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

Technical Proposal

Date
May 20, 2014

Contact
[redacted]

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A. Program Administration

1. Executive Summary

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

a. Required Submission

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

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

Optum[1] respectfully submits this executive summary and the proposal that follows as demonstration of our sincere interest in regaining the awarded contract as the Behavioral Healthcare Administrator (BHA) for the Empire Plan Mental Health and Substance Abuse (MHSA) Program. The Department of Civil Service (the Department), the Governor's Office of Employee Relations (GOER) and Union partners will have direct access to the highest level of leadership—from both Optum and UnitedHealthcare. We understand that serving an account the size, scope and complexity of the Empire Plan MHSA Program requires our most experienced leaders, so, as your previous vendor, we established a unique account partnership. Optum's Chief Growth Officer, [redacted], UnitedHealthcare National Accounts, Senior Vice President, Specialty Client Group, will jointly serve as executive sponsors. [redacted] will ultimately be responsible for account oversight. [redacted] will again provide MHSA Program administration working in collaboration with Carl Mattson, UnitedHealthcare Vice President, Empire Plan Medical Program. These leaders regarded their service to the MHSA Program as a privilege and will work each day to demonstrate our capabilities and earn the Department's continued trust.

We will serve Enrollees from the dedicated care advocacy center at [redacted] that we established specifically to administer the MHSA Program in 2008. The site is staffed with clinicians who live in the area and know providers and community support resources first hand. They understand the Enrollee population as a whole, as well as on an individual Enrollee basis, and can make informed decisions for those individuals suffering from complex and chronic conditions. Similarly, our New York based network managers are connected to the provider community and focus on strengthening relationships that will better serve Enrollees.

During the past five years we have learned much from the Department about its objectives, requirements and the needs of Enrollees. Building on this understanding and experience, we believe Optum is the best partner to meet the demands of the continually evolving needs of the State and we will work with you to create a Value-Based offering for The New York State Insurance Program.

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[1] A brand name of the legal entity United Behavioral Health, headquartered at 425 Market Street, San Francisco, California 94105

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

Executing on MHSA Program Requirements

During our five year contract to administer the Empire Plan MHSA Program, we were committed to offering a service to meet the challenges of a large public program. Optum's core components for the MHSA Program include:

- An Albany based, dedicated account management deeply involved in each decision that impacts the operation of the Empire Plan MHSA Program.
- Easy access to telephonic assessments, consultations and referrals through the Clinical Referral Line (CRL), answered by a dedicated, New York-based team of expert licensed clinicians, 24 hours a day, seven days a week.
- A seamless Enrollee experience provided by our Empire Plan-dedicated customer service team, who assist Enrollee's with benefit and claims questions or warm transfer them to a clinician for assistance in finding the most appropriate level of treatment or the best-suited provider
- An established, dedicated clinical team of licensed care advocates, who live and work in the local provider community and know the Enrollee population, their culture and expectations
- A customized website for Enrollee access to disease management programs, specific condition information, benefit explanations, claims answers and view-only authorizations
- A shared claims platform and easy-to-understand, real-time shared accumulator information across medical and behavioral programs
- An enhanced offering for the Empire Plan's disease management programs that has proven to increase participation for the identified population dealing with a significant illness
- Management of the Enrollees requesting continued Empire Plan coverage due to a disability, including review of the PS-451 form; determination usually made within 24 to 48 hours but never to exceed 10 business days
- A specialized autism care advocacy center to provide expert assistance to enrollees seeking services and a comprehensive autism management program that fully complies with the New York State autism insurance mandate

Optum's experience in combination with advanced clinical tools and dedicated clinical resources forms the foundation of our approach to best serve as the administrator of the Empire Plan MHSA Program. The strength of our network complements our clinical expertise—we offer convenient access to clinicians qualified to address multiple needs and preferences—clinical, language, gender, faith, ethnicity and cultural—as well as a broad spectrum of facility-based treatment programs that have earned autonomy by meeting our standards for quality and efficiency.

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

Experience with State Governments and Large Employers

Optum brings twenty-five years of experience providing highly customized programs for very large public and private organizations with complex and challenging needs. [redacted]

Through our partnerships with multiple state government employers and union representatives, we have developed and tested new initiatives, built stronger partnerships with providers and promoted cross-vendor collaboration. We have learned much, and we have leveraged this experience to shape our products and services, applying proven results on a broader scale to the advantage of all our customers. For example, in partnership with our state government customers, we have:

- Created new clinical programs that address high utilizing populations, such as our Suboxone Initiative for Opiate Dependence—effectively addressing the increasing incidence of opiate addiction in young adults by treating the psychosocial issues as an integral component of suboxone treatment for opiate dependence.
- Partnered with a network preferred facility to create a four-day intensive stabilization program (for appropriate patients based on a thorough clinical evaluation) that, along with the short length of stay, also reduces readmissions.
- Created eating disorder centers of excellence to provide a full continuum of care that has increased collaboration among providers, patients and families and reduced the number of peer reviews.
- Pioneered performance-driven network contracting that rewards providers for outcomes, thereby strengthening provider partnerships and enhancing member outcomes.
- Fostered partnerships with multiple vendors and carriers to share benefit information, promote cross-referrals and enhance coordination of care.

Optum's extensive experience of administering large public programs, coupled with the knowledge we have gained in our five years of service to the Department and Enrollees, strongly positions us to advance the Department's goals over the next five years with no disruption in service.

Strengths and Tools for the Next Phase of Our Partnership

The longstanding relationship of UnitedHealth Group's senior leaders and individuals directly accountable for serving the Empire Plan, combined with our experience administering the MHSA Program, uniquely positions Optum to not only execute on the required program elements but also to advance the Department's goals for the future. We understand that the Department's priorities are as follows:

- Ensuring the affordability of the plan, especially with the move from a fully insured to an administrative services only (ASO) funding arrangement
- Providing broad access to care through a cost-effective, stable network, through which the vast majority of care is delivered
- Delivering a positive Enrollee-focused experience with high levels of satisfaction
- Actively consulting with the Department to ensure that the plan design delivers value and remains compliant with changing regulatory requirements
- Achieving efficient program delivery that results in the highest level of execution for overall quality plan administration

Optum brings proven clinical tools and technology, the nation's largest performance-driven network, synergies with other vendor partners, satisfied enrollees, and established processes and people that will enable the Department to once again provide a valuable benefit program for Enrollees.

Proven Clinical Approach Protects Plan Affordability

From our long-term service to the Department, we clearly understand our mandate: to control costs through determining medical necessity and effectively managing high-risk cases—to focus our resources where we can add the most value. For more routine cases, we will promote provider autonomy and preserve the Enrollee/provider relationship. We recognize that with the shift to an ASO arrangement, the Department will now, more than ever, require a behavioral health administrator who will successfully ensure the affordability of the MHSA Program, while delivering service excellence to Enrollees. Optum has enhanced its clinical model with *industry-leading predictive modeling tools that increase our accuracy in identifying potential high-cost claimants*, stratifying them according to risk, and intervening proactively and appropriately to get ahead of high-cost events. With these clinical tools as the foundation, we provide a dedicated care advocacy model that drives early intervention, evidence-based treatment, intensive case management for high-risk cases, and innovative outpatient management.

Advanced Stratification: High Impact Opportunity Groups

Using our extensive data analysis capabilities, we have developed scientific case stratification methodology to categorize inpatient cases as either intensive or standard and to better inform case oversight from admission to beyond discharge. We can identify Enrollees with clinical similarities and common gaps in care, and focus our resources on these *high impact opportunity groups.* Care advocates, who specialize in these types of cases, will collaborate with clinicians, Enrollees and their families to develop recovery-focused, strengths-based treatment plans. We know that keeping the post-discharge outpatient appointment is a critical first step, so we will assist the member in making that appointment and then call to make sure it was kept. Care advocates will also identify community resources that a member may need upon discharge, closing any gaps that would keep an Enrollee from adhering to the treatment plan. [redacted], in spite of federal reform regulations that have increased utilization—the Mental Health Parity Act and the expanded coverage for 19 to 26 year-olds under the Affordable Care Act.

Clinical Rounds: Experts Address the Most Costly Cases

We will routinely conduct clinical rounds as part of MHSA Program administration and as a clinical best practice. Care advocates, clinical program managers and behavioral medical directors will hold collaborative discussions on the most complex cases to ensure evidence-based treatment and aggressive interventions that will drive positive outcomes and manage costs. Our medical directors for the Empire Plan MHSA Program, will be available for ad hoc case reviews and consultations with our care advocates, as well as leading clinical rounds. Our clinical rounds are focused on:

- Intensive cases involving the most complex and chronic diagnoses
- Outliers for average lengths of stay in inpatient or intermediate levels of care.

Our clinical leadership will pay close attention to the management of 18 to 26 year old dependents (including out-of-state substance abuse cases), which has been a high-utilizing segment of the Enrollee population since the Affordable Care Act granted expanded coverage. When we did this under our previous partnership with the MHSA Program, these cases were often reviewed during clinical rounds because of gaps in psychosocial supports and complex medical-behavioral issues. Because these Enrollees were often in crisis and required inpatient discharge follow-up, we assigned a care advocate to help the Enrollee follow a strengths-based treatment plan with a qualified provider and connect them with the community resources that further promote recovery and resiliency.

The clinical leaders for the MHSA Program will also participate in our Optum-wide clinical rounds for eating disorders. Given the complexity of the disorders and the challenges in treatment, we will convene our expert specialists from our care advocacy centers around the country to drive the most effective care in the most appropriate setting. Through our case reviews with eating disorder treatment programs and hospitals, we also gain greater transparency for our network facilities, which drives tiering and centers of excellence designation.

Medical-Behavioral Integration Best Practices

We recognize that achieving medical-behavioral integration can only enhance Enrollees' treatment outcomes and reduce the cost of these complex cases. [redacted] The objective of the initiative is to improve coordination of care within each program, as well as identify opportunities for cross referrals to other Empire programs that may available to the Enrollee.

Performance-Driven Network Delivers Quality and Efficiency

[redacted] the Optum behavioral network is the largest in the industry, providing Enrollees with easy and convenient access to a choice of clinicians and a complete continuum of care. Recent geographic access analysis shows that we exceed the Department's Enrollee access standard of 95 percent for all defined provider types in urban, suburban and rural settings—[redacted]. Our network also includes numerous intermediate-level treatment programs (e.g., residential, intensive outpatient, day treatment), which provide cost-effective yet therapeutic alternatives to inpatient care.

Of equal importance is the fact that it is a performance-driven network; therefore *Enrollees will choose clinicians who meet our standards for quality and efficiency*. We use tiering and contracting strategies that reward clinicians and facilities who meet efficiency and quality standards with more referrals and greater autonomy. There are also opportunities for financial incentives and continuing education.

Optum also fosters strong relationships with clinicians by reducing their administrative tasks as much as possible. Our dedicated website for our clinical network enables clinicians to check on enrollee benefits and eligibility, report administrative and demographic changes and submit claims.

Strong collegial relationships translate into better service for Enrollees overall, and Optum has worked hard to establish collaborative relationships in the provider community. Our dedicated, New York-based provider relations team participates in meetings with key professional organizations, such as the New York State Psychological Association and the National Association for Social Workers. Our network and clinical teams will also conduct several on-site meetings with key facilities providing care to Empire Plan MHSA Program Enrollees. As a result of our positive relationships in the provider community, we are able to address variability in practice patterns, using tools and technology that encourage provider awareness and adoption of clinical best practices.

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

(a) Account Team

(b) Premium Development Services

(c) Implementation

(d) Customer Service

(e) Enrollee Communication Support

(f) Enrollment Management

(g) Reporting

(h) Consulting

(i) Transition and Termination of Contract

(j) Network Management

(k) Claims Processing

(l) Clinical Management/Utilization Review

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

Established Operational and Administrative Components

In choosing Optum as the Behavioral Healthcare Administrator once again, the Department will have the advantage of established leaders who are thoroughly knowledgeable about the Program and all administrative components—functions that have been customized for the Program and that are able to be re-implemented easily.

The individuals responsible for these functions (summarized below) are shown in the organizational chart, included as Attachment 1.

Account Team

For our Department, GOER and Union partners, we have worked diligently to establish:

- A dedicated, Albany-area based account management team
- A New York-based dedicated clinical utilization review department familiar with providers and facilities where the majority of Enrollees reside
- A customized, unique set of management and utilization reports specifically designed and provided for the Empire Plan MHSA Program
- A well-received annual Joint Labor Committee meeting to highlight the success and progress of the Empire Plan MHSA Program as administered by Optum

Because of our sister company relationship with UnitedHealthcare, we are in the unique position to leverage the knowledge and experience of UnitedHealthcare and its Empire Plan-dedicated staff in administering certain aspects of the MHSA Program. Optum Empire MHSA account management team [redacted] will again work closely with the UnitedHealthcare Empire Medical account management team led by [redacted]. The Department, GOER and Union representatives have direct access to senior leadership through executive sponsors [redacted], who ultimately oversee the account. Through this dedicated and knowledgeable partnership on behalf of the Department, these leaders promote coordination between the behavioral and medical benefits and oversee all contractual obligations for the Program.

Premium Development Services

To support the Department's requirements for premium development services, we will provide a team of MHSA financial experts, all of whom are senior members of our finance department. This team, led by [redacted], will deliver underwriting assistance and consultation in the development of premium rates, projected aggregate claims trend analyses and detailed examinations of the program components that will impact MHSA costs. Annual premium analyses include inputs such as trend factors, legislative mandate analyses, incurred claims reports and program design and enrollment changes.

Implementation

We believe our experience as the Department's former MHSA Program vendor positions us to minimize both the burden on the Department for MHSA Program implementation. An Optum implementation project manager will assume overall responsibility for the planning and execution of the implementation process. Incorporating key information gathered from the pre-implementation discussions, the project manager will work closely with [redacted] and Optum operational staff members to define processes, identify accountabilities, anticipate any implementation bottlenecks and pinpoint the Department's implementation priorities. Given our history providing MHSA Program services, and our connection to UnitedHealthcare (as the medical carrier), we are uniquely positioned to perform a smooth, efficient and on-time implementation.

Customer Service

Dedicated New York-based customer service representatives will provide answers to a variety of questions regarding benefit plan design information, eligibility and claims status. They will also warm-transfer callers to the Clinical Referral Line to speak directly to a trained, licensed clinician. Our CRL will be available to Enrollees 24 hours a day, seven days a week.

Enrollee Communication Support

The Department's dedicated account management team will work with the Department to review and provide feedback on communication materials developed and distributed by the Department. In addition, customized Plan materials on various topics can be prepared by Optum staff, as required and requested by the Department.

Enrollment Management

We offer the Department dedicated eligibility staff located in our Kingston service center for both the UnitedHealthcare Medical and MHSA programs. We will integrate the enrollment process so that the Department only needs to provide a single data feed. In addition, the Kingston eligibility analysts have access to the New York Benefits Eligibility and Accounting Systems (NYBEAS) and direct contact with the Department eligibility staff to deliver efficient management of enrollment and eligibility. We will also cooperate with Department initiatives to use new technologies, processes and methods to increase Enrollment maintenance efficiencies.

Reporting

Comprehensive reporting, submitted according to a schedule defined by the Department, will be prepared and submitted for the Empire Plan covering Program financial status, performance guarantees, website analytics, provider monitoring and various call and clinical data. Reporting activity will be a coordinated effort between Optum staff and UnitedHealthcare staff dedicated to the Program.

Consulting

[redacted], and her team will keep the Program abreast of the latest developments in the MHSA field and make benefit plan recommendations. Empire's clinical team, including the medical director and clinical director will work closely with our account management team to inform the Department of upcoming legislation and trends. In addition, we have a dedicated research department, Behavioral Health Sciences, which partners with academic research institutions and our customers to advance the behavioral health field. The Empire Plan MHSA Program account management team will collaborate with UnitedHealthcare on pending legislation on both a state and federal level and provides consultative services to the Department and GOER regarding possible implications of new legislation to the Program. We have established relationships with regulatory and legal personnel, including government affairs within the organization. These experts are available to review and interpret state and federal legislation, Enrollee communication materials, and ensure compliance with these regulations.

Transition and Termination of Contract

As we did with the termination of our 2009 contract, we will work closely with the Department and the new vendor to design a transition plan that will exceed all requirements and enable full transition in a timely manner. Key elements and tasks in our transition plan to ensure completion of all required duties and responsibilities include development of an approved plan, establishing contacts with new vendor, transition of program and clinical data, as well as managing safe and effective transitional care for those Enrollees who are active and ongoing treatment. We offered additional transitional activities in an effort to minimalize the disruption of the enrollees and offer a successful implementation of the new MHSA program administrator.

Network Management

Optum has built a robust national network of providers. Because of the high concentration of Enrollees in New York State, [redacted] In addition, our local network management team in Albany ensures that we fully meet network access and composition guarantees and that any areas with high concentrations of active and/or retired employees living outside of New York State have convenient access to providers.

Claims Processing

To ensure we meet all performance guarantees for claims accuracy and turnaround times, Optum will provide the MHSA Program with a dedicated claims processing team, trained in plan-specific protocols, including customized fraud, waste and abuse training. Our claims system, which is the same system used by our sister company, UnitedHealthcare, will contain unique MHSA Program benefit details, including copayments, deductibles, accumulators and plan design features specific to the Program. Not only does our claims system have appropriate edits in place to manage clinical authorization for prior authorization and concurrent reviews, it integrates a variety of functional areas—claims, customer service, eligibility and clinician/facility data—providing the Program's dedicated claims staff with the tools necessary to ensure accurate, responsive service.

Further, we will provide the Department with a special investigations unit (SIU) to pursue every instance of potential claim submission errors from fraud, waste and abuse. The investigators bring specialized understanding of behavioral health claims, which is critical due to the CPT codes changes which caused provider confusion and claim errors, as well as the potential for fraud. The SIU is part of the larger corporate SIU, which establishes best practices and maximizes opportunities for fraud, waste and abuse identification.

Clinical Management/Utilization Review

Clinical management and utilization review will be provided by a team of licensed care advocates, who perform assessment and triage 24 hours a day, seven days a week. These care advocates precertify and conduct concurrent review for higher levels of care, as well as provide enrollees with the best provider referrals to meet their clinical needs. Our care advocates are distinguished by their broad experience, the depth of their clinical skills, and their active involvement in decisions about patient care.

In Summary

We were honored to have been selected as the administrator of the Empire Plan MHSA Program in 2009 and welcome the opportunity to build on what we accomplished together.

We believe that together, we built a strong foundation for a future partnership that was distinguished by:

- A performance-driven network that delivers access and quality at an affordable price
- Expert consultation on legislative issues and benefit plan design to ensure that the Department stays abreast of trends and regulations
- State-of-the art predictive modeling tools that accurately predict high-cost claimants and enable proactive intervention
- Unparalleled collaboration with UnitedHealthcare that drives clinical and administrative synergies and efficiencies

Drawing from our shared expertise, we can create plans and programs that will deliver the strongest outcomes for Enrollees and reflect the interests of the Department's stakeholders. We appreciate our partnership, and with this RFP response, express our sincere commitment to contribute our resources and expertise in helping the Department meet future challenges.

2. General Qualifications of the Offeror

The MHSA Program covers over one million lives and incurs costs in excess of $180 million annually. The Offeror/ Contractor must have the experience, reliability and integrity to ensure that each Enrollees' mental health and substance abuse care needs are addressed in a clinically appropriate and cost effective manner. The terms of the Offeror's proposal must demonstrate explicit acceptance of and responsiveness to the MHSA Program's duties and responsibilities set forth in the RFP, ensuring full compliance with the MHSA Program Services.

a. Required Submission

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

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

In addition to managing The Empire Plan MHSA Program, Optum has a long history of managing large complex accounts, subject to legislative changes and public visibility and scrutiny, including state governments, large public university systems, and numerous counties, municipalities and school districts. Our corporate customer roster includes industry leaders from the fields of finance, manufacturing, telecommunications, technology and more, giving us the scope of experience and resources necessary to effectively implement and administer the Program, meeting all requirements.

[redacted] working for public employers, including states, counties, cities, fire and port authorities, sheriff's departments, schools and similar organizations. As with our relationship with the Department, we have fostered our long-term relationships with these customers because we have learned how to work with the departmental structures unique to public sector employer groups. This experience enables us to anticipate the needs and preferences of their members and to respond successfully to the difficulties often associated with these customers.

On a regular basis, we respond to the complexities associated with public contracts, including stressors caused by working under continual scrutiny by the public, downsizing, hiring freezes, reduced work schedules and increased workloads. We work in trusted partnership with multiple levels of benefit program key stakeholders and decision-makers within these public agencies, and our strategic account executives know how to work cost-effectively with limited budgets across their varied and numerous functions and departments.

We have become experts at providing specialized service to departments within the organization, such as transportation, law enforcement and other personnel that require flexible support due to their job types and/or schedules. We also serve the needs of bargained groups within many of these populations, including education, transportation, construction and custodial service workers. Many of our large public, self-funded programs face challenges that the Department and GOER may. There are varied benefit programs, a diverse workforce, safety-sensitive positions and public exposure. Much like the work we do with [redacted] including union employees, we work with large customers to develop customized programs and services that address the issues that concern them most.

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

Account Management Team

[redacted], the dedicated account management team for the Empire Plan MHSA Program combines account expertise and enrollee support with guidance from our senior leadership sponsor, [redacted] provides oversight for the administrative and operational aspects of the account and works in close coordination with operational and clinical leadership.

We recognize that an account the size and complexity of the Program requires the careful attention that only a dedicated team can provide. The account team will be involved in the day-to-day operations and [redacted] will be deeply involved in any decision or direction impacting the Empire Plan MHSA Program.

Leadership Support

We believe it is also critical to provide the Program team with senior-level support. Therefore, we integrate the support of Optum senior leaders into the mode. This means that individuals who are connected with the overall design and operation of the Program are available to support [redacted]g and the account team in ensuring the Program's success. Through this team-based approach, we have delivered a well-rounded and cohesive program that draws upon our staff's expertise throughout our company. By empowering our account management team to escalate issues within Optum to ensure that the appropriate staff is involved, decisions can be made quickly. [redacted] has direct access to corporate department heads and is empowered to act across all departments to ensure smooth functionality for Program delivery and to leverage internal resources in ways that add value.

As the Program's executive sponsor, [redacted] ensures an immediate channel to the most senior executives in Optum, for both the Optum account management team and Department representatives, should the need arise. [redacted]

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

We will provide significant financial, legal and audit oversight and support of the Empire Plan MHSA Program, as we did when we were the MHSA Program vendor. The account management team will to collaborate with the Empire Plan medical account management team regarding regulatory updates or concerns identified for New York State as well as capture the resources of the corporate Optum legal, financial and audit team.

Account management leadership and the Department will have direct access to and support from senior leadership to leverage our organizational resources and escalate issues as needed. The account management team will be located in Upstate New York for the length of the contract.

The team will be prompt in advising the Department of any changing costs or service delivery issues for the Program and we will comply with the legal advisory requirements as described in the RFP, notifying the Department of any changes in legislation and ensuring compliance and proactive consultation about legislative changes. The account management team will conduct operational meetings to ensure that all departments servicing the enrollees covered by the Empire Plan MHSA Program are monitoring service metrics, policies/procedures and addressing any issues that arise promptly.

Other systems and procedures that aid the team in their oversight of the MHSA Program will include customized reporting of key metrics, website reporting to identify trends, member satisfaction surveys and provider satisfaction surveys. These resources can be used to monitor performance, make recommendations and address potential issues. Further, our dedicated fraud, waste and abuse function will assure funds are used only for legitimate services.

We also use analytical research and reporting to bridge areas of financial assessment, clinical utilization, product performance and network operations. Healthcare economics make it possible for us to look at drives market trend and use that information to develop new strategies, review pricing, make changes to our networks and benefit design, review treatment protocols and other program infrastructure components.

B. Proposed Empire Plan MHSA Program Services

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

1. Account Team

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

a. Duties and Responsibilities

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

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

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

The organizational chart for the dedicated Empire Plan MHSA Program account management team is included as Attachment 1 and illustrates the reporting relationships of the various individuals on the account management team. Below, we describe how these various team members collaborate internally with operational departments and senior leadership as well as how they will interface with the Department and the Governor's Office of Employee Relations (GOER) to provide a comprehensive and responsive program for all Empire Plan MHSA Program Enrollees.

Account Management

Through [redacted], you have single point of contact for all issues, concerns and needs for the overall plan administration and service. [redacted] has a long standing history of serving the Empire Plan MHSA Program in various roles, and therefore, understands the unique culture and challenges of the New York State Health Insurance Plan. She is a strategic executive who uses her industry knowledge, product expertise, creativity and market intelligence to support the needs and expectations of the Empire Plan MHSA Program. This enables her to oversee the consistent, timely and quality administration of the MHSA Program and to strategically partner with the Department and GOER as a trusted advisor. Acting as a liaison and advocate for the MHSA Program, [redacted] is empowered to act across all our departments to ensure smooth functionality for MHSA Program delivery and to leverage internal resources in ways that add value. She leads a dedicated team of experts in assuring the Program requirements and Enrollee needs are met. In addition, through consultation and collaboration, she leverages the knowledge and experience of the UnitedHealthcare Empire Medical account management team led by [redacted].

This liaison function further extends to integrating Optum senior leaders, who are connected with the overall design and operation of the account so they can fully support [redacted] in ensuring the Program's success. Through this team-based approach, we deliver a well-rounded and cohesive program that draws upon our staff's expertise throughout our company.

Through a collaborative effort with all the operational areas, [redacted] is a proactive voice for the Empire Plan MHSA Program throughout Optum, ensuring a comprehensive understanding of the unique needs of the MHSA Program and the Department across all functional areas.

Access to Executive Leadership

As illustrated in the organizational chart, [redacted] has more than 20 years in the healthcare industry and is accountable for the overall satisfaction, retention and growth of some of UnitedHealth Group's most complex and strategic clients nationally. She leads a team focused on delivering value through innovative solutions that result in consumer engagement and improvement in the health, wellness and productivity of an employer population. [redacted] enjoys a close working relationship with [redacted] from previous account management experience.

[redacted] is an executive leader who is available to consult with the Department on the Empire Plan. [redacted] is [redacted] history with the Empire Plan provides the Department with a senior resource with knowledge of the Plan and established relationships with the Department and GOER representatives.

Our executive sponsorship program gives our most significant customers an additional, high-level avenue for providing feedback about our performance and shaping the direction of our services. As part of the program, we appoint a senior executive to each account, giving customers direct, ongoing access to our leadership team to voice their concerns, ask questions and work closely with key decision-makers to develop new ways to strengthen our partnership. [redacted] is currently designated as the Department's executive sponsor. The Department and GOER representatives are familiar with [redacted] from his [redacted]

All senior leaders mentioned above have been and will continue to be available to the account management team for consultation, support and escalation of urgent issues.

Clinical Operations

To ensure that all the Department's needs are met in delivering a comprehensive clinical management program, [redacted] will work in close collaboration with [redacted] will provide executive-level insight and support to the administration of the Empire plan, and will take a leading role in the recruitment and hiring of key staff positions for the MHSA Program, including those of the Medical Director and Clinical Director. [redacted] is responsible for oversight of clinical and administrative operations within [redacted] expertise will be leveraged on behalf of the Department to hire director leads who are focused on delivering MHSA Program services that meet the needs of Enrollees.

Additionally, [redacted]

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

In addition to completing Exhibit IB, Biographical Sketch Form, for the key members of the account and management team, we provide a brief description of each describe the roles and responsibilities of each member of the program account team member below:

Account Management

[redacted] will lead the account team and provide a single point of contact for all issues, concerns and needs for the overall plan administration and service.

[redacted] and oversee day-to-day account service needs. During the previous contract, [redacted] was dedicated to the Empire Plan MHSA Program and also served as the primary point of contact for New York State union representatives who may have questions or concerns related to a specific Enrollee concern. As account director, he will particiapte in internal and external meetings in an effort to ensure excellent service to the Empire Plan. [redacted] has more than 20 years of experience in account management.

[redacted] manages a team of New York-based provider relations staff that will be focused on the Empire Plan MHSA Program. In addition to the local (New York State) focus, [redacted] has served, and will continue to serve, as an advocate for the MHSA Program on a national basis to ensure that all participants have appropriate access and service through our national provider network.

[redacted] has over 20 years of experience in the health insurance industry with an extensive background in Customer Service. [redacted] currently leads Customer Service teams for Optum Physical Health and Behavioral Solutions.

[redacted] will oversee the quality management program including quality improvement initiatives and the compliance standards required for URAC accreditation. [redacted] will be involved in hiring the director to oversee quality improvement and reporting for the MHSA Program.

[redacted] will manage the dedicated claims team for the Empire Plan MHSA Program. [redacted] is responsible for overseeing the policies, procedures, training and day-to-day operations of the claims department located in [redacted] plays an integral role in meeting and exceeding claims turnaround times, and will work closely with the account management team to respond to audit questions or concerns. [redacted] will also work closely with the special investigations unit for the Empire Plan MHSA Program in an effort toward early identification of suspect claims billing practices.

[redacted] has a broad operational and health care background including underwriting, administration and national account client services. In our role as former MHSA Program vendor, [redacted] was responsible for overseeing the MHSA Program renewal process and program reporting requirements. In addition to [redacted] the [redacted], will provide oversight responsibility for the Empire Plan's financial reporting requirements.

Clinical Operations

As referenced in response to Question (1)(a) above, [redacted] will take a leading role in the recruitment and hiring of key staff positions for MHSA Program, including those of the Medical Director and Clinical Director. In addition to overseeing clinical and administrative operations within [redacted] oversight also includes intake, outpatient and inpatient behavioral and substance abuse care management, utilization management, review for medical necessity and appeals and complaints administration.

We have completed the requested Biographical Sketch Forms (Exhibit I.B) for the individuals named above and provided them as Attachment 2.

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

As your former MHSA Program vendor, Optum is aware of the level of staffing required to effectively manage the MHSA Program. If we are awarded the MHSA Program contract, our first priority is to reassemble as many previously dedicated Empire staff who have accumulated years of experience serving the MHSA Program. As a testament to the low employee turnover rate Optum is able to achieve, most of the former Empire MHSA Program clinical staff were placed in alternative positions within our company. [redacted]

The qualifications requirements listed below reflect key staff positions we will fill as part of our effective administration of the MHSA Program. The following job descriptions are positions required by URAC:

Empire Medical Director

The Empire Medical Director will be responsible for clinical oversight of the MHSA Program's Utilization Management program to ensure that quality of care and care advocacy activities are clinically sound. To ensure compliance with state and federal law, and Optum policies and procedures, the Medical Director is responsible for overseeing adverse determinations, appeals, and the peer review processes. The Medical Director is involved in the Utilization Management program as evidenced by providing input into policy development and implementation, overseeing Utilization Management Program implementation, meeting attendance, documented input, case review, clinical supervision and training, and provision of medical/psychiatric consultation to clinical personnel. In addition, the Medical Director serves as the liaison with network practitioners and other medical delivery systems. The Medical Director [redacted]

Qualifications

- Doctor of Medicine or Osteopathy.
- Current license to practice as a physician without restrictions.
- Board certified in Psychiatry.
- Five (5) years post-degree clinical experience; 2-3 years management experience.
- Experience determining coverage of mental health/substance abuse services.

Responsibilities

- Overall responsibility for implementation of the Utilization Management program.
- Clinical oversight of the Utilization Management program.
- Clinical supervision, training, and consultation with Care Advocates.
- Utilization Review determinations.
- Peer and appeal reviews.
- Case review.
- Consultation with practitioners in the Optum clinical network.

Peer Advisor

Peer Advisors are psychiatrists or PhD-level psychologists who have a minimum of five years of clinical experience. Optum uses peer advisors to render medical necessity decisions.

Qualifications

- Ph.D. or Psy.D. in a mental health field.
- Current non-restricted license to practice as a psychologist.
- Minimum of five (5) years post-degree clinical experience in a variety of settings, preferred.
- Specialized knowledge and in-depth experience in psychological testing, peer review, inpatient, outpatient, and/or medical/behavioral treatment.
- Managed care experience strongly preferred.
- Computer and typing skills required.

Responsibilities

- Review requests for psychological assessments.
- Provide psychological testing determinations.
- Conduct peer-to-peer reviews with psychologists and other non-MD providers to determine the appropriateness of requested services.
- Discuss treatment plans with providers and negotiate changes in accordance with Optum's clinical guidelines and other generally accepted standards of practice.
- Participate in staff meetings, case conferences, and in-service opportunities.
- Comprehensively document clinical data and review outcomes
- Provide for peer-to-peer consultation on reconsideration
- Enter certifications for treatment in a timely manner.
- Perform other duties as requested by supervisors.

Director of Clinical Operations

The Director of Clinical Operations for the MHSA Program is responsible for executing the Utilization Management Program. However, certain utilization management responsibilities may be delegated to the Regional Medical Director, Associate Medical Director(s), Clinical Operations Director(s), Clinical Program Manager(s), and Care Advocates.

Qualifications

- Doctoral degree in psychology from an APA-approved program or its equivalent, or a Master’s degree in a mental health discipline.
- Five (5) years of post-training clinical experience.
- Experience in a managed care environment.
- Current non-restricted license in a behavioral health field or in nursing.
- Demonstrated success in staff management including hiring, leading, retaining, and motivating effective leaders and employees.
- Excellent communication skills with demonstrated ability to develop strong and influential relationships with customers and potential customers.
- Strong operational experience including analysis, utilization management, and problem solving with a record of achieving operational goals.

Responsibilities

- Oversight of the utilization management operations within the Care Advocacy Center.
- Development and management of quality clinical care, utilization, and the meeting of financial goals for designated Health Plans, types of business and/or specific locations.
- Management of staff efforts to meet or exceed clinical quality and customer service goals.
- Coordination and collaboration with leadership of share service functions such as customer service, claims, account management, and clinical network services to ensure seamless service to clients, represent clinical operations in the development of cross-functional efforts to provide excellent service and maintain positive relationships with Health Plans and/or employer groups as well as with practitioners and treatment facilities.
- Development and implementation of plans that have a positive impact on utilization management.
- Ensure clinical operations meet regulatory standards and reporting requirements.

Clinical Program Manager

The Clinical Program Manager will be a dedicated resource to the MHSA Program. This individual will supervise our care management team and is a seasoned clinician whose credentials include state licensure, an advanced professional degree, and more than five years of experience. Clinical program managers are specialists in community mental health, child and adolescent services, eating disorders, substance abuse and psychiatric care, are readily available to care advocates for consultations and support. They are actively involved in cases requiring intensive care management.

Qualifications

- Master's or doctoral degree in psychology, social work, counseling or a related field, or registered psychiatric nurse.
- Current non-restricted license in a behavioral health field or nursing.
- Five (5) years post-Master's clinical experience, preferably in managed care.
- 2 years of clinical and administrative management experience in a managed care environment strongly preferred
- 2-3 years supervisory experience preferred.
- Ability to work in a team environment, leading groups of personnel toward defined goals.

Responsibilities

- Oversight of quality of clinical care, and utilization and the meeting of goals for designated health plans, types of business and/or specific locations.
- Management of staff efforts to meet or exceed clinical quality and customer service goals.
- Coordination with Vice President of Clinical Operations, Account Management and Clinical Network Services to maintain positive relationships with health plan (s) and/or employer groups as well as with practitioners and treatment facilities.
- Development and implementation of plans that have a positive impact on Utilization Management, Access and overall quality of service delivery.
- Provide training opportunities and clinical education to staff through training and day-to-day guidance.
- Provision of leadership and supervision to Care Advocates
- Ensuring that department goals are communicated clearly, and that goals are met or exceeded through team efforts
- Scheduling of adequate phone service coverage, including on-call after-hours support
- Monitoring of utilization and quality trends, auditing files for appropriate documentation, conducting clinical case reviews and involvement in committees and other meetings as necessary
- Handling exceptions to policies and procedures, appeals and problematic cases as needed
- Familiarity and competence in compliance activities and/or accreditation surveys
- Experience managing staff and processes that relate to utilization and appeals
- Manage specific account service requirements/guarantees related to the appeals, complaint, and non-certification processes

Care Advocates

Care advocates are dedicated to the MHSA Program and are available to all callers accessing the clinical referral line, 24 hours a day, seven days a week. They pre-certify and conduct concurrent review for higher levels of care as well as outpatient treatment beyond the initial assessment visits. Our care advocates are distinguished by their broad experience, the depth of their clinical skills, and their active involvement in decisions about patient care. All care advocates are licensed clinicians with a minimum of five years of clinical experience post-licensure.

Qualifications

- Master's degree in relevant mental health field
- Current non-restricted license in a behavioral health field or nursing.
- Three (3) years post-Master's clinical experience in an appropriate mental health environment.
- Minimum 3 years clinical experience with demonstrated familiarity and experience with DSM IV, ICD-9/10, time efficient models of intervention and other standard criterion
- Broad experience with inpatient, outpatient and/or day treatment strongly preferred
- Prior clinical experience.
- Demonstrated knowledge of behavioral health service delivery systems emphasizing time-efficient models of intervention.
- Familiarity and competency with psychiatric diagnoses.

Responsibilities

- Utilization Management of behavioral health services, including crisis assessment and intervention.
- Pre-authorization/notification of inpatient and other treatment services.
- Concurrent review of inpatient and other treatment services.
- Discharge planning and other Care Advocacy activities.

We are happy to involve the Department in our hiring process and look forward to an opportunity to collaborate.

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

We recognize that an account the size and significance of the Empire Plan MHSA Program requires ongoing attention from our experienced professionals located near the Department offices in Albany. Our account management team, enrollment, claims processing, clinical operations including CRL and customer service are all located in New York.

In addition, [redacted] remain easily accessible and able to attend in-person meetings at the Department's request.

Staffing Totals

Based on our experience with the MHSA Program, we have allocated the following staff to work on the Empire Plan MHSA Program account:

- Account Services - [redacted] [redacted] staff members, Latham, NY
- Enrollment – [redacted] [redacted] staff member, Kingston, NY
- Claims processing – [redacted] staff members, Kingston, NY
- Clinical Staff – [redacted] staff members, Latham, NY
- Customer Service – [redacted] staff members, Latham, NY

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

Recognizing the importance of the UnitedHealth Group relationship with the State of New York, the Empire Plan MHSA Program will have direct access to [redacted]. This will give the Department ongoing access to a senior leader to whom you may voice your concerns, ask questions and resolve any issues. [redacted] position within the company ensures the scope of authority, visibility and organizational access to successfully handle any issues that may arise and work closely with Department decision-makers.

[redacted] long standing history with the Empire Plan provides a senior resource with knowledge of the Plan and established relationships with the Department and GOER representatives.

[redacted] will perform the following functions:

- Serve as executive-level liaisons for the Department and provide an additional point of access to Optum and the broader UnitedHealthcare organization
- Reach out at least quarterly to the Department to ensure the Program is meeting or exceeding the Department's expectations
- Ensure that the MHSA Program continues to serve the Department's strategic objectives and priorities
- Participate in an annual meeting to review high-level accomplishments of the partnership between the Department and Optum and assess any needed changes or enhancements
- Ensure an immediate response to resolve any problem the Department may have that requires executive-level intervention

Leadership access is a cornerstone of our approach to account management. We achieve it by empowering our account management team to escalate issues within Optum to ensure that the appropriate staff is involved and decisions can be made quickly. [redacted], [redacted], has direct access to corporate department heads and is empowered to *act across all our departments* to ensure smooth functionality for the program delivery and to leverage internal resources in ways that add value.

We believe it is also critical to provide the MHSA Program team with senior-level support. Therefore, this liaison function further extends to integrating Optum senior leaders, who are connected with the overall design and operation of the MHSA Program so they can fully support [redacted] in ensuring the MHSA Program's success. Through this team-based approach, we have delivered a well-rounded and cohesive program that draws upon our staff's expertise throughout our company.

In addition to the upper level management resources described above, we have established numerous internal tools and corporate resources that will benefit the Empire Plan MHSA Program. These tools and resources include:

- Reporting – A robust reporting infrastructure that reports the internal key metrics of administering the plan monthly. This includes the financial, clinical, network, claim and customer service.
- Customized Website – The Empire Plan MHSA Program account management team, as well as the Department, will have access to your customized Enrollee website. Our website utilization reports include metrics on number of visitor sessions, page views, page views for cases and top/popular topics accessed. Reports also include number of page views for the following: comprehensive information by category (e.g. anxiety, depression, parenting, etc.), claims & coverage, My Benefits & Programs, top assessments and calculators, forums and multimedia. This information can be analyzed by the account management team to identify trends, which can be incorporated into online engagement and communication strategies. The site also features a provider search tool, enabling Enrollees to search for providers 24 hours a day, seven days a week.
- Seamless Inter-Program Referral System – Optum care advocates can use our electronic referral application to cross-refer Enrollees to other available programs, such as NurseLine. We use a web-based application that makes this process seamless for Enrollees.
- Outpatient Predictive Modeling – Optum's Wellness Assessment is a peer-reviewed, scientifically validated tool that allows us to identify at-risk members and monitor treatment. The Wellness Assessment is given to the member by his/her clinician at the onset of outpatient treatment and again between sessions three and five. By applying a set of clinical algorithms against member responses to the Wellness Assessment and quantifiably measuring the effectiveness of the treatment being provided, ALERT, our outcomes-informed outpatient clinical care model, helps care advocates support both members and treating clinicians.
- Pharmacy Claims Integration – Should the Department be interested, Optum has the capability to integrate pharmacy claims into our ALERT outpatient predictive model. Filtering pharmacy claims through pharmacy algorithms in ALERT can assist with outpatient medication adherence and detect instances of non-adherence to provide early warning interventions.
- Recognizing High-Quality Facility-Based Care – Our facility quality management (FQM) program provides facilities with a scorecard of their relative performance using key, industry-standard quality and efficiency metrics. FQM publicly recognizes facilities that achieve clinical outcomes and tiers them based on those outcomes.

Specifically, we track facility performance on an ongoing basis and measure the following three metrics against national benchmarks:

- 30-day readmission rate
- Percent of follow-up appointments scheduled to occur within 7 days of discharge
- Percent of follow-up appointments kept within 7 days of discharge

- Identification and Stratification for Complex Cases – Using a comprehensive, data-based model known as Identification, Stratification, Intervention and Engagement (ISIE), we are able to go beyond merely predicting which Enrollees are likely to drive higher costs. ISIE actually identifies the segment of the population that is subject to gaps in care (or issues with adherence) and most likely to experience improved outcomes after targeted care advocacy interventions. The model matches the identified Enrollee care gap with specific evidence-based interventions that our care advocates can use to facilitate closing the gaps.
- Member Satisfaction Surveys - Provide an external evaluation from Empire Plan MHSA Program Enrollees on overall administration and their service experience. We utilize this valuable end-user feedback to consistently improve our operational processes, as well as making strategic recommendations to the Department and GOER representatives regarding the MHSA Program's design and benefits.
- Provider Satisfaction Surveys – Also an external evaluation from key stakeholders, the network providers. This data helps us identify continuous process improvement opportunities. Furthermore, the feedback provides assurance of the satisfaction levels needed to maintain a stable network.
- Fraud, Waste and Abuse – To assure funds are only expended on legitimate services we administer a dedicated fraud, waste and abuse function that is specifically in place for the Empire Plan MHSA Program. Furthermore, Optum administers claim system edits and provides account management team members with corporate level access that benefits the MHSA Program.
- Professional Organizations – Our strong relationships with external professional organizations provides support and serves as a resource to the internal Optum team in program delivery. These relationships provide account management team members with information on national trends and issues.
- Optum Labs – Optum Labs is a center for collaborative research and innovation that brings together a community of health care stakeholders dedicated to improving patient care by sharing information assets, technologies, knowledge, tools and scientific expertise that enable stakeholders to drive advances leading to improved patient care. Optum Labs offers access to a rich pool of high-quality integrated health care data, spanning millions of lives with de-identified claims and clinical data that is cleansed, tested and refreshed regularly. This depth of data allows for unique insights into populations and the people within them. Behavioral and policy research is an area of exploration in Optum Labs. Research is linked to the clinical environment, where clinical translation can proceed through prototyping and testing in Optum and partner care settings.
- Healthcare Economics - We develop and target analytical research, and report to bridge the areas of financial assessment, clinical utilization, product performance and

network operations. Through focus and execution expediency of analytical requests, we illuminate the what/where/when/why/how of market trend drivers that become factors for new strategy development, new pricing, network expansion/retraction, benefit design, clinical treatment protocols and other components of program infrastructure. Specific service offerings are:

- Statistical trending
- Financial versus economic cost modeling
- Provider-type profiling
- Burden of disease prevalence
- Patient consumption profile
- Large case magnitude

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

Our clinical operations staff will be dedicated exclusively to serving only the Empire Plan MHSA Program Enrollees. [redacted].

In addition to [redacted]

Our award winning member website, liveandworkwell.com, that we will customize for the MHSA Program, has been accredited by URAC. This accreditation means that website has met URAC's rigorous standards for quality and accountability. This URAC accreditation underlines Optum's commitment to our member's health and well-being in mind and body.

NCQA Accreditation

[redacted]

2. Premium Development Services

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

a. Duties and Responsibilities

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

We confirm our ability to meet the Premium Development Services Duties and Responsibilities as detailed above.

b. Required Submission

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

The following are the names, qualifications and job descriptions of the individuals who will provide premium rate development services for the MHSA Program. Biographical sketch forms have been completed for all individuals:

- [redacted] [redacted] has more than 20 years of experience in the health insurance industry. [redacted]

[redacted]z has a broad operational and health care background including underwriting, administration and national account client services. He currently leads the Optum underwriting department and will be responsible for the Empire Plan MHSA Program's financial reporting services.

- [redacted] has more than 20 years of experience in the health insurance industry. [redacted] is an associate in the Society of Actuaries (A.S.A.) and a member of the American Academy of Actuaries (M.A.A.A.). As vice president of actuarial services, he is responsible for setting monthly incurred but not reported (IBNR) reserves for Optum, and for trend and claim analytic reporting.
- [redacted] has more than 19 years of experience in the health insurance industry working for health insurance companies located within the State of New York and 11 years dedicated to the Empire Plan. [redacted] is familiar with the Department's financial reporting requirements and the expectations of the Department's financial management staff. He also has oversight responsibility for the annual renewal process and presentation to the Health Insurance Council and the Joint Labor Management Committee.

Additional underwriting, medical economics and actuarial staff will support the individuals identified above.

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

Optum will follow a process similar to the underwriting process we used as your former MHSA Program vendor, eliminating insured financial elements and including additional adjustments specific to the Empire MHSA Program. Development of ghost premiums or premium equivalents for a program such as the Empire Plan MHSA Program is a complex process.

[redacted]

- [redacted]
- [redacted]
- [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

We are committed to working with the Department and its actuarial consultant to develop premium equivalent recommendations that support the performance of the upcoming plan year. Optum will be available to present annual renewal recommendations to the Health Insurance Counsel and the Joint Labor Management Committee, as well as other meetings as required.

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

Confirmed.

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

3. Implementation

The Contractor must ensure that the MHSA Program is fully functional by the first day of the month following a minimum 90-day implementation period after the Office of the State Comptroller approves the Agreement. The implementation plan must be detailed and comprehensive and demonstrate a firm commitment by the Contractor to complete all implementation activities within the 90-day implementation period.

a. Duties and Responsibilities

(1) During the 90-day implementation period, the Contractor must undertake and complete all implementation activities, including but not limited to those specific activities set forth in Section IV.B.3.a(2)(a)--(e). Such implementation activities must be completed no later than the first day of the month following a minimum 90- day implementation period after the Office of the State Comptroller approves the Agreement.

Confirmed.

(2) Implementation and Start-up Guarantee: The Contractor must guarantee that all Implementation and Start-up activities will be completed the first day of the month following a 90-day implementation period after the Office of the State Comptroller approves the Agreement (Implementation Date) so that Contractor can assume full operational responsibility for the MHSA Program on the designated date. For the purpose of this guarantee, the Contractor must, on the designated date, have in place and operational;

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

Confirmed.

(b) A fully operational Dedicated Call Center, including a Clinical Referral Line, providing all aspects of customer support and clinical services as set forth in Section IV.B.4 and Section IV.B.12 of this RFP. The Dedicated Call Center must be open and operational a minimum of thirty (30) days prior to Program Implementation Date to assist Enrollees with questions concerning Program transition;

Confirmed.

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

Confirmed.

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

Confirmed.

(e) A fully-functioning, customized MHSA Program website available a minimum of thirty (30) days prior to the Program Implementation Date, with a secure dedicated link from the Department's website able to provide Enrollees with on-line access to the specific website requirements as set forth in Section IV. B.4 of this RFP.

Confirmed.

b. Required Submission

(1) Provide an implementation plan (via a detailed narrative, diagram, and timeline) that results in the implementation of the Dedicated Call Center and customized website a minimum of thirty (30) days prior to the Program Implementation Date and implementation of all other MHSA Program services by the Implementation Date, including but not limited to: roles, responsibilities, estimated timeframes for individual task completion, testing dates and objectives, and areas where complications may be expected. For all tasks that require Department review and approval, a minimum review period of five (5) Business Days must be built into the implementation plan. Include key activities such as member and Provider communications, training of a Dedicated Call Center and Clinical Referral Line staff, report generation, network development, transition benefits, customized website design, eligibility feeds and claims testing.

Optum's MHSA Program implementation will result in implementation of a Dedicated Call Center in Latham, New York, a customized version of our **liveandworkwell.com** website at a minimum of thirty (30) days prior to the Program Implementation Date and implementation of all other MHSA Program services by the Implementation Date as required by the Department. We have included a sample Implementation Project Plan as Attachment 3, which serves as an overview and timeline identifying major tasks we will perform in order to implement the MHSA Program effectively and on time. As the MHSA Program's recent administrator, we understand what is required for successful implementation, and operation, of the MHSA Program. We are including a breakdown of major implementation steps below.

Implementation Roles and Responsibilities

To ensure the MHSA Program reflects the Department's priorities from the outset, your dedicated account management team led by [redacted] will engage the Department's representatives in the implementation planning process as soon as possible. The purpose of this process is to highlight implementation activities required from both Optum and the Department, respectively, review the implementation plan so that a minimum load is placed on the Department's representatives and clearly define milestones so that the Department's implementation requirements are methodically met. We will meet the timeframe for the following activities:

- Member communication approvals and distribution
- Staff training
- Establish reporting requirements
- Determine if there are network development needs and establish recruitment schedule
- Establish a coordinated effort for transition benefits with the Department, GOER and former vendor

- Testing schedule for eligibility feeds, claims processing and website setup

An Optum implementation project manager will assume overall responsibility for the planning and execution of the implementation process. Incorporating key information gathered from the pre-implementation discussions, the project manager will work closely with [redacted] and Optum operational staff members to define processes, identify accountabilities, anticipate any implementation bottlenecks and pinpoint the Department's implementation priorities. In addition, our implementation project manager will perform the following key functions:

- Serve as the Department's primary contact for day-to-day implementation questions
- Develop and manage project action plans to ensure milestones are met
- Track and report on the status of all tasks on the implementation project plan and develop corrective action plans for any issues that arise, escalating the issues as necessary
- Assess progress and report status to [redacted] and the Department
- Investigate, communicate and lead resolution of all issues presented by the Department

Our implementation project manager will own and be accountable for the Implementation Project Plan. As such, this individual will work closely with [redacted] and supportive resources within Optum to ensure implementation workflows and operational services are established in keeping with the Department's goals. The implementation project manager will be available to the Department to answer any implementation questions and will co-lead implementation status meetings with key Department personnel.

The Department's Role in Implementation

To ensure a timely and successful implementation of the MHSA Program, we respectfully request that the Department allocate key personnel to function as primary points of contact for our implementation team. These resources are defined as follows:

- **Project Lead.** The project lead is an individual who is at a level with decision-making authority and who will engage with our implementation project manager over the course of the implementation period. The primary involvement of this individual is to participate in ongoing status meetings that typically take place weekly, during which the project lead is able to provide Optum with feedback to help ensure the implementation is on-track from the Department's perspective and provide input on implementation activities
- **Supportive Roles.** Our experience shows that there are several individual resources that should be involved in implementations (to varying degrees) to assist in ensuring implementation success. These individuals include benefits/human resources contacts, communications representative, data and eligibility specialists, legal team member, training team member, vendor relations owner for carriers/vendors.
- **Project Sponsor.** We also recommend the involvement of a project sponsor who would provide executive level input. Such high-level involvement is in line with our experience that top-down involvement is important for program visibility and is a process that begins at implementation.

In line with the Department's requirements, we will build five (5) Business Days into the implementation plan for all tasks that require Department review and approval.

Implementation Project Plan

The attached Implementation Project Plan identifies a project timeline along with required implementation resources and assignment of specific tasks in accordance with the Department's requirements that all Implementation and Start-up activities will be completed by the first day of the month following a 90-day implementation period after the Office of the State Comptroller approves the Agreement (Implementation Date). These activities include [redacted], establishing the MHSA Program's Clinical Referral Line, re-launching the Empire Plan's fully-functional, customized MHSA Program website, among other implementation activities. Please note that identifying specific dates is contingent upon the Office of the State Comptroller approving the Agreement. Should Optum be selected as the MHSA Program vendor, we will engage the Department immediately upon approval to begin pre-implementation meetings and define specific dates for implementation milestones in line with the Department's requirements.

The Implementation Project Plan incorporates key activities that include member and Provider communications, training of a Dedicated Call Center and Clinical Referral Line staff, reporting requirements, provider network review, transition benefit planning, re-establishing eligibility feeds and claims testing.

Our implementation project manager will ensure efficient coordination of all tasks outlined on the Implementation Project Plan and will ensure that implementation activities are sensitive to the needs, objectives and timeline identified by the Department for the MHSA Program. To ensure all key stakeholders are apprised of the latest implementation developments, the project manager will provide regular implementation project plan updates to the Department and Optum staff members.

Areas for Potential Complication

We believe our experience as the Department's former MHSA Program vendor positions us to minimize both the burden on the Department for MHSA Program implementation as well as the potential for complications. Generally, we perform implementations for new customers or for customers seeking to expand the programs offered to their employees. In these instances, the most common implementation issues include responsiveness or turnaround time (i.e., both from the customer and from other external vendors), as well as complexities in benefit plan design or administration that are not readily evident or come to light late in the implementation process. However, given our history providing MHSA Program services, and our connection to UnitedHealthcare (as the medical carrier), we are uniquely positioned to perform a smooth, efficient and on-time implementation.

An Extensive Provider Network Facilitating the Transition of Enrollees in Treatment

During our time as The Empire Plan MHSA Program administrator, we maintained a provider network in New York that exceeded the access standards for Enrollees. For Enrollees currently in treatment (open cases) and for those who have received referrals and/or authorizations to a clinician at the time of transition (pending cases), we provide transition plans that are sensitive to the needs of Enrollees in transition. We will work in partnership with the Department to customize our transition approach and develop a transition plan that promotes Enrollee satisfaction and continuity of care.

We will work with the Department's incumbent vendor to ensure the timely and orderly transfer of all necessary Enrollee information, including information regarding Enrollees in treatment during implementation. We will identify high-volume clinicians and if not already part of the large Optum provider network, recruit them for inclusion in our network. To ensure continuity of care, new Enrollees may have their clinicians contact Optum and request an application. If the network manager finds that the clinician fits a network need and verifies that the clinician is qualified, we will send him/her an application. The clinician will then go through the normal credentialing process; the Credentialing Committee ultimately approves or denies the clinician's participation in our network. We expect that the nominated clinician will inform the Enrollee of the outcome of his or her application to join the network, or that the Enrollee will call either the clinician or our toll-free number to inquire about whether the clinician has become contracted.

Enrollees Receiving Acute or Intermediate Care

To plan for stepped-down levels of care for Enrollees who are in acute or residential settings at the time of transition, we will work closely with the treating clinician(s) in advance of the program start date to ensure effective discharge planning. Once the Enrollee is discharged to a lower level of care, we will coordinate care advocacy responsibilities with the facility and the prior MHSA administrator.

Enrollees Receiving Outpatient Care from Clinicians Not Participating in Optum's Provider Network

We recommend that the Department allow Enrollees in outpatient treatment with a provider not yet established in the Optum provider network to continue therapy uninterrupted and be able to receive network level benefits for the first 90 days of the transition period. . At the end of the transition period, should their provider decide against joining the Optum provider network, the Enrollee can either select a network clinician or may opt to continue therapy with the non-network clinician at the non-network benefit level.

MHSA Program Communications

Approximately 60 days in advance of the Implementation Date, Optum will work with the Department to create letters to Enrollees announcing the transition benefit. Communications will emphasize easy access to the Optum network, as well as information about benefit plans through the NYSHIP toll-free number.

Transition from Implementation to Account Management

Throughout implementation, our implementation project manager will work closely with [redacted] [redacted] and keep her apprised of implementation status. Once implementation is complete, [redacted] will assume account management responsibilities for the MHSA Program. [redacted] [redacted] experience with the MHSA Program will make this transition a seamless one for the Department.

(2) The Offeror must guarantee that all of the Implementation and Start-Up requirements listed above in Section B.3.a.(2) will be in place on the Implementation Date, with the exception of opening the Dedicated Call Center and completing work on the customized website each of which must be completed a minimum of thirty (30) days prior to the Implementation Date. The Offeror shall propose the forfeiture of a percentage of the 2015 Administrative Fee (prorated on a daily basis) for each day that all Implementation and Start-Up requirements are not met.

We agree and guarantee that all Implementation and Start-Up requirements will be in place as indicated.

The Standard Credit Amount for each day that all Implementation and Start-Up requirements for the MHSA Program are not met is a minimum of fifty percent (50%) of the 2015 Administrative Fee (prorated on a daily basis). However, Offerors may propose higher percentages.

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is_____percent (%) of the 2015 Administrative Fee (prorated on a daily basis).

The Offeror's quoted percent to be credited for each day that all Implementation and Start-up requirements are not met is [redacted] of the 2015 Administrative Fee (prorated on a daily basis).

