

REDACTED COST PROPOSAL

B. Cost Proposal Components

1. Network Claims
 - a. Duties and Responsibilities
 - b. Required Submission
2. Non-Network Claims
 - a. Duties and Responsibilities
 - b. Required Submission
3. Administrative Fee
 - a. Duties and Responsibilities
 - b. Required Submission
4. Assessments
 - a. Duties and Responsibilities
 - b. Required Submission
5. Shared Communication Expense
 - a. Duties and Responsibilities
 - b. Required Submission

C. Payments/ (Credits) to/ from the Contractor

- a. Duties and Responsibilities
- b. Required Submission

D. Cost/Transparency Related Questions

1. Network Provider Questions
2. Transparency of Financial Interests – Post Contract Award Requirements
3. Transparency During the Procurement Process
4. Contractual and Financial Relationships
5. Protections/Processes to Mitigate Conflicts of Interest

Exhibits

Exhibit I.C Freedom of Information Law – Request for Redaction Chart

Exhibit V.A. Claims Analysis

Exhibit V.B Administrative Fee Quote

Section 1: Network Claims (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) In accordance with Section IV of the RFP, the Contractor must contract with Network Providers. The amount charged to the MHPA Program shall be the contracted Network Provider fee less, any applicable Copayment and coordination of benefits when the claim is processed as secondary coverage.	Yes
(2) Claim Payments are to be made based on the requirements contained in Section IV and Articles 6.11.0 and 12.1.0 of Section VII of this RFP, including but not limited to each group's Copayment as reflected in Exhibit II.B; and Exhibit II.B2 of this RFP as well as the annual maximum for Applied Behavioral Analysis (ABA) services as reflected in the most current Plan Communication materials.	Yes
(3) Throughout each Plan Year, the selected Contractor shall charge to the Program the incurred claims cost for Network services based on the amounts actually paid by the Contractor to Network Providers.	Yes
(4) Network Pricing Guarantee: The Offeror must develop and propose a Guarantee Average Unit Cost (GAUC) for the Network Outpatient Services presented in Exhibit V.A.2 and the Network Inpatient/Alternative Level of Care (ALOC) Services presented in Exhibit V.A.3. The Contractor is required to guarantee that the Actual Average Unit Cost (AAUC) for each category shall not exceed the proposed GAUC. a) Based on incurred claims for each Plan Year that are paid as of June 30 th of the following year, the Contractor shall calculate the AAUC for the Inpatient Services and Outpatient Services categories. Such Network Services shall include all services/days paid at the Network benefit level including services/days rendered by Non-Network Providers when the Contractor determines that it is appropriate for either access or clinical reasons. Network Services shall not include non-network services where the Contractor had no opportunity to direct the care or Transition of Care services. The calculation of the AAUC shall be equal to the amounts that would be paid by the Contractor to the Network Provider for Plan primary claims only and prior to the application of the Copayment and Bad Debt and Charity assessments. b) The Contractor acknowledges that the GAUC for the Inpatient Services set forth in Exhibit V.A.3 may incorporate the inpatient professional service component pertaining to global reimbursement arrangements. Amounts actually paid and reported to the Department for Inpatient Services will include the inpatient professional service component of global arrangements. Any adjustments in the calculation of the AAUC shall be at the sole discretion of the Department and	Yes

Section 1: Network Claims (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
<p>subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.</p> <p>c) If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee as follows:</p> <p>For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in Exhibit V.A.2, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the Contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charged to the MHPA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.</p> <p>For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in Exhibit V.A.3, the Contractor shall pay the Department a performance credit equal to 1.5% of the total Administrative Fee charged for the applicable Plan Year. Any amounts due from the contractor to the Department for failure to meet the performance guarantee shall be applied as a credit against the Administration Fee charge to the MHPA Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.</p> <p>d) For the first Plan Year (2015), no change to the proposed GAUC will be allowed, except in the event of circumstances outside the control of the Contractor that may have a significant effect on cost, such as legislation or substantial enrollment risk profile fluctuations. Any proposed change made by the Contractor in the GAUCs for the 2015 Plan year shall be at the sole discretion of the Department and subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.</p> <p>e) For each Plan year after 2015, the Contractor may request in writing an increase in the GAUC. The annual increase shall not exceed the percentage increase in CPI-W for Medical Care, as reported by the Bureau of Labor Statistics for the month of July of the preceding calendar year. If the prior increase in the GAUC occurred more than 12 months prior to the effective date of the requested increase, the maximum</p>	

