



An RFP Response for the
New York State Department of Civil Service



Request for Proposals #2014-MH-1

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

Cost Proposal

Date

May 20, 2014

Contact

[Redacted contact information]

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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.

We have reviewed Section V and confirm that we are able to meet all requirements. We have responded to each required submission item as requested below.

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 after the coordination of benefits when the claim is processed as secondary coverage.

Confirmed.

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.

Confirmed.

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.

Confirmed.

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 30th 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.

Confirmed.

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 subject to Article II, Agreement Duration and Amendments, of the resulting Agreement.

Confirmed.

c) If the AAUC for each category exceeds the GAUC, the Contractor shall forfeit a portion of the Administrative Fee for failure to meet this guarantee, as follows:

For each 1.0% the AAUC exceeds the Outpatient Services GAUC proposed in 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 MHP Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Outpatient Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

For each 1.0% the AAUC exceeds the Inpatient and ALOC Services GAUC proposed in 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 MHP Program within thirty (30) days after the Contractor is notified in writing that the calculated performance credit was approved by the Department. The performance credit for the Inpatient and ALOC Services GAUC shall not exceed 50% of the total Administrative charged for the applicable Plan Year.

Confirmed.

d) 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.

Confirmed.

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 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.

Confirmed.

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, V.B.4 and V.B.5 of this RFP

Confirmed.

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 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.

We have provided Exhibit V.A.2 (Network Outpatient Services) and Exhibit V.A.3 (Network Inpatient and Alternative Level of Care (ALOC) Services) as attachments to our proposal.

2. Non-Network Claims

a. Duties and Responsibilities

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

Confirmed.

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.**

Confirmed.

b. For the Student Employee Health Plan: using the Network Provider allowed amount applicable for Downstate New York;

Confirmed.

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.B.2 as well as the annual maximum for ABA services.

Confirmed.

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 and include these charges in the calculations of the annual AAUC.

Confirmed.

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.

Confirmed.

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.

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.

[Redacted]

- [Redacted]
- [Redacted]
- [Redacted]

[Redacted]

- [Redacted]
- [Redacted]
- [Redacted]

[Redacted]

[Redacted]

3. Administrative Fee

The Administrative Fee is the fee quoted by the Offeror representing the charge to the MHPA 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.

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;

Confirmed.

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

Confirmed.

- 3) Implement any changes necessary to accommodate MHPA Program modifications resulting from collective bargaining, legislation or within the statutory discretion of the State within 60 days of notice;

Confirmed.

- 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;

Confirmed.

- 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 MHPA 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;

Confirmed.

- 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 MHPA 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;

Confirmed.

7) Agree that the Administrative Fee shall be calculated based on the number of covered MHSA Program 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 in force.

Confirmed.

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 date the last day of coverage; therefore, Offerors should take this into consideration in developing their proposed Administrative Fee.

Confirmed.

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.B.

We have provided Exhibit V.B (Administrative Fee Quote) as an attachment to our proposal.

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 Agreement resulting from this RFP. 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 in consultation with the Contractor 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.

Confirmed.

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

Confirmed.

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.

Confirmed.

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.

[REDACTED]

[Redacted content]

5. Shared Communication Expense

The cost of Empire Plan communication expenses, including Empire Plan reports, At-A-Glance summaries and general information books are allocated among the four Empire Plan Program components. The MHPA Program allocation of shared communication expenses was \$532,000 in 2014 and \$456,000 in 2013.

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.

Confirmed.

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.

Confirmed.

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 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 contract totals include Empire Plan and Medicare primary enrollees. The enrollment mix and benefit characteristics are presented in Exhibit II.A through Exhibit II.A.4; Exhibit II.C; Exhibit II.C.2; 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.A.4; Exhibit II.C; Exhibit II.C.2; and Exhibit II.D will exist.

a. Duties and Responsibilities

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 of receiving a bill of the claims processed by the Contractor. The Department may consider comparable alternatives to this approach during implementation.

Confirmed.

2) The Plan will pay an Administrative Fee on a monthly basis within 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.

Confirmed.

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.

Confirmed.

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.

Confirmed.

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 thirty (30) Days of receipt of such recoveries; however, the Contractor is not responsible to credit amounts that are not recovered.

Confirmed.

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

Confirmed.

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.

Confirmed.

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 claim 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.

We agree to comply with all the duties and responsibilities outlined in Section V.C.a. Given the requirement that the department shall pay the Contractor by wire transfer within seven

days of having received a bill of the claims processed, our preferred arrangement would be to provide the Department with a daily notification of claims processed, thereby enabling the Department to wire-transfer the necessary funds to a bank selected by OptumHealth.

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

[Redacted]

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

[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?

[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 Network Providers, if requested, both during the procurement process and throughout the term of the Agreement resulting from this RFP.

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? Are the proposed Network Provider fees included in this RFP response currently in place in NYS?

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 Key Subcontractor's Affiliates have other business arrangements with Network Providers from which the Offeror or any of its Affiliates or any Key Subcontractor's Affiliates have derived revenues? If the Offeror and/or any of its Affiliates or any Key Subcontractor'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 MHS 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 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]

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]

[Redacted content]

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 Subcontractor 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. Agreeing 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, 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 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 the 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 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, 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.

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.

