The intensity of services includes multidisciplinary assessment and treatment plan, minimum of weekly psychiatric visits, family therapy, individual therapy and medication monitoring, as defined by medical necessity criteria. This setting may be used in lieu of an inpatient admission when an Enrollee's presenting problem and associated symptoms could be safely treated outside a 24-hour acute medical setting, and when the Enrollee's condition cannot be safely treated in a less intensive form of ambulatory care.

Intensive Outpatient

Intensive outpatient is a structured day or evening program that provides specialized treatment for MHSA conditions. Intensive outpatient programs should provide at least three hours of structured treatment per

day. Intensive outpatient programs offer therapeutic services of a type and frequency specified in medical necessity criteria for the specific age group and/or type of intensive outpatient program. Enrollees admitted to an intensive outpatient program have well-defined clinical rationale that explains why they are not a reasonable candidate for a less restrictive level of care. Intensive outpatient programs are the preferred setting for substance abuse rehabilitation when there is no evidence of or potential for serious or complicated withdrawal, no imminent psychiatric emergency and when the Enrollee is motivated to be treated. For substance abuse service when inpatient detoxification has occurred, intensive outpatient is typically the follow-up level of care.

Traditional Outpatient

Traditional outpatient services are generally provided in an office setting for an Enrollee who is diagnosed with (or there is strong evidence for) an MHSA diagnosis that requires treatment, and the Enrollee is likely to respond to treatment. Services may include individual, group, family therapy and medication management. Precertification of these services are required after the he initial pass through visits are exhausted.

Our current staffing ratios of utilization management representatives who handle intake pre-certification are approximately one representative to 130,000 Enrollees. The care manager ratio for utilization management activities is one licensed care manager to 90,000 Enrollees. These ratios are based on our standard product offerings for utilization management and our standard customer service-level expectations.

Below is a sample of the number of cases reviewed, approved and declined for a similar book of business in 2012, covering approximately one million lives.

	Similar Book of Business
Total number utilization management review determinations performed	**16,773**
Total number of reviews approved	**15,434**
Total number of reviews clinically declined	**1,339**

Please see samples of Empire BCBS's precertification forms in Appendix H.

(e) A description of the steps that will be taken to meet the needs of Enrollees who require a Provider with subspecialties, especially those who require pediatric, adolescent or geriatric mental health services. How will you meet the ongoing therapy needs of those Enrollees whose first language is not English; who are hearing impaired; or who request a Provider with a particular ethnic background?

Empire BCBS anticipated the need for a multidisciplinary network panel in all locations serviced for the MHSA Program and proposed a network that meets these criteria. Our network was established and is maintained with that philosophy, alleviating the need for urgent recruiting situations

When recruiting providers to satisfy certain specialty and sub-specialty needs, Empire BCBS requests that providers complete a form identifying their clinical areas of expertise which also includes language skills, including American sign language, and some aspects of cultural competencies. The Empire BCBS provider finder allows for sub-searches on areas of expertise (sub-specialties). In addition, the language skills of the providers are maintained in a database which can be accessed by the behavioral health team to ensure enrollee's needs are met.

In situations where a network provider cannot easily be identified, Empire BCBS will work with the member to search for a provider to meet the member's needs regarding language, sub-specialty and other ethnic needs.

(f) An explanation of how urgent and emergency cases will be identified. Who on the Clinical Management team will be responsible for making such determinations? Describe the procedures that will be followed for ensuring that Enrollees receive appropriate care in urgent and emergency situations.

Urgent and emergent cases will be identified through the Clinical Referral Line, serviced by licensed clinicians with a background in crisis assessment and triage. A standardized protocol will be applied to ensure Enrollees will receive appropriate care in urgent and emergency situations. This protocol will be based on industry standard crisis intervention assessments, and will include the following components:

- **All calls requiring clinical referral and triage will be handled by the Clinical Referral Line, which is staffed by licensed MHSA clinicians with a background in crisis assessment and triage.**
- **Clinical Care Managers will contact the local community emergency response system where the Enrollee lives in situations where life or safety is imminently threatened, or in situations in which a prudent lay person acting reasonably would believe an emergency exists (such as threats to harm self and/or others).**
- **The Clinical Care Managers should document in the medical management system a summary of the conversation with the Enrollee, any actions advised by the clinical care manager, any actions taken by the clinical care manager and any follow-up documentation relating to the outcome of the situation.**

Privacy

Disclosing an Enrollee's address in this type of situation is considered a "specialized disclosure" by Empire BCBS's privacy policy. If there appears to be an imminent threat to health or safety, MHSA associates are expected to take immediate steps to prevent or lessen the serious or imminent threat. This includes disclosing an Enrollee's address to the appropriate emergency authority. However, to help ensure the disclosure has been tracked and recorded, MHSA associates must promptly report the disclosure to Empire BCBS's Privacy and Security Office.

Emergency Procedures

If the emergency appears to be non-life threatening, the MHSA associate must:

- **Strongly advise the Enrollee to contact his/her physician. If the Enrollee refuses, advise the Enrollee to seek care from the nearest hospital emergency department.**
- **Document the nature of the suspected emergency, advice provided to Enrollee and any other outcomes of the call as appropriate in the medical management system.**
- **Follow-up as appropriate with Enrollee or Enrollee's representative to determine if medical care was obtained.**
- **Document any follow-up attempts in the medical management system.**

If emergency appears to be life threatening, in that the MHSA associate determines the Enrollee is a threat to the safety of himself/herself and/or others, the following protocols are followed:

- **Keep the Enrollee on the line.**
- **Determine whether or not the Enrollee is alone. If the Enrollee is alone or will not let the MHSA associate speak with someone else, the MHSA associate should signal to another nearby clinician to call the**

community emergency response system where the Enrollee is located.

- **If another person with the Enrollee is available to talk, the MHSA associate will speak to that person and direct him/her to contact local community emergency response system.**
- **If there is not another person/MHSA associate to contact emergency response, the MHSA associate will dial 911 and advise the emergency operator that they are calling for another party.**
- **The MHSA associate will stay on the line as long as the emergency operator directs.**
- **The MHSA associate promptly reports the disclosure to Empire BCBS's Privacy and Security Office.**
- **The MHSA associate documents a summary of the situation, including why situation appeared to be life threatening and the outcome of the emergency notification intervention in the medical management system.**

(g) An explanation of the procedures followed in cases where a Network Provider is contacted directly by an Enrollees seeking treatment.

For outpatient services, an in-network provider can provide treatment up to 10 sessions without contacting the Clinical Referral Line for prior authorization. However, providers are encouraged to contact Empire BCBS prior to rendering treatment to verify benefits and eligibility. They can do this either by calling the provider call center or by accessing the secure provider portal on the Empire BCBS website, empireblue.com.

For intensive services providers are educated and instructed to contact the Clinical Referral Line for a review of the Enrollee's clinical status and determination of the most appropriate level of care based on their assessment in accordance with the established medical necessity criteria.

(h) A description of the steps you will take to encourage the use of the toll-free number for the Clinical Referral Line to minimize self-referrals to Providers, as well as steps you will take to encourage the use of Network Providers; (i) Specify the location where Clinical Referral Line and other clinical management services for the Program will be provided. How will you ensure that CRL and clinical management staff are aware of MHSA community resources?

Enrollees will be encouraged to contact Empire BCBS directly prior to seeking treatment. This will be emphasized through a variety of communications including Enrollee newsletters, the custom website and the inclusion of articles and reminders about the advantages of utilizing network providers in the Department's correspondence. Empire BCBS's Care Managers and Clinical Referral Line staff have several years of experience managing MHSA benefits for Enrollees throughout New York State and nationally, and have developed extensive knowledge of community resources and network providers.

The Clinical Referral Line will be co-located with our national MHSA Resource Center in Denver, Colorado. This center is available 24/7 and 365 days a year. It has been operational since January 1, 2008 and serves over 2,000,000. Our staff is experienced in serving Enrollees nationally and are accustomed to assisting Enrollees in crisis and with specific MHSA needs, including triaging them to the most appropriate provider or providing a referral to MHSA Disease Management or Case Management as appropriate. The MHSA utilization management clinical team will be located in the Northeast, with clinical care managers located in New York and Connecticut, and co-located with the hospital clinical team.

(i) The methods you use to measure the effectiveness of the Clinical Referral Line and pre-certification services *(Do not include any reference to specific monetary savings).*

The MHSA associates who staff the Clinical Referral Line attend ongoing training sessions, seminars and workshops, and those with a clinical license are required to participate in 36 hours of state-approved continuing education to maintain and renew their state license every two years. They are also required to participate in annual ethics and compliance training. All calls are recorded and each staff has, at minimum, two calls audited on a monthly basis to ensure compliance with policies and procedures. The results of the audits are incorporated into the individual's performance appraisal and feedback is provided timely. In addition, the licensed care managers are tested annually for clinical decision-making based on consistency through inter rater reliability. Care mangers with scores that fall outside of the norm are required to go through additional re-training and receive additional supervision. Following this corrective action plan they are required to be re-tested.

Methods utilized to measure the effectiveness of precertification include retrospective audits and readmission rates by facility. We have instituted weekly communications with high-volume network facilities where readmission rates are shared and Enrollee follow-up to discharge plan adherence is shared. These results are blindly compared with other facilities. Within the context of these meetings and communications, facilities are encouraged to identify interventions to improve their rates and collaborate with Empire BCBS to enhance the discharge process.

(j) How you will transition Enrollees with existing precertifications with a Network Provider into your system. Confirm you will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

Confirmed. Empire BCBS will develop a detailed transition plan during the implementation of the MHSA Program, and will honor all services authorized prior to the transition which extend beyond the implementation date.

(2) Confirm that you will prepare and send approved communications to notify Enrollees and/or their Providers of the outcome of their pre-certification and/or prior authorization request.

Confirmed.

(3) Confirm that you will promptly load into the clinical management and/or claims processing system approved pre-certification and prior authorizations determined by the Offeror.

Confirmed.

(4) Describe the steps the Contractor will take to pre-certify inpatient hospital admissions for alcohol detox and manage the patient's care if transferred to rehab.

Empire BCBS's MHSA Clinical Care Managers review each proposed inpatient alcohol detox admission to ensure that medical necessity criteria are met and that the proposed treatment setting is appropriate to the Enrollee's clinical condition. In some cases, alternative settings for alcohol detox may be available. If inpatient admission is certified, the care manager initiates a discussion of aftercare planning. We expect that most patients can be treated in

outpatient settings following alcohol detox. The care manager works with the detox facility to identify appropriate aftercare options using Network Providers. If the Enrollee requires follow-up treatment in rehab, the care manager works with the facility to identify network providers and to ensure a seamless transition to rehab treatment following detox.

In addition, Empire BCBS will work with the Empire Plan's Hospital Program to identify enrollees admitted to a medical bed with substance use issues. Referrals can be made directly to the MHSA Utilization Management or to the MHSA case management program allowing for an easy transition and coordination of care for the Enrollee.

(5) Confirm the Contractor will load into the clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the January 1, 2014 implementation date, once acceptable files are received.

Confirmed.

(6) ***Non-Network CRL Guarantee:*** The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non-emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

(7) ***Emergency CRL Guarantee:*** The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life- threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below one hundred percent (100%) of Enrollees who call the CRL in need of emergency care will be contacted by either the Network Provider or the clinicians within 30 minutes of the Enrollee's call to the Clinical Referral Line, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

[redacted]

Amended March 11, 2013

(8) ***Urgent Care CRL Guarantee:*** The MHSA Program's service level standard requires that at least ninety-nine percent (99%) of Enrollees who call the CRL in need of urgent care will be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within 48 hours of the call to the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) of cases when an Enrollee calls the CRL and requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, is $10,000per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

Concurrent Review

The Program's concurrent utilization review process assists the Provider in identifying MHSA care that is medically necessary and cost effective, without compromise to the quality of care.

a. Duties and Responsibilities

(1) To safeguard Enrollee health and ensure adherance with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:

(a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;

Confirmed.

(b) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services. The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;

Confirmed.

(c) is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;

Confirmed.

(d) The Contractor must perform concurrent review of outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

Confirmed.

(e) For inpatient admissions, the Contractor must recognize when to utilize more appropriate and less restrictive levels of care when medically appropriate. The Contractor must have procedures for identifying when transfer to an alternate inpatient or outpatient setting is appropriate and for arranging such transfers;

Confirmed.

(f) Establishes maximum time frames for inpatient review based upon the level of care provided, and a time frame that allows for discharge planning where the continued stay is not certified;

Confirmed.

(g) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment; and

Confirmed.

(h) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions.

Confirmed.

(2) For Enrollees admitted to non-network facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if the facility was in the network, including negotiating discounts with the facility;

Confirmed.

(3) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by a care manager, as follows:

(a) Care managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and

Confirmed.

(b) Care managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.

Confirmed.

(4) The Contractor must provide case management on a voluntary basis for complex cases or cases requiring long-term treatment. The Contractor must cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases of medical/mental health multiple diagnoses in accordance with guidelines established by the Department. Under those guidelines, in cases where there is

both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan;

Confirmed.

(5) The Contractor must use care managers or Peer Advisors to manage the care of members;

Confirmed.

(6) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA care and MHSA Program costs;

Confirmed.

(7) ***Outpatient Treatment UR Guarantee:*** The Offeror must guarantee that, at the least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider notified within twelve (12) Business Days of receipt of the report as calculated on an annual basis; and

Confirmed.

(8) ***Inpatient Treatment UR Guarantee:*** The Offeror must guarantee that, at least, ninety percent (90%) of requests for authorization of inpatient care be reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis.

Confirmed.

b. <u>Required Submission</u>

(1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the Program, including:

Empire BCBS's integrated solution includes MHSA utilization management and case management. Our services are fully integrated with medical management to the fullest extent possible based on the MHSA Program's structure. At this level, we facilitate management and delivery of health care resources to individuals within the structure of the Program's benefit design for intensive inpatient, partial hospitalization and intensive outpatient programs, residential treatment centers and outpatient services (if requested). It includes MHSA utilization review, case management for inpatient transition to outpatient services and coordination with medical utilization management, pharmacy and other Empire BCBS programs.

Our integrated solution for the MHSA Program adds Behavioral Health Resources for individualized support to Enrollees with MHSA conditions through proactive outreach and condition management programs. Behavioral Health Resource features include:

- **Clinical Referral Line**
- **Health care management**
- **Depression care management**

- **ADHD care management**
- **Eating disorder care management**
- **Other utilization management wrap-around programs**

Clinical Referral Line

The Clinical Referral Line is the gateway to MHSA services and information. Enrollees may directly call the Clinical Referral Line or be transferred from another service area based on their need. Clinical Referral Line representatives can view all programs available to the Enrollee, facilitating integration with other programs and services. Trained MHSA customer care representatives guide Enrollees with routine concerns to the most appropriate resource available. Licensed MHSA clinicians handle complex issues and provide specialized crisis support for urgent services or emergencies.

(a) The qualifications of the staff responsible for oversight of your concurrent UR program;

The utilization management /medical management program is under the leadership and guidance of the MHSA Program's Medical Director. Additional information about the responsibilities of the Medical Director are detailed below. Utilization management ensures that qualified licensed health care professionals supervise all utilization management/medical management associates.

The Utilization Management Department implements program activities under the guidance of the Medical Director and the managers of Utilization Management Services. The Utilization Management Department is directly supervised by the Manager of Utilization Management Services, who is a licensed practitioner with five or more years of post-licensure experience.

Empire BCBS employs an experienced, multidisciplinary staff of licensed clinical care managers who are largely drawn from the local clinical

community to enhance a collaborative approach with local providers regarding Enrollee care and to afford more knowledgeable referrals for Enrollees. The following is a description of these positions, including their qualifications and responsibilities:

Medical Director

The Medical Director is the senior MHSA practitioner involved in utilization management. The medical director supervises all clinical decision-making and oversees approval and implementation of the utilization management program. The medical director is a board-certified psychiatrist.

Care Management Director

The Care Management Director oversees the utilization management process through various quality outcomes and programming. This position works with care managers on a daily basis assisting with complicated cases. This interface and experience are used to identify opportunities for improved programming and new utilization management wrap-around services to better serve our Enrollees.

Manager, UM Services

This position is responsible for the management of the Utilization Management /Medical Management department and ensures adequate staffing coverage and performance management. Responsibilities also include managing of daily operation for medical management to include pre-certification, concurrent review, retrospective review, discharge planning, referral management, utilization management, case management or medical review. This individual will identify process and work-flow issues as well as recommendations for improvements, as needed. In addition, this position may serve as the lead on company project initiatives.

Clinical Peer Reviewers

All clinical peer reviewers are licensed, board-certified psychiatrists or licensed, doctoral-prepared clinical psychologists. Clinical peer reviewer refers to employed or contracted licensed MHSA specialists, including MHSA medical directors, who provide professional consulting services for utilization review.

- **Clinical peer reviewers are responsible for peer consultation and issuance of recommendations for clinically based adverse utilization determinations (initial and appeal decisions).**
- **Psychiatrists may review requests for intensive levels of care, outpatient services and matters that involve clinical concerns such as ambulatory detoxification.**
- **Psychologists may review requests for services within the practice scope of a psychologist, such as outpatient psychotherapy and psychological testing.**

Care Managers

All care managers are licensed MHSA professionals. Minimum educational qualifications for a care manager including earning a registered nurse degree, or master's level MHSA licensure such as Licensed Clinical Social Worker (LCSW), Licensed Professional Counselor (LPC) or Licensed Marriage and Family Therapist (LMFT), plus three years post-licensure clinical experience. Doctoral level MHSA professionals meeting the above qualifications are also eligible to work as care managers.

Care managers perform pre-certification, concurrent review, retrospective review and discharge planning services for Enrollees accessing MHSA services. Care managers assess the current clinical status using medical necessity criteria to determine the appropriate level of care for benefit authorization. Care managers can approve services, but do not have the authority to make adverse medical necessity determinations. Care

managers demonstrate the ability to comprehend complex policies and medical criteria as they pertain to Enrollee care from pre-certification through discharge, while ensuring that quality Enrollee care is provided.

(b) Review of outpatient care;

Outpatient treatment, beyond the initial administrative certification (pass throughs) must have prior authorization. This is accomplished through the outpatient treatment report; the provider submits the outpatient treatment report to Empire BCBS prior to commencing any visits not previously approved. Psychological testing requests are also included in the outpatient prior authorization process and are reviewed by a licensed clinical psychologist or psychiatrist. Providers are responsible for report submission beyond the administratively authorized visits.

The care manager reviews the report for medical necessity. Based on clinical criteria and review protocols, the care manager either authorizes a specified number of sessions and length of authorized period or refers the report to a clinical peer reviewer when medical necessity appears to not be met or when treatment goals are unclear. Determination letters are sent to the provider and the enrollee within established timeframes. A new report, with updated clinical information, must be submitted to pre-authorize any additional visits.

The utilization management process is designed to gain information in the most efficient manner and to gather sufficient information upon which to make a medical necessity determination. While the basic document to gain this information is the outpatient treatment report, when necessary, direct telephone dialogue between utilization management staff and providers will be initiated to provide education regarding utilization management practices or to clarify a treatment plan data.

(c) Review of inpatient care;

For intensive treatment, concurrent continued stay reviews are conducted by telephone before the current certification expires. The care manager schedules continued stay reviews with the treating provider or facility staff at intervals (based on the Enrollee's clinical presentation) throughout treatment. Determinations of benefit certifications are based on medical necessity criteria, consideration of the severity and complexity of the Enrollee's symptoms and progress in meeting treatment goals. Cases where clinical indications are unclear or where medical necessity appears to not be met are referred to a clinical peer reviewer. Each review is concluded prior to the expiration of the current certification and the provider is informed of the review outcome at the conclusion of the review. Adverse determinations are confirmed in writing to the provider and the Enrollee within established timeframes.

(d) Discharge planning and follow-care; and

The care manager and/or outreach care coordinator, provider and Enrollee have an active role in discharge planning. Discharge planning focuses on establishing the next appropriate level of care that will enable the Enrollee to return to his/her maximum level of functioning, as well as the services that will be needed.

The following areas are evaluated for discharge considerations, according to the Enrollee's situation:

- **Appropriateness of transition to a less intensive level of care including the Enrollee's clinical status, safety and welfare**
- **Aftercare treatment plan including record of first follow-up appointment**
- **Availability of social support network**

- **Availability of community-based resources to adjunct social support network and aftercare treatment**
- **Geographic considerations**
- **Date and time of expected discharge**

(e) Case management of high risk cases.

Empire BCBS provides a comprehensive and integrated approach to care, focusing on early identification, appropriate treatment, intensive care management and individualized recovery support for Enrollees at high risk for a complex MHSA condition.

Our treatment philosophy is based on the knowledge that there is an established connection between mental and physical health. Therefore, our MHSA Program is integrated with medical management to the fullest extent possible based on the MHSA Program's structure. This approach empowers Enrollees to actively partner with the clinical team to better understand their condition, enabling them to take control of their health care needs, to achieve optimal treatment outcomes and improved quality of life.

Because early intervention is key in addressing the needs of at-risk Enrollees, we utilize a variety of triggers to identify and outreach those most at risk. Our model utilizes the following identifiers:

- **High risk Enrollees with one of the following diagnoses:**
  - **Bipolar disorder**
  - **Alcohol/drug dependence**
  - **Schizophrenia**
  - **Psychotic disorder**
  - **Panic disorder**
  - **Obsessive compulsive disorder**
  - **Post-traumatic stress disorder**

AND

- **Have an inpatient, residential or partial hospitalization episode of care**
- **Enrollee that has made a suicide attempt in the last six months**
- **Non-adherent treatment (left against medical advice, history of poor outpatient follow-up)**
- **History of non-adherence to medication**
- **Unstable and complex health conditions with acute risk including:**
  - **Psychiatric/substance abuse**
  - **Medical/psychiatric**
  - **Narcotic abuse/pain management conditions**
  - **Other identified MHSA issues that impact the Enrollee's health or ability to comply with medical service, or are amenable to program interventions**

In addition to identified triggers, Enrollees may be referred to the MHSA Program via a medical care manager, their primary care physician, or others involved in their care.

Once the Enrollee is enrolled in a program Empire BCBS employs a comprehensive approach to care. Interventions are collaborative in nature, driven by the Enrollee's goals for improved health and level of readiness to change. We fully integrate care management strategies for an Enrollee-centric approach to ensure that each Enrollee's care is managed effectively with a primary assigned care manager to ensure seamless delivery of services and a single point of contact.

Treating complex care conditions often involves multiple providers. Therefore, we optimize health care benefits by coordinating quality health care services through the most appropriate, cost-effective and timely care management plan. This goal is achieved through a collaborative approach based on the guiding principles of Enrollee, family and provider involvement; clinically indicated, informed decision-making; and advocacy. In addition we encourage the Enrollee to actively participate in the care process. We believe that Enrollee engagement is of critical importance to

achieving wellness. In order to achieve this we help Enrollees learn about their condition. We empower Enrollees with self-care management of these conditions and encourage specific evidence-based behavior changes throughout the continuum of care.

While every case management plan is unique there are some common interventions we use for all Enrollees. If the Enrollee meets the criteria and agrees to participate, the care manager will initiate telephonic contact with the Enrollee and treating providers to:

- **Review the program and roles/expectations with the Enrollee, support system and treating providers**
- **Discuss the Enrollee's needs and desired outcomes for participation in this program**
- **Determine the treating providers' plan of care and the Enrollee's level of compliance with said care plan**
- **Identify any untapped benefits or alternate/community resources that can be accessed to assist in meeting the needs of the Enrollee and augment the current care plan**
- **Identify education needs and appropriate resource material to assist Enrollees in learning about their illness**
- **Ensure coordination of care amongst treating providers**
- **Identify family and/or other support system resources for inclusion in the care plan**
- **Establish a plan for routine, ongoing telephonic contact with the Enrollee, support system and treating providers, as necessary**
- **Establish and communicate a case management plan based on the above information**

Empire BCBS intends the care management program to last no less than three months and no more than 12 months. Ideally, the Enrollee and care manager will jointly agree on termination when the Enrollee's goals for participation have been achieved and no further goals exist to be addressed. Participation in a care management program is completely voluntary and requires the written consent of the Enrollee. Enrollees may choose to terminate their participation in the program at any time. Enrollees may also be terminated from the program involuntarily for failure to participate. Treating providers will be notified telephonically of the termination of program services.

MHSA care managers maintain the highest ethical and confidentiality standards with mutual respect, cultural sensitivity, effective communication, teamwork and a flexible approach to challenges. MHSA care management program value is demonstrated in quality outcomes as measured by improvements in achieving optimal health and life functioning, appropriate benefit usage and Enrollee satisfaction.

(2) Describe the software you will utilize to administer the concurrent UR program and any other technologies that will be used to apply UR.

Empire BCBS's medical management tracking system, CareConnect, will be used to record, track, monitor and generally administer all care management processes and determinations. This system consists of fully integrated modules for utilization management, and is integrated with the claims payment and membership databases on the CS90 claims payment system. Nightly downloads occur from CareConnect to CS90 to ensure that the most accurate and update data used for benefit determination.

All services authorized or denied are recorded in CareConnect, including original requests, clinical presentations and clinical notations regarding reviews. All clinical peer reviewers must adhere to prescribed templates for

documentation of relevant clinical information and review protocols. Documentation performance is regularly audited to ensure consistent and correct application.

(3) Completely describe the criteria used to establish medical necessity as defined by the Program and how medical necessity is determined.

Medical necessity criteria is established for all levels of care based on national standards to be consistent with Empire BCBS's corporate medical policy. MHSA Medical Necessity Criteria are developed by an internal committee of licensed clinical care managers and psychiatrists. Criteria are based upon the latest clinical research and upon criteria developed by the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry and the American Society for Addiction Medicine. Criteria are updated annually or more frequently, and are reviewed and approved by a panel of outside practicing MHSA clinicians serving on a MHSA subcommittee of the Medical Policy & Technology Assessment Committee. The criteria are used as a general guideline and are applied based on the local delivery system and practice patterns.

All care managers, medical directors and clinical peer reviewers use written clinical criteria in rendering utilization review determinations for medical necessity and appropriateness of services. All criteria must be based on sound clinical judgment and local practice standards. Copies of the clinical criteria are available to providers and Enrollees on request.

It should be emphasized that these criteria are not meant to be exhaustive and will not cover all clinical situations. It is for this reason that psychiatrist reviewer/peer clinical reviewers make final authorization decisions after discussion with the treating clinician. The reviewing psychiatrist must always also take into account any specific needs of the individual Enrollee (such as age, co-morbidities, complications, psychosocial situation and progress) or

characteristics of the local delivery system (such as the availability of alternative levels of care) when applying the medical necessity criteria.

Variation exists in the availability of services in different geographic and regional areas. If an indicated service is not available within an Enrollee's community at the level of service indicated by the criteria, authorization may be given for those services at the next highest available level.

(4) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.

Confirmed. Our utilization review process would include the following:

- **Outpatient review after the 10th session to balance barrier-free access with accountability per mental health parity requirements**
- **Review of inpatient admissions within one business day to appropriately evaluate Enrollees and ensure they receive the most effective treatment available, while considering any possible comorbid medical/behavioral conditions**
- **Concurrent review based on best practices and national medical necessity criteria**
- **Coordination with facility review personnel and the treating provider to ensure an effective treatment plan and develop and implement an effective discharge plan**

<u>Outpatient Outlier Program</u>

The utilization review process is parity compliant as required by MHPAEA, as it is in parity with New York State chiro, speech and other therapies. However, recent litigation is questioning the compliance with "medical" parity. As such, Empire BCBS can offer an alternative to prior authorization after the 10th visit, which is a process followed for other Empire BCBS local commercial accounts. The program is detailed in Exhibit I.X.