4. Customer Service

The MHSA Program requires that the Contractor provide quality customer service to Enrollees and Providers. The MHSA Program provides access to customer service representatives through The Empire Plan's consolidated toll-free number. Through this toll-free number members access MHSA Program representatives who respond to questions, complaints and inquiries regarding MHSA Program benefits, Network Providers, claim status etc., and, when a call involves a clinical matter, refer the caller to the Contractor's Clinical Referral Line. In 2013, the customer service line received 127,498 calls and the Clinical Referral Line received 90,423 calls for a total of 218,408 calls. The Offeror/Contractor is required to agree to customer service performance guarantees that reflect strong commitments to quality customer service. Exhibit II.I provides the number of members who have utilized the DCS customized MHSA Program website in 2013.

a. Duties and Responsibilities

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

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

Confirmed.

(2) The Empire Plan consolidated toll-free telephone service is provided through the AT&T voice network services under a contract with The Empire Plan's medical carrier/third party administrator and is available to callers twenty-four (24) hours a Day, 365 Days a year. The Contractor must establish and maintain a transfer connection with AT&T (T-1 line), including a back-up system which will transfer calls to the Offeror's line at their Dedicated Call Center service site. The Contractor must sign a shared service agreement with The Empire Plan's medical carrier/third party administrator (currently UnitedHealthcare) and AT&T. Programming and scripting changes to The Empire Plan's consolidated phone line takes 4-6 weeks. In addition, the Contractor is also required to provide twenty-four (24) hours a Day 365 Days a year access to a TTY number for callers utilizing a TTY device because of a hearing or speech disability. The TTY number must provide the same level of access to call center service as required by this Section of the RFP;

Confirmed.

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

Confirmed.

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

Confirmed.

(b) Provides access to fully trained customer service representatives and supervisors a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday, except for Business Holidays; and

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(7) Maintaining and timely updating a secure online Empire Plan specific customized website accessible by Enrollees a minimum of thirty (30) days prior to the Implementation Date, which is available twenty-four (24) hours a Day, 365 Days a year, except for regularly scheduled maintenance, which will provide, at a minimum access to information regarding: MHSA Program benefits: Network Provider locations; eligibility; Copayment information; pre-authorization information; claim status; and clinically-based educational material. The website may not contain any links to the Contractor's standard website used for other customers. The website Provider search may only contain Provider types that are covered under The Empire Plan. The Department shall be notified of all regularly scheduled maintenance at least one (1) Business Day prior to such maintenance being performed. The Contractor must establish a dedicated link to the customized website for the MHSA Program from the Department's website with content subject to the approval of the Department and limited to information that pertains to the MHSA Program. Links bringing a viewer back to the Department website must be provided. No other links are permitted without the written approval of the Department. Access to the online Network Provider locator must be available to Enrollees without requiring them to register on the website. Any costs associated with customizing and updating the website or establishing a dedicated link for the MHSA Program shall be borne solely by the Contractor. Also, the Contractor shall fully cooperate with any Department initiatives

to use new technologies, processes, and methods to improve the efficiencies of the customized website including development of an integrated Enrollee portal; and

Confirmed.

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

Confirmed.

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

Confirmed.

(b) Call Center Telephone Response Time: The MHSA Program's service level standard requires that, at the least, ninety percent (90%) of the incoming calls to the Contractor's telephone line will be answered by a customer service representative within thirty (30) seconds. Response time is defined as the time it takes incoming calls to the Contractor's telephone line to be answered by a customer service representative or a Clinical Manager, if after hours. The call center telephone response time shall be reported weekly for the first month of the Agreement and then monthly for the remainder of the Agreement and calculated annually;

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

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

Confirmed. Enrollees will have access to the Clinical Referral Line (CRL) and to the Empire Plan MHSA Program information 24 hours a day, 365 days a year through a consolidated toll-free number.

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

Confirmed. As in the previous contract administration, we will enter into a shared service agreement with the Empire Plan medical carrier/third party administrator, or other party designated by the Department, and AT&T. We confirm that we provide access 24 hours a day, 365 days a year to TTY services for Enrollees with hearing and/or speech disabilities.

(3) Confirm you maintain a Dedicated Call Center for the MHSA Program located in the United States, employing a staff of Clinicians and a staff of fully trained customer service representatives (CSR's) and supervisors. Confirm that customer service representatives will be available, for the MHSA Program a minimum of thirty (30) days prior to the Implementation Date and through and including four (4) months after termination of the Agreement between the hours of 8:00AM to 5:00PM, Monday through Friday except for Business holidays. If additional hours are proposed, please state. Confirm that access to Clinical Managers through the Clinical Referral Line will be 24 hours a Day, 365 Days a year.

Confirmed. [redacted] will be staffed with experienced clinicians, customer service representatives (CSR) and supervisors who will be fully trained on the Empire Plan MHSA Program and serving its Enrollees. As your former MHSA Program vendor, [redacted]. CSRs are readily available to answer benefits, eligibility and claim status questions, Monday through Friday from 8:00 A.M. until 5:00 P.M. ET. In addition, access to the CRL is available 24 hours a day, 365 days a year to service the Enrollees.

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

All of our CSRs are supported by our online tracking system technology, "Integrated Service Experience Tool" (ISET), described below, which offers comprehensive member specific information. ISET provides end-to-end call management of the customer inquiry and dispute resolution process; ensuring issues are resolved promptly and accurately. ISET provides the CSRs with access to Empire Program benefits and eligibility as well as a comprehensive call and claims history, which allows them to answer Enrollees' questions accurately and resolve problems in a timely manner.

ISET serves as a data consolidator for CSRs, providing them with a single call documentation tool to help Enrollees with questions that may cross multiple systems and platforms, such as:

- Eligibility
- Claims history/status (including scanned claim forms)
- Benefit descriptions
- Authorization status
- Hospital and physician network status/information

Every incoming call is logged into ISET and the system starts tracking and collecting data from the onset of the inquiry to identify the type of call and track the issue reason. ISET documents 90 percent of the recorded information through auto-documentation so there is less need for manual data entry. This allows the interaction between the Enrollee and the CSR to be more natural and fluid, with minimal disruptions to the member. At the end of the call, CSRs can manually enter notes and additional documentation to record any details that may not have been automatically stored by the system to provide a comprehensive history of the call status and resolution.

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

Yes, as one of our many self-service options provided to Enrollees we will use an Avaya Definity G3 communication system for the Empire Plan MHSA Program, which handles all calls initiated by the Program's Enrollees. Our IVR system collects a variety of Enrollee and provider data, which can then be translated into the Empire Plan MHSA Program reporting used to evaluate service provision and utilization, and inform strategic decision-making for future Program revisions. For example, information regarding the types of questions Enrollees call with can help to determine future planning and emphasis on specific program components.

Enterprise Voice Portal

Our Enterprise Voice Portal (EVP) capabilities enable us to efficiently route callers to the resources they need while also affording us the ability to collect important data on calls for reporting purposes. Our Computer Telephony Integration (CTI) application facilitates excellent customer service by passing along the following data to customer representative desktops via a pop up screen:

- Caller Type – Member, Provider, or Other
- Member ID / DOB Collection and Authentication
- Provider ID Collection
- Question Type – What are you calling about?

Additionally, the system also has a self-service option for behavioral health providers. This information also includes:

- Claim Status – Paid, Denied, Pending, Adjusted (by service date, processed date, charge amount, paid amount to patient & provider, allowed amount, check number, patient responsibility, claim number)
- Benefits & Eligibility – In & Out of Network / In-Patient & Out-Patient (Effective dates, Deductibles, Co-Pays, Co-Ins, Visit Limits

The system's data capture capabilities afford end-to-end reporting. The CTI data identified above is collected and stored as is call data about where each call was transferred to and from. Through our United Experience Survey, Enrollees are able to voice their satisfaction, or dissatisfaction, with their telephonic experience. The MHSA Program's account management and customer service teams will use this data to improve call quality and Enrollee satisfaction. Our EVP capabilities enhance Enrollee customer service and improve first call resolution rates.

We use load balancing for dynamic call allocation which allows us to control which EVP data center is used to service calls. We have two EVP data centers, both of which have been engineered to handle 100 percent of our expected peak season traffic. This dynamic call allocation enables us to route calls away from a site if it is experiencing issues handling call volume.

Intelligent Caller Needs Identification

UnitedHealthcare's Intelligent Caller Needs Identification (iCNI) system is an IVR application platform that performs intelligent caller steering. iCNI provides results in less dependence on the carrier and its lead times while also making call processing highly available and redundant. iCNI includes an Environmental Health Check that places a call to two data centers (redundant environment) every seven seconds. In the event a problem is detected, call traffic is moved to the alternate, redundant site and the Call Delivery Team is immediately notified. Benefits of the iCNI system include:

- Enables member authentication at the onset of the call
- Member eligibility data is duplicated and made available to iCNI through a direct link to a database
- This data, along with other data that we've captured throughout the call flow are screen populated into Customer Representative's Desktop

We will work with UnitedHealthcare to leverage platform technology to ensure a seamless experience for Enrollees.

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

We have included a sample IVR Script and Flowchart as Attachment 4.

We will work with the Department to customize elements of our phone system, as necessary, including modifying our standard touchtone routing options and tailoring messages to meet particular Enrollee needs. Phone prompts are scripted to provide detailed information on the type of services available for each touchtone option, or can be limited to basic descriptions to enhance interaction speed and message clarity. As in our previous administration, a prompt for direct telephonic access to a clinician will be available to any caller.

In the future, we can offer additional options to this system to increase efficiency of call handling. These options include collection of data in the IVR system that includes provider and Enrollee identification, claim information, caller type (Enrollee or provider), question type, and pertinent Enrollee demographics. This information would then be passed to the virtual call center (VCC) desktop and displayed to the CSRs at the beginning of the call in a pop-up screen through the computer telephony integration (CTI). Additionally, Enrollee information would be passed to our ISET system, which would then perform an automatic search for the Enrollee. We look forward to discussing these potential options with the Department.

The IVR collects and uses a unique key to identify each call, and passes that data to VCC Desktop which allows for end-to-end reporting. We can run a report on a call that shows what path a caller took in the IVR, if they were transferred, where they were transferred to and what data was passed throughout the call path. This includes all legs of the call unless they are transferred outside of our network.

The Department can select from several self-service features available with our IVR system. These include the ability to access member information regarding claims and payment status, benefits and eligibility for the MHSA services. Optum will work with the Department to determine which capabilities will work best for the MHSA Program.

In addition, the VCC desktop reporting capability of the system can provide a number of standard reporting options, which are described in Section 7 – Reporting. The Department may also customize tracking and reporting of phone system statistics.

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

All call center data that are collected by our Avaya Definity G3 communication system are captured in the Quarterly Performance Guarantee Reports requested by the Department in the Reporting section of this RFP. These reports detail the Empire Plan MHSA Program's activity, utilization and performance standards.

Additionally, information gathered from the ISET program used by our CSRs, such as call issue tracking, call resolution, and other commonly provided information, can be reported to the Department as requested.

Tracking and Reporting Phone System Statistics

Our phone system is capable of tracking and reporting detailed information on the performance of the Program's dedicated phone lines. Among the metrics that we have reported for the Department are:

- Average Speed of Answer – Average time for a call to be answered after being placed in queue
- Call Abandonment Rate – Percent of callers who hang up after being placed in queue
- Telephone Service Level – Percent of calls answered within target time (e.g., within 30 seconds)
- Talk Time – Average talk time for all calls
- First Call Resolution – Percent of customer service inquiries resolved in one call
- Call Volume – The volume of calls received by the clinical or customer service line for various reporting periods

In addition to the described reporting, we propose to report key statistics from our call center data including:

- Number of calls successfully transferred
- Transfer type: warm/cold transfer, warm/cold conference, etc.
- Destination transfer number
- Transfer reason
- Survey results

The Optum Empire Plan account management team will coordinate with the Department to determine exactly which key statistics are most helpful to report.

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

Our Empire Plan call center is served by an Avaya Definity G3 telephone routing system. Our system has call recording capabilities enabling us to monitor the quality of the services we provide to Enrollees. This system can efficiently and effectively route calls to appropriate personnel resources and skills based on call volume and Enrollee needs. Key features of the system include the following:

- Permits complex routing patterns so that calls can be forwarded to the appropriate Optum representative
- Allows special handling of calls based on the priority status assigned to the specific call, routing emergency calls ahead of others
- Reduces telephone wait time by permitting incoming calls to be queued to several splits at the same time
- Incorporates customizable tools to effectively manage the call center (including real-time and historical reporting) as well as alarms if identified service thresholds are met or exceeded
- Empowers clinical staff to manage and improve their own performance by providing real-time status updates on 25 management-defined parameters on their display sets
- Includes a prompt for a post-call survey for Enrollees to voice satisfaction or dissatisfaction with their experience. This functionality enables the Empire Plan MHSA Program's call center and account management teams to improve customer service by analyzing and addressing areas of dissatisfaction.

The system also monitors and tracks key data including transfer types, reason for the call and transfer, time to answer, average hold time and abandonment rates.

We can also include additional functionality to the phone system that was not in place during our previous contract. This would include use of the IVR function to collect member information through the VCC desktop reporting, which the customer service representative (CSR) will be able to view on their screen at the onset of the call. This will increase the efficiency of each call since the CSR will not have to request this information from the enrollee or provider.

Most calls to our CSRs are questions on routine non-clinical issues. As a result of the integration between our phone system and ISET, accurate routing of calls will ensure that CSRs can resolve these inquiries quickly, leaving them more time available to devote to calls with a higher level of complexity that require their skills and expertise.

Our phone system interfaces with ISET, the innovative online system developed to log, report and follow up on the concerns of Enrollees and practitioners. CSRs can access the phone data transferred to ISET, where they can track incoming inquiries by originator type, call reason and outcome. ISET is unique in that it consolidates all customer service information data into the call log and allows our CSRs the ability to respond to a full array of benefit, referral and claim inquiries on the MHSA program.

Upon resolution of the call, the CSR will document the outcome so that this information is available for reporting and analysis. Information regarding call resolution allows for tracking and trending of the reasons Enrollees and providers call in addition to how each inquiry was resolved. This data will provide Optum Empire Plan leadership a means to identify and address any issues to ensure continued satisfaction of Enrollees and the Department.

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

We will thoroughly train customer service representatives (CSRs), and CRL clinicians prior to them taking their first phone call from an Empire Plan Enrollee.

Customer Service Representative Training

The Empire Plan customer service training for CSRs will be an intense, comprehensive 10-week program that includes four weeks of class room prior to live call training to help prepare the new hire CSRs for the unique Empire Plan MHSA benefit design. Our training provides practical and in-depth job-applicable skills, and knowledge to the dedicated Empire Plan MHSA Program customer service staff, with the purpose of ensuring accuracy of information provided and increasing enrollee satisfaction.

During week one of training, CSRs will learn about the managed care industry and certain insurance policies and procedures. They will begin to learn specific information about the benefit plan design and the culture of the Empire Plan's membership. During week two of training, the newly hired CSRs will meet with operational department leaders and begin to learn about claims procedures and other information they will be expected to explain to the Empire Plan Enrollees.

Weeks three through nine will focus on specific responsibilities of CSRs dedicated to the Empire Plan MHSA Program and fine-tune their customer interaction and phone answering skills. They will also learn about privacy policies and how to document the incoming call reasons and resolution. During weeks six through nine of training, our dedicated site trainer will perform new-hire training audits and testing in order to provide them additional feedback or enroll them in additional training classes prior to answering "live" enrollee phone calls.

This intensive training program produces assessment and testing scores with on-the-job quality results, which lead to certification. In addition, we will provide quality coaching sessions conducted by the on-site dedicated trainer and collect trainer observation data from training leaders and operations staff. Operational staff will also provide feedback through meetings with internal customers to ensure that CSRs are meeting expectations.

In order to assist newly trained CSRs, Optum established a centralized repository of all policies/procedures, FAQs and benefit design specifications which is easily accessible while on the phone with an enrollee in order to answer any member or provider inquiry. This repository allows all CSRs to have access to consistent, MHSA Program-specific information to enhance the Enrollee customer service experience.

Training to Recognize When a Caller Should be Transferred to the Clinical Referral Line (CRL)

CSRs will be readily available to respond to a wide variety of Enrollees inquiries regarding eligibility, benefit and claim status questions. Additionally, the CSRs will be trained to warm transfer callers to the Empire Plan MHSA Program Clinical Referral Line (CRL) care advocacy team in certain circumstances, which at times, requires quick, calm and thoughtful considerations. The most common reasons for CSRs to transfer callers to the CRL include:

- Crisis Issues – CSRs are trained to identify a caller in crisis by the caller's tone, their comments and any overt requests for immediate assistance. Follow-up and refresher trainings on identifying and handling callers in crisis are conducted periodically in addition to the distribution of educational materials.
- Referral Requests – CSRs primarily handle routine, non-clinical calls regarding benefits, eligibility, claims status/history and payments inquires. All requests for clinical referrals will be transferred to a CRL care advocate who is trained to assist the Empire Enrollees in facilitating with network referrals. The CSRs will also educate the caller that network provider information can be obtained on the customized MHSA Program website located at **www.liveandworkwell.com**.
- Clinical Facility Information – CSRs are trained to transfer any calls from a care facility regarding the provision of clinical information for inpatient or intermediate care to a CRL clinician to begin the precertification process.

Clinical Referral Line Care Advocate Training

Optum maintains a dedicated clinical learning and staff development department that oversees the training of our clinical staff. Our clinical learning department will ensure that Empire Plan MHSA Program care advocates receive comprehensive training on treatment best practices so they can effectively collaborate with network clinicians and administer treatment for Enrollees.

Each new care advocate will participate in an Enrollee-focused, six-month orientation and training period designed to teach clinical staff how to follow clinical best practices and ensure that Enrollees receive care at the most effective, least restrictive level possible. The program consists of three phases.

Phase I: Initial Orientation

Similar to the orientation provided to CSRs and described above, CRL care advocates participate in activities designed and administered by training coordinators. The program consists of topics including an overview of Optum, mandatory all-staff training, and department-specific training such as care advocacy interface with other Optum departments, communicating with clinicians and Enrollees, understanding the Empire Plan MHSA Program benefit plan and managing the triage and referral process.

CRL care advocates also receive specialized clinical training including information regarding parity, risk screening, level of care guidelines and URAC health utilization management. We provide a series of training sessions on recovery and resilience so that care advocates can develop a full understanding of the change process through which Enrollees improve their health and wellness, live a directed life and strive to reach their potential. Support for this information is offered by a fully staffed clinical learning team of site trainings, supervisors and mentors.

Phase II: The Optum Care Advocacy Mentor Program

Each new CRL care advocate is paired with a skilled, experienced care advocate through the orientation and training period to provide instruction, structure and support. The mentor observes the care advocate and identifies any necessary areas of development. The mentor also meets weekly with the new care advocate for the first six weeks of this phase, reviewing technical skills learned and providing retraining when necessary.

Phase III: Completing the Training Cycle

The next three months complete the training cycle. During this period, care advocates are expected to function independently with weekly supervision from their mentors. In addition, they have ongoing “drop-in access” to supervisors, who are licensed psychiatrists.

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

To ensure that CSRs meet our high service standards, as well as the needs of The Empire Plan MHSA Program Enrollees, we will monitor their performance regularly, paying particular attention to the accuracy and efficiency of their work, their follow-through to resolution as well as their professionalism and courtesy.

Key monitoring activities and customer service improvement initiatives are described below.

Formal Quality Assurance Call Monitoring Program

The Optum quality assurance call monitoring program is conducted by the quality assurance analyst for customer care professionals (CSRs) and the Clinical Referral Line (CRL) care advocates. The Optum staff dedicated to the Empire Plan MHSA Program will be evaluated and scored individually on a variety of areas. The quality assurance analyst completes a minimum of ten samples/audits per CSR and care advocate per month. Immediate feedback is provided to the employee and supervisor to address opportunities for improvement in service delivery as well as recognizing those CSRs and care advocates who excel at their job. The audits provide an opportunity for the CSRs and care advocates to listen to the call and talk about best practices for continued excellent service to the Empire Plan MHSA Program.

The Quality Guidelines and Scoring Sheet used by Quality Analysts to monitor and rate CSRs are provided as Attachment 5.

Call Monitoring by Supervisors

The customer service supervisor regularly listens in on incoming Enrollee and Provider calls for quality assurance control. This live call review helps to evaluate the ongoing performance of the CSR or care advocate and helps to track and trend call inquiries and identify training opportunities. Areas reviewed for call quality include: promptness of response, accuracy of information given to the caller, appropriate redirection of the inquiry when appropriate, call documentation skills and display of professionalism and courtesy (i.e., appropriate tone of voice, use of proper grammar, demonstrating full attention to caller).

Refresher trainings/Coaching sessions

We continue to improve performance by conducting refresher trainings built around operational systems and plan details. The refresher trainings, which are administered by the dedicated customer service or clinical trainer, ensure that CSRs and care advocates have the most up-to-date, in depth information and hands on training that they need in order to provide exceptional service to our callers. Care advocates also have access to continuing education opportunities addressing clinical topics such as the assessment and treatment of ADHD, psychoeducation in bipolar disorder, substance use disorders in adolescents and psychopharmacological updates.

In addition, we conduct monthly coaching sessions which are administered by the customer service trainer and clinical trainer as needed. The coaching sessions offer a breakdown of the CSRs or care advocates current performance and team goals and help to identify opportunities for service improvement.

(b) The first call resolution rate for the proposed Dedicated Call Center;

As your former MHSA Program provider, [redacted] We will report the monthly first call resolution rate to the Department. This reporting has a one-month lag, with information provided for the month prior to the month of the report.

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

The turnover rate [redacted] Our results compare favorably [redacted], which demonstrates the Optum Empire Plan's ability to retain skilled and experienced staff.

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

Our proposed staffing model has a supervisory staff (including supervisors and team leaders) to customer service representative ratio of approximately [redacted].

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

The proposed Optum staffing statistics for the Empire Plan dedicated call center, as depicted in the table below, are based on our experience as the former MHSA Program vendor and also modeled using the Erlang calculator. The Erlang calculator is widely used in the industry to assist with telecommunications traffic design and analysis, including the projection of staffing requirements for these functions. We have found this method to be an accurate predictor of staffing needs.

Additionally, our telephone system automatically monitors call volume, providing managers and supervisors with real-time data regarding the current status of all call activity. By analyzing the number of calls in queue, average hold time and status of all call center staff, call center management is able to readily use this data allowing us to recursively refine our model and adjust staffing levels as needed.

Position	Number Proposed
Supervisor	[redacted]
Clinical Program Manager	[redacted]
Operational Trainer	[redacted]
Customer Service Representative	[redacted]
Clinical Referral Line Care Advocates	[redacted]

[redacted] who will be performing concurrent UR program functions and other duties related to Enrollee care management.

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

Our telephony infrastructure is based on our concept of Virtual Call Center (VCC). We maintain four hardened data centers that provide the space for supporting our 12 Avaya S8720 Series Communications Managers Automatic Call Distribution (ACD) nodes, along with the peripheral adjunct equipment necessary to support a state of the art call center environment. These data centers are protected from power outages and hardened against natural disasters. Business continuity features include redundancy for power and telecommunication connections. Each VCC node is capable of supporting 2,600 concurrent agents.

Each of our call centers are connected to the VCC Node via two (for redundancy) high speed Multiprotocol Label Switching (MPLS) data circuits provided by two carriers. The only equipment required at each of the call centers will be the phones and desktop computers. Each desktop will be imaged with VCC Desktop (PC-based softphone application) software which provides all of the ACD agent information to flow between the call center and the VCC Node.

The dedicated Empire Plan MHSA Program service center in Latham does not utilize any other call center to handle overflow calls. As your former MHSA Program vendor, [redacted]

In the event of a site emergency, our disaster recovery plan and technology allows for the customer service calls to be answered uninterrupted, by a call center located in Houston, Texas. Designated CSRs are trained on the specifics of the Empire Plan MHSA Program thereby eliminating the need for a call back from the Latham location.

In the same scenario, CRL calls are answered by staff trained on the Empire Plan MHSA Program in Chicago, Illinois and Houston, Texas. Our call flow definitions will include pre-planned routing to ensure smooth transitions of calls in a site emergency. By design, all emergency or urgent clinical calls are uninterrupted and answered immediately even in the event of a phone system failure.

When Optum was the MHSA Program vendor, in the past two years of servicing the MHSA Program, we utilized a back-up call center one time during the Hurricane Sandy disaster.

We confirm that calls are handled exclusively by the dedicated Empire Plan MHSA Program call center and that the backup system will only be used in the event of a crisis or emergency situation.

(7) Describe the information and capabilities your website provides to members and describe the process you will utilize to develop it. Confirm that you will develop an Empire Plan specific customized website for the MHSA Program that will be complete a minimum of thirty (30) days prior to the Implementation Date. Also, confirm that the following information, at a minimum, will be available on the website: MHSA Program benefits; Network Provider locations; eligibility; Copayment information Pre-authorization information; claim status and clinically-based educational material. Provide the URL of your main website and provide a dummy ID and password so that the Department may view the capabilities and user-friendliness of your website; and

Our customized website for the MHSA Program, **liveandworkwell.com** (LAWW), is a URAC accredited health and well-being portal that facilitates network use and promotes proactive health management with an array of online resources that is unmatched in the industry. The site offers Enrollees the ability to explore thousands of articles, videos, interactive self-help programs, financial calculators and other tools to help them with the ins and outs of everyday life—even if they do not have any pressing concerns.

As your former MHSA Program vendor, we provided a direct link to LAWW from the New York State Department of Civil Service website for easy access to the following Empire Plan customized website. Site capabilities include:

- **Easy Online Provider Search**: The Empire Plan MHSA Program's customized Provider Search feature on www.**liveandworkwell.com** allows Enrollees to access a complete directory of all network providers and facilities throughout the United States and Puerto Rico. Enrollees are able to narrow their selection by clinician name, location, specialty, ethnicity, language, gender or area of expertise.
- **Personalized claims and benefit coverage information:** The secure *Claims & Coverage* area of **www.liveandworkwell.com** has been customized for the Program to allow Enrollees to view eligibility and benefits including copayment information, check clinician visit certification status, and claim status. Enrollees can manage their benefits privately 24 hours a day, seven days a week.
- **Interactive tools and other MHSA Information: wwwliveandworkwell.com** makes it easy for Enrollees to access comprehensive, clinically based resources that reduce obstacles to seeking behavioral health information through the confidentiality and convenience of online access at any time or place.
- **The Empire Plan Disease Management Program:** From the Program's customized home page **www.liveandworkwell.com,** Enrollees can link directly to Depression, ADHD and Eating Disorder Disease Management programs.

The user-friendly navigation of **www.liveandworkwell.com** makes it easy for Enrollees to find what they want quickly, including benefit and claim information, customized disease management links, educational material and resources and interactive content on a variety of health and wellness topics. We believe the easy use of the website has resulted in increased usage since 2009.

During Optum's tenure as the Empire Plan MHSA Program vendor, our dedicated account management team worked with the Department to enhance and customize the Enrollee website to better meet the needs of Empire Enrollees. Upon renewal, Optum's Web development team will be available to suggest additional enhancements for the Department's approval.

Department representatives may access the website at **www.liveandworkwell.com** with the access code **Empire** to view its capabilities and user-friendliness.

We will customize **liveandworkwell.com** to meet all the requirements of the Department, including branding the website with the Empire Plan logo. All links, information, and content are subject to Department approval, and can be removed from the site upon request.

We confirm that we will develop an Empire Plan specific customized website for the MHSA Program that will be complete a minimum of thirty (30) days prior to the Implementation Date. Also, we confirm that the following information, at a minimum, will be available on the website: MHSA Program benefits; Network Provider locations; eligibility; Copayment information Pre-authorization information; claim status and clinically-based educational material.

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

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

The Offeror's amount to be credited against the Administrative Fee for each .01 to .50% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours calculated on an annual basis is $____per year.

The Offeror's amount to be credited against the Administrative Fee for each .01 to .50 percent below the standard of [redacted] (the Offeror's proposed guarantee) that the Offeror's telephone line is not operational and available to Enrollees, Dependents and Providers during the Offeror's Call Center Hours calculated on an annual basis is [redacted] per year.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is $____per year;

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0 percent of incoming calls to the Offeror's telephone line below the standard of [redacted] (the Offeror's proposed guarantee) that is not answered by a customer service or Clinical Referral Line representative within thirty (30) seconds, calculated on an annual basis, is [redacted] per year.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of three percent (3%) (or the Offeror's proposed guarantee), calculated on an annual basis, is $_____per year; and

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0 percent of incoming calls to the Offeror's telephone line in which the caller disconnects prior to the call being answered by a customer service or Clinical Referral Line representative in excess of the standard of [redacted] (the Offeror's proposed guarantee), calculated on an annual basis, is [redacted] per year.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%) (or the Offeror's proposed guarantee), calculated on an annual basis, is $____per year.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0 percent of incoming calls to the Offeror's telephone line that is blocked by a busy signal, in excess of the standard of zero percent (0%) (the Offeror's proposed guarantee), calculated on an annual basis, is [redacted] per year.

5. Enrollee Communication Support

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

a. Duties and Responsibilities

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed. Optum will work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits, appeal letters, etc. We will provide the Department with a comprehensive communications plan to educate and inform Enrollees of the benefits available with the MHSA Program. We agree to meet all Enrollee Communication Support requirements detailed in the Duties and Responsibilities section.

b. Required Submission

(1) Please describe the organizational resources currently dedicated to Enrollee communications including any changes that would occur if you were awarded the resultant Agreement. Please detail the process that will be utilized to develop Enrollee communications including, but not limited to the role of the Offeror's legal department. Provide several examples of the MHSA Program communications you have developed for Enrollees. Confirm your understanding that all MHSA Program communications developed by the Offeror are subject to the Department's final approval.

Led by [redacted], [redacted], the Department's dedicated account management team will develop all communications materials, as requested, mailed to Enrollees and posted to the Department website and NYSHIP online. We will be responsible for reviewing communications materials developed by the Department and provide feedback regarding reference material on the Empire Plan MHSA Program. Optum legal representatives will be available to review proposed communication materials and assure accuracy and compliance with state and federal laws and regulations. We will ensure that all pertinent information regarding the Empire Plan MHSA Program, including benefit and other updates, is sent to the Department for inclusion in communication materials.

Communication Development Process

Optum will identify topics for materials relevant to Enrollees and their dependents and will collaborate with the Department to identify the most effective distribution method to get this information to the target audiences.

We will work with the Department to review the Empire Plan MHSA Program to identify and develop relevant, fact-based articles for all member communications and publications as requested. The account management team will partner with the Department to determine the most effective means of communicating with Enrollees, as well as developing an ongoing communication plan to promote the MHSA Program and provide topics for materials relevant to Enrollees. Any and all proposed communication materials distributed by Optum will be subject to approval by Department representatives before publishing.

Customization

As your former MHSA Program vendor, Optum's in-house communication team produced a variety of customized communications, created specifically for the MHSA Program, that included disease management mailings for depression, attention deficit hyperactivity disorder and eating disorders, which were approved by the Department and the Governor's Office of Employee Relations (GOER). The customized communications materials were distributed to Enrollees identified by claims data as well as Enrollees referred to these programs by their treating provider or primary care physician.

Additionally, our account management team and quality department have worked with the Department to highlight opportunities for promoting awareness of the MHSA Program and the many resources available to Enrollees via specific topics of interest. Examples include the Baby Blues Postpartum article in "Healthy Babies" and the Diabetes and Depression articles, which are included with this proposal as Attachment 6. These articles are examples of what Enrollees may find online on the customized Enrollee website.

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

The dedicated Optum Empire Plan MHSA Program account management team, led by [redacted] will be available to the Department to ensure that all Enrollee communications contain accurate information prior to publishing. The account team has access to our in-house marketing communications team and will work with the Department to make this resource available to you to support the development of various Enrollee communications. [redacted] will partner with the Department to develop a communications plan, which will include seeking the Department's input into customized communications and identifying the most effective timing and distribution methods for communicating to Enrollees. Communications materials will be created internally and the communications plan will include engagement strategies both for program launch as well as for ongoing promotion of the MHSA Program. [redacted] will discuss with the Department which topics will be most relevant to various Enrollee populations and will help identify the best ways to disseminate articles and newsletters. For example, electronic copies of materials and content is available for e-mail distribution and inclusion on the customized website we will design for the Department.

We will meet required deadlines in the review and production of communications of all information and ensure feedback is provided to the Department in a timely fashion.

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

Confirmed. Optum will pay the allocated portion of Shared Communication Expenses covering costs incurred and bill the MHSA Program for reimbursement according to Article XIII of the Agreement.

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

Confirmed. The Optum team will be available to attend Health Benefit Fairs, Union Delegate and other conferences in New York State and elsewhere on behalf of the Empire Plan MHSA Program. The members of the team attending these events will be able to answer any questions about benefit coverage and how to contact Optum for services or questions. [redacted] are client service managers who represented Optum and the Empire Plan MHSA Program at past events.

[redacted] joined Optum in 2009 at the beginning of the Empire Plan contract and has held previous positions as a call center manager and customer service trainer for the Empire Plan. She is well-versed in the specific benefit design and nuances of the Empire Plan MHSA Program. [redacted] was a point of contact for the Department and GOER for questions or concerns related to a specific enrollee issue.

[redacted] joined Optum in 2009 as part of the client services team. Prior to 2009, he worked at UnitedHealthcare for 20 years as a customer advocate working with multiple employer groups and was the main contact for issues with claims, eligibility or benefit questions. [redacted] was an additional point of contact for the New York State union representatives.

(5) Confirm you will work with the Department to develop appropriate customized forms and letters for the MHSA Program, including but not limited to claim forms, pre-certification forms and letters, explanation of benefits and appeal letters. Provide samples of customized communications you have produced for other large clients.

Confirmed. Optum will work with the Department to ensure that appropriate customized forms, letters and SBCs are developed for the MHSA Program. This includes, but is not limited to, an Empire Plan customized explanation of benefits, appeal letters and disease management program mailings. Examples of the materials we have developed for the Department in the past are included as Attachment 7. In addition, we have attached various program letters and flyers that were produced by Optum's in-house communication department for other large clients.

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

Confirmed. Upon Enrollee request, we will distribute SBCs to Enrollees in a timely manner.

6. Enrollment Management

The MHSA Program requires the Contractor to ensure the timely addition of enrollment data as well as cancellation of benefits in accordance with the Program's eligibility rules. The Department utilizes a web-based enrollment system for the administration of Employee benefits known as the New York Benefits Eligibility & Accounting Systems (NYBEAS). NYBEAS is the source of eligibility information for all Empire Plan, Excelsior Plan, and SEHP Enrollees and Dependents. Enrollment information is set forth in Exhibits II.A through II.A.4.

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

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

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

a. Duties and Responsibilities

(1) The selected Contractor will be responsible for the maintenance of accurate, complete, and up-to-date enrollment files, located in the United States, based on information provided by the Department. These enrollment files shall be used by the Contractor to process claims, provide customer service, identify individuals in the enrollment file for whom Medicare is primary, and produce management reports and data files.

Confirmed.

(2) The Contractor must provide enrollment management services including but not limited to:

(a) Initial Testing:

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

Confirmed.

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

Confirmed.

(b) Providing an enrollment system capable of receiving secure enrollment transactions (Monday through Friday) and having all transactions fully loaded to the claims processing system within twenty-four (24) hours of release of a retrievable file by the Department. The Contractor shall, on a daily basis, manually review and load any transactions which did not process correctly from the daily ANSI x.12 834 standard 005010x220 file by reviewing the correct enrollment date maintained in the NYBEAS. The Contractor shall immediately notify the Department of any delay in loading enrollment transactions. In the event the Contractor experiences a delay due to the quality of the data supplied by the Department, the Contractor shall immediately load all records received (that meet the quality standards for loading) within twenty-four (24) hours of their release, as required. The Department will release enrollment changes to the Contractor in an electronic format daily (Monday through Friday). On occasion, the Department will release more than one enrollment file within a twenty-four (24) hour period. The Contractor must be capable of loading both files within the twenty-four (24) hour performance standard. The format of these transactions will be in an EDI Benefit Enrollment and Maintenance transaction set, utilizing an ANSI x.12 834 standard 005010x220 transaction set in the format specified by the Department. The latest transaction format is contained in Exhibit II.H. The Contractor must also have the capability to receive alternate identification numbers and any special update files from the Department containing eligibility additions and deletions, including emergency updates, if required;

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

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

As the MHSA Program's former vendor, our plan is to reinstate the previous Empire Plan programming to our enrollment system. Our past experience with the MHSA Program affords us a familiarity of what is required to efficiently reestablish this process. Our testing plan to ensure that the initial enrollment load and daily enrollment transition files for the MHSA Program are accurately updated to our system and that they interface correctly with our claims system includes performing an audit on specialized scenarios prior to loading any records to the production environment. Before the initial enrollment load is processed, our audit plan will incorporate an end-to-end testing process that loads into the enrollment system after flowing through the claims system. Our dedicated eligibility staff will facilitate this process. For the daily enrollment transaction files, we will reactivate our integrated enrollment process with UnitedHealthcare to eliminate the need for the Department to send separate enrollment files.

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

Prior to loading enrollment transactions into our claims adjudication system, our quality controls define detailed, adjustable and systematic processing thresholds in the processing rules. These thresholds prevent the inadvertent application of an eligibility file that might produce an undesired result. For example, we may allow a maximum of five percent of incoming records to produce errors during a file application. In the event that an eligibility file has more than five percent of its records in error, the file would fail to update our production system, as it exceeds the maximum allowed threshold.

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

We have an automated system that identifies transactions that do not load into our enrollment system. The process is overseen and reviewed by our dedicated eligibility staff located in the Kingston service center for the medical program. After a file is applied, a report of the transactions that did not load is generated. Examples of transactions that may need to be updated manually include multiple-birth newborns and reinstatements when the Enrollee has not had Empire Plan coverage since before 2003 and has no previous alternate identifier on file. This report is analyzed on a daily basis and the exception records will be added to the enrollment file on a daily basis. The Kingston eligibility analysts have access to the New York Benefits Eligibility and Accounting Systems (NYBEAS) and also have direct contact with the Department eligibility staff to resolve these transactions quickly. Exception records will be added into our enrollment system within 24 hours (one business day) of the time the file is sent from the Department to UnitedHealthcare.

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

As your former MHSA Program vendor, Optum integrated our enrollment process with UnitedHealthcare to eliminate the need for the Department to send separate enrollment files. Should we be awarded this business, we would adopt this model again. UnitedHealthcare maintains enrollment information for the medical program, and we cooperate with Department initiatives to use new technologies, processes and methods to improve Enrollment maintenance efficiencies.

Our HIPAA-compliant eligibility system captures membership enrollment data including demographics, product enrollment and other critical information about each enrolled individual. We currently receive enrollment information from the Department and process it within 24 hours.

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

The UnitedHealthcare consolidated eligibility system (CES) maintains a history of enrollment transactions on both the file level and the member level. On the file level, an electronic log is maintained that includes the file received date, the file application date, the file name and other basic statistics. On the member level, a record of each transaction that impacts a member is maintained (this could be the result of an eligibility file, a manual transaction or any other event that might change a record). The Empire Plan history is currently being maintained indefinitely. CES does not impose a limit on the number of transactions that are kept.

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

Retroactive changes and corrections are accepted and updated within the enrollment system; there is no rule in place to prevent an Enrollee record from being retroactively updated or corrected for the Empire Plan.

(c) Detail how your enrollment system captures the information necessary to produce the reports entitled "Claims and Credits Paid by Agency" and "Quarterly Participating Agency Claims" required in the Reporting Section of this RFP;

The consolidated eligibility system (CES) captures Agency codes that are transmitted by the Department. The Agency codes are retained on an individual Enrollee's eligibility file. We will match the Enrollee's eligibility file, including Agency codes, with our claim files and report on claims and credits by Agency. We will identify members with Part B Medicare coverage and retain information in our system including the Medicare effective date. This information is also maintained and utilized in the same manner for the Empire Plan MHSA Program.

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

Confirmed. Our enrollment system has the capacity to administer a social security number, employee identification number and an alternate identification number, and our enrollment system is linked to our claims system. As stated above, we use the medical eligibility file to administer the MHSA Program so we will be accepting the nine-digit alternate identification number assigned by the Department and transmitted to UnitedHealthcare. There are no special requirements to accommodate these three identification numbers. Dependents are linked to the Enrollee in the enrollment and claims processing systems by the Enrollee's unique identifier, whether that is the social security number or an alternate identifier.

(e) Confirm you will, on a daily basis, manually review and load any transactions which did not process correctly from the daily 834 file.

Confirmed. On a daily basis, we will manually review and load any transactions which did not process correctly from the daily 834 file.

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

Should Optum be awarded the MHSA Program business, we will use an enrollment process integrated with UnitedHealthcare. UnitedHealthcare's enrollment system, data transfers and processes for handling enrollment data are HIPAA compliant. Our security measures conform to federal regulations (including HIPAA) and corporate policies that define the handling and privacy of protected health information.

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

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

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

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

Our back-up system maintains a current and complete version of the eligibility system application, software and data in off-site locations that are well protected against disaster. The data backups are created in a timely manner so as to provide a safeguard against data loss. Our data center monitors systems on a 24-hour basis to ensure that eligibility systems are available and to minimize, if not eliminate, systems breakdowns. We have a formal disaster recovery process in the event of a disaster that enables us to run our applications from our primary data center.

In the event Enrollee information cannot be located within the customer database, we still refer to care. Any certifications are accompanied by a verbal disclaimer that coverage of accessed services is dependent upon subsequent confirmation of eligibility.

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

Confirmed. We cooperate fully with any State initiatives to use new technologies, processes and methods to improve the efficiencies of maintaining enrollment data including any enrollment file conformance testing requested during the course of the Agreement.

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

Confirmed. We maintain a read-only connection to the NYBEAS enrollment system, and our staff are available to access enrollment information through NYBEAS during the required hours, Monday through Friday, from 8:00 AM to 5:00 PM, with the exception of NYS holidays.

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

Our enrollment system can store the information required by the National Medical Support Orders and dependents covered by a Qualified Medical Child Support Order (QMCSO). Once we receive the notice, we update the eligibility system with the required dependent coverage information including a different mailing address for the dependent for the EOBs, and checks, if necessary. A copy of the notice is retained for documentation. A dedicated team controls the release of written information for any dependents with support orders. In addition, automated system alerts are placed on the family's file for customer care to prevent the verbal release of information to others.

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

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

The Offeror's quoted amount to be credited against the Administrative Fee for each twenty-four (24) hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is $.

The Offeror's quoted amount to be credited against the Administrative Fee for each twenty-four (24) hour period beyond twenty-four (24) hours from the release by the Department that one hundred percent (100%) of the MHSA Program enrollment records that meet the quality standards for loading is not loaded into the Offeror's enrollment system, is [redacted].

7. Reporting

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

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

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

a. Duties and Responsibilities

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(a) Forecasting and trend analysis data

Confirmed.

(b) Utilization data

Confirmed.

(c) Utilization review savings

Confirmed.

(d) Benefit design modeling analysis

Confirmed.

(e) Reports to meet clinical program review needs

Confirmed.

(f) Reports segregating claims experience for specific populations

Confirmed.

(g) Reports to monitor Agreement compliance

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

Annual Reports

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

Confirmed.

Annual Premium Renewal Report: The Contractor must submit an Annual Premium Renewal no later than September 1st of each Calendar Year. This report must detail all assumptions utilized to support recommended premium level necessary for the following Plan Year. The report must include, but not be limited to: paid claim amounts; projected incurred claims; trend; Administrative Fees and changes in enrollment;

Confirmed.

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

Confirmed.

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

Confirmed.

Quarterly Reports

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

- **annual financial performance;**
- **assessment of MHSA Program costs;**
- **incurred claim triangles;**
- **audit recoveries;**
- **settlement and litigation recoveries;**
- **administrative expenses;**
- **trend statistics; and**
- **such other information as the Department deems necessary.**

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

Confirmed.

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

Confirmed. We completed Exhibit I.Y.2 and GeoAccess Reports as part of our proposal and included them in our electronic submission as Attachments 11 and 25, respectively.

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

Confirmed.

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

Confirmed. We have completed Exhibit I.Y.3 and included it as Attachment 12.

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

Confirmed.

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

Confirmed.

Quarterly Website Analytics Report: The Contractor must submit a quarterly report that provides comprehensive performance information for the Contractor's customized MHSA Program website as set forth in Section IV.B.4.a.(7) of this RFP. The report must include summarized and detailed website performance information and statistics, as well as proposed modifications to the layout and design of the website to improve communications with Enrollees. The report is due thirty (30) Days after the end of the quarter;

Confirmed.

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

Confirmed.

Monthly Reports

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

Confirmed.

MHSA Program Customer Service Monthly Reports: Each month, the Contractor must submit a customer service report that measures the Contractor's customer service performance including call center availability, call center telephone response time, the telephone abandonment rate, the telephone blockage rate, claims processing, enrollment, and claims turnaround. The final format of these reports will be determined by the Department in consultation with the Contractor. The reports are due thirty (30) Days after the end of the month. For the first month of the Agreement, these reports will be due on a weekly basis; and

Confirmed.

Detailed Claim File Data: The Contractor must transmit to the Department and/or its Decision Support System (DSS) Vendor, currently Truven Health Analytics, a computerized file via secure transfer, containing detailed claim records using data elements acceptable to the Department to support the claims processed each reporting period and invoiced to the Department. The Department requires that all claims processed and/or adjusted be included in claims data. The file must facilitate reconciliation of claim payments to amounts charged to the MHSA Program. The Contractor must securely forward the required claims data to the Department and/or its DSS vendor within fifteen (15) Days after the end of each month and submit a summarized report by month utilizing a format acceptable to the Department. The Contractor must continue to send the Detailed Claim File each month after termination of the Agreement until such time as the Department and Contractor mutually agree that the claims run-out is complete; and

Confirmed.

In-Network Triangle Report: Total Paid In-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP. The report is due the fifteenth (15th) Calendar Day after the end of the month;

Confirmed.

Out-of-Network Triangle Report: Total Paid Out-of-Network claims per month of incurral; separate triangles for Empire, Excelsior and SEHP. The report is due the fifteenth (15th) Calendar Day after the end of the month;

Confirmed.

Claim Production Report: Summary of claims processed for the month just ended (also aging of claims): paid, declined, deductible not satisfied, other and # outstanding. The report is due fifteenth (15th) Calendar Day after the end of the month;

Confirmed.

Copayment Savings Report: Outpatient Participating Provider Paid Claim Dollars per Month and Related Per Month Co-Payment Dollars. The report is due the fifteenth (15th) Calendar Day after the end of the month; and

Confirmed.

Coordination of Benefits Savings Report: Medicare and Other COB Savings for the month just ended (and all prior current calendar year months). The report is due the fifteenth (15th) Calendar Day after the end of the month.

Confirmed.

b. Required Submission

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

Optum agrees to meet all of the reporting requirements for the Empire Plan Mental Health and Substance Abuse (MHSA) Program, as detailed in the Duties and Responsibilities above. Additionally, our flexible reporting capabilities give us the ability to work collaboratively with the Department as we move forward to enhance our reporting package to better serve the needs of the Empire Plan MHSA Program Enrollees.

Our reporting package for the MHSA Program will be customized to the Department’s requirements and adapted as needed. UnitedHealthcare has built a team of experts from within the organization to meet the Department’s reporting requirements. This has resulted in Optum’s ability, in consultation with Tom Coy, UnitedHealthcare director of underwriting and financial reporting, to offer a customized, professional reporting package for the MHSA Program. We have provided a collection of sample reports as Attachment 8.

Empire Plan Customized Reporting Capabilities

The Optum resources dedicated to the MHSA Program will focus on providing valuable information and insight that will help maximize the MHSA Program performance. The reports will show current market trends and incorporate in-depth analytics to provide the Department with data to make decisions on benefit design as well as strategy determinations to improve the overall administration and effectiveness of the MHSA Program.

In producing the MHSA Program reports, we will leverage [redacted], who will play an active role in the production and analysis of our reports as he did when we were the MHSA Program vendor. [redacted] is familiar with the Department's financial reporting requirements and the expectations of the Department's financial management staff. [redacted] also has oversight responsibility for the annual renewal process and presentation to the Health Insurance Council and the Joint Labor Management Committee and participates in an annual meeting with the unions to review historic and projected program performance.

Our extensive reporting capabilities provide a powerful tool for tracking and controlling expenses, planning for the future of the program and improving the well-being of the Empire Plan MHSA Program Enrollees. We will work closely with the Department to produce the reports you need—when you need them—to meet reporting and accounting standards and better serve Enrollees.

Beyond the Requirements

We bridge financial assessment, clinical utilization, product performance and network operations through focused analytics. Reporting is then provided to detail these analyses to our customers. By responding quickly to analytical requests, we can highlight the details of market trend drivers. As a result, this information can inform new strategy development, pricing, network development, benefit design, clinical protocols and best practice, and other issues regarding program infrastructure. Specific service offerings include statistical trending, financial versus economic cost modeling, provider-type profiling, burden of disease prevalence, patient consumption profile and large case magnitude.

Two examples of special requests and ad hoc reporting are described below:

- **DEAS Voluntary Terminations (included within Attachment 8)**: We coordinated with the Empire Medical and Pharmacy account teams to provide periodic Enrollee files to the Department with data pertaining to the Dependent Eligibility Project including Enrollee information, claims payments, overpayment amounts and amounts recovered.
- **Sample Ad Hoc Request (included within Attachment 8)**: We provided specific data to the Department by Collective Bargaining Units. Attached report includes the 1) number of union Enrollees/dependents denied inpatient treatment for lack of medically necessity for 2009 and 2010; 2) specific denials for behavioral health treatment; and 3) number of new providers by county contracted for the years of 2009 and 2010.

We will work with the Department to determine the best format and frequency of additional reports. These include:

- **Customer Service Quality Management Reports** – Customer service representatives are regularly evaluated and scored individually on multiple criteria, such as accuracy, efficiency and courtesy using a point system. Monthly quality scores are produced for each individual and the entire team, with summary results provided annually.
- **IVR** – Our IVR system collects a variety of Enrollee and provider data, which can then be translated into Empire Plan reporting, including information regarding the types of

questions Enrollees call with, what path a caller took in the IVR, if they were transferred, where they were transferred to and what data was passed throughout the call path.

- **High-Amount Claimant Reports** – We generate high-amount claimant reports to help the Department identify Enrollees with the highest claims expenses, allowing the Department to analyze Program costs based on a variety of criteria, including demographic information such as Enrollee age and geographic location, treatment type and frequency, or any other collected data. This information can be used to identify at-risk populations, create new support programs to better serve Enrollee needs, and develop targeted communication plans.
- **Annual Enrollee Satisfaction Survey Summary Report** – We conduct Enrollee satisfaction surveys at least annually. This assessment is based on a survey of a random sample of Enrollees, with results trended against previous years. Results are analyzed at least annually by national and regional quality improvement committees, with the goal of continuous improvement of services.
- **Annual Provider Satisfaction Survey Summary Report** – We also conduct an annual practitioner satisfaction survey. The survey evaluates the clinical management methods and the satisfaction of our network practitioners. We provide a detailed report to the Department and analyze year over year trending.
- **Utilization Management Reporting –** Quarterly utilization and outcome reporting will include provider practice activity and clinical outcomes.

Fully Integrated Information System

Our information system fully integrates all eligibility, clinical certifications, network status and claims processing outcomes for better reporting functions. The system stores data from these various system modules in the Optum data warehouse enabling us to provide Empire Plan specific reports.

Designed for decision support applications, our data warehouse provides many advantages for reporting, including expanding the range of data that can be collected for reporting; streamlining data collection techniques; extending the range of existing analytical tools; and aiding Department representatives in pinpointing the data they need. This data and reporting also helps to identify practices and providers that drive inefficiencies and/or increased costs. Through these capabilities, we will support the Department in both day-to-day and long-term decision making, leading to positive outcomes for the Department and Enrollees.

Sample Reporting

Sample reports are provided as Attachment 8, including:

Annual Reports

- Annual Financial Experience Report
- Annual Premium Renewal Report
- Annual Summary Reporting

Quarterly Reports

- Quarterly Financial Summary Reports

- Quarterly Coordination of Benefit Report
- Quarterly Website Analytics Report
- Quarterly Provider Audit Report

Monthly Reports

- MHSA Program Customer Service Monthly Reports
- Detailed Claim File Data (Note: The sample is a template containing the required data elements without Enrollee information or required narrative.)

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

Confirmed. Reporting is presented in the format requested by the Department. We are able to provide reporting in various electronic formats, such as Microsoft Access, Excel and Word. Reporting can also be provided in hard copy format.

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

Confirmed. Direct, secure access to our claims system will be provided to the Department, which includes a data sharing agreement. As part of this proposal, as indicated in the submission of our signed Formal Offer Letter, we affirm our acceptance of the request for proposal terms and conditions and associated agreements. This acceptance includes those conditions and agreements regarding data sharing activities. We have included a copy of our proposed data sharing agreement as Attachment 9.

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

Confirmed. We will provide Ad Hoc Reports, along with other data analysis, to the Department. Should we be awarded the MHSA Program contract again, we will review all reporting formats and assist in developing new formats with the approval of the Department. Our reports are designed to be easy to read and be designed to provide the information that is important to the Department. Ad Hoc reports can be produced in a little as two weeks. Examples of the Ad Hoc Reports we have completed for the Department are included in the sample reports we provided as Attachment 8.

We produce ad hoc reports for our customers that meet each customer's specific reporting needs. Examples of ad hoc reports we have created, include:

- CPT codes
- Zip codes
- Customer division or location.
  - Our systems support the setup of customer structure at two levels (group and package) for which standard reporting is available. Typically, workgroups/locations are identified at the group level and benefit plan groupings are at the package level.

- Number of claims paid for the period
- Copayments and coinsurance information
- Amounts adjusted for COB
- Amounts determined to be ineligible
- Claims by provider type
- Specific time or date ranges
- Date references (paid or service)
- Custom high-cost threshold

Our data warehouse—a collection of databases that enable us to collect data from our various system modules—provides the ability to create a wide range of ad hoc and customized reports. We will work with the Department to determine your ad hoc and/or customized reporting needs and can provide associated costs.

(5) Management Reports and Claim File Guarantees: The MHSA Program's service level standard requires that accurate management reports and claims files will be delivered to the Department and Decision Support Vendor, as applicable, no later than their respective due dates. For the management reports and claim files listed in Section IV.B.7.a. (7) of this RFP, the Offeror must propose a performance guarantee. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this standard.

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

The Offeror's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not received by its respective due date, is $____per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department and Decision Support Vendor, as applicable, inclusive of the date of receipt.

The Offeror's quoted amount to be credited against the MHSA Program's Administrative Fee for each management report or claim file that is not received by its respective due date, is [redacted] per report for each Business Day between the due date and the date the accurate management report or claims file is received by the Department inclusive of the date of receipt.

8. Consulting

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

a. Duties and Responsibilities

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

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

In today’s ever evolving healthcare arena, Optum is diligent in navigating state and federal regulatory changes and monitoring legislative policy activity. Optum’s consultants in the field are at the forefront for state and federal healthcare policy and reforms. The account management team dedicated to the MHSA Program will advise the Department and the

Governor's Office of Employee Relations (GOER) of the latest developments in the MHSA field, as well as reviewing new legislation on a state and federal level during Optum's previous administering of the Empire Plan MHSA Program, [redacted] conducted quarterly and annual face-to-face meetings with the Department to discuss upcoming issues or trends. [redacted] also participates in the monthly Empire Plan meetings with the Department and GOER to provide collaboration on any issues or legislation impacting the medical and/or MHSA programs. The account management team regularly conducts analysis of utilization within the Program and provides the Department with reports on existing trends within the population, member satisfaction, cost management and other analytics.

Additional meetings are conducted both in-person and telephonically for any regulatory change to the MHSA benefit. For example, [redacted] met with the Department and GOER regularly in 2013 with the Department and GOER to inform and discuss regulatory changes related to the Autism Insurance Mandate and changes to CPT coding. [redacted] included several key Optum staff members from provider networks, as well as our expert legal and financial representatives.

During our last contract termination, the Empire Plan MHSA Program's account management team conducted Annual Joint Labor Commission Meetings to inform the Department, GOER and union representatives of the program utilization, trend analysis, and potential implication to cost or service and announce any regulatory changes impacting the Empire Plan MHSA Program. The annual events, which includes participants from clinical operational departments, underwriting and the Empire medical plan, is informative and well-received.

The Program's account management team will continue to leverage broad resources to ensure they have the latest information available to provide industry updates to the Department. We have internal resources dedicated to following and shaping changes to the mental health and substance abuse field, as described below, which are available to consult with the Department and GOER at any time.

New York State Subject Matter Expertise

Optum has specialized resources available to advise the Department on MHSA legislation and regulations. [redacted] has over 20 years professional experience in New York State government negotiating legislation and regulations with state agencies and authorities, developing state public policy, and collaborating with third party partners to advance solutions to challenging issues facing all New Yorkers. In her current role for UnitedHealth Group, [redacted] During the past contract term with the MHSA Program, [redacted] participated in several meetings with the Department and GOER to assist in regulatory alerts for the Empire Plan Medical and MHSA Programs.

Shaping Clinical Innovation through Our Dedicated Research Department

Through our unique clinical science and research division, Behavioral Health Sciences, we have successfully attracted esteemed researchers and valid funding sources to implement studies. Our Behavioral Health Sciences Department, led by [redacted] who conduct research and evaluation on a wide variety of behavioral health topics, in partnership with our customers, providers and acclaimed academic researchers. [redacted] and her team are responsible for bringing scientific evidence and methodology to Optum clinical programs and internal initiatives, as well as external vendor products. As the leader of our Behavioral Health Sciences, she has extensive experience in research related to behavioral health outreach, workplace depression and treatment outcomes. She oversees the design and implementation of all research studies conducted at Optum, as well as the dissemination of results for publication. This research has helped inform our clinical operations in new and innovative ways. We publish in peer-reviewed journals and present at professional meetings to influence colleagues, policy-makers and opinion leaders.