Section 1: Network Claims (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
<p>increase shall not exceed the cumulative CPI-W observed since the implementation of the prior increase. Any increase in the GAUC requires written approval by the Department and amendment of the Agreement, upon documentation by the Contractor to the satisfaction of the Department, that such increase is required to maintain adequate Network access.</p> <p>f) For purposes of both the development of the GAUC and AAUC, claims processed as secondary to the Plan shall be excluded from the calculations and network pricing guarantees. In addition, the GAUC and AAUC shall not include any fees or assessments set forth in Section V.B.3, and V.B.5 of this RFP.</p>	

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.1a.above, Section IV of the RFP and Section VII, Articles 6.10.0 and 12.1.0 of the RFP.

We confirm our agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.1a.above, Section IV of the RFP and Section VII, Articles 6.10.0 and 12.1.0 of the RFP.

- 2) The Offeror must complete Exhibit V.A.2, Guaranteed Average Unit Cost of Outpatient Services, including ABA services, Exhibit V.A.3, Guaranteed Average Unit Cost of Inpatient Services and ALOC services by Revenue Code, in accordance with the instructions contained in Exhibit V.A.1 of the RFP.

Please see **Exhibit V.A.2 Guaranteed Average Unit Cost of Outpatient Services, including ABA services, and Exhibit V.A.3, Guaranteed Average Unit Cost of Inpatient Services and ALOC services by Revenue Code**, provided in the Exhibits section of this volume.

Section 1: Network Claims (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee (or Approved Facility) in a timely manner.	Yes
(2) The Contractor will process Non-Network claims, as follows: a. For the Empire Plan and Excelsior Plan: using Reasonable and Customary charges based on the 90th percentile of charges for each service performed, as determined by Fair Health. Reasonable and Customary means the lowest of: 1. The actual charge for services; or 2. The usual charge for services by the Provider for the same or similar service; or 3. The usual charge for services of other Providers in the same or similar geographic area for the same or similar service.	Yes
(3) The claim payments are to be made based on the requirements contained in Section IV of the RFP, including but not limited to each group's Co-insurance and Deductible as reflected in Exhibit II.B; and Exhibit II.B2 as well as the annual maximum for ABA services.	Yes
(4) Where a Network Provider is not available because of clinical or access considerations, the Contractor must negotiate a Single Case Agreement with a Non-Network Provider in a manner consistent with what is typically allowed for a Network Provider in the same discipline for the same service. The Contractor must pay the claim and charge the MHSA Program as if the services were incurred in-network.	Yes
(5) The Contractor will update its database with Fair Health's Reasonable and Customary amounts in a timely manner, at a minimum of twice a year.	Yes

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.2.a. above, Section IV of the RFP and Section VII, Article 12.2.0 of the RFP.

We confirm our agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.2.a. above, Section IV of the RFP and Section VII, Article 12.2.0 of the RFP.

- 2) Does the Offeror establish a different allowed amount for Non-Network Provider charges based on licensure type or some other clinical criteria for the same CPT code? Please describe the Offeror's methodology in developing the allowed amount for each CPT code if it varies based on licensure type or some other clinical criteria.

Yes. Our reimbursement methodology varies by licensure type for non-network providers. ValueOptions applies its usual, customary and reasonable (UCR) fees to the adjudication of claims from out of network providers. ValueOptions' clients have defined UCR fees at various levels from the 50th to the 90th percentile of charges.