(5) Describe the methods you utilize to measure Program effectiveness (*Do not include any reference to specific monetary savings).*

Continual review and quality improvement efforts occur to constantly improve the effectiveness of the MHSA Program. We use retrospective audits, readmission rates and follow-up after hospitalization to measure the MHSA Program's effectiveness. Working collaboratively with network providers, we have instituted regular communications with high-volume, network facilities where readmission rates, follow-up after hospitalization rates and audit results are shared. These results are sometimes blindly compared with other facilities. Within the context of these communications, facilities are encouraged to identify interventions to improve their rates and work more effectively and collaboratively with Empire BCBS.

(6) ***Outpatient Treatment UR Guarantee:*** The MHSA Program's service level standard requires that, at least, ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Day of receipt of the report, calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of outpatient treatment plans that the Offeror reviews and does not notify the Provider within twelve (12) Business Day of receipt of the report is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

(7) ***Inpatient Treatment UR Guarantee:*** The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee or Provider be notified within one (1) Business Day of the determination calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

Disabled Dependent Determinations

During the term of the Contract, the Contractor shall be responsible for making Disabled Dependent Determinations for dependents with a disability that is Mental Health and Substance Abuse related. Disabled dependents of NYSHIP enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those dependents are incapable of self support. For The Empire Plan, the medical component contractor determines disability status for those with physical disabilities and the mental health Contractor determines disabled status for mental health and substance abuse related disabilities. An Application for Coverage for your Disabled Dependent Child For Medical, Dental and/or Vision Coverage (form PS-451) is completed by the Enrollee, the Dependent's Physician, the Enrollee's employer and then evaluated by the Contractor to determine if the Dependent is disabled. All determinations are subject to review by the Contractors on a periodic basis. The following guidelines are used for all disabled dependent reviews:

If improvement of the dependent's condition is:

- "Expected," the case will be normally reviewed within six to eight months, unless the Contractor determines a need for a more frequent review.
- Possible," the case will be normally reviewed no sooner than three years, unless the Contractor determines a need for a more frequent review.
- "Not expected," the case will normally be reviewed no sooner than seven years, unless the Contractor determines a need for a more frequent review.

a. Duties and Responsibilities

(1) The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse-related dependent disabilities. The review must be completed in the United States and clinical determination must be completed within 10 Business Days of receipt of a complete form.

Confirmed.

Amended March 11, 2013

(2) The Contractor must send a determination letter, approved in advance by the Program, to the Enrollee and to the Department advising of the determination within 3 Business Days of the determination

Confirmed.

b. <u>Required Submission</u>

(1) Provide a description of your process when determining disabled dependent status. Confirm that the Offeror will review the PS-451 form and all additional medical information required to make a clinical determination within 10 Business Days.

Empire BCBS will use the following process to determine if covered dependents of NYSHIP Enrollees are entitled to continued coverage under the Enrollee's family coverage due to a MHSA related disability:

1. **The Enrollee or the employer submits a completed form PS-451 and any supporting documentation to Empire BCBS via mail or fax.**
2. **Empire BCBS will conduct an initial review of the form to ensure that it has been completed and is legible. The Enrollee and/or the Employing Agency will be notified if additional information is required to make a coverage determination.**
3. **An Empire BCBS board-certified psychiatrist will review the completed form and all additional medical information and will render a clinical determination within 10 business days. The results of the determination will be communicated via letter to the Enrollee and to DCS within three business days of the determination.**
4. **If the Dependent is determined to be disabled, we will use the following timeframes to determine future review intervals:**
    a. **If improvement of the Dependent's condition is expected, Empire BCBS will normally review the case within six to eight months, unless we determine a need for a more frequent review.**

b. If improvement of the Dependent's condition is possible, Empire BCBS will normally review the case no sooner than three years, unless determines a need for a more frequent review.

c. If improvement of the Dependent's condition is not expected, Empire BCBS will normally review the case no sooner than seven years, unless we determine a need for a more frequent review.

(2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within 3 Business Days of the determination.

Confirmed.

Appeal Process

When UR results in a decision to deny authorization or reduce the level of services authorized, and the denial is based on medically necessary, experimental or investigational treatment, members may appeal to the Contractor any utilization review decisions. The appeals committee shall make a determination within 10 Business Days of the receipt of the necessary medical records. The Contractor will comply with the utilization review process requirements and **external appeal** process found in Article 49 of NYS Insurance Law, as amended.

a. Duties and Responsibilities

The Contractor must:

(1) Perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer;

Confirmed.

(2) Administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment, including:

(a) Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment;

Confirmed.

(b) Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and

Confirmed.

(c) Integrating the appeal decisions into the clinical management and claims processing systems.

Confirmed.

(3) Establish two levels of internal clinical appeals as follows:

(a) A level 1 clinical appeal must be performed by an independent Peer Advisor; and

Confirmed.

(b) A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case.

Confirmed.

(c) Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:

(i) For a second level clinical appeal of a post-service claim, within 30 days of the member's request;

Confirmed.

(ii) For a second level clinical appeal of a pre-service request for benefits, within 15 days of the member's request; and

Confirmed.

(iii) For clinical appeals involving urgent situations, in no more than seventy-two hours following receipt of the appeal.

Confirmed.

(4) Oversee and enforce the MHSA Program's appeal processes including reporting the results of the administrative, clinical and external appeal processes for the MHSA Program to the Department in the format and frequency required in the "Reporting" section of this RFP;

Confirmed.

(5) Interface with the New York State Department of Financial Services' External Appeals Process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service;

Confirmed.

(6) ***Inpatient Appeal Guarantee:*** The Contractor must guarantee that at least ninety-five percent (95%) of level one appeals for inpatient care shall be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis; and

Confirmed.

(7) ***Outpatient and Alternate Level of Care Appeal Guarantee:*** The Contractor must guarantee that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals shall be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

Confirmed.

b. <u>Required Submission</u>

(1) Confirm the Contractor will perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer.

Confirmed.

(2) Confirm the Contractor will administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

Confirmed.

(3) Describe in detail how you would administer the required appeal processes for the Program, including:

Enrollees, providers and their authorized representatives are offered a standard internal appeal process within 180 days from the date of the receipt of the initial determination. A second-level internal appeal review is also available. Additionally, an external appeal through a state-certified independent review organization may be made available after the internal appeal process is exhausted or, in some Plans, as an alternative to the second-level internal appeal review.

(a) Turnaround time;

All reviews are conducted according to the standards for timely response as defined by state or federal regulations. Standards are established using the most responsive timeframe required by state law, national accrediting bodies or the health plan for each type and level of review. The Enrollee will be provided with a written communication of the appeal decision. Prospective (pre-service) urgent and expedited appeals are also communicated telephonically.

An expedited appeal is offered in the case of emergency or life-threatening situation, denial of an admission or continued stay for emergency services and the when an Enrollee remains hospitalized. Expedited decisions are issued within 72 hours from receipt of all necessary information. To ensure

we are compliant with the required appeal guarantees for the MHSA Program, appeals will be closely monitored for timeliness.

(b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;

Level l standard appeals reviews are conducted by a licensed MHSA practitioner (medical director or other clinical peer reviewer in the same profession and similar specialty) who was not previously involved in the case. The review will be handled by individual who is neither the individual who made the initial determination nor the subordinate of such an individual. Reviews are based on the relevant clinical record and any additional information submitted by the appealing party. The medical director has the final authority to approve the denial of benefits based on the recommendation of the peer reviewer.

(c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;

Cases are reviewed in accordance with the MHSA medical necessity criteria. Medical necessity criteria are guidelines used by utilization review and care management staff (licensed registered nurse or licensed independent MHSA practitioners). Empire BCBS's internally developed criteria are consistent with guidelines of the American Psychiatric Association, American Society for Addiction Medicine and the American Academy of Child and Adolescent Psychiatry.

When clinical information given meets this criterion, the cases may be certified by the utilization review or care manager. When cases do not meet these criteria, cases must be sent to a psychiatrist reviewer/peer clinical reviewer for an assessment of the case.

A provider who is requesting services must be afforded the opportunity for a peer-to-peer conversation regarding an adverse decision. The psychiatrist reviewer/peer clinical reviewer should use these guidelines to help frame their decision for consistency, but must also use their clinical experience and judgment to make exceptions to the criteria when indicated. The MHSA services should not be primarily for the avoidance of incarceration of the Enrollee or to satisfy a programmatic length of stay. There should be a reasonable expectation that the Enrollee's illness, condition or level of functioning will be stabilized, improved or maintained through treatment known to be effective for the Enrollee's illness. Custodial care is not typically a covered service.

Empire BCBS emphasizes that these criteria are not meant to be exhaustive and will not cover all clinical situations. It is for this reason that a psychiatrist reviewer/peer clinical reviewer makes a final authorization decision after discussion with the treating clinician. The reviewing psychiatrist must always also take into account any specific needs of the individual Enrollee (such as age, comorbidities, complications, psychosocial situation and progress) or characteristics of the local delivery system (such as the availability of alternative levels of care) when applying the medical necessity criteria.

Variation exists in the availability of services in different geographic and regional areas. If an indicated service is not available within an Enrollee's community at the level of service indicated by the criteria, authorization may be given for those services at the next highest available level.

(d) Do you currently administer an appeals process as described above for MHSA? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the Program (for the most recent calendar year); and

Yes, we currently administer an appeals process as described above for a client with similarities to this Program. In 2012 the total number of appeals for a similar client was 1,550. The approval rate was approximately 5% and the upheld rate was approximately 95%. These statistics are consistent for all MHSA Programs Empire BCBS administers across all books of business.

(e) How is the Enrollee's care handled during the appeal process?

The provider is responsible for determining and providing the appropriate level of care for the Enrollee during the appeal process. We would extend coverage for the level of care that we feel is medically necessary at that time.

(4) Confirm that you will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

Confirmed.

(5) ***Inpatient Appeal Guarantee:*** The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to

provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of level one appeals for inpatient care that are not be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

(6) ***Outpatient and ALOC Appeal Guarantee***: The MHSA Program's service level standard requires that, at the least, ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

[redacted]

13. Other Clinical Management Programs

a. Duties and Responsibilities

(1) The Contractor must provide voluntary opt-in programs for Depression Management, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD). The cost of the Depression Management, Eating Disorder and ADHD Programs shall be included in the Administrative Fee. The programs must include:

(a) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail;

Confirmed.

(b) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;

Confirmed.

(c) accepting referrals to Network Providers;

Confirmed.

(d) telephonic support, coordination with treating providers and referrals to community services; and

Confirmed.

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

Confirmed.

(2) The Offeror may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to not participate in any program offered and the right to opt out of any program at any time.

Confirmed.

b. Required Submission

(1) Describe the depression management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

A description of Empire BCBS's proposed MHSA program features are identified below. It is Empire BCBS's intent to maximize the referral process for these programs not only from the Clinical Referral Line, but through an integrated process with the Hospital Program's Medical Management Team, this collaboration will expedite referrals based on triggers when an Enrollee is admitted to a medical facility and demonstrates a co-morbid issue. Access to the complete clinical information and collaboration on a coordinated approach between the Hospital and MHSA Programs Medical Management Teams.will lead to a timely case transition.

Depression Care Management Program

Depression is the most common behavioral health condition affecting individuals, their families, and by extension, the workplace. As a response, Empire BCBS provides a comprehensive Depression Care Management program that focuses on helping Enrollees address their depression and return to emotional wellness. The program addresses the Enrollee's needs throughout the entire care experience, supporting the most appropriate level of care as well as the timely application of evidence-based interventions. Our approach enables the clinical team to focus on successful management of depression.

Goals of the program include:

- **Maximize Enrollee health status**
- **Improve health outcomes**
- **Control associated health care expenses, both medical and behavioral**
- **The promotion of best practice care for Enrollees**

Referral

Enrollees may be referred into the program through a variety of sources, including medical management care managers, MHSA care managers or the Enrollee's outpatient treating provider.

Program Interventions

Program interventions are based on early identification of risk factors and participant education to help promote emotional health. Each of the elements of our Depression Care Management program helps Enrollees through interventions, risk assessments and education. Key components include:

- **An assigned licensed MHSA care manager**
- **Thorough assessment and risk stratification of each Enrollee**
- **Screening and service coordination for high-risk Enrollees with depression**
- **Screening and service coordination for our maternity depression program (described below)**
- **24-hour toll-free telephonic access to MHSA Clinical Referral Line clinicians**
- **Education concerning depression and the management of depression**
- **Health care services coordination and ancillary referrals**
- **Co-morbidity management (Empire BCBS will establish a process with The Medical Program Contractor to expect referrals and co-manage cases as appropriate)**
- **Intensive care management for the most severely compromised Enrollees with depression**
- **Pharmacy education**
- **Reinforcement of the treating provider plan of treatment and education on the importance of adherence to the plan of care**
- **Education to promote self-management**
- **Easy-to-understand, target-specific information based on the Enrollee's understanding of their condition, motivation to address their condition and resources available to the Enrollee.**
- **Telephonic follow-up and ongoing screening for anxiety and depression**

Maternity Depression Program

Empire BCBS's Maternity Depression program provides depression screenings, education and support, along with treatment options for Enrollees during pregnancy and following the delivery of their child.

Identification and Referral

Enrollees may be referred to the program by a variety of sources, including medical management or care management program referral if the Enrollee reports mental health concerns. As an additional identification method, Empire BCBS's Future Moms program for maternity management will screen Enrollees for depression; positive screens will be referred to Empire BCBS's Maternity Depression program using an automated, expedited referral process through our integrated medical and MHSA management system.

Interventions

Once Enrollees enter into the program, a licensed clinician reaches out to them telephonically with the main objective being to identify, screen, refer and support the Enrollee into treatment.

- **Prenatal referrals are assessed with the maternal mental health Survey. Enrollees receive education, discuss treatment options and help accessing MHSA treatment. All prenatal referrals receive a postpartum screening call after the delivery of their baby and follow the protocol for postpartum referrals.**
- **Postpartum referrals receive a secondary depression-screening tool (maternity mental health survey) by phone. Enrollees who score positive receive depression education, help understanding their treatment options and support obtaining appropriate care.**
- **Coordination of Care: After the initial screening, the clinician will encourage coordination and continuity of care among all medical and MHSA providers, as well as provide updates to the original referral source. We will make multiple calls if necessary through the course of the**

first two months of the Enrollee's participation in the program to encourage compliance with treatment recommendations. Clinical follow up and indicated interventions are repeated as necessary, and all Enrollees receive a three month follow-up call post-delivery.

Participation on the Depression Care Management program is completely voluntary. Because participation is voluntary, Enrollees may choose to terminate their participation in the program at any time. Members may also be discharged from the program involuntarily for failure to participate after the enrollment process is complete.

(2) Describe the eating disorder management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

Our Eating Disorder Care Management program is specifically designed to help Enrollees address the varied and complex nature of this condition. While sharing some common procedures (assessment, treatment planning, evaluation, service coordination, discharge planning) with other care management programs, this program uses proactive and reactive case identification and a more intensive schedule of outreach and follow-up.

The Eating Disorder Care Management program ensures Enrollees and their families:

- **Understand their ongoing, multiple behavioral and medical issues**
- **Obtain necessary treatment and support**
- **Understand how to access both plan and community resources**
- **Receive ongoing support over an extended period**
- **Receive assistance when they encounter barriers to care**

Identification

There are multiple identification methods for the program:

- **Medical management care managers**
- **MHSA care managers**
- **MHSA utilization managers**
- **Other disease management programs**
- **Outpatient treating provider**
- **Claims data**
- **Predictive modeling (if professional and pharmacy claims information is available and timely)**
- **Self-referral**

If vendor integration occurs with disability, vendor referrals can be accepted from those sources when the appropriate workflow is developed and implemented.

Interventions

If the Enrollee meets the criteria and agrees to participate, the MHSA care manager will initiate telephonic contact with the Enrollee and treating providers to:

- **Review the program and roles/expectations with the Enrollee, support system and treating providers**
- **Discuss the Enrollee's needs and desired outcomes for participation in this program**
- **Determine the treating provider's plan of care and the Enrollee's level of compliance with the plan of care**

- **Identify any untapped benefits or alternate/community resources that can be accessed to assist in meeting the needs of the Enrollee and augment the current care plan**
- **Identify education needs and appropriate resource material to assist Enrollees in learning about their illness**
- **Ensure coordination of care amongst treating providers**
- **Identify family and/or other support system resources for inclusion in the care plan**
- **Establish a plan for routine, ongoing telephonic contact with the Enrollee, support system and treating providers, as necessary**
- **Establish and communicate a case management plan based on the above information**

The MHSA care manager will:

- **Initiate ongoing, scheduled contact with the Enrollee, their support system and treating providers to review the care management plan for participation, compliance and modification as needed**
- **Provide ongoing assistance and resources as needed**
- **Document all contacts and all progress/changes to the care management plan**
- **Monitor ongoing compliance, participation and continued necessity for participation in the program to determine the appropriateness of termination or program services**

Empire BCBS intends Enrollee participation in the Eating Disorder Care Management program to last no less than three months and no more than 12 months. Ideally, the Enrollee and care manager will jointly agree on termination when the Enrollee's goals for participation have been achieved and no further goals exist to be addressed.

Enrollee participation in the Eating Disorder Care Management program is completely voluntary. Because participation is voluntary, Enrollees may choose to terminate their participation in the program at any time. Enrollees may also be discharged from the program involuntarily for failure to participate after the enrollment process is completed.

(3) Describe the ADHD management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

Our Attention Deficit and Hyperactivity (ADHD) Care Management program is designed to work with Enrollees 18 year old or younger and their caregivers to address the varied and complex nature of ADHD.

Identification

The program uses proactive and reactive case identification of Enrollees to identify and engage in the program. This may be accomplished by one or more of the following mechanisms/individuals:

- **Medical management care managers**
- **MHSA care managers**
- **Outpatient treating provider**
- **Positive response to MHSA issues on the health risk assessment**
- **Pharmacy data (if pharmacy claims information is available and timely)**
- **Diagnosis of ADHD (if professional data is available and timely)**
- **Enrollee on ADHD medications**
- **Inpatient admissions with a primary or secondary diagnosis of ADHD**

Interventions

We understand that treatment for ADHD may be lengthy, requiring ongoing support to the Enrollee and their caregivers over an extended period of time. As a result, education and care coordination are key, and our comprehensive program is designed to meet these needs. If the Enrollee meets the criteria and their caregiver agrees to participate, a MHSA care manager will initiate telephonic contact with the Enrollee and treating providers to:

- **Review the program and roles/expectations with the Enrollee and their caregivers, support system and treating providers**
- **Discuss the Enrollee's needs with the Enrollee and their caregivers, and desired outcomes for participation in the program**
- **Determine the treating provider's plan of care and the Enrollee's level of compliance with the plan of care**
- **Identify any untapped benefits or alternate/community resources that can be accessed to assist in meeting the needs of the Enrollee and augment the current care plan**
- **Identify education needs and appropriate resource material to assist Enrollees and their caregivers in learning about ADHD**
- **Ensure coordination of care amongst treating providers**
- **Identify family and/or other support system resources for inclusion in the care plan**
- **Establish a plan for routine, ongoing telephonic contact with the Enrollee and their caregivers, support system and treating providers, as necessary**
- **Establish and communicate a case management plan based on the above information**

The MHSA Care Manager will:

- **Initiate ongoing, scheduled contact with the Enrollee's caregivers, support system and treating providers to review the care management plan for participation, compliance and modification as needed**
- **Provide ongoing assistance and resources as needed**
- **Document all contacts and all progress/changes to the care management plan**
- **Monitor ongoing compliance, participation and continued necessity for participation in the program to determine the appropriateness of termination or program services**

Empire BCBS intends Enrollee and caregiver participation in the ADHD Care Management program to last no less than three months and no more than 12 months.

Enrollee and caregiver participation in the ADHD Care Management program is completely voluntary. Because participation is voluntary, Enrollees and caregivers may choose to terminate their participation in the program at any time. Enrollees may also be discharged from the program involuntarily for failure to participate after the enrollment process is completed.

(4) Please describe any other voluntary clinical management or utilization review programs that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees.

Healthcare Effectiveness Data and Information Set (HEDIS) Programs

Empire BCBS has two HEDIS programs:

- **Ambulatory Follow-Up After Mental Illness**
- **Alcohol and Other Drug**

These programs include both an Enrollee and provider outreach component to ensure that Enrollees are receiving appropriate after care.

Ambulatory Follow-Up After Mental Illness Program

The Ambulatory Follow-Up After Mental Illness program targets Enrollees recently discharged from an inpatient mental health unit with the goal of having an aftercare appointment within seven days of discharge. Specifically, these Enrollees are contacted by outreach care coordinators within 24 to 72 hours of discharge to remind them of their aftercare appointment and to assist with referrals as necessary. In addition, calls to outpatient providers are made within 24 hours after the scheduled appointment to confirm if appointments have been kept and to promote rescheduling if the Enrollee missed the appointment. Lastly, facilities are provided with specific information about their ambulatory follow-up rates, reinforcing the importance of discharge planning.

Alcohol and Other Drug Program

The Alcohol and Other Drug program targets Enrollees with a primary alcohol or other drug diagnoses who have been discharged from either an inpatient mental health or medical unit and encourages them to follow up with recommended aftercare. Outreach care coordinators contact these Enrollees within 24 to 72 hours of discharge to remind them of their aftercare appointment and to assist with referrals as necessary. There are also substance abuse treatment guidelines and screening tools posted on the website.

Emergency Room Behavioral Health Over-Utilization Program

Empire BCBS offers an Emergency Room Behavioral Health Over-Utilization program using recent claims-based data. This program will integrate the data Empire BCBS already maintains for the Hospital Program. On a monthly basis, a report of emergency room claims are run to identify Enrollees who have accessed emergency services for a MHSA issue (psych or substance) twice within a two-month period, but did not result in

an inpatient admission. These are individuals who would have been missed, as emergency services do not require any pre-certification. Enrollees who we identify on this report receive outreach from an Empire BCBS MHSA associate to assist with finding an outpatient provider or community resource, or by responding to other needs that the Enrollee may have to improve their health.

<u>Inpatient Child/Adolescent Family/Guardian Outreach Program</u>

Empire BCBS's Inpatient Child/Adolescent Family/Guardian Outreach program has demonstrated excellent quality outcomes since its inception in 2012. Upon a child/adolescent inpatient admission, an MHSA care manager reaches out to the child's caregivers within 48 hours. The MHSA care manager will discuss the following:

- **Answer questions and provide an overview of what should be expected as part of a MHSA inpatient admission**
- **Importance of family therapy attendance while the child is in inpatient care (active participation)**
- **If the child had an outpatient provider, that provider should be advised of hospitalization (we do not assume the hospital will perform outreach)**
- **Answer questions about medication (side effects, generics, formularies, co-pay constraints) and discuss the importance of medication adherence upon discharge**
- **Discuss discharge planning with the caregivers including:**
    - **Assist in identifying the right local resources (for the child and caregivers)**
    - **Identify crisis diversion programs should the child decompensate after the discharge (avoid an emergency room visit if possible)**
    - **Stress the importance of family therapy and active participation upon discharge**

The MHSA care manager will be available to the caregivers throughout the hospitalization and upon discharge at the caregivers' request. If the caregiver would like longer term MHSA case management, a transition plan will be developed with an MHSA case manager.

Autism Family Outreach Program

Empire BCBS offers an Autism Family Outreach Program focused on the family members and caregivers of a child diagnosed with autism. Empire BCBS recognizes the emotional and multifaceted issues arising from an autism diagnosis. An MHSA care manager will outreach to the caregiver/guardian of a child following a request for Applied Behavior Analysis (ABA) therapy for the child. The outreach to the parent/caregiver is to assist in identifying any of their behavioral health needs when such a diagnosis is given to their child. These needs can include:

- **Identifying a provider whose expertise is working with families/caregivers of children with autism**
- **Identifying local community resources and support groups, educational materials and other resources customized to the needs of that individual**

Biographical Sketch Forms

Exhibit I.B

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Ethel Graber

Job Title: VP and General Manager

Relationship to Project: Ethel has overall responsibility for the Dedicated Account Management which will support the Empire Plan Mental Health Substance Abuse Program. She serves as Executive Sponsor for the NYS Account reporting directly into the New York Market President.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Schenectady BOCES Program Schenectady, NY	LPN	1975	Nursing
New York State Life, Accident & Health Certificate			
New Jersey State Life & Health Certificate			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1996-Present	Empire BCBS	VP & General Manager
1994-1996	BSNENY	Sales Manager
1992-1994	CHP	Manager, National Accounts
1986-1992	BCBS of CNY	Account Manager
1985-1986	National Healthcare Review	Medical Consultant/Auditor
1975-1985	St. Clare's Hospital	LPN – Staff Nurse

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Ethel Graber is a seasoned healthcare professional with over 20 years experience in the healthcare industry. During this time, she has held positions of increasing responsibility and has diverse capabilities relating to leadership, operations, sales, and account management, complimented with a clinical background. She has had overall responsibility for the management of the Empire Plan's Hospital program for 17 years since joining Empire BCBS. Ethel had overall responsibility for the Empire Plan Prescription Drug Program implementation in 2005 for a 1/1/06 effective date. As the NYS Account's Executive Sponsor, Ethel provides a link to senior management for all aspects of the Plan.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Aron Halfin, MD

Job Title: Staff VP, Medical Director

Relationship to Project: Manager of the Behavioral Health Team

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
The University of Costa Rica School of Medicine, Costa Rica	MD	1981	Medical Doctor
Columbia University College of Physicians and Surgeons New York, NY		1981-1985	Psychiatric Residency
Psychopharmacology Research Fellowship		1985	
Columbia University College of Physicians and Surgeons New York, NY		1984-1985	Chief Resident

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2009-Present	Wellpoint, Inc.	Staff VP, Medical Director
2007-2009	WellPoint, Inc	Manager, Medical Director BH Services, East Zone
2005- 2007	BCBS of GA	Medical Director, BH Services
2003-2005	Centene Corporation Specialty Division	VP Clinical Operations, Medical Director
1996-2003	Magellan Health Services	Sr. VP/Chief Medical Officer, Health Plan/Public Solutions
1998-1999	Magellan Health Services	VP Medical Services, Health Plan NE and Atlantic Midwest

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

1996- 1998	Magellan Health Services	VP Medical Services/Medical Director. Georgia Reg. Svc. Ctr.
1994-1996	Quality Behavioral Health Management	President & Chief Manager
1985-1996	Adult Psychiatry Chattanooga, TN	Private Practice

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Responsible for Behavioral Health Operations and enterprise business strategy serving commercial, Medicare, Medicaid, and state employee populations. Managed a team of approximately 600 clinicians and non-clinicians.

Developed and implemented new organizational structure and operating plan, which resulted in exceeding cost of care expectations while lowering administrative costs and improving employee morale.

Co-led development of an improved strategic plan in greater congruence with that of the division, resulting in a complete integration of behavioral and medical services.

Developed and implemented several special payment arrangements with provider groups that resulted in significant improvement in the care members received, improved provider and member experience, and achieved significant administrative and cost of care savings.

Designed innovative high-intensity case management program for successful management of high-cost co-morbid medical/behavioral health members.

Managed multi-site operations, creating operational and financial synergies for 14 large business units.

Assumed full operational responsibility for all Medicaid and Medicare membership, developing utilization management and QI programs, which resulted in significant cost of care and administrative savings.