We have previously partnered with large customers, leveraging the rich real-world data their membership provides, in order to conduct studies that not only provide insights about particular populations but also inform the industry. Findings from our most recent study in collaboration with [redacted] This study examined the impact of an eight-session telephonic coaching program for depression-related work impairment on clinical outcomes and workplace functioning and productivity. Our research informs care advocacy centers and helps improve the quality of care we provide which will benefit the Empire Plan membership.

Behavioral Health Sciences conducts research on topics covering health care policy, clinical services interventions, integrated medical and behavioral health care and influencing provider practice patterns. Our position as a leader in the industry is based on our commitment to evidence-based practices and the latest clinical and scientific research in mental health and substance abuse services. Behavioral Health Sciences reviews the latest available clinical and scientific evidence and provides the organization with subject matter experts through their pool of academic consultants to ensure that benefit coverage and clinical operation policies, as well as product innovations, are based on the latest evidence-based practices.

The synergies that result from these academic partnerships, grounded in scientifically valid evaluations and reviews, contribute invaluably to the quality of our new products and their effectiveness for our customers and distinguish us from other behavioral health organizations.

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

Confirmed. We will assist the Department with recommendations and evaluation of proposed benefit design changes and implement any changes necessary to accommodate Program modifications resulting from collective bargaining, legislation, or within the statutory discretion of the State. As the former MHSA Program vendor, we have experience assisting the Department with federal and state Mental Health Parity and PPACA changes, as well as the New York State Insurance Law requiring Applied Behavioral Analysis services for enrollees with an autism spectrum diagnosis.

9. Transition and Termination of Agreement

The Contractor shall ensure that upon termination of the Agreement, any transition to another organization be done in a way that provides Enrollees with uninterrupted access to their MHSA benefits and associated customer services through the final termination of the Agreement . This includes, but is not limited to: ensuring Enrollees can continue to receive services from Network Providers; the processing of all claims; verification of enrollment; providing sufficient staffing to ensure members continue to receive good customer service and clinical management service even after the termination date of the Agreement; and developing a strategy for addressing the treatment needs of those members in treatment with Providers that are not in the successor contractor's network.

It is also imperative that the MHSA Program continue to have dialogue with key personnel of the Contractor's dedicated account team, maintain access to online systems and receive data/reports and other information regarding the MHSA Program after the termination date of the Agreement. In addition, the Contractor and the successor contractor shall fully cooperate with the Department to create and carry-out a Transition Plan in a timely manner.

a. Duties and Responsibilities

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

Confirmed.

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

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

(i) Providing a test file to the successor contractor at least seventy-five (75) days in advance of the Implementation Date to allow the successor contractor to address any potential formatting issues;

Confirmed.

(ii) Providing one or more pre-production files at least eight (8) weeks prior to implementation that contains the above MHSA Program data as specified by the Department and working in conjunction with the successor contractor;

Confirmed.

(iii) Providing a second production file four (4) weeks prior to implementation; and

Confirmed.

(iv) Providing a third production file to the successor contractor by the close of business three (3) days after the Agreement terminates;

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(11) The Contractor must continue to manage and pay for Covered Services of Enrollees who are confined as inpatient and in Residential Treatment Centers on or before the Agreement termination date until the earlier of the step down of care or midnight on the 90th day subsequent to the Agreement termination date;

Confirmed.

(12) The Contractor must forward to the successor contractor on a weekly basis all mis- directed authorization requests received by the Contractor after the Agreement termination date for a period of ninety (90) days.

Confirmed.

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

Confirmed.

b. Required Submission

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

Confirmed.

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

As we did in December, 2013, in the event of a transition, we will work closely with the Department and the new vendor to design a transition plan that will meet all requirements for complete and successful transition in a timely manner. For the transition of the MHSA Program in 2013, Optum exceeded these requirements in order to assist in the least amount of disruption to the Empire Plan enrollees and the provider community. Key elements and tasks in our transition plan to ensure completion of all required duties and responsibilities include:

Development of a Transition Plan to be Approved by the Department

We will provide the Department with a written transition plan complete with tasks, milestones and deliverables within thirty days of any notification of termination. We understand that the Department will have 15 days to approve the plan or suggest changes. We will then incorporate any changes within the 15 days and adhere to that final plan through termination of the contract.

Establish Contacts with New Vendor

With the help of the Department, we will communicate with the new vendor early on to understand their plan design, network and information technology structure. We will obtain their member services phone number and initiate dialogue between our relevant department heads and their corresponding staff.

Transition of Program Data

We will send open-authorization benefit files to the Department and the new vendor in the following order:

- A test file before implementation to the new vendor to check for formatting issues
- A pre-production file to the Department a few weeks before implementation
- A production file to the new vendor

Transition of Clinical Information

After obtaining a confidentiality agreement approved by all three parties, we will commence the transfer of clinical information to the new vendor to ensure continuity of care for Enrollees.

Continued Account Services

We will continue to provide our administrative services to the Department through the transition period. We will come to an agreement with the Department on processing enrollment updates, maintaining phone lines and adequate staffing levels. During transition, our staff will be able to warm-transfer calls to the new vendor’s lines.

We will respond to any State audits requests in a timely manner. We will fully cooperate with audit findings and perform timely reviews. We will remit reimbursement due to the Program consistent with the requirements of this RFP.

Transition of Care for Enrollees in Treatment

We place a strong emphasis on ensuring continuity of care when transitioning Enrollees who are in active, current and ongoing mental health and/or substance abuse treatment. Although specific transition plans are based on the Enrollee’s clinical needs, benefit plan coverage and any provisions set by the Department, our primary focus is on avoiding Enrollee disruption.

- We will work closely with the new vendor to establish a system that ensures continuity of care for Enrollees, including those who will be required to change providers to maintain the network level of benefits. Based on an agreement between the three parties, we may assist the new vendor with Enrollee transition in the following ways:
    - Producing a list of all Enrollees currently receiving treatment for the new vendor (including identification of the treating provider)
    - Preparing a letter for Enrollees to advise them of their financial responsibilities if they continue to receive services from a provider outside of the new network
    - Scheduling regular phone calls between the account team and the new vendor’s designated account manager to streamline Enrollee transition
    - Facilitating communication between our clinical program managers and the corresponding individuals associated with the new vendor
- On a case-by-case basis we will develop plans for extended management of care for high-risk Enrollees who are nearing the end of a course of treatment.
- Disabled Enrollees will continue to receive services for 90 days after the end of the Agreement, or until their disability ends, whichever occurs first.
- We will provide the new vendor with contact information for providers that are not in their network but are currently treating Enrollees at the time of transition. We will assist as needed in the new vendor’s effort to recruit these providers into their network.

In addition, we will perform internal processes during the transition period. Across Optum departments, we will complete the following activities:

- Complete and distribute Cancellation Form
- Alert all Optum departments simultaneously through our integrated care management online system of the details of the termination, including the term date of the account, and the new vendor's contact information and benefit plan
- Notify frontline staff (care managers, customer service representatives, claims) of termination and how to handle calls right before and immediately following the termination date, including instructions for routing new service requests
- Complete a final reconciliation of the performance guarantees for the previous year
- Provide a final annual report to the Department

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

After the termination date of the Agreement resulting from this RFP, our primary focus would be avoiding Enrollee disruption, both at a clinical and customer service/claims level. During transition, our priority is to ensure continuity of care for Enrollees in current and ongoing mental health and/or substance abuse treatment. When a signed Agreement between the Department and the new vendor is obtained, the account management team will forward a copy to the care advocacy center that manages the Program. In addition, account management is responsible for ensuring that information about the transition plan is available for care managers, customer services representatives and claims staff.

The transition plans for Enrollees in treatment vary depending on the level of care:

Inpatient Care

- High-risk inpatient Enrollees receive extended care management on a case-by-case basis
- Enrollees at all inpatient levels of care (acute inpatient psychiatric treatment, inpatient chemical dependency detoxification, inpatient chemical dependency rehabilitation and residential treatment) continue to be managed by Optum until they are discharged or stepped down to a lower level of care, unless otherwise stipulated by state law, the Enrollee's certificate of coverage or the Optum agreement with the employer group, customer or health plan.
- As part of the discharge planning process, the Enrollee's care manager informs the facility that discharge plans should be made based on the knowledge that the Enrollee's benefit is transitioning to a new vendor, that the facility needs to contact the new vendor and that discharge plans should be made in accordance with the procedures of the new vendor. Furthermore, we are happy to assist each Enrollee in accessing the new plan by connecting them directly to the new services available to them.
- At the point of discharge or step-down to another level of care, the care manager closes the Enrollee's case with Optum.

- In accordance with the Optum confidentiality policy, Enrollee protected health information may not be provided without the Enrollee signing a Release of Information form.
- With a confidentiality agreement signed by all three parties, we will provide the new vendor with clinical information on all Enrollees, including those receiving services during the transition.
- We will notify the MHSA Program's designated clinical program manager of the transition/termination. The clinical program manager will work closely with the new vendor to discuss protocol and coordinate transition and step-down of inpatient and high-risk Enrollees.

Outpatient Care

- Enrollees in active and ongoing outpatient treatment managed by Optum are the responsibility of the new vendor at the time the contract with Optum ends.
- Payment of benefits for these Enrollees ends on the last day of the contract with Optum.
- Inquiries by Enrollees or clinicians related to outpatient services taking place after the last day of the contract with Optum are to be directed to the new vendor.

Customer Service Continuity for Program Enrollees

As noted above, in the case of transition to another vendor, all frontline departments including customer service will be simultaneously notified of termination and provided with instructions on how to handle calls right before and immediately following the termination date, including instructions for routing new service requests. Customer service representatives will continue to have access to all Enrollees' case information post-termination through our online care management system. Should an Enrollee call our toll-free number after termination, we will be able to direct them to their new vendor's customer service lines.

During the transition period, we will reach a mutually acceptable agreement with the Department on receiving and applying enrollment updates, keeping dedicated phone lines open with adequate available staffing and transferring calls to the new vendor's lines. In addition, we confirm that we will provide sufficient customer service staffing to ensure Enrollees continue to receive good customer service after the termination date. Specific details will be agreed upon during contract negotiations.

Extended Claims Processing

The termination plan we publish with the Department's approval will further detail our post-termination services including claims processing through timely filing and claims run-out.

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

We confirm that if we do not meet all the Transition Plan requirements in the timeframes stated above, we will permanently forfeit 100 percent of all Administrative Fees (prorated on a daily basis) from the due date of the Transition Plan requirements to the date the Transition Plan requirements are completed to the satisfaction of the Department.

10. Network Management

Empire Plan Enrollees reside throughout the United States and are guaranteed access to Network Providers under the design of the MHSA Program. The Contractor must have a comprehensive, nationwide Provider Network in place to allow adequate access for Enrollees to obtain all MHSA Covered Services through the Provider Network. Through this RFP, the MHSA Program is seeking a Provider Network that delivers cost-effective, clinically appropriate MHSA Covered Services, while meeting the minimum guarantees for Network Provider access. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed Masters Level Clinicians (MLC) (in NYS, the MLC must qualify for the "R" designation issued by the State Education Department; elsewhere they must have the highest licensure offered in the state for a MLC), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network.

Provider Network

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

a. Duties and Responsibilities

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

Confirmed.

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

Confirmed.

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

Confirmed.

(4) In developing its proposed MHSA Provider Network, the Contractor is expected to use its best efforts to substantially maintain the composition of Network Providers included in the MHSA Program's current Provider Network. The Contractor's proposed MHSA Provider Network must be composed of an appropriate mix of licensed and/or certified psychiatrists, and psychologists, licensed Masters Level Clinician (MLC) (in NYS, MLCs must qualify for the "R" designation issued by the State Education Department; elsewhere, they must have the highest licensure offered in the state for a MLC), Registered Nurse Clinical Specialists, psychiatric nurse/clinical specialists and registered nurse practitioners, Certified Behavioral Analysts, Structured Outpatient Programs and Partial Hospitalization Programs including: residential treatment centers, group homes, hospitals and alternative treatment programs such as day/night centers, half-way houses and treatment programs for dually diagnosed individuals (e.g., mental health diagnosis and substance abuse diagnosis). Programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) must be included in the MHSA Provider Network. The MHSA Provider Network must include Providers throughout New York State and in areas with high concentrations of active and/or retired employees living outside of New York State such that the network access guarantees established by the terms of the Agreement are fully satisfied;

Confirmed.

(5) Network Composition Guarantee: The Contractor must guarantee that throughout the five-year term of the Agreement and optional eleven (11) month extension period, if exercised at the sole discretion of the Department, that at least ninety percent (90%) of the Providers in each of the Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or in other states a Masters Level Clinician with highest licensure, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner- Other Prescriber, listed on Exhibit I.Y.2; will be maintained. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee. This standard shall be measured annually.

Confirmed.

(6) Network Provider Access Guarantee: The Contractor must guarantee that effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement:

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Offerors should propose a guarantee for each of the three (3) areas (urban, suburban and rural) for each of the following two (2) Provider types: Network Facility (Inpatient, ALOC and Outpatient Clinic Group for Mental Health and Substance Abuse combined) and Network Practitioner types (Psychiatrist; Psychologist; Masters Level Clinician combined) for a total of six (6) separate guarantees. These guarantees are based on the distance, in miles, from a MHSA Program Enrollee's home address to the nearest MHSA Provider Network Provider location.

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

Confirmed. We have completed the tables in b. (1).

(7) Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee: The Contractor must propose a guarantee for access to Network Certified Behavioral Analysts and Applied Behavioral Analysis Facilities that will be effective the first day of the month following 90 day implementation period after OSC approves the Contract, and throughout the term of the Agreement:

Confirmed. We have proposed our Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee in the required submission below.

b. Required Submission

(1) Propose access guarantees for the MHSA Program's Provider Network (excluding all Certified Behavior Analysts, Applied Behavior Analysis Agencies, Mental Health & Substance Abuse Practitioners – Other Prescribers,) that meet or exceed the minimum set forth above. The access guarantee must be provided in terms of actual distance from Enrollees' residences and must meet or exceed the minimum access guarantees stipulated above.

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

[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]s

(2) Understanding that Applied Behavioral Analysis is often provided in a home setting and it is most applicable to young children, confirm which of the sixty-two (62) counties within the State of New York are served by Network Certified Behavioral Analysts and Applied Behavioral Analysis Agencies.

[redacted]

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

We have provided Exhibit I.Y.4 - Comparison of 2014 MHSA Program Providers as Attachment 13 and the Offeror's Proposed Provider Network as an attachment to our electronic proposal (per file instructions).

(4) Please confirm that if selected, you will provide updated Exhibits I.Y.2, I.Y.3 and I.Y.4 thirty (30) days prior to the Implementation Date confirming that the Offeror's proposed Provider Network will be implemented as required on the first day of the month following a 90 day implementation period after OSC approves the Contract. If necessary, the selected Offeror shall submit a second file affirmatively identifying any deviations from the proposed Provider Network along with a detailed explanation for all deviations.

Confirmed.

(5) Describe the types of Providers, inpatient facilities and Alternative Levels Of Care (ALOC) included in your proposed Provider Network. Include a listing of programs certified by the NYS Office of Alcoholism and Substance Abuse Services (OASAS) which are included in the Provider Network. Provide a listing of Comprehensive Care Centers for Eating Disorders and continuum of care providers (as established by Article 27-j of the NYS Public Health law) that are included in the Provider Network.

Nationally, our network consists of licensed qualified professionals from the disciplines of psychiatry, psychology, psychiatric nursing, and clinical social work in mental health and chemical dependency. Our panel also includes an array of facility-based programs that will offer all levels of services to Enrollees. [redacted] Many of our acute care facilities provide alternative levels of care such as day treatment and intensive outpatient facilities. In addition, [redacted] should that level of care be required.

Our network team provides oversight of our national initiatives that would impact Empire Plan retirees and Enrollees both inside and outside of New York State. We will maintain a contracted and credentialed provider network that meets or exceeds [redacted] proposed in the tables above throughout the contract term.

New York Network

Our New York State network is a robust, multi-disciplinary network of professional behavioral health specialists, including psychiatrists (M.D. and D.O.), doctorate-level practitioners (Ph.D.), licensed clinical social workers (LCSW with R designation in New York State) and advance practice registered nurses (APRN).

To increase access, Optum emphasizes recruitment and retention of practitioners with prescriptive authority, such as psychiatrists and advance practice nurses (APRN). These specialties [redacted]. With psychiatrists in short supply nationwide, we have intensified our efforts to recruit APRNs who can play an important role in managing and prescribing medications. We continue to target APRNs for recruitment in all areas and the current [redacted]. We have grown our network to ensure Enrollee options and access to all levels of service.

Our contracting principles also ensure that we maintain a network that is culturally and linguistically appropriate for our membership. Ongoing network analysis ensures diversity among clinicians to meet Enrollees' cultural needs and an adequate ratio of bilingual and multilingual clinicians. [redacted] (including Arabic, Cantonese, Farsi, French, German, Hebrew, Hindi, Italian, Japanese, Korean, Mandarin, Portuguese, Punjabi, Romanian, Russian, Sign

Language, Spanish, Urdu, Vietnamese and Yiddish) [redacted], including African American, Asian, Chinese, Filipino, Hispanic, Indian, Israeli, Japanese, Korean, Native American, Persian, Portuguese, Romanian and Russian.

Comprehensive Care Centers for Eating Disorders

Providers or facilities that provide a coordinated, individualized plan of care for an individual with an eating disorder, across a continuum that includes all necessary non-institutional, institutional and practitioner services and treatments, from initial patient screening and evaluation, to treatment, follow-up care and support are considered Comprehensive Care Centers for Eating Disorders. [redacted].

Inpatient Facility Network and Alternative Levels of Care

[redacted], providing facility-based mental health and substance abuse services for all ages, ranging from geriatric populations to children and adolescents. A continuum of services is offered to ensure that Enrollees receive the most appropriate care in the least restrictive setting.

Certified Alcoholism and Substance Abuse Services

Our network [redacted] certified by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). New York State-based substance abuse facilities must hold this certification to participate in our network. Our Certified OASAS network [redacted]. Please see Attachment 14 for a complete listing of providers.

As we advance our clinical model to incorporate the principles of recovery and resiliency, we have contracted with more alternative care settings, such as halfway houses and Community Mental Health Centers. The current [redacted] providing our Enrollees the convenience and accessibility of community-based alternative treatment settings.

Other provider and facility types represented in our network include:

- **Sober Living Arrangements (a.k.a. Drug-Free Housing, Alcohol/Drug Halfway House):** Transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment, and support for recovery from alcohol or drug use.
- **Outpatient Care:** Treatment provided in an ambulatory setting for the purpose of assessing and treating a behavioral health condition.
- **Partial Hospital Program (PHP):** A structured program that maintains hours of service for at least at least 20 hours per week during which assessment and diagnostic services, and active behavioral health treatment are provided to individuals who are experiencing serious signs and symptoms and/or significant psychosocial and environmental issues with the goal of monitoring and maintaining stability, decreasing moderate signs and symptoms, increasing functioning, and assisting an individual with integrating into community life. The term is synonymous with Day Treatment Program.
- **Residential Treatment Center (RTC):** A program which delivers 24-hour/7-day assessment and diagnostic services, and active behavioral health treatment to

members who do not require the intensity of nursing care, medical monitoring, and physician availability offered in Inpatient.

- **Intensive Outpatient Program (IOP):** A structured program that maintains hours of service for at least three hours per day, two or more days per week during which assessment and diagnostic services, and active behavioral health treatment are provided are provided to individuals who are experiencing moderate signs and symptoms that result in significant personal distress and/or significant psychosocial and environmental issues with the goal of monitoring and maintaining stability, decreasing moderate signs and symptoms, increasing functioning, and assisting an individual with integrating into community life.
- **Inpatient:** A structured hospital-based program which provides 24-hour/seven-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, active behavioral health treatment, and specialty medical consultation with an immediacy needed to avoid serious jeopardy to the health of the member or others.
- **Inpatient Detoxification:** A hospital-based program which provides 24-hour/seven-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, and active behavioral health treatment services for the purpose of completing a medically safe withdrawal from alcohol or drugs.
- **Inpatient Rehabilitation:** A hospital-based program which provides 24-hour/seven-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, and active behavioral health treatment services for the purpose of initiating the process of assisting an individual with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder.
- **Residential Rehabilitation:** Residential Rehabilitation is comprised of 24-hour/seven-day assessment and diagnostic services, and active behavioral health treatment services that are provided in a facility-based setting to members who do not require the intensity of nursing care, medical monitoring, and physician availability offered in Inpatient for the purpose of initiating the process of assisting an individual with gaining the knowledge and skills needed to prevent recurrence of a substance-related disorder**.**
- **23-Hour Observation:** A facility-based program that provides a medically safe environment for up to 23 hours during which rapid and time-limited assessment, stabilization and referral services are provided in order to assist members in coping with a crisis and gaining access to the next appropriate level of care.
- **Wraparound Services:** Community resources or natural supports which enhance or supplement treatment. Wraparounds can be divided into two categories: those that by their absence prohibit access or initiation of treatment (e.g., transportation), and those that are important to positive treatment outcomes (e.g., Case Management).

(6) For the Master Level Clinician category, provide a chart listing the licensure types that you include in your network in each State and indicate which of those licensure types the Offeror considers to be the highest licensure type in each State.

We have included a list of master’s-level therapist licenses available by state as Attachment 15.

(7) Explain how you determine the highest licensure type in each State.

We consider all licenses that allow a clinician to practice independently, without need of supervision, to be eligible for our network. At each license level, those that allow for independent practice are considered the highest level.

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

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

We have experience working with the Department and the Governor's Office of Employee Relations (GOER) to expand network coverage for enrollees residing in a limited access area and requiring behavioral health services. [redacted] They will design a campaign to approach and recruit those providers by letters, phone outreach and in-person meetings.

To determine if inclusion of additional clinicians is appropriate, the following factors are considered:

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

We will work closely with New York-based and accrediting bodies, such as the OASAS, to identify programs and services that will help round out the Empire Plan MHSA Program's network. We actively recruit qualified facilities and clinicians through:

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

(9) Describe the criteria the Offeror will use to determine Providers to recruit into the Network to allow Enrollees to continue successful therapy plans with current Network Providers that are not in the Offeror's Networkor who are in an underserved area).

For the contract award in 2009, Optum provided a customized transition plan to Enrollees using the Empire Plan MHSA Program. We offered Enrollees the opportunity to nominate their current provider if that provider was not in the Optum provider network. Our dedicated network management team outreached to providers with a high volume of Empire Plan Enrollees being seen in their practice. We also conducted a focused outreach to providers in rural communities where access to behavioral health providers was limited. In addition, we offered a transition period to any Enrollee currently receiving mental health or substance abuse services from a provider who was contracted with the prior vendor but not yet contracted with Optum. [redacted]

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

The Empire Plan MHSA Program account management team will work closely with our network management team to conduct ongoing network analysis, using annual GeoAccess and utilization reports to review existing network coverage and identify any additional recruitment needs. We will review non-network utilization annually and aggressively recruit high volume providers, as well as those practicing in underserved areas, in order to maximize the availability of network providers for all Empire Plan MHSA Program Enrollees.

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

We offer clinicians several easy and convenient ways to notify us regarding closed practices. These include the following:

- Using the "update practice info" feature on Provider Express (providerexpress.com), our network provider-dedicated Web portal. We post reminders of the need to notify us if they are unable to accept referrals online and in our biannual network newsletter.
- Providing a dedicated email address to specifically accommodate clinician requests for short-term office closures, or via a secure fax line
- Telephonically communicating closed office practice status through our behavioral network services' 800 number
- Through our provider recredentialing process every three years

Network managers make it a routine part of contact with a provider to confirm their availability and remind providers to notify us whenever they may need to go on "Unavailable" status for new referrals. Network managers also work closely with our intake and customer service teams to follow up on any member reports of a provider not accepting new referrals, so that we can confirm this with the provider directly and update our database accordingly. Once we have confirmed that the provider is not accepting new patients, we will not make referrals to the clinician for up to six months. (Clinicians may close their offices for up to six months and still maintain network participation status while being unavailable to accept new referrals.) Clinicians are advised to notify us prior to the end of the six-month period to provide an update regarding the office status.

We firmly believe that our performance relative to network access should take into account provider availability, and our routine approach to access analysis is to only include clinicians with open practices. For our proposed access standards in this request for proposal, providers without availability were excluded.

[redacted] Should we encounter an area where an enrollee requires services and our network providers are not available to schedule a timely appointment, we will adhere to Guaranteed Access requirements of the Empire Plan MHSA Program and offer a non-network provider referral at a network benefit level.

(12) Network Composition Guarantee: The MHSA Program's service level standard requires that at the least ninety percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the"R" designation in NYS or a MLC with highest licensure in other states, Certified Behavior Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber), listed on Exhibit I.Y.2; will be maintained throughout the five-year term of the Agreement and optional eleven (11) month extension. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

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

The Standard Credit Amount for each .01 to 1.0% below the MHSA Program's service level standard requiring that at least ninety-percent (90%) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician (MLC) who qualifies for the "R" designation in NYS or a MLC with highest licensure in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber) listed on Exhibit I.Y.2 will be maintained is $25,000 per year. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is

$____for each .01 to1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health and Substance Abuse Facility, Mental Health Outpatient Clinic Group, Substance Abuse Outpatient Clinic Group, Psychiatrist, Psychologist, Licensed Masters Level Clinician who qualifies for the "R" designation in NYS or MLC with highest licensure level in other states, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Mental Health/Substance Abuse Practitioner – Other Prescriber) listed on Exhibit I.Y.2 as reported quarterly and calculated on an annual basis is $____. Providers who are retired, deceased or no longer actively practicing will be excluded from the annual calculation and guarantee.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted] for each .01 to1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of the Providers in each of the eleven (11) Facility or Practitioner Licensure type categories (Mental Health Facility, Substance Abuse Facility, Mental Health ALOC, Substance Abuse ALOC, Psychiatrist, Psychologist, Licensed Clinical Social Worker with "R" designation in NYS, Certified Behavioral Analyst Provider, Applied Behavioral Analysis Agency, Registered Nurse Practitioner, Registered Clinical Nurse Specialist or psychiatric nurse/clinical specialist) listed on Exhibit I.Y.2 as calculated on an annual basis is [redacted]. Providers who are no longer actively practicing will be excluded from the annual calculation and guarantee.

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

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

The Offeror's quoted amount to be credited against the Administrative Fee is

$ ____ for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access-for Urban Areas Guarantee, is not met by the Offeror.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted] for each .01 to1.0% below the [redacted] minimum access guarantee (the Offeror's proposed guarantee) for any quarter in which the Network Facility Access-for Urban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access for Suburban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $____for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access-for Suburban Areas Guarantee, is not met by the Offeror.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted] for each .01 to1.0% below the [redacted] minimum access guarantee (the Offeror's proposed guarantee) for any quarter in which the Network Facility Access-for Suburban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee, for any quarter, in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access for Rural Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is

$____for each .01 to1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Facility (Inpatient, ALOC and Outpatient Clinic Groups for Mental Health and Substance Abuse combined) Access-for Rural Areas Guarantee, is not met by the Offeror.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted]for each .01 to1.0% below the [redacted] minimum access guarantee (the Offeror's proposed guarantee) for any quarter in which the Network Facility Access-for Rural Areas Guarantee, is not met by the Offeror.

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

The Offeror's quoted amount to be credited against the Administrative Fee is $____for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access-for Urban Areas Guarantee, is not met by the Offeror.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted]for each .01 to 1.0% below the [redacted] minimum access guarantee (the Offeror's proposed guarantee) for any quarter in which the Network Practitioner Access-for Urban Areas Guarantee, is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access for Suburban Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $____for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access-for Suburban Areas Guarantee is not met by the Offeror.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted] for each .01 to 1.0% below the [redacted] minimum access guarantee (the Offeror's proposed guarantee) for any quarter in which the Network Practitioner Access-for Suburban Areas Guarantee is not met by the Offeror.

The Standard Credit Amount for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined) Access for Rural Areas is not met by the Offeror, is $6,000 per each quarter. However, Offerors may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee is $____for each .01 to 1.0% below the ninety-five percent (95%) minimum access guarantee (or the Offeror's proposed guarantee) for any quarter in which the Network Practitioner (Psychiatrist, Psychologist and Master's Level Clinician, combined)Access-for Rural Areas Guarantee, is not met by the Offeror.

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted]for each .01 to 1.0% below the [redacted] minimum access guarantee (the Offeror's proposed guarantee) for any quarter in which the Network Practitioner Access-for Rural Areas Guarantee, is not met by the Offeror.

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

Confirmed.

(14) Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee: (The Offeror must quote a performance standard and amount to be credited against the Administrative Fee for access that is below the Offeror's proposed guarantee for any quarter in which the Network Certified Behavioral Analyst and Applied Behavioral Analysis Facility Access Guarantee is not met by the Offeror.)

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted]**0** for failure to maintain a minimum access guarantee in which [redacted] of Empire's membership has access to an available Network Certified Behavioral Analyst or Applied Behavioral Analysis Facility at an in-network level in any quarter.

Provider Credentialing

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

a. Duties and Responsibilities

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

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

Confirmed.

(2) Describe the Offeror's process to ensure that Network Providers meet the applicable state licensing requirements and are in compliance with all other federal and state laws, rules and regulations. What is the resource, data base, or other information used by your organization to verify this information?

Our network meets all applicable state licensing requirements and complies with all federal and state laws, rules and regulations, and uses a credentialing approach in accordance with NCQA standards. Any provider not meeting state or federal requirements must take corrective action or we will remove them from our network. We ensure compliance through our rigorous credentialing process, described in detail below, which utilizes both the Council for Affordable Quality Healthcare's (CAQH) and Universal Credentialing DataSource® a nationally recognized online credentialing application.

(3) Describe your approach for credentialing Network Providers.

Our network management team credentials all network providers. The team ensures accurate and efficient processing of clinician and facility applications, monitors the ongoing quality of the Optum network and helps enforce our credentialing policies and procedures. The credentialing team ensures that participating clinician and facility files meet all Optum and NCQA accreditation requirements, including processing turnaround time and recredentialing compliance.

As mentioned above, we utilize the CAQH as our credentialing application.

CAQH Universal Credentialing Application

The CAQH Universal Credentialing application simplifies the process for clinicians and collects all clinician information necessary for credentialing. A one-time completion of the CAQH application eliminates the need for clinicians to complete repeated recredentialing applications for any healthcare organizations that participate in CAQH.

The CAQH application process obtains information on: licensure, hospital privileges, malpractice history, professional liability insurance and amounts, education and training, board-certification information for MDs and American Nurses Credentialing Center (ANCC) certification information for RNs, statement of ability to perform duties, work history, Federal Drug Enforcement Agency (DEA) certification, appointment/office hours availability, cultural considerations (including language proficiency) and areas of clinical expertise.

All practitioners undergo a rigorous screening that includes a formal credentialing process prior to being accepted on our panel.

We obtain verification of the following:

- The clinician’s license (to ensure it is valid, in good standing and has no disciplinary actions against it)
- Board certification (for physicians) and ANCC certification for advanced nurse clinicians (where applicable)

In accordance with our NCQA-approved credentialing process, we also confirm the following:

- The highest level of education/training completed (if not board certified)
- Current valid DEA and/or state-controlled substance permits, if applicable
- Information regarding medical malpractice payments, any adverse actions taken against a clinician’s licenses and clinical privileges, any Medicare/Medicaid sanction activity and any criminal activity related to medical practice through a query of the National Practitioner Data Bank
- Any other verification required by state regulations or customer requirements

We also review the application to be sure all areas have been completed, check the clinician’s work history and verify that he/she is covered by adequate professional liability insurance. The committee evaluates the complete file and approves or denies the clinician’s application to join the network.

Facility Credentialing Process

The facility credentialing process is initiated by the network manager, who will send the facility application to facilities that meet criteria and fill a current business need. Upon receipt of a completed facility application, the network manager will review the application in concert with our care advocacy centers and medical directors to ensure compatibility with our clinical model and concurrent review procedures. Optum staff interviews the facility's program director and administrative staff by phone. We also gather a range of information on the following:

- The program's goals and structure
- Methods of treatment planning and documentation
- Credentials of the program and management staff
- The physical plant of the facility and sample treatment plans
- Agency approvals and accreditations
- Liability insurance and malpractice history, if any

The facility application is sent to the credentialing department for approval. Once approved by the credentialing committee, the facility is contacted by a contracting manager to initiate contract negotiations.

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

We do not use an external credentialing verification organization.

Optum constantly reviews practitioners and facilities at minimum every three years for continued participation in our networks. Specific details regarding monitoring continued compliance are outlined below.

Recredentialing - Practitioners

Our computer tracking system allows us to determine which clinicians need to be recredentialed by a specific date, and the identified clinicians are sent recredentialing packets six months prior to their due date for recredentialing. Recredentialing applications are sent out according to our cycle, and applications are returned straight to primary source verification. Applications are prepopulated with basic demographic information, to reduce the amount of time clinicians must spend completing them.

Along with primary source verification of provider credentials, we also perform a query of the National Practitioner Data Bank (NPDB), the industry-standard method of reviewing for any history of malpractice settlements or disciplinary actions by state licensing boards.

During recredentialing, much of the same information requested during the credentialing process is requested in the recredentialing process to ensure the clinician continues to meet our administrative and professional standards. For example, we ask for the following:

- Updated answers to questions listed on the original clinician application
- A current copy of the clinician's professional and general liability insurance

- Unlimited release granting Optum permission to conduct primary verification and/or contact any professional society, hospital, insurance company, present or past employer or other entity that may have information pertaining to the network clinician

Behavioral network services, in partnership with the performance improvement team and the credentialing/database team, also review the following during recredentialing:

- Patient complaints
- Quality of care or service issues
- Patient satisfaction if anything practitioner specific is identified
- Medical records review
- Results of office site visits

Our credentialing committee makes the final determination on the clinician's status. Based on the committee's review, the clinician is sent a letter stating either that he/she is recredentialed as an Optum clinician or that he/she is being terminated from the network.

Recredentialing - Facilities

At minimum every 36 months, Optum reviews facilities for continued participation in the network. Optum's clinical network services staff reviews all submitted documents to determine whether the facility continues to meet the minimum requirements for participation. As part of this process, we obtain the following:

- Copies of current licensure, accreditation, professional liability insurance, etc.
- An Healthcare Integrity and Protection Databank query
- A signed application attesting that the facility's licenses are free of sanction and they continue to be in good standing with accreditation organizations

As with contracted clinicians, we also may consider patient complaints and satisfaction, quality of care or service issues, medical records review and results of office site visits during the recredentialing process.

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

Optum actively monitors clinician performance, as well as any complaints that arise in regard to our clinicians outside of the credentialing/recredentialing cycle:

- First, we review the Medicare and Medicaid Sanction and Reinstatement Report issued by the Office of the Inspector General (OIG) and Excluded Parties List System on the System For Award Management website on a monthly basis, which limits participation or terminates any practitioner or facility listed on the report per the requirements of our Credentialing Plan.

- Second, we have robust continuous quality improvement programs that include monitoring practitioner complaints and conducting site and random audits, when indicated. We also maintain close collaboration with our fraud and abuse unit.
- Third, Optum reviews licensing boards on a schedule based on when the boards publish adverse actions. Practitioners and facilities must inform Optum of any material change of information supplied to Optum between (re)credentialing cycles. This includes any changes in hospital privileges, licensure, prescribing ability, ability to perform professional duties, malpractice claims, investigations, or change in sanction or debarment status. All restriction and termination reporting to appropriate authorities is completed in accordance with state laws.

We may suspend, restrict or terminate a clinician/facility contract immediately if we determine that the health or safety of any plan member is in imminent danger because of the action or inaction of a participating clinician/facility. The clinician/facility is notified of this action immediately by certified letter. Optum will also provide the Department with a quarterly report of network terminations or sooner should there be a substantial change to the composition of the network.

When we terminate a practitioner, we also notify members immediately and help them locate a new practitioner. In cases where the practitioner voluntarily terminates, we notify the member 30 days prior to the termination.

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

To stay abreast of provider practices, attitudes and concerns in New York State and other areas, we regularly meet with New York professional associations such as the New York State Psychological Association and New York Chapter of National Association of Social Workers and attend their annual conferences. This allows us to interact with providers, share and receive feedback and gain valuable insights to inform our practices and systems.

We also participate in local task forces and support local health initiatives to understand the needs and concerns of our providers. Additionally, we conduct provider surveys, perform outreach calls and participate in local provider initiatives. Because we continue to engage our network providers, keep them educated on the specifics of our programs and are able to readily meet with providers in person to address any concerns, we see high ratings in our provider satisfaction surveys.

On an ongoing basis, our New York-based network team will have the responsibility to analyze member and network needs throughout New York State. Each year, the network team meets regularly with key facilities in the Optum network. As a key part of the account management team, [redacted], provider relations director, is available for ongoing questions and routinely participates in meetings to advise the Department and GOER on individual and collective provider issues.

The network management team participates in provider engagement meetings to review provider performance on industry-standard quality metrics, as well as to keep abreast or practice patterns and community needs. The team also provides ongoing education and training related to Optum policies and procedures, provider portal functionality, industry changes (i.e. MH parity, CPT codes, NY regulatory updates). Finally, the team maintains relationships with provider advocacy groups/professional associations.

Outside of New York State, we have the resources of other network managers who share a similar responsibility for provider communication and supporting a strong information infrastructure.

Web-based Information Infrastructure

We regularly post information on our clinician website, **providerexpress.com**, and we distribute a biannual newsletter, *Network Notes*. Both of these sources provide clinicians and facilities with the latest information or changes at Optum, best practices and other issues of interest that may impact their practice, and updates to Optum resources such as new customers or new product offerings. We have a section of Network Notes dedicated to New York providers that includes specific events in New York, clinical articles, disease management programs specific to the Empire Plan MHSA Program, New York autism mandates and regulatory changes impacting our providers.

We also have found email communications to be an effective and expedient way to distribute time-sensitive information and highlight updates to **providexpress.com**. For clinicians who do not have email, we send information to them via fax or telephonically. This multi-source communication approach fosters a positive collegial relationship with our provider network.

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

We help network providers achieve patient-centered care by forming collegial relations with practitioners and facilities, and offering them resources to keep them abreast of the industry's best practice diagnosis and assessment approaches. We do this through *Level of Care Guidelines, Best Practice Guidelines,* ALERT, Facility Quality Management, and Collaboration and Care Coordination, which guide patient-centered delivery.

Level of Care Guidelines

We have developed a set of *Level of Care Guidelines* that provide objective and evidence-based admission and continuing stay criteria for mental health and substance abuse services offered by our clinician network. They are intended to standardize care advocacy decisions regarding the most appropriate and available level of care needed to treat a member's presenting problems.

Our *Level of Care Guidelines* are based on the following:

- The broad clinical experience of Optum staff
- Multidisciplinary input from our national clinician network
- Published references from the industry's most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine and DSM-IV-TR

Care advocates, peer reviewers and appeal reviewers reference the current *Level of Care Guidelines* when conducting clinical review activities. *Guidelines* are used in a flexible manner, and care advocacy decisions are informed by the unique clinical aspects of the case and the treatment resources available to the member.

Best Practice Guidelines

We also have adopted nationally recognized *Best Practice Guidelines* that were developed by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry. These guidelines define an objective and evidence-based standard of care.

We review the current list of adopted *Best Practice Guidelines* at least annually to determine whether a guideline has been updated based on new scientific evidence. We also monitor whether new guidelines that are relevant to our membership have been issued. Updated guidelines and relevant new guidelines are then presented to our clinical policy and standards committee for adoption.

Promoting Evidence-Based Care through Outpatient Management

Our outpatient outcomes management program, ALERT (**Al**gorithms for **E**ffective **R**eporting and **T**reatment), affords us the opportunity to promote clinician compliance with evidence-based practices. ALERT helps network practitioners sharpen their diagnosis and assessment abilities while care is being delivered. Through this process, we identify various risks that could potentially lead to poor clinical outcomes, including risk of chemical dependency, disability, medical/behavioral comorbidity, hospital admission/readmission and lack of improvement in treatment.

When an Enrollee’s responses to the voluntary Wellness Assessment indicate the presence of an unidentified clinical condition (e.g., depression or substance abuse), risk for the need for a higher level of care and/or a medical comorbidity, the treating clinician receives an ALERT letter. The letter details why the clinician is receiving the ALERT and provides a list of evidenced-based practices that have proven effective in treating Enrollees with similar risk profiles, including a link to applicable *Best Practice* guidelines. The letter also reminds the clinician of the availability of Optum care advocates and medical directors for case-specific consultation. Additionally, the letter reminds the clinician of the wealth of online resources available to him/her and the member via **providerexpress.com** and **liveandworkwell.com**.

In addition, we use outpatient management to ensure each member receives the outpatient care and support that is most appropriate for his/her presenting issues. A set of algorithms are applied to the claims submitted by both network and non-network clinicians to identify cases that may require clinical intervention because of a high-risk or complex diagnosis, behavioral/medical comorbidity and/or unusual utilization patterns. Outreach is performed by our care advocates to review the treatment plan and discuss the need for further treatment, or treatment modifications. Through this process, we are able to ensure we apply our clinical resources to those cases with the greatest need while also having a positive impact on potential over utilization of behavioral health services.

Facility Quality Management

We track facility (hospitals and other inpatient facilities) performance on an ongoing basis through a process called facility quality management (FQM), which measures facility performance on the following three metrics against national benchmarks:

- 30-day readmission rate

- Percent of follow-up appointments scheduled to occur within seven days of discharge
- Percent of follow-up appointments kept within seven days of discharge

Each facility is placed in a tier based their respective performances on the Network Facility Scorecard. We then use our FQM program to identify our highest performing network facilities on member search sites, allowing both Enrollees and Optum staff to identify our highest performing facilities when conducting searches. In addition, the FQM initiative allows us to focus our resources on managing those facilities that require close collaboration to improve their performance.

Collaboration and Care Coordination

We conduct treatment record reviews each quarter to assess whether communications are occurring between behavioral health and medical practitioners, as well as among behavioral health practitioners and programs. We also audit to determine whether medical and chemical dependency screenings occur. The audits validate that the behavioral practitioner documents the enrollee’s primary physician, and that cross-communications occur. We conduct similar audits when multiple behavioral health specialists are involved, such as when a treatment team includes a psychiatrist who monitors medication only, and therapy is provided by another master’s or doctorate-level practitioner. Our audits show that a significant portion of our practitioners engage and support medical-behavioral coordination and communication.

Nurses use the Optum Referral Application (ORA) to refer Enrollees who agreed to outreach from the MHSA Program care advocate to discuss referrals for services. When new referrals are loaded into ORA they are automatically assigned to a care advocate who specializes in responding to the comorbid condition referrals to services including medical and EAP.

In addition to offering training to achieve patient-centered, coordinated care, we communicate clear guidelines to foster and encourage an effective collaboration process and appropriate exchange of patient information between medical and behavioral practitioners. Guidelines are communicated in our *Network Manual*, which is given to both practitioners and facility providers at orientation, and is always accessible and available on **providerexpress.com**. Providers can also access coordination of care forms which make collaboration and exchange of information easier.

We also engage in interventions with Optum network clinicians and primary physicians. We will work to promote awareness of all the MHSA Program elements (including the ADHD Program) through various methods, including articles published in the Optum Provider Newsletter, *Network Notes*, and the *Empire Plan Network News*. We also send periodic communications to the Empire Plan primary physicians and pediatricians to promote awareness of the ADHD Management Program and to alert physicians of the resources available to MHSA Program Enrollees with ADHD and to educate them on ADHD treatment best practices. Primary physicians can also access Enrollee and provider-oriented materials on ADHD and its treatment, as well as the American Academy of Child and Adolescent Psychiatry’s *Practice Parameter for the Assessment and Treatment of Children, Adolescents, and Adults with Attention-Deficit/Hyperactivity Disorder* as described above.

Provider Trainings

To further promote evidence-based practices within our network, we staff a dedicated Clinical Learning Department, which provides network clinicians and primary care physicians with free continuing education unit (CEU) courses, conveniently available via teleconference, Web cast, pod cast, and CD-ROM. These courses are led by some of the industry's most esteemed clinical leaders.

We also provide a number of resources, links, webinars and trainings on CPT code changes on **providerexpress.com** as well as other monthly webinars on a variety of topics.

In addition, we have conducted trainings/presentations specific to the New York provider community through webinar and professional association meetings/conferences on the following topics:

- Autism Mandate
- Federal Mental Health Parity
- Health Care Reform
- Disease Management Programs

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

Confirmed.

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

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

The Offeror's quoted amount to be credited against the Administrative Fee is

$____for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days (or the Offeror's proposed guarantee).

The Offeror's quoted amount to be credited against the Administrative Fee is [redacted] for each Provider application to join the MHSA Program's Network where the review, including credentialing, and notification of the determination to the Provider is not completed within sixty (60) Days (or the Offeror's proposed guarantee).

Provider Contracting

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

a. Duties and Responsibilities

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

(1) Explain your approach to Network Provider fee schedules, including a description of the type(s) of financial arrangements you have with each type of Provider (e.g., per diems, case rates, hourly rates, all inclusive per diems covering Facility and Practitioner fees, etc.).

Financial arrangements with network providers and facilities are detailed below.

Practitioner Reimbursement

We use a state-by-state fee schedule to reimburse all network clinicians, with discounts varying depending on CPT code, licensure level and geographic location. Each clinician who joins our network agrees to accept the Optum fee schedule for their specific location and licensure level. For example, in the New York State region, the ability to achieve a fair reimbursement rate is achieved with the Empire Plan MHSA Program enrollee population. Fee schedules vary based on the licensure of the treating clinician for the services delivered to the member using industry standard billing codes. Fees are adjusted to account for regional market dynamics, and our discounts are often higher in major metropolitan areas.

Facility Reimbursement

We reimburse facilities on a per diem basis, an industry-preferred method that streamlines billing and reimbursement. Services covered in facility per diems vary based on the agreement in place with the facility, the benefit plan that governs the member’s care, the level of care under which the member is treated and/or state mandates that may be in place governing facility-based care.

Typically, the following services are included in per diems rates, when not otherwise mandated by the member’s benefit plan or state/federal regulation:

- Oral medications administered during the course of the inpatient stay
- Medically necessary laboratory tests required during the course of the stay
- Room and hospital charges
- Therapeutic programming (including group, individual, and family therapy) provided by non-MD professionals such as nurses, counselors and social workers

Professional fees, or services delivered by the attending physician, are not always included in the per diem and the attending physician files his or her claims for services rendered. However, in instances when we contract with staff-model facilities, where attending clinicians are employed by the facility, reimbursement for physician professional fees are also included in the per diem rates.

Diagnostic procedures, such as encephalograms, brain wave tests, magnetic resonance imaging (MRI) and psychological and neuropsychological testing are generally excluded from most per diems. Electroconvulsive therapy (ECT) also may be excluded.

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

Confirmed. When executed, the completed provider agreements would also include all required documentation, supplements, and addenda, such as New York Standard Contract Clauses, Regulatory Appendices, Lobbying Forms, etc. Sample base provider contracts are included as Attachment 16.

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

Confirmed.

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

Confirmed.

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

Facilities/ALOCs/Practitioners	**2013**	**2012**	**2011**
Voluntary Terminations:	[redacted]	[redacted]	[redacted]
Dissatisfaction with fees	[redacted]	[redacted]	[redacted]
Disagreement with clinical decision	[redacted]	[redacted]	[redacted]
Dissatisfaction with administrative process or paperwork	[redacted]	[redacted]	[redacted]
Dissatisfaction with contractual terms	[redacted]	[redacted]	[redacted]
Other (describe)	[redacted]	[redacted]	[redacted]
Total Voluntary terminations	[redacted]	[redacted]	[redacted]
Number of Network Providers on December 31st	[redacted]	[redacted]	[redacted]
Voluntary terminations as a Percent of Network	[redacted]	[redacted]	[redacted]

[redacted]

The total above includes both clinician and facility terminations represented below.

Clinician Termination Reason	2013	2012	2011
Deceased	[redacted]	[redacted]	[redacted]
Left Practice	[redacted]	[redacted]	[redacted]
Missing in Action	[redacted]	[redacted]	[redacted]
Recred Non-Response	[redacted]	[redacted]	[redacted]
Resignation	[redacted]	[redacted]	[redacted]
Total Voluntary Terms	[redacted]	[redacted]	[redacted]
Network Count on December 31	[redacted]	[redacted]	[redacted]
Percent of Network	[redacted]	[redacted]	[redacted]
Facility Term Reason	**2013**	**2012**	**2011**
No Longer Provides MHSA	[redacted]	[redacted]	[redacted]
Recred Non-Response	[redacted]	[redacted]	[redacted]
Facility Closure	[redacted]	[redacted]	[redacted]
Total Voluntary Terms	[redacted]	[redacted]	[redacted]
Network Count on December 31	[redacted]	[redacted]	[redacted]
Percent of Network	[redacted]	[redacted]	[redacted]

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

Single case agreements—where we create special arrangements enabling specific Enrollees to see non-network practitioners on a network benefit level—are used in the following circumstances:

- When there are no network options that exist within minimum access standards or appointment availability
- When clinically indicated to prevent harm to self/others and to avoid transition to a higher level of care

- When a specialty is not available in network (i.e., bilingual, bicultural, eating disorders, medical management, etc.)

Single case agreements are based on geographic or clinical specialty needs. Therefore, if we don't have a network provider in the Enrollee's area or one with the clinical specialty needs of the Enrollee, our CRL care advocate will find a non-network provider for the Enrollee to be reimbursed at the network benefit level.

During our previous contract with the Empire Plan MHSA Program, we provided accommodations data to the Department and GOER in our quarterly utilization reports and annual GUAC reports.

We anticipate the frequency will be less than one percent of total claims paid each year.

Provider Audit and Quality Assurance

The Contractor must support a high quality and cost-effective MHSA Program. The protection of MHSA Program assets must be a top priority of the Contractor. The Contractor must have a strong audit presence throughout its organization. The Contractor shall be responsible for the oversight and audit of Providers that provide MHSA services to MHSA Program Enrollees.

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

a. Duties and Responsibilities

(1) The Contractor must have a staffed and trained audit unit employing a comprehensive

Provider audit program that includes but is not limited to:

(a) Conducting routine and targeted on-site audits of Network Providers.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

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

Confirmed.

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

Confirmed.

(c) Network Provider profiling;

Confirmed.

(d) Peer review procedures;

Confirmed.

(e) Outcome and Quality Measurement analysis; and

Confirmed.

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

Confirmed.

b. Required Submission

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

Our provider performance unit is dedicated to monitoring and enhancing the quality of the Optum network, improving the performance and effectively communicating with network providers. Our behavioral network services department supports quality improvement process at each Optum regional care advocacy center to help monitor the quality of patient care delivery within our national network.

Quality monitoring includes performing site audits of network clinicians and facilities, tracking and trending clinician complaints for analysis and review and conducting quality of care audits when deemed necessary by the compliance department and clinical operations' peer review committees.

The provider performance unit conducts the following audits at varying intervals:

- Site audits on high volume providers are conducted where mandated by the state or by specific customer requirement. All site audits include a review of providers' medical records to ensure appropriate documentation and secure record-keeping is in place at provider sites. We provide formal feedback to audited clinicians and facilities within 30 days of the audit, and we have protocols in place to follow up with providers on any corrective action plans that may be necessary for them to meet required standards.
- Quality of care audits are conducted as necessary per clinical operations requests, and we provide formal feedback to all audited providers within 30 days of the audit.
- Complaints monitoring is ongoing and feedback occurs immediately upon complaint resolution.

The Behavioral Network Services staff may conduct site visits for:

- Complaints about practitioner office site quality
- High-volume practitioners
- Unaccredited facilities
- High-volume practitioners (as required by customer or state law)
- Home-office settings
- Quality of care concerns

Site visits include a review of the environmental facility and a sample of treatment records. If the practitioner or facility treatment record review fails to meet an established goal, corrective action and/or a re-audit is required. Follow-up reviews measure progress on corrective actions until the goal is met. Results of practitioner and facility treatment record reviews are included in practitioner and facility credentialing/recredentialing files.

For each clinician chosen for audit, a quality improvement specialist audits the office's clinical charts. If the clinician scores below an 85 percent on the audit, we require the clinician to submit a Corrective Action Plan (CAP) for our review and approval. If the score is below 75 percent, the CAP is required along with a re-audit by the quality improvement specialist within six months to ensure the clinician is meeting our standards. Our quarterly feedback surveys in the last year indicate an average 98 percent of clinicians who have undergone a site visit scored the audit experience as excellent or good.

Fraud and Abuse Audits

The special investigations unit (SIU) audits providers who are suspected of committing fraud, waste or abuse. Suspects are identified through a variety of sources including, but not limited to internal employee tips, external tips, data mining and media articles. The SIU's partnership with other departments such as Practice Management (PM), Provider Performance Audits (PPA), claims and network have resulted in the majority of the SIU tips. Upon analysis of tips and claims data, providers are audited in the area of suspected fraud, waste and/or abuse. The SIU primarily reviews records to ensure that documentation supports the codes billed. Overpayments are calculated when records are not consistent with the code billed and paid to provider.

We conduct either onsite or desk audits depending on a variety of factors (i.e., suspect responsiveness, allegation, previous suspect activity, and claims analysis and background investigation findings). Medical records will be reviewed by a highly trained and skilled Certified Professional Coder (CPC). This individual will review all documentation from the provider to determine if all necessary guidelines have been followed. Any violation in the national coding or plan guidelines will be noted for provider education and potential corrective action. The CPC works with the SIU investigator to confirm or deny the allegation or any evidence of potential fraud or abuse. The investigation also includes a review of any history of quality complaints against the provider, as well as any history of previous site audits performed by the network audit team.

Part of the anti-fraud and abuse program will include appropriate referrals to state and federal agencies on suspected fraud and abuse. These referrals are handled by the Investigator handling the case, who will ensure timeliness of referrals and compliance with all plan, state and federal guidelines. If at any point during the course of the investigation it is determined that suspicion or confirmation of fraud, waste and abuse is reached, law enforcement involvement is determined on a case-by-case basis, and when necessary, a referral to the appropriate agency or organization is made.

The account management team works closely with the New York State network team to communicate fraud, waste and abuse reporting to the Department in a timely fashion and in accordance with the Department approved process. We report instances of fraud, waste and abuse to the New York Department of Financial Service’s Insurance Frauds Bureau. These instances are immediately reported at the time allegations are made and again when instances are confirmed.

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

In some cases when a provider is billing incorrectly or otherwise taking action against the interests of the Empire Plan MHSA Program, we may be able to offer education as a corrective action. However, in cases where a practitioner’s conduct represents a clear ethical violation or substandard quality that coaching or education has not helped to correct, the practitioner’s status is referred immediately to the Regional Peer Review Committee for investigation. Optum’s peer review committees comprise regional medical directors and representatives from operational departments, including clinical operations and clinical network services. If concerns persist after completion of an investigation, the file, along with the Peer Review Committee’s recommendations, are forwarded to the credentialing committee for review and final determination of the practitioner’s status with Optum. There may be times when it is necessary to terminate the relationship when the behavior places the member at risk.

Optum's fraud and abuse unit identifies suspected physicians/providers through various data detection techniques and reviewing their claims prospectively (prior to payment) and as potential recovery cases (post-payment).

The unit is staffed by more than 200 personnel who conduct or support the fraud and abuse detection and investigative process. They include prospective and recovery investigators, case development analysts, certified coders, IT professionals who conduct data mining and analysis, associate investigators (or investigative assistants), and clinical personnel. The staff is organized into operational teams with expertise in particular functions, including validation of tips of suspected fraud and abuse; prospective investigations; data analytics; clinical review; and retrospective investigations, including retrospective recoveries. Together, these teams perform provider-based, end-to-end fraud detection and investigations.

To pursue every instance of potential claim submission errors from fraud, waste and abuse, when a tip or referral is received, the investigator pulls the claim data from our system, analyzes it, conducts patient interviews and surveys, performs records review, site visits, provider and attorney conferences, among other activities.

The investigator proactively identifies fraud and abuse through external intelligence resources, such as National and State news media, health care organizations, and internal tips. Further, the investigator identifies providers that may have billed possible fraudulent claims and places appropriate flags and edits for further review. In any extreme case of illegal activity, we would terminate our agreement immediately and notify the appropriate law enforcement agency. For less egregious situations, the provider is held to a stricter monitoring of billing practices with practice management reviews or audits. The provider is a partner with Optum to ensure proper follow-up for an identified issue.

We perform prospective and retrospective investigations to analyze and monitor claim submissions to promptly identify errors and fraud, waste and abuse.

Prospective Claims Investigation

In analyzing and monitoring claim submissions prospectively, we have a number of checks in place on our UNET claims system. We are proactive in performing prospective investigations, which are conducted before the claim is paid, and the following activities are embedded in UNET:

- Providers are monitored for potential suspicious behavior and/or outlier submissions based on industry standards and our book of business. We maintain a suite of databases housing physician and other health care professional demographic, license, sanction and educational information. The databases validate the existence of a physician or other health care professional, confirm license status and monitor sanctions against the physician or other health care professional communities.
- If providers are found to be submitting potentially fraudulent or abusive claims the provider will be flagged on a pre-payment basis.
- Providers can be flagged based on either internal data mining or referrals and/or information received either internally or externally.

- A request for medical records is sent to the provider advising them that additional information is required before claims can be allowed to process. Once additional information is received it will be reviewed by Optum staff to determine if the billed claims were administratively coded appropriately:
  - If the services billed are supported by the medical documentation, the claims will be allowed through the standard claims process.
  - If the services billed are not supported by the medical documentation the claims will be denied based on the findings of Optum staff.
- Appeals rights apply on any claims denied and the standard process will be followed.

We analyze aggregate claim data to detect fraudulent or abusive trends. The analysis identifies those physicians or other health professionals responsible for any significant trend within their billing patterns that is deemed suspicious for their specialty or aberrant from their peers.

We supplement our prospective claims investigation with retrospective investigation, described below.