ValueOptions uses its claims data to compute the various UCR levels requested by clients for use in large metropolitan areas at the three digit zip level. ValueOptions has a sufficient number of claims in virtually all large metropolitan areas to compute the required UCRs by licensure level for these zip codes directly from its claims data. There are smaller population centers throughout the United States, however, where ValueOptions' clients have little or no membership. In these situations, the volume of claims submitted to ValueOptions is also very small and the resulting sample of charge data is inadequate for purposes of calculating UCR fees.

In order to calculate UCR fees in these smaller population centers, where its claims samples are also relatively small, ValueOptions uses a formula-based approach. Through extensive data analysis of provider charges in the large population centers, ValueOptions has been able to determine a consistent relationship between physician charges at any UCR percentile for each licensure level and the Medicare fees used in these same regions for each licensure level. ValueOptions has proven, through extensive testing, that the UCR fees it has set, for both large and small population centers, produce the results anticipated by its clients at each UCR percentile and licensure level.

The Administrative Fee is the fee quoted by the Offeror representing the charge to the MHSA Program to cover all of the administrative services provided by the Contractor, with the exception of Shared Communication Expenses. Do not include amounts for the Patient-Centered Outcomes Research Institute (PCORI) fee as that will be paid directly by the Plan.

Section 3: Administrative Fee (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) Be bound by its quoted Administrative Fee, as proposed in the Contractor's Cost Proposal for the entire term of the Agreement, unless amended in writing;	Yes
(2) Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;	Yes
(3) Implement any changes necessary to accommodate MHSA Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice;	Yes
(4) Implement all benefit designs as required by the Department with or without final resolution of any request for an Administrative Fee adjustment. Refusal to implement benefit design changes will constitute a material breach of the Agreement and the Department will seek compensation for all damages resulting;	Yes
(5) Agree not to request a higher Administrative Fee, and the Department will not consider any increase to the Administrative Fee that is not based on a material change to the MHSA Program requiring the Contractor to incur additional costs. The determination of what constitutes a material change will be at the sole discretion of the Department;	Yes
(6) Submit detailed documentation of additional administrative/clinical costs, over and above existing administrative/clinical costs, with any request for an increase in the Administrative Fee resulting from a material change in the benefit structure of the MHSA Program. The Department reserves the right to request and the Contractor agrees to provide any additional information and documentation the Department deems necessary to verify that the request for an increase to the Administrative Fee is warranted. The Department's decision to modify the Administrative Fee to the extent necessary to compensate the Contractor for documented additional costs incurred shall be at the sole discretion of the Department, subject to the approval of a formal amendment to the Agreement by the New York State Attorney General and New York State Office of State Comptroller;	Yes
(7) Agree that the Administrative Fee shall be calculated based on the number of covered MHSA Enrollees as reported by NYBEAS on the first Thursday of each month. The Department shall furnish to the Contractor a written statement for each month showing the number of Enrollee contracts then	Yes

Section 3: Administrative Fee (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
in force.	
(8) Claims incurred during the coverage period of the contract but processed/paid after the last day of coverage, as well as applicable Disabled Lives claims incurred after the last day of coverage of the agreement will be administered by the Contractor selected in response to this RFP. An Administrative Fee will not be payable/due beyond the last day of coverage; therefore, Offerors should take this into consideration in developing their proposed Administrative Fee.	Yes

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.3.a. above.

We confirm our agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.B.3.a. above.

- 2) The Offeror is required to provide the Offeror's Administrative Fee quote in Exhibit V.B.

Please see **Exhibit V.B. Administrative Fee Quote**, provided in the Exhibits section of this volume.

In accordance with the Health Care Reform Act of 1996, two assessments/surcharges are chargeable to applicable health plans, including the Empire Plan: 1) Graduate Medical Expense (GME) and 2) Bad Debt and Charity (BDC) Assessment. The GME component of the Empire Plan is assessed on the Hospital component of the Empire Plan and therefore not chargeable under the MHSA Program. The BDC is applicable to the MHSA Program.

In addition, other fees and assessments as stipulated by State or federal law may be applicable over the term of the contract. Such amounts shall be paid by the MHSA Program either through the Contractor or directly to the authorized agency after a determination is made by the Department regarding the applicability of each fee/assessment to the MHSA Program.