Developed and implemented data-reporting program to enable evaluation of clinical and quality operations.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Bill Corrigan

Title: Regional Vice President, Underwriting

Relationship to Project: Bill has oversight responsibility for the Underwriting of the NYS Account.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Baruch College, NY, NY	MBA	1997	Accounting
SUNY College, Oswego, NY	BA	1979	Economics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1985 – Present	Empire BCBS	RVP, Underwriting
1982 – 1985	Metropolitan Life	New Business UW

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Bill Corrigan is has over 30 years experience in the Health Insurance Industry. During this time he has held positions of increasing responsibility in areas relating to Underwriting, Sales, Account Management and Customer Service. Bill has underwriting responsibility for Empire's largest accounts including the NYS Hospital program. In addition, he managed the underwriting of the NYS Prescription Drug Program when it was with Empire.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: William "Brink" Hartman

Job Title: Staff Vice President, Service Operations

Relationship to Project: Oversight responsibility for claims processing and customer service for the MHSA Program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Marist College Poughkeepsie, NY	BS	1992	Business Administration Finance
The College of St. Rose Albany, NY	MBA	1996	Business Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2000 - Current	Empire BCBS	Staff VP, Service Operations
1997-2001	Empire BCBS	Manager, FEP Claims
1997	Physicians Health Services	Data Analyst
1993-1997	Empire BCBS	Expense and Budget Analyst

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Brink has extensive experience with working on the Empire Plan account at Empire during his tenure. Since 2001 he has had responsibility for service operations at Empire with responsibility for claim and adjustment processing related to the Empire Plan. Through his work with the Empire Plan, Brink has experience in dealing with other carriers on data exchange, and coordination related to claim processing.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: John Caby

Job Title: VP, Provider Engagement and Contracting – New York

Relationship to Project: John has overall responsibility for developing the provider networks that will support the MHSA Program, including network development, provider contracting and provider relationships.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Pennsylvania Philadelphia, PA	Bachelor of Arts	1989	Economics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 – present	Empire BCBS	Vice President, PE&C-New York
2009 – 2011	Empire BCBS	RVP, Network Management
2007 - 2009	WellCare of New Jersey	Executive Director/COO – New Jersey
2004 – 2007	Empire BCBS	Vice President, Senior Plan
2003 – 2004	HealthNet of NE, Inc.	Director of Contracting – New York
2001 – 2003	HealthNet of NE, Inc.	Director of Finance – New York
2000 – 2001	Empire BCBS	VP, Business Development & Finance
1998 – 2000	Empire BCBS	AVP, Reporting & Financial Control
1997 – 1998	Prudential	Managing Audit Consultant
1990 – 1997	NYL Care Health Plans	Various positions of increasing responsibility culminating in AVP, Small Group Administration
1989 – 1990	Summit Financial	Financial Planner

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

John is a seasoned executive with more than 20 years of health insurance industry experience. During this time, he has held positions of increasing responsibility and diverse leadership capabilities. He possesses an in-depth knowledge of the health care delivery system. This includes sales and account management, operations, and cost trends as well as negotiation and relationship management.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Peter A. Ambrose, Jr., PhD, MBA

Job Title: RVP – Behavioral Health Operations

Relationship to Project: Behavioral Health Collaborator to the project with oversight of all behavioral health services/clinical operations functions related to the program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Washington University, St. Louis, MO	MBA	1996	Business Administration
University of Missouri, Columbia, MO	PhD	1987	Counseling Psychology
Boston College, Chestnut Hill, MA	MA	1980	Psychology
Fairfield University, Fairfield, CT	BA	1978	Psychology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2002 - Present	WellPoint, Inc.	RVP-Behavioral Health
1997 – 2001	BJC HealthCare	VP – Behavioral Health
1997 – 2001	Behavioral Health Partners	Executive Director
1992 – 1997	Alliance BlueCross BlueShield	Clinical Director/Product Manager
1988 - 1992	Washington University School of Medicine	Director, Consultation Liaison Psychology
1988 - 1992	Wash University School of Medicine	Asst. Prof – Pediatrics/Child Psychiatry

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Utilization and case management oversight of WellPoint's 24 million behavioral health members. Responsible for the implementation of new initiatives involving the integration of behavioral and medical care including patient-centered medical homes, accountable care organizations and other elements of healthcare reform to improve and maintain the health of members in efficient programs.

Experience with management of large national accounts , public sector and small group private sector including some account membership in excess of 500,000.

Experience managing and oversight of 24/7 call centers including UM functions and crisis services.

Experience as a provider in a private practice recognizing the importance of patient engagement . and the value of coordination of care while in therapy to improve their health.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Director, Account Management

Relationship to Project: This position will be responsible for the leadership and direction of all management activities associated with the administration of the Program and will also have direct access to Senior Level Management. The Director will be responsible for proactively identifying corporate initiatives that require discussion with the State, lead discussions on industry trends and for ensuring the State's overall expectations regarding the Program are met. A qualified candidate for this position will have account management experience as well as a clinical background.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Will require a Bachelor's Degree and a current New York State Life, Accident and Health license for this position. Clinical education or licensing would be preferred.			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

3-5 years progressive Account Management experience, including oversight of Account facing teams. Experience managing complex clinical programs for large national or municipal clients.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Title: Account Executive, Account Management

Relationship to Project: Responsible for the activities involved in the daily management of the Program. This position serves as the central point of contact for internal and external business partners involved in the Program. Provides direction on the administration of the Program and continually works to improve the service provided to NYS and the enrollees of the Empire Plan.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline

Empire BCBS will require a Bachelor's Degree and a current New York State Life, Accident and Health license for this position. Clinical education or licensing would be preferred.

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
3 to 5 years	Insurance or Behavioral Health	Sales / Account Management / Management

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Empire BCBS will require three to five years Sales or Account Management experience, preferably in the insurance industry or behavioral health field. A clinical background and experience is preferred. Strong interpersonal and presentation skills will be required. Industry knowledge is required along with experience strategically managing key customers. Must have the ability to work cross functionally throughout the organization and accurately represent the interests and requirements of NYS with regards to strategic initiates and changes that may impact the Program.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Operational / Clinical Account Executive

Relationship to Project: The Operational/Clinical Account Executive will work directly with the Account Team to assure that all Clinical aspects of MH SA services run smoothly. The position presents MH SA utilization reports to the Account, providing analysis and program recommendations. The position will aid in the development of member communication plans in response to this data. The position will stay current with industry and legislative developments, making recommendations to the Account and Plan as services are impacted. The position will address customer service issues, developing plans to address needs and ensuring resolution of them.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline

Position will require a Master's Degree in a Behavioral Health discipline and five years post-graduate experience in account management and a demonstrated history of clinical expertise and industry knowledge.

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Experience with Clinical Account Management or a Clinical background with Account Management experience is required, preferably with large public sector accounts.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Account Representative

Relationship to Project: The Account Representative will manage the daily activities associated with the Program and serve as a contact for internal and external business partners involved in the Program. Reporting to the Director, this position will be the primary contact for resolution of service related issues escalated to the Department, GOER and the unions. The Account Representative will also have primary responsibility for review of enrollee communications and attendance at enrollment or educational meetings as requested by the Department.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
A high school diploma or equivalent will be required. A Bachelor's Degree and Business or Clinical coursework is preferred.			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1 - 2 yrs professional experience	Insurance or Behavioral Health	Account Representative

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Empire BCBS will require one to two years of experience in Account Management or Clinical service environment. Experience working with large or government clients is preferred. Candidates must have strong interpersonal and presentation skills as well as knowledge of the Insurance or Behavioral Health Industry.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Reporting Analyst

Relationship to Project: This position will have primary responsibility to ensure that monthly, quarterly and annual reporting is accurate and delivered timely, acting as the primary reporting contact for the Department and GOER. The Reporting Analyst will also have responsibility for responding to all ad hoc report requests.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
A 2-4 year degree will be required.	A Bachelor's Degree is preferred.		

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
1 to 2 years experience insurance or behavioral health.		

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Empire BCBS will require one to two years of relevant analytical experience in the Insurance or Behavioral Health Industry. The candidate must have experience working with large or government clients, with proven experience meeting deadlines and preparing concise and accurate external correspondence. Candidates must have strong interpersonal skills as well as the ability to manage multiple priorities.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Audit Liaison

Relationship to Project: This position will be responsible for ensuring all audit activities are coordinated and executed timely. In this capacity, they will have responsibility for responses to audit inquiries from various State entities and will coordinate the implementation of recommendations associated with audit findings. They will track and monitor all aspects of audits in process and ensure the required reporting is provided to the Department.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
A high school diploma or equivalent will be required. A Bachelor's Degree is preferred.			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Empire BCBS will require one to two years of relevant analytical experience in the Insurance or Behavioral Health Industry. The candidate must have experience working with large or government clients, with proven experience meeting deadlines and preparing concise and accurate external correspondence. Candidates must have strong interpersonal skills as well as the ability to manage multiple priorities.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Kathy L. Colon

Job Title: Director, Customer Service

Relationship to Project: Responsible for the Empire Plan's dedicated customer service center.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Middletown High School Middletown, NY	HS Diploma	1988	
Non-certification courses in Business Fundamentals and Leadership			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2010–Present	Empire BCBS	Director, Customer Care
1999–2009	Empire BCBS	Manager, Customer Care
1992–1998	Empire BCBS	Supervisor, Coordination of Benefits/Clerical Services
1989–1991	Empire BCBS	Member Services

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Extensive call center management and leadership experience with over 20 years of experience in the health care industry.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Manager, Customer Service

Relationship to Project: This position will be responsible for direct management of front line customer service staff.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
A Bachelor's Degree is required.			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2-3 years	Insurance Industry	Senior/Supervisory Experience

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Previous experience managing or supervising front line service staff. Familiar with creation of goals and evaluation practices. Able to motivate and train staff effectively.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Manager, Claims

Relationship to Project: This position will be responsible for direct management of front line claims staff.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
A Bachelor's Degree is required.			

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2-3 years	Service Organization	Supervisor/Manager

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Prior supervisory experience in a claims environment is required. Several years experience in a claims department with varying levels of responsibility.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Yong Chong

Job Title: Director, Underwriting (Labor and Public Sector)

Relationship to Project: Yong is directly responsible for the underwriting of the NYS Account.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
New York University	MBA	1998	Finance
Arizona State University	BS	1993	Accounting

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2002 - Present	Empire BCBS	Underwriting Director
1998 - 2002	Ernst & Young (Management Consulting)	Consulting Manager
1993 - 1996	CIGNA Healthcare	Group Underwriter

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Yong has over ten years of group health underwriting experience working with accounts of all sizes and industries. At Empire BCBS, he has worked as an underwriter and a manager for various accounts, including the Empire Plan Hospital Program.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Peter Klinedinst

Job Title: Group Underwriter Consultant Senior (Labor and Public Sector)

Relationship to Project: Provide underwriting support to the MHSA Program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Rutgers University	BS	1993	Nutrition/Food Service Administration

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2004-Present	Empire BCBS	Group Underwriter
2001-2004	HealthNet Inc.	Group Underwriter
2000-2001	Pricewaterhouse Coopers, LLP	Associate Consultant
1999-2000	Empire BCBS	Group Underwriter

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Peter has over eighteen years of group health underwriting experience working with accounts of all sizes and industries.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Larry Grab

Job Title: Director, Behavioral Health Services

Relationship to Project: Larry is responsible for the management of the Northeast Behavioral Health Intake and Utilization Management unit including the existing Empire BlueCross BlueShield membership.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of New Haven	MBA	2001	Business
Rutgers University	BS	1988	Economics

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2009-present	WellPoint, Inc.	Director of BH Services
2003-2009	WellPoint,Inc.	Manager, BH Provider Networks
1990-2003	St. Francis Hospital & Med Ctr	Director of Finance, Behavioral Health
1988-1990	National Medical Enterprises	FinanceConsultant

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Experience managing Behavioral Health Utilization Management and Intake operations for large national accounts and public sector groups, including several groups in excess of 100,000 members.
Experience implementing new services/programs to improve quality outcomes of member health.
Extensive relationships with BH providers including contracting, program and service evaluation and rate development
Leading pilot studies on integrating/coordinating behavioral health with medical and identifying measurement outcomes
Experience managing large budgets and multi-faceted business units with a large staff at multiple sites

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Brad Witte, Ph.D.

Job Title: Care Management Director, Behavioral Health

Relationship to Project: Assistance with development of utilization review and care management protocols.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Boston University, Boston, MA	Ph.D.	1987	Clinical Psychology
Boston University, Boston, MA	M.A.	1983	Clinical Psychology
Pomona College, Claremont, CA	B.A.	1977	Government

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2003-Present	WellPoint, Inc	Care Management Director
1991-2003	Cigna	Regional Care Center, Director
1989-2001	Institute of Living	Head, Outpatient Eating Disorder Program

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Experience with management of large national accounts
Experience with management of state and municipal business
Previous management of call center with clinical referral line

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Wesley Horton, LCSW, CAC III

Job Title: Director, Clinical Programs

Relationship to Project: Wesley will provide clinical and operational oversight of the behavioral health care management programs.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of New Haven	MSW	1998	Social Work
Regis University	BS	1991	Psychology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2011 – present	WellPoint, Inc.	Director Clinical Programs
2008 – 2011	WellPoint, Inc.	Clinical Manager II
2003 – 2008	Kaiser Permanente	Clinical Supervisor
2001 –2003	Kaiser Permanente	Assistant Clinical Supervisor
1998 – 2001	Kaiser Permanente	Outpatient Therapist
1996 – 1997	Arapahoe House	Outpatient Therapist
1994 – 1996	Arapahoe House	School Based Counselor
1994 – 1994	Arapahoe House	Adolescent Counselor
1993 –1994	Arapahoe House	Detoxification Shift Supervisor
1992 – 1993	Arapahoe House	Detoxification Counselor
1991 – 1992	REM, Inc.	Unit Coordinator
1991 – 1991	Mt. Saint Vincent	Milieu Counselor

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Wesley is responsible for our behavioral health care management program. He oversees the clinical programs; program reporting, program quality, program development and serves as a subject matter expert with internal and external resources. He works directly with accounts to ensure members are receiving the full benefit of the programs being offered. He also manages vendor partner relationships to ensure that services are coordinated and the member experience meets clinical and service expectations.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: Steven Korn, M.D.

Job Title: Behavioral Health Medical Director, Northeast Region

Relationship to Project: Steven will be the Behavioral Health Medical Director for the Empire Plan MHSA Program, and will be the senior healthcare practitioner responsible for the Program.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
Earlham College, Richmond, IN	BA	1977	Biology Major
Northwestern University Chicago, IL	MD	1981	Medicine
Framingham Union Hospital Framingham, MA		1982	Flexible Internship
Boston University Medical Center Boston, MA		1984	Residency in Psychiatry
Tufts-New England Medical Center Boston, MA		1986	Fellowship in Child and Adolescent Psychiatry

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2006–present	WellPoint, Inc.	Behavioral Health Medical Director
2003-2006	Value Options Inc	Physician Advisor
2003-2006	Arizona's Children Association	Staff Psychiatrist
1993-2003	Arizona's Children Association	Medical Director
1993-2003 .	Palo Verde Behavioral Health Professionals, Inc.	Staff Psychiatrist
1996-1998	Health Partners of Southern Arizona	Behavioral Health Population Leader

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

1990-1993	California Pacific Medical Center	Staff Psychiatrist
1988-1993	Silverado Psychiatric Associates	Staff Psychiatrist
1988-1990	St. Helena Hospital and Health Center	Medical Director, Adolescent Inpatient Services
1986-1988	North Central Health Care Facilities	Staff Psychiatrist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Managed Behavioral Health Care for both public sector/Medicaid and commercial membership populations, including implementations of large membership integrations (Empire BC/BS, New Hampshire BC/BS)

Clinical experience with children, adolescents and adults in inpatient, residential, outpatient and hospital consultation treatment settings

Medical Director for two inpatient Adolescent Psychiatric services and one non-profit children's residential treatment and outpatient program

Presentations to professionals on clinical topics in Child and Adolescent Psychiatry and treating depression in primary care

Presentations to teachers, family members and peer support organizations on clinical topics in behavioral health.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: David Wright

Job Title: Director, Behavioral Health Services

Relationship to Project: Responsible for 24/7 Clinical Referral Line (referred to internally as Behavioral Health Resource Center).

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
University of Denver (Denver, CO)	Psy.D.	2004	Clinical Psychology
University of Colorado (Denver, CO)	M.A.	1997	Clinical Psychology
Miami University (Oxford, OH)	B.A.	1993	Psychology, Zoology

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
2009 to present	Wellpoint, Inc.	Director, BH & EAP Services
1997 to present	Exempla Healthcare	Assessment & Referral Specialist
2008 – 2009	Saint Joseph Hospital, Denver, CO	BH Manager
2003 – 2007	Kaiser Permanente,	BH Manager
2001 - 2003	Kaiser Permanente,	Staff Therapist

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

Director with oversight of BH Resource Center EAP staff since 2009 including a 24/7 clinical crisis area and Member resource center focused solely on behavioral health issues. Currently services members across the United States for large national and public sector accounts. Responsible for all aspects of operations, including hiring, performance evaluation, metrics and reporting, technology upgrades, account interaction, vendor relationships and web development.

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: To be recruited

Job Title: Manager, Case Management/Disease Management, Behavioral Health

Relationship to Project: Reporting to the Director, Behavioral Health, the Manager is Responsible for the Case Management and Disease Management area including personnel management, and implementation of policies and procedures, implementation of supporting workflows/processes. Manages daily operations to ensure optimal productivity and quality outcomes. Identifies opportunities for improvement, streamlines processes, problem-solves, identifies new programs and projects, fosters teamwork, and evaluates team performance.

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline

RN (Bachelors degree or higher, preferred); or Masters Level Licensed Behavioral Health Professional (e.g. LCSW, LPC, LMFT); or Doctoral Level Clinical Psychologist

Current active professional clinical license required; the current active license must be from the state in which the associate is employed

Minimum five years' clinical experience required.

Two to three years' leadership and management experience required.

Two years' Managed Care experience required.

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

This position requires 2-3 years of management experience in a clinical environment as well as a demonstrated ability to manage multiple tasks.

Extraneous Terms

Exhibit I.X

Extraneous Terms Template
(Instructions for Documentation and Submission)

Offerors shall identify all Extraneous Terms in the table provided on the following page, and shall adhere to all instructions below for preparing the table.

INSTRUCTIONS:

RFP Section and Sub-Section Reference: The Offeror must insert the exact RFP Section, and Sub-Section number of the requirement(s) that the Offeror is proposing to modify. The Offeror must insert the nature of the proposed change and its impact on the Requirement.

RFP Requirement: The Offeror must insert a concise description of the requirement(s) that the Offeror is proposing to modify.

Proposed Extraneous Term Type: The Offeror must insert a one-word description, of the type of modification to each of the requirement(s) that the Offeror is proposing to modify, selected from the following list:

- ☐ Additional;
- ☐ Supplemental;
- ☐ "Or Equal"; or
- ☐ Alternative

Proposed Extraneous Term: The one-word description must be followed by proposed alternate wording of the requirement(s).

Impact on RFP Requirement: The Offeror should describe the impact of the alternate wording. Then, the comments should explain how the modification(s) would benefit the State and provide best value. If there is a corresponding impact on the Administrative, Technical or Financial Proposal(s), that impact should be explained here with reference(s) to the parts of the volume(s) that are affected. However, **DO NOT INCLUDE ANY COST DATA IN THE ADMINISTRATIVE OR TECHNICAL PROPOSALS**.

The Offeror must use the table format described above and detailed on the following page to summarize its proposed Extraneous Terms, if any. The Offeror may refer to more voluminous narratives, tables, figures and appendices that more fully describe aspects of the Extraneous Terms, provided that the additional material is fully cross-referenced by this required table.

Exhibit I.X - Extraneous Terms Template

EXTRANEOUS TERM(S)			
No.	**RFP Section and Sub-Section Reference**	**RFP Requirement**	**Proposed Extraneous Term Type**
1.	Section IV.B.12. Clinical Management/Concurrent Review/Question 4.	Under the MHSA Program, recurring outpatient therapy visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit.	☐ Additional; ☐ Supplemental; ☐ "Or Equal"; or ☒ Alternative

Proposed Extraneous Term(s):

Under the MHSA Program, recurring outpatient therapy visits may be reviewed prior to the 11th visit and may not be denied prior to the 11th visit, or conducted via a review of rolling 12 months of claims data to identify outpatient outlier Enrollees.

Impact on RFP Requirement:

The impact on the RFP requirement includes an alternative method to review frequent and ongoing outpatient therapy.

The Outpatient Outlier Program consists of a review of rolling 12 months of claims data to identify outpatient outlier Enrollees. An outpatient outlier is identified using various triggers which include:

- Extensive or frequent visits on a rolling 12-month basis without a history of higher levels of MHSA care
- Specific diagnosis with a therapist and no indication of a prescriber for conditions where medication has proven helpful
- Enrollees seeing multiple therapists simultaneously

After a review of the clinical history, Enrollee outliers are then contacted telephonically, as appropriate, to discuss their treatment plan and the situation which placed them on the report. Empire BCBS recognizes there are clinically justified reasons for frequent and ongoing therapy, and not every Enrollee would be considered an outlier. Within the context of this program, providers may also be contacted by Empire BCBS only after a discussion with the Enrollee.

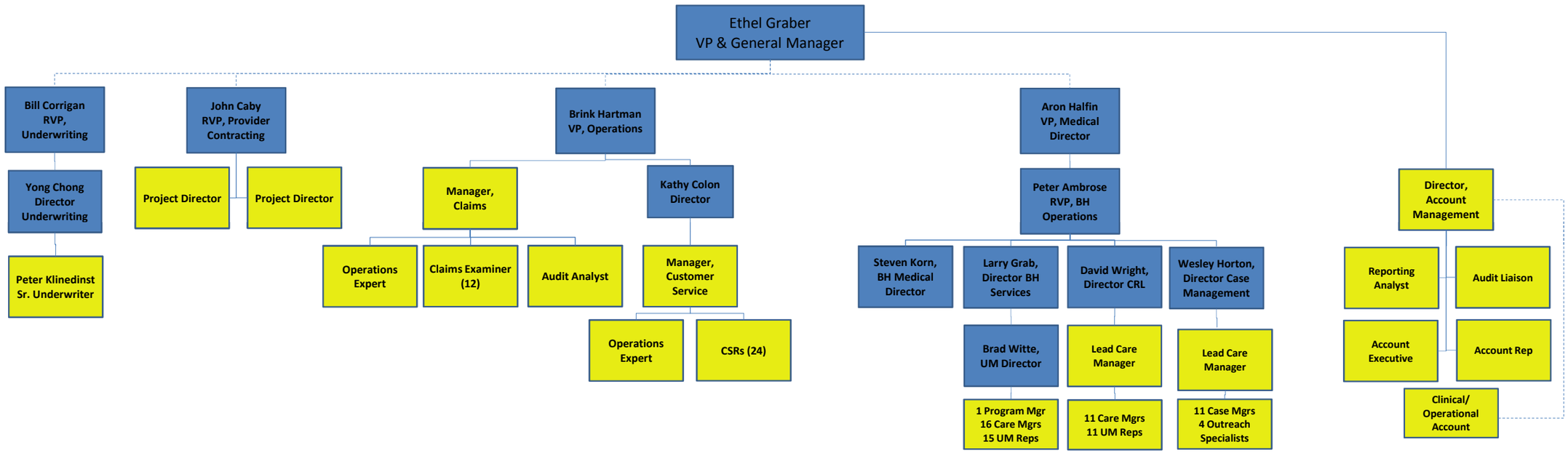
The advantages of this program include:

- Review on a rolling 12 month period provides a better view of overall treatment
- Enrollee outreach occurs vs. provider only contact, creating a new Enrollee touch point
- Improved use of staff time via Enrollee outreach
- Referral trigger for case management

Organizational Chart

Appendix A

Empire Plan Mental Health and Substance Abuse Program
Organizational Chart



Blue denotes shared resources

Yellow denotes resources dedicated to the NYS MHSA Program

Empire BCBS Staffing Model

Director, Account Management

- Responsible for leadership and direction of all account management activities for the Mental Health and Substance Abuse Programs
- Proactively identifies corporate initiatives that require discussion with the State
- Leads discussions on industry trends
- Ensure that the State's overall expectations are met regarding the Program

Account Executive

- Responsible for the activities involved in the daily management of the Program
- Central point of contact for internal and external business partners involved with the Program
- Coordinates and leads discussions on benefit and industry information and formulates strategies to maintain member satisfaction
- Provide higher level presentations as necessary at the direction of the Department or GOER

Operational/ Clinical Account Executive

- Primary liaison between the Account Team and the Clinical Management service staff for day-to-day administrative functions of the Program
- Assists in responding to all types of inquiries while providing direction and oversight of clinical operations to ensure expectations are met and identify opportunities for improvement
- Participates on inter-departmental teams to ensure the interests of the Program are represented
- Serves as the subject matter expert for clinical discussions and utilization analysis with NYS

Account Representative

- Responsible for the daily service activities of the account
- Attend enrollment meetings and interact with enrolled and prospective members
- Serves as a point of contact for all NYS MHSA benefit administrators and internal and external business partners

Reporting Analyst

- Responsible for ensuring that monthly, quarterly and annual reports are accurate and timely
- Primary contact for the Department and GOER for reporting
- Responsible for Empire BCBS' responses to all report requests

Audit Liaison

- Ensures that all audit activities are coordinated and executed timely.
- Responsible for Empire BCBS' responses to audit inquiries from various NYS entities and coordinate the implementation of recommendations that are the result of audit findings
- Tracks and monitors all aspects of audits in process and ensure the required reporting is provided to NYS

VP of Underwriting

- Oversight responsibility for the Underwriting function (premium development, administrative fee review, etc…)

VP of Contracting

- Oversees all aspects of network development, provider contracting, provider relationship, etc…
- Represent NYS interests in Senior Level network strategy decisions

Project Director / Network Analyst (Contracting)

- Responsible for network development and contracting, monitoring network access and composition to ensure requirements are met
- Provide contracting related reporting and support to the Account Team

VP, Medical Director / RVP Behavioral Health Operations

- Oversight responsibility for the clinical aspects of the Mental Health and Substance Abuse Program

Behavioral Health Medical Director

- Senior behavioral healthcare practitioner directly responsible for the Program
- Provides clinical oversight, guidance, and consultation to Quality Management committee members, providers, Care and Case Managers
- Interprets existing clinical policies and recommends modifications based on industry changes

Director, Case Management / Director, Behavioral Health Services

- Responsible for leadership and direction of all care management activities for the Mental Health and Substance Abuse Program
- Proactively identifies corporate initiatives and impact on the State
- Work collaboratively with the Clinical Account Executive to ensure that the State's clinical expectations are met regarding the Program

Director, CRL

- Responsible for leadership and direction of all CRL activities for the Mental Health and Substance Abuse Programs
- Proactively identifies corporate initiatives and impact on the State
- Work collaboratively with the Clinical Account Executive to ensure that the State's clinical expectations are met regarding the Program

Care Manager Lead

- Oversees team of Care Managers – ensuring quality work, accurate documentation and assists in facilitating resolution on complex cases
- Assists in facilitating resolution on complex cases or situations
- Works collaboratively with Manager and Medical Director ensuring clinical or educational needs of the Care Managers are identified and addressed

Care Manager

- Assessment and stratify risks of each participant for appropriate level of care
- Manages psychiatric and chemical dependency facility-based, ambulatory program and outpatient professional treatment through telephonic or written review
- Utilizes skills and knowledge in psychiatric and chemical dependency assessment, negotiation, coordination, implementation, case planning, monitoring, and evaluating to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources.

