Proposal for

The Empire Plan

Project

Mental Health And Substance Abuse Program For The Empire Plan, Excelsior Plan And The Student Employee Health Plan

#2013MH-1

Cost Proposal

Date

April 16, 2013

Contact

[redacted]

Table of Contents

Attachments

Exhibit_V.A - CPT-Revenue Code Avg Cost_Amended

Exhibit_V.B - Applied Behavioral Analysis Fee Quote

Exhibit_V.C - Administrative Fee Evaluation_Amended

SECTION V: COST PROPOSAL REQUIREMENTS

A. Introduction

As described in this RFP, the Mental Health and Substance Abuse Program provides health benefits to covered members on a self-funded basis. The costs associated with the MHSA Program include Network Claims Costs, Non-Network Claim Costs, Administrative Fees, Shared Communication Expenses and Assessments made through State or federal legislation. Section V presents the Cost Proposal submission requirements as well as the requirements concerning the financial transactions and other cost/transparency related questions.

B. Cost Proposal components

The following present the Cost Proposal components, associated duties and responsibilities and the Cost Proposal submission requirements.

1. Network Claims

a. Duties and Responsibilities

1) **In accordance with Section IV of the RFP, the Contractor must contract with Network Providers. The amount charged to the MHSA Program shall be the contracted Network Provider fee less, any applicable Copayment and coordination of benefits when the claim is processed as secondary coverage.**
2) **The Contractor agrees that the weighted average of the actual Network Provider fees to be charged to the MHSA Program for each CPT, HCPCS and Revenue Code implemented on January 1, 2014 shall not exceed the amounts quoted in Exhibit V.A. During implementation, the Contractor shall submit an analysis confirming that the weighted average contracted 2014 Provider Network fees are less than or equal to the fees quoted in Exhibit V.A, subject to the review and written approval of the Department. No increases to the Network Provider fees, charged to the MHSA Program, will be permitted for the 2014 Plan year.**
3) **For each Plan year after 2014, the Contractor must manage the Network Provider fee charged to the Department such that the annualized aggregate impact on MHSA Program costs of any proposed modification to the Network Provider fee is capped by the annual 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.**
4) **Claim Payments are to be made based on the requirements contained in Articles 6.11.0 and 12.1.0 of the Agreement resulting from this RFP, including but not limited to each group's Copayment, Co-insurance, Deductible as reflected in Exhibit II.B; and Exhibit II.B2 as well as the annual maximum for ABA services as reflected in the most current Plan Communication materials.**

5) Network Pricing Guarantee: The Contractor is responsible for managing modifications , if any, to the fees paid to Network Providers in Plan years two through five of the Agreement to the extent such modifications in the Provider Network fees are in the best financial interest of the MHSA Program and the Department, as solely determined by the Department. During each Plan year, the Contractor must report any proposed Provider Network fee schedule modifications, if any, and the estimated financial impact to the MHSA Program to the Department prior to any such changes. The MHSA Program allows for Network Provider fee increases every Plan year after 2014; however, the annualized aggregate impact on MHSA Program costs of any modification to the Network Provider fees shall be reviewed and shall be capped by the annual 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. This annual review of any modification to the Network Provider fees shall be completed by the Contractor, in writing, for final review and written approval by the Department. The annual review provided by the Contractor shall include a calculation of the aggregate impact of the modification of Network Provider fees, for that Plan year, as compared to the Network Provider fees paid in the base year, based on the actual utilization of each Network Provider and service in the base year. The following presents the current and base years for each annual review covered by the Agreement:

Report Due	Base Year	Current Year
6/30/16	2014	2015
6/30/17	2015	2016
6/30/18	2016	2017
6/30/19	2017	2018

The calculated aggregate impact of the Network Provider fee modification for that Plan year, normalized for any change in enrollment, will be compared to the maximum allowable CPI increase to determine the Contractor's compliance with the Network Provider pricing guarantee. At the conclusion of each annual review, the Contractor shall forfeit a specific dollar amount of the Administrative Fee for failure to meet this guarantee, as follows.