Section 4: Assessments (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor shall calculate the applicable BDC each month from the applicable paid claims and may charge the MHSA Program at the time this assessment is paid to the regulatory agency/intermediary by the Contractor.	Yes
(2) The Contractor shall advise the Department of any new applicable assessments in a timely manner.	Yes
(3) The Contractor shall bill the MHSA Program for any new assessments within thirty (30) days after the amounts are paid to the regulating entity.	Yes

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.4.a. above.

We confirm our agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.4.a. above.

- 2) Disclose other applicable assessments, if any, including the amount and basis of the assessment, made by other states/federal government that are applicable to the MHSA Program. Advise whether these assessments can be paid by the Offeror on behalf of the MHSA Program or if they would be directly paid by the Department.

We are not aware of any other applicable assessments at this time. We are excluding taxes (premium) from such assessments given the ASO status of this contract and the instruction to not include taxes in the administrative fee. The Department and Contractor will mutually agree which of the taxes or assessments will be paid by the Contractor on behalf of the Program and charged back to the Department and which will be paid directly by the Department.

Section 5: Shared Communication Expense (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor will pay the medical carrier/third party administrator on a quarterly basis an amount billed for Shared Communication Expenses. The Contractor will be notified prior to the beginning of each Plan Year the amount of Shared Communication Expenses that will be billed.	Yes
(2) The Contractor shall seek reimbursement of the Shared Communications Expense from the Department by including the amount with the voucher for the payment of the next Administrative Fee to be paid.	Yes

- 1) Confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.5.a. above.

We confirm our agreement to perform/fulfill and comply with the duties and responsibilities in Section V.B.5.a. above.

This Section presents information regarding the financial structure and timing of financial transactions related to the Agreement and the specific items Offerors must submit with their Cost Proposal and questions related to those requirements.

The following information is presented for use by Offerors in developing their Cost Proposal. As of January 2014, there were 233,912 individual contracts and 288,551 family contracts with Empire Plan Mental Health and Substance Abuse coverage. In addition to the Empire Plan contracts, there are 112 individual contracts and 105 family contracts with the Excelsior Plan and 4,837 individual contracts and 804 family contracts with the Student Employee Health Plan (SEHP) benefits. The enrollment mix and benefit characteristics are presented in Exhibit II.A through Exhibit II.A4; Exhibit II.C; Exhibit II.C2; and Exhibit II.D. of this RFP. However, the Department cannot guarantee that, during the term of the Agreement, the same enrollment mix and benefit characteristics as those set forth in Exhibit II.A through Exhibit II.A4; Exhibit II.C; Exhibit II.C2; and Exhibit II.D will exist.

Section C: Payments/(Credits) to/from the Contractor (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
(1) The Contractor will bill the Department periodically, as proposed, by the Contractor, after claims have been processed. The Department shall pay the Contractor by "wire transfer" within seven days have receiving a bill of the claims processed by the Contractor. The Department may consider comparable alternatives to this approach during implementation.	Yes
(2) The Plan will pay an Administrative Fee on a monthly basis thirty (30) Days after receipt of an accurate invoice. Any credit amounts due from the Contractor to the Department for failure to meet the performance guarantees set forth in the Agreement shall be applied as a credit against the Administrative Fee charged to the MHSA Program. Alternatively, the Department may request and receive payment of any performance guarantee amount directly from the Contractor, as opposed to a credit against the Administrative Fee payable to the Contractor.	Yes
(3) The Contractor will be billed the MHSA Program's portion of the Shared Communications Expense by the medical carrier/third party administrator in 2015 and each Plan Year thereafter in four (4) equal installments. The Contractor will pay the medical carrier/third party administrator the amount billed and may seek reimbursement from the MHSA Program. Subsequent years' amounts will be calculated by the Department and communicated to the Contractor during the annual rate renewal process. Upon receipt of each Shared Communications Expense bill, the Contractor may bill and the Plan will pay the Contractor an identical amount within thirty (30) Days.	Yes
(4) Upon final audit determination by the Department, any audit liability amount assessed by the Department shall be	Yes