Case Manager

- Assess and stratify risk assessment of each Member for participation in case management or disease management program
- Communicate with members working to ensure the coordination of care and community-based services and compliance with their clinical treatment plans
- Educating members and families on clinical issues and interventions to assist members in their health maintenance

Program Manager

- Coordinate communications and reporting to Account team
- Liaison between clinical team and other support service units including problem-solving and facilitating/triaging resolution of complex cases and issues

Outreach Specialist

- Coordinate member outreach to assist with discharge planning and follow-up
- Assist in completion of low-level assessments based on identified triggers
- Provide necessary referral follow-up and support to clinical team

Medical Mgmt Specialist

- Oversee and facilitate Applied Behavior Analysis request in accordance with NYS mandate
- Assist clinical team to identify appropriate discharge planning

UM Representatives

- Complete initial intake requests for all levels of care in medical management system
- Processes incoming requests, collection of information needed for review from providers, utilizing scripts to screen basic and complex requests for precertification and/or prior authorization
- Facilitates responses to more complex member/provider issues which cannot be handled through standard customer service areas

VP of Operations

- Oversee all aspects of claims and customer service
- Represent NYS interests in Senior Level Operations discussions and decision-making sessions

Director of Customer Service

- Responsible for all aspects of Customer Service
- Act as a resource for frontline management

Claims Manager

- Direct management of front line claims staff
- Escalates issues as required to Senior decision makers

Manager of Customer Service

- Direct management of front line customer service staff
- Escalates issues as required to Senior decision makers

Operational Expert/Customer Service Rep/Claims Examiner

- Frontline staff responsible for the corresponding function (claims, service, etc…)

Program Implementation

Appendix B

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
1	Close of Sale	1 day	Thu 08/01/13	Thu 08/01/13	Sales
2	**Finalized documentation provided to Account Installations / Project Manager**	**5 days**	**Fri 10/11/13**	**Thu 10/17/13**	**Sales**
3	Group Application	5 days	Fri 10/11/13	Thu 10/17/13	Sales
4	Underwriting	5 days	Fri 10/11/13	Thu 10/17/13	Sales
5	Financial Agreement	5 days	Fri 10/11/13	Thu 10/17/13	Sales
6	**Pre-Implementation**	**1 day**	**Mon 08/05/13**	**Mon 08/05/13**	**Lead,Sales**
7	Issue Notification of New Sale to all supporting areas	1 day	Mon 08/05/13	Mon 08/05/13	Acct Mgr/Sales
8	**Schedule Implementation Meetings**	**4 days**	**Tue 08/06/13**	**Fri 08/09/13**	**Lead,Sales**
9	Schedule Kickoff Meeting	1 day	Tue 08/06/13	Tue 08/06/13	Lead
10	Provide all kickoff meeting documents to team members participating via phone	1 day	Wed 08/07/13	Wed 08/07/13	Lead
11	Attend Kick-Off Meeting	1 day	Thu 08/08/13	Thu 08/08/13	Sales,Acct Mgr,Imp Mgr,Opts Dir
12	Obtain Open Enrollment Dates & Any Communication Materials	1 day	Fri 08/09/13	Fri 08/09/13	Lead,Acct Mgr
13	**Schedule future implementations meetings**	**9 days**	**Mon 08/12/13**	**Thu 08/22/13**	**Sales Rep,Acct Mgr,Imp. Mgr.**
14	Set up call in number for future calls	1 day	Mon 08/12/13	Mon 08/12/13	Lead
15	Create Administrative/Technical Contact List	3 days	Tue 08/13/13	Thu 08/15/13	Lead
16	Start a Deliverables/Decisions Document	3 days	Wed 08/14/13	Fri 08/16/13	Lead
17	Create Information Gathering Document with Account Manager	4 days	Thu 08/15/13	Tue 08/20/13	Lead,Acct Mgr
18	Finalize Performance Guarantees	5 days	Fri 08/16/13	Thu 08/22/13	Acct Mgr,Sales Rep
19	Determine if Account will have a Pre-Implementation Audit.	1 day	Fri 08/16/13	Fri 08/16/13	Acct Mgr,Sales Rep
20	**Administration**	**6 days**	**Fri 08/16/13**	**Fri 08/23/13**	**Sales Rep,Legal,Account,Acct Mgr,Opts**
21	Determine if a new and/or update existing Customer Service Phone number will be needed	1 day	Fri 08/16/13	Fri 08/16/13	Lead/Telephony
22	Create draft of CQ tracking document and provide to the team members	5 days	Mon 08/19/13	Fri 08/23/13	Lead
23	**Telephony**	**6 days**	**Fri 08/16/13**	**Fri 08/23/13**	**Telephony**
24	Determine date phone lines need to be activated	1 day	Fri 08/16/13	Fri 08/16/13	Telephony
25	Obtain toll free number	5 days	Mon 08/19/13	Fri 08/23/13	Telephony
26	Send customer service phone number to Imp Resource	1 day	Fri 08/23/13	Fri 08/23/13	Telephony
27	**IVR and Go Live/Effective Date Call Flow**	**55 days**	**Thu 08/29/13**	**Tue 11/12/13**	**Acct Mgr,Lead,NYS**
28	Review IVR script	1 day	Thu 08/29/13	Thu 08/29/13	Acct Mgr,Lead,NYS
29	Obtain Medical Management team's approval of IVR and prompt order	1 day	Fri 08/30/13	Fri 08/30/13	Lead
30	Approve IVR script	2 days	Tue 09/03/13	Wed 09/04/13	Acct Mgr,NYS
31	Determine if customization needed and explain post imp process and timeframes	1 day	Thu 09/05/13	Thu 09/05/13	Acct Mgr,NYS
32	Obtain on and off-shore routing skills for provider calls	3 days	Fri 09/06/13	Tue 09/10/13	Lead
33	Complete charter with phone information	2 days	Wed 09/11/13	Thu 09/12/13	Lead
34	Submit completed charter for coding	1 day	Thu 09/12/13	Thu 09/12/13	Lead

Feb 13, '05
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Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
35	Submit request to update the “Stat_Fax” table to have the proper branded forms applied	1 day	Fri 09/13/13	Fri 09/13/13	Lead
36	Determine custom route codes	1 day	Fri 09/13/13	Fri 09/13/13	Acct Mgr,Lead
37	Create the Department profile for Customer Service	3 days	Mon 09/16/13	Wed 09/18/13	Telephony,Lead
38	Code IVR	25 days	Thu 09/19/13	Tue 10/22/13	Telephony
39	Obtain the Department signoff on IVR scripts	2 days	Thu 10/24/13	Fri 10/25/13	Telephony
40	Activate IVR	1 day	Mon 10/28/13	Mon 10/28/13	Telephony
41	Test IVR	10 days	Tue 10/29/13	Mon 11/11/13	Telephony
42	Move IVR into production	1 day	Tue 11/12/13	Tue 11/12/13	Telephony
43	**Develop Group Structure**	**7 days**	**Thu 08/15/13**	**Fri 08/23/13**	**Lead**
44	If applicable, obtain requirements & create Group Structure for Account	6 days	Thu 08/15/13	Thu 08/22/13	Lead
45	Send acct group structure to Membership/ID Card team for review & approval	2 days	Fri 08/16/13	Mon 08/19/13	Lead,Acct Mgr
46	Obtain Account signoff on group structure	5 days	Mon 08/19/13	Fri 08/23/13	Lead
47	**Billing for Administrative Fees**	**1 day**	**Fri 08/16/13**	**Fri 08/16/13**	**Acct Mgr,Lead**
48	Determine type of billing (standard or self bill)	1 day	Fri 08/16/13	Fri 08/16/13	Lead
49	**Standard Billing**	**5 days**	**Mon 08/19/13**	**Fri 08/23/13**	**Acct Mgr,Lead**
50	Notify Finance area that the Department is standard bill	3 days	Mon 08/19/13	Wed 08/21/13	Lead
51	Schedule Finance conference call either during weekly the Department call or separate call	4 days	Tue 08/20/13	Fri 08/23/13	Lead
52	Determine if wire transfer or check	1 day	Tue 08/20/13	Tue 08/20/13	NYS
53	**Medical Management Benefits/VRU Options**	**1 day**	**Thu 08/15/13**	**Thu 08/15/13**	**Acct Mgr,Lead**
54	Identify any potential VRU MM changes & scripts/ WEB related tasks	1 day	Thu 08/15/13	Thu 08/15/13	Lead,MM
55	**Transition and Continuation of Care**	**21 days**	**Thu 08/15/13**	**Thu 09/12/13**	**Acct Mgr,Lead**
56	**Member self referrals**	**21 days**	**Thu 08/15/13**	**Thu 09/12/13**	**Acct Mgr,Lead**
57	Determinie if member self referrals are applicable	1 day	Thu 08/15/13	Thu 08/15/13	Lead
58	Add specific region information to the Member Self Referral Form	1 day	Fri 08/16/13	Fri 08/16/13	Lead
59	Obtain internal approval on the updated Member Self Referral Form	4 days	Mon 08/19/13	Thu 08/22/13	Lead
60	Send TOC COC Member Self Referral Form to the Department	1 day	Fri 08/23/13	Fri 08/23/13	Lead
61	Determine Member Self Referral Form (Transition of Care) guideline with the Department	15 days	Fri 08/23/13	Thu 09/12/13	MM
62	Send TOC COC Member Self Referral Form to Operations	1 day	Thu 09/12/13	Thu 09/12/13	Lead
63	Send TOC COC Member Self Referral Form to Acct Mgmt to post to portals	1 day	Thu 09/12/13	Thu 09/12/13	Lead
64	**Prior Carrier Case Transfers**	**29 days**	**Thu 08/15/13**	**Mon 09/23/13**	**Acct Mgr,Lead,NYS,MM**
65	Determinie if prior carrier case transfers are applicable	0.75 days	Thu 08/15/13	Thu 08/15/13	Acct Mgr,Lead,NYS,MM
66	Determine prior case transfer guidelines with the Department	5 days	Thu 08/15/13	Wed 08/21/13	MM

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Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
67	Obtain prior vendor contact info for open precert and case management files	5 days	Thu 08/15/13	Wed 08/21/13	Acct Mgr,Lead
68	Send prior date requirements we need them to provide to us	1 day	Wed 08/21/13	Wed 08/21/13	MM
69	Obtain case transitions with prior carrier	24 days	Wed 08/21/13	Sun 09/22/13	MM,NYS
70	Send case listing to Medical Management	1 day	Mon 09/23/13	Mon 09/23/13	Lead
71	**Transmission of Historial Claims and Eligibiltiy Data**	**27 days**	**Tue 08/06/13**	**Wed 09/11/13**	**Acct Mgr,Lead,NYS**
72	Obtain feeds needed, vendors and contacts at kick-off meeting and send to HWS or IHM	1 day	Tue 08/06/13	Tue 08/06/13	Acct Mgr,Lead,NYS
73	Review the importance of historial data with the Department	1 day	Wed 08/07/13	Wed 08/07/13	Acct Mgr,Lead,NYS
74	Review outreach with vendors/carrier process and the role the Department will play	2 days	Wed 08/07/13	Thu 08/08/13	Acct Mgr,Lead,NYS
75	Obtain legal documents needed for file transfer	24 days	Fri 08/09/13	Wed 09/11/13	Acct Mgr
76	Obtain ongoing status with vendor outreach and progress	24 days	Fri 08/09/13	Wed 09/11/13	Lead
77	Determine file layout	3 days	Fri 08/09/13	Tue 08/13/13	Acct Mgr,Lead,NYS,CS90 systems
78	Set-up FTP with prior carrier and HWS or IHM set-up, if FTP is being used	10 days	Tue 08/13/13	Mon 08/26/13	CS90 systems
79	Test FTP and file layout	10 days	Mon 08/26/13	Fri 09/06/13	CS90 systems
80	Receive and load historial claims data	2 days	Tue 09/10/13	Wed 09/11/13	CS90 systems
81	Receive and load historial eligibility data	2 days	Tue 09/10/13	Wed 09/11/13	CS90 systems
82	**Plan Appeals Process**	**5 days**	**Fri 08/16/13**	**Thu 08/22/13**	**MM**
83	Obtain all information needed to complete the Administrative Tab of the Plan Design	5 days	Fri 08/16/13	Thu 08/22/13	MM
84	Audit all external third party phone numbers by calling each one to ensure accuracy	5 days	Fri 08/16/13	Thu 08/22/13	MM
85	Determine the claims appeal address with the appeal area	5 days	Fri 08/16/13	Thu 08/22/13	MM
86	Review appeals process with the Department	5 days	Fri 08/16/13	Thu 08/22/13	MM
87	Review COB options and standards with the Department	5 days	Fri 08/16/13	Thu 08/22/13	MM
88	Determine claims processing method	5 days	Fri 08/16/13	Thu 08/22/13	MM
89	Determine the secondary payment calculation	5 days	Fri 08/16/13	Thu 08/22/13	MM
90	Send administrative information to BAC to be inputted into plan design	5 days	Fri 08/16/13	Thu 08/22/13	MM
91	**Determine if currently membership eligibility file feeds submission is changing**	**7 days**	**Thu 08/15/13**	**Fri 08/23/13**	**Membership**
92	If Electronically , determine if multiple file feeds will be sent	1 day	Thu 08/15/13	Thu 08/15/13	CS90 systems
93	Obtain contacts for Multiple files	3 days	Fri 08/16/13	Tue 08/20/13	CS90 systems
94	Determine File layout	3 days	Fri 08/16/13	Tue 08/20/13	CS90 systems
95	Supply Account with the ARMS layout	4 days	Fri 08/16/13	Wed 08/21/13	CS90 systems
96	Determine what layout will be used to report electronic eligibility	2 days	Thu 08/22/13	Fri 08/23/13	CS90 systems
97	**Eligibility (Active and Retirees)**	**48 days**	**Mon 08/26/13**	**Tue 10/29/13**	**Acct Mgr,Lead**
98	Send introduction letter and updated Emergency Enrollment document to the Department	4 days	Mon 08/26/13	Thu 08/29/13	Lead
99	Complete Membership Ellibility Questionnaire	1 day	Fri 08/30/13	Fri 08/30/13	NYS

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Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
100	Schedule internal conference call and IT/Membership and the Department/Consultant	1 day	Tue 09/03/13	Tue 09/03/13	Lead
101	Enter test file receipt date	3 days	Wed 09/04/13	Fri 09/06/13	Lead
102	Obtain SHDP sign-off on finalized membership questionnaire	2 days	Thu 09/05/13	Fri 09/06/13	Lead
103	Open SSCR and Ops log in order for IT to start programming	1 day	Fri 09/06/13	Fri 09/06/13	Lead
104	Code file mapping	15 days	Wed 10/09/13	Tue 10/29/13	CS90 systems
105	Send finalized group information (NIDB) to Membership Operations as needed	2 days	Tue 09/10/13	Wed 09/11/13	Lead
106	Obtain VIP listing if applicable	2 days	Tue 09/10/13	Wed 09/11/13	Acct Mgr,Lead
107	**File Transfer Protocol (FTP) Transmission**	**31 days**	**Thu 09/05/13**	**Wed 10/16/13**	**Acct Mgr,Lead**
108	Obtain all FTP file required information from the Department	1 day	Thu 09/05/13	Thu 09/05/13	CS90 systems
109	Conduct conference call with the Department and Empire (if necessary)	5 days	Mon 09/09/13	Fri 09/13/13	CS90 systems
110	Determine FTP timelines	1 day	Tue 09/10/13	Tue 09/10/13	CS90 systems
111	Notify Implementation Team of FTP timeline and information	1 day	Wed 09/11/13	Wed 09/11/13	CS90 systems
112	Set up FTP connectively	10 days	Tue 10/01/13	Mon 10/14/13	CS90 systems
113	Confirm triggers are on and coordinate timing	1 day	Tue 10/15/13	Tue 10/15/13	CS90 systems
114	Determine when first FTP transmission will be sent	1 day	Wed 10/16/13	Wed 10/16/13	CS90 systems
115	Test FTP with the Department	10 days	Tue 09/17/13	Fri 09/27/13	CS90 systems
116	**System Development**	**10 days**	**Tue 09/17/13**	**Fri 09/27/13**	**CS90 systems**
117	Technical team develops testing criteria based on requirements	10 days	Tue 09/17/13	Fri 09/27/13	CS90 systems
118	**Test File for Eligibility File Feeds**	**13 days**	**Thu 10/24/13**	**Mon 11/11/13**	**Mbrshp Syst.**
119	Test file sent	1 day	Thu 10/24/13	Thu 10/24/13	CS90 systems
120	Test file received	1 day	Fri 10/25/13	Fri 10/25/13	NYS
121	Systems Testing	10 days	Tue 10/29/13	Mon 11/11/13	CS90 systems
122	**Benefit Plan Approvals Process**	**13 days**	**Mon 10/07/13**	**Wed 10/23/13**	**Lead**
123	Identify benefits	3 days	Mon 10/07/13	Wed 10/09/13	Lead
124	If applicable, create benefit plan design/chart	2 days	Thu 10/10/13	Fri 10/11/13	Lead
125	Obtain signoff of benefit plans from Account.	4 days	Tue 10/15/13	Fri 10/18/13	Lead
126	Provide approved benefit plans to PLASM Analyst to review.	1 day	Mon 10/21/13	Mon 10/21/13	Lead
127	Load PDF copy of the Department sign off e-mail to the CIP Log	1 day	Tue 10/22/13	Tue 10/22/13	Lead
128	Assign Contract Number	1 day	Tue 10/22/13	Tue 10/22/13	Benefit Coder
129	Load plan designs to NIC SharePoint site	1 day	Wed 10/23/13	Wed 10/23/13	Lead
130	**Medical Benefits (Active and Retiree)**	**12 days**	**Mon 10/07/13**	**Tue 10/22/13**	**Acct Mgr,Lead,NYS**
131	Confirm number of benefit plans required	3 days	Mon 10/07/13	Wed 10/09/13	Acct Mgr,Lead,NYS
132	Send Product Codes to Implementation team	1 day	Mon 10/21/13	Mon 10/21/13	Benefit Coder
133	Determine claims cutover run-in/run-out procedures	2 days	Mon 10/21/13	Tue 10/22/13	CS90,Lead
134	**Benefit Profiling**	**4 days**	**Wed 10/23/13**	**Mon 10/28/13**	**Benefit Coder,Mbrshp Ops**
135	Load Enterprise Product ID number	1 day	Wed 10/23/13	Wed 10/23/13	Benefit Coder

Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
136	Load HPCC code	1 day	Wed 10/23/13	Wed 10/23/13	Mbershp Ops
137	Create benefit profile	1 day	Thu 10/24/13	Thu 10/24/13	Benefit Coder
138	Audit benefit profile	3 days	Thu 10/24/13	Mon 10/28/13	Operations Test Team
139	**Benefit Testing and Auto Adjudication**	**28 days**	**Thu 10/24/13**	**Mon 12/02/13**	**CS90,Operations Test Team,Benefit Coder**
140	Determine need for claims audit (based on build out of any benefits)	1 day	Thu 10/24/13	Thu 10/24/13	Operations Test Team
141	Confirm case and group numbers are loaded in the system	2 days	Thu 10/24/13	Fri 10/25/13	Benefit Coder
142	Complete benefit testing	10 days	Fri 11/01/13	Thu 11/14/13	Operations Test Team
143	Conduct readiness review with the Department to demonstrate success testing of benefits and claims	5 days	Fri 11/15/13	Thu 11/21/13	Operations Test Team
144	Validate all customize document output (letters, EOBs, etc.)	4 days	Fri 11/22/13	Wed 11/27/13	Operations Test Team
145	Turn on auto adjudication	1 day	Mon 12/02/13	Mon 12/02/13	Operations
146	**Behavioral Health**	**24 days**	**Fri 08/16/13**	**Wed 09/18/13**	**Acct Mgr,Lead,NYS,MM,ABH**
147	Send ABH team with group information	1 day	Fri 08/16/13	Fri 08/16/13	Lead
148	Assign ABH Acct Manager and advise imp team of contact	1 day	Mon 08/19/13	Mon 08/19/13	ABH
149	Add ABH Account Manager to the weekly the Department meetings	2 days	Mon 08/19/13	Tue 08/20/13	Lead
150	Determine disability carrier	1 day	Mon 08/19/13	Mon 08/19/13	ABH
151	Determine phone number and if number will appear on ID cards or calls routed via the IVR	2 days	Mon 08/19/13	Tue 08/20/13	Acct Mgr,Lead,NYS
152	Determine call routing logic and phone scripts	2 days	Mon 08/19/13	Tue 08/20/13	Acct Mgr,Lead,NYS
153	Determine Behavioral Health benefits and exclusions with the Department	2 days	Tue 08/20/13	Wed 08/21/13	ABH
154	Notify ABH Account Manger of finalized Benefit Plan Designs	1 day	Wed 08/21/13	Wed 08/21/13	Lead
155	Assign BH/SA service level indicator in the ASF	1 day	Wed 08/21/13	Wed 08/21/13	ABH
156	Determine Transition of Care guidelines	3 days	Thu 08/22/13	Mon 08/26/13	Acct Mgr,Lead,ABH
157	Determine coordination procedures with medical management, UM/CM, Complex Care Units	2 days	Mon 08/26/13	Tue 08/27/13	ABH
158	Create any the Department specific BH appeals and UM letters as needed	5 days	Wed 08/28/13	Tue 09/03/13	ABH
159	Determine if account specific communication materials are needed	2 days	Tue 09/03/13	Wed 09/04/13	Acct Mgr,Lead,NYS
160	Create account specific communication materials	5 days	Wed 09/04/13	Tue 09/10/13	Acct Mgr,Lead,ABH
161	Determine which ABH program materials to be loaded on the website	1 day	Tue 09/10/13	Tue 09/10/13	ABH,Acct Mgr,Lead
162	Conduct ABH team staff training	3 days	Tue 09/10/13	Thu 09/12/13	ABH
163	Review reporting samples with the Department	5 days	Thu 09/12/13	Wed 09/18/13	Acct Mgr,Lead
164	Review BH/SA section of the Department SPD or benefit booklet	5 days	Thu 09/12/13	Wed 09/18/13	NYS
165	**Transition Benefits**	**3 days**	**Mon 08/19/13**	**Wed 08/21/13**	**Lead**
166	Confirm if there are benefits that will need to be transitioned	1 day	Mon 08/19/13	Mon 08/19/13	Lead
167	Identify system involvement	2 days	Tue 08/20/13	Wed 08/21/13	Lead
168	**Network Development**	**9 days**	**Mon 09/09/13**	**Thu 09/19/13**	**Systems**
169	Determine network development tasks	1 day	Mon 09/09/13	Mon 09/09/13	Systems

Feb 13, '05
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Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
170	Identify all areas involved	3 days	Tue 09/10/13	Thu 09/12/13	Systems
171	Set-up timeframes and schedules for completion	4 days	Fri 09/13/13	Wed 09/18/13	Systems
172	Finalize communication plan with Local Blues Plans	1 day	Thu 09/19/13	Thu 09/19/13	Systems
173	**Clinical Staff Preparation**	**3 days**	**Mon 08/19/13**	**Wed 08/21/13**	**MM**
174	Determine number of staff required	1 day	Mon 08/19/13	Mon 08/19/13	MM
175	Identify skill sets	2 days	Mon 08/19/13	Tue 08/20/13	MM
176	Ensure appropriate equipment and reference documentation is supplied	2 days	Tue 08/20/13	Wed 08/21/13	MM
177	**Web Site Development**	**19 days**	**Thu 08/22/13**	**Tue 09/17/13**	**Acct Mgr,Lead,eBusiness**
178	Identify Requirements	1 day	Thu 08/22/13	Thu 08/22/13	Acct Mgr,Lead
179	Create custom site	19 days	Thu 08/22/13	Tue 09/17/13	eBusiness
180	Finalize custom provider search	1 day	Tue 09/17/13	Tue 09/17/13	eBusiness
181	**Banking (Claims Fund) Set-up**	**8 days**	**Mon 08/19/13**	**Wed 08/28/13**	**Acct Mgr,Lead,Finance**
182	Obtain the Department contact for funding	1 day	Mon 08/19/13	Mon 08/19/13	Acct Mgr
183	Conduct meeting with the Department Treasury department to finalize ASO funding arrangement	1 day	Tue 08/20/13	Tue 08/20/13	Acct Mgr
184	Send funding package to the Department	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr,Lead
185	Review funding process with the Department	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr,Finance
186	Determine if consolidated bank account will be used: Wellpoint acct	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr
187	Determine method of payment; demand debit or wire	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr
188	Add payment method selected to the Funding's document banking financial portion	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr
189	Determine frequency of financial reports	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr
190	Determine if the Department has stoploss insurance	1 day	Wed 08/21/13	Wed 08/21/13	Acct Mgr
191	Obtain completed and signed bank account forms	3 days	Thu 08/22/13	Mon 08/26/13	Acct Mgr,Lead
192	Send completed and signed bank account forms to Finance	1 day	Mon 08/26/13	Mon 08/26/13	Lead
193	Set up bank account	3 days	Mon 08/26/13	Wed 08/28/13	Finance
194	**eBusiness**	**14 days**	**Thu 08/22/13**	**Tue 09/10/13**	**eBusiness,Acct Mgr,Lead**
195	The Department Custom Member Web Portal	1 day	Thu 08/22/13	Thu 08/22/13	Acct Mgr
196	Determine if the Department would like a pre-enrollment website	1 day	Fri 08/23/13	Fri 08/23/13	Acct Mgr
197	Submit request for pre-enrollment site via email to Doug.Costello@anthem.com	1 day	Fri 08/23/13	Fri 08/23/13	Lead
198	Determine if the Department will be using the Cost Advisor Tool	1 day	Fri 08/23/13	Fri 08/23/13	Acct Mgr
199	Submit forms to request the Cost Advisor tool be added to the portal	1 day	Fri 08/23/13	Fri 08/23/13	Lead
200	Review request and send site set up package to sales	2 days	Mon 08/26/13	Tue 08/27/13	e-Business
201	Complete pre-enrollment form and return to Doug.Costello@anthem.com	1 day	Tue 08/27/13	Tue 08/27/13	Lead
202	Review form and confirm site delivery date 1 day	2 days	Tue 08/27/13	Wed 08/28/13	eBusiness
203	Create pre-enrollment site	5 days	Wed 08/28/13	Tue 09/03/13	eBusiness

Feb 13, '05
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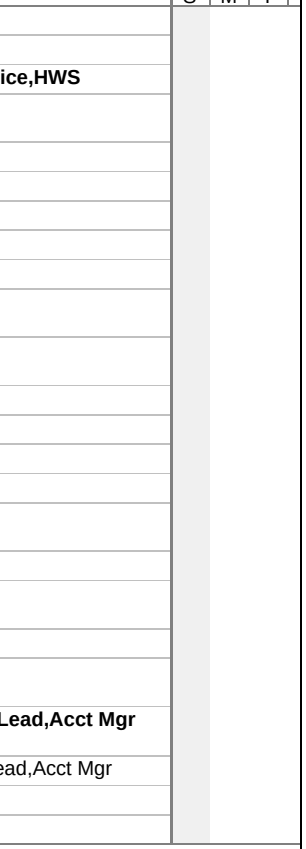
PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
204	Audit website	2 days	Tue 09/03/13	Wed 09/04/13	Acct Mgr.
205	Test and sign off via email	5 days	Wed 09/04/13	Tue 09/10/13	Acct Mgr
206	Deploy pre-enrollment site to the Department	1 day	Tue 09/10/13	Tue 09/10/13	eBusiness
207	Notify the Department site is in production	1 day	Tue 09/10/13	Tue 09/10/13	eBusiness
208	**Member Portal**	**19 days**	**Thu 08/22/13**	**Tue 09/17/13**	**Inteplan,Acct Mgr,Lead**
209	Send alpha prefix to Ingenix for National Provider Finder Tool	1 day	Thu 08/22/13	Thu 08/22/13	Interplan
210	Confirm the alpha prefix update is in production	1 day	Thu 08/22/13	Thu 08/22/13	Interplan
211	Complete and Submit Member Portal Request Form (MPRF)	1 day	Thu 08/22/13	Thu 08/22/13	Acct Mgr
212	Load MPRF business requirements into production	14 days	Thu 08/22/13	Tue 09/10/13	eBusiness
213	Obtain test membership for testing member portal	1 day	Tue 09/10/13	Tue 09/10/13	eBusiness
214	Register membership information into member portal	3 days	Wed 09/11/13	Fri 09/13/13	eBusiness,Acct Mgr
215	Confirm member portal set up including Online Plan Selector Tool functionality	1 day	Fri 09/13/13	Fri 09/13/13	Acct Mgr
216	Send feedback to eBusiness for updates needed or give approval if it is correct	1 day	Fri 09/13/13	Fri 09/13/13	Lead,Acct Mgr
217	Update corrections to member portal as needed	1 day	Fri 09/13/13	Fri 09/13/13	eBusiness
218	Confirm the alpha prefix search works in the National Provider Finder tool	1 day	Fri 09/13/13	Fri 09/13/13	Interplan
219	Audit that member portal displays QHE services (CDH only)	1 day	Fri 09/13/13	Fri 09/13/13	Interplan
220	Audit that corrections were completed correctly and provide sign off	3 days	Fri 09/13/13	Tue 09/17/13	Interplan
221	Notify Account Management group set up is complete	1 day	Tue 09/17/13	Tue 09/17/13	Interplan
222	**The Department Custom Member Web Portal Micro-site Setup with Plan Comparison Tool**	**14 days**	**Fri 09/13/13**	**Tue 10/01/13**	**eBusiness**
223	Configure Micro-site	10 days	Fri 09/13/13	Wed 09/25/13	eBusiness
224	Confirm Micro-site setup	5 days	Wed 09/25/13	Tue 10/01/13	eBusiness
225	Validate Plan Comparison Tool	3 days	Wed 09/25/13	Fri 09/27/13	eBusiness
226	**Claims Processing**	**26 days**	**Mon 09/09/13**	**Fri 10/11/13**	**Interface Lead,Lead,Acct Mgr**
227	Identify Claims Processing Area	1 day	Mon 09/09/13	Mon 09/09/13	Interface Lead,Lead,Acct Mgr
228	Determine how claims testing will be initiated	4 days	Tue 09/10/13	Fri 09/13/13	Interface Lead,Lead,Acct Mgr
229	Set timeframes as to when claims testing will be completed	5 days	Mon 09/16/13	Fri 09/20/13	Interface Lead,Lead,Acct Mgr
230	Determine if an Incoming or Outgoing (or both) File Transfer is needed	13 days	Mon 09/23/13	Wed 10/09/13	Interface Lead,Lead,Acct Mgr
231	Determine Medium of Incoming/Outgoing File	13 days	Mon 09/23/13	Wed 10/09/13	Interface Lead,Lead,Acct Mgr
232	Determine Frequency of Incoming/Outgoing File	15 days	Mon 09/23/13	Fri 10/11/13	Interface Lead,Lead,Acct Mgr
233	**Claims Testing File Feeds**	**13 days**	**Thu 10/24/13**	**Mon 11/11/13**	**CS90 systems**
234	Test file sent	1 day	Thu 10/24/13	Thu 10/24/13	CS90 systems
235	Test file received	1 day	Fri 10/25/13	Fri 10/25/13	NYS
236	Systems Testing	11 days	Mon 10/28/13	Mon 11/11/13	CS90 systems
237	Expand current shared Accumulator process to include MHSA	11 days	Mon 10/28/13	Mon 11/11/13	CS90 systems
238	Add WC recovery feed to MRM	10 days	Tue 10/29/13	Mon 11/11/13	CS90 systems

Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

PROPOSED TIME LINE
New York State Empire Plan for Mental Health and Substance Abuse Program
EFFECTIVE: 01/01/2014

ID	Task Name	Duration	Start	Finish	Resource Names
239	**Report Generation**	**2 days**	**Tue 11/12/13**	**Wed 11/13/13**	**Acct Mgr**
240	Determine and Confirm date for generating report(s)	2 days	Tue 11/12/13	Wed 11/13/13	Acct Mgr,NYS
241	**Customer Service and Claims Teams**	**9 days**	**Mon 09/09/13**	**Thu 09/19/13**	**Acct Mgr,Lead,Customer Service,HWS**
242	Confirm if additional staffing is required ensure support for open enrollment period	1 day	Mon 09/09/13	Mon 09/09/13	Acct Mgr,Customer Service
243	Obtain unit code and unit name	1 day	Mon 09/09/13	Mon 09/09/13	Acct Mgr,Customer Service
244	Submit claims routing form	2 days	Mon 09/09/13	Tue 09/10/13	Lead
245	Obtain claim route code	3 days	Tue 09/10/13	Thu 09/12/13	Lead
246	Send staff members all open enrollment materials	1 day	Wed 09/11/13	Wed 09/11/13	Lead
247	Conduct staff training on Medicare Advantage Part D	4 days	Wed 09/11/13	Mon 09/16/13	Customer Service
248	Conduct staff training on benefits, the Department Culture, expectations, etc	4 days	Wed 09/11/13	Mon 09/16/13	Customer Service
249	Send staff policies and procedures (personnel, hours, access/response standards, monitoring, etc)	1 day	Mon 09/16/13	Mon 09/16/13	Customer Service
250	Open BTS to add the Department to open enrollment worksheet	1 day	Mon 09/16/13	Mon 09/16/13	Customer Service
251	If IHM, create trigger lists for HWS programs	1 day	Mon 09/16/13	Mon 09/16/13	HWS
252	Send trigger list to Customer Service and provide training	4 days	Mon 09/16/13	Thu 09/19/13	Lead,Customer Service
253	**Member- Provider Communication- Mailings**	**9 days**	**Thu 08/22/13**	**Tue 09/03/13**	**Lead,Acct Mgr**
254	Confirm if Account has requested specific communications mailings to providers	2 days	Thu 08/22/13	Fri 08/23/13	Lead,Acct Mgr
255	Confirm date communications will be mailed to providers	3 days	Fri 08/23/13	Tue 08/27/13	Lead,Acct Mgr
256	Provide copies of all communication materials to CS prior to being mailed to members	5 days	Wed 08/28/13	Tue 09/03/13	Lead,Acct Mgr
257	Include communication of provider portal and provider newsletters	2 days	Thu 08/29/13	Fri 08/30/13	Lead,Acct Mgr
258	Provider notification wording of UHL for provider inclusion into newsletter	2 days	Thu 08/29/13	Fri 08/30/13	Lead,Acct Mg
259	**Technical Status**	**15 days**	**Mon 12/02/13**	**Fri 12/20/13**	**CS90 systems,Interface Lead,Lead,Acct Mgr**
260	On-going communication of test results and status	15 days	Mon 12/02/13	Fri 12/20/13	CS90 systems,Interface Lead,Lead,Acct Mgr
261	**Post Implementation Evaluation**	**11 days**	**Fri 01/03/14**	**Fri 01/17/14**	**Interface Lead,Lead,Acct Mgr**
262	Identify any issues and determine resolution	11 days	Fri 01/03/14	Fri 01/17/14	Interface Lead,Lead,Acct Mgr



Proposed timeline assumes 8/1 contract award date and will be adjusted based on actual award date.

Customer Service

Appendix C

Proposed Consolidated NYSSC SCRIPT
NYS Hospital / Mental Health & Substance Abuse

Call Prompter

(Good Morning) Thank you for calling the New York State Service Center at Empire BlueCross BlueShield.

If you are a healthcare provider, **press pound now**.

- go to Provider Sub Call Prompter/Empire Fast Check

< **Seasonal Call Prompter Message>**
"For information regarding your open enrollment, Press #, 2, 1, now."

EMI

< *Broadcast*>

Members: <pause> "Enter your identification number followed by the pound sign. Enter only the numbers skip any letters or symbols."

- Caller enters ID continue in Member IVR

Sub Call Prompter

Hospitals and Medical Providers, Press 1

Hospitals and facilities, Press 1

Medical providers, 2

For an explanation of provider types, 3

All others, 2.

If you are not enrolled and would like information. Press1

<Re-prompt Menu>

Member IVR Main Menu

For Claims, press 1

- For Claims Status, Press 1

  Go to Claim Status

- Claim Reviews and Appeals, Press 2.

  Transfers directly to an agent
  Transfer to agent
  Hospital/facility to hospital agent
  MHSA to MHSA agent

- How to submit a claim, Press 3

  - Go to Claim Submission Address ARL
    - To repeat this information, Press 1
    - To end this call, 9
    - To return to the Main Menu, *

For a Customer Service Representative, **0**

Transfer to agent
Hospital/facility to hospital agent
MHSA to MHSA agent

If, at any time, you wish to return to the Main Menu, *

Coverage and Benefits, 2

Speak out Eligibility Benefit Dialogue

- For Benefits for specific services, Press 2
  - To repeat this information, **Press 1**
  - To end this call, **9**
  - To return to the Main Menu, *

Pre-Admission Certification for Hospital, Facility Services, Mental Health Services or Substance Use Services, 3

For hospital services, Press 1

The Benefits Management Program requires pre-admission certification for hospital services.

- To transfer, **press 1**
- To end this call, **9**
- To return to the Main Menu, *

For Mental Health or Substance Abuse Services, Press 2

- To transfer, **press 1 transfer to MHSA clinical**
- To end this call, **9**
- To return to the Main Menu, *

To contact the Future Moms program for maternity, 3

All Other Sevices and Information, 4

- To update your coordination of benefits information**, Press 1**

- To request an Identification Card, **Press 2**
  Go to ID card ARL
  - To repeat this information, **Press 1**
  - To end this call, **9**
  - To return to the Main Menu, *

- Verify names ofparticipating provider , **Press 3**
  Go to Particating Provider ARL
  - To repeat this information, **Press 1**
  - To end this call, **9**
  - To return to the Main Menu, *

- All Others, **Press 4**
  - To change your name or address, **Press 1**
  - Go to Name and Address ARL
  - To repeat this information, **Press 1**
  - To end this call, **9**
  - To return to the Main Menu, *

- For information on our confidentiality policy, **2.**
- Go to the Confidentiality ARL
  - To repeat this information, **Press 1**
  - To end this call, **9**
  - To return to the Main Menu, *

Speak 1st Pass

For a Customer Service Representative, **0.**

Transfer to agent

Hospital/facility to hospital agent

MHSA to MHSA agent

If, at any time, you wish to return to the Main Menu, *

Sample Enrollee Communication Materials

Appendix D

Behavioral Health Resource

Getting the help you need is just a phone call away

If you're stressed or depressed, chances are you'll feel it from your head down to your toes. It's no secret that mental health and physical well-being go hand in hand. And, if it's a family member who's struggling, you're bound to be hurting too.

Our Behavioral Health Resource offers a total-health solution that can help you or your loved ones deal with:

- Anxiety
- Depression
- Drug or alcohol abuse
- Eating disorders
- Other personal issues

When you call the Behavioral Health Resource center, you'll talk with someone who has experience helping others manage problems and finding the right treatment programs and care.

If you have questions, we're here to listen. We want to find out what's important to you and how we can help you cope with your situation before it takes a greater toll on your life and your health.

Get a head start

Just one call can connect you to the right care at the right time. To get the help you need, call the Behavioral Health Resource center at any time of the day or night at **the customer service number on your ID card**.

Empire BlueCross BlueShield

MNYSH3139YN Rev. 4/12 F0011625

Healthy and happy. They just go together.

When you choose an Empire behavioral health plan, your business and your employees are getting the best of both worlds.

You want your employees to be healthy and happy. And helping them stay that way is one of the best ways to keep your business strong. But in today's fast-paced world, more and more businesses are losing time, money and talent due to employees suffering from anxiety, depression and extreme stress.

When left untreated, mental health problems can turn very serious, resulting in decreased employee productivity and increased absences. In fact, depression is one of the top five disabling medical problems – and its frequency and cost are increasing faster than all conditions except cancer.[1]

Empire's behavioral health plans offer smart, integrated solutions. Here's why:

Our behavioral health plans are fully integrated with our health plans. That means operations, customer service, behavioral health managers and medical managers are all working together to give your employees the best possible care.

> Continued

Major Depressive Disorder is the leading cause of disability in the U.S. for ages 15-44.[2]

Empire BlueCross BlueShield

360°Health℠

1 The Mercer National Survey of Employer-sponsored Health Plans and Mercer/March Survey on Health: Productivity and Absence Management Programs, 2007 Survey Reports

2 The World Health Organization website. The global burden of disease: 2004. www.who.int/en

19162NYEENEBS 3/11 F0044904

Not sure which Empire behavioral health program is right for your company? Let us walk you through.

1. Behavioral Health Utilization Management – core coverage included in your medical plan

This program is designed to make sure employees get the right care at the right time. Here's what's included:

- **Medical reviews:** Done before, during and after treatment to make sure of medical need and to oversee treatment and discharge planning
- **A choice of medical review levels:** Inpatient only, inpatient and facility or all levels of care
- **Three basic clinical management services:**
  - Support and guidance for illnesses that happen at the same time (like a medical problem with depression)
  - Maternity depression screening for all new and expecting moms
  - Medicine compliance programs - automated over-the-phone outreach

2. Behavioral Health Resource – greater personal support for employees with mental issues and diseases

This program includes all of the core Behavioral Health Utilization Management services and a much deeper level of support. The goal is to help you get the most from your benefits by proactively reaching out to employees, improving long-term health outcomes and increasing your cost-savings. Here's how:

- **24/7 Resource Center** offers employees around-the-clock access to clinicians who can help them learn what programs they can use, take care of referrals, answer questions, approve care and gain access to extra resources they may need.
- **Depression Care Management** is designed for employees who suffer from more common problems like depression and anxiety.
- **Behavioral Health Care Management** is a proactive outreach program for employees with more serious behavioral problems that could be high-cost and have increased risk. These include eating disorders, bi-polar disorders, substance abuse, etc. This program also manages care with multiple providers, both medical and behavioral health, and helps employees stick with their treatment.
- **Both Care Management services include:**
  - Screening/service coordination for those at high-risk
  - Intensive care management for those most affected by their mental health problem
  - Personal over-the-phone outreach by a care manager
  - Automated over-the-phone outreach for employees taking medicine that's related to their behavioral health problem (includes in- and out-of-network pharmacies)

3. Employee Assistance Program (EAP) – can be added for more support

Employees and their household members have easy access to these services:

- In-person, confidential counseling
- Access to legal and financial counseling (first consultations are free)
- Access to a work/life website and over-the-phone help with stress, wellness, childcare needs, eldercare needs, and more

When you integrate the EAP with our behavioral health plans, your employees benefit from access to our full range of services. It also gives our care managers better ability to decide what type of care will benefit employees most. This could be a referral to an EAP counselor, assistance from a work-life specialist or through services from their mental health benefit.

Bottom line? Happy healthy employees are great for business.

Let's work together to keep your employees at their best. If you have questions or would like to know more about our behavioral health plans, feel free to call your Empire sales representative. We're happy to help.

Empire BlueCross BlueShield

360°Health

April 9, 2013

[Member Name]
[Address]
[City]

Dear LastName,

Enclosed is the information you recently requested. It is our hope that this material will be helpful to you.

Please feel free to call us whenever you have questions or concerns.

Thank you for participating in our Program. We look forward to continuing to work with you.

Sincerely,

April 9, 2013

[Member Name]
[Address]
[City]

Dear LastName,

Recently, we tried to phone you to introduce a valuable service that is being offered by your health benefits company. This program has been designed to help you get the most out of your health plan benefits and improve your overall quality of life.

There is **no additional cost** to you if you decide to take advantage of this program. Participation is voluntary, but we hope you will give us a call at the toll-free number below, so we can tell you more about the service.

We would welcome the opportunity to help you achieve your health goals.

Sincerely,

Behavioral Health Clinical Team
PhoneNumber

Understanding Depression

Depression is a common condition that affects 1 in 10 Americans each year.[1] It can affect a person of any age, race or social standing.

People misunderstand depression to be sadness, or a down mood that you can just snap out of. This isn't the case. Job loss, divorce or the death of a loved one can cause grief and sadness that lifts over time. Depression is a medical condition with both physical and emotional symptoms that can occur even when things are going well. If it isn't treated, it can last for months or even years.

Am I suffering from depression?

The symptoms of depression are different for everybody. Talk to your doctor if you're experiencing any of these signs for long periods:[2]

- A sad, anxious or empty mood
- Feelings of hopelessness, pessimism, guilt, worthlessness or helplessness
- Loss of interest in activities you used to like, including sex
- Fatigue, low energy or being slowed down
- Trouble remembering or making decisions
- Difficulty sleeping, like insomnia, waking up too early or oversleeping
- Overeating and weight gain
- Loss of appetite and weight loss
- Thoughts of death or suicide; suicide attempts
- Restlessness or irritability
- Physical problems that don't respond to treatment, like headaches, stomach aches and chronic pain

How can I help someone I know?

A depressed person often feels overwhelmed, hopeless and apathetic. These feelings can make it difficult for them to get help. Tell your loved one to speak with a doctor about what they are feeling.

A depressed person needs your support. Be kind but firm, and offer understanding, patience and encouragement. Listen carefully when you talk with your loved one, and try to get them to spend time with other people. Don't push too hard, but suggest activities they used to like.

If they express negative feelings, point out what's positive and offer hope. If they speak of suicide, report this to their therapist or doctor.

What if I'm suffering from depression?

If you think you are depressed, ask for help. Call your doctor, or talk with a trusted friend or family member so they can get you the help you deserve.

Most people don't just "snap out" of a depression. It's important to get professional help and follow your doctor's advice.

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1 National Center for Chronic Disease Prevention and Health Promotion, *Health-Related Quality of Life; Behavioral Risk Factor Surveillance System* (2008): cdc.gov

2 National Institute of Mental Health, *Depression* (September 23, 2009): nimh.nih.gov

3 WebMD, *Depression Guide* (May 4, 2008): webmd.com

4 Depression and Bipolar Support Alliance, *Depression Across the Lifespan* (August 25, 2006): dbsalliance.org

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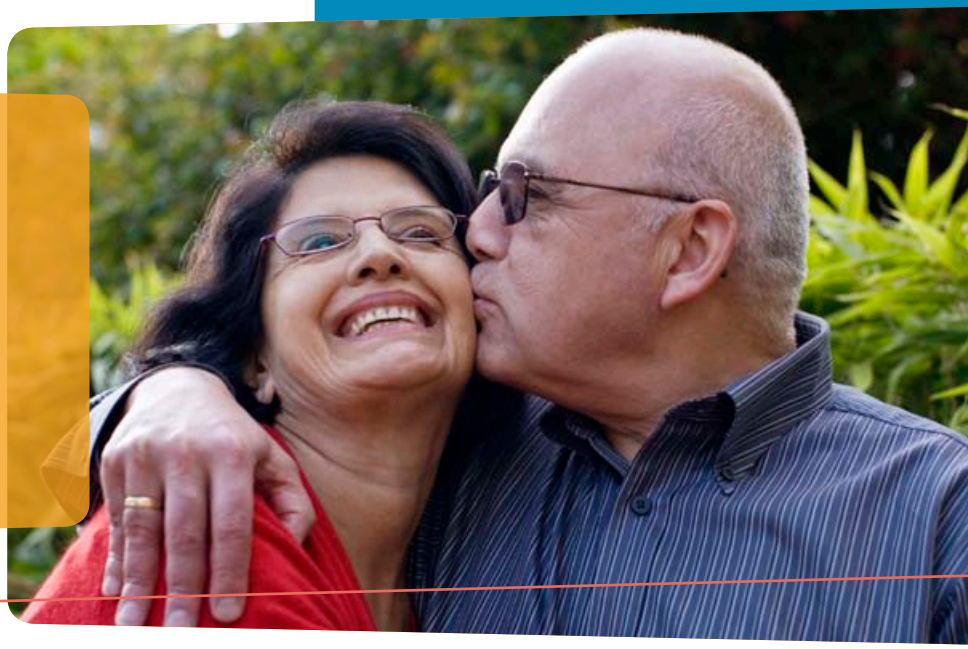
Behavioral Health Care Management

Personalized care when you need it most



Healthy mind, healthy body

When you don't feel good emotionally, relationships with your family and friends can suffer. You can have problems at work. And, your body can suffer, too. Depression and other behavioral health conditions are often tied to other illnesses, such as diabetes and heart disease. When you manage behavioral health conditions well, it can help you maintain or improve your physical health.

Dealing with all of these things on your own can be confusing. It can be frustrating. Fortunately, you don't have to face them alone. Our Behavioral Health Care Management programs were created to help you through it all.

Care managers provide support

Our care managers are licensed mental health professionals. We'll help you succeed with strong support for you and your family. Our goal is to help you take control of your health care and improve the quality of your life.

Your care manager will work with you to:

- Help you and your family understand your condition.
- Develop a personalized plan to help you reach your behavioral health goals.
- Identify and help you overcome hurdles that may be keeping you from reaching your goals.
- Connect with helpful community and online resources.
- Review and coordinate services you get from local and community providers.
- Help ensure you're getting all the benefits available to you under your health plan.
- Become your own advocate.

Getting started

On the first call, your care manager will ask questions to help understand what you're dealing with, where you are in your treatment and what you hope to achieve. After the call, they'll use the information to make a plan to help you meet your goals. And your care manager will stay in touch with you as you work to meet your goals.

If you'd like to learn more about the Behavioral Health Care Management programs, call us toll free at **888-441-8673.**

Additional resources

To learn more about depression and mental health, visit:

- WebMD.com
- Nimh.nih.gov
- empireblue.com

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360° Health

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Tips for partners

A caring partner can make a real difference to a woman who is dealing with the baby blues or maternal depression. Here's how:

- Encourage her to talk about her feelings. Listen carefully and do not discount or belittle her feelings.
- Help her reach out to others for support and health care.
- Help her cope practically and emotionally. For instance, give her breaks from household and child care duties; schedule dates with her, etc.
- Pitch in before she asks for help with feeding, diapering and household chores.
- Offer reassurance, positive feedback and patience.
- Express confidence in her strength and her ability to recover. But if she doesn't improve after a few weeks, help her find professional help.

Additional resources

Here are some places where you can learn more about the baby blues and maternal depression:

- Postpartum Support International
  postpartum.net
- MedEdPPD Mothers and Others
  mededppd.org
- National Women's Health Information Center
  800-994-9662 · 4women.gov
- 360° Health
  anthem.com

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360°Health

Sources: The American College of Obstetricians and Gynecologists (ACOG).
The American Academy of Pediatrics, guidelines for Perinatal Care, 5th edition.
MedEdPPD Mothers and Others.

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Balancing your emotions during pregnancy and after childbirth

Empire BlueCross BlueShield
360°Health

Feeling blue?

Most women experience emotional and behavioral changes during pregnancy and after the birth of a child. These changes can include the "baby blues." Sad feelings may be due to hormonal changes or the disruptions to lifestyle and sleeping habits that a baby can bring. These feelings usually last for a few days to a few weeks, and may go away on their own.

But what if the blues don't go away? It may be maternal depression.

Who's at risk?

Women of all ages and from all economic, racial and ethnic backgrounds can be affected by symptoms of depression during pregnancy or after delivery. In fact, about one out of every eight new mothers will experience maternal depression*. It can occur weeks or even months after childbirth and can last a year or longer if untreated. It can happen with any child, not just your first. These changes can drain your energy and keep you from having quality interactions with your baby.

*Source: MedED PPD Mothers and Others, mededppd.org, October 2009.

What are the signs?

The signs and symptoms of maternal depression may include:

- Feeling restless or irritable.
- Feeling sad and depressed.
- Crying a lot.
- Having no energy.
- Being unable to eat, with resulting weight loss.
- Overeating, with resulting weight gain.
- Trouble focusing, remembering things or making decisions.
- Being overly worried about your baby.
- Not having an interest in your baby.
- Not wanting your baby to be near you.
- Feeling worthless and guilty.
- Having no interest and getting no pleasure from activities you used to enjoy, including sex.

If you are worried about hurting yourself or your baby, call your health care provider immediately or go to the nearest emergency room.

What causes maternal depression?

The exact cause is unclear. The condition appears to be a combination of physical, emotional and behavioral changes triggered by pregnancy and childbirth. Some reasons this may happen include:

- Sudden hormonal shifts.
- Loss of sleep.
- Limited help taking care of your baby.
- A difficult pregnancy, birth or post-delivery experience.
- Financial, family or personal stress.
- Past history of depression or other emotional conditions.

Depression is not...

- Your fault.
- Something to be ashamed of.
- A sign of a weak personality.

How can you take care of yourself?

There are a number of things you can do to ease your transition to motherhood:

- Make sure you've scheduled your postpartum checkup with your OB/GYN or other health care provider, and your well-baby checkups with your pediatrician.
- Talk to your health care provider and your baby's pediatrician about your concerns.
- Ask for support from family and friends.
- Always try to nap when your baby naps.
- Stop putting pressure on yourself. Don't try to do everything. Do as much as you can and then ask for help with chores and nighttime feedings.
- Don't spend a lot of time alone. Get dressed, leave the house, take a walk with your baby.
- Do spend time alone with your husband or partner.
- Join a support group for new mothers.

Maternal depression can be successfully treated. The type of treatment depends on the severity of your symptoms. It may include medication, talk therapy or a combination of both. If you are breast-feeding, ask your pediatrician which medications are safe for your baby.

How can we help?

Your health plan offers a program that can help. Call one of our licensed mental health professionals to get more information and referrals to appropriate care providers in your area. The service is included as part of your health care coverage and is offered at no additional cost to you.

You and your baby deserve to be happy and healthy. Don't be afraid to ask for help. Call the Maternity Depression program at this toll-free number, **866-621-0554**.

Empire BlueCross BlueShield

360Health

None for the road

Nothing takes away the fun of the holidays like a drunk driving arrest or accident. Every 48 minutes, someone in the U.S. dies in an auto crash that involves alcohol.[1] Drunk driving is an issue at any time of the year. But during the holidays, when people are going to parties and drinking alcohol, it's more likely that drunk drivers are on the road. Drivers are considered drunk when their blood alcohol is .08 grams per deciliter or more.[2] They could be putting their lives – and the lives of others – in danger. Here's what can happen when blood alcohol levels rise: [1]

- At .02% blood alcohol, drivers will lose some ability to know what's going on around them.
- At .05%, a driver will have trouble steering and responding to driving emergencies.
- At .08%, drivers can lose muscle control, be slow to react in a risky situation and have trouble thinking straight and knowing when they are in danger.
- Anything over .08% can make someone unable to stay in a lane or control the car.

In other words, even a small amount of alcohol – like one drink – may make you unable to drive like you should. It also means that you, other people in the car with you and other drivers on the road have a higher chance of getting in an accident.

This holiday season, make eating fruitcake the biggest risk you take. And keep these things in mind:

- If you're going to drink alcohol, have someone who's not drinking be your driver. If not, call a cab or take the bus or train.
- If you are hosting a holiday party, help your guests stay safe by:
  - Serving drinks that don't have alcohol in them.
  - Focusing on the food and people, not the alcohol.
  - Serving drinks that have very little alcohol and limiting how much is served.
  - Refusing to serve guests who seem drunk or underage.
  - Making sure anyone drinking has a driver who hasn't had any alcohol; have a couple of drivers on standby in case you need to give someone a ride home.
  - Sharing taxi and safe-ride service phone numbers in your area.
  - Letting guests stay at your home for the night or taking their keys so they're not tempted to drive themselves home.

Certain factual or statistical information was derived from the following sources:
1 http://www.cdc.gov/MotorVehicleSafety/Impaired_Driving/impaired-drv_factsheet.html
2 http://www-nrd.nhtsa.dot.gov/Pubs/811155.PDF
http://store.samhsa.gov/shin/content//PHD833/PHD833.pdf

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Life is like a box of chocolates

Wouldn't it be nice to know what you're going to get?

Life gives us lots of choice, change and opportunity. And most of the time we're not quite sure what we'll get. Like trying chocolates, we might take a bite and want more. Or we might want to put it back in the box when no one's looking and pick something else.

Counseling is a lot like a chocolate cheat sheet. It's a way to know more before you take that first bite or try something new. It's also a chance to start over or avoid something unwanted – like the chocolate with the yucky filling. Professionally licensed counselors give helpful advice, skill-building and tips for problem solving. It can help with life's spiritual, relationship, work, education and mental or physical health needs. Seeing a counselor means finding a caring ear and a wise voice. A counselor should be ready and willing to help throughout all stages of life.[1]

Counselors work through independent practices, community agencies, health care organizations, employee support programs and treatment centers.[2] You should be just as careful choosing the right counselor as finding the right medical doctor. So it's important to ask some questions:

- Are you licensed?
- What is your area of expertise or focus?
- How much training have you had dealing with my type of worries?
- What is your approach or process when working with clients?
- How many sessions do most clients need?
- What are your insurance and billing rules?