For each annual review, the Contractor's amount to be credited against the Administrative Fee for each .01 to 1.0% increase in the aggregate MHSA Program Network costs in excess of the annual increase in the CPI-W for medical care as reported by the Bureau of Labor Statistics for the month of July is $250,000.

b. Required Submission

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 the duties and responsibilities listed in 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, Quoted Average Network Fees by CPT, HCPCS and Revenue Code, in accordance with the instructions contained in Exhibit V.A.1 of the RFP.

We have included our completed Exhibit V.A Quoted Average Network Fees by CPT code, HCPCS and Revenue Code.

3) The Offeror must complete Exhibit V.B, Network Fees - Applied Behavioral Analysis Benefits, in accordance with the instructions contained therein.

We have included our completed Exhibit V.B, Network Fees – Applied Behavioral Analysis Benefits.

2. Non-Network Claims

a. Duties and Responsibilities

1) The Contractor will accurately process Non-Network claims and make payments directly to the Enrollee in a timely manner.

2) The Contractor will process Non-Network claims using Reasonable and Customary charges based on the 90th percentile of charges for each service performed. 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.**

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.

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.

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.

b. Required Submission

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 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.

3. Administrative Fee

The Administrative Fee is the fee quoted by the Contractor 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.

a. Duties and Responsibilities

The Contractor is required to:

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;

2) Manage all MHSA Program Enrollees based on the Contractor's Administrative Fee, as proposed by the Contractor in its Cost Proposal;

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;

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;

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;

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;

7) **Agree that the Administrative Fee shall be payable only for the number of covered Enrollees each month and that the number of covered Enrollees for a given month shall be determined by the Department based upon monthly MHSA Program enrollment data contained in NYBEAS; and**

8) **Claims incurred during the period January 1, 2014 through December 31, 2018 but processed/paid after December 31, 2018, as well as applicable Disabled Lives claims incurred after December 31, 2018 will be administered by the Contractor selected in response to this RFP. An Administrative Fee will not be payable beyond December 31, 2018; therefore, Offerors should take this into consideration in developing their proposed Administrative Fee.**

b. Required Submission

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 comply with the duties and responsibilities listed in Section V.B.3.1 above.

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

We have included Exhibit V.C – Administrative Fee Evaluation.

4. Assessments

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.

a. Duties and Responsibilities

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.**

2) The Contractor shall advise the Department of any new applicable assessments in a timely manner.

3) The Contractor shall bill the MHSA Program for any new assessments within 30 days after the amounts are paid to the regulating entity.

b. Required Submission

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

We agree to 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.

The MHSA Program will be subject to all current and subsequently added state taxes, fees, and assessments applicable to self-funded plans, except as explicitly excepted (e.g., NYS HCRA surcharge and covered lives assessment). The MHSA Program will also be subject to applicable federal taxes on self- funded plans. With respect to more material new federal ACA related taxes, specifically: (1) health insurers tax; (2) transitional reinsurance fee; and (3) PCORI tax, based on recent guidance we believe it is likely that the MHSA self-funded plan will only be liable to the PCORI tax.

This belief is premised on the fact that the health insurers tax is not applicable to self-funded employers sponsored plans or governmental plans and the transitional reinsurance fee is only applicable to comprehensive coverage (and MHSA on its own will likely not meet the new definition of comprehensive coverage included in HHS's final rule).

With respect to PCORI fee, this assessment will be made directly on the State and, consequently, we do not include expenses associated to PCORI in this bid nor do we contemplate paying this expense on behalf of the State. We recommend that this be budgeted for separately.

Our bid is based on the assumptions set forth above, however, we reserve the right to make modifications to our bid if any newly adopted (and in some cases not yet adopted or finalized) state or federal taxes, fees, or assessments that are the basis of such assumptions are ultimately interpreted to be inconsistent with the assumptions.

5. Shared Communication Expense

a. Duties and Responsibilities

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.

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.

b. Required Submission

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

We agree to comply with the duties and responsibilities in Section V.B.5.a above.