Section C: Payments/(Credits) to/from the Contractor (a. Duties and Responsibilities)	
Requirement	ValueOptions Acknowledges and Agrees
paid/credited to the MHSA Programs within thirty (30) Days of the date of the Department's final determination, or within thirty (30) Days of receipt of recoveries related to fraud or abuse or Department errors.	
(5) The Contractor shall analyze and monitor claim submissions to promptly identify errors, fraud and/or abuse and report 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 made by the Contractor 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. 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 Program within 30 Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.	Yes
(6) Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.	Yes
(7) The Agreement resulting from this RFP is not subject to Article XI-A of NYS Finance Law. The Contractor agrees that MHSA Program Services provided under the Agreement shall continue in full force and effect for a minimum of at least thirty (30) days beyond the payment due dates as set forth in Article XV of the Agreement. If after the thirty-fifth (35) calendar day after receipt of an accurate invoice, as set forth in Article XV of the Agreement, the Contractor has not yet received payment from the State for said invoice, the Contractor may proceed under the Dispute Resolution provision in Appendix B and the Agreement shall remain in full force and effect until such final decision is made, unless the Parties can come to a mutual agreement, in which case, the Agreement shall also remain in full force and effect.	Yes

- 1) The Offeror is required to confirm the Offeror's agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.C.a above.

We confirm our agreement to perform/fulfill and comply with the duties and responsibilities listed in Section V.C.a.

- 2) Describe, in detail, the Offeror's proposed invoicing process, if any, including the timing for invoice preparation and supporting detail claims files at the end of each payment period, required payment timeframes and whether this structure is in effect for any other self-funded customers.

PROPOSED INVOICING PROCESS

We propose to bill services monthly, and the Department can choose to either self-report or be invoiced. This is a structure that is in effect for other self-funded clients. Self-reporting clients automatically make monthly payments with a detailed summary of services attached. The detail information typically includes the number of covered lives/employees/members multiplied by the contracted rate, and by product if applicable. If the Department prefers to be invoiced, ValueOptions' National Accounting department will send an invoice on the 8th business day of each month, for services rendered that month. Our payment terms are 30 days.

During implementation, we will provide the following information regarding billing and payment procedures:

1. Contact information regarding payment inquiries
2. Payment addresses for checks
3. Bank account information for electronic payments, including:
 - Bank name
 - Bank ABA number
 - Bank account number

1. NETWORK PROVIDER QUESTIONS

a. Describe fully the nature of your reimbursement arrangements with Network Facilities. Distinguish between per diems, case rates, percent of charges versus other types of reimbursement arrangements. Also distinguish between how your reimbursement arrangements are structured in NYS versus states other than NYS with a high concentration of Empire Plan members, such as New Jersey and Florida.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

b. Is there an escalator clause in your Network Facilities contracts to increase fees periodically or are increases negotiated on a case by case basis? What is your Facility contracting cycle? When were the Network Facility fees last increased?

[REDACTED]

[REDACTED]

c. What is your current average Network Facility reimbursement as a percentage of covered charges for your book of business in New York State?

[REDACTED]

d. Is there an escalator clause in your Network Practitioner contracts to increase fees periodically or are any increases negotiated on a case by case basis? What is your Network Practitioners contracting cycle? When were Network Practitioner fees last increased?

[REDACTED]

e. What is your current average Network Practitioner reimbursement as: 1) a percentage of covered charges for your book of business in NYS; and 2) a percentage of the Fair Health 90th percentile reasonable and customary charges? Does Network Practitioner reimbursement vary based on licensure of some other credentialing criteria? If so, please describe methodology.

[REDACTED]

f. Some Offerors negotiate global reimbursement arrangements with Network Facilities to cover certain services such as professional inpatient visits that are normally billed by Practitioners. With respect to global reimbursement, please respond to the following:

- 1) Do you reimburse Network Facilities globally for any Practitioners' services?
- 2) If yes, describe completely the types of services that are globally reimbursed and the prevalence of such reimbursement both within and outside NYS. What percent of your Network Facility claim dollars do you estimate are attributable to global reimbursement??