During your first visit, share information about your reasons for finding help. Listen to the counselor's first thoughts on how to go about dealing with your concerns. Then use it as a chance to decide if the fit is right. If you're not happy, don't be shy about looking somewhere else. After all, it's your choice...and your chocolate.[3]

Additional counseling resources:
National Institute of Mental Health, *How to Find Help*:
nimh.nih.gov/health/topics/getting-help-locate-services/index.shtml
Centers for Disease Control and Prevention FAQs: cdc.gov/mentalhealth/faqs.htm#2

Certain factual or statistical information was pulled from the following sources:
[1] American Counseling Association: counseling.org
[2] American Mental Health Counselors Association: amhca.org
[3] *Web*MD, *Guide to Psychiatry and Counseling* (2010): webmd.com

Empire BlueCross BlueShield

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Six Ways to Sideline Stress

Too much stress can affect your health. Use the following tips to help keep stress from getting the best of you.

1. **Mind Your Health:** No one can completely avoid stress, but physical activity, good nutrition and plenty of rest can help you keep your energy level high and ready to face life's challenges.

2. **Reduce Stressors:** Make a list of the things in your life that cause you stress. Beside each one, write down one or two ways you can lessen the stress and then work toward those goals. If you have trouble finding solutions, talk with your doctor.

3. **Plan Ahead:** Stress can be caused by having too many things to do in too short a period of time. Instead, break larger projects into smaller more manageable tasks; delegate at work and at home when you can. Set priorities. Spend the most time on those things you feel are important and less time on things that are lower priorities.

4. **Be Positive:** If you demand too much of yourself or let negative thoughts run through your mind, you're setting yourself up for added stress. Each time this happens, take a minute to redirect your thoughts to something more positive.

5. **Get Away:** When stress seems to be getting the better of you, take a break. Even a quick five-minute walk away from your office or home can help you relax.

6. **Relax:** Relaxation exercises, which combine deep breathing with releasing muscle tension, are simple to do anywhere and can help lessen the negative effects of a stressful situation. Try the exercise below and talk with your doctor about others:

    - Inhale through your nose slowly and deeply to the count of 10.
    - Make sure that your stomach and abdomen expand but your chest does not rise up.
    - Exhale through your nose, slowly and completely, also to the count of ten.
    - To help quiet your mind, concentrate fully on breathing and counting through each cycle.
    - Repeat five to ten times. Make a habit of doing the exercise several times each day.

Source:
National Mental Health Association, Cleveland Clinic Foundation

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Get Healthy. Stay Healthy.

Drug and Alcohol Awareness

Weddings, birthdays, holidays – we often mark the most significant events of our lives with glasses raised. For many of us, moderate drinking during social occasions is the norm. But for others, moderate consumption can turn into overuse, abuse and sometimes even addiction.

Substance abuse and addiction are common in the United States. In 2006, almost 23 million Americans ages 12 and older – more than 9 percent of the population – had substance abuse problems.[1]

Do you think you have a drinking problem?

Ask yourself the following questions:

- Do you drink alone when you feel angry or sad?
- Does your drinking ever make you late for work?
- Does your drinking worry your family?
- Do you ever drink after telling yourself you won't?
- Do you ever forget what you did while you were drinking?
- Do you get headaches or have a hangover after you've been drinking?

If you answer yes to any of these questions, you may have a drinking problem. Talk to your doctor about it. [13]

Why people consume drugs or alcohol

People use alcohol and drugs as a way to alter their mood and relieve stress. Consuming drugs or alcohol can initially make the user feel better – more powerful, self-confident, energized or relaxed. Over time, people may need to use more of the drug or use it more frequently to feel its effects. Seeking and taking the drug becomes their primary concern. At this point, the drug may cause physical changes in areas of the brain that control judgment, decision-making, learning, memory and self-control.[2]

Alcohol and your health

We've all heard about the supposed benefits of drinking red wine, but do those benefits outweigh the drawbacks? The answer is, it depends – on your age, the state of your health, the medications you're taking and how much you drink.[3] Research has shown that moderate drinkers are less likely to die from coronary artery disease than are people who drink heavily or who don't drink at all.[4] But heavy drinking increases the risk of heart and liver disease, depression, stroke, sleeping disorders and certain cancers.[5] Alcohol abuse also can lead to[6]:

- Damage to the brain, pancreas and kidneys
- High blood pressure, heart attacks and strokes
- Impotence and infertility
- Birth defects and fetal alcohol syndrome
- Premature aging

Illegal drug use

Although drug use isn't a socially accepted activity like drinking alcohol is, almost 19.9 million Americans were using illicit drugs in 2007.[7] An estimated 40 percent of adults in the United States will use an illegal drug – street drugs like marijuana and cocaine – at some point in their lives.[8] When abused, legal substances such as prescription drugs, over-the-counter medications and household chemicals can be as harmful or addictive as their illegal counterparts.[9]

Most drugs interact with the regions of the brain that control movement, emotions, motivation and pleasure. The drugs rush dopamine to these regions, leaving the user feeling exhilarated and euphoric. When a person continues to abuse the drug, the brain responds by producing less dopamine or reducing the number of dopamine receptors. That means the person must use larger amounts of the drug to get the dopamine high.[10]

Is addiction inevitable?

Drinking alcohol or using drugs doesn't necessarily mean you'll become addicted. But even though taking a drink or a drug is a voluntary action, continuing to use these substances can lead to becoming physically or psychologically dependent on them.[11]

You may be concerned about your own use of drugs and alcohol or that of a friend or family member. Here are just some of the many physical and behavioral signs to watch out for[12]:

- Change in sleep patterns
- Bloodshot eyes
- Sudden weight loss or gain
- Poor hygiene
- Emotional instability
- Missing work or school
- Secretive behavior

Resources

For information on understanding alcohol and drug usage, treatment and prevention, visit these sources:

- National Institute on Drug Abuse: **nida.nih.gov**
- National Institute on Alcohol Abuse and Alcoholism: **niaaa.gov**
- Substance Abuse and Mental Health Services Administration: **samhsa.gov**
- National Council on Alcohol and Drug Dependence: **ncadd.org**
- Partnership for a Drug-Free America: **drugfree.org**

Visit empireblue.com for more ways to get healthy – and stay healthy.

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Sources: (1) Partnership for a Drug-Free America, *You Are Not Alone* (October 3, 2008), drugfree.org, (2) National Institute on Drug Abuse, *The Science of Addiction* (September 17, 2008), drugabuse.gov, (3) Rethinking Drinking, National Institute on Alcohol Abuse and Alcoholism, *Alcohol and Your Health* (accessed June 16, 2009), rethinkingdrinking.niaaa.nih.gov), (4) National Institute on Alcohol Abuse and Alcoholism, *FAQs for the General Public* (February 2007), niaaa.nih.gov, (5) Rethinking Drinking, National Institute on Alcohol Abuse and Alcoholism, *What Are the Risks?* (accessed June 2009), rethinkingdrinking.niaaa.nih.gov, (6) National Clearinghouse for Drug and Alcohol Information, *What You Can Do About Drug Abuse in America* (accessed July 2009), ncadi.samhsa.gov, (7) U.S. Department of Labor, *General Workplace Impact* (accessed June 2009), dol.gov, (8) Partnership for a Drug-Free America, *Alcohol and Drug Problems Overview* (April 24, 2008), drugfree.org, (9) National Institute on Drug Abuse, *Commonly Abused Drugs* (May 5, 2009), drugabuse.gov, (10) National Institute on Drug Abuse, *Understanding Drug Abuse and Addiction* (May 6, 2009), drugabuse.gov, (11) U.S. Department of Labor, *Addiction (Dependence)* (accessed June 2009), dol.gov, (12) Partnership for a Drug-Free America, *Signs Someone Is Using Drugs or Alcohol* (June 16, 2006), drugfree.org, (13) National Clearinghouse for Drug and Alcohol Information, *How to Cut Down on Your Drinking* (accessed May 2009), ncadi.samhsa.gov.

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Stress Awareness

What is stress?

Life asks a lot of us – spouses, jobs, arguments with friends, sick pets – and at a certain point we have more to deal with than we can handle emotionally.[1] That's when stress kicks in.

It's your response to danger

You know the feeling – sweaty palms, racing heartbeat, an upset stomach. This is stress, and it's how your body responds to physical dangers. The hormones that are released used to help people face physical threats. But since we don't fight saber-toothed tigers anymore, the hormones aren't as helpful.

Serious side effects

Nowadays, stress tends to last for weeks or longer due to the demands of modern life, instead of minutes or hours. Your system is in overdrive and these hormones can disrupt some of your body's processes. This can lead to:

- Higher risk of heart disease.
- Obesity.
- Digestive problems.
- Memory loss.
- Insomnia.
- Depression.[2]

Don't panic, though. You can do plenty to fight the side effects.

Tame your stress

If you can't get rid of the things that cause the stress, then you'll have to find more power to deal with it. Here are some activities that can help:

- **Get out and exercise**
  Consider walking, jogging, biking or anything else that gets you active.
- **Laugh out loud**
  Laughing lightens your mental load and does good things for your body.
- **Talk to friends and family**
  They can distract you, provide support, help you weather life's up and downs.
- **Do yoga**
  Yoga uses both physical and mental moves to create peace of body and mind. This helps you relax and manage stress. Try yoga on your own or find a class in your area.
- **Get more rest**
  Sleep is when your brain and body recharge. Get the right amount and you'll improve your mood and energy level.
- **See a counselor or therapist**
  They can help you find the sources of your stress and learn new coping tools.[3]

Try some of these tips to live your life with less stress. And talk to your doctor if you're feeling really stressed. Sometimes other health problems have similar symptoms.[2]

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Sources:
(1) American Institute of Stress (2009).
(2) http://www.mayoclinic.com American Institute of Stress, Stress Management (March 19, 2009): stress.org.
(3) http://www.mayoclinic.com Stress relievers: Top 10 Picks to Tame Stress (September 28, 2010).

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Reporting

Appendix E

Settlement Summary for the Year Ending December 31, 201X

RECONCILIATION

Paid Claims 1/1/201X - 12/31/201X	$XXX
Paid Bad Debt & Charity 1/1/201X - 12/31/201X	$XXX
Total Paid Claims	$XXX
Total Claim Dollar Funded by New York State	$XXX
Difference Between Claims Paid and Funded	$XXX
Total Administrative Fees	$XXX
Total Taxes/Assessment	$XXX
Total Shared Expenses	$XXX
Total Actual Expenses	$XXX
Total Reconciled Administrative Fees Funded	$XXX
Difference Between Reconciled Administrative Fee and Funded	$XXX
Credit for XXX/(XXX)	$XXX
Net Amount Due NYS/Empire	$XXX

BUDGET

Total Paid Claims	$XXX
Reserve as of 12/31/20XX	$XXX
Total Actual Expenses	$XXX
Total Actual Credit XXX/(XXX)	$XXX
Total Estimated 201X Budget	$XXX

Monthly Paid Claims

Paid Date Mo. / Yr.	Paid Claims	Bad Debt & Charity
January	$XXX	$XXX
February	$XXX	$XXX
March	$XXX	$XXX
April	$XXX	$XXX
June	$XXX	$XXX
July	$XXX	$XXX
August	$XXX	$XXX
September	$XXX	$XXX
October	$XXX	$XXX
November	$XXX	$XXX
December	$XXX	$XXX
Total	$XXX	$XXX

Monthly Dollars Paid to Empire

Mo. / Yr.	Claim	Administrative Expense
January	$XXX	$XXX
February	$XXX	$XXX
March	$XXX	$XXX
April	$XXX	$XXX
June	$XXX	$XXX
July	$XXX	$XXX
August	$XXX	$XXX
September	$XXX	$XXX
October	$XXX	$XXX
November	$XXX	$XXX
December	$XXX	$XXX
Total	$XXX	$XXX

201X Administrative Fees

Per Contract Per Month Fee	$XXX
Total Number of Contracts	X
Administrative Charges:	$XXX
Control Plan Shared Communication Charges (Printing)	$XXX
Total Administrative Charges:	$XXX

201X Taxes and Assessment Summary

Assessment X Rate	$XXX	Per Member Per Month
Assessment X Calculation	X	Number of Members
Total Assessment X Dollars	$XXX	

Assessment X Rate	$XXX	Per Contract Per Month
Assessment X Calculation	X	Number of Contracts
Total Assessment X Dollars	$XXX	

Recovery Summary

	Recovery A	Recovery B	Recovery C	Recovery D	Combined
Jan					
Feb					
Mar					
Apr					
May					
Jun					
Jul					
Aug					
Sep					
Oct					
Nov					
Dec					
Totals					

Summary of 201X and 201X Empire Plan Budget Rates

201X AND 201X Budget Rates:

		201X	201X	% CHANGE
[1] Plan A	Employee	$XXX	$XXX	%
	Dependent	$XXX	$XXX	%
[2] Plan B	Employee	$XXX	$XXX	%
	Dependent	$XXX	$XXX	%
[3] Plan C	Employee	$XXX	$XXX	%
	Dependent	$XXX	$XXX	%

Projected Annual Budget:

	Enrollment	201X	201X	% CHANGE
[1] Plan A	XXX	$XXX	$XXX	%
[2] Plan B	XXX	$XXX	$XXX	%
[3] Plan C	XXX	$XXX	$XXX	%

Reserve Calculations
Regular Reserves
201X & Prior Claim Incurrals

Incurred Mo. / Yr.	(1) Contracts	(2) Paid Claims	(3) Unpaid Claims	(4) Projected Incurred Claims
January	XXX	$XXX	$XXX	$XXX
February	XXX	$XXX	$XXX	$XXX
March	XXX	$XXX	$XXX	$XXX
April	XXX	$XXX	$XXX	$XXX
May	XXX	$XXX	$XXX	$XXX
June	XXX	$XXX	$XXX	$XXX
July	XXX	$XXX	$XXX	$XXX
August	XXX	$XXX	$XXX	$XXX
September	XXX	$XXX	$XXX	$XXX
October	XXX	$XXX	$XXX	$XXX
November	XXX	$XXX	$XXX	$XXX
December	XXX	$XXX	$XXX	$XXX
201X Total		$XXX	$XXX	$XXX
January	XXX	$XXX	$XXX	$XXX
February	XXX	$XXX	$XXX	$XXX
March	XXX	$XXX	$XXX	$XXX
April	XXX	$XXX	$XXX	$XXX
May	XXX	$XXX	$XXX	$XXX
June	XXX	$XXX	$XXX	$XXX
July	XXX	$XXX	$XXX	$XXX
August	XXX	$XXX	$XXX	$XXX
September	XXX	$XXX	$XXX	$XXX
October	XXX	$XXX	$XXX	$XXX
November	XXX	$XXX	$XXX	$XXX
December	XXX	$XXX	$XXX	$XXX
201X Total		$XXX	$XXX	$XXX
January	XXX	$XXX	$XXX	$XXX
February	XXX	$XXX	$XXX	$XXX
March	XXX	$XXX	$XXX	$XXX
April	XXX	$XXX	$XXX	$XXX
May	XXX	$XXX	$XXX	$XXX
June	XXX	$XXX	$XXX	$XXX
July	XXX	$XXX	$XXX	$XXX
August	XXX	$XXX	$XXX	$XXX
September	XXX	$XXX	$XXX	$XXX
October	XXX	$XXX	$XXX	$XXX
November	XXX	$XXX	$XXX	$XXX
December	XXX	$XXX	$XXX	$XXX
201X Total		$XXX	$XXX	$XXX
Total - 201X through 201X Incurral Years:		$XXX	$XXX	$XXX
Reserve Total		$XXX	$XXX	$XXX

Reserve Calculations
Bad Debt & Charity Reserves
201X & Prior Incurrals

Incurred Mo. / Yr.	(1) Contracts	(2) Paid BDC Charges	(3) Unpaid Charges	(4) Projected Incurred BDC Charges
January	XXX	$XXX	$XXX	$XXX
February	XXX	$XXX	$XXX	$XXX
March	XXX	$XXX	$XXX	$XXX
April	XXX	$XXX	$XXX	$XXX
May	XXX	$XXX	$XXX	$XXX
June	XXX	$XXX	$XXX	$XXX
July	XXX	$XXX	$XXX	$XXX
August	XXX	$XXX	$XXX	$XXX
September	XXX	$XXX	$XXX	$XXX
October	XXX	$XXX	$XXX	$XXX
November	XXX	$XXX	$XXX	$XXX
December	XXX	$XXX	$XXX	$XXX
201X Total		$XXX	$XXX	$XXX
January	XXX	$XXX	$XXX	$XXX
February	XXX	$XXX	$XXX	$XXX
March	XXX	$XXX	$XXX	$XXX
April	XXX	$XXX	$XXX	$XXX
May	XXX	$XXX	$XXX	$XXX
June	XXX	$XXX	$XXX	$XXX
July	XXX	$XXX	$XXX	$XXX
August	XXX	$XXX	$XXX	$XXX
September	XXX	$XXX	$XXX	$XXX
October	XXX	$XXX	$XXX	$XXX
November	XXX	$XXX	$XXX	$XXX
December	XXX	$XXX	$XXX	$XXX
201X Total		$XXX	$XXX	$XXX
January	XXX	$XXX	$XXX	$XXX
February	XXX	$XXX	$XXX	$XXX
March	XXX	$XXX	$XXX	$XXX
April	XXX	$XXX	$XXX	$XXX
May	XXX	$XXX	$XXX	$XXX
June	XXX	$XXX	$XXX	$XXX
July	XXX	$XXX	$XXX	$XXX
August	XXX	$XXX	$XXX	$XXX
September	XXX	$XXX	$XXX	$XXX
October	XXX	$XXX	$XXX	$XXX
November	XXX	$XXX	$XXX	$XXX
December	XXX	$XXX	$XXX	$XXX
201X Total		$XXX	$XXX	$XXX
Total - 201X through 201X Incurral Years:		$XXX	$XXX	$XXX
Reserve Total		$XXX	$XXX	$XXX

Reserve and Paid Claims Reconciliation
201X & Prior Incurrals

Regular

Incurral Year	(A) Total Projected Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) Claims Paid in 201X	(D) Claims Paid 1/1/201X Through 01/31/201X	(E) Projected Unpaid at 1/31/201X
201X	$XXX	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX	$XXX

Bad Debt & Charity

Incurral Year	(A) Total Projected Incurred Charges	(B) Charges Paid Through 12/31/201X	(C) Charges Paid in 201X	(D) Charges Paid 1/1/201X Through 01/31/201X	(E) Projected Unpaid at 1/31/201X
201X	$XXX	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX	$XXX
	$XXX	$XXX	$XXX	$XXX	$XXX

Reserve Summary Inclusive of Bad Debt & Charity

Reserve Summary	Claims Paid 1/1/201X Through 01/31/201X	Projected Unpaid at 1/31/201X	Total 201X Reserve
Regular	$XXX	$XXX	$XXX
Bad Debt & Charity	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX

Development of Projected Budget Increase
For the Period 1/1/201x - 12/31/201x

Projected 201X Incurred Claims w/o BDC	$XXX
Projected 201X Bad Debt & Charity Charges (BDC)	$XXX
Projected 201X Incurred Claims	$XXX
Average Monthly Number of Contracts	X
Demographic Adjustment	X
Claim Payment Pattern Adjustment	X
Plan Change Adjustments	X
Annualized 201X Cost per Contract w/o BDC	$XXX
Annualized 201X Cost per Contract for BDC Charges	$XXX
Annualized 201X Proj'd. Incurred Claims	$XXX
Trend Percentage: 201X Projection	$XXX
Projected 201X Incurred Claims per Contract	$XXX
Admin Fee per Contract +Shared Communication Charges	$XXX
Fees/Assessments	$XXX
Proj'd 201X Claims & Admin. Fees + Communication Charges	$XXX

Summary of 201X and 201X Empire Plan Budget Rates

201X AND 201X Budget Rates:

		201X	201X	% CHANGE
[1] Plan A	Employee	$XXX	$XXX	%
	Dependent	$XXX	$XXX	%
[2] Plan B	Employee	$XXX	$XXX	%
	Dependent	$XXX	$XXX	%
[3] Plan C	Employee	$XXX	$XXX	%
	Dependent	$XXX	$XXX	%

Projected Annual Budget:

	Enrollment	201X	201X	% CHANGE
[1] Plan A	XXX	$XXX	$XXX	%
[2] Plan B	XXX	$XXX	$XXX	%
[3] Plan C	XXX	$XXX	$XXX	%

Reserve and Paid Claims Reconciliation - 201X

Regular

Incurral Year	(A) Projected Regular Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) 201X Paid Claims	(D) = (A) - (B) - (C) Projected Outstanding Regular Reserve at 12/31/201X
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX

Bad Debt & Charity

Incurral Year	(A) Projected BDC Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) 201X Paid Claims	(D) = (A) - (B) - (C) Projected BDC Reserve at 12/31/201X
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX

Combined

Incurral Year	(A) Total Projected Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) 201X Paid Claims	(D) = (A) - (B) - (C) Outstanding Total Reserve at 12/31/201X
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX

201X Administrative Fees

Per Contract Per Month Fee	$XXX
Total Number of Contracts	X
Administrative Charges:	$XXX
Control Plan Shared Communication Charges (Printing)	$XXX
Total Administrative Charges:	$XXX

201X Taxes and Assessment Summary

Assessment X Rate	$XXX	Per Member Per Month
Assessment X Calculation	X	Number of Members
Total Assessment X Dollars	$XXX	

Assessment X Rate	$XXX	Per Contract Per Month
Assessment X Calculation	X	Number of Contracts
Total Assessment X Dollars	$XXX	

Monthly Enrollment

Mo. / Yr.	Monthly Enrollment Employee	Family
January	X	X
February	X	X
March	X	X
April	X	X
May	X	X
June	X	X
July	X	X
August	X	X
September	X	X
October	X	X
November	X	X
December	X	X
January	X	X
February	X	X
March	X	X
April	X	X
May	X	X
June	X	X
July	X	X
August	X	X
September	X	X
October	X	X
November	X	X
December	X	X

Average Cost per Employee & Dependent

	201X Cost	Pct. Change	201X Cost	Pct. Change	201X Cost	Pct. Change
Inpatient	$XXX	%	$XXX	%	$XXX	%
Outpatient	$XXX	%	$XXX	%	$XXX	%
Professional	$XXX	%	$XXX	%	$XXX	%
Total	$XXX	%	$XXX	%	$XXX	%
Incurred Claim Cost	$XXX	%	$XXX	%	$XXX	%
Population						
Employees	X		X		X	
Dependents	X		X		X	
Total	X		X		X	

Claims per 1000 Employee and Dependent

	201X Number	Pct. Change	201X Number	Pct. Change	201X Number	Pct. Change
Inpatient	$XXX	%	$XXX	%	$XXX	%
Outpatient	$XXX	%	$XXX	%	$XXX	%
Professional	$XXX	%	$XXX	%	$XXX	%
Totals						
Population						
Employees	X		X		X	
Dependents	X		X		X	
Total	X		X		X	

Average Cost per Claim - Employee and Dependent

	201X Cost	Pct. Change	201X Cost	Pct. Change	201X Cost	Pct. Change
Inpatient						
Number of Claims	X	%	X	%	X	%
Incurred Claims	$XXX	%	$XXX	%	$XXX	%
Outpatient						
Number of Claims	X	%	X	%	X	%
Incurred Claims	$XXX	%	$XXX	%	$XXX	%
Professional						
Number of Claims	X	%	X	%	X	%
Incurred Claims	$XXX	%	$XXX	%	$XXX	%
Summary						
Total No. of Claims	X	%	X	%	X	%
Total Incurred Claims	$XXX	%	$XXX	%	$XXX	%

MHSA Annual Premium Renewal Report Sample

200X Incurred Claims Development
Claims Paid Through XXX
Regular

	Incurred Month													
Month Paid	January	February	March	April	May	June	July	August	September	October	November	December	**Total By Month Paid**	**Accumulative Total**
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
Total														
Completion Factor														
Incurred														

MHSA Annual Premium Renewal Report Sample

200X Incurred Claims Development
Claims Paid Through XXX
BDC

	Incurred Month													
Month Paid	January	February	March	April	May	June	July	August	September	October	November	December	**Total By Month Paid**	**Accumulative Total**
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
Total														
Completion Factor														
Incurred														

EMPIRE BLUECROSS BLUESHIELD

MHSA Annual Premium Renewal Report Sample

Amount of Claims Incurred Through XXX and Paid Through XXX - Monthly

Incurred Mo. / Yr.	Outpatient	Inpatient	Professional	Total
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				

MHSA Annual Premium Renewal Report Sample

Amount of BDC Incurred Through X/XX/20XX - Monthly

Incurred Mo. / Yr.	Outpatient	Inpatient	Professional	Total
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				

MHSA Annual Premium Renewal Report Sample

Number of Claims Incurred Through X/XX/20XX and Paid Through X/XX/20XX - Monthly

Incurred Mo. / Yr.	Outpatient	Inpatient	Professional	Total
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				

Development of Projected Incurred Claims (Inclusive of BDC) - 201X

Month of Incurral	PROJECTED 201X CLAIMS EXCL. BAD DEBT	BAD DEBT & CHARITY	PROJECTED 201X CLAIMS INCL. BAD DEBT	PROJECTED 201X CLAIMS EXCL. BAD DEBT	BAD DEBT & CHARITY	PROJECTED 201X CLAIMS INCL. BAD DEBT
JAN	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
FEB	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
MAR	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
SUB-TOTAL	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
APR	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
MAY	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
JUN	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
SUB-TOTAL	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
JUL	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
AUG	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
SEP	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
SUB-TOTAL	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
OCT	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
NOV	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
DEC	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX
SUB-TOTAL	$XXX	$XXX	$XXX	$XXX	$XXX	$XXX

Top Ten Health Conditions By Relationship and PMPM

Health Conditions	Subscriber /Self		Spouse /Partner		Child /Dependent		Total Plan Top Ten		
	Paid Amount	PMPM	Paid Amount	PMPM	Paid Amount	PMPM	Paid Amount	PMPM	Trend
Supplemental	$10,692,910	$33.94	$7,158,037	$36.06	$10,087,990	$38.77	$27,939,352	$36.11	9.3%
Musculoskeletal	$14,146,166	$44.91	$9,814,079	$49.44	$3,572,037	$13.73	$27,532,264	$35.58	-3.8%
Neoplasms	$9,578,069	$30.41	$6,794,824	$34.23	$1,581,992	$6.08	$17,954,829	$23.21	-4.5%
Ill-Defined	$6,911,105	$21.94	$5,277,808	$26.59	$3,823,600	$14.69	$16,012,514	$20.70	-0.4%
Injury and Poisoning	$5,838,489	$18.53	$3,495,060	$17.61	$3,828,606	$14.71	$13,162,154	$17.01	10.0%
Digestive System	$6,308,024	$20.03	$4,125,077	$20.78	$2,483,666	$9.54	$12,916,767	$16.69	10.3%
Circulatory System	$7,299,940	$23.17	$5,150,335	$25.95	$415,344	$1.60	$12,865,619	$16.63	6.2%
Mental Disorders	$2,753,182	$8.74	$1,597,636	$8.05	$6,353,012	$24.41	$10,703,830	$13.83	16.2%
Nervous System	$4,445,973	$14.11	$2,668,829	$13.45	$2,868,919	$11.03	$9,983,446	$12.90	-2.7%
Genitourinary System	$4,597,740	$14.60	$3,832,287	$19.31	$1,159,561	$4.46	$9,589,588	$12.39	-2.7%
Subtotal	**$72,571,597**	**$230.38**	**$49,913,971**	**$251.46**	**$36,174,727**	**$139.02**	**$158,660,361**	**$205.06**	**2.9%**

☼ Highlights:

The health conditions show a declining PMPM trend compared to the prior 12 month period

The Subscriber is responsible for 43.4% of spend; the Spouse is responsible for 32.5% and the Child 24.1%

- The Spouse PMPM is higher than the Subscriber, consistent with what we see across the Anthem Book of Business

Trends/Patterns:

- Injury & Poisoning, Digestive System and Mental Disorders showed the most significant increase in PMPM
- *The Child/Dependent is identified as a key driver of the behavioral health trend of 16.2% accounting for 59.4% of total dollars paid for the category of "Mental Disorders"*

Behavioral Health: Total Plan

PMPM	2012	2011	2010	PMPM Variance	Ref. Pop.
Total Plan	$13.83	$11.90	$10.12	16.2%	
Total Actives	$16.34	$13.95	$11.47	17.1%	$20.33
Total Retirees	$5.72	$5.53	$5.82	3.4%	$9.54

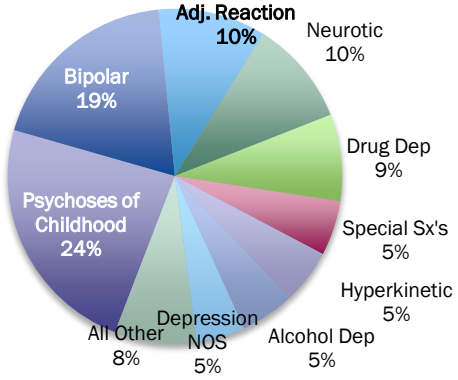
☼ Highlight(s):

- Behavioral Health Planed for 5.4% of Total Medical spend ($10,703,830)
- Inpatient Planed for 15.4% of Behavioral Health Spend
- Psychiatric treatment Planed for 86.4% of the total Behavioral Health spend, a 14.2% increase from 2011
- Substance abuse treatment Planed for 13.6% of total Behavioral Health spend, a 38.8% increase from 2011

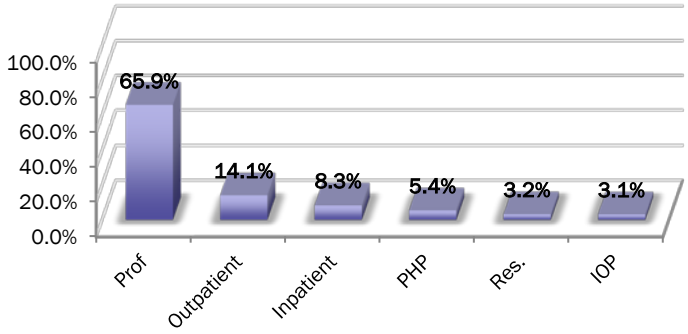
Trends/Patterns:

- The Child Plans for 59.4% of spend; Spouse 14.9% and the Subscriber 25.7%
- The Average Cost Per Claimant was $1,258, a 13.4% increase from $1,109 in 2011.
  - *Bipolar disorder average cost/claimant: $1,115*
  - *Childhood psychotic disorders average cost/claimant: $14,192*
  - *Drug Dependence average cost/claimant: $7,831*
  - *Alcohol Dependence average cost/claimant: $6,495*
- *Drug Dependence PMPM increased 56.1% and Alcohol Dependence increased 43.2% (while the actual dollar values are low we anticipate this trend to continue)*

Percent of Spend By Relationship



Percent By Utilization in a Facility Setting



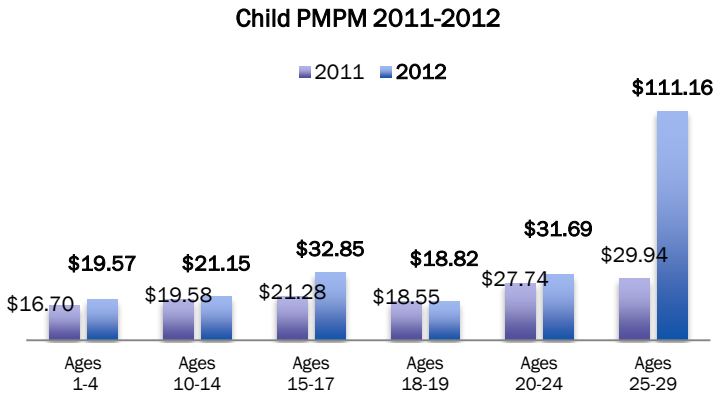
Behavioral Health Top Ten Diagnoses

Major Diagnosis	Paid Amount		Unique Claimants		Paid Amount PMPM		
	Total Paid	Percent Total	Unique Claimants	Paid Amount Per Claimant	Current	Prior	Trend
Psychoses of Childhood	$2,526,147	23.6%	178	$14,192	$3.26	$2.45	33.5%
Affective Psychoses	$2,036,329	19.0%	1,827	$1,115	$2.63	$2.67	-1.3%
Adjustment Reaction	$1,114,414	10.4%	1,954	$570	$1.44	$1.43	1.0%
Neurotic Disorders	$1,093,540	10.2%	2,490	$439	$1.41	$1.38	2.1%
Drug Dependence	$900,515	8.4%	115	$7,831	$1.16	$0.75	56.1%
Special Symptom NEC	$564,661	5.3%	292	$1,934	$0.73	$0.59	23.1%
Hyperkinetic Syndrome	$563,274	5.3%	1,586	$355	$0.73	$0.59	22.7%
Alcohol Dependence Syndr	$552,115	5.2%	85	$6,495	$0.71	$0.50	43.2%
Depressive Disorder NEC	$498,454	4.7%	1,284	$388	$0.64	$0.53	21.0%
Specific Develop Delays	$200,622	1.9%	182	$1,102	$0.26	$0.26	1.1%
All Other Behavioral Health	$653,757	6.1%	748	$874	$0.84	$0.76	10.9%
Total	**$10,703,830**	**100.0%**	**8,507**	**$1,258**	**$13.83**	**$11.90**	**16.2%**

☼ Highlight(s):

The PMPM trend increase of 16.2% is driven by Psychoses of Childhood and Drug Dependence

- *The **Psychoses of Childhood** category includes schizophrenia, autism, and other psychotic disorders.*
  - *For the age band of 1-19 years old, the PMPM increased 20.3% while the prevalence /1000 increased 6.5%.*
  - *For the age band 19+, the PMPM increased 38.9%, and the prevalence/1000 increased 5.0%*
- ***Drug and Alcohol Dependence** is driven by young adults. The actual number of unique members are 115 and 85 respectively*



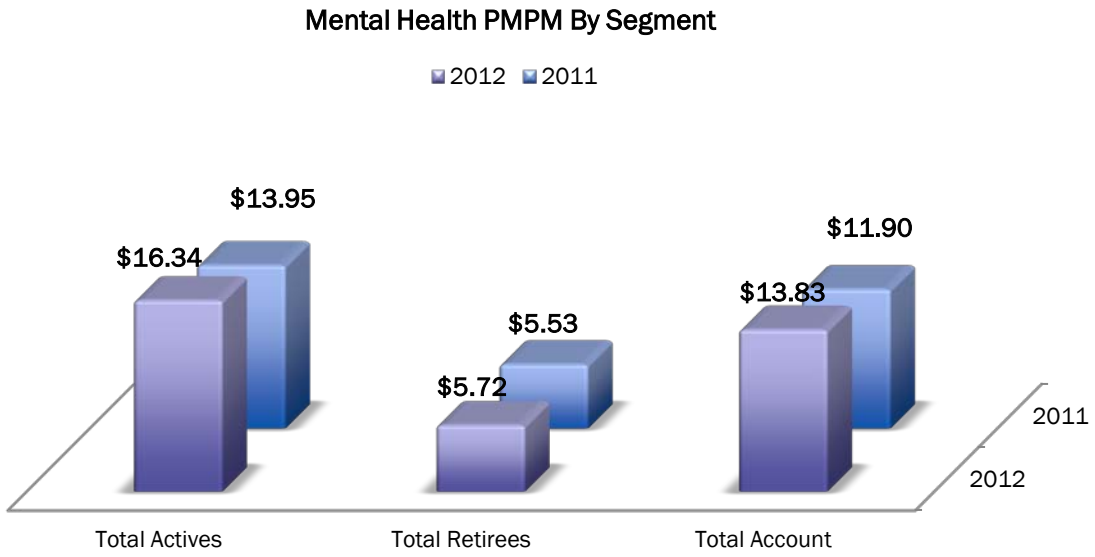
Behavioral Health PMPM

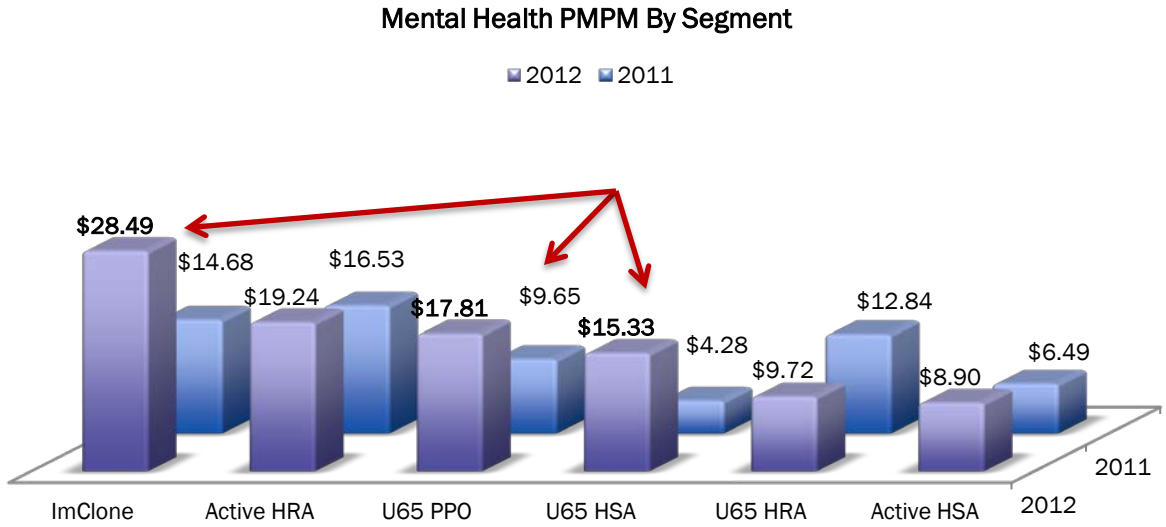
☼ Highlight(s):

Each segment showed a PMPM increase compared to 2011. The U65 HSA population had the highest PMPM increase at 258.2% due to an Alcohol related admission and an increase in Neurotic Disorders in the Outpatient and Professional settings

Trends/Patterns:

- Total Plan PMPM increased 16.2%
- Total Actives PMPM increased 17.1%
- *Total ImClone PMPM increased 94.1%*
- *Under 65 PPO PMPM increased 85.6%*
- *U65 HSA PMPM increased 258.2%*





Behavioral Health By Segment

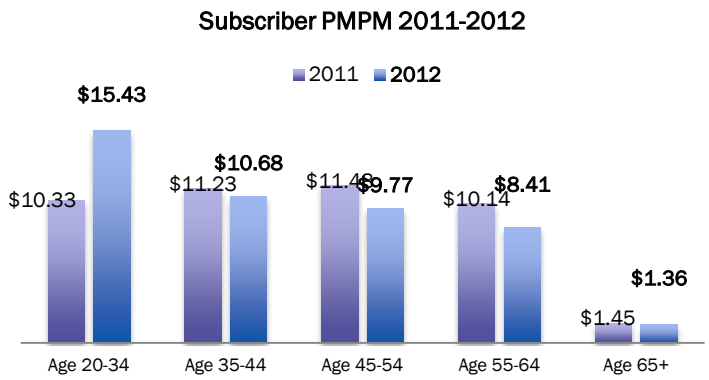
Major Diagnosis	Lilly Paid Amount PMPM					
	Active HRA	Active HSA	ImClone	U65 HRA	U65 HSA	U65 PPO
Schizophrenia	--	--	$9.71			
Psychoses of Childhood	$5.10	$2.12	--	--	$	$
Affective Psychoses	$3.65	$1.15	$1.33	$2.57	$2.16	$4.39
Adjustment Reaction	$2.12	$0.66	$0.89	$1.59	$0.39	$1.37
Neurotic Disorders	$2.04	$0.75	$6.73	$1.47	$2.63	$1.21
Drug Dependence	$1.19	$1.10	$0.00	$0.99	$	$6.30
Special Symptom NEC	$1.24	--	$0.11	$	$	$0.53
Hyperkinetic Syndrome	$1.07	$0.43	$0.00	$0.29	$0.04	$0.76
Alcohol Dependence / Psychoses	$0.46	$1.79	$9.01	$1.41	$9.14	$1.89
Depressive Disorder NEC	$0.88	$0.43	$0.78	$0.68	$0.16	$0.63
Specific Develop Delays	$0.39	$0.20	--	--	$	--
All Other Behavioral Health	$1.11	$0.74	$0.00	$0.21	$0.00	$0.49
Total	**$19.24**	**$8.90**	**$28.49**	**$9.72**	**$15.33**	**$17.81**

☼ Highlight(s):

Subscribers Plan for 25.7% of Behavioral Health spend.

Treatment Setting Highlights

- 66.8% of Behavioral Health dollars are spent in the Professional Setting and 15.4% at the Inpatient Setting
- The Outpatient Setting is the both the appropriate and primary location for Alcohol and Drug dependence treatment



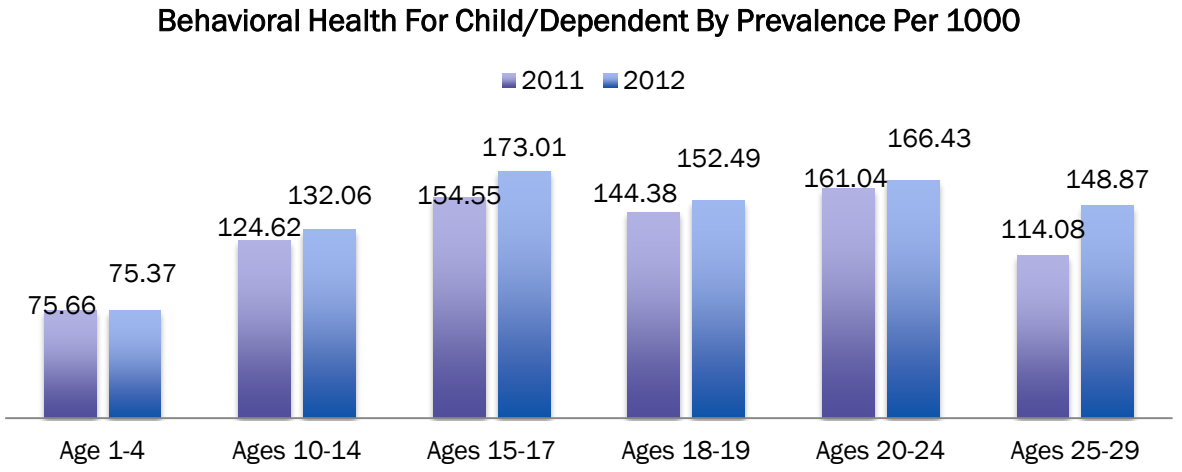
Behavioral Health Overview By Child/Dependent

☼ Highlight(s):

The Prevalence per 1000 trend for the Child /Dependent increased 30.5% for the 25-29 age band

Trends/Patterns:

- The primary driver of cost for this age band has been bipolar, schizophrenia, alcohol and drug dependence

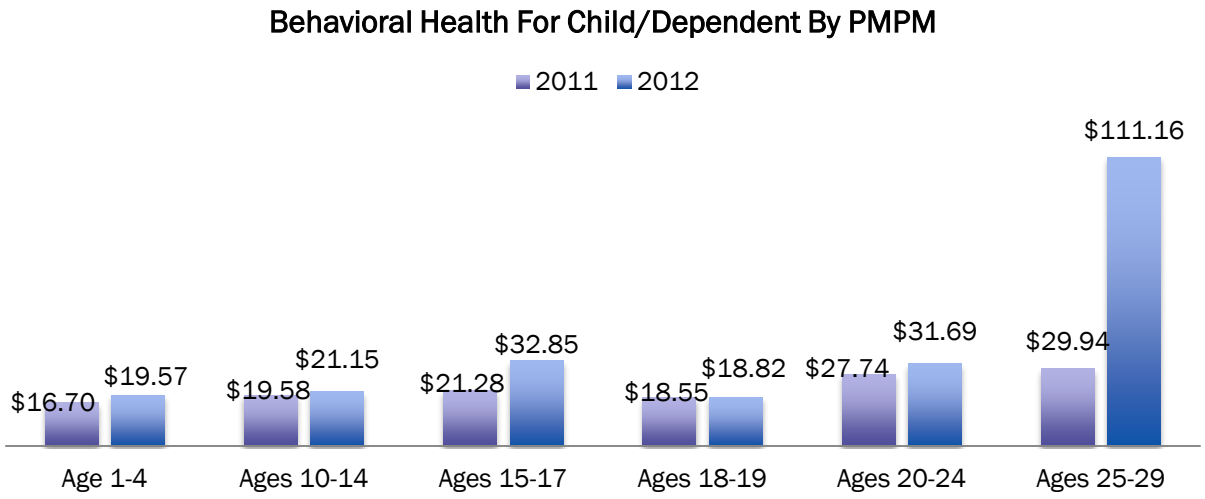


☼ Highlight(s):

The PMPM trend for the Child /Dependent for the age band 25+ increased 271.3% from the prior 12 months

Trends/Patterns:

- High cost claimants, and treatment settings play a key role in the trends



Experience of Current Quarter and Year-to-Date 201X

	(1) Estimated YTD Prior Quarterly Report	(2) Revised Estimated YTD Thru Prior Quarter	(3) Estimated Experience Current Quarter	(4) Estimated YTD Experience
Budget	$XXX	$XXX	$XXX	$XXX
Paid Claims	$XXX	$XXX	$XXX	$XXX
Bad Debt & Charity (BDC)	$XXX	$XXX	$XXX	$XXX
Liability for Outstanding Claims at End of Reporting Period	$XXX	$XXX	$XXX	$XXX
Liability for Outstanding Claims at Beginning of Reporting Period	$XXX	$XXX	$XXX	$XXX
Incurred Claims	$XXX	$XXX	$XXX	$XXX
Total Incurred Claim Cost	$XXX	$XXX	$XXX	$XXX
Administrative Fees	$XXX	$XXX	$XXX	$XXX
Taxes/Assessments	$XXX	$XXX	$XXX	$XXX
Total Retention	$XXX	$XXX	$XXX	$XXX
Total Premium Budget	$XXX	$XXX	$XXX	$XXX

201X Projected Experience

	(1) Projected Budget at Time of Budget Establishment	(2) 1st Quarter Report	(3) 2nd Quarter Report	(4) 3rd Quarter Report	(5) 4th Quarter Report
Budget Premium	$XXX	$XXX	$XXX	$XXX	$XXX
Paid Claims	$XXX	$XXX	$XXX	$XXX	$XXX
Bad Debt & Charity (BDC)	$XXX	$XXX	$XXX	$XXX	$XXX
Liability for Outstanding Claims at End of Reporting Period	$XXX	$XXX	$XXX	$XXX	$XXX
Liability for Outstanding Claims at Beginning of Reporting Period	$XXX	$XXX	$XXX	$XXX	$XXX
Incurred Claims	$XXX	$XXX	$XXX	$XXX	$XXX
Total Incurred Claim Cost	$XXX	$XXX	$XXX	$XXX	$XXX
Administrative Fee	$XXX	$XXX	$XXX	$XXX	$XXX
Taxes/Assessments	$XXX	$XXX	$XXX	$XXX	$XXX
Total Retention	$XXX	$XXX	$XXX	$XXX	$XXX
Total Premium Budget	$XXX	$XXX	$XXX	$XXX	$XXX

Development of Projected Budget Increase
For the Period 1/1/201x - 12/31/201x

	Optimistic Assumptions	Best Estimate Assumptions	Pessimistic Assumptions
Projected 201X Incurred Claims w/o BDC	$XXX	$XXX	$XXX
Projected 201X Bad Debt & Charity Charges (BDC)	$XXX	$XXX	$XXX
Projected 201X Incurred Claims	$XXX	$XXX	$XXX
Average Monthly Number of Contracts	X	X	X
Demographic Adjustment	X	X	X
Claim Payment Pattern Adjustment	X	X	X
Plan Change Adjustments	X	X	X
Annualized 201X Cost per Contract w/o BDC	$XXX	$XXX	$XXX
Annualized 201X Cost per Contract for BDC Charges	$XXX	$XXX	$XXX
Annualized 201X Proj'd. Incurred Claims	$XXX	$XXX	$XXX
Trend Percentage: 201X Projection	$XXX	$XXX	$XXX
Projected 201X Incurred Claims per Contract	$XXX	$XXX	$XXX
Admin Fee per Contract +Shared Communication Charges	$XXX	$XXX	$XXX
Fees/Assessments	$XXX	$XXX	$XXX
Proj'd 201X Claims & Admin. Fees + Communication Charges	$XXX	$XXX	$XXX

MHSA Quarterly Financial Summary Report Sample

Monthly Budget Premium Rate Projections - "201x Compared to "201x Budget Rates

	Plan A 201X Budget Rates		Plan B 201X Budget Rates		Plan C 201X Budget Rates	
Individual:						
Dep:						

	1st Qtr. 201X Report 201X Budget Rates			2nd Qtr. 201X Report 201X Budget Rates			3rd Qtr. 201X Report 201X Budget Rates			4th Qtr. 201X Report 201X Budget Rates		
	201X Budget Rates		% Change over 201X	201X Budget Rates		% Change over 201X	201X Budget Rates		% Change over 201X	201X Budget Rates		% Change over 201X
	Individual	Dep		Individual	Dep		Individual	Dep		Individual	Dep	
Plan A												
Realistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Pessimistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Optimistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Plan B												
Realistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Pessimistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Optimistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Plan C												
Realistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Pessimistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%
Optimistic:	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%	$XXX	$XXX	%

MHSA Quarterly Financial Summary Report Sample

Reserve and Paid Claims Reconciliation - 201X

Regular

Incurral Year	(A) Projected Regular Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) 201X Paid Claims	(D) = (A) - (B) - (C) Projected Outstanding Regular Reserve at 12/31/201X
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX

Bad Debt & Charity

Incurral Year	(A) Projected BDC Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) 201X Paid Claims	(D) = (A) - (B) - (C) Projected BDC Reserve at 12/31/201X
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX

Combined

Incurral Year	(A) Total Projected Incurred Claims	(B) Claims Paid Through 12/31/201X	(C) 201X Paid Claims	(D) = (A) - (B) - (C) Outstanding Total Reserve at 12/31/201X
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
201X	$XXX	$XXX	$XXX	$XXX
Total	$XXX	$XXX	$XXX	$XXX

Reserve Summary Inclusive of Bad Debt & Charity
Incurred but Unpaid Claims - @ 12/31/201X
Incurred but Unpaid Bad Debt & Charity Charges @ 12/31/201X
Projected Reserve at 12/31/201X:

Recovery Summary

	Recovery A	Recovery B	Recovery C	Recovery D	Combined
Jan					
Feb					
Mar					
Apr					
May					
Jun					
Jul					
Aug					
Sep					
Oct					
Nov					
Dec					
Totals					

201X Administrative Fees

Per Contract Per Month Rate	$XXX
Total Number of Contracts	X
Administrative Charges:	$XXX
Control Plan Shared Communication Charges (Printing)	$XXX
Total Administrative Charges:	

201X Taxes and Assessment Summary

Assessment X Rate	$XXX	Per Member Per Month
Assessment X Calculation	X	Number of Members
Total Assessment X Dollars	$XXX	

Assessment X Rate	$XXX	Per Contract Per Month
Assessment X Calculation	X	Number of Contracts
Total Assessment X Dollars	$XXX	

Average Cost per Employee & Dependent Units Combined

	201X Cost	Pct. Change	201X Cost	Pct. Change	201X Cost	Pct. Change
Inpatient	$XXX	%	$XXX	%	$XXX	%
Outpatient	$XXX	%	$XXX	%	$XXX	%
Professional	$XXX	%	$XXX	%	$XXX	%
Total	$XXX	%	$XXX	%	$XXX	%
Incurred Claim Cost	$XXX	%	$XXX	%	$XXX	%
Population						
Employees	X		X		X	
Dependents	X		X		X	
Total	X		X		X	

Claims per 1000 Employee and Dependent Units Combined

	201X Number	Pct. Change	201X Number	Pct. Change	201X Number	Pct. Change
Inpatient	$XXX	%	$XXX	%	$XXX	%
Outpatient	$XXX	%	$XXX	%	$XXX	%
Professional	$XXX	%	$XXX	%	$XXX	%
Totals						
Population						
Employees	X		X		X	
Dependent	X		X		X	
Total	X		X		X	

Average Cost per Claim - Employee and Dependent Units Combined

	201X Cost	Pct. Change	201X Cost	Pct. Change	201X Cost	Pct. Change
Inpatient						
Number of Claims	X	%	X	%	X	%
Incurred Claims	$XXX	%	$XXX	%	$XXX	%
Outpatient						
Number of Claims	X	%	X	%	X	%
Incurred Claims	$XXX	%	$XXX	%	$XXX	%
Professional						
Number of Claims	X	%	X	%	X	%
Incurred Claims	$XXX	%	$XXX	%	$XXX	%
Summary						
Total No. of Claims	X	%	X	%	X	%
Total Incurred Claims	$XXX	%	$XXX	%	$XXX	%

NUMBER OF CONTRACTS

Mo. / Yr.	Employee	Dependents	Mo. / Yr.	Employee	Dependents
January	X	X	January	X	X
February	X	X	February	X	X
March	X	X	March	X	X
April	X	X	April	X	X
May	X	X	May	X	X
June	X	X	June	X	X
July	X	X	July	X	X
August	X	X	August	X	X
September	X	X	September	X	X
October	X	X	October	X	X
November	X	X	November	X	X
December	X	X	December	X	X
January	X	X	January	X	X
February	X	X	February	X	X
March	X	X	March	X	X
April	X	X	April	X	X
May	X	X	May	X	X
June	X	X	June	X	X
July	X	X	July	X	X
August	X	X	August	X	X
September	X	X	September	X	X
October	X	X	October	X	X
November	X	X	November	X	X
December	X	X	December	X	X

200X Incurred Claims Development
Claims Paid Through XXX
Regular

Month Paid	Incurred Month: January	February	March	April	May	June	July	August	September	October	November	December	Total By Month Paid	Accumulative Total
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
Total														
Completion Factor														
Incurred														

200X Incurred Claims Development
Claims Paid Through XXX
BDC

Month Paid	Incurred Month: January	February	March	April	May	June	July	August	September	October	November	December	Total By Month Paid	Accumulative Total
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
January														
February														
March														
April														
May														
June														
July														
August														
September														
October														
November														
December														
Total														
Completion Factor														
Incurred														

Empire BlueCross BlueShield

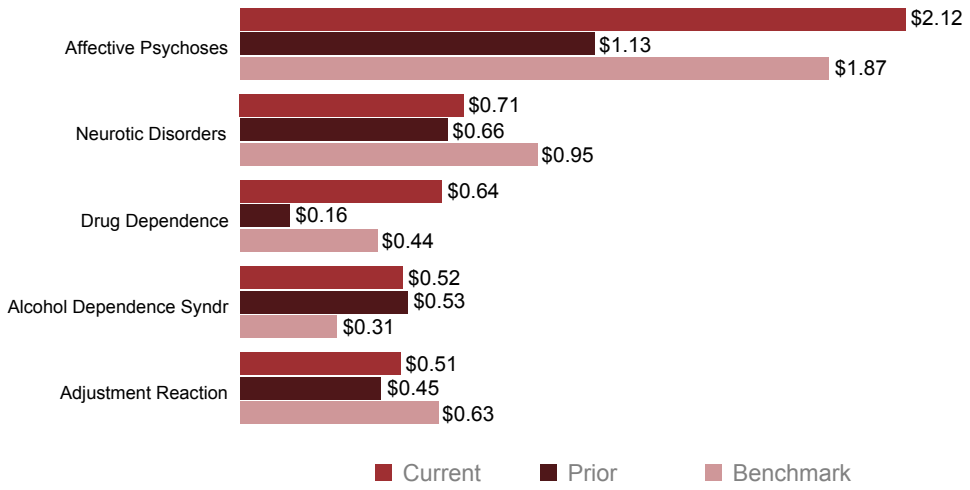
Current Period (CP): Oct 2011 - Sep 2012
Prior Period (PP): Oct 2010 - Sep 2011