Retrospective Claims Investigation

In retrospectively analyzing and monitoring claims, our SIU receives tips and referrals from both internal and external sources about potential fraud and abuse. Once the referral is received, we perform due diligence and data analysis on the specific claim to substantiate or disprove the allegation. In addition, we conduct retrospective claims analysis to detect potential schemes in provider and member data. Fraud and abuse activities identified through data mining are: upcoding, unbundling, over-utilization, not covered services and/or misrepresentation of services.

In addition to investigating tips, SIU partners with practice management to identify providers suspected of committing fraud, waste or abuse. Practice management uses clinical algorithms to identify instances of high frequency providers, greater than eight hours in a day, mismatch of procedure to licensure, upcoding and other errors or irregularities. Practice management will review and conduct outreach calls to providers to conduct clinical education, however, if any element of fraud, waste or abuse is identified through their review or outreach call, they will refer the case to the SIU for further investigation. These investigations include:

- Claim/Chart Audit
  - SIU cases may require a chart audit to determine if the CPT or Healthcare Common Procedure Coding System (HCPCS) codes are supported by the medical documentation;
  - Chart audits may be necessary in order to perform an administrative review of the provider’s claims and confirm administrative appropriateness of billing. We use industry and plan standards to perform administrative audits on claims.
- On- Site Audits
  - SIU cases may require an on-site audit to determine if the CPT or HCPCS codes are supported by the medical documentation. We reserve the right to perform on-site audits as necessary to appropriately perform administrative reviews.

- Interviews, surveys and/or surveillance may be necessary to substantiate or disprove the potential fraud, waste and abuse.
- Peer review and/or external reviews may be necessary to confirm medical appropriateness and quality of care concerns.
  - SIU cases consisting of chart audits may require peer reviews and/or external peer reviews to determine medical necessity or quality of care.
  - External reviews comply with Optum and UnitedHealth Group privacy requirements.

If at any point during the course of the investigation it is determined that suspicion or confirmation of fraud, waste and abuse is reached, the investigator is immediately required to refer the case to the appropriate agency or organization, as applicable. Law enforcement involvement may be necessary and is determined on a case-by-case basis.

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

A copy of audit and fraud and abuse language contained in our contract(s) is included as Attachment 17.

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

Confirmed.

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

In addition to the claim system and SIU processes described above, we use a number of tools to identify possible abusive or fraudulent practices:

Provider Verification: A suite of databases housing physician and other health care professional demographic, license, sanction and educational information. The databases validate the existence of a physician or other health care professional, confirm license status and monitor sanctions against the physician or other health care professional communities.

Sanctions Monitoring: We are responsible for collecting and reporting sanction activity from over 500 sites as it relates to provider licenses. The Sanction Provider Database (SPD) is a repository of health care providers who have had disciplinary action taken against them by governing state boards and/or by federal programs across the United States. SPD is comprised of sanctions taken by all reporting state boards and federal agencies.

Fraud Hotline: A fraud message is printed on the explanation of benefits (EOB). The message directs the member to contact UnitedHealthcare customer care if the services paid were not performed. After speaking with the member, if the customer service representative determines a referral to FWA is warranted, they may submit an online referral or soft transfer the call to our Fraud Hotline directly.

External Intelligence Monitoring: Process to proactively identify fraud and abuse through external intelligence resources, such as national and state news media, health care organizations and internal tips. Investigators identify providers that may have billed possible fraudulent claims and place appropriate flags/edits for further review. Referrals are also made to our recovery teams for potential recoupment of paid claims related to allegations.

Ad hoc Reporting: In addition to the tools above, we analyze aggregate claim data to detect fraudulent or abusive trends. Ultimately, the analysis seeks to define those physicians or other health professionals responsible for any significant trend within their billing patterns that is deemed suspicious for their specialty or aberrant from their peers.

ALERT Monitoring

Our regional quality improvement committees use ALERT to monitor utilization in the aggregate by analyzing claims data to identify trends. ALERT flags outliers in quality/practice pattern or fraud and abuse for follow up.

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If the clinician or facility-level analysis reveals a trend of over- or under-utilization, we work with the clinician or facility to identify potential root causes and work together to develop appropriate interventions. The effectiveness of the intervention put in place is measured at appropriate time intervals. In addition, all information informs our Predictive Model and our provider quality monitoring established to protect the financial interest and integrity of our customer's benefit plan designs.

(6) Describe the Offeror's ongoing quality assurance procedures for Network Practitioners. With respect to Network Practitioners, do you:

(a) Share practice pattern with the respective Network Practitioners?

Yes. Providers can see their ALERT results via alertonline.com.

(b) Validate patient satisfaction?

We do not currently validate patient satisfaction, although patient satisfaction and patient complaints are reviewed during our recredentialing process. We do quarterly member satisfaction surveys on our book of business, but that information is not shared specifically with providers.

(7) Describe the Offeror's ongoing quality assurance procedures for Network Facilities including inpatient, ALOC and other healthcare Facilities. With respect to Network Facilities do you:

(a) Require that treatment protocols be used?

We are using data obtained from our facility quality management (FQM) program to rate facilities based on our quality and efficiency metrics (e.g., 30-day readmission rates, percentage of follow-up appointments scheduled to occur within seven days of discharge and percentage of follow-up appointments kept within seven days of discharge). We then use our Star Designation program to identify our highest performing network facilities on member search sites, allowing both members and Optum staff to identify our highest performing facilities when conducting searches.

To be considered for the Star Designation program, network facilities must have 15 or more in-network discharges of either commercial members or Medicare/Medicaid members (or both) in the most recent 12-month period; and sufficient data must be available from those discharges for evaluation on each of the quality metrics. Facilities receive one star if they have met or exceeded quality benchmarks. Facilities that achieve a quality star are then eligible for a second affordability star if they meet or exceed efficiency metrics.

The star designation is intended to identify facilities that have met or exceeded quality and efficiency metrics. Facilities that do not want to be recognized with a star designation may opt-out. Facilities making this choice will not have a star rating published on member search websites, even if their FQM score would result in a star rating.

(b) Investigate whether changes to quality controls are made after adverse outcomes?

All serious events are reported to our sentinel event committee. Our team completes an on-site visit to investigate the majority of these events. If warranted, we make the facility unavailable for new referrals immediately.

After our visit, we make recommendations to the facility to improve—they must submit a corrective action plan (CAP) which is reviewed by the sentinel event committee before it is accepted. The CAP is put in place and, when necessary, we do a second site visit to ensure that they have followed through.

(c) Monitor readmission rates after inpatient discharge?

We use our outpatient management model, Algorithms for Effective Reporting and Treatment (ALERT), to identify members at risk for facility levels of care and members with chronic or co-occurring conditions, including chemical dependency, who have transitioned to the outpatient setting and are not making expected progress. Patients are monitored for risk and lack of progress through ALERT, which triggers intervention by a care advocate whenever a member shows signs of deterioration or lack of improvement —before a relapse occurs.

We retrospectively run reports on all admissions that occurred within a 30-day period to determine if any members have been readmitted during that time. When a readmission is identified by this method, the case is sent to a medical director for review. If the medical director believes there are issues with the facility that contribute to recidivism, he or she will advise the network manager for the particular region that further investigation and follow-up are needed.

We have developed a facility quality management (FQM) program in response to both member and customer demands for increased transparency, value, and choice within behavioral health services. This program provides facilities with a scorecard of their relative performance using key quality and efficiency metrics. The scores are based on industry-standard quality metrics. Our long-term goal is to publicly recognize facilities that demonstrate solid clinical outcomes by consistently meeting or exceeding normed results.

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The FQM scorecard is a tool to enhance the partnership between Optum and the facilities in our network and foster collaboration discussions on ways to improve quality processes and clinical outcomes. For example, if a facility is ranked among the highest in our network, it might be eligible to be placed on “self-management,” reducing the administrative burden on its staff in the spirit of shared goals and clinical responsibility.

We also review readmission rates and average length of stay for facilities in particular regions, establishing utilization norms and comparing facilities within a given geographic area. If a facility’s readmission rates or average length of stay fall outside the norm, we initiate a discussion with the facility to determine the reasons for the outlier utilization patterns. For example, as part of our collaboration with a facility, we may consider whether its aftercare program is optimally effective and whether we need to assess the performance of clinicians providing outpatient care post-discharge.

Value Based Initiatives

The Offeror will play a key role in promoting and enhancing the value-based services under the Program.

a. Duties and Requirements

(1) The Contractor must establish a tiered MHSA Provider Network and/or incentives including but not limited to financial, administrative and continuing professional education to promote value-based MHSA Services and enhance Provider performance and clinical outcomes.

Confirmed.

b. Required Submission

(1) Describe the tiering criteria and/or incentives you propose for the MHSA Program to promote value-based MHSA services.

Each facility is placed in a tier based their respective performances on the Network Facility Scorecard. These tiers consist of the following.

Tier	Baseline Score
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The Facility Quality Management initiative allows us to focus our resources on managing those facilities that require close collaboration to improve their performance.

Campaign for Excellence

Capitalizing on our ALERT outpatient care management model, which uses member Wellness Assessments to track treatment progress, we have implemented a clinician quality program that recognizes network clinicians who demonstrate their commitment to evidence-based practice by using Wellness Assessments with their patients. Our clinician quality program is called the campaign for excellence (CFE) and is designed to:

- Evaluate and recognize clinician performance
- Promote collaboration with clinicians to improve performance in terms of quality and efficiency
- Provide increased transparency for our members in support of consumer-driven health care
- Drive referrals to high-performing clinicians

The campaign for excellence is a voluntary program with participation invitations sent to the entire clinician network, including clinician groups. Clinicians and clinician groups are invited to sign up for recognition based on quality outcomes. Initially, ALERT Wellness Assessment completion rates, from which outcome data is derived, are the campaign's primary quality metric. As a clinician's/clinician group's submission volume of member Wellness Assessments increases, the clinician's/clinician group's report will factor in data regarding member engagement in treatment. Once a clinician/clinician group meets quality thresholds, efficiency metrics also will be incorporated into the algorithms to measure overall performance.

As we continue to gather outcomes data from the member Wellness Assessments, we will continue to tier the network and increasingly direct referrals to high-performing clinicians/clinician groups. CFE scores and associated data are posted quarterly to the secure transaction section of Provider Express (our provider website) for enrolled clinicians and groups allowing them to access their feedback. Data is posted online near the beginning of each quarter (January, April, October, and December). Enrolled clinicians and groups are notified via email when new data is posted.

Members currently have access to network tiering information via liveandworkwell.com (preferred clinicians and facilities are designated with a “star” and appear first in clinician/facility searches).

CFE members are eligible to purchase products and services from our business partners at a discounted rate. Current CFE incentives available through the Business Partner Rewards Programs include: discounts available through Insight, Wells Fargo Employee Financial Services, Regal Ware and Hewlett Packard.

Facility Quality Management

We use data obtained from our facility quality management (FQM) program to rate facilities based on our quality and efficiency metrics (e.g., 30-day readmission rates, percentage of follow-up appointments scheduled to occur within seven days of discharge and percentage of follow-up appointments kept within seven days of discharge). We then use our Star Designation program to identify our highest performing network facilities on member search sites, allowing both Enrollees and UBH staff to identify our highest performing facilities when conducting searches.

To be considered for the Star Designation program, network facilities must have 15 or more network discharges of either commercial members or Medicare/Medicaid members (or both) in the most recent 12-month period; and sufficient data must be available from those discharges for evaluation on each of the quality metrics. Facilities receive one star if they have met or exceeded quality benchmarks. Facilities that achieve a quality star are then eligible for a second affordability star if they meet or exceed efficiency metrics.

The star designation is intended to identify facilities that have met or exceeded quality and efficiency metrics. Facilities that do not want to be recognized with a star designation may opt out. Facilities making this choice will not have a star rating published on member search websites, even if their FQM score would result in a star rating.

(2) Describe any experience you currently have with emerging alternative care delivery models (e.g. Accountable Care Organizations – ACOs).

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ACO Support for the Empire Plan

[redacted]

(a) Are you currently working with any Medicare or other ACOs? What are your goals and objectives for working with these groups?

[redacted]

(b) Provide an overview of the general ACO structure, including the breadth of the networks.

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(c) What requirements do you have for working with these groups, such as size requirements, for credentialing; for monitoring their care and services; for measuring their quality; and for measuring and managing their cost and utilization?

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Assessment Criteria Categories	Points	Weight
Leadership & Organizational Structure	50	14%
IT Infrastructure	50	14%
Patient Activation & Engagement Capabilities	35	10%
Care Coordination Across All Care Settings	45	13%
Care Standardization	35	10%
Proactive Care Management	45	13%
Performance Management	45	13%
Financial Systems and Strength	30	8%
Risk Sharing and Pay For Performance Experience and Future Participation With Other Payers	20	6%
Total	**355**	**100%**

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(d) What are the lengths, start dates, and end dates of your existing ACO contracts?

[redacted]

(e) Do you use different reimbursement models with these groups? Do not include any cost information in the technical proposal.

[redacted]

(f) List all methods of payment utilized for your various ACO relationships.

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(g) Describe steps you have taken to further integrate care, such as behavioral health, reducing readmissions and preventing unnecessary emergency room visits.

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[redacted]

(h) How do you monitor and measure the ongoing care, quality results, cost results, and outcomes provided by these organizations?

[redacted]

(i) What performance guarantees are offered?

[redacted]

[redacted]

(j) What are your plans for adding ACO delivery in the future?

[redacted]

(k) Describe important outcomes you have achieved as a result of ACOs with which you have been involved. This might include improved health, reduced utilization of expensive services, improved member experience, and reduced costs.

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(l) What have you learned from initiatives that have already been implemented, and how has this program evolved from these learnings?

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(3) Do you ever incorporate pay-for-performance, shared savings, risk pools, risk sharing, and/or withholds into the payment methodologies for Network Providers? If yes, describe. Describe any potential future plans to develop any of these care delivery models, including a timeline for implementation.

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(4) How do or will your alternative provider contract payment methodologies reflect quality performance (i.e., measured against standard)?

[redacted]

(5) To what extent, if any, would your MHSA Network Practitioners and Facilities be paid under an alternative (non-fee-for-service) provider payment structure

[redacted]

(a) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will be or is expected to be paid exclusively on an alternative basis, and therefore, not paid according to the schedule shown on Exhibit V.A.2, and Exhibit V.A.3?

[redacted]

(b) For each year of the proposed contract effective period (2015 through 2019), what proportion of Network Providers will or is expected to optionally be paid on an alternative basis, and therefore, the State can choose to pay these providers according to the schedule shown on Exhibit V.A.2 and Exhibit V.A.3?

[redacted]

(6) How do your Network Provider contract payments encourage adherence to clinical guidelines?

[redacted]

(7) How will the Network Provider payment structures result in savings to the State and its members, and ensure high quality of care is provided? Do not include cost information in the technical proposal.

[redacted]

[redacted]

(8) Does the Offeror utilize a predictive modeling tool to identify individuals at risk for mental health or substance abuse admissions or re-admissions? Explain how the tool is used, including the type of data utilized.

Yes. We use predictive modeling in both the outpatient and inpatient components of our behavioral health program, as detailed below.

Outpatient Predictive Modeling

ALERT® (Algorithms for Effective Reporting and Treatment) is our innovative program for managing outpatient care. Moving beyond the traditional method of reviewing treatment plans from clinicians to identify risk, we proactively apply a series of clinical algorithms that identify outpatient members who may be at risk for adverse outcomes. These algorithms use member responses to the Wellness Assessment, a survey instrument measuring clinical status and claims data. One of the algorithms in the portfolio is a predictive model that uses the member's response to the Wellness Assessment to identify patients at risk for hospitalization.

Another model predicts members at risk for premature termination from treatment as a result of inadequate change. Patients identified by the predictive model are triaged to care advocates who contact the treating clinician to review the determined risks, ensure the treatment plan is sufficient and offer additional resources or support as needed. The logistic regression facility predictive model with an appropriate selection threshold was found to have a sensitivity of 54 percent and a specificity of 95 percent, meaning that it accurately predicted 54 percent of the members who would be hospitalized and 95 percent of those who would not.

Inpatient Predictive Modeling

Optum's Full Care Management product features an innovative, highly effective predictive model for identifying and stratifying members entering facility-based care to determine which members are most likely to benefit from enhanced interventions by our intensive care advocacy team.

The model, known as ISIE (for identification, stratification, intervention and engagement), is unique in that it goes beyond merely predicting which members are likely to drive higher costs. ISIE actually identifies the segment of the population that is subject to gaps in care (or issues with adherence) that are most likely to experience improved outcomes after care advocacy interventions. This design attribute minimizes the misdirection of resources to members likely to get better without enhanced interventions (an issue of alternative models in the market).

ISIE is further differentiated in that it doesn't just identify gaps in care, but the model matches the identified gap with specific evidence-based interventions that our care advocates can use to facilitate closing the gaps.

ISIE's identification rules are based on risks arising from clinical gaps in treatment and adherence that are established by evidence-based medicine. The rules, along with corresponding interventions, were designed by a team of Optum behavioral health leaders, medical directors and analytics experts. The ISIE team's work was based on published science, Optum data and trending analytics, experience of our frontline clinicians, and the clinical philosophy that is the foundation Optum's care advocacy model.

ISIE rules are first applied during the initial call from the facility or provider seeking admission. An Optum assess & triage care advocate gathers the clinical information necessary to apply ISIE, and then stratifies members for care advocacy according to criteria established by the model. The model includes eight high opportunity groups, each of which have underlying criteria that establish whether the falls into the particular subgroups where the most opportunity lies.

While all members entering facility-based care benefit from the care advocacy provided by Optum's licensed advocates, individuals identified by ISIE as matching a high opportunity group are stratified for assignment to a designated advocate from our intensive care advocacy team. This team was designed exclusively to provide interventions to meet the needs of complex cases receiving facility-based care.

Once assigned to a case, the care advocates from intensive facility-based care team reapply ISIE as a quality check to confirm the initial application. The assigned care advocate then consults ISIE for the recommend interventions for closing the gap that triggered the intensive stratification. Optum intensive care advocates are skilled at working with the facilities, attending physicians, and the members themselves to align treatment with ISIE recommendations.

The high opportunity cases identified by ISIE were verified using matched cohorts where high opportunity group would on average result in behavioral health claims costs of $12,000, versus $5,000 for the low opportunity group. On average, this high opportunity group represents 20 to 25 percent of a given facility-based care admission population. While the model is newly developed, and data detailing the impact of the ISIE recommended intervention on outcomes, early results have been encouraging and we look forward to sharing additional data as it becomes available.

Optum is an industry leader in leveraging advanced analytics to identified pockets of opportunity for intervention within populations, wherever possible with goal of targeting and closing gaps before costs are incurred. Our behavioral health specialty network offering includes a number of these powerful event management tools and ISIE is the most recent addition.

(9) Describe any emerging provider payment or delivery system pilot initiatives in which the State's population would eligible to participate.

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11. Claims Processing

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

To be covered, Enrollee Submitted Claims are required to be submitted to the Contractor no later than one hundred twenty (120) Days after the end of the Calendar Year in which the MHSA service was rendered, or one hundred twenty (120) Days after another plan processes the claim, unless it was not reasonably possible for the Enrollee to meet this deadline. The MHSA Program count of claims can be found in Exhibit II.G.3 of this RFP.

a. Duties and Responsibilities

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(h) Agreeing that all claims data is the property of the State. Upon the request of the Department, the Contractor shall share claims data with other MHSA Program carriers and consultants for various programs (e.g. Disease Management, Centers of Excellence) and the Department's Decision Support System vendor at no additional cost. The Contractor cannot share, sell, release, or make the data available to third parties in any manner without the prior consent of the Department;

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(l) Loading a daily claims file from the Empire Plan medical carrier/third party administrator and hospital carrier that reports Shared Accumulators;

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(q) Processing claims pursuant to Enrollees covered under the Disabled Lives Benefit.

The Department agrees to reimburse the Contractor for claims processed under the Disabled Lives Benefit in accordance with Section V of this RFP;

Confirmed.

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

Confirmed.

(s) Mailing Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service.. Explanation of Benefits for all MHSA services must be mailed to the Enrollee upon request from the Contractor's Dedicated Call Center and available for download by register users of the Contractor's customized website. An annual Explanation of Benefits statement must be mailed to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year; and

Confirmed.

(t) Following the guidelines for escheatment as outlined on the NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm

Confirmed.

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

Confirmed.

(3) Non-Financial Accuracy Guarantee: The Offeror must meet or exceed the following performance guarantee. The Program's service level standard requires that the Program's non-financial accuracy be maintained for a minimum of at least ninety-five percent (95%) of all claims processed and paid during the first contract year. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety- seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Non- financial errors include, but are not limited to, entry of incorrect: patient name, date of service, Provider name, Provider Identification Number, and remark code, as well as incorrect application of Deductibles and/or Coinsurance amounts to the Shared Accumulators. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety- five percent (95%) confidence level with precision of +/- three percent (3%);

Confirmed.

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

Confirmed.

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

Confirmed.

b. Required Submission

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

Optum has extensive experience processing claims for a variety of benefit plan designs for both our fully insured and self-funded businesses. Optum processes network and non-network claims using our UNET claims system. UNET integrates a variety of functional areas such as claims, customer service, eligibility and clinician/facility data. This enables our claims processing experts to have all the tools necessary to ensure accurate and timely claims processing. UNET is the same claims processing system used by our sister company, UnitedHealthcare, when processing claims for the Empire Plan Medical Program. This offers a unique opportunity to provide an integrated claims process to the Empire Plan. With the recent implementation of shared accumulators to fulfill Federal Mental Health Parity requirements, Optum is fully integrated and able to transfer claims data seamlessly to UnitedHealthcare to remain in compliance.

Our claims processing methodology and comprehensive claims edits are described below.

Claims Processing Methodology

Our automated claims processing system processes all claims received electronically or manually from network clinicians/facilities, non-network clinicians/facilities and Enrollees. A single platform combines all claim administration elements, including online eligibility, benefit design provisions, notification, clinician and other health care professional data (e.g., network status and negotiated rates), claim payment and claim history.

Paper claims will arrive at the Empire Plan dedicated mail office. Mail is opened, prepped and sorted on the day it is received. An envelope tracking system tracks incoming envelopes received which will allow the creation and tracking of all batches placed in the scanning software and through the life of each document.

The mail is sorted according to document type and claims are then sent through our high performance scanning system. The scanning process converts the paper document into an electronic image, assigns a document index number (FLN) to the document which can be used to track the document as it is released to the keying location or any other location for processing. Keyable documents are data entered utilizing an advanced optical character recognition technology before being released into the UNET system for processing. Non-keyable claims are presented to the claims processor through the Workflow Automation for Non-keyable Documents system (WAND). Paper documents are stored in our intranet document retrieval system (iDRS) for easy access.

Electronic Claims

For optimal efficiency and accuracy, we encourage network clinicians/facilities to submit claims electronically. When an electronic claim is received (or after a paper claims has been converted into an electronic format), our systems reviews the claim for the required information.

Once the claim has been verified and validated, the system automatically assigns a unique Internal Control Number (ICN) and adds it to the electronic processing flow.

Ensuring Proper Adjudication of Claims

Our claims system reviews submitted claims for completeness and accuracy. Any claim that requires further attention will be automatically flagged and an electronic message delivered to the processor. Any claims that exceed standards are automatically edited for further review.

The following edits, which alert the claims processor that additional investigation and review is required prior to the claim be finalized, are in place:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

If the claim is from a non-network facility and a non-network rate does not exist, the claim will be processed in accordance with the accommodated rate negotiated with the facility.

Once any edits are resolved by an examiner, the claim is adjudicated to completion and an explanation of benefits (EOB) is produced and sent to the Enrollee, as appropriate.

We monitor the claims process through our continuous quality improvement program and search for more efficient, automated ways to process claims. We have provided a flow chart of our claims process, as well as a chart depicting our front end claims process, as Attachment 18.

[redacted]

[redacted]

[redacted]	[redacted]	[redacted]	[redacted]
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[redacted]	[redacted]		
[redacted]	[redacted]		
[redacted]	[redacted]		
[redacted]	[redacted]		

[redacted]

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

UNET, our claims processing system, is a real-time system using UnitedHealth Group's Online Processing System (TOPS) at its core. TOPS is an IBM mainframe based system, running CICS on a Z/OS 1.13 operating system. The database utilizes DB2 version 10 and VSAM. IBM RACF access control is used to restrict and monitor user and process access to applications and files on the IBM systems. Additionally, user-specific security is maintained within the TOPS application itself.

Access to sensitive data is controlled at both the operating system and application level in TOPS. All data is secured within a UnitedHealth Group managed data center.

Backup System Utilized

UnitedHealth Group's backup policy maintains two copies of operational data at its secured technology centers. A Virtual Tape Library System is maintained at the primary data center that emulates physical tape and stores data on hard drives for the purpose of daily operational recovery in case of data corruption or accidental deletion. The data is then electronically transmitted to another disk-based array or Physical Tape Library located in UnitedHealth Group's geographically dispersed data centers. UnitedHealth Group maintains sole custody of the data at all times by transmitting over our secured channels.

UnitedHealth Group's robust control structure ensures that data is protected. These controls include in- sourcing of tape management facilities; in-sourcing of IT engineering, maintenance and administrative functions; and, a Rapid Recovery/Disaster Recovery solution to ensure data is protected and quickly available for a recovery event.

Disaster Recovery Plan

As Optum's parent company, UnitedHealth Group has developed an Enterprise Resiliency & Response Program that houses our disaster recovery plan and minimizes customer impact from disrupted service caused by a disaster, while aiding compliance to published regulatory guidelines. In the event of a system failure, our disaster recovery plan will ensure Enrollee disruption is minimized. Plans are developed to address all natural and man-made disasters (e.g., hurricanes, floods, fires, terrorism attacks and disease pandemics).

The disaster recovery and business continuity plans focus on critical business functions and planning for the worst-case scenario so that we can react quickly and efficiently, adding value to our business and customers through effective risk reduction, compliance with industry, contractual or regulatory standards and safeguarding of operations and assets.

UnitedHealth Group's business impact analysis and subsequent business continuity plans are written to accommodate the following four scenarios, which provide safeguards to keep Enrollee disruption to a minimum during a system failure:

Loss of Facility

- Complete interruption of facilities without access to its equipment, local data and content. The interruption may impact a single site or multiple sites in a geographic region. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

Loss of Critical Resources

- Complete interruption with 100 percent loss of personnel within the first 24 hours and 50 percent loss of personnel long-term. The interruption may impact a single site or multiple sites in a geographic area. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

Loss of Critical Systems

- Complete interruption and/or access of critical systems and data located at the various UnitedHealth Group Data Centers for an extended period of time. Recovery from anything less than complete interruption will be achieved by using appropriate portions of the Plan.

Loss of Vendors

- Complete interruption in a service or supply provided by a third-party vendor(s).

Recovery from anything less than complete interruption will be achieved by using appropriate portions of the plan. The impact of the operational loss due to one, or all, of these scenarios are assessed as part of the original Business Impact Analysis and annually thereafter. The business continuity plans are updated quarterly and tested annually.

UnitedHealth Group recognizes and acknowledges that the protection of its assets and business operations is a major responsibility to its employees, shareholders, business associations, customers, members and communities that it services. Therefore, it is UnitedHealth Group's policy that business continuity and disaster recovery plan must be developed, tested, and maintained in order to limit Enrollee disruption.

The plan encompasses a layered approach to continuity planning and applies an appropriate combination of safeguards within our operations that work together to address inter-segment dependencies and meet the business continuity requirements of the segments individually, as well as UnitedHealth Group as a whole.

UnitedHealth Group's Disaster Recovery plan is based on a number of relevant industry standards and frameworks. Our disaster recovery plans follow standard lifecycle maintenance and are refreshed at least annually. Application disaster recovery plans are approved and certified annually by the appropriate business segment senior leadership team.

The Enterprise Resiliency & Response program, including disaster recovery controls, are audited by UnitedHealth Group Internal Auditors which is currently performed by Ernst & Young.

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

[redacted]

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

Our claims processing system integrates each of the following required MHSA Program components, as described below.

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

Our claims processing system integrates prior authorization for inpatient services, psychological testing and electro-convulsive treatment, Applied Behavioral Analysis, and concurrent review of outpatient services. Our claims system has appropriate edits in place to manage clinical authorization for prior authorization and concurrent reviews. Further, all of the unique benefit details from the MHSA Program, including but not limited to copayments, deductibles, authorization limitations, concurrent review features specific to the MHSA program, and maximums can be loaded into our claims system. Additionally, claims edits can be set up based on the Empire Plan's benefit plan design.

Authorizations are entered into our LINX case management application after verification of Enrollee information in iBAAG, and are specific to the clinician, service, dates approved and concurrent review details. The transmission of data placed in LINX by our care management staff to the UNET claims processing system occurs daily through an upload process. Authorization information appears in the UNET claims application, which can be viewed by our claims staff.

Claims received that require authorization and are an exact match to the authorization data will automatically adjudicate without claims examiner intervention. Claims requiring authorization that do not have an exact match will edit for examiner review. Our claims system is set up to authorize claim payment based off of concurrent reviews for medical necessity for outpatient services.

(b) Eligibility verification;

Our UNET claims system and LINX case management system interface directly with our online eligibility system and will provide real-time Enrollee information to Optum staff, ensuring claims and authorizations are issued only to eligible Enrollees.

The claims system automatically verifies eligibility for each expense processed based on service dates in relation to effective and termination dates as well as COB and/or Medicare eligibility. When necessary, the system will advise the claims processor via a system edit of action required due to change of status in eligibility, Medicare eligibility or COB status. To ensure proper claim payment, we exercise strict claim management using a combination of automatic system edits and controls and the expert judgment of our highly trained staff.

For online certification, our system records the following individual data:

- Personal Information
  - Social Security Number and/or alternate identifier
  - Last name
  - First name
  - Date of birth
  - Sex
  - Street address
  - City
  - Zip code

Our processor accesses dependent information using the employee Social Security number or alternate identifier, relationship, and dependent name. Our claim system stores dependent information in the family register.

- Coverage Information
  - Employment effective date
  - Coverage effective date
  - Cancellation date
  - Retirement date
  - Medicare effective date
  - Deceased date
  - Other group insurance effective date
  - Individual or family code
  - Location indicator
  - Surviving spouse indicator
  - Agency code

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

We are able to customize edits for variations in the negotiated benefit design among the various unions that are required in order to ensure accurate claim adjudication for the Empire Plan. Specific to the MHSA Program, we can customize system edits for such unique claim situations as the waiver of copayments for crisis intervention services, telephonic counseling and paying nurse practitioners at the network level only.

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

Our system has the capability for historic claims and clinical information look up. Each claims examiner has the ability to review history of previously processed claims by using the following two system screens:

- An abbreviated history screen provides limited information regarding claim payment, such as remark codes, amount paid and provider name.
- A medical history screen provides a concise version of history where the examiner can view additional information, including the billed amount, provider TIN, draft number, remark codes and closure codes. All claims that are closed, paid or denied are in the history screens so that an examiner can verify information such as maximum visits used.

Claims examiners can also review purged history. After 24 months in the system, we purge the data to the Enterprise Data Storage System (EDSS), which is an online system that maintains data for at least six years (actual claims history is retained for a period greater than this in accordance with our internal Document Retention Requirements). If history extends beyond 24 months on a claim, the examiner will receive an edit in the system indicating that the claim has been purged. In this event, the examiner will be able to access and look up historical claim information in the EDSS system to view claim data.

From a claims processing perspective, an examiner is able to view clinical authorizations on the authorization record screen in our claims system. This screen contains Enrollee-specific authorization information from the case management system used by our clinical team.

(e) Multi-level cost sharing (Deductibles, Coinsurance, Copayments).

Yes, our claims system provides multi-level cost sharing of claims. Our claims system can be configured to track the accumulation of out-of-pocket maximums, coinsurance, and copayments as required by the MHSA Program.

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

Confirmed. We have an enhanced process already in place with the Department’s medical carrier/third party administrator, which is our sister company UnitedHealthcare. We have the ability to send claims files several times per day in close to real time. Also, we can send a file containing accumulator amounts from claims processed the previous day to the hospital carrier each day.

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

Confirmed. We have an enhanced process in place with the medical carrier/third party administrator, which is our sister company UnitedHealthcare, that allows us to receive and load medical claims files several times per day in close to real time. Additionally, we can receive daily files from the hospital carrier and load them each night.

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

Changes to the benefit design for the MHSA Program will be monitored, verified and tested using our quality assurance protocols. As part of this benefit design change process, we will work closely with the Department to establish the specific benefit and designated plan application, as well as any potential plan impact (e.g., authorization changes).

When we receive final benefit change approval from the Department, the new benefits are loaded in our online information system, with an effective date for the benefit design change. Our system retains the old benefit plan information and all claims with incurred dates of service prior to the effective date of the new benefits are processed in accordance with the previous plan of benefits.

Quality Assurance

We are dedicated to ensuring that the quality of the installation meets the high standards expected by our customers. Our benefit tools include the utilization of extensive testing and multiple iterations of quality assurance protocols as appropriate to ensure accuracy and can guarantee that changes to other client benefit programs will not impact the MHSA Program. Our Benefit Intent Certification tool addresses the validation of all key implementation components for all existing business if changes are made. The primary components of the program are:

- Review and test a comprehensive set of claim scenarios in pre-production
- Ensure plan documents are accurate and reconciled to one another
- Subject matter experts from each functional area of the case implementation team
- Extensive overall case implementation knowledge
- Expertise of product control analysts through active participation in all training that occurs throughout the year
- Focused quality audit of changes post-production

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

Confirmed. Optum currently participates in Medicare Crossover and has extensive experience doing so as the previous vendor for the MHSA Program. Crossover is handled electronically by our claims system via the Coordination of Benefit Contractor (COBC) intermediary:

- UnitedHealth Group Information Technology transmits biweekly eligibility files (every other week on a day designated by the COBC) to the COBC for Enrollees who are enrolled in Medicare Part B. Medicare then enrolls those Enrollees in Medicare Crossover and we begin receiving secondary claims through Medicare Crossover on a daily basis.
- UnitedHealth Group Information Technology receives daily 837i and 837p crossover files from the COBC.

Described below are the primary functions performed in Medicare Crossover process for the MHSA Program:

- The United Front End (UFE) technology system logic identifies any claims received that should be considered by Optum for mental health or substance abuse services and immediately electronically forwards the claims to Optum for consideration, thereby eliminating the need for file transmission between vendors and potential delay in claim payment.
- Claims will be processed in accordance with the MHSA Program benefits and either automatically adjudicate within 24 hours of receipt or are manually determined by an experienced claims examiner on our dedicated claims team.

Through this Medicare Crossover process, our data capture goal is to maximize electronic receipt of clinician claim transactions, thereby eliminating the need for Enrollees to submit paper claim transactions with Medicare Explanation of Benefits.

(9) Describe your pursue and pay procedures for the collection, storage and investigation of coordination of benefit (COB) information other than Medicare. Explain how frequently COB information is updated.

Our pursue and pay procedures for the collection, storage and investigation of COB information other than Medicare include capturing COB information from directly interfacing with the Department's medical provider, UnitedHealthcare (our sister company) and from Enrollees when they call in with inquiries. When Enrollees call in, our system generates a pop-up screen that our customer support staff use to collect updated COB information. We use the same eligibility system as UnitedHealthcare, which facilitates collecting and storing COB information. Our system is automated to collect updated COB information on a yearly basis.

Our claims system has edits and warnings informing us when we need to verify COB information. COB information entered into our system is fed into our claim system and is programmed to determine order of benefits as specified by the Plan documents.

Investigation

We investigate all claims for which we suspect other coverage might apply. However, the timing and process for our investigation varies depending on the amount of the claim.

[redacted]

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

Potential claim overpayment situations are identified by claims adjusters, claims examiners, quality analysts, account management administrators and clinical network services staff and electronically routed via our Online Routing System (ORS) for confirmation by a specialized team of claim experts. After review, if the overpayment is confirmed, we collect overpayments from network providers as follows:

- The claim is adjusted by a claims adjuster and an overpayment is calculated and logged in our Overpayment Tracking System (OTS).
- An overpayment letter describing how the overpayment occurred and the amount of the overpayment is sent to the provider by the claims adjuster.
- If the provider responds to the letter and refunds the overpayment, the refund is routed to the claims department for application to the individual file in which the overpayment occurred satisfying the overpayment request in the system.
- The refund is credited to the claims experience.

If the provider does not respond after 60 days, the recovery request in the system is automatically moved to a bulk recovery status. Once this occurs, the system will perform a search for a Provider Tax ID match for payments being issued under the same Provider Tax ID and will hold back those payments and apply them to the overpayment until it is satisfied. An EOB is sent out on both the claims on which the overpayment occurred and the claims where additional monies have been applied toward the overpayment showing that the money currently owed by the provider has been applied to the existing overpayment.

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

Claims are adjudicated in our UNET claims platform in real time. Claims in inventory are those that have been entered into the claims system and are waiting for manual review. Daily reports are run to track the volume of these claims for the claims operations team to monitor so that they can ensure timely processing. In addition, a monthly summary is provided for use in the Claims Production Report.

Once claim processing is complete, our data warehouse is updated from UNET with statistical claim data. The statistical data from the data warehouse is used for reporting and is updated in a timely manner to meet all of the reporting requirements included in the request for proposal.

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

Confirmed. We will adjust all attributes of claim records processed in error and credit the MHSA Program for all costs associated with the claim processed in error.

(13) Describe how the Offeror will analyze and monitor claim submissions to promptly identify errors, fraud and abuse and report such information in a timely fashion to the State in accordance with a State approved process. Confirm the MHSA Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses. Confirm the Offeror will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to Offeror error. In cases of overpayments resulting from errors only found to be the responsibility of the Department and for fraud and abuse, the Offeror shall use reasonable efforts to recover any overpayments and credit 100% of any recoveries to the Program upon receipt; however the Offeror, is not responsible to credit amounts that are not recovered.

We perform prospective and retrospective investigations to analyze and monitor claim submissions to promptly identify errors and fraud, waste and abuse. We will provide the Department with reports of potential fraud, waste and abuse cases that warrant further investigation. In addition, we can conduct customized fraud, waste and abuse training for all new hires working with the MHSA Program.

Prospective Claims Investigation

In analyzing and monitoring claim submissions prospectively, we have a number of checks in place on our UNET claims system. We are proactive in performing prospective investigations, which are conducted before the claim is paid, and the following activities are embedded in UNET:

- Providers are monitored for potential suspicious behavior and/or outlier submissions based on industry standards and our book of business. We maintain a suite of databases housing physician and other health care professional demographic, license, sanction and educational information. The databases validate the existence of a physician or other health care professional, confirm license status and monitor sanctions against the physician or other health care professional communities.
- If providers are found to be submitting potentially fraudulent or abusive claims the provider will be flagged on a pre-payment basis.
- A request for medical records is sent to the provider advising them that additional information is required before claims can be allowed to process. Once additional information is received it will be reviewed by Optum staff to determine if the billed claims were administratively coded appropriately:
  - If the services billed are supported by the medical documentation, the claims will be allowed through the standard claims process.
  - If the services billed are not supported by the medical documentation the claims will be denied based on the findings of Optum staff.
- Appeals rights apply on any claims denied and the standard process will be followed.

We analyze aggregate claim data to detect fraudulent or abusive trends. The analysis identifies those physicians or other health professionals responsible for any significant trend within their billing patterns that is deemed suspicious for their specialty or aberrant from their peers.

We supplement our prospective claims investigation with retrospective investigation, described below.

Retrospective Claims Investigation

In retrospectively analyzing and monitoring claims, our special investigation unit (SIU) receives tips and referrals from both internal and external sources about potential fraud and abuse. Once the referral is received, we perform due diligence and data analysis on the specific claim to substantiate or disprove the allegation. In addition, we conduct retrospective claims analysis to detect potential schemes in provider and Enrollee data. Potential fraud and abuse activities identified through data mining are: upcoding, unbundling, over-utilization and/or misrepresentation of services.

In addition to investigating tips, SIU partners with practice management to identify providers suspected of committing fraud, waste or abuse. Optum clinical practice management team uses clinical algorithms to identify instances of high frequency providers, billing greater than eight hours of services in a day, mismatch of procedure to licensure, upcoding and other irregularities. The clinical practice management team will review and conduct outreach calls to providers to conduct billing education. However, if any element of fraud, waste or abuse is identified through their review or outreach call, they will refer the case to the SIU for further investigation. These investigations include:

- Claim/Chart Audit
  - SIU cases may require a chart audit to determine if the CPT or Healthcare Common Procedure Coding System (HCPCS) codes are supported by the medical documentation;
  - Chart audits may be necessary in order to perform an administrative review of the provider’s claims and confirm administrative appropriateness of billing. We use industry and plan standards to perform administrative audits on claims.
- On- Site Audits
  - SIU cases may require an on-site audit to determine if the CPT or HCPCS codes are supported by the medical documentation. We reserve the right to perform on-site audits as necessary to appropriately perform administrative reviews.
- Interviews, surveys and/or surveillance may be necessary to substantiate or disprove the potential fraud, waste and abuse.
- Peer review and/or external reviews may be necessary to confirm medical appropriateness and quality of care concerns.
  - SIU cases consisting of chart audits may require peer reviews and/or external peer reviews to determine medical necessity or quality of care.
  - External reviews comply with Optum and UnitedHealth Group privacy requirements.

If at any point during the course of the investigation it is determined that suspicion or confirmation of fraud, waste and abuse is reached, the investigator is immediately required to refer the case to the appropriate agency or organization, as applicable. Law enforcement involvement may be necessary and is determined on a case-by-case basis.

Reporting Information to the Department

We will provide fraud, waste and abuse reporting to the Department in a timely fashion and in accordance with the Department approved process. We will report instances of fraud, waste and abuse to the New York Department of Financial Service's Insurance Frauds Bureau. These instances are immediately reported at the time allegations are made and again when instances are confirmed. These notifications are reported on a form created by the Insurance Frauds Bureau and contain the name of the complainant, address and phone number of complainant, a brief statement of the allegation, name and address of the suspect, occupation of suspect, employer of suspect, name and address of insurance company and information on any law enforcement agency notified. In addition to the ongoing notification to the Department, we will supply the Department with an annual report which cases investigated by the SIU.

In the event of overpayment, overpaid dollars are typically settled through negotiations with the parties involved. When fraud, waste or abuse has been confirmed, the party is notified in writing of the estimated overpayment amount along with a summary of findings. Once a case has been settled, the party will usually send the plan reimbursement via a check payment, which is then credited to the account. We may also offset future claim payments as an additional vehicle for collection.

To pursue every instance of potential claim submission errors from fraud, waste and abuse, we will provide the Department with dedicated SIU staff for the Empire Plan MHSA Program. When a tip or referral is received, our dedicated investigator will pull the claim data from our system, analyze it, conduct patient interviews and surveys, perform records review, site visits, provider and attorney conferences, among other activities.

Our investigator proactively identifies fraud and abuse through external intelligence resources, such as National and State news media, health care organizations, and internal tips. Further, our investigator identifies providers that may have billed possible fraudulent claims and places appropriate flags and edits for further review.

Our processes and procedures for identifying claim submission errors and fraud and abuse ensure that risk to the MHSA Program is minimized.

Confirmations

We confirm the MHSA Program shall be charged only for accurate (i.e., the correct dollar amount) claims payments of covered expenses and will be charged an Administrative Fee only for Final Paid Claims. We confirm that we will credit the MHSA Program the amount of any overpayment regardless of whether any overpayments are recovered from the Provider and/or Enrollee in instances where a claim is paid in error due to our error. In cases of overpayments resulting from errors only found to be the responsibility of the Department and for fraud and abuse, we shall use reasonable efforts to recover any overpayments and credit 100 percent of any recoveries to the Program upon receipt; however we are not responsible to credit amounts that are not recovered.

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

Confirmed. We currently update our claims adjudication system with FAIR Health, Inc.'s database of Reasonable and Customary amounts a minimum of twice a year.

(15) Confirm that the Offeror will:

(a) mail Explanation of Benefits to Enrollees for all Non-Network claims and any other claims for which the Enrollee cost share is in excess of the applicable Copayment for the MHSA service;

Confirmed.

(b) mail Explanation of Benefits for all MHSA services to the Enrollee upon request from the Contractor's Dedicated Call Center;

Confirmed.

(c) make available Explanation of Benefits for all MHSA services for download by register users of the Contractor's customized website; and

Confirmed.

(d) mail an annual Explanation of Benefits statement to all Enrollees who have submitted claims within thirty (30) days of the end of each Plan Year.

Confirmed.

(16) Confirm the Offeror will follow the guidelines for escheatment as outlined on the NYS Office of the State Comptroller's website at: www.osc.state.ny.us/agencies/guide/MyWebHelp/Content/XIV/1.htm

Confirmed.

(17) Financial Accuracy Guarantee: The MHSA Program's service level standard requires that the MHSA Program's financial accuracy be achieved for a minimum of ninety-nine percent (99%) of all claims processed and paid each year.

Financial accuracy shall be measured by dividing the number of claims paid correctly by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Offeror's proposed guarantee) that the MHSA Program's financial accuracy isn't achieved as reported quarterly and calculated on an annual basis is $____.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of all claims processed and paid that the MHSA Program's non-financial accuracy isn't achieved as reported quarterly and calculated on an annual basis is [redacted].

(18) Non-Financial Accuracy Guarantee: The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-five percent (95 %) of all claims processed and paid during the first year of the Agreement. The MHSA Program's service level standard requires that the MHSA Program's non-financial accuracy be maintained for a minimum of ninety-seven percent (97%) of all claims processed and paid during years two through five of the Agreement. Non-financial accuracy shall be measured by dividing the number of claims with no errors by the total number of claims reviewed. Results shall be determined based on an annual audit conducted by the Department using statistical estimate techniques at the ninety-five percent (95%) confidence level with precision of +/- three percent (3%). The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (of the Offeror's proposed guarantee) of all claims processed and paid during the first contract year (ninety-seven percent (97%) (or the Offeror's proposed guarantee) in years two through five of the Agreement) that the MHSA Program's non- financial accuracy isn't achieved, as reported quarterly and calculated on an annual basis is $.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of all claims processed and paid that the MHSA Program's non-financial accuracy isn't achieved, as reported quarterly and calculated on an annual basis is [redacted].

(19) Turnaround Time for Network Claims Adjudication Guarantee: The MHSA Program's service level standard requires that a minimum of ninety-nine and five-tenths percent (99.5%) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror be turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received electronically or in the Offeror's designated post office box to the date the Provider payment is received by the mailing agent. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five tenths percent (99.5%) (or the Offeror's proposed guarantee) of Provider-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Provider payment is received by the mailing agent, as calculated on a quarterly basis, is $ ----.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is [redacted]

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

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

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine and five-tenths percent (99.5%) (or the Offeror's proposed guarantee) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is $____.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of enrollee-submitted claims that require no additional information in order to be properly adjudicated that are received by the Offeror and not turned around within eighteen (18) Business Days or twenty-four (24) Days from the date the claim is received in the Offeror's designated post office box to the date the Explanation of Benefits is received by the mailing agent, as calculated on a quarterly basis, is [redacted].

12. Clinical Management

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

Both inpatient hospital and MHSA admissions are subject to pre-certification, except in Emergencies, concurrent review and retrospective review.

Currently, under the MHSA Program, outpatient therapy visits may be reviewed prior to the 11th visit, but services may not be denied prior to the 11th visit. Based on the Final Regulations issued in November 2013, the Contractor will be responsible for proposing a Mental Health Parity and Addiction Equity Act (MHPAEA) compliant concurrent review process. Please refer to Exhibit II.L for a listing of how the Plan's medical carrier addresses the Non-Qualitative Treatment Limitations (NQTL) identified in the Final Regulations.

For the period January 1, 2013 through December 31, 2013 clinical management of the MHSA Program resulted in authorization of approximately 1,504,914 outpatient visits and the certification of nearly 6,232 inpatient and Alternate Level of Care admissions.

Pre-Certification of Care

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

a. Duties and Responsibilities

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

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

Confirmed.

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

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

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

Confirmed.

(7) Upon denial of pre-certification for Inpatient care, the Contractor is required to provide the Enrollee with facility options where the Enrollee may receive the pre-certified lower level of care. If the Enrollee confirms with the Contractor which facility is chosen, the Contractor is required to promptly notify the facility of the pre-certification of the lower level of care. The Contractor must follow-up with the Enrollee and selected facility within twenty-four (24) hours to confirm that the lower level of care has commenced.

Confirmed.

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

Confirmed.

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

Confirmed.

(a) Non-Network CRL Guarantee: The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non- emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate MHSA Non-Network Provider or program within two (2) Business Days of the call in, a minimum of at least ninety percent (90%) of the cases as calculated annually.

Confirmed.

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

Confirmed.

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

Optum confirms our ability to meet the Clinical Management: Pre-Certification of Care Duties and Responsibilities as detailed above.

b. Required Submission

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

The Empire Plan MHSA Program (MHSA Program) allows Enrollees to seek services in the following ways:

- By contacting the dedicated MHSA Program Clinical Referral Line (CRL) – Our CRL customer service representatives will connect Enrollees to a dedicated team of licensed clinicians (care advocates) for assistance. Our care advocates will help Enrollees by identifying safety concerns, assisting with finding the most appropriate provider referral and precertifying specific benefits. Our CRL is available to Enrollees and providers 24 hours a day, seven days a week.
- By contacting a network provider directly – Our Enrollee website, liveandworkwell.com is available 24 hours a day, seven days a week for those Enrollees seeking referral information from the convenience of an online resource. Enrollees can access a complete directory of all network program providers and facilities throughout the United States. Enrollees are able to narrow their selection by clinician name, location, specialty, ethnicity, language, gender or area of expertise. Should an Enrollee contact a network provider directly, our network provider will contact the CRL for any required authorizations or to register the beginning of treatment. Should the Enrollee contact a provider who is not appropriate for their clinical needs, the Optum network provider will assist the Enrollee with a more appropriate referral.
- By contacting a non-network provider directly – In advance of any non-network facility admissions, the non-network facility should contact our CRL in advance of the inpatient admission. However, the Enrollee is also able to request the facility contact the CRL in order to participate in a precertification medical necessity review. If the admission is an emergency admission, the Empire Plan MHSA Certificate of Coverage allows a 48-hour period in order to obtain authorization. Should a family member contact the CRL to notify us of the admission, a care advocate will outreach to the facility to begin the precertification process.

The goal of our care advocacy model is to effectively manage mental health and substance abuse care so that we can successfully improve the Enrollee experience, clinical outcomes and affordability. We have provided additional detail on our precertification services and processes below.

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

Our Clinical Referral Line (CRL) will be available through a dedicated toll-free number, staffed 24 hours a day, 365 days a year (including holidays) by qualified and licensed clinicians. Enrollees with non-clinical questions for our Customer Service Representatives (CSRs) will be connected via warm transfer to a dedicated team of care advocates for any clinical matters. [redacted]

The dedicated MHSA Program care advocates provide professional, courteous guidance and are trained to handle a variety of clinical scenarios. Clinical situations managed by the CRL care advocates include:

- Assessing the clinical and safety needs of Enrollees seeking use of the MHSA Program services. Should an Enrollee have difficulty obtaining an appointment, the CRL care advocate will assist the Enrollee in scheduling an appointment in a timely manner; a network referral is guaranteed.
- Providing guidance on any appropriate community resources depending on the Enrollee’s presenting issue.
- Identifying any specialty clinical presentations, unique provider requests or physical, language or communicative requirements.
- Providing guidance on a variety of mental health or substance abuse concerns and determining the right care at the right time depending on the presentation of the Enrollee.
- Arranging for emergency care, including but not limited, to contacting family members, police or ambulance services should the situation warrant.
- Upon determining that an urgent appointment is necessary, the care advocate will outreach to one of our designated network providers who have immediate appointments available and complete the referral in a timely fashion.
- Educating any Enrollee seeking services from a non-network provider on his or her financial responsibility and offer an alternate referral
- Authorizing services requiring a pre-certification or scheduling a peer review for services where medical necessity cannot be determined.

Care advocates reached through the CRL are always available to ensure Enrollees are receiving the right care at the right time and receive accurate benefit information with appropriate referrals for any level of care.

Established Pre-certification Process for the Program

When an Enrollee contacts the CRL prior to receiving clinical services, they are connected to a care advocate who screens for safety concerns or risks to assure that clinical needs are identified and met. The care advocate will ask the Enrollee a series of questions designed to obtain the most precise evaluation. The care advocate collects clinical information on the presenting issue as well as current stressors, substance abuse patterns, severity of current symptoms and risk factors for harm to self or others. This intake process helps the care advocate identify the most appropriate level of care and specifically match the caller with a provider according to their treatment needs. Although there is a standard process, the care advocate is trained to respond to any clinical situation, including a suicidal caller.

Additionally, LINX, our state-of-the-art integrated case management application, is designed to provide comprehensive consultation and resource services within a single application. LINX has been carefully designed to match the workflow of our clinical staff, providing an easy and convenient way to enter or find information about all aspects of an Enrollee’s care. A single Enrollee record displays all of the following data:

- Complete demographic information, including dependent relationships

- Eligibility information
- For Enrollees who have received behavioral health care services, the Enrollee record also displays:
  - Full information about the Enrollee's diagnosis and treatment authorizations
  - Contact information for all practitioners to whom the Enrollee has been referred
  - Detailed notes from intake and all subsequent reviews, covering the Enrollee's full treatment history
- Background information regarding precipitating factors, support systems, medical history and/or any medications currently being taken
- Notes regarding all follow-up or other contacts, including any appeals

In addition, the software gives our clinical staff the ability to search for network providers without leaving the Enrollee record. For example, a care advocate can find a provider by name or geographical proximity (with the capability to identify preferences for ethnicity, language, gender, expertise, licensure and accessibility), then proceed immediately to certify treatment.

The software's user-friendly design enables our clinical staff to spend their time helping Enrollees rather than looking up information or switching between multiple applications.

Once an Enrollee has received a referral for services, the Optum network provider is responsible for contacting the CRL and initiating any required precertification process.

Should an Enrollee choose services from a non-network provider, the Enrollee should contact the CRL before or early in the treatment process in order to initiate the certification process. When the Enrollee contacts the CRL, the care advocate will verify eligibility, provide information on benefits and services and answer any clinical questions. The care advocate will obtain information about the presenting issue and screen for severity or acuity. The care advocate will also discuss network options with the Enrollee and provide alternate network referrals if requested.

Certification of Outpatient Visits

In our experience serving the MHSA Program, the majority of treatment is completed between eight and 14 visits, depending on diagnosis, therefore a review after the tenth visit can be clinically appropriate and non-restrictive. If an Enrollee is receiving MHSA services that go beyond the expected number of visits for a particular diagnosis, we review the provider's clinical assessment to determine medical necessity and continued certification. We base the certification period on individual clinical presentation, diagnosis, acuity and severity of each case. In line with the Program plan design, our clinical philosophy is to focus our resources on those areas where we can add the most value: identifying potentially high-risk cases and minimizing intrusion into routine cases.

Certification for Higher Levels of Care

Our care advocates are specialists in a variety of conditions and treatment approaches. Care advocates obtain all necessary clinical information to assess for all inpatient treatment decisions. Clinical program managers are available for case consultation whenever necessary.

Individualized assessment and treatment planning is done in collaboration with treatment clinicians and supported by the Optum Level of Care Guidelines, which are used by both care advocates and network providers in the care management review process. Our Level of Care Guidelines are derived from our own clinical experience and published references from the industry's most esteemed professional sources. We also continually update the Level of Care Guidelines to reflect industry best practices.

Innovative Identification and Stratification Capabilities

We use an innovative, highly effective predictive model for identifying and stratifying Enrollees entering facility-based care to determine which Enrollees are most likely to benefit from enhanced interventions by our intensive care advocacy team. The model, known as ISIE (for identification, stratification, intervention and engagement), is unique in that it goes beyond merely predicting which Enrollees are likely to drive higher costs. ISIE actually identifies the segment of the population that is subject to gaps in care (or issues with adherence) and most likely to experience improved outcomes after care advocacy interventions.

ISIE rules are first applied during the initial call from the facility or provider seeking admission. The CRL care advocate will assess & triage the clinical information necessary to apply ISIE, and then stratifies Enrollees for care advocacy according to criteria established by the model. Individuals identified by ISIE as matching a high opportunity group are stratified for assignment to a designated advocate from our intensive care advocacy team. This team was designed exclusively to provide interventions to meet the needs of complex cases receiving facility-based care. Further, the intensive facility care advocate partners with one of our wellness recovery care advocates who follows the Enrollee post-discharge and provides other customized interventions, including interfacing with outpatient treatment providers and families to ensure the Enrollee receives the support he or she needs. In this way, our ISIE capabilities monitor Enrollees throughout the process of receiving care and re-entering the community.

Additionally, when conducting facility admissions, care advocates consider the Enrollee's diagnosis, treatment history, functional capacity, and risk level, and they authorize treatment at the level of care that fits each individual Enrollee's circumstances. Consistent with the expectations of the Department, Optum is oriented toward the use of alternatives to inpatient care (residential programs, partial hospitalization, evening and weekend structured outpatient programs, and intensive outpatient psychotherapy) whenever it is in the Enrollee's best clinical interests. Both research studies and our own clinical experience affirm that intermediate levels of care are often equally or more effective than inpatient treatment and significantly more cost-effective, promoting continued progress by being less restrictive and disruptive to the Enrollee's daily life.

Services the Program Should Consider for Pre-Certification

Based on our significant experience with the Empire Plan MHSA Program certificate of coverage, Optum has identified specific covered services where a precertification should be requested prior to services being rendered. These services are typically non-routine, are required because of a clinical complexity, have a high risk factor and are typically costly services. Through education and communication, we encourage Enrollees to contact the CRL prior to receiving services in order to receive the highest level of benefit allowed. The MHSA Program as administered by Optum, suggests precertification for the following covered services based on our experience with parity requirements and the MHSA Program:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

We will align our prior certification and concurrent review processes with those of the Empire Plan Medical Program and in line with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). We have worked closely with the Department during the previous four years of our contract term to ensure the MHSA Program is parity compliant.

All treatment requests must establish medical necessity in order to be certified. The MHSA Program care advocates will gather the information necessary to determine medical necessity and notify the provider and Enrollee of the determination both verbally and in writing.