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

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 October 2012, there were 231,297 individual contracts and 290,800 family contracts with Empire Plan Mental Health and Substance Abuse coverage. In addition to the Empire Plan contracts, there are 126 individual contracts and 110 family contracts with the Excelsior Plan and 4,737 individual contracts and 767 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.

a. Duties and Responsibilities

(1) The Department will set up an imprest bank account from which the Contractor may issue claim payments by check or wire transfer. The claim amounts charged to the imprest account will occur when checks to Providers and Enrollees are presented for payment and cleared, or when wire transfers to Providers are completed.

(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 on the first invoice issued by the Contractor subsequent to the Department's written approval of the performance guarantee calculation. 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.

(3) The Contractor will be billed the MHSA Program's portion of the Shared Communications Expense by the medical carrier/third party administrator in 2014 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.

(4) Upon final audit determination by the Department, any audit liability amount assessed by the Department shall be 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.

(6) Litigation recoveries and settlements shall be paid/credited to the MHSA Program within fifteen (15) Days of receipt by the Contractor.

(7) The Contract 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.

b. Required Submission

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 agree to comply with the duties and responsibilities listed in Section V.C.a above.

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.

In our self-funded banking arrangement, we open and administer a demand deposit account (DDA) on your behalf under our tax identification number at [redacted], the bank we use

to issue payments of benefits under the plan. This account is established to support your claim payments from our own self-insured check writing and non-draft remit bank accounts. The cost of this banking arrangement is included as part of the self-funded arrangement and are included in the quoted administrative fee. The charges related to the DDA and our check writing bank accounts are charged to Optum. The DDA is a non-interest bearing account. A daily internal transfer of funds, initiated by Optum is preauthorized and covers the amount of funds that were withdrawn from our payment bank accounts during the previous business day.

Deposit Required in Account

The initial unassigned liability balance (imprest amount) required is deposited into the account by the effective December 31, 2013 and is drawn down daily as checks clear our check writing bank account or when we make non-draft payments/settlements and assign the liability overnight to the DDA for checks and non-drafts paid. Each customer deposits and maintains a minimum imprest in the unique benefits DDA. This balance covers claim costs between the dates on which the claim check and/or non-draft is charged/settled to our account, and the date you transfer supporting funds from your designated external bank account. We prefer to initiate automated transfers to minimize errors and late deposits. Daily data are available to you the following banking day to validate any automated transfer we make.

Amount Required

The amount of the imprest balance is established based on your expected daily plan benefit payments, with appropriate adjustments for anticipated non-daily activity (e.g., administrative fee payments), as well as the frequency and method of funding.

Funding Method

Our preferred funding method is an Optum/UnitedHealthcare initiated bank wire transfer, also known as a FED 1031 drawdown wire. This is a same-day settlement transfer that is affected by Bank of America according to repetitive transfer instructions established by Optum/UnitedHealthcare. We also initiate or accept Automated Clearing House (ACH) transfers.

With a wire transfer, you enter into an agreement with your bank that allows our organization to charge your external funding bank account. A request is sent by our organization to the bank where the demand deposit account (DDA) is maintained in the morning, and the funds are transferred from the external funding bank account the same day. ACH transfers require an overnight process, increasing the settlement time, which in turn requires an additional day's imprest balance amount to be maintained in the DDA.

Timing and Frequency

Transfers to reimburse us are initiated on a daily basis. The initial minimum required balance must be deposited into the demand deposit account (DDA) at [redacted]. Reimbursement of cashed drafts and non-draft payments will be debited daily from the DDA. Replenishment funding will be initiated per our instructions by our bank, and the DDA will be funded by Automated Clearing House (ACH) transfers or drawdown wire transfers from your own external claim funding bank account. We offer a daily fax and/or email advising you of pending transfers.

Notification

We can provide State of New York – Empire Plan MHSA Program with daily notification of banking activities as follows.

Daily Notification

Daily notification of bank account activity can be provided to you via email and/or fax which are sent by 9:30 a.m. ET. This notification provides:

- Prior day's demand deposit bank account (DDA) balance
- Minimum maintained balance requirement (determined if account balance is sufficient)
- Aggregated daily claim/bank charges or credits (by splits)
- Amount due

D. Cost/Transparency Related Questions

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 verses other types of reimbursement arrangements. Also distinguish between how your reimbursement arrangements are structured in NYS verses states other than NYS with a high concentration of Empire Plan members, such as New Jersey and Florida.