Attachments

Exhibit V.A.2 - Network Outpatient Services

Exhibit V.A.2

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

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

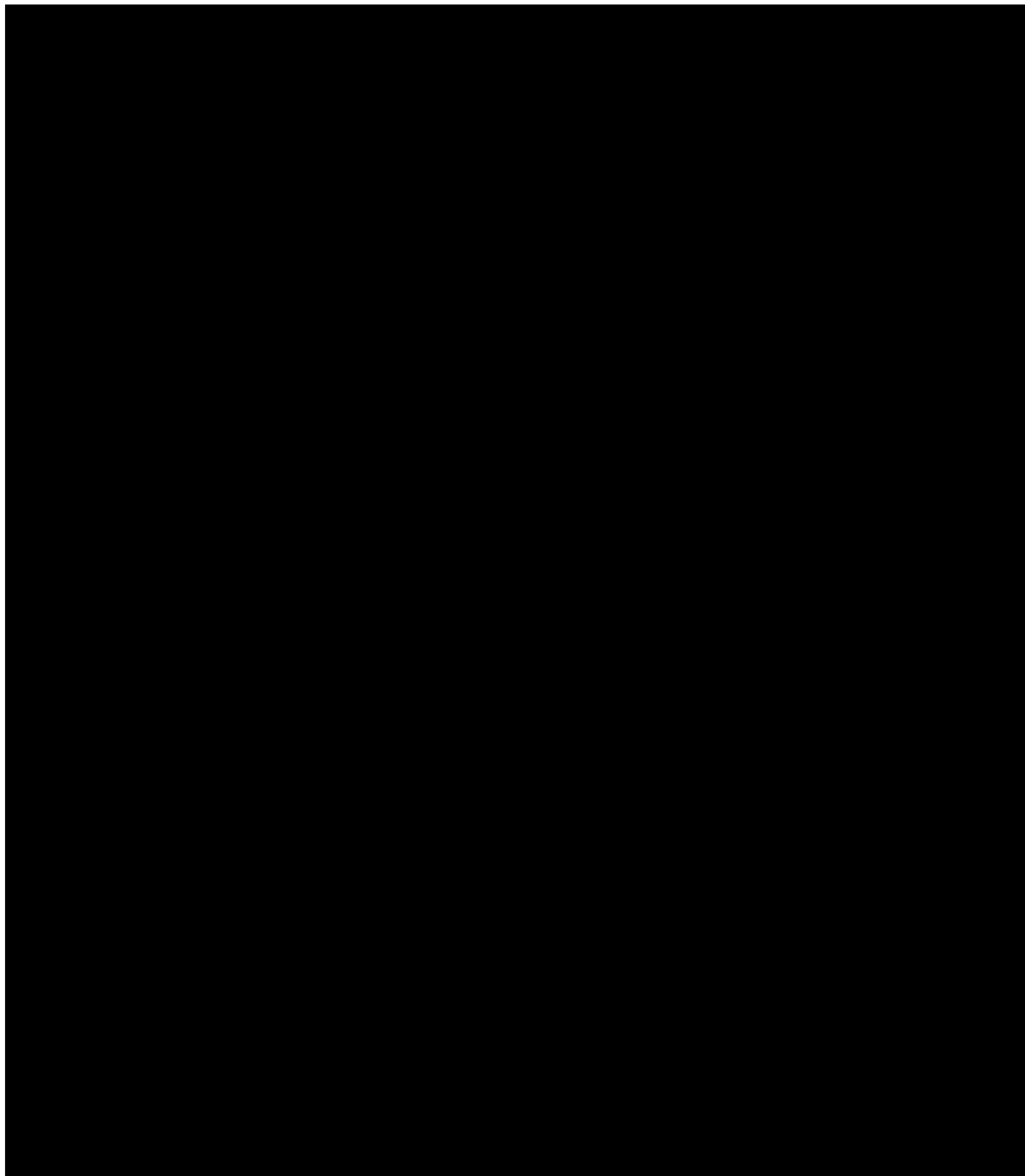
"The rest of this Exhibit has been redacted."

Exhibit V.A.3 - Network Inpatient and Alternative Level of Care (ALOC) Services

Exhibit V.A.3

**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**

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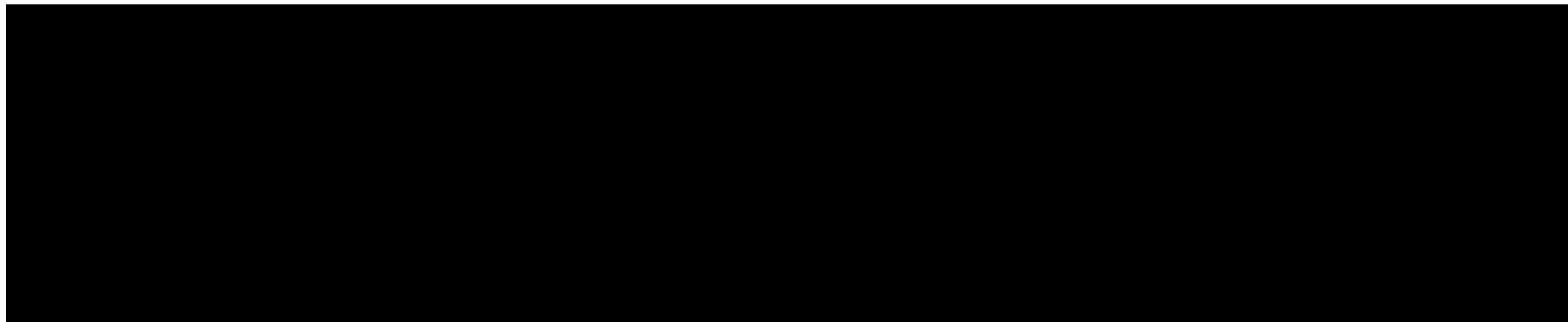


Exhibit V.B - Administrative Fee Quote

Exhibit V.B

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

	Fee Quote	Basis
Monthly Administrative Fee Quote	—  —	<u>Per Enrollee Per Month</u>