Criteria for Selecting Conditions/Services for Pre-Certification

We worked closely with the Department during the last four years of our contract to ensure the MHSA Program was parity compliant. Optum has used the following criteria to select conditions and services for utilization management:

- The cost of a service used to diagnose or treat a behavioral health condition is high relative to a commonly used alternative
- Services that are ancillary for diagnosing or treating a behavioral health condition
- Services that do not conform with established standards of practice
- Over-utilized services
- Services or conditions that may be inconsistently covered under the benefit plan such as experimental, investigational or unproven services

We also worked closely with the Department to control costs. Critical to this effort was the use of our predictive model which takes into account the key, weighted, relational data points about each Enrollee collected by our care advocates and identifies risk around the length of stay and/or readmission potential.

We also understand that the best way to control costs is not to limit benefits, but to provide early intervention and easy access to the *right* care.

(b) Your proposed Clinical Referral Line staffing and qualifications of each level of clinician rendering authorizations and denials of care. Will clinical management staff be dedicated to the Program or will they service other customers as well?

[redacted] Their first priority is serving the referral and assessment needs of the Empire Plan MHSA Program enrollees 24 hours a day, 365 days a year.

Our dedicated staff of Clinical Referral Line clinicians will answer Enrollee calls to the CRL. Customer Service Representatives (CSRs) will answer claims questions and benefits questions, offer provider search assistance and transfer any Enrollee with clinical questions to our dedicated team of CRL care advocates. CSRs have the following qualifications:

Our care advocates are supervised by licensed behavioral health care professionals and will collect clinical data for pre-service and concurrent reviews. For outpatient care, the care advocates make referrals to the most appropriate provider for the Enrollee.

Care advocates serving Enrollees may approve care using our Level of Care Guidelines, however, they do not deny care. If they are unable to issue a certification on the clinical information they have obtained, they will refer the case to a peer advisor for review.

[redacted]

- [redacted]
- [redacted]
- [redacted]

Our care advocates are distinguished by their broad experience, the depth of their clinical skills and their active involvement in decisions about patient care. Our care advocates include specialized experts in substance abuse, child and adolescent disorders, eating disorders, and post-traumatic stress reactions.

Specialized Care Advocacy

As part of the care advocacy model we propose for the MHSA Program, we have additional care advocates who are licensed behavioral health care professionals and who are responsible for providing specialized care advocacy to Enrollees. Specialized care advocates include those performing assess and triage, intensive facility-based and wellness recovery functions.

We selected these care advocates for their skill sets and specialization in functional areas. For example, care advocates with experience in providing outpatient treatment will review outpatient treatment plans, care advocates with facility-based expertise partner with our network facilities, and care advocates with expertise in discharge and preventing readmissions support Enrollees at high-risk of readmission with discharge planning. This approach ensures that ongoing review of clinical care is tailored to meet the specific needs of each Enrollee.

As part of this model, a team of licensed care advocates exclusively supports Enrollees while they are in facility-based care and is further specialized into two groups, intensive care advocacy and standard care advocacy, depending on risk factors identified upon certified admission. Care advocates' activities include contacting and engaging Enrollees at designated points just prior to and after discharge, contacting providers who Enrollees are scheduled with for follow-up appointments, arranging follow-up appointments for Enrollees when necessary and assisting Enrollees with eliminating barriers to follow-up care. For intensive cases, the care advocate provides additional support during the inpatient stay, helping to coordinate and arrange the support network resources that will improve the likelihood of successful discharge.

These care advocates have at least five years of clinical experience with an in-depth knowledge of a full range of treatment settings and experience in available treatment modalities.

Peer Advisors

A peer advisor will review clinical cases not certified by a care advocate. Peer advisors are at least the same licensure as the requesting treating provider, have competency in the same or similar specialty area and hold an active, unrestricted license.

Peer advisors are licensed psychologists or licensed psychiatrists with at least five years clinical experience. Our peer advisors are specialists in psychopharmacology, addiction, geropsychiatry, medical/psychiatric, eating disorders, and the treatment of children and adolescents.

(c) For the calendar year 2013, the percentage of Enrollees who called the CRL and who received a referral at a different level of care from the one initially requested.

It is very rare that Enrollees contacting the CRL receive a different level of care from the one initially requested. In these circumstances, an Enrollee not yet evaluated by a provider may be identified at higher risk and require a higher level of care after a clinical assessment is completed by the CRL care advocate. [redacted].

(d) A description of your proposed precertification program including the type of services subject to precertification, staffing levels, the timeline for completion, clinical information requested, and the number of cases reviewed, approved and declined for a client similar to the Program (for the most recent calendar year). Provide a sample of any pre-certification forms used by the Offeror.

Our precertification program aligns with the MHSA Program's plan design and precertification requirements. Our dedicated team of licensed care advocates will conduct assessments and triage precertification services through the CRL for the MHSA Program. Our team of dedicated care advocates assesses each Enrollee's problem and explains benefit coverage and service options.

When an Enrollee first calls, the care advocate screens for risk using our advanced tool, which guides the care advocate through appropriate inquiries to obtain the most precise evaluation; this tool is embedded in our clinical management system. Additionally, our real-time information system contains complete information about the Program, reinforcing the care advocate's ability to explain the specific services being certified, any applicable copayments or deductibles, and coverage variations if the Enrollee chooses to receive treatment from a non-network clinician.

Type of Services Subject to Precertification

As indicated in our previous Empire Plan MHSA Program certificate of coverage, Optum identified specific covered services where a precertification should be requested prior to services being performed. The MHSA Program as it was administered by Optum, suggested precertification for the following covered services:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

Timeline for Completion

The timeline for completion of the precertification process varies according to the level of care requested and will follow New York State Managed Care laws and the Empire Plan MHSA Program certificate of coverage. [redacted]

For alternative levels of care and outpatient care, the timeline is typically three business days.

[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Clinical Information Requested

For all higher levels of care and outpatient ECT, psychological testing, and Applied Behavioral Analysis, we request comprehensive information, including and as relevant, regarding: diagnosis, psycho/social/environmental factors, suicidal ideation, homicidal ideation, substance abuse, mental status, psychiatric medications, discharge planning, treatment goals, etc. We include this information on our Initial Facility-Based Review form.

For outpatient care, we request medical record information including: symptoms/functional impairment, history of psychiatric hospitalization, psychiatric medications, a progress update, comorbid conditions, expected outcomes, etc.

2013 Cases Reviewed, Approved and Declined

Because our CRL care advocates are typically able to accurately assess or modify the levels of care requested for precertification, most of our cases are certified. When a care advocate is unable to make a medical necessity determination, the case is given to a peer advisor for a case review. The number of cases that go to peer review is a small percentage of overall cases that are reviewed. In most instances care advocates will make coverage determinations. [redacted]

Sample Precertification Forms

We have provided a sample of our Initial Facility Based Review form and our psych testing form as Attachment 19.

(e) A description of the steps that will be taken to meet the needs of Enrollees who require a Provider with subspecialties, especially those who require pediatric, adolescent or geriatric mental health services. How will you meet the ongoing therapy needs of those Enrollees whose first language is not English; who are hearing impaired; or who request a Provider with a particular ethnic background?

To meet the needs of Enrollees who require a provider with subspecialties, all of our care advocates have real-time access to our online clinician database, which includes information on each network provider's clinical expertise, cultural competencies and languages spoken, office hours and accessibility requirements compliant with the Americans with Disabilities Act (ADA). The steps are simple. The Enrollee calls the CRL and is referred to a licensed care advocate who assesses the Enrollee's presenting issue and provider referral request. The care advocate then searches online to provide an appropriate match.

We maintain a network that is culturally and linguistically appropriate for Enrollees. We complete ongoing network analyses to ensure that we maintain an adequate ratio of bilingual and multilingual clinicians—that the ethnicity of clinicians reflects that of Enrollees to fully meet cultural needs. [redacted]

[redacted] We also ensure that the CRL is accessible to the hearing-impaired, through TDD communication 24 hours a day, seven days a week. Included in our network are providers who work in sign language or are able to use the assistance of a sign language interpreter.

Clinical Subspecialties

Our position as the industry's clinical leader is grounded in the breadth and depth of our behavioral health network, which allows us to precisely match the clinical needs of Enrollees. We highlight our specialized approach and expertise in the following sections.

Specialized Treatment for Children and Adolescents

We emphasize that, whenever possible, children and adolescents should be treated in a setting, program or unit that:

- Is age and/or developmentally appropriate.
- Addresses the unique and special clinical issues pertaining to children.
- Is staffed with treating clinicians who are trained and experienced in child/adolescent mental health treatment.
- Is located as close as possible to the home community to promote optimal involvement of the family and other key people in the child's environment. This is often the critical element in planning quality treatment and in encouraging adherence to the treatment plan.

Support for ADHD and ADD

Many resources are available to parents and Enrollees who struggle with ADHD or ADD. When parents call us suspecting that their child may have ADD or ADHD, they speak with a licensed care advocate who will do the following:

- Review exactly what their benefit covers and how to make the best use of it
- Explain how we can help them coordinate with school personnel and other important people or groups in the child's life
- Provide information about special educational services and associated resources available through their school system, as well as community support and advocacy groups
- Make a referral to a network provider who specializes in the care of children and the treatment of ADD/ADHD, and who can conduct an assessment and recommend the appropriate next step in the child's treatment
- Authorize a clinical assessment to determine the correct diagnosis and appropriate treatment plan

For adult children, we can also offer information on home and community supportive services, advocacy groups, or make a referral to a network provider who specializes in the care of adults with ADD or ADHD.

Support for Geriatric Enrollees

Geriatric Enrollees, including populations covered by Medicare and Medicaid, have a higher incidence of chronic care needs. To address these issues associated with the Medicare population, our approach to treatment includes the following:

- Facilitating care from the best-qualified treatment resources, including a specialty network of geriatric psychiatrists
- Visiting network providers who travel to Enrollees' homes or long-term care facilities to provide psychotherapy or counseling services
- Coordinating with medical clinicians, including home health care providers, primary care doctors, skilled-nursing and long-term care facilities
- Identifying community and other socially sponsored resources and providing education to the families

We have designed our approach by listening and responding to the concerns of older adults, and we continue to develop and refine our interventions based on what our Enrollees, providers and customers tell us.

Treatment of Eating Disorders

Obtaining the appropriate treatment for eating disorders is crucial and require particular care during the referral process.

Once treatment is initiated, outcomes are monitored by the care advocate based on the Enrollee's progress toward meeting specific goals established by the provider and Enrollee (e.g., improvement in weight, adherence to a healthy nutrition plan, eliminating restricting and purging behaviors, correction of medical problems, addressing comorbid conditions, correcting eating behaviors, improving self-esteem and helping family issues).

[redacted]

In an effort to improve outcomes, Optum eating disorders experts review current research literature, maintain relationships with national experts and participate in national forums to explore new treatments and outcomes (e.g., NIMH, AMBHA, Columbia University Psychiatric Institute, UCLA, UC San Diego), as well as participate in research with academic partners.

We also regularly conduct biweekly eating disorder rounds on a nationwide Optum conference call that deals with challenging eating disorder cases and bring Optum's best practices for the clinical management of eating disorders.

(f) An explanation of how urgent and emergency cases will be identified. Who on the Clinical Management team will be responsible for making such determinations? Describe the procedures that will be followed for ensuring that Enrollees receive appropriate care in urgent and emergency situations.

Our care advocates are trained in crisis intervention, risk assessment and identifying urgent and emergency cases. We have protocols and procedures in place to assure the appropriate handling of any call that is identified as urgent or emergent. We use a consistent approach to emergency interventions and have developed a risk assessment and safety protocol that guides care advocates through the process of assessing for homicidal or suicidal ideation/intention, potential for violence, presence of substance abuse and other risk indicators. Care advocates use a sensitive, flexible interview approach to defuse the crisis and evaluate the situation in order to determine the appropriate intervention to ensure the Enrollee's safety.

Making Determinations

Licensed care advocates provide crisis triage and intervention around the clock through our toll-free number to handle emergency calls, providing continuous telephonic support while arranging for the most appropriate intervention that will ensure the caller's safety. Care advocates will assess the caller's risk to harm self or others through empathic, non-judgmental interviewing, and help the caller articulate the level of urgency. Clinical program managers who supervise care advocates are also located in the Latham, New York care advocacy center to provide consultative support as needed. Care advocates and clinical program managers also have 24-hour access to our team of medical directors for consultation, as needed.

Handling Urgent and Emergency Situations

The care advocate triages cases according to three levels of risk and ensures access to care within clinically appropriate timeframes, as follows:

- Emergent Life-threatening – In an emergency situation, the care advocate keeps the Enrollee (if not incapacitated) on the line while a partner care advocate can arrange the appropriate intervention, including transportation to a facility if necessary, to assure the Enrollee's safety. The care advocate will contact the emergency room triage department to inform them of the arriving Enrollee and confirm the risks identified. Then, the care advocate will confirm the Enrollee has arrived within 30 minutes and inform the hospital staff of the MHSA Program contact information. If the Enrollee is not admitted to the hospital, the case is assigned to a care advocate for follow-up within 24 hours to assist with referral needs and conduct additional risk assessments.
- Emergent Non-life-threatening – Once identified as an emergent but non-life threatening referral, the Enrollee will be contacted by a network provider or care advocate within 30 minutes of original call. We contact a network provider who has designated urgent appointments available. This provider will contact the Enrollee and schedule an assessment. As a follow- up, our care advocate will outreach to the network provider or Enrollee within 24 hours of the appointment to confirm the appointment was kept, identify additional needs, etc.
- Urgent – In urgent cases we contact a network provider who has designated urgent appointments available. This provider will contact the Enrollee and schedule an assessment within 48 hours of the original call. As a follow-up, our care advocate will outreach to the Enrollee within 48 hours of the initial call and again within 24 hours of the appointment to confirm the appointment was kept, identify additional needs, etc.

Our care advocates continue to work with Enrollees identified with urgent or emergent needs to further stabilize clinical needs and determine the appropriate next step.

Examples of How We Have Supported Enrollees in Emergencies

The following are examples of how we have supported MHSA Program Enrollees in emergency situations.

- A care advocate answered a call in the early morning and heard one of our Enrollee's say "I am going to kill myself today." The care advocate quickly took action to ensure the safety of this Enrollee and provided the counseling, support and empathy that this Enrollee needed to remain safe. The woman stated that she has a six-year-old child in the house and a baby, who was in the bathtub. The care advocate could hear the baby crying and inquired further. Our care advocate encouraged the woman to get the child out of the bathtub to ensure she was safe. A second care advocate outreached to the police and was able to get emergency services out to the house quickly. The police were able to get the children to a safe place and transport the Enrollee to an emergency room.
- A care advocate answered a call from an Enrollee who reported she was in crisis. She stated that she was in chronic pain, addicted to her pain medication and alcohol,

> and repeatedly said that she did not want to live anymore. The Enrollee told the care advocate that she was planning on overdosing on her pain medication. While the care advocate spoke with the Enrollee, two of her colleagues worked together to get the police department out to the Enrollee's home. The Enrollee was transported to the emergency room.

Our Optum care advocates understand that any incoming phone call may be an Enrollee at significant risk, requiring our fast-action, calming influence and crisis support.

(g) An explanation of the procedures followed in cases where a Network Provider is contacted directly by an Enrollees seeking treatment.

We understand that some Enrollees will seek the use of our online network provider search tool instead of contacting the CRL. As with our CRL, our Enrollee website is also available 24 hours a day, seven days a week, and some Enrollees prefer this method of obtaining a network provider name, especially if they have received a recommendation from friends or family. Should an Enrollee contact a network provider directly, our network provider will contact the CRL for any required authorizations or to inform us of the beginning of treatment.

Should the network provider determine that the Enrollee requires a different provider because of a specialty need, the provider will take responsibility for contacting the CRL for an alternate provider and ensuring an appropriate referral is made to the Enrollee.

[redacted]

(h) A description of the steps you will take to encourage the use of the toll-free number for the Clinical Referral Line to minimize self-referrals to Providers, as well as steps you will take to encourage the use of Network Providers; (i) Specify the location where Clinical Referral Line and other clinical management services for the Program will be provided. How will you ensure that CRL and clinical management staff are aware of MHSA community resources?

Optum's account management team, dedicated to the MHSA Program, will always be available to promote the advantages of the CRL toll-free number through attendance at any event the Department views as appropriate. We have historically participated in Health Benefits Administrators conferences throughout New York State which is an opportunity to educate Enrollees and administrators about the benefits of contacting the CRL. In our previous experience as your MHSA Program vendor, benefit fairs were typically conducted in coordination with UnitedHealthcare client service managers who also assist in educating Enrollees seeking information about the Empire Plan medical program. We also developed communications materials, articles and Enrollee messages, as approved by the Department. Key points of our communications (whether in person or through materials) included:

- Immediate access to licensed care advocates on the phone for precise problem identification and consultation
- Immediate help in a crisis
- Careful provider matching to address clinical, cultural and geographic needs
- Educating primary physicians to encourage them to refer Enrollees directly to the CRL for any behavioral health needs

Educating Enrollees on Their Benefit

We understand that Enrollees generally use non-network providers because of an existing relationship with the provider or because of a referral from a trusted physician, friend or family member. Since Enrollees may not recognize the value of network-based services, we discuss the financial impact of using a non-network provider. This discussion can happen when the Enrollee contacts the CRL directly to request certification or will be warm-transferred by our customer service call center staff when an Enrollee is requesting benefit information for non-network use.

We seek to educate Enrollees about the following benefits of seeing a network provider:

- The Enrollee does not have to worry about certification or claims submission when seeing a network provider.
- With a network provider, the only upfront financial responsibility is the Enrollee’s copayment for covered services. Using a non-network provider could result in substantial amount of money up-front if the Enrollee is being seen for visits at a regular frequency.
- Our Optum network providers are credentialed and audited to ensure quality.

Convenient Access to Online Provider Searches

Our online directory, which is updated daily, plays a large role in keeping Enrollees within the network. Through a direct link to **liveandworkwell.com**, Enrollees can conduct immediate searches and select providers who meet their specified criteria, such as evening or weekend hours, convenience to public transportation, and language or specialty preferences.

On the homepage of **liveandworkwell.com** and throughout the website, we advise Enrollees they can contact the CRL at any time for further assistance.

Cross-Referral from Nurses

Enrollees with chronic medical conditions with unmet or under-met behavioral health needs may be referred to the CRL for any psychosocial need (even financial, legal, or dependent care problems) that may be affecting their well-being.

As a sister company of UnitedHealthcare, we offer an established interface with chronic condition nurses or NurseLine to ensure enhanced comanagement of care for co-occurring medical and behavioral diagnoses. We have developed integrated business processes that assess all high-risk medical Enrollees identified by the nurse for depression or anxiety, and then proactively offer these Enrollees behavioral health interventions.

Nurses use the Optum Referral Application (ORA) to refer Enrollees who agreed to outreach from the MHSA Program care advocate to discuss referrals for services. Nurses may also warm transfer those Enrollees who agree to an MHSA referral directly to the CRL. We can then encourage Enrollees who need care to access network providers.

Provider Support for Contacting the CRL

We promote the CRL through the provider community on our Provider Express website and through our Network Notes newsletter. In addition, we also educate primary care physicians to encourage them to refer Enrollees directly to the CRL for any behavioral health needs.

Clinical Staff is Part of the Local Community

Our New York-based, licensed care advocates are experts in community resources that support Enrollees toward a path of sustained recovery and resiliency. Since the Empire Plan MHSA Program will be administered in our Latham, New York care advocacy center, our CRL and clinical staff are very familiar with the provider community and frequently have worked in regional agencies, community mental health centers, private practices and other organizations that have a statewide or local New York presence.

For referral sources outside of New York State, care advocates have access through LINX, our case management system, to a clinical and non-clinical provider database which houses over 100,000 community resources and consists of 35 different profile categories, including three profiles created specifically for behavioral health resources:

- Behavioral health community resources
- Behavioral health mental health resources
- Physical health resources

The information in each individual profile is personally verified every 90 days via a phone call to the resource provider to ensure that the information entered into the non-clinical provider database is accurate. We frequently refer Enrollees to the following types of resources and organizations:

• 12-step programs	• Geriatric services
• Support groups	• United Way agencies
• Self-help groups	• Battered women’s shelters
• AIDS-related assistance	• Family service agencies
• Community mental health agencies	• Child abuse services

[redacted]

(i) The methods you use to measure the effectiveness and efficiency of the Clinical Referral Line and pre-certification services (Do not include any reference to specific monetary savings).

To measure the effectiveness of the CRL and precertification services, we review Enrollee and provider satisfaction data and care advocacy center availability trends, conduct audits on CRL care advocates and peer advisor performance, review our modification rate and review results from our Facility Quality Management (FQM) Program.

We have provided additional description of these methods below.

Enrollee Satisfaction

We believe that one of the best measures of our program’s effectiveness is the satisfaction of Enrollees who use the service. [redacted] ome highlights of the survey included the following:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

Care Advocacy Center Staff Performance Audits

We conduct ongoing audits on the documentation and activity of clinical staff within the Latham care advocacy center. The purpose of these audits is to continuously monitor the activity of clinical staff to ensure quality and adherence to expected processes among the clinical staff as well as to proactively identify and correct quality issues.

Monitoring Performance of Care Advocates

Care advocates receive multi-dimensional evaluations, supervision and staff development opportunities, including the following:

- Structured and spontaneous feedback about care advocates from clinicians, programs and facilities in the Optum network
- Feedback from Enrollees on services received
- Weekly face-to-face supervision with their clinical program managers and daily small-group meetings with a psychiatric supervisor
- Participation in clinical rounds conducted by our medical directors with the regional vice president and the full care advocacy teams for the review of complex cases
- Weekly random case audits of each care advocate by clinical program managers to ensure complete documentation, timeliness of service and proper treatment plan development with additional supervision as necessary

Inter-Rater Reliability

We ensure the consistency of our process through our inter-rater reliability program, established to provide a standard means to evaluate staff knowledge and application of our Level of Care Guidelines.

We conduct an annual inter-rater reliability evaluation which includes the medical director, care advocates and peer reviewers. Responses are recorded and then reviewed for accuracy. Supervisors address results, and the evaluation is repeated if a pattern of discrepancies is identified.

Auditing Cases

A sample of clinical cases from each level of care (including inpatient, residential, partial hospital, intensive outpatient and outpatient) is audited each quarter. The focus of a clinical case review is the overall quality of the management of the case across the care advocacy center, rather than just the performance of any single staff member. However, if a pattern of deficiency is found in the quality of an individual staff member's performance, we may conduct a more thorough audit.

Modification Rate

Another way in which we measure the success of our CRL and our precertification process is in our modification rate. In the past for the MHSA Program, [redacted] of our network facilities agree to a modified level of care from what they originally requested. Modifications typically occur when the facility has multiple levels of care contracted with Optum and are able to admit the Enrollee into a less restrictive level of care when appropriate for the Enrollee's presenting symptoms and supportive environment.

The knowledge and day-to-day expertise of our care advocates and other clinical team staff has been critical to this rate of diversion. Such diversions occur only with the agreement of the Enrollee and/or treating clinician/facility. The expertise of our care advocates lends them credibility with treating clinicians/facilities, resulting in a high level of cooperation and productive interaction.

As noted, our approach is oriented toward the use of alternatives to inpatient care (residential programs, partial hospitalization, evening and weekend structured outpatient programs and intensive outpatient psychotherapy) whenever it is right for the Enrollee. Both research studies and our own clinical experience affirm that intermediate levels of care are often equally or more effective than inpatient treatment and significantly more cost-effective, promoting continued progress by being less restrictive and disruptive to the Enrollee's daily life.

Facility Quality Management Program

For higher levels of care, we measure the effectiveness of precertification primarily through our Facility Quality Management (FQM) program, which tracks the performance of network facilities and allows us to drive referrals to the highest quality setting for the Enrollee's particular needs.

The FQM measures facility performance against the following metrics:

- Number of admissions
- Readmission rates
- Average length of stay
- Discharge planning
- HEDIS
- Aftercare compliance (percent of kept appointments)
- Percent of appointments scheduled prior to discharge
- Enrollee outcomes and satisfaction

This methodology allows us to monitor the effectiveness of precertification in terms of both the level of care approved and the performance of the selected facility.

(j) How you will transition Enrollees with existing precertifications with a Network Provider into your system. Confirm you will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.

Confirmed. To transition Enrollees with existing precertifications with a Network provider into our system, we will load one or more files of pre-certifications and Prior Authorizations approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received. For example, in 2009, we developed a specific access database for the Empire Plan MHSA Program for collection and easy access to the previous vendor's prior authorization and claims history. This database assisted CRL and Customer Service Representatives to easily identify and assist Enrollees with speedy answers to their questions during the transition period.

(k) The guidelines you use to determine length of stay. Have these guidelines been peer reviewed?

Our clinically licensed care advocates gather information from treatment providers and use our *Level of Care Guidelines* and *Best Practice Guidelines* to guide medical necessity determinations and length of stay.

Level of Care Guidelines

Our *Level of Care Guidelines* provide objective and evidence-based admission and continuing stay criteria for mental health and substance use disorders services offered by our provider network. They are intended to standardize care advocacy decisions regarding the most appropriate and available level of care needed to treat a member's presenting problems, while taking into account the specific needs of each individual.

Our *Level of Care Guidelines* are based on the following:

- Optum's clinical experience
- Input from clinicians from a wide geographic distribution and all disciplines
- Published references from the industry's most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine and DSM IV

Care advocates, peer reviewers and appeals reviewers reference the current *Level of Care Guidelines* when conducting clinical review activities. Guidelines are used in a flexible manner, and all care advocacy decisions, including medical necessity, are informed by the unique clinical aspects of the case and the treatment resources available to the member.

The Level of Care Guidelines is derived from generally accepted standards of practice for the treatment of behavioral health conditions. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

Best Practice Guidelines

To ensure that members receive evidence-based care, we have adopted nationally recognized *Best Practice Guidelines* that were developed by the American Psychiatric Association (for adults) and the American Academy of Child and Adolescent Psychiatry (for children and adolescents). These guidelines detail patient care strategies that assist clinicians in making treatment decisions, based on scientific evidence or expert consensus. Our care advocates reinforce these best practice guidelines through our outpatient management program and concurrent review of facility-based care.

Additionally, we use predictive modeling and diagnostic benchmarks to determine the frequency and focus of concurrent reviews. Our internally developed Predictive Model takes into account key, weighted, relational data points about each member collected by our care advocates and identifies risk around the length of stay and/or readmission potential.

(2) Confirm that you will prepare and send approved communications to notify Enrollees and/or their Providers of the outcome of their pre-certification and/or prior authorization request.

Confirmed. Providers and Enrollees are typically notified of services requiring precertification through Department-approved certification or denial letters. As applicable, verbal confirmation of certification determinations are conducted as well.

Certifications can also be easily verified online by our providers through our website, **providerexpress.com** as well as by Enrollees through our website at **liveandworkwell.com**.

(3) Confirm that you will promptly load into the clinical management and/or claims processing system approved pre-certification and prior authorizations determined by the Offeror.

Confirmed. Precertification and prior authorizations are loaded into our clinical management system and our claims processing system immediately in real-time.

(4) Describe the steps the Contractor will take to pre-certify inpatient hospital admissions for alcohol detox and manage the patient's care if transferred to rehab.

Although hospital-based detoxification admissions are reimbursed by Empire Blue Cross Blue Shield, Optum will conduct clinical reviews at precertification in order to manage the case once an agreed step-down plan is in place.

To precertify inpatient hospital admissions for alcohol detoxification, we follow the same process as precertifying any other inpatient hospital admission. During our period as your MHSA Program vendor, we developed a customized process that we can use again for the MHSA Program. We have significant experience working with Empire Blue Cross Blue Shield for exchanging data and information in regards to this process and we provided a seamless approach for Enrollees and facility providers for certification and claims payment.

Once the care advocate is alerted to a detoxification admission into a hospital based facility, the care advocate will document all clinical information to precertify the admission and assist with discharge planning or step-down treatment options. The care advocate will also enter the notification into LINX case management system which will populate into a daily report transferred to Empire Blue Cross Blue Shield in order to notify them of the admission so they may facilitate claims payment. The facility is informed that claims for the admission should be sent to the Empire Plan Hospital Program vendor, Empire Blue Cross Blue Shield.

A care advocate with specialization in working with facilities is assigned to the case in order to facilitate continued treatment planning and arrange for transfer to less acute substance abuse treatment as necessary.

Managing Care for Enrollees in Substance Abuse Treatment

If an Enrollee is transferred to a substance abuse facility for rehabilitation after detoxification, the assigned care advocate continues treatment planning and enters applicable certifications in our LINX case management system. Optum believes it is imperative that any case with the potential for relapse and high utilization receives appropriate interventions early in the treatment protocol to improve outcomes and reduce recidivism. We accomplish this through:

- **The application of predictive algorithms.** Relapse, readmission, dual diagnosis, medical comorbidity, chronic pain and substance dependence, multiple substance abuse/dependence. Our predictive model takes into account the key, weighted, relational data points about each member collected by our care advocates and identifies risk around the length of stay and/or readmission potential. For Enrollees scoring high risk for length of stay or readmission, our care advocates access a “Predict” tab on our care management system, which displays the risk(s) that have been identified so that the care advocate can initiate discharge planning and care management.
- **Identification, Stratification, Intervention and Engagement.** We use an innovative, highly effective predictive model for identifying and stratifying members entering facility-based care to determine which members are most likely to benefit from enhanced interventions by our intensive care advocacy team. The model, known as ISIE (for identification, stratification, intervention and engagement), is unique in that it goes beyond merely predicting which members are likely to drive higher costs. ISIE actually identifies the segment of the population that is subject to gaps in care (or issues with adherence) and most likely to experience improved outcomes after care advocacy interventions.
- **Full continuum of care.** Effective rehabilitation options in settings that are clinically therapeutic while allowing Enrollees to resume activities of daily life as quickly as possible. Our network includes:
  - Acute inpatient care for substance abuse treatment
  - Residential treatment
  - Partial hospitalization
  - Structured outpatient programs including family sessions
- **Recovery and resiliency focus**. Optum has developed an overarching clinical philosophy that is based on recovery principles. Care advocates conducting concurrent reviews collaborate with facility team to align care with a recovery-focused approach, ensuring that treatment is built on strengths, not illnesses, and is engaging the Enrollee and Enrollee’s family in full partnership in treatment decisions. Community and peer resources are also emphasized.
- **Active discharge planning and support.** Discharge planning begins during the very first admission review and is revisited at every concurrent review. Care advocates emphasize the importance of a comprehensive plan, including details on the next

level of care, medication regimes, community resources, and the significance of a first appointment within seven days of discharge. Care advocates who specialize in supporting intensive cases provide additional support during the inpatient stay, helping to coordinate and arrange the support network resources that will improve the likelihood of successful discharge.

In addition, a true Optum differentiator is our Algorithms for Effective Reporting and Treatment (ALERT) outpatient model. While not mandatory, ALERT allows us to identify and intervene when individuals with chronic conditions, including chemical dependency, have transitioned to the outpatient setting and are not making expected progress. Moving beyond the traditional method of reviewing treatment plans from clinicians to identify risk, with ALERT we proactively apply a series of clinical algorithms that identify outpatient Enrollees who may be at risk for adverse outcomes. Enrollees are monitored for risk and lack of progress through ALERT, which triggers intervention by a care advocate whenever an Enrollee shows signs of deterioration or lack of improvement—before a relapse occurs.

(5) Describe the steps the Contractor will take to ensure that upon denial of pre-certification for Inpatient care, the Contractor will provide the Enrollee with facility options where the Enrollee may receive the pre-certified lower level of care. Also, confirm the Contractor will notify the chosen facility of the pre-certification of the lower level of care and will follow-up with the Enrollee and the selected facility within twenty-four (24) hours to confirm that the lower level of care has commenced.

In instances of denial of pre-certification of Inpatient care, Optum will take steps to provide the Enrollee with alternative level of care options where the Enrollee may receive a pre-certified lower level of care, as appropriate. In all instances, we use our Level of Care Guidelines and clinical expertise to determine the appropriate level of care for each Enrollee's specific situation. In the event a facility contacts us to request an inpatient admission for an Enrollee that has not already occurred and is not emergent, we will evaluate the medical necessity of the specific level of care. Should we determine that the care or level of care is not medically necessary, we would issue a denial. After issuing such a denial, a care advocate will reach out to the Enrollee (or the Enrollee's parents, if a minor) and ensure the Enrollee is aware of alternate treatment options available to him or her. The care advocate will make the appropriate referral and ensure an appointment is secured with a clinician, as necessary. We will also notify the facility of the lower level of care of the precertification and will follow-up with the Enrollee and facility to confirm that care has commenced.

(6) Confirm the Contractor will load into the clinical management and/or claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.

Confirmed. Optum confirms we will load into our clinical management and claims processing system one or more files of Prior Authorization and pre-certification approved-through dates from the incumbent contractor, prior to the Implementation Date, once acceptable files are received.

(7) Non-Network CRL Guarantee: The MHSA Program's service level standard requires that when an Enrollee calls the Clinical Referral Line for a non- emergency or non-urgent referral and a Network Provider is not available for an appointment within a time frame which meets the member's clinical needs, a referral will be made to an appropriate Non-Network Provider within two (2) Business Days of the call in at least ninety percent (90%) of cases. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of cases where Enrollees are referred to Non-Network Providers within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) of cases (or the Offeror's proposed guarantee) that an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available reported quarterly and calculated on an annual basis, is $____.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] of cases (the Offeror's proposed guarantee) when an Enrollee is referred to a Non-Network Provider within two (2) Business Days (in non-emergency or non-urgent situations) because a Network Provider is not available, as reported quarterly and calculated on an annual basis is [redacted]

(8) Emergency CRL Guarantee: The MHSA Program's service level standard requires that when one hundred percent (100%) of Enrollees who call the CRL in need of life-threatening emergency care be referred to the nearest emergency room and be contacted within thirty (30) minutes to assure their safety. Additionally, one hundred percent (100%) of Enrollees in need of non-life threatening emergency care shall be contacted within thirty (30) minutes by a Network Provider or the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below one hundred percent (100%) of Enrollees who call the CRL in need of emergency care will be contacted by either the Network Provider or the clinicians within 30 minutes of the Enrollee's call to the Clinical Referral Line, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of one hundred percent (100%) when an Enrollee requires emergency care, contact will be made by either the Network Provider or the Contractor's Clinical Managers within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line reported quarterly and calculated on an annual basis, is $.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] when an Enrollee requires emergency care, contact will be made by either the Network Provider or the Contractor's

Clinicians within thirty (30) minutes of the Enrollee's call to the Clinical Referral Line, as reported quarterly and calculated on an annual basis is [redacted]

(9) Urgent Care CRL Guarantee: The MHSA Program's service level standard requires that at least ninety-nine percent (99%) of Enrollees who call the CRL in need of urgent care will be contacted by the Contractor to ensure that the Network Provider contacted the Enrollee within 48 hours of the call to the CRL. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-nine percent (99%) of cases when an Enrollee calls the CRL and requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the

Enrollee within forty-eight (48) hours of the call to the CRL, is $10,000per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-nine percent (99%) (or the Offeror's proposed guarantee) when an Enrollee requires urgent care, contact will be made by the Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL reported quarterly and calculated on an annual basis, is $.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted]) (the Offeror's proposed guarantee) when an Enrollee requires urgent care, contact will be made by the Network Provider Contractor to ensure that the Network Provider contacted the Enrollee within forty-eight (48) hours of the call to the CRL, as reported quarterly and calculated on an annual basis is [redacted]

Transition of Care

The MHSA Program offers a ninety (90) day Transition of Care benefit to allow Enrollees who are receiving MHSA services from a network Provider in the incumbent contractor's network to continue therapy at the network level of benefits. The Transition of Care benefit will apply to Enrollees who are currently receiving Outpatient or Alternate Level of Care services. Care for Enrollees who are Inpatient or in a Residential Treatment Center will continue to be managed by the incumbent contractor through the end of the ninety (90) day Transition of Care period or until step down of care, whichever occurs first.

a. Duties and Responsibilities

(1) The Contractor must identify members who are receiving MHSA services from the incumbent contractor's network from a Provider who is not in the Contractor's network. The Contractor must send these members a letter notifying them of the Transition of Care benefit 3-4 weeks prior to the Implementation Date.

Confirmed.

(2) The Contractor must notify the corresponding Providers of the Transition of Care benefit, including how to submit claims so that the member is responsible only for the applicable Copayment.

Confirmed.

b. Required Submission

(1) Confirm that the Offeror will identify appropriate members and mail Transition of Care letters to members and Providers in a timely manner.

Confirmed.

(2) Confirm that the Offeror will process Transition of care benefits so that the member is responsible only for the applicable Copayment.

Confirmed.

Concurrent Review

The MHSA Program's concurrent utilization review process assists the Provider in identifying MHSA care that is medically necessary and cost effective, without compromise to the quality of care.

a. Duties and Responsibilities

(1) To safeguard Enrollee health and ensure adherance with the MHSA Program's benefit design and requirements on mental health parity, the Contractor must administer a concurrent utilization review program in the United States which:

(a) Enforces the MHSA Program's benefit design features and ensures that Network Providers use the latest MHSA care protocols for Enrollees;

Confirmed.

(b) Uses Clinicians to review Provider treatment plans which must detail, at a minimum: past clinical and treatment history; current symptoms, functional impairment; and DSM-IV diagnosis. The Contractor must require that the Network Provider's proposed treatment plan and goals be in writing for outpatient services. The Contractor must review the treatment plan for a member when the member's visits to the Network Provider exceed the expected duration of services for the Enrollee's clinical diagnosis;

Confirmed.

(c) Is conducted in a manner which is parity compliant as required by the Mental Health Parity and Addiction Equity Act;

Confirmed.

(d) Is performed by the Contractor for outpatient and inpatient care rendered by Non-Network Providers when requested by the Enrollee or Non-Network Provider;

Confirmed.

(e) For inpatient admissions, recognizes when to utilize more appropriate and less restrictive levels of care, when medically appropriate. The Contractor must have

procedures to identify when transfer to an alternate inpatient or outpatient setting is appropriate and arrange such transfers;

Confirmed.

(f) Establishes maximum time frames for inpatient review based upon the level of care provided, and a time frame that allows for discharge planning where the continued stay is not certified;

Confirmed.

(g) Employs appropriately skilled clinicians to review treatment plans in a manner that does not disrupt or delay treatment; and

Confirmed.

(h) Renders certification decisions on a timely basis and requires that Peer Advisors render non-certification decisions.

Confirmed.

(2) For Enrollees admitted to Non-Network Facilities, the Contractor must have procedures to either arrange to transfer the Enrollee to a Network Facility as soon as medically appropriate, or manage the care as if it was a Network Facility, including negotiating discounts with the facility;

Confirmed.

(3) The Contractor must perform appropriate discharge planning by identifying when discharge from an inpatient network setting is appropriate and by directing the Enrollee to appropriate outpatient network care following discharge, including scheduling the initial appointment. Discharge planning must include continual review of the progress of aftercare treatment with the Provider by clinical Manager, as follows:

Confirmed.

(a) Clinical Managers must obtain and review, as part of the discharge plan, specifics that include, at a minimum: the name of the follow-up Provider; date and time of initial follow-up appointment; and the names of responsible family members; and

Confirmed.

(b) Clinical Managers must assist Providers in locating aftercare services. The Contractor must maintain a database of local community resources to assist Providers in locating aftercare services or alternative care in their areas.

Confirmed.

(4) The Contractor must provide intensive case management on a voluntary basis for complex cases or cases requiring long-term treatment. The Contractor must cooperate with the Empire Plan hospital carrier and other Empire Plan carriers in cases of medical/mental health multiple diagnoses in accordance with Mixed Services Protocol (MSP) guidelines established by the Department. Under those MSP guidelines, in cases where there is both a medical and a psychiatric diagnosis, responsibility for case management is determined by the unit (medical or psychiatric) to which the admission is made and the specialty of the attending physician. When those MSP

guidelines are insufficient to determine case management responsibility, the Empire Plan hospital carrier and the Contractor must come to an agreement using other factors such as the condition causing the person to remain hospitalized and the proposed treatment plan; the current MSP is presented in Exhibit II.M.

Confirmed.

(5) The Contractor must use Clinical Managers or Peer Advisors to manage the care of members;

Confirmed.

(6) The Contractor must measure and assess the effects of clinical management and utilization review processes and procedures on the quality of MHSA care and MHSA Program costs;

Confirmed.

(7) Outpatient Treatment UR Guarantee: The Contactor must guarantee that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Days of receipt of the report as reported quarterly and calculated on an annual basis; and

Confirmed.

(8) Inpatient Treatment UR Guarantee: The Contractor must guarantee that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider notified within one (1) Business Day of the determination as reported and calculated on an annual basis.

We confirm our ability to meet the Clinical Management: Concurrent Review Duties and Responsibilities as detailed above.

b. Required Submission

(1) Please detail the full scope of the concurrent UR program that you are proposing to utilize for the MHSA Program, including:

Concurrent reviews are an essential component of the end-to-end care advocacy model through which we support Enrollees who require treatment in an inpatient or facility-based care setting. The reviews are live exchanges between the facility and an assigned care advocate, with a frequency and intensity that varies according to need, but may begin early as within 24 hours of admission.

At their foundation, concurrent reviews serve as opportunities for Optum care advocates to consult with the facility, review the current level of care and treatment plan, including the Enrollee’s diagnosis, treatment history, functional capacity and risk level, and then make a benefit determination according to the covered services of the MHSA Program.

The care advocate’s determination will authorize treatment at the level of care that fits each Enrollee’s circumstances, recommending a stepped-down level of care or alternate resource for the Enrollee when the review doesn’t match the level requested.

In the course of conducting our concurrent reviews, our care advocates partner with the facility and look for opportunities maximize the effectiveness of the inpatient treatment setting while minimizing the length of stay. They may help to address adherence issues and precipitants, gaps in aftercare planning and facilitate interactions with providers.

Our end-to-end model also includes an admission review, discharge planning, discharge follow-up, and outpatient complex case management. Additional strengths of Optum's approach to concurrent reviews include:

- [redacted]
- **Specialized care advocacy**. A team of licensed care advocates exclusively supports Enrollees while in facility-based care, and the primary mode of support they provide is conducting concurrent reviews. The team is further specialized into two groups, intensive and standard care advocacy. The care level is determined by the predictive model, and the care advocates on the intensive team are skilled at supporting the complex needs of the Enrollees they support, including recommending specific evidenced-based interventions that are recommended by the predictive model in response to likely gaps in care.
- **Recovery and resiliency focus**. Optum has developed an overarching clinical philosophy that is based on recovery principles. Care advocates conducting concurrent reviews collaborate with the facility team to align care with a recovery-focused approach, ensuring that treatment is built on strengths, not illnesses, and is engaging the Enrollee and Enrollee's family in full partnership in treatment decisions. Community and peer resources are also emphasized.
- **Active discharge planning and support**. Discharge planning begins during the very first admission review and is revisited at every concurrent review. Care advocates emphasize the importance of a comprehensive plan, including details on the next level of care, medication regimens, community resources and the significance of a first appointment within seven days of discharge. For intensive cases, a specialized care advocate provides additional support during the inpatient stay, helping to coordinate and arrange the support network resources that will improve the likelihood of successful discharge.
- **Peer reviews**. In cases where the care advocate, in consultation with our guidelines, recommends an alternate level of care, and the facility does not accept the alternative level of care, the care advocate makes a peer reviewer available, which gives the treating provider an opportunity to review the case with a peer, share additional information, in hopes of reaching of reaching consensus.

Part of the success of our concurrent review process is attributable to the initial admission reviews. These reviews not only determine the initial appropriateness of the admission, but they begin the care advocacy process, as the care advocate gathers extensive clinical detail from the facility, while also communicating our expectation of recovery-focused treatment, and even initiating discharge planning at that very first call. This comprehensive approach ensures that the subsequent concurrent reviews feature care advocates well informed of the Enrollee's condition and facilities that understand Optum's expectations for care and partnership.

At each phase, our model reaches beyond traditional care management to support Enrollees who have the highest clinical risk and require the most intensive and costly behavioral health services, ensuring that Enrollees with acute, chronic or severe mental illness, as well as those with serious medical comorbidities, receive the evidence-based treatments and targeted interventions to improve clinical outcomes and decrease the cost of care.

(a) The qualifications of the staff responsible for oversight of your concurrent UR program;

Oversight of our concurrent utilization review program is provided by an experienced leadership team, [redacted] will provide executive-level insight and guidance to the staff responsible for overseeing our concurrent UR program for the MHSA Program. [redacted]esponsible for oversight of clinical and administrative operations within [redacted] expertise will be leveraged on behalf of the Department to ensure the effective application of the concurrent UR program. [redacted].

Key roles in our concurrent UR program include the following:

Peer Advisors

Peer advisors are licensed psychologists or licensed psychiatrists with at least five years clinical experience. Our peer advisors are specialists in psychopharmacology, addiction, geropsychiatry, medical/psychiatric, eating disorders and the treatment of children and adolescents.

Clinical Program Managers

Optum's dedicated clinical program managers for the MHSA Program supervise the care management team of care advocates and are seasoned clinicians whose credentials include state licensure, an advanced professional degree, and at least five years of clinical experience. Our clinical program managers are readily available to care advocates for consultations and support, and they are actively involved in cases requiring intensive care management.

Specialized care advocacy

A dedicated team of licensed care advocates conducts concurrent reviews for Enrollees in higher or alternate levels of care. This team is made up of facility-based care advocates and discharge specialists. Our facility-based care advocates, which include standard and intensive, are skilled at working effectively with treatment facilities and coordinating and monitoring Enrollee care with treating clinicians. Care advocates serve as a partners and resources for providers, reviewing previous treatment histories to identify and share barriers, adherence issues, and precipitants; closing gaps in aftercare planning; and facilitating clinician interactions. Our goal is to maximize the effectiveness of the inpatient treatment setting while minimizing the length of stay. Additionally, our discharge specialists are responsible for following up with Enrollees who are being discharged from facility care. Specialists also contact and engage Enrollees at designated points following discharge, contact practitioners with whom Enrollees are scheduled for follow-up appointments, arrange follow-up appointments for Enrollees when necessary, and assist Enrollees with eliminating barriers to follow-up care. Discharge Specialists perform their duties under the supervision of our care advocates enabling us to provide holistic care to Enrollees.

(b) Review of outpatient care;

Our experience has shown that the majority of outpatient cases are resolved within eight to 14 visits. By focusing our resources on those complex cases that go beyond these visits, we minimize intrusion into routine care and offer Enrollees and providers the support they need to resolve problems efficiently and sensitively.

A treatment plan is requested for clinical outpatient cases that go beyond the typical duration of a case of similar diagnosis and symptom presentation. The care advocate reviews the treatment plan and consults with the provider as needed for the duration of treatment, using our Level of Care Guidelines and Best Practice Guidelines to inform and support treatment decisions.

Guidelines are used in a flexible manner, and care advocacy decisions are informed by the unique clinical aspects of the case and the treatment resources available to the Enrollee. However, we ensure our concurrent review processes are aligned with those of the Empire Plan Medical Program, in line with the federal Mental Health Parity and Addiction Equity Act (MHPAEA).

Algorithms for Effective Reporting and Treatment (ALERT®) to Target Higher Cost Outpatients

Optum’s outpatient management program allows us to measure treatment progress from the perspectives of both the Enrollee and provider.

Our robust outpatient management model utilizes Enrollee self-reports of symptom severity and impairment as well as claims submissions to identify Enrollees who may be at-risk or who may be over- or under- utilizing outpatient services.

This proprietary system enables us to accurately identify and stratify risk populations and to deliver tailored interventions (through interactions with the treating clinician and/or Enrollee) based on risk level and the individual needs of each Enrollee that indicate risk or have outlier utilization patterns.

There are three unique components of Optum’s outpatient management program:

- **Clinical algorithms.** ALERT identifies any undetected clinical risks, lack of improvement or changes in global distress and alerts our care advocates to contact the treating provider to discuss any needed adjustments in the treatment plan to improve Enrollee outcomes. Through ALERT clinical algorithms, obtained from a Wellness Assessment completed by the Enrollee, we are able to positively impact treatment planning resulting in true clinical outcomes improvement. The ALERT Wellness Assessment is a brief symptom inventory tool that serves as a benchmark for measuring the Enrollee’s level of distress. By quantifiably measuring the Enrollee’s condition at various stages in the treatment process, ALERT helps prevent the over-utilization of unneeded services. The Wellness Assessment is a voluntary part of our ALERT program, therefore is non-intrusive for routine cases, making it compatible with the Program's pass-through visits model.

- **Claims data expands our identification capabilities.** A set of claims algorithms is applied to the claims submitted by providers to identify cases that may require clinical intervention because of a high-risk diagnosis, behavioral/medical comorbidity and/or unusual utilization patterns. In addition, by comparing the information presented by the Enrollee on his or her Wellness Assessment(s) to the claims submitted by his or her provider, we are able to identify instances in which a provider may have overlooked a significant component of the Enrollee's presenting issue.
- **Outcome Measurement and Technology.** Our ability to synthesize and interpret assessment and claims data through proprietary algorithms identifies potential high-risk cases, supports clinician treatment plans, and measures clinical effectiveness. This allows us to focus clinical resources on the cases where we have the most opportunity to impact the course and cost of treatment. Using ALERT, we can quantifiably measure the effectiveness of therapy and thereby reduce over-utilization of ineffective treatment. This will assist in reducing cost and ensuring Enrollees are getting the right treatment at the right time. Upon approval of the Department, we will send a follow-up Wellness Assessment to the Enrollee four months following the initiation of treatment which he or she is asked to complete and return to us. By monitoring the Enrollee's condition four months after treatment began, we are able to determine whether the outcomes achieved during treatment have been sustained.

The Wellness Assessment, used to assess member outcomes and determine the best course of action for a member's treatment plan, is the result of significant psychometric work. The assessment is given to the Enrollee by his/her clinician at the onset of outpatient treatment and again between sessions three and five. By applying a set of clinical algorithms against Enrollee responses to the Wellness Assessment and quantifiably measuring the effectiveness of the treatment being provided, ALERT helps care advocates support both members and treating clinicians.

Care advocates are able to identify any undetected clinical risks, such as depression and substance use disorders, and alert the clinician to any adjustments in the treatment plan that may be necessary. This allows us to positively impact the treatment the Enrollee receives as it is being delivered, resulting in true clinical outcomes improvement. In addition, by quantifiably measuring the Enrollee's condition at various stages in the treatment processes, ALERT helps prevent the over-utilization of services—ensuring Enrollees only remain at a given treatment level when it is clinically appropriate.

Four months following the initiation of treatment, the Enrollee receives a follow-up Wellness Assessment, which he/she is asked to complete and return to us. By monitoring the Enrollee's condition four months after treatment began, we are able to determine whether the outcomes achieved during treatment have been sustained. This not only allows us to "close the loop" on care, but also helps us proactively identify Enrollees who are in need of additional care.

As mentioned, the Wellness Assessment is a voluntary part of our ALERT program, making it compatible with the Program's pass-through visits model.

How ALERT Can Benefit the MHSA Program

The ALERT program utilizes claims data and runs against a set of algorithms to select cases on the basis of high-risk diagnosis and unusual utilization patterns, e.g., high frequency of visits in a brief time period or high total number of visits. While ALERT can use claims data, we can also coordinate clinical efforts with the submission of a Wellness Assessment which allows us to measure each Enrollee's clinical status and response to treatment interventions, and we are able to influence the treatment process and address any potential issues of over- or under-utilization of outpatient care. ALERT will benefit the MHSA Program through:

- Focusing care advocates' effort on those Enrollees that can benefit the most from intervention
- Allowing routine cases to proceed with minimal disruption for Enrollees and top-tiered network providers
- Facilitating accurate identification of at-risk Enrollees
- Identifying outlier cases at any time during treatment and measuring over-utilization of services
- Promoting an outcomes-based psychotherapeutic approach

Providing a systematic and consistent review of provider practice patterns to identify potentially unsafe, wasteful or costly patterns of treatment billing

(c) Review of inpatient care;

Licensed care advocates monitor inpatient and intermediate-level cases. These care advocates have specialized expertise in partnering with facilities and are in frequent contact—every one to three days—with the facility to track the Enrollee's progress, review treatment plans and determine discharge plans. Our goal is to maximize the effectiveness of the inpatient treatment setting while minimizing the length of stay. In the past for the MHSA Program, we have seen 20 percent of our network facilities agree to a modified level of care from what they originally requested. To decrease the need for readmissions, all Enrollees admitted to acute levels of care also receive discharge planning and follow-up.

Care advocates stay in frequent contact with facilities and serve as a partners and resources, reviewing previous treatment histories to identify and share barriers, adherence issues and precipitants; closing gaps in aftercare planning; and facilitating clinician interactions.

During the concurrent telephonic treatment review, the care advocate coordinates with the facility and treating doctors to ensure the treatment plan is appropriate and the least restrictive level of care.

As treatment progresses, the discharge plan is updated with each review according to the Enrollee's condition, level of functioning, degree of required supervision and support networks. This information helps determine the type of intermediate program best suited to the Enrollee's needs whether it is an alternative to inpatient care such as a residential program, partial hospitalization or intensive outpatient psychotherapy. Optum has an expansive provider network available to provide access to the most appropriate level of care.

Innovative Predictive Modeling

As mentioned, we use our innovative identification and stratification model, ISIE, (for identification, stratification, intervention and engagement), which focuses on specific clinical profiles for which we have identified common gaps in treatment care. ISIE's identification rules are based on risks arising from clinical gaps in treatment and adherence that are established by evidence-based medicine. The rules, along with corresponding interventions, were designed by a team of our behavioral health leaders, medical directors and analytics experts. The model includes eight high opportunity groups which are predicted to result in high claim expense if no additional, focused intervention is provided. Each group has required criteria that must be met for members to qualify for that particular group. These groups are: affective disorders; children and adolescents; chronic, non-adherent, high utilizers; early adult dependents; eating disorders; late-life confusional states; Medicare disabled who are under 65; and, substance use disorders.

We use predictive modeling and diagnostic benchmarks to determine the frequency and focus of concurrent reviews. Our internally developed predictive model takes into account key, weighted, relational data points about each Enrollee collected by our care advocates and identifies risk around the length of stay and/or readmission potential.

Using our predictive model, our case management system automatically populates the expected average length of stay next to the name of the attending physician and next to the facility, targeting continuing stay review interval points that take into account both Enrollee clinical information and facility clinical quality information. For those Enrollees scoring high risk for length of stay or readmission, our care advocates access a "Predict" tab on our case management system that displays the risk(s) that have been identified so that the care advocate can initiate high-risk discharge planning and case management.

Non-network Facilities

Should an Enrollee choose a non-network facility for inpatient care, our care advocate staff will communicate with the Enrollee, when able, in order to explain the benefits of choosing a network facility for inpatient care and the financial implications of going out of network. Our care advocates:

- Carefully inform Enrollees, or their designated representative, when they are considering or requesting certification for non-network care about the benefit coverage variables and the financial implications
- After a signed release of information, we will reach out to the families of Enrollees when we are advised that Enrollees are in treatment in a non-network facility to provide information and guide them through the treatment process, discharge planning, etc.
- Establish specific procedures to track Enrollees in non-network facilities, including involvement in planning for stepped-down levels of care, and working with the family in choosing the most effective post-discharge treatment setting
- Identify frequently used non-network facilities to broaden the range of choices for our Enrollees. A referral is given to our network management staff in order to contact the identified facility and discuss participation in the Optum network.

The majority of inpatient admissions to a non-network facility occur when an individual presents at the emergency room. In these cases, the emergency department routinely gathers information to determine benefit coverage and then contacts us for certification and a clinical consultation.

Complex Case Management – 18 to 26 year olds

As your previous MHSA Program provider, our specialized care advocates have experience working directly with Enrollees within the 18 to 26 year old dependent category diagnosed and/or being treated with a substance abuse disorder. With expanded coverage under the Affordable Healthcare Act, a variety of Optum's benefit plans have experienced an increased prevalence of dependents within this age group seeking treatment.

In 2011, the Empire Plan MHSA Program saw a significant increase in utilization of services within this age group. In response to this trend, we worked to develop a comprehensive psychosocial approach to treatment planning with the goal of helping the Enrollee achieve recovery and resiliency in his or her life by connecting them to the appropriate treatment provider as well as community resources. In addition, because this population often has gaps in psychosocial supports, complex medical-behavioral issues, require inpatient discharge follow-up, or are in crisis, we assigned a care advocate to work with the Enrollee as additional support during recovery.

The Enrollee and their assigned care advocate address the following issues over a period of time:

- Development and implementation of short term and long term recovery goals
- Updates on progress being made toward goals
- Medication and treatment adherence
- Current emotional state
- Additional referrals or resources needed such as community resources and peer/family support specialists

As your MHSA Program vendor, we developed special rounds for Enrollees of the MHSA Program seeking care in Florida to ensure we are providing the best possible care for these Enrollees at the most effective and affordable level of care to meet their needs.

(d) Discharge planning and follow-care; and

Optum care advocates who conduct concurrent review and discharge planning are experts in facility-based care. They coordinate with the facility and the provider who will be treating the Enrollee post-discharge to ensure an effective discharge and treatment plan.

We expect that providers will actively involve Enrollees and their families/significant others in their recovery goals and the post-discharge treatment plan. Recovery goals incorporate the Enrollee's strengths and individual needs. To help Enrollees move toward recovery during facility-based care, we assigned specialized care advocates to partner with facilities and work collaboratively with the facility treatment team.

We perform the following functions as part of discharge planning:

- Identify and address any barriers to the Enrollee's adherence to the discharge plan (e.g., ensuring the Enrollee has appropriate means to get to his or her follow-up appointments).
- Secure appropriate involvement of family and other members of the Enrollee's support system, as appropriate.

- Verify that supports are in place to ensure the Enrollee is taking his or her medications, as appropriate.
- Determine which physician will be prescribing any needed medications after the Enrollee leaves the hospital.
- Confirm that the Enrollee has a post-discharge appointment with a network provider, preferably within three working days of the discharge and no more than seven days post-discharge. We require the facility to make the appointment because our experience has shown that having the appointment in place before the patient leaves promotes treatment plan compliance.
- Ensure that the provider and Enrollee have appropriate information about and assistance accessing any community resources that may be beneficial to the Enrollee's continued recovery.