[REDACTED]

g. Confirm your willingness to provide the Department with information pertaining to specific fee arrangements made with Network Providers, if requested, both during the procurement process and throughout the term of the Agreement resulting from this RFP.

[REDACTED]

h. Is the Offeror's Proposed Network a standard Network or has it been specifically contracted to administer the Empire Plan MHSA Program? Are the proposed Network Provider fees included in this RFP response currently in place in NYS?

[REDACTED]

i. Does the Offeror have a single standard contract with Network Providers with consistent terms applied to all of the Offeror's clients? If no, please describe the basis and reasons for the differences.

[REDACTED]

[REDACTED]

[REDACTED]

j. In addition to negotiating agreements with Network Providers on behalf of clients, does the Offeror or any of its Affiliates or any Key sub-contractor's Affiliates have other business arrangements with Network Providers from which the Offeror or any of its Affiliates or any Key sub-contractor's Affiliates have derived revenues? If the Offeror and/or any of its Affiliates or any Key sub-contractor's Affiliates derive revenue or obtain other consideration or compensation from agreements with Network Providers, please identify the recipient(s) of such Network Provider revenue and explain the business relationship from which the revenue is derived. Please detail how the Offeror's business model ensures that these relationships do not create a real or perceived conflict with the clinical and financial interests of the MHSa Program.

[REDACTED]

k. Are the Offeror's Network fee schedules incorporated in formally adopted corporate policies and procedures? Please explain.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

l. Does the Offeror maintain more than one Network fee schedule for purposes of reimbursing Network Providers? Or, does the Offeror have multiple reimbursement agreements with individual Network Providers that are assigned and utilized based on client and/or different Offeror network products?

[REDACTED]

m. Describe how Alternative Level of Care (ALOC) services are billed by providers and reimbursed by the Offeror. Are these services billed on a per service or per diem basis?

[REDACTED]

[REDACTED]

n. Describe how outpatient alcohol treatment center services are billed by providers and reimbursed by the Offeror. Are these services billed on a per service or per diem basis?

[REDACTED]

2. TRANSPARENCY OF FINANCIAL INTERESTS - POST CONTRACT AWARD REQUIREMENTS

The Contractor must agree to be open and forthright in all matters related to the clinical management and cost management of the MHSA Program. The State has strict standard audit provisions, subject to confidentiality requirements. Disclosure obligations include, but are not limited to:

a. Providing full access to all Key Sub-contractor and Network Provider agreements related to the MHSA Program under strict confidentiality provisions;

We agree to provide full access to all sub-contractor and Network Provider agreements related to the MHSA Program under strict confidentiality provisions.

b. Agreeing to the standard audit provisions set forth in Contract Provisions, Section VII of this RFP (see Article XXIII entitled “Audit Authority”), and Appendices A and B; and

We agree to the standard audit provisions set forth in Contract Provisions, Section VII of this RFP and Appendices A and B.

c. Agreement that the Contractor will disclose all agreements related to the provision, servicing and administration of MHSA Program services in effect during the term of the Agreement resulting from this RFP. This includes all relationships between or among the Contractor, and relevant third parties including but not limited to the Contractor, Providers and any other entity from which the Contractor or the Key Subcontractor or Affiliate receives any form of compensation or any other consideration as a consequence of managing and reimbursing for services under the MHSA Program.

We agree to disclose all agreements related to the provision, servicing and administration of MHSA Program services in effect during the term of the Agreement resulting from this RFP. This includes all relationships between or among the Contractor, and relevant third parties including but not limited to the Contractor, Providers and any other entity from which the Contractor or the subcontractor receives any form of compensation or any other consideration as a consequence of managing and reimbursing for services under the MHSA Program.

3. TRANSPARENCY DURING THE PROCUREMENT PROCESS.

3. Contractor must provide all information the Department deems necessary to support their Cost Proposal. This includes but is not limited to submitting adequate information to support the Offeror's Proposal regarding alignment with the financial interests of the MHSA Program as well as other information as the Department determines is necessary to address any perceived or actual conflicts between the Contractor's business model and the financial interests of the MHSA Program. Please confirm.