[redacted]

b. Is there an escalator clause in your contracts with Network Facilities to increase fees or do increases have to be negotiated? What is your contracting cycle with Facilities? When were the Network Facility fees last increased?

[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 for fee increases or are increases negotiated on a case by case basis? What is your contracting cycle with Network Practitioners? When did you last increase these fees?

[redacted]

[redacted]

e. What does the current average Network Practitioner reimbursement represent as: 1) a percentage of covered charges for your book of business in NYS; and 2) a percentage of the reasonable and customary charges?

[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?

[redacted]

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 Providers, if requested.

OptumHealth confirms its agreement to provide the Department with information pertaining to specific fee arrangements.

h. Is the Offeror's Proposed Network a standard Network or has it been specifically contracted to administer the Empire Plan MHSA Program?

OptumHealth is proposing our standard network in addition to targeted recruitment for the Empire Plan.

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.

Yes. Practitioner contracts are standard with consistent terms applied for all of our clients. Ad hoc rate negotiations may be undertaken when necessary to maintain a viable network. In general, we strive to limit ad hoc rate negotiations to MDs.

Facility contracts also utilize a standard template, but contract language and reimbursement negotiations can be pursued regarding specific terms of each facility agreement.

j. In addition to negotiating agreements with Network Providers on behalf of clients, does the Offeror or any of its Affiliates or any sub-contractor's Affiliates have other business arrangements with Network Providers from which the Offeror or any of its Affiliates or any sub-contractor's Affiliates have derived revenues? If the Offeror and/or any of its Affiliates or any 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.

No, OptumHealth does not have any business arrangements with network providers from which we have derived revenue. No affiliates or any subcontractors' affiliates are proposed for the services outlined in this RFP.

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

[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?

[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 sub-contractor and Network Provider agreements related to the MHSA Program under strict confidentiality provisions;

We agree to adhere to be open and forthright in all matters related to the clinical management and cost management of the Program. We will adhere to the State's standard audit provisions, subject to confidentiality requirements. We agree to the disclosure obligation listed above.

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 adhere to be open and forthright in all matters related to the clinical management and cost management of the Program. We will adhere to the State's standard audit provisions, subject to confidentiality requirements. We agree to the disclosure obligation listed above.

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 subcontractor 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 adhere to be open and forthright in all matters related to the clinical management and cost management of the Program. We will adhere to the State's standard audit provisions, subject to confidentiality requirements. We agree to the disclosure obligation listed above.

3. Transparency During the Procurement Process.

Contractor must provide all information the Department deems necessary to support their Cost Proposal. This includes but is not limited to adequate information to support the Offeror's 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. Please confirm.

We confirm our agreement to the above transparency requirements.

4. Explain the contractual and financial relationships among or between the Contractor, subcontractor, 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.

OptumHealth is a service mark of United Behavioral Health (UBH). UBH is a wholly owned subsidiary of UnitedHealth Group. OptumHealth does not have any business arrangements with network providers from which we have derived revenue.

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.

As indicated in our response to Section V.D.4 above, OptumHealth does not have any business arrangements with network providers from which we have derived revenue. We provide MHSA services to both insured and self-funded customers, and in both instances we act according to all applicable laws and regulations and in the best interests of our customers and the members we serve. Our interests in quality of care, cost management, and member satisfaction are well aligned with those of the State.

www.optum.com

425 Market Street, 14th Floor, San Francisco, CA 94105

Mental Health and Substance Abuse Program
Quoted Average Cost Per Each CPT/Revenue Code