Enrollees are provided with written materials that contain information on their specific condition (i.e., educational materials on depression or substance abuse and the available, ongoing treatment options). We also provide providers with educational materials regarding best practices and state-of-the-art approaches to managing care for Enrollees post-discharge, and we follow up with both the provider and Enrollee as needed, based on risk assessment and progress in treatment.

Specialized Follow-Up for High Risk Cases

Enrollees who are at the highest risk for rehospitalization (based on scientifically proven risk criteria) or who have psychosocial barriers for treatment adherence receive follow-up with a more intensive focus. A care advocate will be assigned to the Enrollee stratified into the intensive high priority groups. This specialized care advocate will follow the Enrollee's progress and status of outstanding gaps at discharge and continue to assist in the short term recovery goals after discharge.

Planning for a successful discharge and aftercare program, the care advocate will:

- Conduct a comprehensive assessment to confirm the treatment is meeting the Enrollee's needs, identify any gaps in treatment or unmet needs, and address any benefit issues
- Make outreach calls to treating providers to discuss effective interventions, treatment plans and clinical best practices, based on the Enrollee's specific situation
- Make outreach calls to Enrollees in cases where Enrollee engagement in treatment may be an issue or if a Enrollee is no longer in treatment
- Mobilize additional resources (e.g., family, community services) to promote treatment compliance and improve outcomes
- Follow-up at regular intervals, as needed

These targeted interventions allow us to maximize the effectiveness of the treatment received in the outpatient setting and prevent the need for a return to a more intensive, higher level of care.

(e) Intensive case management of high risk cases.

As your previous MHSA Program vendor, we embedded our disease management/intensive case management program into our Program for the Empire MHSA Plan. The program cast a broad net across the health system to find high-risk Enrollees, regardless of where they enter the system. Our care advocates were able to focus clinical resources on high-risk complex (and potentially costly) cases where we can add the most value.

As part of our intensive case management process, the following Enrollees are automatically identified as high risk cases:

- Enrollees with major depressive disorders not responding to medication or therapeutic intervention
- Chronic, non-adherent, high utilizers identified by care advocates, nurses managing the NurseLine, nurses managing medical disease management cases or nurses managing chronic condition cases
- Eating disorders

We established cross-referral procedures for Enrollees with chronic medical conditions with unmet or under-met behavioral health needs. Enrollees may be referred for any psychosocial need (even financial, legal, or dependent care problems) that may be affecting their well-being. We also assisted Enrollees who were having difficulty making healthy lifestyle changes or complying with an agreed-upon treatment plan.

As a sister company of UnitedHealthcare, we offer an established interface with chronic condition nurses or NurseLine to ensure enhanced comanagement of care for co-occurring medical and behavioral diagnoses. We have developed integrated business processes that assess all high-risk medical Enrollees identified by the nurse for depression or anxiety, and then proactively offer these Enrollees behavioral health interventions.

Nurses use the Optum Referral Application (ORA) to refer Enrollees who agreed to outreach from the MHSA Program care advocate to discuss referrals for services. When new referrals are loaded into ORA they are automatically assigned to a care advocate who specializes in responding to the comorbid condition referrals.

Nurses may also warm transfer those Enrollees who agree to a MHSA referral directly to the CRL.

(2) Describe the software you will utilize to administer the concurrent UR program and any other technologies that will be used to apply UR.

LINX, our state-of-the-art integrated case management application, is designed to provide comprehensive consultation and resource services within a single application. LINX has been carefully designed to match the workflow of our clinical staff, providing an easy and convenient way to enter or find information about all aspects of an Enrollee’s care.

To administer the concurrent utilization review program, our care advocates use our utilization management application, PEGA Utilization Management Application (PUMA), which supports the clinical vision of recovery and resiliency with workflow tools that, depending on the Enrollee’s diagnosis, will ensure critical information is gathered consistently. We recently developed PUMA to further streamline and standardize the collection of clinical information with our providers and further simplify the way we document initial and concurrent facility reviews.

In addition, we use our Identification, Stratification, Intervention and Engagement (ISIE) predictive modeling capabilities to assist in performing our concurrent UR program. ISIE model not only identifies which Enrollees are likely to drive higher costs, but identifies the segment of the population that is subject to gaps in care, or issues with adherence, that are most likely to experience improved outcomes after care advocacy interventions. The assigned care advocate consults ISIE for the recommended interventions generated by the model for closing the care gaps that triggered an Enrollee's intensive stratification. While all Enrollees entering facility-based care benefit from the care advocacy provided by Optum's facility-based care advocates, individuals identified by ISIE as matching a high opportunity group are stratified for assignment to a designated advocate from our intensive care advocacy team. This team was designed exclusively to provide interventions to meet the needs of complex cases receiving facility-based care.

Using this approach, Optum's clinical framework improves our ability to identify groups of Enrollees with clinical similarities and common gaps in care (High Impact Opportunity Groups). We can then better address Enrollee needs where we can have the most impact on clinical, quality and efficiency outcomes. This allows specific Enrollee-focused solutions to identify and address treatment and recovery gaps beginning with admission.

In addition, the software gives our clinical staff the ability to search for outpatient network providers or alternate levels of care without leaving the Enrollee record. For example, a care advocate can find a provider by name or geographical proximity (with the capability to identify preferences for ethnicity, language, gender, expertise, licensure and accessibility), then proceed immediately to certify outpatient treatment. This feature is very well received by our facility partners to lessen the time spent on the phone with discharge planning.

Certification data placed in LINX by our clinical staff is transmitted daily to our UNET claims processing system through an upload process. Claims received that require certification are able to process for payment in a smooth, efficient manner.

(3) Completely describe the criteria used to establish medical necessity as defined by the MHSA Program and how medical necessity is determined.

Optum defines medically necessary services as those services that meet the following criteria:

- Are required to identify and/or treat a Enrollee's mental health and/or substance abuse problem
- Are consistent with the diagnosis and assessment of the disorder(s) or problem(s) identified
- Are consistent in type and amount with the standards of good clinical practice, as defined by standard clinical references
- Can reasonably be expected to improve the Enrollee's condition and/or level of functioning
- Are provided at the least intrusive level of care consistent with maintaining the Enrollee's safety

Determining Medical Necessity

We have developed a set of Level of Care Guidelines that provide objective and evidence-based admission and continuing stay criteria for mental health and substance abuse services offered by our clinician network. As a tool for clinical staff and our network providers, the guidelines are intended to standardize care advocacy decisions regarding the most appropriate and available level of care needed to treat a Enrollee's presenting problems, while allowing the flexibility to best serve each individual's needs.

Our Level of Care Guidelines are based on the following:

- Multi-disciplinary input from our nationwide clinician network
- Published references from the industry's most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine and DSM-IV-TR
- The broad clinical experience of Optum staff members

Care advocates and peer reviewers use the current Level of Care Guidelines as a reference when conducting clinical review activities.

Care advocates are licensed behavioral health professionals distinguished by their broad experience, the depth of their clinical skills and their active involvement in decisions about patient care. Our care advocates include specialized experts in substance abuse, child and adolescent disorders, eating disorders and post-traumatic stress reactions.

Peer reviewers are licensed psychologists or licensed psychiatrists with at least five years clinical experience. Our peer advisors are specialists in psychopharmacology, addiction, geropsychiatry, medical/psychiatric, eating disorders and the treatment of children and adolescents.

Guidelines are used in a flexible manner, and care management decisions are informed by the unique clinical aspects of the case and the treatment resources available to the Enrollee. Our Level of Care Guidelines are reviewed and updated on an annual basis.

(4) Explain which of the Offeror's staff (and their clinical licensure level) has the authority to deny payment for services rendered.

Optum Peer Advisors and Medical Directors have the authority to deny payment for services rendered. In the event that the level or type of care requested by the Enrollee, treating physician/practitioner, or facility does not appear to meet the criteria outlined in our Level of Care Guidelines, Coverage Determination Guidelines, and/or the Psychological and Neuropsychological Testing Guidelines, the care advocate will forward the case to a Peer Advisor for a clinical review, or will consult with an Optum Medical Director. At the time a case is forwarded to a Peer Advisor, the care advocate is to offer the treating physician/practitioner an opportunity to review the case by telephone with a Peer Advisor.

The purpose of a peer-to-peer discussion is to allow the treating physician/practitioner the opportunity to share new or additional information about the case that will assist the Peer Advisor in making a coverage determination. The role of the Peer Advisor is to exercise clinical judgment in reviewing the relevant information, and to review the case against the pertinent Level of Care Guidelines, Coverage Determination Guidelines, or Psychological and Neuropsychological Testing Guidelines, the Enrollee's benefit plan, available community resources, and individual Enrollee need.

Peer Advisors are psychiatrists, certified addiction medicine specialists and doctoral-level psychologists with competency in the same or similar specialty area, with an active, unrestricted license.

Medical Directors are licensed, board-certified psychiatrists or addiction medicine specialists with expertise in behavioral health and who oversees the Utilization Management program.

(5) Describe your utilization review process and confirm that it is parity compliant as required by MHPAEA.

Confirmed. We are able to align our prior certification and concurrent review processes with those of the Empire Plan Medical and Hospital Programs, in line with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Alignment is by MHPAEA classification: inpatient network, inpatient non-network, outpatient network, outpatient non-network and emergencies.

MHPAEA requires that behavioral health services are managed in a manner that is comparable to and no more stringent than medical/surgical services in the same classification. Since the majority of medical/surgical plans do not require prior authorization for routine outpatient services, our program does not require prior authorization of routine outpatient behavioral health services. We have modified our clinical management strategies to be compliant with MHPAEA regulations while providing an optimal level of quality and cost management.

We believe that requiring prior authorization for a small number of non-routine outpatient services is compliant with the requirements of MHPAEA and the Interim Final Rules. Most medical/surgical plans require prior authorization for select outpatient medical/surgical services. UnitedHealthcare for example, requires prior authorization for:

- Non-emergent ambulance
- Durable medical equipment
- Home health care
- Outpatient chiropractic rehabilitation services after 10 sessions
- Therapeutics outpatient – dialysis, intensity modulated radiation therapy (IMRT), magnetic resonance guided focused ultrasound

Several domains are used by the medical plans to determine when medical management, such as outpatient prior authorization requirements, is needed:

1. Practice variation/variability by
   a) Level of care
   b) Geographic region
   c) Diagnosis
   d) Provider/facility
2. Significant drivers of cost trend
   a) High unit cost
   b) High cost episode of care
3. Outlier performance against established benchmarks
4. Disproportionate utilization (“70/10 Rule”)
5. Outcome yield from the utilization management activity/administrative cost analysis

Based on the same domains we have identified a small number of select non-routine behavioral health outpatient services to be subject to a prior authorization requirement:

- Non-emergent admissions or higher levels of care

- Outpatient electro-convulsive treatment
- Psychological testing
- Extended outpatient treatment visits 50+ minutes in duration
- Applied Behavioral Analysis (ABA) for the treatment of autism

During our tenure as the MHSA Program vendor, we worked closely with the Department to ensure the MHSA Program was parity compliant.

(6) Describe the methods you utilize to measure MHSA Program effectiveness (Do not include any reference to specific monetary savings).

Optum has a designated team focused on the Health Care Quality and Affordability Process that is the foundation of our effectiveness measures. This process uses population data to identify outliers in specific populations or for specific levels of care. It is clinically designed to identify and monitor specific outcome measurements over time by tracking preliminary or leading indicators (authorization-based data outcome metrics) that alert us to the need to make adjustments to the MHSA Program. Assumptions based on leading indicators are then verified with paid claims data. The process enables us to not only track the immediate impact of the program but also costs associated with a total episode of care.

Inpatient follow-up rates and readmission rates, shown below for the MHSA Program, are grounded in the Health Care Quality and Affordability Process.

- [redacted]

[redacted]

[redacted]

These rates, which show stability or incremental improvements over time, indicate the effectiveness of inpatient follow-up in ensuring that Enrollees discharged from inpatient care remain stable or continue to progress in outpatient treatment. Progress in these measurements indicates the length of inpatient stay was appropriate determined by concurrent review, as well as the effectiveness of the discharge plan.

We also measure the percentage of cases with appointments scheduled within seven days and within 30 days of a hospital stay with favorable results. [redacted]

ALERT Outcomes Reporting

For the Optum book of business, members' responses to our follow-up Wellness Assessment allow us to report on both their clinical (Global Distress and Workplace Impairment) and health outcomes, as detailed below:

- **Clinical Outcomes.** Measured by comparing baseline Global Distress and Workplace Impairment (both absenteeism and presenteeism) scores against follow-up assessment scores. Adult and Youth results for both Global Distress and Workplace Impairment are reported separately.

- **Health Outcomes.** Shows Enrollee self-reported changes (separated by those who have medical conditions and those who do not) in health. This section of the report compares the percent of Enrollees who reported "good to excellent health" and the percent who reported three or fewer medical visits at baseline against those who reported the same (or the absence of) at follow-up.

Our 2012 Wellness Assessment results for our book-of-business are detailed below.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]

- [redacted]
- [redacted]

[redacted]

[redacted]

- [redacted]
- [redacted]
- [redacted]

Continually Monitoring Effectiveness

Our Quality Improvement Program is designed to define and continuously monitor quality of care and service indicators and continuously monitor performance compared against established goals and benchmarks, including quality and effectiveness of care. These indicators are included in the Annual QI Work Plan and performance on these indicators is reported routinely to internal and external stakeholders. This information is to trend changes over time, identify opportunities for improvement, and implement corrective actions when necessary.

(7) Confirm that you will adhere to the Empire Plan Mixed Services Protocol.

Confirmed. We will adhere to the Empire Plan Mixed Services Protocol.

(8) Will you be providing the Empire Plan with a dedicated Clinical team including the Medical Director and Clinician Referral Line staff? Please provide an organizational chart that indicates the titles and number of people associated with the Clinical team.

Yes. we are providing a dedicated clinical team that includes 38 dedicated clinical team staff members, including a dedicated clinical director and medical director. We have provided the organization chart as Attachment 1 and we have allocated the following staff to work on the Empire Plan MHSA Program account:

- Account Services - [redacted] [redacted]
- Enrollment – [redacted] [redacted] [redacted]
- Claims processing – [redacted] [redacted]
- Clinical Staff – [redacted]
- Customer Service – [redacted]

(9) Outpatient Treatment UR Guarantee: The MHSA Program's service level standard requires that at least ninety percent (90%) of outpatient treatment plans be reviewed and the Provider and Enrollee notified within twelve (12) Business Day of receipt of the report, calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of outpatient treatment plans that the Offeror reviews and does not notify the Enrollee

and Provider within twelve (12) Business Day of receipt of the report is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee) of outpatient treatment plans not reviewed and the Enrollee and Provider notified within twelve (12) Business Day of receipt of the report as reported quarterly and calculated on an annual basis, is $____.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of outpatient treatment plans not reviewed and the Provider notified within twelve (12) Business Day of receipt of the report, as reported quarterly and calculated on an annual basis is [redacted]

(10) Inpatient Treatment UR Guarantee: The MHSA Program's service level standard requires that at least ninety percent (90%) of requests for authorization of inpatient care be reviewed and completed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider be notified within one (1) Business Day of the determination calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety percent (90%) of requests for authorization of inpatient care that are not reviewed within twenty- four (24) hours from the receipt of the request the Enrollee and Provider notified within one (1) Business Day of the determination, is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety percent (90%) (or the Offeror's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request and the Enrollee and Provider notified within one (1) Business Day of the determination as reported quarterly and calculated on an annual basis, is $____.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee of requests for authorization of inpatient care that are not reviewed within twenty-four (24) hours from the receipt of the request the Enrollee or Provider notified within one (1) Business Day of the determination, as reported quarterly and calculated on an annual basis is [redacted]

Disabled Dependent Determinations

During the term of the Agreement, the Contractor shall be responsible for making Disabled Dependent Determinations for dependents with a disability that is Mental Health and Substance Abuse related. Disabled dependents of NYSHIP enrollees are entitled to be covered under the Enrollee's family coverage beyond the normal age-out limits if those dependents are incapable of self support. For The Empire Plan, the medical program contractor determines disability status for those with physical disabilities and the mental health Contractor determines disabled status for mental health and substance abuse related disabilities. An Application for Coverage for your

Disabled Dependent Child for Medical, Dental and/or Vision Coverage (form PS-451) , see Exhibit II.is completed by the Enrollee, the Dependent's Physician and, the Enrollee's employer and then evaluated by the Contractor to determine if the Dependent is disabled. All determinations are subject to re-review by the Contractors on a periodic basis. The following guidelines are used for all disabled Dependent reviews:

If improvement of the Dependent's condition is:

- **"Expected," the case will be normally reviewed within six to eight months, unless the Contractor determines a need for a more frequent review.**
- **Possible," the case will be normally reviewed no sooner than three years, unless the Contractor determines a need for a more frequent review.**
- **"Not expected," the case will normally be reviewed no sooner than seven years, unless the Contractor determines a need for a more frequent review.**

a. Duties and Responsibilities

(1) The Contractor must establish a process to perform reviews of the PS-451 form and all additional medical information for mental health and substance abuse- related dependent disabilities. The review must be completed in the United States (preferably in New York State) and a clinical determination must be completed within ten (10) Business Days of receipt of a complete form.

(2) The Contractor must send a determination letter, approved in advance by the MHSA Program, to the Enrollee and to the Department advising of the determination within three (3) Business Days of the determination.

We confirm our ability to meet the Disabled Dependent Determinations Duties and Responsibilities as detailed above.

b. Required Submission

(1) Provide a description of your process when evaluating disabled Dependent status.

Confirm that the Offeror will review the PS-451 form and all additional medical information required to make a clinical determination within ten (10) Business Days of receipt of a complete form.

To evaluate disabled dependent status for MHSA Program coverage, our evaluative process draws on any relevant clinical, educational or vocational information that will facilitate a fair and accurate determination of this benefit for the Enrollee. This information includes the current provider's report on the PS-451 form, as well as educational and/or vocational records that are provided with the submission.

In the event that there is insufficient information to render a determination of the Enrollee's disability status for continued benefit coverage, additional information is requested the same day that this need is identified.

Optum approaches all submissions for the PS-451 benefit with sensitivity to the Enrollee's current difficulties. Our evaluation focuses on the Enrollee's current level of functioning and treatment; his or her past functioning and treatment history; and the prognosis for his or her improved functioning in the short-term, the mid-term and the longer term.

Determinations fall into four broad categories:

1. Is the Enrollee eligible for any level of disability benefit?
2. Is the Enrollee’s condition more short term and situational in nature? If so, this would grant disability status, but for a period of time when the Enrollee’s level of functioning can reasonably be expected to improve to level of self-sufficiency. Often this is a period of twelve months.
3. Is the Enrollee’s condition more long term and chronic in nature? If so, this would indicate disability status should be granted for longer period of time. However, permanent disability would not be granted if there is a reasonable possibility that improved medications and/or continued vocational rehabilitation programs can enable the Enrollee to function at higher level and possibly not require disability in the future. Often disability is granted for a period of 36 months in these situations.
4. Is the Enrollee’s condition of such a serious and pervasive nature that the granting of permanent disability is clinically indicated?

Timeline for Review and Clinical Determination

We confirm that we will review the PS-451 form and all additional medical information required to make a clinical determination within 10 business days of receipt of a complete form.

(2) Confirm that the Offeror will send a letter to the Enrollee and to the Department advising of the determination within three (3) Business Days of the determination.

Confirmed. We will send a letter to the Enrollee and to the Department advising of the determination within three business days of the determination.

Appeal Process

When UR results in a decision to deny authorization or reduce the level of services authorized, and the denial is based on medically necessary, experimental or investigational treatment, members may appeal to the Contractor any utilization review decisions. The appeals committee shall make a determination within ten (10) Business Days of the receipt of the necessary medical records. The Contractor will comply with the utilization review process requirements and external appeal process found in Article 49 of NYS Insurance Law, as amended.

a. Duties and Responsibilities

The Contractor must:

(1) Perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer;

Confirmed.

(2) Administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment, including:

Confirmed.

(a) Developing a clinical appeal form and criteria for establishing medical necessity and experimental or investigational treatment;

Confirmed.

(b) Reviewing clinical appeals for medical necessity and experimental or investigational treatment and preparing communications to notify Enrollees of the outcome of appeals; and

Confirmed.

(c) Integrating the appeal decisions into the clinical management and claims processing systems.

Confirmed.

(3) Establish two levels of internal clinical appeals as follows:

Confirmed.

(a) A level 1 clinical appeal must be performed by an independent Peer Advisor; and

Confirmed.

(b) A level 2 clinical appeal must be conducted by a panel of two board-certified psychiatrists and a Clinical Manager who work for the Contractor. Panel members must not have been involved in the previous determinations of the case.

Confirmed.

(c) Clinical Appeals must be completed in a timely manner consistent with NYS and federal laws:

Confirmed.

(i) For a second level clinical appeal of a post-service claim, within thirty (30) days of the member's request;

Confirmed.

(ii) For a second level clinical appeal of a pre-service request for benefits, within fifteen (15) days of the member's request; and

Confirmed.

(iii) For clinical appeals involving urgent situations, in no more than seventy- two (72) hours following receipt of the appeal.

Confirmed.

(4) Oversee and enforce the MHSA Program's appeal processes including reporting the results of the administrative, clinical and external appeal processes for the MHSA Program to the Department in the format and frequency required in the "Reporting" section of this RFP;

Confirmed.

(5) Respond to all External Appeals on behalf of the Department as requested by the New York State Department of Financial Services through a process that provides an opportunity for Enrollees and Dependents to appeal where denied coverage on the

basis that a service is not medically necessary or is an experimental or investigational service.

Confirmed.

(6) Inpatient Appeal Guarantee: The Contractor must guarantee that at least ninety-five percent (95%) of level one appeals for inpatient care shall be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis; and

Confirmed.

(7) Outpatient and Alternate Level of Care Appeal Guarantee: The Contractor must guarantee that at least ninety-five percent (95%) Outpatient Care and Alternative Levels of Care level one appeals shall be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Contractor having made and documented three (3) written or telephonic attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

We confirm our ability to meet the Clinical Management: Appeal Process Duties and Responsibilities as detailed above.

b. Required Submission

(1) Confirm the Contractor will perform administrative (non-clinical) appeals in a timely manner by an employee of the Contractor with problem-solving authority above that of the original reviewer.

Confirmed. If an appeal involves an administrative (non-clinical) matter, it is reviewed in a timely matter by an employee of Optum with problem-solving authority above that of the original reviewer. In the event that a request involves a service that may not be a covered benefit, the case is referred to the Vice President of Clinical Operations or designee for an administrative review. Examples of these types of situations are:

- A request for services in situations where the enrollee is not eligible for benefits.
- A request for services in situations where the enrollee has exhausted his/her allotment of benefits.
- A request for services that are excluded under the terms of the enrollee's benefit plan and for which clinical consideration is not relevant to coverage.

(2) Confirm the Contractor will administer an expeditious, HIPAA and PPACA compliant internal clinical appeal process which allows Providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

Confirmed. We will administer an expeditious and HIPAA- and PPACA-compliant internal clinical appeals process for the MHSA Program which allows providers and/or Enrollees to appeal denied coverage on the basis of medical necessity or an experimental or investigational treatment.

Expeditious

[redacted]

HIPAA- and PPACA-Compliant Internal Clinical Appeal Process

We routinely monitor regulatory and compliance issues on any state/federal laws and regulations that may have measurable impact on the services we provide, including HIPAA and PPACA. Our corporate legal department and corporate compliance department share responsibility for keeping us informed about regulatory changes affecting our appeals processes.

When utilization review results in a decision to deny authorization or reduce the level of services authorized, and that decision is based on medically necessary or experimental or investigational treatment, a provider, facility, Enrollee or Enrollee’s authorized representative may appeal the adverse determination verbally or in writing.

Two levels of appeal will be available for the MHSA Program and, for medically necessary or experimental/investigative denials, an external Independent Appeal Review may be requested following the level one appeal determination.

(3) Describe in detail how you would administer the required appeal processes for the Program, including:

For initial adverse determinations based on failure to meet medical necessity guidelines or for treatment deemed experimental and investigative, Enrollees or providers have the opportunity to appeal that decision. The MHSA Program offers two levels of appeals. Enrollees or providers will receive a letter of the adverse determination including instructions on how to appeal the decision as well as information regarding applicable timelines for submitting the appeal.

Level One Appeals

A qualified peer advisor performs all level one clinical appeals. Peer advisors are psychiatrists or PhD-level psychologists who have a minimum of five years of clinical experience. Peer advisors conducting the appeal will not have been previously involved in the original adverse determination.

The peer advisor assigned to the case will review the clinical documentation and contact the treating provider to discuss the case and basis for appeal. This telephonic discussion is completed within the applicable timeframe. Once a determination is rendered, the Enrollee and provider will be informed verbally and in writing of the decision. If the decision is to overturn the original adverse determination, the provider is notified verbally and the certification is entered into our LINX clinical case management system to send certification letters to the Enrollee and provider.

Should the appeal be upheld, the provider is offered second-level appeal options. Both the Enrollee and the provider will receive written confirmation of this decision in a "Final Adverse Determination" document and in accordance with New York State Insurance Law, Article 49, they will receive external appeal rights conducted by the New York State Department of Financial Services.

Appeal decisions are entered into LINX as well in the event the Enrollee or Provider contacts the CRL for the outcome. Written notification sent to the Enrollee includes:

- The outcome of the appeal review
- The rationale for the appeal decision
- Instructions for requesting a copy of the relevant information that was used to make the determination
- The titles and qualifications of the peer advisor who conducted the appeal review
- Information about requesting a level two appeal or an external appeal

Level Two Appeals

If the Enrollee is dissatisfied with the outcome of the level one appeal, he or she may request a level two appeal. Level two appeals will be available when a peer advisor has made a non-certification determination on a request for initial or continued treatment, and a level one appeal has upheld the non-certification decision. The process for level two appeals will be the same for inpatient, outpatient and ALOC cases.

Level two appeals will be performed by an independent review committee comprised of two board-certified psychiatrists not involved in the prior determinations; and Optum's Clinical Director or an appropriate designee. None of the committee members will have been involved in the original adverse determination or first-level appeal.

The level two independent review committee will reach and submit a review determination within 10 business days of receipt of the medical records necessary to conduct the review. Written notification will be sent to the Enrollee and includes:

- The outcome of the appeal review
- The rationale for the appeal decision
- Instructions for requesting a copy of the relevant information that was used to make the determination
- The titles and qualifications of the independent review committee members who participated in the decision

In addition to fully complying with all stated Program requirements and insurance laws, our clinical appeals process empowers Enrollees, providers and facilities to become active participants in the process by providing multiple avenues of communication at all times. Our goal is to foster a collaborative relationship between Optum, Enrollees, providers and facilities to ensure that Enrollees get the most clinically appropriate care in the least restrictive setting, understanding that the right clinical care is invariably the most cost-effective.

(a) Turnaround time;

The following table details our turnaround times for our appeals process, which are consistent with Program requirements and performance standards.

	Turnaround Time	
	Level One Appeal	*Level Two Appeal*
Inpatient	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

(b) Qualifications of the staff that would conduct the reviews for administrative and level 1 and level 2 clinical appeals;

Level one clinical appeal reviews are conducted by Optum peer advisors who are psychiatrists or Ph.D.-level psychologists with at least five years of clinical experience. Peer advisors will make the determination to uphold, modify or overturn the previous adverse benefit determination or level one appeal. Peer advisors conducting the appeal will not have been previously involved in the original adverse determination.

Level two clinical appeal reviews are conducted by an independent review committee comprised of two Optum board-certified psychiatrists and Optum’s clinical director or an appropriate designee. None of the committee members will have been involved in the original adverse determination or first-level appeal.

Optum psychiatrists have a minimum of five years of post-licensure experience, an unrestricted license to practice medicine, completion of an accredited psychiatric residency program and certification by the American Board of Psychiatry and Neurology.

(c) Description of the criteria that would be used to determine whether the care is medically necessary or experimental and/or investigational;

Optum will certify reimbursement for services that are medically necessary for the presenting case. To determine whether care is medically necessary, we ensure services meet the following criteria:

- Are medically required based on our Level of Care Guidelines
- Have a strong likelihood of improving the Enrollee’s condition
- Appropriate for the specific diagnosed condition in accordance with both generally accepted mental health practices and the professional and technical standards adopted by Optum
- Sufficient to meet the specific treatment goals and lessen the individual’s symptoms

Level of Care Guidelines are a general point of reference. Our expert staff of care advocates and peer reviewers also fully take into account the unique needs of the individual Enrollee and any mitigating circumstances impacting him or her that may not fall into any of the above categories.

Care advocates are licensed behavioral health professionals distinguished by their broad experience, the depth of their clinical skills and their active involvement in decisions about patient care. Our care advocates include specialized experts in substance abuse, child and adolescent disorders, eating disorders, and post-traumatic stress reactions.

Peer reviewers are licensed psychologists or licensed psychiatrists with at least five years clinical experience. Our peer advisors are specialists in psychopharmacology, addiction, geropsychiatry, medical/psychiatric, eating disorders and the treatment of children and adolescents.

Level of Care Guidelines

We use our Level of Care Guidelines, which provide objective and evidence-based support for care advocacy decisions, regarding the level of care. Level of Care Guidelines provide objective and evidence-based admission and continuing stay criteria for mental health and substance abuse services offered by our provider network. They are intended to standardize care advocacy decisions regarding the most appropriate and available level of care needed to treat an Enrollee’s presenting problems, while taking into account the specific needs of each individual.

Our Level of Care Guidelines are based on the following:

- The broad clinical experience of Optum staff members
- Multi-disciplinary input from our nationwide provider network
- Published references from the industry’s most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, and DSM-IV-TR

Care advocates and peer reviewers use the current Level of Care Guidelines when conducting clinical review activities. Guidelines are used in a flexible manner, and care advocacy decisions are informed by the unique clinical aspects of the case and the treatment resources available to the Enrollee.

The initial draft of our Level of Care Guidelines was written by a multidisciplinary panel of actively practicing clinicians with recognized expertise in various mental health and substance abuse diagnostic areas. We continually revise and update these Guidelines on an ongoing basis to reflect changes in the mental health field.

Best Practice Guidelines

In addition to our level of care and coverage determination guidelines, we have adopted best practice guidelines from leading national organizations. A practice guideline is a set of patient care strategies developed to assist providers in making treatment decisions, based on scientific evidence or expert consensus, and to promote evidence-based care.

The guidelines we have adopted are from external nationally recognized organizations: the American Psychiatric Association and the American Academy of Child and Adolescent

Psychiatry. They cover a number of, but not all, diagnostic categories, but include high-volume diagnostic categories and disorders that have significant evidence of being high risk.

Experimental and Investigative Treatment

We regularly evaluate and address new developments in behavioral health technology/therapy and new applications of existing technology/therapy for inclusion in medical policy and Enrollee benefit packages. Our Clinical Technology Assessment Committee (CTAC) has a formal process by which clinical evidence is compiled and reviewed with respect to certain behavioral health services. The CTAC meets monthly at a minimum of 10 meetings per year.

(d) Do you currently administer an appeals process as described above for other MHSA Programs? If yes, provide the number of appeals you review annually and the approval and denial rates for a client similar to the MHSA Program (for the most recent calendar year); and

Yes. We currently administer an appeals process as described above for other MHSA Programs. [redacted]

(e) How is the Enrollee's care handled during the appeal process?

Our goal is to ensure MHSA Program Enrollees are in the right level of care at the right time. However, should an adverse determination occur and an appeal be requested, our care advocates make every effort to stay connected with the Enrollee or his or her designated representative during the appeals process.

Except in very rare instances when it has been determined that an Enrollee does not require any clinical treatment, our care advocates offer treatment at an alternative level of care at the time an adverse clinical decision is issued and/or has been upheld on appeal.

For concurrent inpatient determinations that have received a denial, while the appeal is being processed, the care advocate will continue to review the case with the facility utilization review staff to be able to assist with discharge planning. The care advocate will facilitate discussions with the provider and assist with any transfer or appointments to a level of care that would be supported by Optum's Level of Care Guidelines and medical necessity determination.

We also work to find a referral that is a good fit good fit for the Enrollee, incorporating feedback from the family and facility into the Enrollee's recovery plan. We also follow-up with the Enrollee and/or his support system to ensure that he or she is satisfied with the recovery plan and receipt of services.

(4) Confirm that you will interface with the New York State Department of Financial Services' External Appeals Process to provide an opportunity for Enrollees and Dependents to appeal denied coverage on the basis that a service is not medically necessary or is an experimental or investigational service.

Confirmed. As the former MHSA Program vendor, we have experience interfacing with the New York State Department of Financial Services (DFS) for external appeals that have been requested. During our tenure as MHSA Program vendor, DFS contacted Optum directly with any questions and our MHSA Program care advocacy center is compliant with all requirements of the external appeal process as detailed in the New York State Insurance Law, Article 49.

(5) Inpatient Appeal Guarantee: The MHSA Program's service level standard requires that at least ninety-five percent (95%) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis. The Offeror shall propose the forfeiture of a specific dollar amount of the Administrative Fee for failure to meet this guarantee.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of level one appeals for inpatient care that are not be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal as reported quarterly and calculated on an annual basis, is $.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of level one appeals for inpatient care must be reviewed by a Peer Advisor and a determination made within one (1) Business Day of the receipt of the appeal, as reported quarterly and calculated on an annual basis is [redacted]

(6) Outpatient and ALOC Appeal Guarantee: The MHSA Program's service level standard requires that at least ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals must be reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal. Cases in which there has been no success in contacting the Provider despite the Offeror having made and documented three (3) aggressive attempts will be included as having met the standard. Cases in which the Provider is unavailable to discuss the appeal or to provide information necessary to the disposition of the appeal, causing the appeal's disposition to extend beyond the required timeframe, will be included as having met the standard. This standard will be calculated on an annual basis.

The standard credit amount for each .01 to 1.0% below ninety-five percent (95%) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal is $10,000 per year. However, the Offeror may propose higher or lesser amounts.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of ninety-five percent (95%) (or the Offeror's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business

Days of the receipt of the appeal, as reported quarterly and calculated on an annual basis is $.

The Offeror's quoted amount to be credited against the Administrative Fee for each .01 to 1.0% below the standard of [redacted] (the Offeror's proposed guarantee) of Outpatient Care and Alternative Levels of Care level one appeals that are not reviewed by a Peer Advisor and a determination made within two (2) Business Days of the receipt of the appeal, as reported quarterly and calculated on an annual basis is [redacted]

13. Other Clinical Management Programs

a. Duties and Responsibilities

(1) The Contractor must provide voluntary opt-in programs for Depression Management, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD). The cost of the Depression Management, Eating Disorder and ADHD Programs shall be included in the Administrative Fee. The programs must include:

Confirmed.

(a) a method to identify members with depression, eating disorders and ADHD using screening tools, both on-line and by mail;

Confirmed.

(b) methods to educate members about the symptoms, effects and treatment of depression, eating disorders and ADHD;

Confirmed.

(c) accepting referrals to Network Providers;

Confirmed.

(d) telephonic support, coordination with treating providers and referrals to community services; and

Confirmed.

(e) a method to establish contact with Empire Plan primary care physicians, and other medical specialists likely to have patients that present with symptoms of depression, eating disorders and ADHD in order to educate medical Providers about the availability of the depression, eating disorder and ADHD programs.

Confirmed.

(2) The Offeror may propose other voluntary opt-in programs which are available at no additional cost. The Department reserves the right to decide whether or not to participate in any program offered and the right to opt out of any program at any time.

Confirmed.

b. Required Submission

(1) Describe the depression management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

As the former vendor of the Empire Plan MHSA Program, we developed a Depression Management Program specifically for Empire Plan Enrollees 18 years and older. The customized program provided education, support and online resources for individuals and their family members, suffering from or at risk for depression. The program benefits the MHSA Program and Enrollees by providing tailored interventions to support newly diagnosed individuals and those dealing with depression. Our program offers Enrollees the hands-on specialized support they need to manage depression and effectively deal with its effects on their overall health and well-being.

The program was built on the most current evidence-based guidelines and was promoted within both the MHSA provider and primary care network. We identified factors that fell outside best treatment guidelines enabling us to proactively manage costs and enhance outcomes for the Empire Plan MHSA Program and Enrollees. The following subsections detail the components of the Depression Management Program and describe how we deliver the program to the benefit of the MHSA Program and Enrollees.

Data-Driven Identification

We used various methods to identify Empire Enrollees 18 years and older who were newly diagnosed with depression including behavioral health claims data, behavioral health providers, primary care physicians, care advocates, the Empire Plan Medical Program disease management programs, the Behavioral, Medical, Pharmacy Synergy Team (BMPS), employee assistance program (EAP) referrals and self-referrals. Collaborating with these resources was a key component to raising awareness and educating Enrollees on the benefits of the program and drove increased successful outcomes.

Potential participants who were newly diagnosed with a major depressive disorder (MDD) or bipolar disorder were identified by MHSA claims data. Data was analyzed to identify Program Enrollees with a depressive disorder diagnosis for early detection to aid in treatment and recovery.

In re-launching this program, we can increase our ability to identify depression cases by leveraging the Empire Plan Pharmacy Program data. On a monthly basis, we can analyze antidepressant pharmacy claims provided by the Department or vendor to identify Enrollees who are newly starting, restarting and frequently switching antidepressants who would be eligible for the program. This would allow us to identify cases of under-treated depression, a key outcome and cost-management capability. Additionally, pharmacy claims data can be used to monitor for non-adherence to prescribed treatment with antidepressants.

Our care advocates routinely screen for depression and respond according to the urgency of the case—making sure that Enrollees receive the right care at the right time within our network. For newly diagnosed Enrollees, we will send educational materials via mail over an extended period of time to encourage the Enrollee to call if he/she is ready to engage in services. By identifying these Enrollees earlier in the process, we are able to provide the treatment and support services they need and help avoid the need for higher levels of care in the future.

Once in treatment with a network clinician, Enrollee can complete a Wellness Assessment, which measures their depression symptoms and risk factors at the beginning of treatment. Through our outcomes management program for outpatient care, ALERT, results of these assessments, along with claims data, help us identify high-risk Enrollees with depression or Enrollees who are not improving in treatment. The care advocate will call the treating clinician to discuss the case and flag it for further follow-up to promote progress and improvement through treatment.

Educating Enrollees About Their Diagnosis

Enrollees receiving an initial diagnosis of depression (as well as Enrollees identified through pharmacy data-mining) will receive periodic mailings with information to help them understand the importance of follow-through, treatment plan compliance and adjunctive psychotherapy with medication therapy. They are also directed to the customized Empire Plan Depression Management Enrollee website **www.liveandworkwell.com** for additional support. Enrollees can opt out of the program by calling us and asking to be taken off the mailing list.

Each mailing contains a selection of articles on depression and its treatment. (Please refer to Attachment 20 for sample educational materials). Examples include:

- Depression
- Dealing with Depression: Recognition and Acceptance
- Depression and Substance Abuse
- When Anxiety and Depression Coexist
- Treatment Options for Depression
- Depression Treatment
- Coping with Stress
- Resource List (a list of support groups and community resources)
- The Five Levels of Resiliency

In addition, we developed a customized Depression Program Flyer for the Empire Plan MHSA Program, which is used to promote the program to Enrollees and their covered dependents. Enrollees are also provided with a list of support groups and community resources.

Because of our relationship with UnitedHealthcare, we can leverage the communications with the medical network to actively communicate the importance of depression screening. The program expands our identification opportunities by screening for depression and anxiety across the health care continuum.

Enrollee Website

Our Enrollee portal **www.liveandworkwell.com** promotes early awareness, detection and prevention of depression through information, assessments, self-help tools, articles and resources. It has been designed to help anyone affected by depression—adults, children, adolescents, post-partum mothers and those experiencing symptoms related to seasonal affective disorder. From the Empire Plan MHSA Program customized home page, **www.liveandworkwell.com**, Enrollees will be able to link directly to the Depression Management Program. The Program has a dedicated and customized site.

The online Depression Management Program section gives Enrollees access to:

- A brief, anonymous self-appraisal (screening tool)
- Informational articles that address different aspects of each condition
- A list of national organizations with contact information and links to their websites

- Instructions on contacting Optum care advocates for assistance

On the Depression Condition Center Web page, Enrollees find an extensive library of articles on depression and its treatment, as well as an interactive self-help program that will provide Enrollees with techniques for dealing with depression. These programs help Enrollees understand the signs and symptoms of depression and encourage them to seek help through the clinician search function on the site, which matches Enrollees with clinicians who are close to home or work, have clinical specialization in the treatment of depression (adults or children/adolescents), and any needed language or cultural competencies.

Having a centralized, reliable and free source of pertinent health information saves Enrollees hours of searching multiple websites and other resources for the support they need. Unique to Optum and a sister site to liveandworkwell.com, **www.mentesana-cuerposano.com** is specifically tailored for Spanish-speaking Enrollees and can be available if approved by the Department.

Provider Education and Resources

On the *For Providers, Physicians, and Clinicians* page of **www.liveandworkwell.com**, we post information on co-occurring conditions, links to nationally recognized practice guidelines for these conditions, and materials that can be printed out and given to patients. In addition, this site serves as a resource for behavioral health practitioners who are treating patients with comorbid behavioral and medical disorders. For example, the section on depression includes articles on depression specifically geared to clinicians and medical providers as it relates to various medical disorders.

To ensure network practitioners can use these resources to improve treatment outcomes for our Enrollees, we have created a direct link from Provider Express (providerexpress.com), our website for network clinicians. To further promote the program a letter can be sent to high-volume Empire Plan primary physicians educating them on the Depression Management Program and Individualized Case Management Program, described below, available under the MHSA Program.

Individualized Case Management (ICM) Program

Enrollees 18 years and older with a diagnosis of major depressive disorder (MDD) or bipolar disorder can participate in the voluntary Individualized Case Management (ICM) Program. ICM participants are closely monitored by a care advocate with specialization in depression treatment protocols who will provide additional support, care coordination, referrals and assistance in accessing care. Enrollees may be referred to the ICM Program by several different methods:

- Medical director or care management team based on inpatient admission
- UnitedHealthcare medical program
- Treating provider
- Behavioral health claims and authorization data
- Self-referral

Enrollees referred to the ICM Program receive the following:

- Invitation letter asking Enrollees to join the program
- If no response is received from the Enrollee after the initial invitation letter, a few outreach calls will be placed by a clinical operations staff person to invite the Enrollee to the program and increase engagement.
- Once the Enrollee has agreed to participate in ICM, the care advocate facilitates an introduction to the patient, establishes a working rapport with the patient, identifies and resolves with the patient barriers and/or problems with the treatment plan and monitor the patient's status and progress. Outreach calls are made based upon clinical need (and as agreed to by Enrollee). Calls are made first on a weekly basis and then moving to monthly and quarterly as the Enrollee becomes more compliant with their overall treatment plan and as their functioning improves.
- Assistance with treatment planning and care coordination to ensure that the Enrollee has a coherent treatment plan across all providers of care that is within the patient's scope of understanding and compliance.

When interacting with Enrollees, the ICM care advocate uses motivational interviewing and coaching techniques to partner with the Enrollee to set goals/outcomes based on the Enrollee's readiness to change. Care advocates emphasize recovery and resiliency by using a thought-provoking and creative coaching process designed to inspire the Enrollee to maximize personal potential. Care advocates are trained to listen, observe and customize their approach to individual Enrollee needs, seeking to build solutions and strategies with the Enrollee that leverage the Enrollee's skills, resources and creativity. Coaching provides an excellent tool for uncovering problems or needs, and helps Enrollees determine what they want, what they are committed to accomplish and how much change they are able to make.

Inpatient Follow-up to Prevent Rehospitalization

All Enrollees who are hospitalized for depression will receive post-discharge follow-up and support from an assigned care advocate for up to 90 days. The care advocate will promote treatment plan adherence, support community tenure and help reduce the need for readmission. In addition, any Enrollees with dual diagnosis (depression and substance abuse) will receive intensive follow-up for up to six months post-discharge. Adult Enrollees who have been admitted for depression also receive periodic educational mailings. As described above, each mailing contains a selection of articles on depression and its treatment, and we include an additional article appropriate for hospitalized Enrollees entitled, *"The Five Levels of Resiliency."*

Monitoring Adherence to Evidence-Based Treatment Within Our Network

Our clinical staff and network clinicians use best practice guidelines to ensure that the provision of depression treatment is consistent with industry best practices and evidence-based medicine—adopted from the American Psychiatric Association and American Association of Child and Adolescent Psychiatry. These best practice guidelines are made available to clinicians through our clinician Web portal, Provider Express. In addition, we developed a supplemental, measurable guideline for MDD, which is also posted on **www.providerexpress.com**.

We monitor adherence to these best practice guidelines within our network through our Clinician Quality Initiative (CQI), which measures individual clinician performance against specific criteria. For MDD, the following clinical quality indicators are reviewed:

- The Enrollee receives four outpatient visits within eight weeks of diagnosis.
- The clinician is using both psychotherapy and antidepressant medications.
- There is evidence of sustained use of medication for a minimum trial of six to eight weeks before considering dosage adjustments or medication changes during the acute phase of an initial episode of major depressive disorder with continued medication use for at least 16 to 20 weeks after symptom remission.
- For Enrollees who have been admitted to the hospital for depression, the first post-discharge outpatient appointment occurs within seven days of discharge.

Promoting Evidence-Based Treatment with Primary Care Physicians

Our Depression Management Program supports the treatment of depression in the primary care setting. With more than 70 percent of antidepressants prescribed in the primary care setting before the recommended minimum 180 days of therapy, promotion of evidence-based treatment is an important part of our program.

As the former MHSA Program vendor, we worked in conjunction with the Department to develop and send communications to medical physicians. Physicians were identified through pharmacy claims data and other means tailored for the disease management program (ie, ADHD, Depression). Should Optum be named MHSA Program vendor, we would be pleased to explore additional strategies for communicating with the Empire Plan's high-volume primary physcians, including providing information on depression for the Department's Enrollee communications.

We will work to promote awareness of all the Empire Plan MHSA Program elements (including the Depression Management Program) through various methods, including articles published in the Optum Provider Newsletter, *Network Notes* and the Provider & Physicians Corner section of our website contains information about treatment best practices.

(2) Describe the eating disorder management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

As your former MHSA Program provider, we developed an eating disorder program specifically for the Department. The Empire Plan Eating Disorders Program provided education, support and resources for families and individuals with an eating disorder. The program benefitted the MHSA Program and Enrollees by providing individualized, tailored support for individuals diagnosed with an eating disorder. This was an opt-in program distinguished by the following:

- Interventions were targeted toward specific groups of Enrollees based on their individual issues and current status (those seeking services, recently hospitalized, newly diagnosed and engaged in outpatient treatment).
- The program educates all Enrollees with current information about the early detection and treatment of eating disorders.

- The program includes access to educational materials and resources on the Empire Plan customized Enrollee portal including self-care tips, educational articles, information for family members and resources for physicians. A confidential, online risk appraisal tool will be developed and customized for Enrollees.
- Enrollees receive intensive support through the Individualized Case Management (ICM) Program (detailed below) that provides specific and targeted care based on disease progression and promotes recovery and resiliency.
- The program improves treatment outcomes and reduces the risk of relapse for adolescents and adults who have been diagnosed with eating disorders by providing them with information related to the condition and its treatment, as well as information that promotes treatment compliance.
- In addition, the program provides education on clinical best practices through our provider website for behavioral health clinicians and primary physicians treating Enrollees with eating disorders.

Licensed care advocates assess Enrollees during intake and, based on this evaluation, we assign Enrollees to one of the following target groups:

- **Group 1:** All Enrollees covered by Optum
- **Group 2:** Enrollees and their covered dependents seeking services for eating disorders
- **Group 3:** Enrollees and their covered dependents hospitalized for an eating disorder
- **Group 4:** Enrollees and their covered dependents newly diagnosed and engaged in outpatient treatment.

Our clinical interventions for these target groups are highlighted below:

Group 1

All Enrollees. Everyone has access to materials on our customized Enrollee website, **liveandworkwell.com**. These materials include educational resources such as a self-help guide, articles and support groups, as well as resources for family members and loved ones. We provide this information, as well as clinical guidelines and a flier for distribution to patients, to behavioral health providers and primary physicians.

Group 2

Enrollees and their covered dependents seeking services for eating disorders. Parents of Enrollees up to 18 years old (or the Enrollee, him or herself, if over 18 years old) who call the CRL for services for an eating disorder are invited to participate in the Eating Disorder Program. If they express interest and have questions, a care advocate will follow up with them to describe the program in detail. If they agree to participate in the program, we mail information about the particular eating disorder and its treatment options. We will also direct them to supportive resources on the Enrollee portal. In addition, they will be offered ICM services (described below), which include a dedicated care advocate who will work with the Enrollee throughout the course of treatment, providing outreach and support, as needed.

Group 3

Enrollees and their covered dependents hospitalized for an eating disorder. Enrollees who have recently been hospitalized are recruited to participate in the program after discharge. Enrollees are identified through periodic authorization reports specific to eating disorder diagnoses. Enrollees receive an invitation letter to the individualized case management services, whereby the Enrollee is assigned to a care advocate experienced in eating disorder treatments who follows him/her throughout the course of treatment. The program will be presented to the Enrollee/family as part of the inpatient follow-up program, if clinically appropriate. If the Enrollee, or their parents, agrees to participate in the program, they will receive the same mailing as identified for Group 2, plus additional educational articles. All participants will be informed that they can opt out of the program at any time.

Group 4

Enrollees and their covered dependents newly diagnosed and engaged in outpatient treatment. Enrollees are identified for participation by behavioral health claims reports analyzed on a quarterly basis. These reports aid case managers in identifying Enrollees who have been newly diagnosed and are currently receiving outpatient treatment for an eating disorder. Using these reports, we reach out to the patient (age 18 or older or the parents if the patient is under age 18) and invite them to participate in the program. If they agree to participate, they will be sent mailings about the eating disorder, its diagnosis and treatment, with an additional mailing about relapse prevention. In addition, they will be offered individualized case management services, which includes a dedicated care advocate who will work with the Enrollee throughout the course of treatment, providing outreach and support as needed.

Individualized Case Management Services

Enrollees in Group 2 and Group 3 above who receive individualized case management services (ICM) services will be assigned a dedicated care advocate who follows the Enrollee throughout the course of treatment. The dedicated care advocate will perform an introductory outreach call to the Enrollee (or the Enrollee’s parents) to describe the program and its services, encourage the Enrollee to obtain information from the MHSA Program website and provide them with a way to contact the care advocate if they require additional services or assistance. The care advocate contacts the Enrollee at 30, 60 and 180 days, or more frequently if needed, providing care coordination, referrals and assistance in accessing community resources. The goals of this program include promoting recovery, resiliency and reducing the likelihood of readmission.

Once treatment is initiated, care advocates closely monitor patient outcomes. They measure progress on meeting goals established by the clinician and patient, including improvement in weight, adherence to a healthy nutrition plan, eliminating restricting and purging behaviors, correction of medical problems, addressing comorbid conditions, correcting eating behaviors, improving self-esteem and helping with family issues. Because of the high risk and complex nature of eating disorders, our eating disorder experts review these cases at the onset of treatment to ensure progress, coordination of care and professional collaboration with providers.

Enrollee portal

From the customized home page, **www.liveandworkwell.com**, Empire Plan Enrollees can link directly to the Eating Disorder Management program. Each program has a dedicated and customized site which provides topic-specific information and support including: self-help program links, health risk assessments, expert information links, videos/peer stories, access to forums, latest topic news feeds, Webinars, popular articles, self-paced learning and expert advice. From the Empire Plan customized home page **www.liveandworkwell.com**, Enrollees can link directly to the Eating Disorder Management program.

Communication and Educational Materials for all Enrollees

In addition to educational materials on the dedicated Empire Plan MHSA Program website, **www.liveandworkwell.com**, Enrollees have access to self-care tools to support their recovery including relevant articles, goal setting guides, and referrals to external resources like support groups and associations. We also provide educational materials to assist family members and loved ones in supporting the patient in their recovery.

Sample communications and mailings include:

- Anorexia Nervosa
- Bulimia Nervosa
- Through Thick and Thin: Supporting a Love One with an Eating Disorder
- When Someone You Love Has Bulimia
- Healthy approaches to food and exercise
- Healthy view of self to help avoid eating disorders
- Recognizing the Signs and Symptoms of Anorexia and Bulimia
- Eating Disorder Program Flyer

We have included sample eating disorder communications as Attachment 21.

Provider Education and Resources

Optum network clinicians can access material about eating disorders and treatment on the Optum provider portal, Provider Express, under the Empire Specific page. In addition, this site serves as an excellent resource for behavioral health practioners who are treating patients with comorbid behavioral and medical disorders. On the *For Providers, Physicians and Clinicians* page of our website, we post information on co-occurring conditions, and materials that can be printed out and given to patients.

We also engage in interventions with Optum network clinicians and primary physicians. We work to promote awareness of all the Empire Plan MHSA Program elements (including the Eating Disorders Program) through various methods, including articles published in the Optum Provider Newsletter, *Network Notes and the Empire Plan Network News mailings.* The Provider & Physicians Corner section of our website contains information about treatment best practices, and we mail program communications to treating providers with information on how to refer Enrollees, assessment and treatment resources and offering supportive materials for use with Enrollees.

(3) Describe the ADHD management program that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees. Provide samples of communication material that you propose to use in the MHSA Program.

We developed a customized Attention Deficit Hyperactivity Disorder (ADHD) Program for the MHSA Program that provided education, support and resources for Enrollees and their covered dependents that may have ADHD. The ADHD Program focused on improving treatment outcomes and reducing the risk of chronic behavior problems for dependents age 17 and younger who have been newly diagnosed with ADHD.

ADHD interventions are targeted to the needs of specific groups of Enrollees, provides information and resources that promote treatment compliance, and provide current information about the early detection and treatment of ADHD. The program also provided education and feedback to behavioral health clinicians and primary physicians treating Enrollees with ADHD.

The ADHD Program targets the following populations:

- **Group 1:** All Enrollees covered by Optum;
- **Group 2:** Children age 17 and younger and their families who are seeking behavioral health treatment;
- **Group 3:** Children age 17 and younger who have been newly diagnosed with ADHD.

There are differing interventions for the groups of Enrollees as described below. For the Optum network clinicians and primary physicians the interventions are the same for all groups.

Group 1

Interventions for all Enrollees consist of access to a series of online educational articles aimed at early identification and treatment of the ADHD on the customized Empire Plan MHSA Program website with a direct link to the ADHD program. The Web-based resources include an appraisal tool that screens for ADHD. The tool is interactive and provides immediate results. If the Enrollee screens potentially positive for ADHD, it provides direction to support the Enrollee’s parents in obtaining assistance on their behalf by contacting the Empire Plan MHSA Program Clinical Referral Line. In addition to providing the clinical services phone number, the website has a number of tips and resources (including educational materials, support groups and agencies) for parents and caregivers. In addition, there is a segment that is targeted at behavioral health clinicians and primary physicians which aids them in providing care and resources to support their patients. The areas include: Empire-specific fliers for distribution to their patients, articles and resources such as support groups as well as clinical guidelines.

Group 2

When a care advocate determines that an Enrollee would be appropriate for the ADHD Program, he or she gives the Empire Plan MHSA Program website, **liveandworkwell.com**, which gives them access to all of resources described above in Group 1 and offers to add the parents to the educational mailing list. If agreed, they will send additional targeted mailings to the patient’s home.

Group 3

Enrollees newly diagnosed with ADHD will receive access to the educational articles on the ADHD Program's website as well as direct mailings with educational material on ADHD, its diagnosis and treatment as described above. The interventions are designed to improve treatment outcomes by increasing understanding of the condition and its treatment as well as the importance of treatment compliance.

Enrollee Portal

All Enrollees will have access to ADHD materials on the customized MHSA Program website, **www.liveandworkwell.com**. Information includes self-help program links, expert information links, videos/peer stories, access to forums, latest topic news feeds, information for families and others, Webinars (self-paced learning), popular articles, medication logs and other health management forms, as well as expert advice. Resources also include a brief, anonymous ADHD appraisal and instructions on how to contact Optum dedicated staff for help seven days a week, 24 hours a day.

Communication and Educational Materials for all Enrollees

In addition to educational materials on the MHSA Program website, Enrollees will have access to self-care tools to support their recovery including relevant articles, goal setting guides and referrals to external resources like support groups and associations. We also provide educational materials to assist family members and loved ones in supporting the patient in their recovery.

Sample communications (directed at the parent) that we have distributed in the past include:

- ADHD Info and Advice for Parents
- Treatment Options for Your Child's ADHD
- Medications Used to Treat ADHD
- Declaration of Independence: Developing Life Skills for Teens with Learning Disabilities
- Resource List
- ADHD Health Care Appointment Log
- ADHD Child Activity and Behavior Log
- ADHD Medication Log
- ADHD Program Flyer

We have included sample ADHD communications as Attachment 22.

Provider Education and Resources

On the *For Providers, Physicians and Clinicians* page of our website, we post information on co-occurring conditions, and materials that can be printed out and given to patients. In addition, this site serves as an excellent resource for behavioral health practioners who are treating patients with comorbid behavioral and medical disorders.

We also engage in interventions with Optum network clinicians and primary physicians. We will work to promote awareness of all the MHSA Program elements (including the ADHD

Program) through various methods, including articles published in the Optum Provider Newsletter, *Network Notes*, and the *Empire Plan Network News*. We also send periodic communications to the Empire Plan primary physicians and pediatricians to promote awareness of the ADHD Management Program and to alert physicians of the resources available to MHSA Program Enrollees with ADHD and to educate them on ADHD treatment best practices. Primary physicians can also access Enrollee and provider-oriented materials on ADHD and its treatment, as well as the American Academy of Child and Adolescent Psychiatry's *Practice Parameter for the Assessment and Treatment of Children, Adolescents, and Adults with Attention-Deficit/Hyperactivity Disorder* as described above.