ValueOptions confirms that we will provide all information the Department deems necessary to support our Cost Proposal. This includes, but is not limited to adequate information to support our Proposal relative to assuring alignment with the financial interests of the MHSA Program and other information as the Department determines is necessary to address any perceived or actual conflicts between the Contractor's business model and the financial interests of the MHSA Program.

4. CONTRACTUAL AND FINANCIAL RELATIONSHIPS

4. Explain the contractual and financial relationships among or between the Contractor, Key Subcontractor or Affiliate, if any, and key Network Providers. Please describe how the Offeror's proposed business model eliminates any real or potential conflicts with the clinical and financial interests of the MHSA Program.

ValueOptions is not proposing to use the services of any subcontractors in our proposal to the Department. In terms of financial relationships with our network providers, our contracts with network providers set forth the amount we will reimburse them for covered services provided to enrollees. We do not have other financial relationships with our network providers that would present a real or potential conflict of interest (e.g., an ownership interest). From a clinical perspective, our standard network provider contract template includes a provision which states that the contract with the provider shall not change or alter any clinical relationship which exists or may come to exist between the provider and the member and that the provider will use its best medical judgment to treat the patient. The template also includes a provision which states that payment or coverage determinations made by ValueOptions shall not be construed as a directive that medically appropriate treatment be withheld. In sum, ValueOptions' relationship with its network providers creates no real or potential conflicts regarding clinical and financial interests of the MHSA Program.

5. CONFLICTS OF INTEREST

5. The Department recognizes that the Offerors' business model may present potential conflicts between the financial interests of the MHSA Program and the Offeror. Please describe any protections or processes the Offeror proposes to mitigate any conflicts of interest.

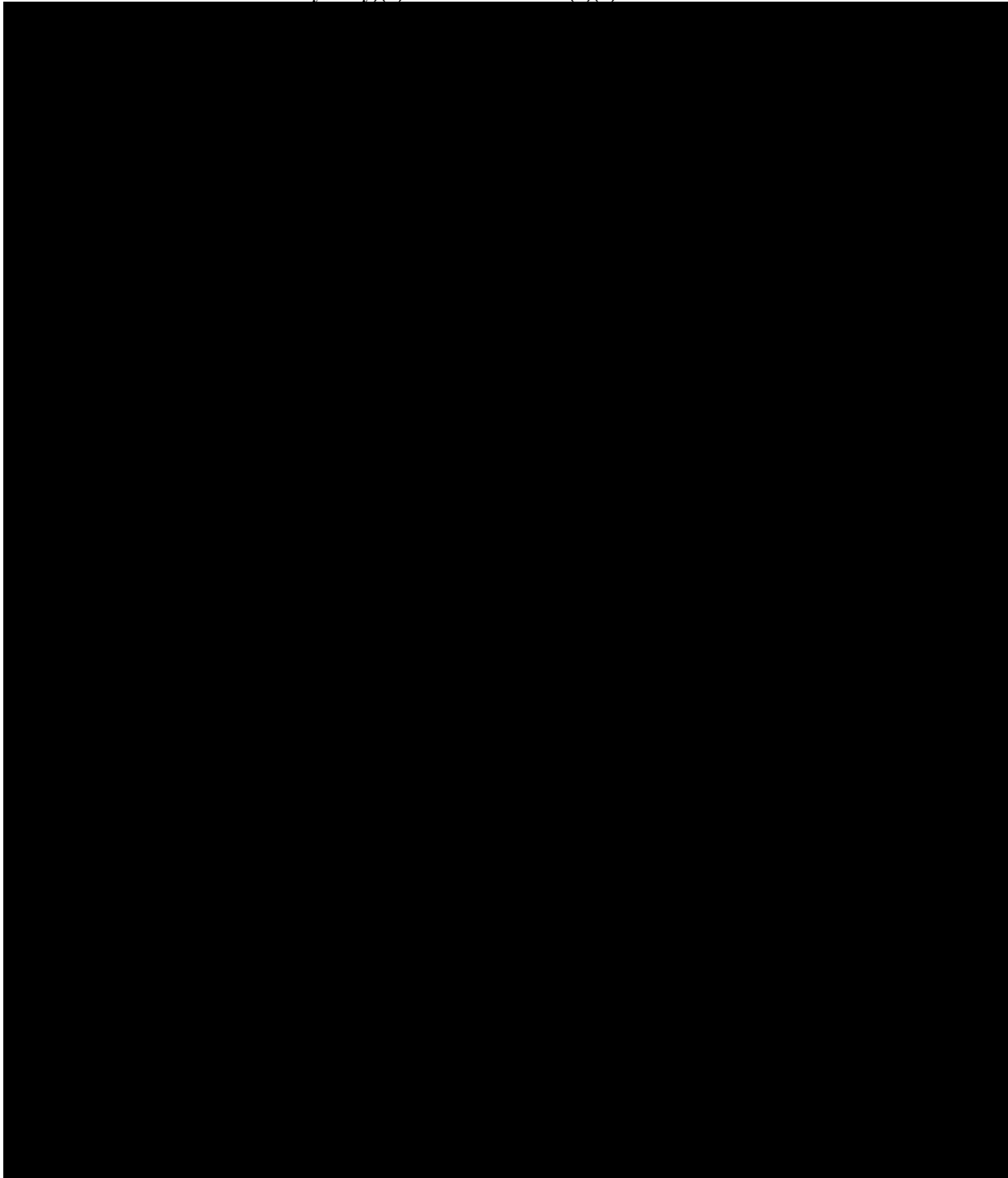
Our business model does not present potential conflicts between the financial interests of the MHSA Program and ValueOptions. We are not including any subcontractors in our proposal to the Department. Further, we have contracts with our network providers which set forth the amount we will reimburse them for covered services provided to members. We do not have other financial relationships with our network providers that would present a real or potential conflict of interest (e.g., an ownership interest). In sum, ValueOptions' relationship with its network providers creates no real or potential conflicts regarding the financial interests of the MHSA Program.