Amended 3-11-13

CPT Code	Revenue Code	Quoted Average Contracted
	0001	[redacted]
	0002	
	0100	
	0101	
	0114	
	0116	
	0120	
	0121	
	0124	
	0126	
	0128	
	0129	
	0130	
	0134	
	0136	
	0138	
	0144	
	0150	
	0151	
	0153	
	0154	
	0158	
	0164	
	0183	
	0190	
	0193	
	0204	
	0220	
	0221	
	0230	
	0250	
	0251	
	0252	
	0257	
	0258	
	0259	
	0260	
	0269	
	0270	
	0271	
	0272	
	0300	
	0301	
	0302	
	0305	
	0306	
	0307	
	0309	
	0320	
	0324	

Mental Health and Substance Abuse Program
Quoted Average Cost Per Each CPT/Revenue Code

Amended 3-11-13

CPT Code	Revenue Code	Quoted Average Contracted
	0350	
	0351	
	0370	[redacted]
	0379	
	0402	
	0412	
	0450	[redacted]
	0451	
	0456	
	0459	[redacted]
	0460	
	0510	[redacted]
	0513	
	0540	
	0611	
	0636	
	0637	
	0657	
	0710	
	0730	
	0762	
	0771	
	0888	
	0900	[redacted]
	0901	
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	0911	
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	0913	
	0914	
	0915	
	0918	
	0919	
	0920	
	0939	
	0941	
	0942	[redacted]
	0944	
	0945	
	0949	
	0961	[redacted]
	0969	
	0981	
	0982	
	0987	
	0988	
	1000	

Mental Health and Substance Abuse Program
Quoted Average Cost Per Each CPT/Revenue Code

Amended 3-11-13

CPT Code	Revenue Code	Quoted Average Contracted
	1001 1002	[redacted]
90785		
90791		
90792		
90832		
90833		
90834		
90836		
90837		
90838		
90839		
90840		
90845		
90846		
90847		
90849		
90853		
90856		
90863		
90865		
90867		
90868		
90870		[redacted]
90876		
90887		[redacted]
90889		
90899		
90901		
93000		
93010		[redacted]
93042		
94760		[redacted]
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96102		
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96116		
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96152		
96360		
96372		
98968		
99050		
99051		[redacted]
99053		

Mental Health and Substance Abuse Program
Quoted Average Cost Per Each CPT/Revenue Code

Amended 3-11-13

CPT Code	Revenue Code	Quoted Average Contracted
99201		[redacted]
99202		
99203		
99204		
99205		
99211		
99212		
99213		
99214		
99215		
99217		
99218		
99220		
99221		
99222		
99223		
99224		
99225		
99231		
99232		
99233		
99234		
99236		
99238		
99239		
99241		
99242		
99243		
99244		
99245		
99251		
99252		
99253		
99254		
99255		
99281		
99282		
99283		
99284		
99285		
99304		
99305		
99306		
99307		
99308		
99309		
99310		
99406		
99408		
99409		

Mental Health and Substance Abuse Program
Quoted Average Cost Per Each CPT/Revenue Code

Amended 3-11-13

CPT Code	Revenue Code	Quoted Average Contracted
99443		
99999		
A0382		
A0384		
A0392		
A0394		
A0398		
A0422		
A0425		[redacted]
A0426		
A0427		
A0428		
A0429		[redacted]
A0432		
A0999		
G0454		
H0001		[redacted]
H0002		
H0004		[redacted]
H0005		
H0014		
H0015		
H0016		[redacted]
H0020		[redacted]
J2426		
M0064		[redacted]
S9480		
S9485		[redacted]
T1016		

(1) Amount quoted per CPT is per service; Amount quoted per Revenue code is per day.

[redacted]

Mental Health and Substance Abuse Program
Applied Behaviorial Analysis Fee Quote

Type of Service	Fee Quote	Basis
Behaviorial Assessment by BCBA (professional)	[redacted]	[redacted]
BCBA (professional) ABA Services	[redacted]	**Per Hour of Service**
BCBA (paraprofessional) ABA Services	[redacted]	[redacted]
Total		

Exhibit V.C

Mental Health and Substance Abuse Program
Administrative Fee Evaluation

Administrative Fee Calculation	**Fee Quote**	**Basis**
Monthly Administrative Fee Quote	[redacted]	**Per Contract Per Month (1)**

[redacted]

(1) A contract is defined as either a contract for Individual coverage or Family coverage.