The Provider & Physicians Corner section of our website contains information about treatment best practices, and we mail program communications to treating providers with information on how to refer Enrollees, assessment and treatment resources and offering supportive materials for use with Enrollees.

Monitoring the Program

We monitor the ADHD Program through the following means:

- Overall "hits" on the website are gathered on a monthly basis. This information is analyzed to identify the specific sections of the website that were viewed by the Enrollee.
- The number of Enrollees in Group 3 who received mailings is tabulated on an ongoing basis.

Number of communications sent to providers treating Group 4 Enrollees and the type of communications they are receiving.

(4) Please describe any other voluntary clinical management or utilization review programs that you are proposing to administer for the MHSA Program. Include a detailed description of how the program operates and its benefit to the MHSA Program and Enrollees.

Please see below for information on voluntary clinical management programs we are proposing to administer for the MHSA Program.

Behavioral, Medical, Pharmacy Synergy Team (BMPS)

Optum facilitated clinical representatives from both the Empire Plan MHSA and medical teams to participate in a synergy initiative to improve the coordination of care for Empire Plan Enrollees. This initiative coordinated care within the respective programs as well as identifying opportunities for cross referrals to other Empire programs that may be available to the Enrollee. During our tenure as MHSA Program vendor, representatives from the MHSA Program, the Medical Program and the Pharmacy Program held monthly multi-disciplinary meetings to facilitate and enhance education, synergy and management of complex cases with medical, pharmacy and behavioral health attributes.

During these meetings, each team brought expertise to a select group of cases that were identified as having opportunities to improve care and support medication compliance and adherence. Ideas and suggestions were shared on how to improve the management of the Enrollee's disease state, drug regimen and overall quality of life. Clinical care advocates incorporated the collective input gained through these group meetings into their continued management of cases. The meetings have resulted in the identification of opportunities in Empire's population for cross referrals and improved outcomes.

Should we be selected to administer the MSHA Program, we would like to offer the Department the opportunity to continue this initiative. Should the Department approve continuance of the BMPS team on behalf of Empire Plan Enrollees, we would welcome the opportunity to include a clinical pharmacist from the Empire Prescription Drug Plan, Caremark, and the medical director from Empire Plan Hospital program to ensure we continue to consider the very critical aspect of medication management in the case evaluations. We are happy to discuss the details of establishing protocols and procedures that would facilitate this inclusion. In addition, we will work with our medical program counterparts to establish and encourage integrated medical-behavioral collaboration.

Promoting Coordination between Behavioral and Medical Practitioners

We recognize that an Enrollee's medical doctor holds important information about the Enrollee's physical health that may be relevant to his or her mental health assessment and treatment. Equally important is making sure that a medical condition is not exacerbated by a mental health/chemical dependency condition. The Optum BMPS Team can offer a more effective treatment plan if communicating with both medical and behavioral providers.

Alcohol and Other Drug Disorders Prevention Program

The Optum Prevention Program for Alcohol and Other Drug (AOD) Disorders is a program designed to provide all Enrollees with current information about the early detection and treatment of alcohol and other drug abuse/dependence. It is also designed to improve treatment outcomes and reduce the risk of relapse for adults who have been diagnosed with alcohol and/or other drug abuse/dependence by providing them with information related to the condition and its treatment, information that promotes treatment compliance, as well as the principles of resilience and recovery.

Educating Enrollees About Their Diagnosis

The AOD Prevention Program targets three overlapping populations:

- **Group 1:** All enrollees covered by Optum
- **Group 2:** Enrollees 18 and older who have been newly diagnosed with AOD
- **Group 3:** Enrollees 18 and older who are currently authorized for Inpatient level of care with AOD diagnosis.

Group 1

From the customized home page, **www.liveandworkwell.com**, Empire Plan MHSA Program Enrollees will be able to link directly to the AOD Program. Interventions for all Enrollees consist of access to the educational articles on Alcohol and Other Drug Disorders. These interventions are aimed at early identification and treatment of the AOD. In addition to providing the Empire Plan MHSA Program Clinical Referral Line information, the website has a number of tips and resources (including educational materials, support groups and agencies) for Enrollees. There is also a segment that is targeted toward behavioral health clinicians and primary care physicians which aids them in providing care and resources to support their patients. The areas include: articles and resources such as support groups and clinical guidelines.

The website is divided into five sections:

- Confidential Alcohol and Drug Abuse Appraisal (Screening)
- Enrollee Educational Articles
- Practitioner and Clinician Educational Articles
- Information on how to contact Clinical Referral Line for assistance
- Family and Loved One Educational Articles
- Online computer based interactive program

All Enrollees would be informed of the AOD Program through Department communications if approved.

Group 2

Enrollees who receive an initial diagnosis of AOD will receive an educational mailing with information to help them understand the importance of follow-through, treatment plan compliance, and adjunctive psychotherapy with medication therapy. The mailing contains an introductory letter and a brochure on Alcohol and other Drug Abuse including its recognition and treatment. (Please refer to Attachment 23 for sample educational material, “The Road to Recovery”).

They are also directed to the Prevention and Condition Centers on our Enrollee website **www.liveandworkwell.com** for additional support and educational materials. Enrollees can opt out of the program by calling us and asking to be taken off the mailing list.

The interventions for Group 2 are designed to improve treatment outcomes by increasing understanding of the condition and its treatment as well as the importance of treatment compliance.

Group 3

Enrollees who have been given an authorization for Inpatient services with a diagnosis of AOD also receive access to the educational articles on the Prevention Program’s website as well as direct mailings. The interventions for Group 3 are designed to improve treatment outcomes by increasing understanding of the condition and its treatment as well as the importance of treatment compliance.

Enrollee portal

From the customized home page, **www.liveandworkwell.com**, Empire Plan MHSA Program Enrollees can link directly to the AOD Program which provides topic-specific information and support including: self-help program links, expert information links, videos/peer stories, access to forums, latest topic news feeds, computer based interactive training, popular articles, self-paced learning and expert advice.

Sample communications on the website include:

- Addictive Substances
- Alcohol Dependence (Alcoholism)
- Binge Drinking – Is it worth risking your life?
- Recognizing Substance Abuse and Dependency

The portal will include online Computer Based Training interactive programs to help Enrollees recognize and take steps early to address alcohol and drug use issues.

Monitoring the Program

We monitor the AOD Program through following means:

- Overall “hits” on the website are gathered on a monthly basis. This information is analyzed to identify the specific sections of the website that were viewed by the Enrollee.
- The number of Enrollees in Group 3 who received mailings is tabulated on an ongoing basis.

(5) If you are proposing to receive a data feed from the Empire Plan’s Prescription Drug Program to be used as a method to identify members with depression, eating disorders and ADHD, please include a copy of your Non-Disclosure Agreement you have executed with CaremarkPCS Health, LLC.

[redacted]

Attachments

Attachment 1 - Optum Empire Plan MHSA Program Org Chart

Attachment 1-1
May 20, 2014

[redacted]

Attachment 2 - Biography Sketches

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]			[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted].

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted]

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: Prepare this form for each key staff individual, including subcontractor provided key staff, if any.

Name: [redacted]
Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]		

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted]

Attachment 2-7
May 20, 2014

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted]

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

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INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

[redacted] [redacted]

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]
1985-1997	UnitedHealthcare	Claims Processor Empire Medical

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Exhibit I.B - BIOGRAPHICAL SKETCH FORM

INSTRUCTION: **Prepare this form for each key staff individual, including subcontractor provided key staff, if any.**

Name: [redacted]

Job Title: [redacted]

Relationship to Project: [redacted]

EDUCATION

Institution & Location	Degree	Year Conferred	Discipline
[redacted]	[redacted]	[redacted]	[redacted]

PROFESSIONAL EMPLOYMENT (Start with most recent.)

Dates From - To	Employer	Title
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

PROFESSIONAL EXPERIENCE (Significant experience/education relevant to program)

[redacted]

Attachment 3 - Sample Implementation Plan

Empire Plan Project Plan

ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
0	**Empire Plan Project Plan**	**71 days**	**Wed 10/1/14**	**Wed 1/7/15**	**NA**		
1	**Initiation**	**5 days**	**Wed 10/1/14**	**Tue 10/7/14**	**NA**	**Implementation Manager**	
2	**Sales Debrief**	**5 days**	**Wed 10/1/14**	**Tue 10/7/14**	**NA**	**Implementation Manager**	
3	New Business Form Complete & PM Assigned	1 day	Wed 10/1/14	Wed 10/1/14	NA	Ewing Faye	
4	Schedule & Conduct Sales Debrief Meeting	1 day	Mon 10/6/14	Mon 10/6/14	NA	Implementation Manager	
5	Obtain Client, Consultant, and Medical Vendor Conta	1 day	Tue 10/7/14	Tue 10/7/14	NA	Implementation Manager	
6	**Planning**	**11 days**	**Wed 10/1/14**	**Wed 10/15/14**	**NA**	**Implementation Manager**	
7	**Detailed Project Plan**	**3 days**	**Wed 10/1/14**	**Fri 10/3/14**	**NA**	**Implementation Manager**	
8	Draft custom project plan	3 days	Wed 10/1/14	Fri 10/3/14	NA	Implementation Manager	
9	Complete Project Communication Plan (Rasci)	1 day	Thu 10/2/14	Thu 10/2/14	NA	Implementation Manager	
10	Integrate Accum Ops and Issue Resolution Plans	1 day	Wed 10/1/14	Wed 10/1/14	NA	Implementation Manager	
11	Complete Risk Management Plan	1 day	Thu 10/2/14	Thu 10/2/14	NA	Implementation Manager	
12	**Kick Off Meeting**	**10 days**	**Thu 10/2/14**	**Wed 10/15/14**	**NA**	**Implementation Manager**	
13	Schedule kick off meeting with Civil Service and GOE	3 days	Thu 10/2/14	Mon 10/6/14	NA	Ewing Faye	
14	Draft kick off meeting agenda	1 day	Tue 10/7/14	Tue 10/7/14	NA	Implementation Manager	
15	Kick Off Meeting complete	1 day	Wed 10/15/14	Wed 10/15/14	NA	Implementation Manager	
16	**Execution**	**65 days**	**Wed 10/1/14**	**Tue 12/30/14**	**NA**		
17	**Data Setup & Collection**	**16 days**	**Thu 10/16/14**	**Thu 11/6/14**	**NA**		
18	**Gather Plan Information**	**16 days**	**Thu 10/16/14**	**Thu 11/6/14**	**NA**	**Implementation Manager**	
19	Confirm benefit plan designs for 2015	10 days	Thu 10/16/14	Wed 10/29/14	NA	Implementation Manager	
20	Obtain copies of any benefit letters from Civil Serv	1 day	Thu 10/30/14	Thu 10/30/14	NA	Implementation Manager	*UHC will forward as received
21	Confirm account structure with group breakouts	1 day	Thu 10/30/14	Thu 10/30/14	NA	Implementation Manager	
22	Finalize 2015 Benefit and Structure	1 day	Thu 11/6/14	Thu 11/6/14	NA	Implementation Manager,Clie	*UNET MHSA structure already in pla
23	**Clinical Model Sign-off**	**6 days**	**Thu 10/30/14**	**Thu 11/6/14**	**NA**		
24	Confirm clinical model matches medical plans for	1 day	Thu 10/30/14	Thu 10/30/14	NA	BPAC	

Empire Plan Project Plan

ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
25	Client Approval	5 days	Fri 10/31/14	Thu 11/6/14	NA	Client	
26	**Pricing Confirmation**	**15 days**	**Thu 10/16/14**	**Wed 11/5/14**	**NA**		
27	UW Finalizes Pricing	10 days	Thu 10/16/14	Wed 10/29/14	NA	Underwriting	
28	Client Approves Pricing	5 days	Thu 10/30/14	Wed 11/5/14	NA	Client	
29	**Benefit Compliance**	**1 day**	**Thu 10/30/14**	**Thu 10/30/14**	**NA**		
30	**ASO**	**1 day**	**Thu 10/30/14**	**Thu 10/30/14**	**NA**	**Underwriting**	
33	**Case Installation**	**26 days**	**Fri 11/7/14**	**Fri 12/12/14**	**NA**		
34	**Plan Design**	**5 days**	**Fri 11/7/14**	**Thu 11/13/14**	**NA**	**SAE**	
35	Optum sends final MHSA benefit plans to UHC	5 days	Fri 11/7/14	Thu 11/13/14	NA	Implementation Manager	
36	**Account Structure**	**6 days**	**Fri 11/7/14**	**Fri 11/14/14**	**NA**	**Implementation Manager**	
37	Optum confirms account structure with UHC	3 days	Fri 11/7/14	Tue 11/11/14	NA	Implementation Manager,Gol	
38	UHC loads account structure	3 days	Wed 11/12/14	Fri 11/14/14	NA	Golden Allison S	*UNET MHSA structure already in pla
39	**Benefit Load**	**21 days**	**Fri 11/14/14**	**Fri 12/12/14**	**NA**	**Account Installation**	
40	Begin Benefit Load to UNET and IBAAG	1 day	Fri 11/14/14	Fri 11/14/14	NA	Golden Allison S	*Previous benefits in IBAAG can be ut
41	Complete Benefit Load to UNET and IBAAG	15 days	Mon 11/17/14	Fri 12/5/14	NA	Golden Allison S	
42	Load all account information into CBMS	1 day	Mon 11/17/14	Mon 11/17/14	NA	Implementation Manager	*Account details already loaded; new
43	Benefits QA	5 days	Mon 12/8/14	Fri 12/12/14	NA	Pooley Donna J	
44	**Eligibility**	**17 days**	**Mon 11/17/14**	**Tue 12/9/14**	**NA**	**Implementation Manager**	
45	**Gather Requirements**	**5 days**	**Mon 11/17/14**	**Fri 11/21/14**	**NA**	**Implementation Manager/El**	
46	Confirm format, frequency are same as previous c	3 days	Mon 11/17/14	Wed 11/19/14	NA	Golden Allison S,Pooley Do	
47	Cobra Requirements	5 days	Mon 11/17/14	Fri 11/21/14	NA	Golden Allison S,Pooley Do	
48	**Eligibility File Setup**	**7 days**	**Thu 11/20/14**	**Fri 11/28/14**	**NA**	**Implementation Manager/El**	
49	Map Eligibility File	5 days	Thu 11/20/14	Wed 11/26/14	NA	Golden Allison S,Pooley Do	
50	Test Eligibility File	2 days	Thu 11/27/14	Fri 11/28/14	NA	Golden Allison S,Pooley Do	
51	**Production**	**7 days**	**Mon 12/1/14**	**Tue 12/9/14**	**NA**	**Eligibility Analyst**	
52	Load Initial File	5 days	Mon 12/1/14	Fri 12/5/14	NA	Golden Allison S,Pooley Do	*Load will be in batches

Empire Plan Project Plan

ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
53	QA Load	1 day	Mon 12/8/14	Mon 12/8/14	NA	Golden Allison S,Pooley Do	
54	Confirm Load Stats with AM / Client	1 day	Tue 12/9/14	Tue 12/9/14	NA	Golden Allison S,Pooley Do	
55	**Account Reporting**	**9 days**	**Thu 10/16/14**	**Tue 10/28/14**	**NA**	**SAE**	
56	**Establish Reporting Needs**	**5 days**	**Thu 10/16/14**	**Wed 10/22/14**	**NA**	**SAE**	
57	Establish Clinical, Financial, and Other Reporting	5 days	Thu 10/16/14	Wed 10/22/14	NA	Ewing Faye	
58	**Confirm Delivery Method**	**4 days**	**Thu 10/23/14**	**Tue 10/28/14**	**NA**	**Implementation Manager**	
59	Determine Reporting Frequency	2 days	Thu 10/23/14	Fri 10/24/14	NA	Ewing Faye,Coy Thomas K	
60	Determine Reporting Delivery Method	2 days	Mon 10/27/14	Tue 10/28/14	NA	Ewing Faye,Coy Thomas K	
61	**Accumulators**	**10 days**	**Thu 10/16/14**	**Wed 10/29/14**	**NA**		
62	**Legal Agreements**	**10 days**	**Thu 10/16/14**	**Wed 10/29/14**	**NA**	**SAE**	
63	NDA In-Place	1 day	Thu 10/16/14	Thu 10/16/14	NA	Ewing Faye	
64	BAA In-Place	1 day	Thu 10/16/14	Thu 10/16/14	NA	Ewing Faye	
65	Confirm UHC will act as gatekeeper for accumulat	10 days	Thu 10/16/14	Wed 10/29/14	NA	Pooley Donna J	
66	**Contract**	**65 days**	**Wed 10/1/14**	**Tue 12/30/14**	**NA**	**SAE**	
67	**PGs**	**33 days**	**Thu 10/16/14**	**Mon 12/1/14**	**NA**	**SAE**	
68	Determine PG Reporting Frequency	3 days	Thu 10/16/14	Mon 10/20/14	NA	Ewing Faye	
69	Identify Standard & Non-Standard PGs	3 days	Tue 10/21/14	Thu 10/23/14	NA	Ewing Faye	
70	Determine Measurement Source	1 day	Fri 10/24/14	Fri 10/24/14	NA	Ewing Faye	
71	PG Language Finalized in Contract	5 days	Mon 11/10/14	Fri 11/14/14	NA	Ewing Faye	
72	PGs Distributed to Operational Areas & Setup in t	1 day	Mon 12/1/14	Mon 12/1/14	NA	Ewing Faye	
73	**Contract Distribution**	**54 days**	**Thu 10/16/14**	**Tue 12/30/14**	**NA**	**SAE**	
74	Determine Internal & External Contacts	1 day	Thu 10/16/14	Thu 10/16/14	NA	Ewing Faye	
75	Determine Delivery Method	1 day	Thu 10/16/14	Thu 10/16/14	NA	Ewing Faye	
76	Distribute Executed Contract as Appropriate	1 day	Tue 12/30/14	Tue 12/30/14	NA	Ewing Faye	
77	**Contract**	**64 days**	**Wed 10/1/14**	**Mon 12/29/14**	**NA**	**SAE**	
78	AD-X Completed for Contract Creation / Amendme	3 days	Wed 10/1/14	Fri 10/3/14	NA	Ewing Faye	
79	Contract Review and Negotiation	30 days	Mon 10/6/14	Fri 11/14/14	NA	Ewing Faye	
80	Contract Signed and Executed	20 days	Tue 12/2/14	Mon 12/29/14	NA	Ewing Faye	

Empire Plan Project Plan

ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
81	**Clinical Operations Readiness**	**42 days**	**Wed 10/1/14**	**Thu 11/27/14**	**NA**		
82	**Engage Clinical Resources**	**10 days**	**Wed 10/1/14**	**Tue 10/14/14**	**NA**	**Implementation Manager,C**	
83	Confirm clinical team leadership	5 days	Tue 10/7/14	Mon 10/13/14	NA	Ewing Faye	
84	Determine clinical team assignments/structure	1 day	Tue 10/14/14	Tue 10/14/14	NA	Director Clinical Ops	
85	Assign program manager to lead transition of care	1 day	Wed 10/1/14	Wed 10/1/14	NA	Director Clinical Ops	
86	**Transition of Care**	**25 days**	**Wed 10/15/14**	**Tue 11/18/14**	**NA**	**Implementation Manager**	
87	Review TOC Options with Client	1 day	Wed 10/15/14	Wed 10/15/14	NA	Implementation Manager	
88	Confirm TOC Details/Timeframe	10 days	Thu 10/16/14	Wed 10/29/14	NA	Implementation Manager	
89	Determine Pre-Launch Strategy	5 days	Thu 10/30/14	Wed 11/5/14	NA	Implementation Manager	
90	Determine TOC Reporting requirements	5 days	Thu 11/6/14	Wed 11/12/14	NA	Implementation Manager	
91	Confirm TOC plan with ValueOptions	3 days	Thu 11/13/14	Mon 11/17/14	NA	Implementation Manager	
92	Execute TOC Strategy Including System Setup &	1 day	Tue 11/18/14	Tue 11/18/14	NA	Implementation Manager	
93	Determine TOC Notification Requirements	10 days	Thu 10/16/14	Wed 10/29/14	NA	Implementation Manager	
94	Determine TOC Payment Level	10 days	Thu 10/16/14	Wed 10/29/14	NA	Implementation Manager	
95	Send TOC Details to Clinical, TA, & Communicati	1 day	Thu 10/30/14	Thu 10/30/14	NA	Implementation Manager	
96	**Appeals**	**31 days**	**Thu 10/16/14**	**Thu 11/27/14**	**NA**	**Implementation Manager**	
97	**Appeals Process**	**11 days**	**Thu 10/16/14**	**Thu 10/30/14**	**NA**	**Implementation Manager**	
98	Identify Compliance Director	1 day	Thu 10/16/14	Thu 10/16/14	NA	Ewing Faye	
99	Determine any changes to previous appeals w	5 days	Fri 10/17/14	Thu 10/23/14	NA	Appeals Director	
100	Meet with Client to Discuss Appeals Process &	5 days	Fri 10/24/14	Thu 10/30/14	NA	Appeals Director	
101	**Appeal Escalation Process**	**15 days**	**Fri 10/31/14**	**Thu 11/20/14**	**NA**	**Implementation Manager**	
102	Determine 1st, 2nd, and Subsequent Levels	5 days	Fri 10/31/14	Thu 11/6/14	NA	Appeals Director	
103	Document Appeals Process	10 days	Fri 11/7/14	Thu 11/20/14	NA	Appeals Director	
104	**Appeal Letters**	**5 days**	**Fri 11/21/14**	**Thu 11/27/14**	**NA**	**Appeals Director**	
105	Client Reviews Appeal Letters	5 days	Fri 11/21/14	Thu 11/27/14	NA	Client	*Confirm if any changes needed for pr

Empire Plan Project Plan

ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
106	**Network**	**51 days**	**Thu 10/16/14**	**Thu 12/25/14**	**NA**	**SAE**	
107	Obtain high volume provider list for recruitment	5 days	Thu 10/16/14	Wed 10/22/14	NA	Implementation Manager	
108	Determine if any provider nominations requested	10 days	Thu 10/16/14	Wed 10/29/14	NA	Implementation Manager	
109	Begin recruitment and contracting for HV and nomina	1 day	Thu 10/23/14	Thu 10/23/14	NA	Network Lead	
110	Complete contracting of HV and nominated providers	45 days	Fri 10/24/14	Thu 12/25/14	NA	Network Lead	
111	Determine notification plan to providers of Empire cor	15 days	Thu 10/16/14	Wed 11/5/14	NA	Network Lead	
112	**Staffing**	**64 days**	**Wed 10/1/14**	**Mon 12/29/14**	**NA**	**Director Clinical Ops**	
113	**Create Staffing Plan**	**8 days**	**Wed 10/1/14**	**Fri 10/10/14**	**NA**		
114	Determine Staffing Needs for Each Functional Are	5 days	Wed 10/1/14	Tue 10/7/14	NA	Ewing Faye	*Confirm reassignment of previously c
115	Determine Start Dates	1 day	Wed 10/8/14	Wed 10/8/14	NA	Implementation Manager/ Cli	
116	Determine New Hire Orientation and Training Date	1 day	Thu 10/9/14	Thu 10/9/14	NA	Implementation Manager/ Cli	
117	Complete and Submit Requisition for Each Positio	1 day	Fri 10/10/14	Fri 10/10/14	NA	Director Clinical Ops,Ewing	
118	**Hire Staff**	**60 days**	**Wed 10/1/14**	**Tue 12/23/14**	**NA**	**Director Clinical Ops**	
119	Post Positions Internally and Advertise Externally	1 day	Thu 10/9/14	Thu 10/9/14	NA	Meinert Rachel J	
120	Begin Interviews for Empire Dedicated Staff	1 day	Fri 10/10/14	Fri 10/10/14	NA	Byra Tracey M	
121	Complete 68% Hire/Re-Assignment of Staff	30 days	Mon 10/13/14	Fri 11/21/14	NA	Byra Tracey M	
122	Complete 92% Hire/ Re-Assignment of Staff	44 days	Wed 10/1/14	Mon 12/1/14	NA	Byra Tracey M	*Necessary staff in place to take calls
123	Complete 100% Hire/ Re-Assignment of Staff	60 days	Wed 10/1/14	Tue 12/23/14	NA	Byra Tracey M	
124	**On-Boarding**	**36 days**	**Mon 11/10/14**	**Mon 12/29/14**	**NA**	**Director Clinical Ops**	
125	Begin On-Boarding	1 day	Mon 11/10/14	Mon 11/10/14	NA	Director Clinical Ops	*Phone staff in pace by 12/1
126	Complete On-Boarding	35 days	Tue 11/11/14	Mon 12/29/14	NA	Director Clinical Ops	
127	**Staff Training**	**20 days**	**Wed 10/8/14**	**Tue 11/4/14**	**NA**	**Director Clinical Ops**	
128	**Training Plan**	**20 days**	**Wed 10/8/14**	**Tue 11/4/14**	**NA**	**Director Clinical Ops**	
129	Determine Training Leads	1 day	Wed 10/8/14	Wed 10/8/14	NA	Byra Tracey M	
130	Develop Training Curriculum	10 days	Wed 10/8/14	Tue 10/21/14	NA	Training Lead	
131	Develop Training Schedule	5 days	Wed 10/22/14	Tue 10/28/14	NA	Training Lead	
132	Determine Training Method / Location	5 days	Wed 10/22/14	Tue 10/28/14	NA	Training Lead	
133	Develop Training Materials	10 days	Wed 10/22/14	Tue 11/4/14	NA	Training Lead	

Empire Plan Project Plan

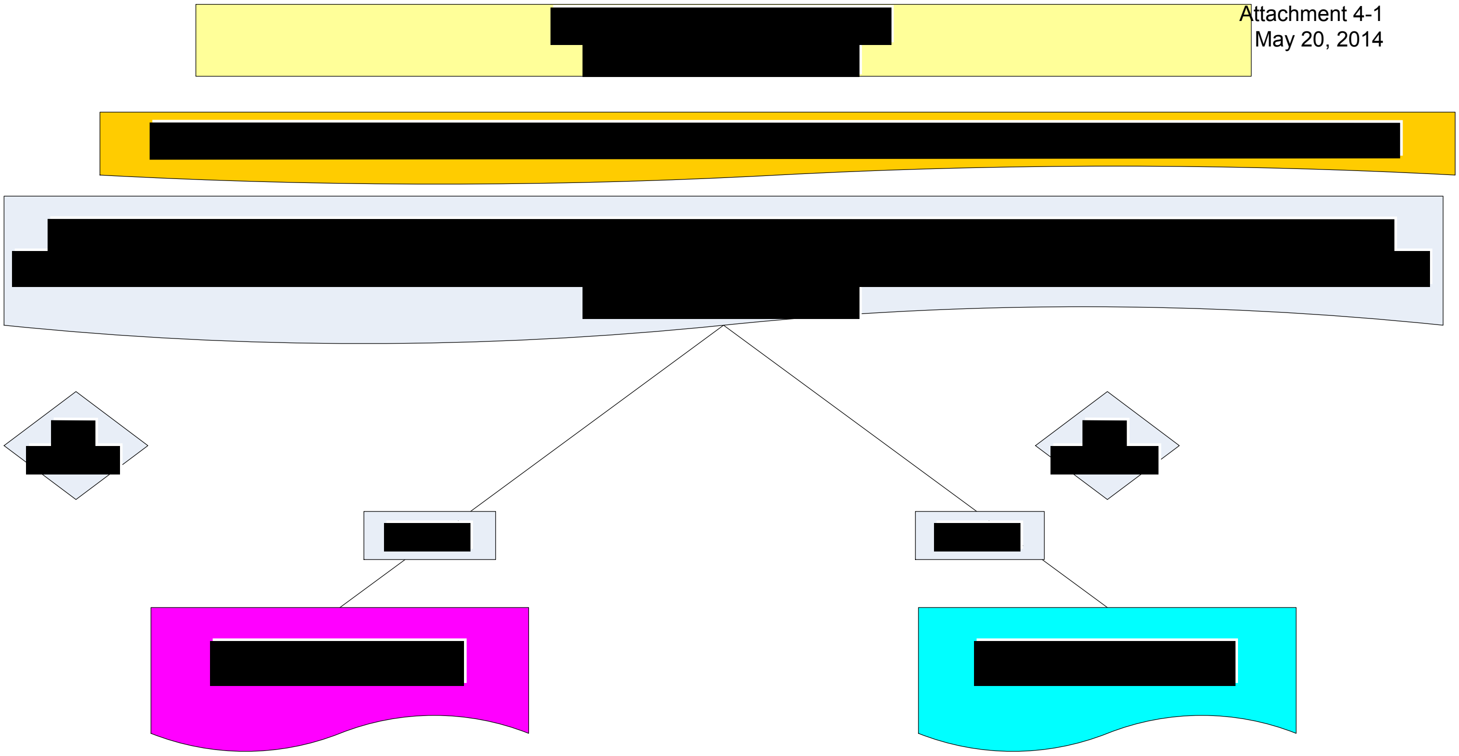
ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
134	**Communications**	**36 days**	**Thu 10/16/14**	**Thu 12/4/14**	**NA**	**SAE/CSM**	
135	**Communication Strategy**	**5 days**	**Thu 10/16/14**	**Wed 10/22/14**	**NA**	**SAE**	
136	Develop Communication Strategy	5 days	Thu 10/16/14	Wed 10/22/14	NA	Ewing Faye	
137	**Member Materials**	**36 days**	**Thu 10/16/14**	**Thu 12/4/14**	**NA**	**Implementation Manager**	
138	Provide Communication Material Samples	1 day	Thu 10/16/14	Thu 10/16/14	NA	Implementation Manager	
139	Obtain Client Logo	5 days	Thu 10/23/14	Wed 10/29/14	NA	Implementation Manager	*Custom logo already in place
140	Verify Order Amounts & Locations	6 days	Thu 10/23/14	Thu 10/30/14	NA	Implementation Manager	
141	Material Production & Delivery	15 days	Fri 10/31/14	Thu 11/20/14	NA	Implementation Manager	
142	Verify Materials Received and Distributed	10 days	Fri 11/21/14	Thu 12/4/14	NA	Implementation Manager	
143	**Telecommunications**	**34 days**	**Thu 10/16/14**	**Tue 12/2/14**	**NA**	**Implementation Manager**	
144	**Scripting**	**17 days**	**Thu 10/16/14**	**Fri 11/7/14**	**NA**	**Implementation Manager**	
145	Determine scripting changes to NYSHIP toll free	2 days	Thu 10/16/14	Fri 10/17/14	NA	Implementation Manager	
146	Determine date for new MHSA options	10 days	Mon 10/20/14	Fri 10/31/14	NA	Implementation Manager	
147	Civil Service approves prompt and date changes	5 days	Mon 11/3/14	Fri 11/7/14	NA	Implementation Manager	
148	**Work Order Detail**	**17 days**	**Mon 11/10/14**	**Tue 12/2/14**	**NA**		
149	Determine Correct Skill & VPNs to Ensure Proper	1 day	Mon 11/10/14	Mon 11/10/14	NA	Telecom Analyst	
150	Determine change dates for NYSHIP toll free MHS	1 day	Mon 11/10/14	Mon 11/10/14	NA	Telecom Analyst	
151	Obtain Visio of Custom TFN Setup	1 day	Tue 11/11/14	Tue 11/11/14	NA	Telecom Analyst	
152	Go live with new prompt options	1 day	Mon 12/1/14	Mon 12/1/14	NA	Telecom Analyst	
153	Confirm Test Results or Request Changes	1 day	Tue 12/2/14	Tue 12/2/14	NA	Telecom Analyst	
154	**LiveandWorkWell.com**	**21 days**	**Thu 10/16/14**	**Thu 11/13/14**	**NA**	**Implementation Manager**	
155	**Client Site Orientation**	**21 days**	**Thu 10/16/14**	**Thu 11/13/14**	**NA**		
156	Determine if site review is requested	1 day	Thu 10/16/14	Thu 10/16/14	NA		LWW site was not terminated during r
157	Receive Client Feedback / Customize Site if Appli	20 days	Fri 10/17/14	Thu 11/13/14	NA		
158	**Finance & Billing**	**24 days**	**Thu 10/16/14**	**Tue 11/18/14**	**NA**	**Billing/Banking**	
159	**Structure**	**18 days**	**Thu 10/16/14**	**Mon 11/10/14**	**NA**	**Billing/Banking**	

Empire Plan Project Plan

ID	Task Name	Duration	Start	Projected Finish	Actual Finish	Resource Names	Notes
160	Determine How Admin Fees Will be Paid	15 days	Thu 10/16/14	Wed 11/5/14	NA	Coy Thomas K	
161	Confirm Transfer Process	3 days	Thu 11/6/14	Mon 11/10/14	NA	Coy Thomas K	
162	**ASO Claims Invoicing Setup / Account Funding**	**6 days**	**Tue 11/11/14**	**Tue 11/18/14**	**NA**	**Billing/Banking**	
163	Determine bank account and banking arrangemen	1 day	Tue 11/11/14	Tue 11/11/14	NA	Coy Thomas K,Rice Martha	
164	Client Approval of ASO Claims Invoice	5 days	Wed 11/12/14	Tue 11/18/14	NA	Coy Thomas K,Rice Martha	
165	Ensure Contract is Reviewed by Finance and TAT	3 days	Wed 11/12/14	Fri 11/14/14	NA	Coy Thomas K,Rice Martha	
166	**Go Live Command Center**	**71 days**	**Wed 10/1/14**	**Wed 1/7/15**	**NA**	**Implementation Manager**	
167	**Call Monitoring**	**28 days**	**Mon 12/1/14**	**Wed 1/7/15**	**NA**	**Implementation Manager**	
168	Determine leadership team to meet daily starting on g	1 day	Mon 12/1/14	Mon 12/1/14	NA	Ewing Faye	
169	Schedule daily leadership calls	5 days	Tue 12/2/14	Mon 12/8/14	NA	Implementation Manager	
170	Confirm customer performance reporting schedule an	1 day	Mon 12/8/14	Mon 12/8/14	NA	Implementation Manager	
171	Prepare weekly report on call statistics	5 days	Thu 1/1/15	Wed 1/7/15	NA	Director Clinical Ops	
172	**Risk Management**	**1 day**	**Wed 10/1/14**	**Wed 10/1/14**	**NA**	**Implementation Manager**	
173	Determine workflow for expedited resolution of any pr	1 day	Wed 10/1/14	Wed 10/1/14	NA	Implementation Manager	
174	Meet with leadership from each functional team to rev	1 day	Wed 10/1/14	Wed 10/1/14	NA	Ewing Faye,Implementation	
175	**Close**	**1 day**	**Wed 10/1/14**	**Wed 10/1/14**	**NA**	**Implementation Manager**	
176	**Implementation Transition**	**1 day**	**Wed 10/1/14**	**Wed 10/1/14**	**NA**	**Implementation Manager**	
177	Conduct Transition Meeting with SAE and CSM	1 day	Wed 10/1/14	Wed 10/1/14	NA	Implementation Manager	
178	Document Ownership of Any Open Implementation Ta	1 day	Wed 10/1/14	Wed 10/1/14	NA	Implementation Manager	

Attachment 4 - Sample IVR Script and Flowchart

Attachment 4-1
May 20, 2014



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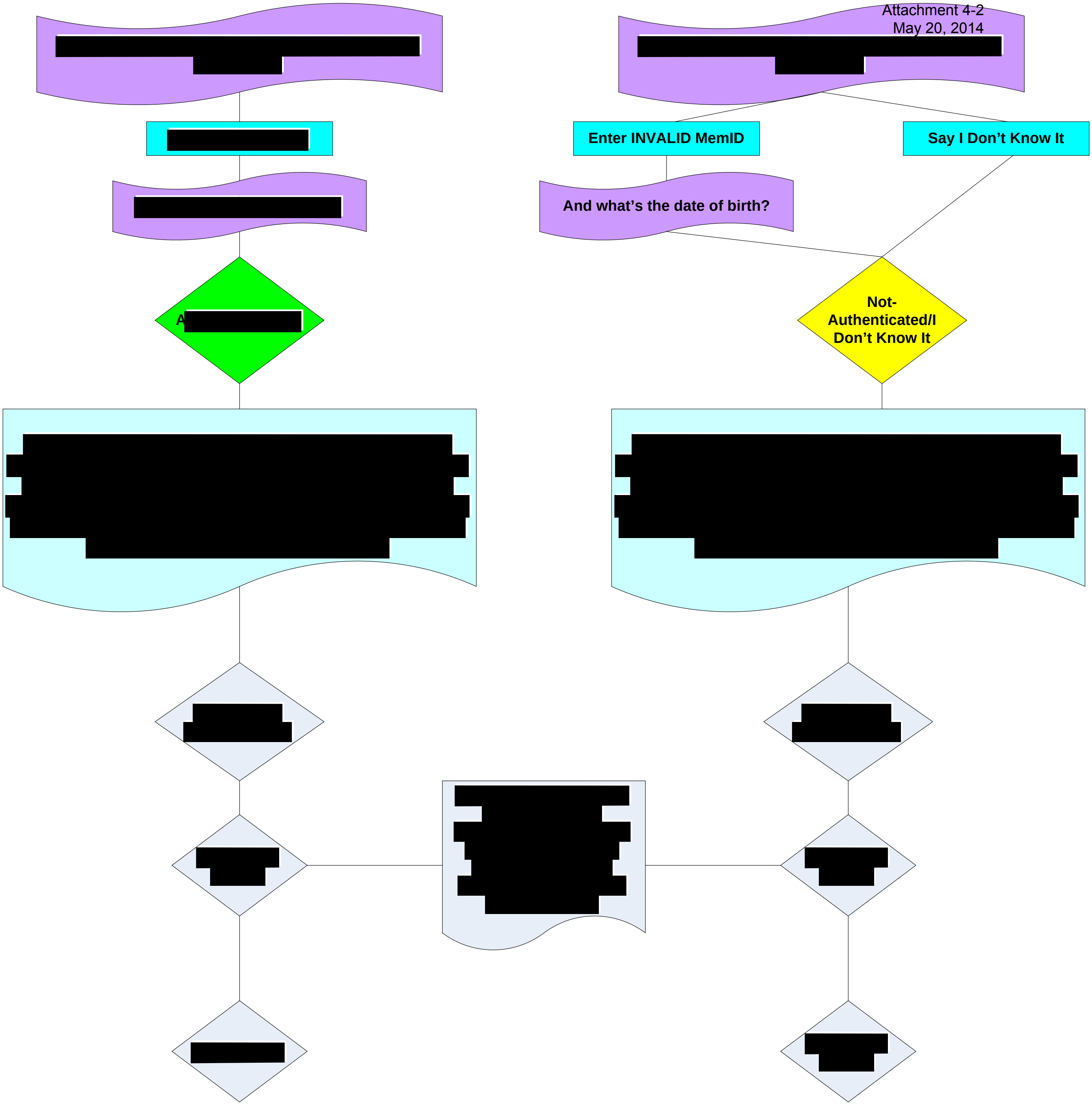
Attachment 4-2
May 20, 2014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Enter INVALID MemID
Say I Don’t Know It
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And what’s the date of birth?
A[redacted]
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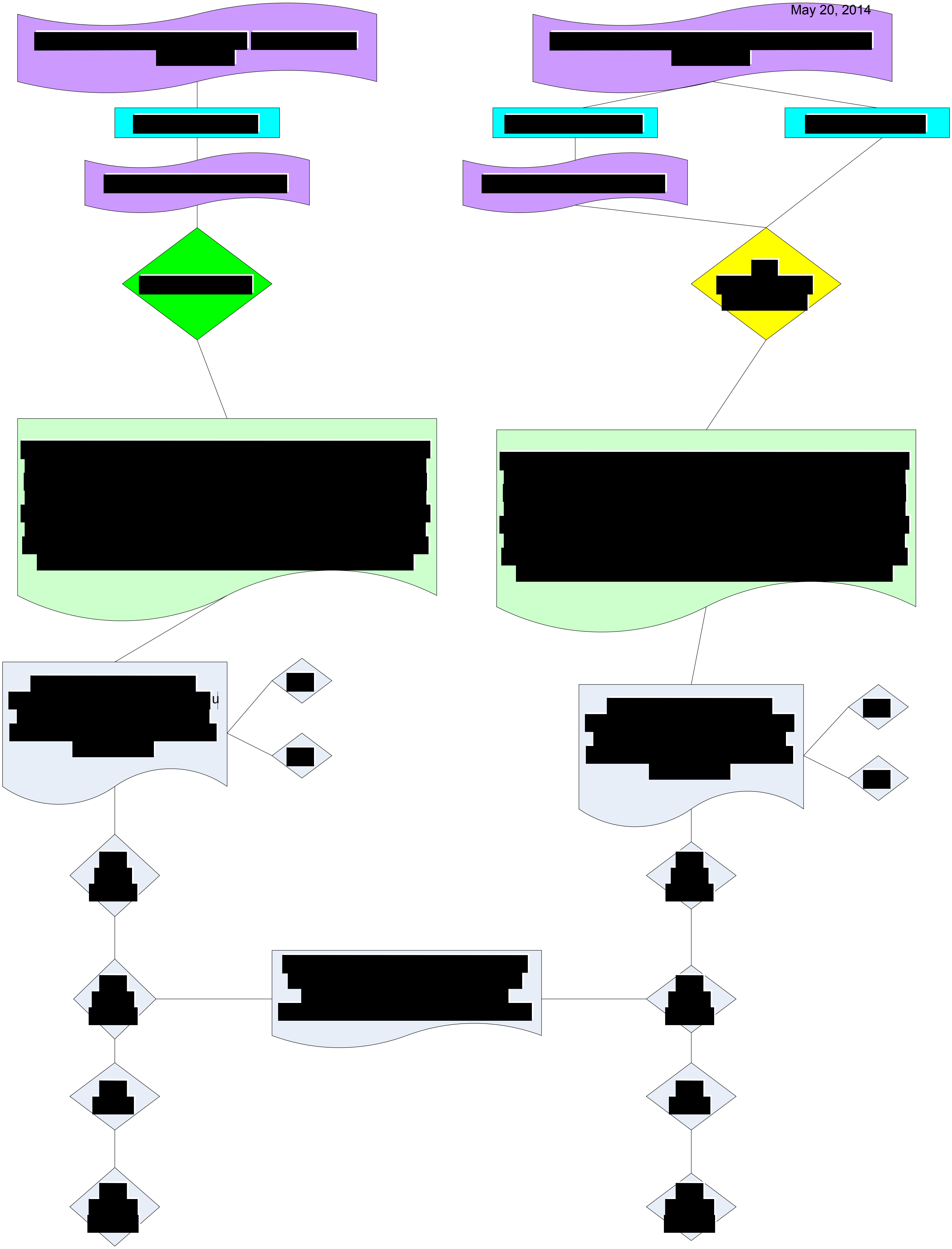
Attachment 4-3
May 20, 2014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Attachment 5 - Sample Quality Guidelines and Scoring Sheet

Attachment 5-1
May 20, 2014

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[redacted]	[redacted]	[redacted]	[redacted] options, documentation and the like
	[redacted]	[redacted]	

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[redacted]

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Attachment 6 - Sample Online Articles

Job Seekers

Employees

Retirees

HR Professionals

Introduction
Benefits Information
Financial Reports
Cost Calculator
Providers/Pharmacies
Civil Service Home
Customer Service
FAQs
Rates
Meetings
HBA Manual for PAs
Contact Us
NYSHIPOnline Home

The Empire Plan is a unique health insurance plan designed especially for public employees in New York State.
Empire Plan benefits include inpatient and outpatient hospital coverage, medical/surgical coverage, Centers of Excellence for transplants, infertility and cancer, home care services, equipment and supplies, mental health and substance abuse coverage and prescription drug coverage.
Compute monthly premiums and annual cost for your agency. The Empire Plan's managed care features and copayments help keep costs down. View recent Empire Plan Quarterly Experience Reports.
Empire Plan Quarterly Experience Reports are mailed to Participating Agency employers. The reports provide comprehensive projections of Empire Plan experience for the remainder of the current year based on claims paid through the previous quarter and the projected premium rates for the following year. The reports explain the basis for the projections.
The Empire Plan has an extensive network of providers, as well as access to non-participating providers worldwide.
At home, at work, on vacation, in college or in retirement, The Empire Plan is with enrollees throughout life.
The Empire Plan offers employers and enrollees superior customer service.
Frequently Asked Questions about NYSHIP and The Empire Plan
Current rates for
The Empire Plan.
Learn when our Empire Plan representatives will be at public employer meetings near you.
Questions about NYSHIP for local governments?

Diabetes - July 2010

Types of Diabetes | Risk Factors for Diabetes | The Empire Plan Home Care Advocacy Program | The Empire Plan Diabetes Management Program | Coping with Diabetes | If Your Child Is Diagnosed with Diabetes | Diabetes Education and Self-Care | Help Manage Your Diabetes with a Simple Test | Smoking Cessation Benefits | Resources

This issue of Reporting On is for informational purposes only. Please see your doctor for diagnosis and treatment. Read your Empire Plan Certificate and Empire Plan Reports for complete information about coverage.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP) for Empire Plan enrollees and for their enrolled dependents, COBRA enrollees with their Empire Plan benefits and Young Adult enrollees

If you or someone you love is diagnosed with diabetes, this report will help you better understand and manage the disease. Those of you who are at risk for diabetes will learn about lifestyle changes that will help delay or prevent the disease.

And, you will learn how The Empire Plan's Home Care Advocacy Program (HCAP) and Diabetes Management Program offer support and guidance for living with diabetes.

Understanding Diabetes

Diabetes is a disease that occurs when your body cannot produce, convert or properly use glucose from food for energy. Glucose is a form of sugar made when the body digests food. Those with diabetes have excess glucose in the bloodstream which, left unchecked, can damage every system in the body.

Even though the disease is more manageable than ever, diabetes is increasing to epidemic proportions in the United States. According to the American Diabetes Association, 23.6 million people in the United States, or 7.8 percent of the population, have diabetes. While an estimated 17.9 million people have been diagnosed, 5.7 million, or nearly one-quarter, are unaware that they have the disease and are already suffering from its complications.

Symptoms of Diabetes

If you have any of these symptoms, contact your doctor:

- Frequent urination
- Extreme thirst
- Extreme hunger
- Sudden weight loss
- Unusual fatigue
- Blurry vision
- Tingling or burning sensation in the hands, fingers, feet or toes
- Frequent infections and poor wound healing
- Cuts or bruises that are slow to heal
- Dry skin

Types of Diabetes

Types of Diabetes

The three main types of diabetes are:

- Type 1 diabetes
- Type 2 diabetes

- Gestational diabetes
  (diabetes during pregnancy)

Of the 23.6 million people in the United States who have diabetes, 90 to 95 percent have type 2 diabetes and 5 to 10 percent have type 1 diabetes. About 4 percent of all pregnant women develop gestational diabetes.

Type 1 Diabetes

In people with type 1 diabetes, formerly called "juvenile-onset diabetes" or "insulin-dependent diabetes mellitus," the body loses the ability to make insulin.

Insulin is a vital hormone made by the pancreas, a gland in the body near the stomach. It is needed to change glucose, the body's primary energy source, into energy.

When insulin is not available, glucose stays in the bloodstream and cannot be used as energy. Left unchecked, excess glucose can damage the blood vessels that nourish the eyes, kidneys and bladder. To regulate their blood sugar levels and prevent this damage, people with type 1 diabetes need to take insulin every day.

Type 1 diabetes usually occurs in children or young adults under age 30, but can develop at any age for unknown reasons. Environmental factors such as viral infections, chemicals, stressful situations and others may also play a role, but the specific role of each of these factors still is not clear.

Type 2 Diabetes

Type 2 is the most common form of diabetes. Formerly called "adultonset diabetes" or "non-insulindependent diabetes," in type 2 diabetes the body does not produce enough insulin or the cells ignore the insulin. As with type 1 diabetes, glucose stays in the bloodstream and cannot be used as energy.

During this period, the pancreas works overtime to make more insulin to overcome the resistance. For a while, the extra insulin moves enough glucose into cells to keep glucose from building up too high in the blood. This can go on for months or years without obvious symptoms.

The pancreas eventually begins to tire. Insulin production levels off, and the body cannot keep up with the amount of glucose in the blood, triggering type 2 diabetes. The condition may not be diagnosed right away, however, because often there are no visible or obvious symptoms.

Some people with type 2 diabetes need to take insulin or medication to help their bodies use insulin better.

Your Prescription Drugs

A list of the most comm only prescribed generic and brand-name prescription drugs including medications used to treat diabetes is available on the New York State Department of Civil Service web site at https://www.cs.state.ny.us. Select Employees or Retirees and follow the links to your group-specific health benefits.

The Empire Plan Flexible Formulary Drug List, Preferred Drug List or Three Level Drug List (depending on your group) will help you and your doctor determine if your prescription is for a generic or a preferred brand-name drug. However, these lists do not include all the prescription drugs covered under The Empire Plan. For specific questions about your prescriptions, please call The Empire Plan Prescription Drug Program toll free at 1-877-7-NYSHIP (1-877-769-7447). Select Option 4.

Gestational Diabetes

Gestational diabetes occurs when a woman's body cannot produce the amount of insulin needed during pregnancy. There are usually no symptoms. Therefore, if you are pregnant, you should be tested for diabetes between the 24th and 28th week of pregnancy. Women already at risk for diabetes should be screened at their first prenatal appointment rather than waiting.

Most pregnant women need two to three times more insulin than when they are not pregnant. This happens because of hormonal changes that are normal in pregnancy.

After pregnancy, blood glucose levels usually return to normal. However, a woman who has had gestational diabetes is at risk for developing type 2 diabetes later in life.

Women who had gestational diabetes have an increased risk of developing type 2 diabetes in the next 10 to 20 years if overweight after pregnancy. The risk is reduced if the mother maintains a reasonable weight after pregnancy.

Sometimes, gestational diabetes may really be the "unmasking" of type 2 diabetes that hasn't been diagnosed yet. If this is the case, diabetes will not go away after the pregnancy, and the blood glucose will become high if diabetes is not treated.

Source: International Diabetes Center

Risk Factors for Diabetes

- **Overweight.** The longer people are overweight and the more overweight they are, the greater their risk for diabetes. Recent studies have shown that losing 5 to 7 percent of body weight can help reduce the risk of type 2 diabetes.
- **Blood pressure** of 130/80 or higher. Sixty to 70 percent of people with undiagnosed diabetes have high blood pressure. Normalizing blood pressure greatly reduces the risk of both stroke and heart attack by slowing the formation of arterial plaque in vessels everywhere in the body, especially the brain, heart, kidneys, eyes and legs.
- **High cholesterol or triglycerides.** More than 75 percent of people with diabetes have high cholesterol or triglycerides, which are components of fat found in the blood. This increases the risk of heart disease by up to four times that of the general population. People with diabetes can reduce their risk of heart and blood vessel disease by lowering cholesterol levels or triglycerides.

  HDL (high-density lipoprotein), or "good" cholesterol, should be no less than 40 mg for men and 50 mg for women; LDL (low-density lipoprotein), or "bad" cholesterol, should be less than 100 mg; and triglycerides should be less than 150 mg.

- **Parent or sibling with diabetes.** A significant number of children or siblings of people with type 2 diabetes eventually will develop the disease unless they take steps to prevent it.
- **Family background of African American, Native American, Asian American, Hispanic/Latino or Pacific Islander.** People in these ethnic groups are at two to three times the risk of developing diabetes compared with all other people.
- **History of gestational diabetes or giving birth to a baby weighing more than 9 pounds.** Up to two-thirds of women who develop diabetes during pregnancy may develop type 2 diabetes.
- **Sedentary lifestyle.** "Sedentary" means doing nothing more than the light physical activity of day-to-day life.People who exercise three to five times a week can reduce their risk of diabetes by up to 58 percent.
- **Prediabetes.** As many as 57 million Americans are on the brink of developing diabetes, a condition called impaired glucose tolerance (IGT), or more commonly known as prediabetes.

Prediabetes is a condition in which blood glucose levels are higher than normal but not yet diabetic. People with this condition have only slightly elevated blood sugar levels. However, they have an extremely high chance of developing fullblown diabetes within 10 years. This also increases the risk for other serious complications of diabetes such as kidney failure, heart disease, stroke, limb amputations due to impaired circulation and blindness.

The latest studies also show that prediabetes occurs earlier than originally thought and that high-risk individuals should be checked more often. Doctors are starting to recommend that people age 45 or older, especially those who are overweight, be screened for prediabetes.

There are three different tests your doctor can use to determine whether you have prediabetes: the A1c test (see page 7), the fasting plasma glucose test (FPG) or the oral glucose tolerance test (OGTT). The blood glucose levels measured after these tests determine whether you have a normal metabolism, or whether you have prediabetes or diabetes.

If your blood glucose level is abnormal following the FPG, you have impaired fasting glucose (IFG); if your blood glucose level is abnormal following the OGTT, you have impaired glucose tolerance (IGT). Both are also known as prediabetes.

If you are diagnosed with prediabetes, you can take simple steps to prevent or delay type 2 diabetes. Improving your diet, increasing your physical activity and taking care of yourself are among the best ways to stay healthy and possibly delay a diabetes diagnosis.

Source: The New England Journal of Medicine

The Empire Plan Home Care Advocacy Program

The Empire Plan's Home Care Advocacy Program (HCAP) covers medically necessary diabetic supplies and diabetic shoes prescribed by your doctor. To be considered for benefits, you must be managing your diabetes under the direction of a doctor, for example, through diet, exercise and/or medication.

Diabetic Supplies

Examples of diabetic supplies include a glucometer (a small, portable machine that you can use to check your glucose levels), test strips, portable lancets, alcohol swabs and syringes.

If you have insulin-dependent diabetes, you are eligible for HCAP benefits for blood-testing supplies, including a glucometer. If you have non-insulin-dependent diabetes, you may be eligible for blood-testing supplies, including a glucometer. Supplies not covered include tape, cotton balls and disposable containers.

Call the HCAP network providers directly at their toll-free numbers for authorization before receiving diabetic supplies, except insulin pumps and Medijectors. For most diabetic supplies, call The Empire Plan Diabetic Supplies Pharmacy at 1-888-306-7337. Tell the network provider that you are an Empire Plan enrollee and provide the prescribing doctor's name and phone number. The supplier will confirm your need for diabetic supplies with your doctor.

For insulin pumps and Medijectors, you must call HCAP for authorization at 1-877-7-NYSHIP (1-877-769-7447). Select Option 1 at the menu.

If you do not call HCAP for precertification before receiving insulin pumps and Medijectors and/or if you use a non-network provider, you will pay a much higher share of the cost.

Diabetic Shoes

If you are diagnosed with diabetes and diabetic foot disease, one pair of custom-molded or depth shoes per calendar year are a covered expense under The Empire Plan.* You must use an HCAP-approved provider and the shoes must be fitted and furnished by a qualified pedorthist, orthotist, prosthetist or podiatrist (shoes ordered by mail or from the internet are not eligible for benefits).

When you use an HCAP-approved provider for medically necessary diabetic shoes, you receive a paid-in-full benefit up to an annual maximum benefit of $500. To ensure that you receive the maximum benefit, you must make a prenotification call to HCAP.

If you receive medically necessary diabetic shoes from a provider who is not an HCAP-approved provider, benefits will be considered under the Basic Medical Program subject to the annual deductible with any remaining covered charges paid at 75 percent of the network allowance with a maximum annual benefit of $500.

Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447), choose UnitedHealthcare and then the Benefits Management Program to make arrangements to receive benefits for medically necessary diabetic shoes through HCAP.

For more information on HCAP, see your *NYSHIP General Information Book* and *Empire Plan Certificate* and *Reporting On HCAP*.

* There is a $500 limit per calendar year for diabetic shoes, customized inserts and/or modifications. This does not apply to prescription orthotics, which are covered under The Empire Plan Participating Provider Program or Basic Medical Program.

The Empire Plan Diabetes Management Program

The Empire Plan's Diabetes Management Program provides guidance for improving, managing and living with diabetes or high blood sugar. The Program aims to prevent long-term complications such as kidney and circulatory disorders, nerve damage and blindness.

If you or your dependents have received treatment for diabetes or a diabetes-related problem, you may be invited to participate in this Program. Depending on the severity of your condition, UnitedHealthcare may telephone you or send a letter inviting you to participate in the Program. Participation is voluntary, free of charge and confidential.

If you agree to participate in the Program, you will receive informational material to help you understand your diabetes. If you are identified as high risk, a diabetes nurse case manager will be assigned to answer your questions and help you better manage your diabetes. The nurse will also coordinate care with the doctor treating your diabetes, as well as doctors treating any other health conditions that may exist.

To find out if you may be considered for the Diabetes Management Program, please call The Empire Plan NurseLine$_{SM}$ toll free at 1-877-7-NYSHIP (1-877-769-7447) and press 5 on the main menu to speak with a nurse.

Coping with Diabetes

Until you are diagnosed with a chronic medical condition such as diabetes, it is difficult to predict how you will react. Much like the stages of grief, coping with a diagnosis also has its stages.

Feeling down once in a while is normal, but some people have a feeling of extreme sadness or hopelessness that just won't go away. Feeling this way most of the day for two weeks or more is a sign of serious depression.

Research by the National Institute of Mental Health has shown that depression is often associated with diabetes. People who have both diabetes and depression tend to have more severe symptoms of both diseases, higher rates of work disability and use more medical services than those who only have diabetes alone.

Also, poor diabetes control can cause depressive symptoms and worsen existing depression. If your doctor has ruled out physical causes for depression, he or she may refer you to a specialist for mental health treatment or you may seek treatment yourself such as psychotherapy or medication. It is important to not only treat the diabetes, but to address any accompanying depression as well.

If you or a loved one has diabetes and may be suffering from depression, help is available through The Empire Plan Mental Health and Substance Abuse Program. Call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select Option 3 for OptumHealth. The OptumHealth Clinical Referral Line is staffed with licensed clinicians who are available 24 hours a day, 7 days a week to answer your questions or locate a local mental health network provider. You can also ask to receive mailings with information to help manage depression as a part of The Empire Plan Depression Management Program. The clinician can help you access this Program.