**Mental Health and Substance Abuse Program RFP #2014-MH-1
 for the Empire Plan, Excelsior Plan and Student Employee Health Plan
 Guaranteed Average Unit Cost Quote - Network Outpatient Services**

		a	b	c = $\Sigma d / \text{sum } \Sigma a$	d = a x b
CPT/HCPCS Code	Provider Licensure(4)	Offeror's Projected Utilization (Plan Primary Only) (1)	Average Contracted Fee Per Licensed Provider Type(2)(3)	Average Weighted Contracted Fee Per CPT Code	Projected Total Cost
[Redacted Content]					

"The rest of this Exhibit has been redacted."

**Mental Health and Substance Abuse Program RFP 2014-MH-1
for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Guaranteed Average Unit Cost Quote - Network Inpatient and Alternative Level of Care (ALOC) Services**

	a	b	c = a x b
	Offeror's Projected Utilization (Plan Primary Only)(1)	Average Contracted Fee Per Revenue Code(2)(3)	Total Cost
Revenue Code			
			

**Mental Health and Substance Abuse Program RFP 2014-MH-1
for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Guaranteed Average Unit Cost Quote - Network Inpatient and Alternative Level of Care (ALOC) Services**

- (1) Offeror's projected utilization for the 2015 Plan Year pertaining to incurred claims paid as primary.
- (2) The Offeror should use its 2015 average contracted fee for each Revenue code in support of its proposed GAUC.
The supporting average contracted fees are not binding to the Offeror.
- (3) The contracted amount per Revenue Code should represent the unit amount per day/service and the amount is prior to the application of the Copayment or Bad Debt and Charity assessments.

**Mental Health and Substance Abuse Program RFP #2014-MH-1
for the Empire Plan, Excelsior Plan and Student Employee Health Plan
Administrative Fee Quote**

Administrative Fee Calculation

Fee Quote

Basis

Monthly Administrative Fee Quote

_____ [REDACTED] _____ [REDACTED] _____