BEHAVIORAL HEALTH TOP TEN MAJOR DIAGNOSES BY PAID AMOUNT

	Paid Amount by Setting					Unique Claimants		Paid Amount PMPM				
Major Diagnosis	Inpatient Facility	Outpatient Facility	Professional	Total Paid	Percent Total	Unique Claimants	Paid Amount Per Claimant	Current	Prior	Trend	Benchmark	Variance to Benchmark
Affective Psychoses	$535,010	$118,876	$280,391	$934,277	34.2%	678	$1,378	$2.12	$1.13	87.8%	$1.87	13.1%
Neurotic Disorders	$32,069	$36,155	$246,410	$314,634	11.5%	1,069	$294	$0.71	$0.66	8.1%	$0.95	-24.7%
Drug Dependence	$71,019	$151,148	$60,289	$282,455	10.3%	86	$3,284	$0.64	$0.16	306.0%	$0.44	46.4%
Alcohol Dependence Syndr	$135,186	$67,305	$25,565	$228,055	8.3%	52	$4,386	$0.52	$0.53	-2.8%	$0.31	67.8%
Adjustment Reaction	$24,813	$11,889	$188,735	$225,438	8.2%	532	$424	$0.51	$0.45	14.0%	$0.63	-19.0%
Depressive Disorder NEC	$47,755	$12,863	$96,079	$156,698	5.7%	558	$281	$0.35	$0.36	-0.3%	$0.36	-2.7%
Hyperkinetic Syndrome	$4,056	$8,153	$119,912	$132,121	4.8%	577	$229	$0.30	$0.35	-15.3%	$0.28	5.3%
Special Symptom NEC	$67,159	$11,907	$19,224	$98,289	3.6%	125	$786	$0.22	$0.10	120.8%	$0.23	-3.5%
Oth Nonorganic Psychoses	$50,525	$4,485	$14,243	$69,253	2.5%	44	$1,574	$0.16	$0.08	102.7%	$0.13	18.7%
Psychoses of Childhood	$4,234	$9,913	$34,991	$49,137	1.8%	38	$1,293	$0.11	$0.09	17.7%	$0.27	-58.8%
All Other Behavioral Health	$84,857	$52,017	$107,679	$244,553	8.9%	264	$926	$0.55	$0.72	-23.6%	$0.95	-41.9%
Total	**$1,056,683**	**$484,711**	**$1,193,517**	**$2,734,910**	**100.0%**	**3,296**	**$830**	**$6.19**	**$4.63**	**33.8%**	**$6.43**	**-3.6%**

Quality Measure	Percentage
Percent of depressive neuroses or psychoses discharges for which a follow-up outpatient visit took place within 30 days.	69.6%

Top Five PMPM Comparison to Benchmark



Monthly Activity Report
2010

Behavioral Health-EAP Complete	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD
Total Eligible Membership																	
Behavioral Health: Resource Center																	
Total Inbound Calls																	
Average Speed of Answer (Seconds)																	
Abandonment Rate																	
Depression Condition Care (Referrals, Contacts & Engagement)																	
Total Referrals Inbound																	
MyHealth Coach																	
Medical Disease Management																	
Behavioral Health: Resource Center																	
Medical Complex Care																	
Future Moms																	
Utilization Management																	
Anthem Care Management: Transplant																	
Outbound Calls																	
Total Initial Outreach Contacts - Successful																	
Total Initial Outreach Contacts - Pending																	
Total Initial Outreach - Unable to Contact																	
Total Members - Successfully Engaged																	
Member Engagement Percentage																	
Member Withdrawals - Program Incomplete																	
Members - Program Complete																	
ADHD Condition Care																	
Total Referrals Inbound																	
Utilization Management																	
MyHealth Coach																	
Behavioral Health: Resource Center																	
Medical Disease Management																	
Medical Complex Care																	
Future Moms																	
Behavioral Health: Health Coach																	
Behavioral Health: Predictive Modeling																	
Anthem EAP																	
Outbound Calls																	
Total Initial Outreach Contacts - Successful																	
Total Initial Outreach Contacts - Pending																	
Total Initial Outreach - Unable to Contact																	
Total Members - Successfully Engaged																	
Member Engagement Percentage																	
Member Withdrawals - Program Incomplete																	
Members - Program Complete																	

Monthly Activity Report

2010

Behavioral Health-EAP Complete	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD
Eating Disorder Condition Care																	
Total Referrals Inbound																	
Utilization Management																	
Behavioral Health: Resource Center																	
Behavioral Health: Predictive Modeling																	
MyHealth Coach																	
Medical Complex Care																	
Medical Disease Management																	
Behavioral Health: Health Coach																	
Future Moms																	
Condition Care: Depression																	
Anthem EAP																	
Outbound Calls																	
Total Initial Outreach Contacts - Successful																	
Total Initial Outreach Contacts - Pending																	
Total Initial Outreach - Unable to Contact																	
Total Members - Successfully Engaged																	
Member Engagement Percentage																	
Member Withdrawals - Program Incomplete																	
Members - Program Complete																	
BH Care Management																	
Total Referrals Inbound																	
Utilization Management																	
Behavioral Health: Resource Center																	
Behavioral Health: Predictive Modeling																	
MyHealth Coach																	
Medical Disease Management																	
Medical Complex Care																	
Pharmacy Benefit Management																	
Behavioral Health: Health Coach																	
Outbound Calls																	
Total Initial Outreach Contacts - Successful																	
Total Initial Outreach Contacts - Pending																	
Total Initial Outreach - Unable to Contact																	
Total Members - Successfully Engaged																	
Member Engagement Percentage																	
Member Withdrawals - Program Incomplete																	
Members - Program Complete																	

Empire BlueCross BlueShield

Current Period (CP): Oct 2011 - Sep 2012
Prior Period (PP): Oct 2010 - Sep 2011

BEHAVIORAL HEALTH UTILIZATION

Product: Behavioral Health

	Current	Prior
Membership		
Average Subscribers	12,175	11,899
Average Members	26,316	25,412

	Mental Health					Substance Abuse				
	Current	Prior	Trend	Benchmark	Percent Variance	Current	Prior	Trend	Benchmark	Percent Variance
Facility Services										
Inpatient Acute										
Claimants	75	63				22	20			
Days	728	661				383	1,530			
Paid Amount	$531,417	$263,213				$126,425	$91,169			
Claimants per 1000	1.7	1.5	16.7%	1.3	30.5%	0.5	0.5	7.8%	0.3	47.2%
Annual Days per 1000	19.8	18.9	4.8%	19.1	3.3%	10.4	43.7	-76.2%	10.6	-2.2%
Paid Amount per Claimant	$7,086	$4,178	69.6%	$5,380	31.7%	$5,747	$4,558	26.1%	$3,962	45.0%
Paid Amount per Day	$730	$398	83.3%	$512	42.6%	$330	$60	454.0%	$177	87.0%
Paid Amount PMPM	$1.20	$0.63	92.2%	$0.82	47.3%	$0.29	$0.22	32.0%	$0.16	82.9%
Residential Treatment										
Claimants	5					4	2			
Days	460					112	111			
Paid Amount	$105,379					$21,247	$19,350			
Claimants per 1000	0.1			0.0	468.0%	0.1	0.0	96.0%	0.0	117.0%
Annual Days per 1000	12.5			5.5	125.7%	3.0	3.2	-4.0%	7.3	-58.5%
Paid Amount per Claimant	$21,076			$18,007	17.0%	$5,312	$9,675	-45.1%	$6,415	-17.2%
Paid Amount per Day	$229			$91	152.4%	$190	$174	8.8%	$51	271.0%
Paid Amount PMPM	$0.24			$0.04	469.6%	$0.05	$0.05	4.5%	$0.03	53.9%
Partial Hospital Program										
Claimants	12	11				20	17			

BEHAVIORAL HEALTH UTILIZATION

Product: Behavioral Health

	Mental Health					Substance Abuse				
	Current	Prior	Trend	Benchmark	Percent Variance	Current	Prior	Trend	Benchmark	Percent Variance
Visits	39	23				116	38			
Visits per 1000	1.1	0.7	61.4%	1.1	-2.1%	3.2	1.1	190.5%	1.5	111.1%
Visits per Claimant	3	2	55.4%	3	15.2%	6	2	159.5%	3	67.1%
Paid Amount	$38,546	$26,008				$89,423	$59,287			
Paid Amount per Visit	$988	$1,131	-12.6%	$1,671	-40.9%	$771	$1,560	-50.6%	$1,315	-41.4%
Paid Amount PMPM	$0.09	$0.06	41.1%	$0.15	-42.1%	$0.20	$0.14	43.6%	$0.16	22.8%
Intensive Outpatient Program										
Claimants	12	10				19	15			
Visits	38	49				56	60			
Visits per 1000	1.0	1.4	-26.2%	1.0	0.6%	1.5	1.7	-11.2%	1.8	-17.0%
Visits per Claimant	3	5	-35.4%	3	-7.3%	3	4	-26.3%	4	-23.9%
Paid Amount	$42,231	$26,269				$90,226	$38,309			
Paid Amount per Visit	$1,111	$536	107.3%	$815	36.4%	$1,611	$638	152.3%	$852	89.1%
Paid Amount PMPM	$0.10	$0.06	53.0%	$0.07	37.2%	$0.20	$0.09	124.2%	$0.13	56.9%
Professional Services										
Professional - Inpatient										
Claimants	120	82				26	22			
Visits	705	450				176	115			
Visits per 1000	19.2	12.8	49.1%	25.6	-25.2%	4.8	3.3	45.7%	3.1	53.8%
Visits per Claimant	6	5	7.1%	5	11.1%	7	5	29.5%	4	57.5%
Paid Amount	$71,577	$42,455				$18,550	$9,878			
Paid Amount per Visit	$102	$94	7.6%	$62	62.7%	$105	$86	22.7%	$91	16.2%
Paid Amount PMPM	$0.16	$0.10	60.5%	$0.13	21.7%	$0.04	$0.02	78.7%	$0.02	78.7%
Professional - Outpatient										
Claimants	3,032	2,855				218	191			
Penetration	8.2%	8.1%	1.1%	8.6%	-4.4%	0.6%	0.5%	8.6%	0.6%	-4.4%
Visits	16,761	15,993				979	805			

BEHAVIORAL HEALTH UTILIZATION

Product: Behavioral Health

	Mental Health					Substance Abuse				
	Current	Prior	Trend	Benchmark	Percent Variance	Current	Prior	Trend	Benchmark	Percent Variance
Visits per 1000	455.3	456.5	-0.3%	523.5	-13.0%	26.6	23.0	15.8%	24.6	8.1%
Visits per Claimant	6	6	-1.3%	6	-9.0%	4	4	6.6%	4	13.0%
Paid Amount	$1,005,748	$935,446				$93,593	$70,576			
Paid Amount per Visit	$60	$58	2.6%	$73	-17.6%	$96	$88	9.0%	$98	-2.7%
Paid Amount PMPM	$2.28	$2.23	2.3%	$3.18	-28.3%	$0.21	$0.17	26.2%	$0.20	5.2%
All Services Combined										
Paid Amount	$1,794,897	$1,293,391				$439,464	$288,569			
Paid Amount PEPM	$9.10	$6.81	33.6%	$8.43	7.9%	$2.23	$1.52	46.6%	$1.36	63.9%
Paid Amount PMPM	$4.06	$3.08	32.1%	$4.39	-7.4%	$0.99	$0.69	44.9%	$0.71	40.6%

The Empire Plan Mental Health and Substance Abuse Program Coordination of Benefits Savings Report

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
							COB Savings				
	Total # Claims	Covered Charges	Actual Liability if Primary	Workers' Compensation	No Fault	Commercial	Medicare	Blue Cross	Non-Solicited Subrogation	Savings * (Columns 4 through 9)	Actual Payment (Column 3 less 10)
Jan-12	3,150	$ 25,842,727	$ 25,761,012	$ 28,424	$ 55,078	$ 518,907	$ 24,136,319	$ 218,229	$ -	24,956,958	$ 804,055
Feb-12											
Mar-12											
Apr-12											
May-12											
Jun-12											
Jul-12											
Aug-12											
Sep-12											
Oct-12											
Nov-12											
Dec-12											
Totals	3,150	$ 25,842,727	$ 25,761,012	$ 28,424	$ 55,078	$ 518,907	$ 24,136,319	$ 218,229	$ -	$ 24,956,958	$ 804,055

State of New York
Mental Health and Substance Abuse Program
Quarterly Participating Agency Claim Report
First Quarter 2012

QTR PD	YR INC	AGNCY CD	COV	TYPE	EESV NOMED	EEPD NOMED	EESV MED	EEPD MED	SPSV NOMED	SPPD NOMED	SPSV MED	SPPD MED	DEPSV NOMED	DEPPD NOMED	DEPSV MED	DEPPD MED	TOTSV NOMED	TOTPD NOMED	TOTSV MED	TOT PD MED	TOTSV ALL	TOT PD ALL
D12	02	003214	02	O																		
D12	12	003527	02	I																		
D12	12	003527	02	O																		
D12	12	003589	01	O																		
D12	12	003944	02	O																		
D12	12	003947	01	I																		
D12	12	003947	01	O																		
D12	12	003947	02	I																		
D12	12	003947	02	O																		
D12	12	003958	02	I																		
D12	12	003958	02	O																		
D12	12	003959	01	I																		
D12	12	003959	01	O																		
D12	12	003959	02	I																		
D12	12	003959	02	O																		
D12	12	003960	01	O																		
D12	12	003960	02	I																		
D12	12	003960	02	O																		
D12	12	003961	02	I																		
D12	12	006216	02	O																		
D12	12	006244	02	O																		
D12	12	006256	01	I																		
D12	12	006256	01	O																		
D12	12	006256	02	O																		
TOTAL					0	0	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	$ -	$ -	$ -	0	$ -	$ -

Quarterly Website Analytics Report
for
State of New York
Reporting Period: (Begin:End Date)

	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Total
NewRegistrations	19,926	7,296	6,726	4,674	3,294	3,552							**45,468**
Cumulative Registrations	**19,926**	**27,222**	**33,948**	**38,622**	**41,916**	**45,468**							

Transaction Type	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Total Health Claims	12,600	18,600	24,600	30,600	36,600	42,600							**165,600**
View Claims Recap	4,200	5,400	6,600	7,800	9,000	10,200							**43,200**
Total Claims	**16,800**	**24,000**	**31,200**	**38,400**	**45,600**	**52,800**	**0**	**0**	**0**	**0**	**0**	**0**	**208,800**

Transaction Type	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Plans & Benefits Landing Page Visits	18,000	24,000	30,000	36,000	42,000	48,000							**198,000**
View Explaination of Benefits	12,000	18,000	24,000	30,000	36,000	42,000							**162,000**
Health View Eligibility & Benefits Visits	9,000	15,000	21,000	27,000	33,000	39,000							**144,000**
Total Benefits and Eligibility	**21,000**	**33,000**	**45,000**	**57,000**	**69,000**	**81,000**	**0**	**0**	**0**	**0**	**0**	**0**	**306,000**

Transaction Type	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**	**Jun-11**	**Jul-11**	**Aug-11**	**Sep-11**	**Oct-11**	**Nov-11**	**Dec-11**	**Total**
Change Password	0	0	0	0	0	0							**0**
Accessing EOBs	3,150	3,750	4,500	5,700	7,200	10,200							**34,500**
Accepting Electronic EOBs	2,400	3,000	3,600	4,200	5,400	6,600							**25,200**
eMail Capture	3,000	3,600	4,200	4,800	5,400	6,000							**27,000**
View Authorizations	3,900	9,900	15,900	21,900	27,900	33,900							**113,400**
Total Self Service Transactions	**12,450**	**20,250**	**28,200**	**36,600**	**45,900**	**56,700**	**0**	**0**	**0**	**0**	**0**	**0**	**200,100**

Total Online Transactions	**50,250**	**77,250**	**104,400**	**132,000**	**160,500**	**190,500**	**0**	**0**	**0**	**0**	**0**	**0**	**714,900**

Empire Plan Mental Health and Substance Abuse Program
Quarterly Provider Audit Report Sample
Fourth Quarter 2012

Audit Type (i.e. DRG, CPT Correct Coding for E&M)	Audit Scope	Status P=Pending IP = In Progress R = Recovery Stage C = Closed	Audit Scheduled Start Date	Audit Actual Start Date	Audit End Date	Corrective Action Letter Provider Flagged Recovery Termination Referral to Law Enforcement	$ Recovered	$ Credited to NYS

The State of New York
Mental Health and Substance Abuse Program
Monthly Customer Service Report

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUGUST	SEPT	OCT	NOV	DEC	TOTAL
CLAIM ACCURACY													
PROCESSED	114,470												
ACCURACY SAMPLE	40												
CHARGED ERRORS	2												
NON-FINANCIAL ACCURACY (%)	96.22%												
FINANCIAL ACCURACY (%)	99.77%												
DOLLAR POPULATION	$109,235,990.49												
CLAIM TIMELINESS NON-NETWORK													
POPULATION	107,191												
MEAN	3.83												
% PROCESSED WITHIN 18 BUSINESS / 24 CALENDAR DAYS	95.50%												
TELEPHONE ACCESSIBILITY CUSTOMER SERVICE													
CALLS RECEIVED	5,721												
CALL CENTER AVAILABILITY	100.00%												
BUSY CALLS	-												
BLOCKAGE RATE	0.00%												
CALLS ABANDONED	62												
ABANDONED CALL RATE	1.08%												
AVERAGE SPEED OF ANSWER (SECONDS)	17.55												
CALLS HANDLED	5,659												

TELEPHONE ACCESSIBILITY **CLINICAL REFERRAL LINE**	
CALLS RECEIVED	9,069
CALL CENTER AVAILABILITY	100.00%
BUSY CALLS	-
BLOCKAGE RATE	0.00%
CALLS ABANDONED	87
ABANDONED CALL RATE	0.96%
AVERAGE SPEED OF ANSWER	10.63
CALLS HANDLED	8,982

<On Account Rep Letterhead>

<Date>
<Group Contact Name>
<Group Name>
<Address>

RE: Confidentiality of Information

Dear <Group Contact Name>:

You recently requested Empire BlueCross BlueShield ("Empire") to provide a data extract or report to you or to another entity (each a "Vendor"), for use on your behalf. This Letter Agreement pertains to the confidentiality of:

- the information in the data extract or report that you have requested, and
- information in other data extracts or reports that you may request us to provide to you or any of your vendors in the future.

A data extract or report may include:

- Protected Health Information ("PHI"), as defined in the Health Insurance Portability and Accountability Act of 1996 and its associated regulations ("HIPAA"); and/or
- Empire's Proprietary and Confidential Information, as defined below.

If the data extract or report includes PHI, we will comply with all terms of our Business Associate Agreement ("BAA") with you, which sets forth our obligations to protect, use, and disclose the PHI only as permitted by HIPAA. Similarly, your BAA with the Vendor who will receive the extract or report (if any) governs the Vendor's obligations with respect to the PHI.

This Letter Agreement addresses the confidentiality of Empire's Proprietary and Confidential Information.

Empire's Proprietary and Confidential Information (the "Information") means:

1. ***Empire's Proprietary Information*** – Non-public, trade secret, commercially valuable, or competitively sensitive information of Empire or any of its affiliated companies; including but not limited to:
   - Information about our provider networks, provider negotiated fees, provider discounts, and provider contract terms;
   - Information about the systems, procedures, methodologies, and practices we use in performing our services such as claims processing, payment, and health care management; and
   - Combinations of data elements that would enable information of this kind to be derived or calculated.

2. ***Empire's Confidential Information*** – Information that Empire or any of its affiliated companies is obligated by law or by contract to protect. It includes, but is not limited to:
   - Social Security Numbers;
   - Provider tax identification numbers (TINs) and National Provider Identification Numbers (NPIs);
   - Provider names, addresses, and other information we must protect under the terms of our provider agreements.

By signing this Letter Agreement and returning it to me, you acknowledge and agree that:

- You must treat the Information confidentially and institute commercially reasonable safeguards to protect it;
- You are permitted to use the Information only to administer your group health plan;
- You must not disclose the Information to any other person or entity without our prior approval;
- You must not contact any health care provider concerning the Information unless the contact is coordinated by us;
- A Vendor who will receive the Information (if any) must first enter into a confidentiality agreement with us; and
- You have the authority to execute this Letter Agreement on behalf of <Group Name>.

Thank you for your cooperation.

Sincerely,

<Account Rep Name>

Client Authorized Signature: _____ Date: _____

Network Management

Appendix F

Claims Processing

Appendix G

[redacted]

Empire BlueCross BlueShield

PO BOX 1407, CHURCH STREET STATION
NEW YORK NY 10008-1407

APPROVED OMB-0938-0008

For ser vices rendered out of area, provider should submit claim to the local Blue Cross and Blue Shield plan.

CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (Include prefix) (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No. Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐

Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)

ZIP CODE | TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER NAME OR BENEFIT PLAN? ☐ YES ☐ NO

READ BACK OF FORM BEFORE COMPLETING THIS FORM.

12. I AUTHORIZE THE RELEASE OF INFORMATION AS DESCRIBED ON THE REVERSE SIDE OF THIS CLAIM FORM.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. ____ . ___ 3. ____ . ___

2. ____ . ___ 4. ____ . ___

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE FROM MM DD YY	TO MM DD YY	B PLACE OF SERVICE	C TYPE OF SERVICE	D PROCEDURES, SERVICES, OR SUPPLIES (EXPLAIN UNUSUAL CIRCUMSTANCES) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT FAMILY PLAN	I EMG	J COB	K RESERVED FOR LOCAL USE
1												
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS
"I CERTIFY THAT THE CARE, SERVICES AND SUPPLIES ENTERED ON THIS FORM HAVE BEEN RENDERED TO THE PATIENT, AND THAT I AM ENTITLED TO REIMBURSEMENT OF THE CHARGES INDICATED."

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIANS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE NUMBER

PIN# | GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500

PATIENT'S SIGNATURE

The patient must sign the claim form, authorizing the release of information to Empire or its designee as described below. If the patient is a minor, the signature must be that of the patient's parent or legal guardian.

I authorize any health care provider, payor of health claims, or government agency to furnish to Empire or its designee all records pertaining to medical history, services rendered, and payments made regarding me or my dependents for review and evaluation of any claim or services.

I authorize Empire or its designee to disclose such information to another payor or self-insurer. If my coverage is under a group contract held by an employer, association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

This authorization shall become effective immediately, and shall remain in effect until the latest of six years after the termination of coverage, or the last determination or payment by Empire on a claim or service under the coverage. This authorization shall be binding upon me, my dependents, my heirs, executors or administrators.

INSURANCE FRAUD STATEMENT

The New York State Department of Insurance requires we notify you that "any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation."

Clinical Management

Appendix H

OUTPATIENT TREATMENT REPORT

Empire BlueCross BlueShield

***INSTRUCTIONS: Please print all information. Fax completed form to* 888-479-6431 (NY).**

PATIENT

Name _____ ID # _____ DOB _____

PROVIDER *Individual and/or Group*

Name _____ Tax ID # _____ License # _____ Phone # _____

Address _____ City _____ State _____ ZIP _____ Fax # _____

ICD-9 DIAGNOSIS *numeric + description for AXIS I-III/* ***DSM-IV*** *for Axis IV-V*

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

current *highest past year*

MEDICAL CONDITIONS

☐ None ☐ Chronic Pain

☐ Asthma/COPD ☐ Dementia

☐ Cancer ☐ Diabetes

☐ Cardiovascular Problems ☐ Obesity

☐ Other _____

CURRENT RISK ASSESSMENT

☐ Suicidal ☐ Ideation ☐ Plan ☐ Intent ☐ Hx of harming self ☐ N/A

☐ Homicidal ☐ Ideation ☐ Plan ☐ Intent ☐ Hx of harming others ☐ N/A

MEDICATIONS

Medication	Psychotropic	Medical	Prescribing MD	PCP	Psychiatrist	Other
_____	☐	☐	_____	☐	☐	☐
_____	☐	☐	_____	☐	☐	☐
_____	☐	☐	_____	☐	☐	☐

If affective or psychotic disorder is present and no medications are prescribed, please explain: _____

COORDINATION OF CARE

I have communicated with patient's

☐ PCP ☐ Specialist ☐ Psychiatrist ☐ Therapist

TREATMENT HISTORY

☐ Inpatient: ☐ Within past yr ☐ 1 to 3 yrs ago ☐ More than 3 yrs ago

☐ Outpatient: ☐ Within past yr ☐ 1 to 3 yrs ago ☐ More than 3 yrs ago

SYMPTOMS and FUNCTIONAL IMPAIRMENT *If present, check degree (✓)* On Disability ☐ Yes ☐ No

	Mild	Mod.	Severe		Mild	Mod.	Severe		Mild	Mod.	Severe
Anxiety	☐	☐	☐	Hopelessness	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐
Decreased Energy	☐	☐	☐	ADLs	☐	☐	☐	Significant Weight Change	☐	☐	☐
Delusions	☐	☐	☐	Family/Relationships	☐	☐	☐	Panic Attacks	☐	☐	☐
Depressed Mood	☐	☐	☐	Inattention	☐	☐	☐	Sleep Disturbance	☐	☐	☐
Hallucinations	☐	☐	☐	Irritability/Mood instability	☐	☐	☐	Physical Health	☐	☐	☐
Hyperactivity	☐	☐	☐	Impulsivity	☐	☐	☐	Work/School	☐	☐	☐
Substance Abuse/Dependence	☐	☐	☐	☐ Active ☐ In Remission							

If Substance Abuse is current or focus of treatment, complete the information below:

Substance of Choice	Amount	Frequency	Date of Last Use
☐ Alcohol	_____	_____	_____
☐ Marijuana	_____	_____	_____
☐ Heroin	_____	_____	_____
☐ Opioids _____	_____	_____	_____
☐ Cocaine *list*	_____	_____	_____
☐ Methamphetamine	_____	_____	_____
☐ Prescrip. Drugs _____	_____	_____	_____
☐ Inhalants *list*	_____	_____	_____

Is patient currently participating in a community-based support group? (Includes AA, NA, etc.)

☐ Yes ☐ No

If Yes, frequency of attendance: _____

Is there a sponsor?

☐ Yes ☐ No

DESIRED OBSERVABLE OUTCOMES

Patient agrees with treatment goals ☐ Yes ☐ No

_____

_____

PROVIDER'S CONTINUED TREATMENT PLAN

Modality and CPT Code	Frequency	Anticipated Completion
☐ Individual 90832	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90833	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90834	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Individual 90836	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Couple/Family 90847	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Group 90853	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)
☐ Other _____	____ x per ☐ wk ☐ mo ☐ yr	____ mo(s)

TREATMENT PROGRESS

Level of improvement to date ☐ Minor ☐ Moderate ☐ Major

☐ No progress to date ☐ Maintenance tx of chronic condition

# of sessions provided to date _____

Start date for new authorization _____

My signature confirms that I am providing the requested services.

_____ _____

Provider's Signature ***DATE***

FAX to: 888-479-6431 (NY) **Anthem UM Services, PO BOX 892, North Haven, CT 06473**

Rev 11282012

A note about our binders and tabs: Our binders and tabs are made from Premium Grade polypropylene, which is an environmentally friendly material. Polypropylene is produced without using water and no harmful emissions are released. Additionally, Polypropylene is:

- A strong, non-toxic, durable material
- 100% recyclable and biodegradable
- Free from chlorine and harmful additives

Since Polypropylene is up to 35 percent lighter than many traditional plastics, this helps to reduce transportation costs and the output of carbon dioxide. In a world where more companies are increasingly aware of the need to reduce our environmental impact, Polypropylene is considered the natural choice.

Green is more than a color! Being green saves trees and lowers costs. Binder contents can be requested electronically. Consider requesting our eBinders, e-zines and microsites instead!