If you would like more information about depression, you can access the customized Empire Plan Mental Health and Substance Abuse web site at www.liveandworkwell.com (use access code Empire in the right-hand navigation). This web site contains self-help questionnaires, articles and other resources on coping with depression and chronic medical conditions such as diabetes.

Sources: National Institute of Mental Health and American Diabetes Association

If Your Child Is Diagnosed with Diabetes

Nearly one child in every 400 to 500 between the ages of birth and 19 is diagnosed with type 1diabetes. Type 2 diabetes currently accounts for up to 50 percent of all new cases of diabetes in children. This is a significant increase from even a decade ago, when the majority of cases for pediatric diabetes was type 1 diabetes.

One of the main causes of type 2 diabetes is obesity, which contributes to both insulin resistance and cardiovascular problems. Since the 1970s, the rate of obesity in children has more than doubled. Many attribute this to an increasingly sedentary lifestyle, as well as poor nutritional habits and choices. Given the rise of childhood obesity, it is estimated that more than one third of all children who were born in 2000 will eventually develop diabetes, either during childhood or after adolescence.

Often diet, exercise and lifestyle changes can help children manage diabetes or prevent it from developing, but sometimes medications may be needed as well.

Goals of Managing Diabetes in Children

Managing diabetes in children involves several goals. These goals are to:

- keep blood sugar levels normal
- improve insulin sensitivity, which helps control blood sugar levels
- treat cardiovascular issues and fatty liver disease
- prevent complications associated with diabetes, such as nephropathy or kidney disorder, neuropathy, which is nerve damage, especially to the feet and legs, and retinopathy, which is eye disease

Underlying all of these goals is the essential challenge to instill lifestyle changes to combat obesity, which will help all ages of people achieve all the other treatment goals for diabetes.

Benefits of Diet and Exercise

Doctors recommend that children with diabetes or prediabetes consume more fresh fruits, vegetables and whole grains, eat fewer high-fat and processed foods, and eliminate sweetened beverages, such as soda, entirely from the diet.

In addition to adopting healthy eating habits, children with diabetes can - and should - play games and sports and should make a habit of engaging in physical activity for at least 60 minutes daily. Exercise helps to lower blood glucose levels, maintain a healthy heart and lungs and to control weight. Your child will reap these benefits even if he or she remains overweight.

The National Institutes of Health recommends that children limit watching television and playing video games to no more than one hour per day. Instead of sedentary entertainment, doctors recommend active playing and/or participation in organized sports such as soccer or baseball, dance or other physical activities at home.

What's for Lunch?

If your child has diabetes, then most likely he or she is on a diet plan to help manage the disease. It's easier to watch your child's eating habits at home, but what happens in the school cafeteria?

School cafeterias are nutritional minefields. Traditional school lunches often contain starchy, high-calorie foods and many items have trans fats and corn sweeteners in them.

How can parents help their children stick with healthy lunches and not be tempted by the onslaught of overindulgence around them? First, it's better to bring a lunch from home rather than rely on the school cafeteria choices. A nutritious and filling lunch may consist of a sandwich on whole-grain bread, a homemade cookie or treat, fresh fruit or veggies, a low-fat cheese stick and 1 or 2 percent milk.

Second, have children make the choices for what healthy items they would like in their lunch. Having control over what's in their lunch may help them to be satisfied with what they are eating and to create a different lunch every day.

Medications and Other Treatments for Children

The first and most important factor in combating diabetes for children is by making lifestyle changes with diet and exercise. Ideally, a diabetes health care team for children and adolescents will include nutritionists and activity leaders to help patients and families incorporate these healthy changes into their lives.

If Your Child Is Diagnosed with Diabetes Even if no symptoms of diabetes such as increased thirst or urination are present (see front cover), health care providers may prescribe antidiabetic medications if lifestyle changes fail to decrease the risks involved with diabetes.

With good medical care and support from adults, children with diabetes can lead healthy, active, fun-filled lives.

Sources: LifeWire, a part of The New York Times Company and the National Institutes of Health

Diabetes Education and Self-Care

Diabetes education can be an important part of a treatment plan for diabetes. Diabetes educators provide information on nutrition and lifestyle improvement that can help diabetics better manage their disease.

The Empire Plan network now includes Diabetes Education Centers that are accredited by the American Diabetes Association Education Recognition Program. If you have a diagnosis of diabetes, your visits to a network center for self-management counseling are covered and you pay only an office visit copayment for each covered visit. Covered services at a non-network diabetes education center are considered under the Basic Medical Program subject to deductible and coinsurance.

The Diabetes Self-Management Education (DSME) available at a network center is a series of weekly individual or group sessions. Both individual and group DSME focus on sharing information about self-care skills and habits for diabetes control such as checking blood sugar, taking oral medicines and insulin, if indicated, on time and in the right doses, following a food or meal plan, exercising, and checking feet.

Effective DSME does more than provide knowledge and skills. Enrollees can get emotional support and help from certified diabetes educators and other group members to solve problems in their everyday lives. On an ongoing basis, DSME fosters a level of selfcare that is essential to prevent the debilitating effects of diabetes and to have a higher quality of life.

To find an Empire Plan participating Diabetes Education Center, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and press Option 1 to reach UnitedHealthcare. Or, go to the New York State Department of Civil Service web site at https://www.cs.state.ny.us, click on Benefit Programs and then NYSHIP Online. Select your group if prompted, click on Find a Provider and then Medical and Surgical Providers under UnitedHealthcare. Select the Search the Provider Directory tab, then Search for laboratories or other facilities, then scroll down to Click here to view a list of Diabetes Education Centers.

Source: American Diabetes Association

Help Manage Your Diabetes with a Simple Test

If you have been diagnosed with diabetes, ask your doctor about a Hemoglobin A1c test, which shows the average amount of sugar that has been in your blood over the last two to three months. In addition to monitoring your daily blood sugar levels at home, the A1c test can help determine if your treatment is working effectively. It also gives you and your doctor important information about how to manage your diet and exercise plan, as well as how to adjust dosages of insulin and other prescription drugs.

Through The Empire Plan Diabetes Management Program, work with your doctor to lower your hemoglobin A1c level to less than 7 percent. The normal range for people who do not have diabetes is between 4 and 6 percent. This will significantly reduce your risk of diabetic complications, including serious eye and kidney disease, and most commonly heart attack and stroke.

Smoking Cessation Benefits

If you have diabetes and want to quit smoking, The U.S. Public Health Service has recommended medications and individual counseling as effective in helping smokers quit. Research shows that smokers are more likely to make a quit attempt and, most importantly, to succeed when they have easy access to smoking cessation treatments.

Through The Empire Plan Prescription Drug Program, you have access to prescription drugs that can help you to quit smoking. Talk to your doctor about which prescription drug(s) would be appropriate for you. Also, individual smoking cessation counseling is covered by The Empire Plan if Medicare is your primary insurance.

For more information and support, you can contact the New York Smokers' Quitline and the North American Quitline Consortium at the numbers listed below. Call today.

Based on information from Partnership for Prevention®

Resources

Keep these telephone numbers and web site addresses handy for your reference and to order your prescribed services, equipment and supplies.

The Empire Plan Home Care Advocacy Program (HCAP)
1-877-7-NYSHIP
(1-877-769-7447)
Press or say 1 on the main menu for UnitedHealthcare. Then press or say 3 for HCAP.

The Empire Plan Diabetic Supplies Pharmacies
HCAP network supplier for diabetes supplies
1-888-306-7337

The Empire Plan NurseLine$_{SM}$
Health information and support 24 hours a day, 7 days a week
1-877-7-NYSHIP (1-877-769-7447)
Press or say 5 on the main menu. Press 2 to reach the library, enter PIN 335, and then enter the four-digit topic code.

American Association of Diabetes Educators
1-800-338-3633
www.diabeteseducator.org

American Diabetes Association
1-800-DIABETES
(1-800-342-2383)
www.diabetes.org

Centers for Disease Control and Prevention
www.cdc.gov/diabetes

Children with Diabetes
www.childrenwithdiabetes.com

Exercise is Medicine™
www.exerciseismedicine.org
Health Information from FirstGov
www.healthfinder.gov

International Diabetes Center
1-888-825-6315
www.parknicollet.com/diabetes

Juvenile Diabetes Research Foundation International
1-800-533-CURE
(1-800-533-2873)
www.jdrf.org

Let's Move
www.letsmove.gov

National Diabetes Education Program
1-800-438-5383
www.ndep.nih.gov

National Diabetes Information Clearinghouse
1-800-860-8747
www.diabetes.niddk.nih.gov

New York State Smokers' Quitline
NY residents: 1-866-NY-QUITS
(1-866-697-8487)
for free assistance
www.nysmokefree.com

North American Quitline Consortium
Residents of other states:
1-800-QUIT-NOW
(1-800-784-8669)
www.naquitline.net

PDF Version

Job Seekers

Employees

Retirees

HR Professionals

Introduction
Benefits Information
Financial Reports
Cost Calculator
Providers/Pharmacies
Civil Service Home
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HBA Manual for PAs
Contact Us
NYSHIPOnline Home

The Empire Plan is a unique health insurance plan designed especially for public employees in New York State. Empire Plan benefits include inpatient and outpatient hospital coverage, medical/surgical coverage, Centers of Excellence for transplants, infertility and cancer, home care services, equipment and supplies, mental health and substance abuse coverage and prescription drug coverage.
Compute monthly premiums and annual cost for your agency. The Empire Plan's managed care features and copayments help keep costs down. View recent Empire Plan Quarterly Experience Reports.
Empire Plan Quarterly Experience Reports are mailed to Participating Agency employers. The reports provide comprehensive projections of Empire Plan experience for the remainder of the current year based on claims paid through the previous quarter and the projected premium rates for the following year. The reports explain the basis for the projections.
The Empire Plan has an extensive network of providers, as well as access to non-participating providers worldwide. At home, at work, on vacation, in college or in retirement, The Empire Plan is with enrollees throughout life.
The Empire Plan offers employers and enrollees superior customer service.
Frequently Asked Questions about NYSHIP and The Empire Plan
Current rates for
The Empire Plan.
Learn when our Empire Plan representatives will be at public employer meetings near you.
Questions about NYSHIP for local governments?

Healthy Babies - July 2010

Prenatal Testing | **Exercise During Pregnancy** | **Low-birthweight Babies** | **Feeding Your Baby** | **Choosing Your Baby's Doctor** | **Avoiding Preterm Birth** | **Expectant Father?** | **Baby Blues** | **Questions and Answers** | **Resources**

This issue of Reporting On is for informational purposes only. Please see your doctor for diagnosis and treatment. Read your Empire Plan Certificate and Empire Plan Reports for complete information about coverage.

NEW YORK STATE HEALTH INSURANCE PROGRAM (NYSHIP) for Empire Plan enrollees and for their enrolled dependents, COBRA enrollees with their Empire Plan benefits and Young Adult enrollees

You're pregnant?

Congratulations! Every baby deserves a healthy beginning. You can take steps before your baby is even born to help ensure a great start for your infant. That's why The Empire Plan offers mother and baby the coverage they need. When your primary coverage is The Empire Plan, The Empire Plan Future Moms Program provides you with special services.

Five Important Steps to Having a Healthy Baby

1. Call your doctor

As soon as you think you are pregnant, call your doctor. You can do the most for your baby during the first three months of pregnancy, so try to start your doctor visits as soon as possible. The Empire Plan covers your maternity care under the Medical/Surgical Benefits Program. Under The Empire Plan, you may choose a participating or non-participating provider for your maternity care.

Participating Provider

If you choose a participating provider (obstetrician, family practice physician or certified nurse-midwife), there are no copayments for prenatal visits, delivery or your six-week checkup after delivery. You pay only your copayment for covered services at participating laboratories.

To locate an Empire Plan participating provider or laboratory, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select UnitedHealthcare. Or, visit the New York State Department of Civil Service web site at https://www.cs.state.ny.us, choose Benefit Programs, then NYSHIP Online and click on Find a Provider. Always check with the provider before you receive services to make sure he or she participates in The Empire Plan for New York government employees.

Non-Participating Provider

If you choose a non-participating provider (obstetrician, family practice physician or certified nurse-midwife), after the annual deductible is met, The Empire Plan pays 80 percent of the reasonable and customary charges for maternity care up to your coinsurance maximum. You pay the balance. There are separate charges for services at non-participating laboratories.

2. Call The Empire Plan at
1-877-7-NYSHIP
(1-877-769-7447)

The Empire Plan Hospital Benefits Program provides your hospital coverage at hospitals or licensed birthing centers through Empire BlueCross BlueShield. You must call for preadmission certification before maternity and other hospital admissions related to your pregnancy.

3. Enroll in the Future Moms Program

As soon as you know you are pregnant, call 1-877-7-NYSHIP (1-877-769-7447) for preadmission certification and select Option 2 for Empire BlueCross BlueShield and to learn about the Future Moms Program. Call early - during the first month of pregnancy, if possible - and tell the representative you're calling about your pregnancy. The maternity specialist will ask you some questions to determine if there are any potential concerns. Questions may include:

- Is this your first pregnancy?
- Have you had problems during previous pregnancies?
- Do you have diabetes?
- Do you have urinary tract infections?

The maternity specialist can also send you materials that include:

- Prenatal Kit
- *Your Pregnancy Week by Week* pregnancy book
- Maternity Care Guide
- *Eating for Two* brochure

Doctors report problems in three out of every ten pregnancies; however, early diagnosis and care can help you have a healthy baby.

If you choose to enroll in the Future Moms Program, you will be assigned a registered nurse who specializes in pregnancy to support you with things such as:

- Proper self-care
- Signs and symptoms of possible pregnancy-related complications
- Breastfeeding
- Delivery options
- Smoking cessation
- Nutrition counseling

Your nurse will check in with you periodically about your progress. He or she can also help you develop questions to ask at your next doctor's visit and may also call your doctor to discuss possible follow-up. Under The Empire Plan, you, your doctor and your nurse work as a team.

As you get closer to your due date, your nurse will help you start planning your baby's birth and your recovery. And once you've delivered, you will receive a birth kit with handy tools to help you care for your little one.

4. Be informed

Ask your doctor or nurse-midwife, the doctor's nurse and the maternity specialist all your questions. Community resources and web sites listed here provide even more information. Be informed. Make sure you know how you can have a healthy pregnancy and baby.

5. Enroll your baby for coverage

Remember to change from individual coverage to family coverage or add your baby to your family coverage. If you are an active employee, contact your agency Health Benefits Administrator within 30 days of your baby's birth.

If you are a retiree, write to the Department of Civil Service Employee Benefits Division, Alfred E. Smith State Office Building, Albany, New York 12239, within 30 days of your baby's birth.

* Your *NYSHIP General Information Book* has more information about changing your coverage.

* Retirees of Participating Agencies: Call the Health Benefits Administrator at your former agency.

Prenatal Testing

Prenatal tests are medical tests you receive while you are pregnant. They help your doctor monitor your health during pregnancy and the health of your developing baby.

Some prenatal tests are given to almost all pregnant women. These include blood pressure checks and blood and urine tests.

The Empire Plan covers in full all routine pre- and postnatal visits and urinalyses received from Empire Plan participating obstetricians/gynecologists, family practice physicians or certified nurse-midwives. Additional testing, based on medical necessity, is also covered but may be subject to a copayment. The Empire Plan Basic Medical Program covers services received from non-participating providers. (See your *NYSHIP General Information Book* and *Empire Plan Certificate* for more information about The Empire Plan Basic Medical Program.)

Your doctor will listen to your baby's heartbeat at each visit (beginning when your baby's heart is developed enough to be heard - usually by about 12 or 13 weeks). After about 20 weeks, your doctor will begin measuring your abdomen to follow your baby's growth. A normal heartbeat and growth rate are important signs that your baby is developing properly. Prenatal care also usually includes tests for:

- Hepatitis B, syphilis and other sexually transmitted diseases that could be dangerous to a developing baby. A Pap smear to rule out possible cancer of the cervix is given and a test for HIV, the virus that causes AIDS, is offered.
- Presence of antibodies in your blood to show immunity to rubella (German measles) and varicella (chickenpox), which can cause birth defects if you are infected during pregnancy.
- Anemia (low red blood cell count) to make sure you are getting enough iron. Too little iron could cause you to feel especially tired and possibly increase your risk of delivering your baby too soon.
- Your blood type, including whether or not you carry a protein called the Rh factor. Women who do not have the Rh factor are considered Rh negative and usually need a series of injections to protect their babies from a possible blood problem.
- Bacteria in your urine, which could indicate an infection that can pose a serious risk for both you and your baby.
- Sugar in your urine, which can be a sign of diabetes. Your doctor may suggest additional tests if sugar shows up in your urine.
- Protein in your urine, which can indicate a urinary tract infection or, later in pregnancy, a pregnancyrelated condition that includes high blood pressure. Your doctor may suggest additional tests if your urine has protein in it.
- Gestational diabetes. A glucose tolerance test that is usually performed at about 28 weeks identifies this condition.
- Presence of Group B streptococcus (GBS). Your doctor performs a cervical test at about the sixth month of your pregnancy. If the bacteria is present (common for many women and considered a normal part of a woman's reproductive system), you may receive treatment during labor to protect the baby from becoming infected during birth.
- Cystic fibrosis (CF), an inherited disease that can severely affect breathing and digestion.

Your doctor may perform other prenatal tests, depending on your medical and family history and that of the father, as well as the course of your pregnancy. These tests include a blood screening for alphafetoprotein (AFP) given between the 16th and 18th weeks of pregnancy. This screening determines a baby's risk for certain disorders including Down syndrome. One or more ultrasounds may also be offered. An ultrasound uses sound waves to create a picture of the baby and helps the doctor date the pregnancy and follow the baby's growth and development. This test also helps determine the presence of more than one baby, the level of fluid around the baby, the health and location of the placenta and the sex of the baby.

Women at increased risk of certain pregnancy problems may be offered additional tests. These tests include amniocentesis, a test of the fluid surrounding the baby that detects certain genetic abnormalities; chorionic villus sampling (CVS), a sampling of the baby's tissue from the fingerlike projections in the placenta; and/or a fetal non-stress test that measures the frequency of a baby's movement in the womb and how the baby's heart rate relates to the movement.

If you have any questions about prenatal tests or the terms used in this article, talk with your doctor. If you are unsure whether a test will be covered, call The Empire Plan toll free at 1-877-769-7447 (1-877-7-NYSHIP) before you receive the test.

Exercise During Pregnancy

You may wonder if it is safe to exercise during pregnancy. Unless there is a medical reason to avoid exercise, the American College of Obstetricians and Gynecologists (ACOG) recommends moderate exercise for at least 30 minutes on most - if not all - days of your pregnancy. Exercise can:

- Prevent high blood pressure and gestational diabetes (that sometimes develop during pregnancy).
- Build stamina for labor and delivery.
- Ease common discomforts like constipation, backache, fatigue and varicose veins.
- Enhance well-being and promote early recovery and weight loss after labor and delivery.
- Relieve some emotional strains during the postpartum period when baby blues may begin.

A few notes about safety

- Before you begin exercising, discuss your plans with your doctor.
- Be careful choosing your exercises. Stay away from activities that may put you at high risk for injury, such as horseback riding or downhill skiing.
- Do not engage in activities like soccer or kickboxing that could injure your abdomen.
- After your first trimester, avoid exercise that requires you to lie flat on your back, which can reduce blood flow to the uterus and endanger your baby.
- Brisk walking, swimming, hiking or dancing are usually safe choices.
- Try aerobics and yoga classes designed for pregnant women.
- Avoid overheating while exercising, and do not exercise on hot, humid days.
- Drink plenty of fluids before, during and after exercise.

Low-birthweight Babies

Low birthweight is considered to be a weight of 5 pounds 8 ounces or less at birth. One of every 12 babies born each year in the United States has a low birthweight. This low birthweight is linked to 65 percent of infant deaths and serious risk for long-term health challenges such as mental retardation, cerebral palsy and impairments in lung function, sight and hearing. According to the March of Dimes, you may prevent low birthweight if you:

- Have pre-pregnancy checkups.
- Take a multivitamin containing 400 micrograms of B-vitamin folic acid (the amount in most multivitamins) every day before and early in your pregnancy. Natural sources of folic acid include orange juice, peanuts, green leafy vegetables, beans, broccoli, asparagus, peas, lentils and enriched grain products. (Folic acid

helps prevent birth defects of the spine and brain. A baby's spinal column is formed a few days after a woman first misses her period.)

- Stop smoking. Smokers, on average, have smaller babies than nonsmokers. Exposure to another person's smoking when you're pregnant may decrease your baby's birthweight. Smoking during pregnancy may lead to preterm birth and stillbirth. Babies of mothers who smoked during pregnancy are more likely to have poor lung development, asthma and respiratory infections and to die of sudden infant death syndrome (SIDS). See here for smoking cessation resources.
- Stop drinking alcohol, using illicit drugs, or taking prescription or over-the-counter drugs (including herbal preparations) that are not prescribed by a doctor who knows you are pregnant. Drug and alcohol use limits fetal growth and can cause birth defects.

When you are pregnant:

- Get early, regular care.
- Eat a balanced diet with enough calories for a developing baby (usually about 300 calories a day more than a woman normally eats). A fetus is nourished by what a mother eats, and it can suffer if the mother eats poorly.
- Gain enough weight, but not too much. Health care providers recommend that a pregnant woman of normal weight gain 25 to 35 pounds.

Based on information from the March of Dimes

Feeding Your Baby

The most precious gift you can give your baby is a healthy start in life. Whether to feed your newborn breast milk or formula is one of the first, most important health decisions you make for your baby. Babies fed either breast milk or formula can grow and develop normally, and each offers advantages. Cow's milk is not recommended for the first year.

Feeding time is a wonderful opportunity to bond with as well as nourish your baby and to stimulate intellectual, social and emotional development.

What you feed your baby is a very personal decision. Talk to your doctor early in your pregnancy about whether breast milk or formula is best for you and your baby. Then you'll have time to think about it before your baby is born.

Breast Milk

Breast milk is a complete form of nutrition for almost all babies. And, as an infant grows, the mother's milk changes to adapt to the child's changing needs. Extra ingredients are present in breast milk, a unique source of food that cannot be duplicated. Breast milk usually is easily digested by a baby, and may reduce gas and discomfort. It naturally provides ideal amounts of protein, sugar, fat, most vitamins, growth factors, hormones and other substances a baby needs for healthy growth and development. Breast milk also contains fatty acids to promote brain development, antibodies and other substances that help protect a baby from illness.

Studies show that babies fed breast milk may have a lower incidence of vomiting, diarrhea, ear infections, lower respiratory infections, urinary tract infections and bacterial meningitis, and that breastfeeding may protect against sudden infant death syndrome (SIDS). Breast-fed children may have fewer childhood cancers and allergies, stronger bones, lower blood pressure, better pain relief and stress reduction and higher intelligence than formula-fed children. Later in life, diabetes, asthma and obesity are less common among adults who were fed breast milk as babies. Breastfeeding also promotes correct development of jaws, teeth and speaking abilities.

Breastfeeding increases the mother's production of hormones that help reduce her risk of uterine bleeding after delivery. These hormones may calm and relax her, which may protect her from postpartum depression. Breastfeeding mothers may lose weight gained during pregnancy more easily, have less chance of developing anemia after delivery and are less likely to develop osteoporosis later in life. Mothers who breastfeed are at reduced risk for ovarian, uterine, endometrial and breast cancer.

Economic Advantages of Breastfeeding

- Breast milk is almost always available and has no charge.
- Breastfeeding helps babies fight off disease and infection and, therefore, lessens medical bills.
- Breastfeeding is good for the environment: no disposable bottles, cans or boxes, and no energy demands like those created for the production and transport of formula.

The American Academy of Pediatrics recommends feeding a baby breast milk exclusively (no water, juice, nonhuman milk, formula or food) for the first six months of a baby's life, and continuing breastfeeding throughout the baby's first year.

Formula

Formula is a satisfactory alternative to breast milk, and particularly appropriate when the baby is adopted or maternal illness, breast abnormality or breast surgery prevents breastfeeding.

A variety of formulas are available and each offers essential nourishment and different compositions for the digestive and dietary needs of babies.

If you decide to feed your baby formula, be sure the one you choose provides DHA and ARA, nutrients that build healthy brains and eyes. Ask your pediatrician for a recommendation about which formula is best as your child grows and changes.

Calcium, iron, easy-to-digest protein, a healthy level of calories and vitamins and minerals are vital to the baby's health and development and should be in any formula you choose.

Certain formulas are very similar to breast milk. Some mothers combine breast milk and formula feeding, which benefits the baby by providing special nutrients and enables the mother and other caregivers to take advantage of the conveniences and other benefits of formula feeding.

Based on information from the American Academy of Pediatrics, Centers for Disease Control, March of Dimes, National Cancer Institute and WebMD

Choosing Your Baby's Doctor

By the second trimester, follow this checklist of questions when choosing your baby's doctor:

___ Is the doctor an Empire Plan participating provider?

___ What are the office hours?

___ When is the best time to call with routine questions?

___ Is emergency coverage available 24 hours a day, including weekends?

___ Who covers for the doctor if he or she is unavailable?

___ What is the physician's pediatric background? Is he or she board certified? Does the doctor have a subspecialty if your child has special medical needs?

___ At what hospitals does the doctor admit patients? Are the hospitals in The Empire Plan network?

___ Are the doctors who cover for the doctor affiliated with the same hospitals? Are they board certified?

___ Are waiting rooms and exam rooms clean and engaging for you and your child?

___ How friendly and helpful is the office staff?

Your Pediatrician

Choosing a pediatrician is an important part of planning for a new baby. This is the doctor who will care for your child as he or she grows and develops.

A good time to start looking is about six or seven months into your pregnancy. Ask relatives and friends for recommendations. Talk to parents in your neighborhood or get referrals from your own doctor.

Avoiding Preterm Birth

A new survey shows a majority of new and expectant moms have not discussed preterm birth with their doctors, despite the fact that early prenatal care, including discussion about lifestyle habits and personal and family medical history, may give babies a better chance of a healthy, full-term birth.

Preterm birth, or the birth of a baby prior to 37 completed weeks of pregnancy, is a serious problem that affects more than half a million babies in the United States each year. It is the leading cause of infant death in the United States and babies who survive often face serious complications and lifelong disability.

Talking about preterm birth with your doctor early enough and covering all important topics, such as risk factors, represents a challenge for moms and doctors. According to the survey, only one in four new or expectant moms say they discussed preterm birth with their doctors before the second trimester. Also, although one of the most significant risk factors is having had a preterm birth before, nearly 40 percent of moms who have previously delivered preterm were not informed that they may be at risk for a subsequent preterm birth.

The March of Dimes recommends that every woman have a medical checkup before getting pregnant to identify and manage conditions that contribute to preterm delivery. They also urge women and doctors to talk about risk factors for premature birth as early as possible.

Expectant Father?

Many men - like many women - have never cared for a baby until their own is born. So, for both dads and moms, a baby can be exciting and unfamiliar at the same time. As a dad, you have a vital role in the health and well-being of your baby.

- Hold and cuddle your baby. Your baby will feel safe in your arms.
- Smile and laugh with your baby. Studies show that a baby can recognize his or her parents within the first week of life.
- Play with your baby. This helps both you and your baby thrive and form a strong bond.
- Talk to your baby. Your baby will quickly learn your voice and know that you are his or her father.

- Change your baby's diapers. Many fathers remember this seemingly tiresome chore as a good memory instead of a bad one.
- Offer to help with feeding so that mom can get plenty of rest.
- Take your baby for walks. Babies love the sights and sounds of the outdoors.

Dependent Care Advantage Account (DCAAccount)

For eligible employees of the State of New York Executive Branch who are Management/Confidential or represented by Council 82, CSEA, DC-37, Legislature, NYSCOPBA, PBA, PEF, PIA, Unified Court System, UUP.

Will you need child care for your baby? The Dependent Care Advantage Account (DCAAccount) could help save you money by allowing you to pay for your child's care with pre-tax dollars. Under this program, you may set aside up to $5,000 in pre-tax salary for eligible child care. See your agency Health Benefits Administrator for details or visit www.flexspend.state.ny.us.

Employees of Participating Employers and employees of Participating Agencies: Ask your agency Health Benefits Administrator if a similar benefit is available to you.

Baby Blues

For most women, the birth of a child is a time of joy and pleasure. At the same time, 50 to 80 percent of new mothers experience the "baby blues" during the first week after delivery. These feelings of moodiness, depression, anxiety, irritability, and fatigue, sometimes attributed to after-delivery hormonal changes, typically last only a few days and are gone within two weeks of the birth.

However, for some new mothers, a more serious form of depression may develop *any time within a year* of childbirth. Women with this "postpartum depression" can experience any number of symptoms, the most common of which are extreme sadness, crying, guilt, feelings of hopelessness and/or worthlessness, difficulty concentrating, fatigue, changes in eating habits and insomnia. In more extreme cases, fear of harming the baby (though this rarely happens) and suicidal thoughts can occur.

What causes postpartum depression?

Most experts agree that it is the result of many factors. Evidence suggests that changes in hormones after delivery such as estrogen, progesterone and thyroid are involved. Complications during labor and delivery, a severe case of baby blues, having a "difficult baby," and stress and lack of emotional support related to the care of the child also may contribute to the problem. In addition, there are factors unrelated to delivery that place the mother at risk for developing postpartum depression. These include a personal or family history of depression or mood disorders, relationship problems, unemployment of the mother or her partner or other stressful events during the preceding year.

What should you do if you think you are suffering from postpartum depression?

First, don't be afraid to let your doctor know what you've been experiencing. Unfortunately, you may be one of as many as 50 percent of women with this problem who never acknowledge the symptoms or seek treatment and therefore suffer needlessly. Once your doctor is aware of the problem, he or she can help you determine the best form of treatment for you. This may include counseling from the physician or a mental health professional, involvement in a postpartum depression support group, medication or a combination of two or more of these approaches.

Remember that you may get valuable support by telling your partner or a relative or friend how you're feeling. Finally, take care of yourself. Eat well, get plenty of rest, try to exercise every day, ask for help from others and spend time with friends.

More about Baby Blues

There is helpful information about postpartum depression on the customized Empire Plan Mental Health and Substance Abuse Program web site at www.liveandworkwell.com (use access code Empire in the right-hand navigation). You can find self-help questionnaires, articles and other resources by going to the Mental Health Condition Center and selecting Depression, then choosing Postpartum Depression.

If you think you or a loved one is suffering from postpartum depression, or if you have questions, call The Empire Plan toll free at 1-877-7-NYSHIP (1-877-769-7447) and select Option 3 for OptumHealth.

Questions and Answers

Q. Will my dental work pose a risk to my unborn baby?

A. Routine dental work should continue throughout your pregnancy and should not cause concern. In fact, delaying needed dental work could be risky. Badly decayed teeth or impacted wisdom teeth can cause infection that could spread and endanger both you and your baby. When your body is fighting to stay healthy, by-products and chemicals are produced and travel through your bloodstream. If these chemicals reach your uterus, they may cause premature labor. Research suggests that women who have gum disease or periodontitis may be seven times more likely to have a baby born too early and too small.

Be sure to tell your dentist or hygienist you are pregnant so necessary precautions are taken. Avoid X-rays unless they are absolutely necessary. The American Dental Association recommends brushing teeth thoroughly twice a day with fluoride toothpaste to remove plaque and prevent tooth decay and periodontal disease and cleaning between teeth daily with floss or interdental cleaners.

Q. My friend told me I shouldn't touch raw meat or clean my cat's litter during my pregnancy. Is she right?

A. Germs that cause only mild or no symptoms at all in adults can be deadly to an unborn fetus. The parasite that causes toxoplasmosis is found in raw meat and cat feces and can cause severe brain damage in the fetus. Pregnant women should practice good hygiene when handling raw meat, avoid contact with sandboxes and litter boxes and wear gloves when gardening.

Q. I am a victim of domestic violence. Where can I go for help?

A. Call the New York State Coalition Against Domestic Violence hotline toll free at 1-800-942-6906; for a Spanish-speaking representative, call 1-800-942-6908. And, talk with your doctor. Your baby's health is at stake.

Q. Is it safe for me to use household cleaning products while I'm pregnant?

A. Some cleaning agents may cause birth defects after prolonged direct contact with your skin. Be careful not to use cleaners with strong fumes, like oven cleaners. Wear gloves and facial protection and work in a well-ventilated area. Read labels to check if the substance is dangerous for pregnant women. Contact the manufacturer, talk with your agency health and safety officer or ask your doctor if you have questions.

Childbirth Education Classes

In the sixth or seventh month of your pregnancy, you and your partner (or a family member or friend who will be your labor support or coach) may want to start taking a childbirth education class. These classes usually run for six or eight weeks and include:

- information about what you can expect during pregnancy, labor and delivery;
- suggestions of proper diet and exercise during pregnancy;
- relaxation and breathing techniques to use during labor and delivery;
- how your partner or labor coach can best help you during delivery; and
- a chance to meet and spend time with other expecting parents.

Taking a childbirth education class can reduce your stress by preparing you to deal with what might happen during pregnancy, labor and delivery. Contact your doctor's office or your local hospital or birthing center for more information about childbirth education classes. Call early in your pregnancy to make a reservation. **Note: Any charges for these services will not be reimbursed by The Empire Plan.**

Q. If a woman is HIV positive, will her baby be born HIV positive too?

A. Women who are HIV positive can help protect their babies. New drugs can reduce the risk of HIV positive mothers passing the virus onto their babies to 2 percent or less, compared to a risk of about 25 percent for untreated mothers. It is important for a woman considering pregnancy or who is already pregnant to have a simple blood test to determine if she is HIV positive. The New York State AIDS Hotline provides information about free anonymous testing. Call toll free 1-800-541-2437; for a Spanish-speaking representative, call toll free 1-800-233-7432.

It is better to be tested for HIV during pregnancy than to wait until delivery. If a woman without prenatal HIV test results declines HIV testing during delivery, hospitals are required to conduct expedited HIV testing on her newborn. Treatments for mom during or shortly after delivery can reduce transmission from mother to baby by up to two-thirds. If you are HIV positive, do not breastfeed your baby. The HIV virus can be carried in breast milk.

Q. I'm 36 years old. Is pregnancy safe after age 35?

A. Most women who are 35 and over have healthy pregnancies. However, the risks associated with pregnancy increase gradually with age. While advances in medical care can help women over age 35 have safer pregnancies than in the past, pregnancy complications for this age group are higher than for younger women.

Good prenatal care is especially important for women over 35 because they're more likely to develop high blood pressure and gestational diabetes for the first time during pregnancy. They're also at increased risk of having placental problems, a miscarriage or stillbirth, or having a baby with a genetic disorder like Down syndrome.

If you have decided to delay having a child, you should understand the risks associated with this so you can take precautions to minimize risks and improve your chances for a healthy pregnancy and child. Talk to your doctor and enroll in The Empire Plan Future Moms Program.

Q. Is there any reason to limit fish intake during my pregnancy?

A. Yes. Although fish and shellfish are an important part of a healthy diet, certain types of fish may be contaminated with high levels of mercury or industrial pollutants, which can be harmful during pregnancy. When a pregnant woman consumes large amounts of mercury, her baby may suffer brain damage.

The U.S. Food and Drug Administration (FDA) recommends that women who could become - or who are - pregnant avoid eating swordfish, shark, king mackerel or tilefish, which can contain high levels of mercury. Instead, the FDA recommends eating up to 12 ounces (two average meals) a week of a variety of fish and shellfish that are lower in mercury such as shrimp, salmon, pollock, catfish and canned light tuna. Because tuna steak and albacore ("white") tuna generally contain higher levels of mercury than canned light tuna, the FDA recommends limiting intake of tuna steak and albacore tuna to six ounces (one average meal) per week. Talk with your doctor about diet recommendations.

Q. Is it possible for me to transfer a sexually transmitted disease (STD) to my unborn baby?

A. Sexually transmitted diseases in pregnant women may cause spontaneous abortion and/or infection in the newborn. Complications for the newborn may include pneumonia, eye infections and permanent neurological damage. If you think you have a sexually transmitted disease, see your doctor as soon as possible. Most STDs are treated easily. The earlier a woman seeks treatment, the less likely she is to pass the disease on to her baby.

Q. How can I prevent exposing my baby to dangerous levels of lead?

A. Renovating a home built before 1978 may expose you, your baby and young children in your home to high lead levels. Be aware of lead paint on surfaces such as windowsills, railings and stair edges, especially at a height that a child may chew or mouth. Before renovating, consider testing the painted surfaces for lead. Your local health department can recommend experts. Pregnant women exposed to high levels of lead may be at increased risk for miscarriage, preterm labor or having a baby with developmental delays. If lead is found, hire an expert who follows safety precautions (such as blocking off the room) to remove it. Stay out of the home until the paint is gone and cleanup is completed. Have workers wet-mop dust or chips from the paint to prevent them from becoming airborne. After your baby is home, make sure painted surfaces are in good condition, especially those your baby can touch.

To minimize levels of lead in tap water, the Environmental Protection Agency recommends running your tap water until it is cold - at least 60 seconds - and a minimum of two minutes if the tap has not been used for more than six hours. Use only cold tap water for drinking, cooking and making infant formula. Call your local health department or your doctor if you have questions.

Q. I have heard of babies dying of SIDS. What is it and how can I reduce my baby's risk?

A. SIDS is "sudden infant death syndrome," the diagnosis for the sudden unexplained death of an infant under one year of age. SIDS is the leading cause of death in infants between one month and one year of age. Most SIDS deaths occur between the ages of two and four months. While there is no way to predict which babies will die from SIDS, there are ways to lower your baby's risk:

- Put your baby to sleep on his or her back (unless advised otherwise by your doctor), even for naps.
- Place your baby on a firm mattress and not a soft surface (like a waterbed).
- Do not use fluffy pillows or comforters, or put soft pillow-like toys in your baby's crib.
- Keep your baby's face and head uncovered during sleep.
- Do not let your baby get too warm during sleep.
- Take your baby for regular well-baby checkups and routine immunizations.
- Smoking during pregnancy has been associated with increased risk of SIDS. Do not smoke during pregnancy or allow smoking around your baby. See here for smoking cessation resources.

Resources

All 1-800, 1-877 and 1-888 telephone numbers are toll free.

Alcoholism and Substance Abuse
NYS Office of Alcoholism and Substance Abuse Services
1-800-522-5353

Cancer
National Cancer Institute
1-800-4-CANCER
(1-800-422-6237)

Diabetes
American Diabetes Association
1-800-DIABETES
(1-800-342-2383)

Domestic Violence
NYS Coalition Against Domestic Violence Hotline
1-800-942-6906

Spanish NYS Coalition Against Domestic Violence Hotline
1-800-942-6908

Environmental Health
NYS Department of Health
1-800-458-1158

Food and Nutrition
Growing Up Healthy Hotline, NYS Department of Health
1-800-522-5006

Heart Health
American Heart Association
1-800-AHA-USA-1
(1-800-242-8721)

HIV/AIDS
NYS AIDS Information Hotline, NYS Department of Health
1-800-541-2437

NYS Spanish AIDS Information Hotline, NYS Department of Health
1-800-233-7432

Lead Exposure
National Lead Information Center Hotline, U.S. Environmental Protection Agency
1-800-424-LEAD
(1-800-424-5323)

Oral Care
American Dental Association
312-440-2500

Pregnancy and Birth Defects
March of Dimes
1-888-MODIMES
(1-888-663-4637)

Smoking Cessation
New York State Smokers' Quitline, NY Residents
1-866-697-8487

North American Quitline Consortium, Residents of Other States
1-800-QUIT-NOW
(1-800-784-8669)

This Reporting On is based in part on information from:

- American Academy of Pediatrics (www.aap.org)
- American College of Obstetricians and Gynecologists (www.acog.org)
- American Dental Association (www.ada.org)
- American Medical Association (www.ama-assn.org)
- Centers for Disease Control and Prevention (www.cdc.gov)
- March of Dimes (www.marchofdimes.com)
- National Institutes of Health (www.nih.gov)
- U.S. Environmental Protection Agency (www.epa.gov)
- U.S. Food and Drug Administration (www.fda.gov) and
- WebMD (www.webmd.com).

Visit the web sites of the sources listed here for more details. The Empire Plan NurseLineSM at 1-877-7-NYSHIP (1-877-769-7447) offers health information and support from an experienced registered nurse, 24 hours a day, 7 days a week. You can call the same number to reach The Empire Plan NurseLine's Health Information Library. Enter PIN number 335 and a four-digit topic code from The Empire Plan NurseLine brochure. If you do not have your brochure, ask the NurseLine nurse to send you one.

PDF Version

Attachment 7 - Sample Customized Forms and Communications

Sample Customized Forms and Communications

1. Empire New EOB Sample **1**

2. Adverse_Determination Letter **5**

3. Empire Plan_Appeal Rights and Instructions **11**

4. Sample Customizable Communications **17**

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Attachment 72
August 15, 2010
May 20, 2014

THE EMPIRE PLAN
New York State Health Insurance Program

[redacted]

[redacted]

[redacted]

August 15, 2010

[redacted]

THE EMPIRE PLAN
New York State Health Insurance Program

[redacted]

Use this EOB statement as a reference or retain as needed

[redacted]

THE EMPIRE PLAN
New York State Health Insurance Program

[redacted]

Use this EOB statement as a reference or retain as needed

[redacted]

THE EMPIRE PLAN
New York State Health Insurance Program

[redacted]

[redacted]

Use this EOB statement as a reference or retain as needed

[redacted]

Attachment 7-7
May 20, 2014

[redacted]

[redacted]

Attachment 7-10
May 20, 2014

[redacted]

[redacted]

Reviewed 03-2013

The Empire Plan

[redacted]

The Empire Plan

[redacted]

The Empire Plan

[redacted]

The Empire Plan

[redacted]

The Empire Plan

[redacted]

Attachment 7-18
May 20, 2014

OPTUM™

Logo Box

Your Behavioral Health Benefit

Live Area

At times you may feel overwhelmed. Maybe you have a personal or workplace issue that consumes your thoughts. Perhaps you, your child or your spouse is struggling with stress, depression or addiction.

We can help. Your Behavioral Health Benefit is designed to provide confidential support for those everyday challenges, and for more serious problems. It's available around the clock — anytime you need it.

What Can My Behavioral Health Benefit Do For Me?

Your Behavioral Health Benefit — which includes counseling and substance abuse recovery services — can help you effectively deal with stressful and challenging situations. People often call for such personal issues as:

- Depression
- Anxiety and stress
- Alcohol abuse
- Drug abuse
- Anger management
- Coping with grief and loss
- Marital problems
- Domestic violence
- Eating disorders
- Compulsive spending or gambling
- Medication Management

For more information, give us a call or visit **www.liveandworkwell.com**.

(See back for details.)

Call toll-free

(800) 000-0000

TDD/TTY Information limited to a character count

or log on to
www.liveandworkwell.com
access code: 00000

We're here to help you and your family with a wide range of personal and work-related needs.

OPTUM™

Logo Box

Your Behavioral Health Benefit

Live Area

How Does It Work?

Accessing your Behavioral Health Benefit is easy and available 24 hours a day. Simply call the toll-free number on this flyer. A specialist will help you identify the nature of your problem and the appropriate resources to address it. If you want to see a clinician, we'll match you with one in our network who has the appropriate experience to help.

Connecting Online

For 24-hour, confidential access to your Behavioral Health Benefit and tools to help you enhance your work, health and life, simply visit liveandworkwell.com. You can check your benefit information and submit online requests for services, search our online directory of clinicians, access information and resources for hundreds of everyday work and life issues in one of our many virtual help centers, and participate in interactive, customizable self-improvement programs. Any member of your household may access these online resources, including dependents living away from home.

How Much Will This Benefit Cost?

Services received through your benefit may require pre-authorization and/or a copayment, and there may be a deductible. There is no charge for obtaining a referral, and you may access information and develop personal plans at liveandworkwell.com as often as you want for free. For more information, please refer to your employer-provided benefit information.

Are Services Confidential?

We'll never share your personal records with your employer or anyone else without your permission. All records, including medical information, referrals and evaluations, are kept strictly confidential in accordance with federal and state laws.

In an emergency, the first concern is your health.
Call 911 or get to an emergency room as soon as possible.

Free.
Confidential.
All day, every day.

Your Behavioral Health Benefit

Call any time for help with the demands of everyday life.

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Attachment 7-20
May 20, 2014

OPTUM™

Helpful Hints for Managing Bipolar Disorder

Bipolar disorder is an illness characterized by extreme and unpredictable mood swings that occur in between periods of generally even mood. If you have this illness, you may find yourself feeling "on top of the world" and capable of doing anything, only to feel devastated by depression and worthlessness several days to weeks later.

If you or a loved one has been diagnosed with bipolar disorder, there are many useful strategies you can use to maintain normalcy and live a happy, healthy, productive life.

Learn all you can about your illness and share the information with your family

Read books, attend lectures, talk to your doctor and therapist, and consider joining a nearby chapter of the Depressive and Manic-Depressive Association or the National Alliance for the Mentally Ill.

Maintain a stable sleep pattern

Go to bed around the same time each night and get up about the same time each morning. Disrupted sleep patterns can cause chemical changes in the body that can trigger mood swings. If you are having trouble sleeping or are sleeping too much, tell your doctor and therapist.

Maintain a regular pattern of activity

Schedule regular activities in your day — such as work, exercise, and social events with friends. Do not overburden yourself with activity, but be careful not to isolate yourself and withdraw from activities and friends. Social interaction is an important part of mood regulation.

Do not use alcohol or illicit drugs

These chemicals cause an imbalance in how the brain works and can trigger mood swings. You may be tempted to use alcohol or drugs to treat your mood or sleep problems, but this almost always makes matters worse.

Take your prescribed medications correctly

You may be tempted to stop your medications, skip a dose or take less than prescribed. Non-adherence with medications has been shown to significantly increase your risk of relapse. Talk to your doctor if you are thinking of stopping or reducing your medications.

Know your early warning signs

Talk with your therapist, doctor and family, and learn to identify your early warning signs. Changes in sleep patterns, energy level and thinking are some possible warning signs to watch for. Once you learn them, you and your treating clinicians can take action before the symptoms become too extreme.

Keep track of your moods

Sometimes slight changes in mood can lead to full-blown episodes of depression and/or mania. Talk to your therapist about simple techniques for monitoring your mood and other warning signs.

Stay open to feedback

Most people can tell when they are going through depression, but not when they are going into a manic episode. The people around you might notice warning signs before you do. Be willing to listen to feedback and talk to your doctor and therapist about it.

Know the stressors that put you at risk for returns

Events don't have to be negative to cause stress. Even positive events like weddings, the birth of a child, a job change, or a relocation can create stress. Once you know your stressors, you can collaborate with your providers to proactively plan coping strategies.

Try to reduce stress at work

Try to keep predictable hours that allow you to get to sleep at a reasonable time. If mood symptoms interfere with your ability to work, talk to your doctor or therapist to discuss possible options.

Seek support from family and friends

Bipolar illness often causes severe family distress. If you find this to be the case for your family, talk to your therapist and doctor. Family therapy and/or support groups might be useful.

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OPTUM™

Common Questions about Depression and Treatment

When is an antidepressant necessary?

Brief periods of depression can be normal, especially following a traumatic event (e.g., the loss of a loved one), and depression may go away on its own. Other times, talk therapy or counseling can be used effectively. But if feelings of depression last beyond 4-6 weeks, the recovery time could be decreased with the use of an antidepressant.

Normal grief or sadness can progress in some people to a depression that may include one or more of these symptoms:

- Irritability
- Sleep or appetite problems
- Fatigue
- Difficulty with concentration or memory
- Loss of interest in activities that once brought pleasure
- Chronic pain
- Anxiety attacks
- Nervousness or tension

A major depressive episode can last 6-9 months, but with treatment it can be shortened to a matter of weeks. Everyone is different, and while some people may only take antidepressants for six months, others will need to stay on them indefinitely (also known as maintenance therapy).

Are antidepressants habit-forming?

Antidepressants are not addictive. You will not become dependent on them. However, when discontinued, they may need to be tapered off slowly to avoid any physical discontinuation symptoms, and it is important to speak to your doctor beforehand.

Will antidepressants change my personality?

While antidepressants may radically change the way you feel, they will not affect your personality. They simply give you the chance to realize your potential by correcting an imbalance in the chemicals in your brain related to mood.

What are the side effects of antidepressants?

While there may be side effects while taking an antidepressant, they are usually mild and rarely dangerous to your health. Make sure to get a list of potential side effects from your doctor or pharmacist. Side effects usually occur in the first two weeks after beginning an antidepressant, and usually diminish as your body gets used to the medication. You should not discontinue taking your antidepressants because of side effects but rather discuss them with your doctor, who can adjust the dosage or switch to another antidepressant that doesn't cause you to have side effects.

Can I stop taking my antidepressants if I feel better?

No. The biggest mistake people make when taking antidepressants is stopping them as soon as they feel better. If you discontinue the medication before your course of treatment is through, you run the risk of having your depression return.

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Attachment 7-24
May 20, 2014

OPTUM™

Getting a Good Night's Rest

It's Monday night and you have to work in the morning.

11 p.m.: "Time to go to sleep."

12 a.m.: "I just need some warm milk, then I'll fall right to sleep."

1 a.m.: "If I fall asleep in the next five minutes, I'll still be able to get six hours."

2 a.m.: "I'll just drink lots of coffee tomorrow. I'll be just fine."

Either you or someone you know couldn't sleep last night. The National Sleep Foundation has found that 50 million Americans are sleep-deprived. Nearly 40 percent of Americans report getting fewer than seven hours of sleep per night and 60 percent say they experience insomnia several nights a week. Insomnia is characterized by a difficulty falling asleep or waking up too early or periodically during the night.

Many of us strive to get more done in a day and, in the process, forgo sleep. This lifestyle has a dangerous consequence — sleep deprivation. Sleep deprivation is linked to a myriad of problems — obesity, high blood pressure, a weakened immune system, irritability, decreased productivity, as well as concentration and memory problems. It can also contribute to accidents at home, at work and on the road.

Sleeping on It

People who go without sleep in order to get more done may actually end up getting less accomplished. Scientific evidence is beginning to show a link between sleep and brain function. Researchers suspect that sleep helps organize memories, solidify new learning and sharpen thinking. Creativity may also be enhanced after a good night's sleep.

In a German study, participants were asked to complete a math test that contained a shortcut. Those who had eight hours of sleep the night before were three times more likely than the sleep-deprived participants to figure out the right answers using the shortcut. Another study, at Harvard University, tested participants on a visual-identification task. The group that got a full night's sleep performed better on the task than the sleep-deprived group. These findings give credence to the stories of artists and scientists who awake to epiphanies after hours, even days, of frustration with trying to solve a problem.

Causes of Insomnia

Insomnia is often brought on by stress as people dwell on the day's concerns throughout the night. Night-shift work, eating too much too late, prolonged use of sleeping pills, medical issues (such as sleep apnea, hyperthyroidism, pain, or asthma) and psychological problems (such as depression or anxiety) are also contributing factors.

Getting to Sleep

Sleep experts say adults need between seven and nine hours of sleep each night. When you have insomnia, it's easy to accumulate a sleep debt. However, it's difficult to make up for lost sleep. In fact, when sleep-deprived individuals finally do sleep, they experience hyper-vivid dreams and nightmares, according to studies at the University of California, Los Angeles' Center for Sleep Research. That's why it's important to try to get plenty of sleep every night.

For most people, insomnia is a temporary condition and can be alleviated by taking some simple steps:

- Try going to bed and getting up at the same time every day.
- Cut down on caffeine and alcohol late in the day.
- Establish a regular bedtime routine in order to relax from a busy day.
- Shut out bright lights in the bedroom.
- Exercise regularly, but not within three hours before bedtime.
- If you do not fall asleep within 20 minutes, get out of bed and do a calming activity.

For some people, getting adequate sleep is not that easy. If you follow these tips and still have trouble sleeping, a visit to your medical doctor can determine if you have a physical problem that is affecting your sleep. Once you rule out a physical condition and if sleep problems persist, it may be a good idea to speak with a mental health professional. A psychological issue or stressor could be the cause.

The benefits of sleep serve as a strong incentive for getting a good night's rest, particularly for those who skip sleep in order to get more done. They'd be more productive and creative if they slept instead of burning the midnight oil. It's all the more reason to respect the need for sleep.

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Coping with Mental Illness and Addiction

Mental illness and substance abuse problems are each challenging disorders in their own right. But when people with a mental illness begin to use alcohol or drugs, the situation becomes even more difficult. Substance abuse may worsen the course of some mental disorders and make treatment much more challenging. Seeking professional help is the first step toward recovery. You can not do it alone. Once under the care of a trained professional, there is a lot you can do to ensure your own recovery and mental health.

The following are some simple tips:

Learn about your illness and share the information with your family and support group

Read books, attend lectures, talk to your doctor and therapist and ask questions. Educate your family and loved ones about the illness. Ask them to support you in your effort toward recovery.

Get involved in the treatment planning

Set small realistic goals with the help of your therapist. If your family is interested in being supportive, make them aware of your goals and tell them how they can help you achieve them.

Work an honest program

Denying or minimizing the impact of substance abuse or making excuses for using are not uncommon, but they do get in the way of treatment. Be honest with yourself and others about the extent of your substance abuse and your feelings about abstinence and/or medication compliance. Also, be honest about your strengths and weaknesses. It is quite possible that some of your strategies for coping have not been helpful to you.

Be open to feedback even if it is not particularly positive

The first step in making serious changes in your life is to accept that you need to do things differently. Be willing to listen to others. Find out what has worked for them. Try new strategies and don't be too proud to change your ways.

Take your medications as prescribed

You may be tempted to stop your medications or to not take them as they are prescribed. Non-adherence to medications can put you at risk for a worsening of your psychiatric symptoms. Always speak to your doctor first before changing the dosage and/or stopping your medications. Also, be sure to let all of your treatment providers know about your problems with substance abuse (this includes medical doctors, dentists, and all other physicians). Make them aware that some prescribed medications could compromise your recovery.

Substances may worsen the symptoms of psychiatric illness and make treatment difficult. They also reduce the effectiveness of your medications. Attend support groups such as Alcoholics Anonymous or Dual Recovery Anonymous. Stay away from friends who drink or use drugs.

Know your relapse triggers and warning signs

Work with your therapist and support group to identify your warning signs. A relapse starts long before you take a drink. There are generally many warning signs that precede a relapse and they all involve slipping back into old habits. Some common examples include erratic attendance at recovery groups or treatment sessions, reconnecting with peers who drink or use drugs, forgetting to tell your medical doctor about your problems with substance abuse, and being prescribed a mood-altering medication.

Structure your day

Too much idle time can be a set-up for relapse. Make sure you fill your schedule with healthful, productive activities. If you are not working, consider taking classes, doing volunteer work, or attending a day treatment program.

Don't lose hope

Even though progress can sometimes seem slow, don't lose sight of your goals. Use your therapist, family, and support system to get you through the challenging times. Always keep your strengths and values in mind. Remember to have compassion for yourself.

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Attachment 8-2
May 20, 2014

Sample Mental Health / Substance Abuse Annual Utilization Report

Produced for the New York State Empire Plan

Optum Behavioral Solutions

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2014 Annual Summary
The Empire Plan Mental Health and Substance Abuse Program

I Introduction

Optum Health Behavioral Solutions (Optum) is pleased to present the 2014 Annual Report for the Empire Plan Mental Health and Substance Abuse (MHSA) Program. We are pleased to have this opportunity to serve the New York State (NYS) membership and look forward to continuing to do so in the coming years.

Included in this report is an overview of the activities that took place throughout 2014 for the Empire Plan MHSA Program. A few highlights include:

Sample

- Successful implementation of Mental Health Parity and Addiction Equity Act for the Empire Plan.
- Updates on the three Empire Plan Disease Management Programs: Depression Management, Attention Deficit and Hyperactivity Disorder (ADHD) and the Eating Disorder Programs.
- Optum's presentation of the 2013 Annual Report and overview of the Empire Plan MHSA Program that included presentations on Substance Abuse Treatments and Overview, the Empire Plan Disease Management programs and Federal Mental Health Parity updates.
- Updates on the Behavioral Health, Medical, Pharmacy Synergy (BMPS) Initiative led by the Regional Medical Director for the Empire Plan MHSA Program.
- Optum held two Network Clinician Advisory Council (NCAC) meetings in 2014.
- Successfully concluded the Phase 3 recruitment for the Empire Plan MHSA Provider network.
- A communication to the medical provider community took place to promote awareness of the ADHD Disease Management Program and to alert physicians of the resources available to Empire Plan MHSA Program members with ADHD and to educate them on ADHD treatment best practices. The communication included a letter educating physicians on the ADHD program and an article containing helpful tips for parents of ADHD children.

II Program Performance

Optum continued to administer and enhance the Empire Plan's Mental Health and Substance Abuse Program in 2014. There was an overall increase in utilization for Acute Inpatient and Alternate Levels of Care (ALOC) and longer lengths of stay for enrollees admitted to these levels of care. Additionally, the number of outpatient visits in 2014 increased for both Mental Health and Substance Abuse as compared to 2013. This increase was anticipated and is attributed mostly to the utilization of dependents (18-26 year old) compared to the enrollee and spouse population of previous years. Healthcare Reform legislation, effective 1/1/2011, allows for young adult children up to age 26 to be covered as a dependent under the Empire Plan which is a main factor for this growth in utilization. Optum continues to see a larger percentage of enrollees in this age group seeking treatment. Other associated factors supporting this increase in utilization include the recent unstable economic climate, the increase in bullying, continued unemployment and resulting stress on the membership.

Sample

The ratio of utilization for all levels of care (Inpatient/ALOC and Outpatient) by Region for Mental Health and Substance Abuse remained stable in 2014.

Clinical Utilization

Plan wide Observations by Level of Care:

Mental Health Inpatient and Alternate Levels of Care (ALOC):

Mental Health Inpatient and ALOC days; admissions per thousand and average lengths of stay increased in 2011. The Mental Health Inpatient and ALOC days/1000 were xx.x/1000 in 2011 compared to xx.x/1000 in 2010 (see Chart A below). The Mental Health Inpatient and ALOC average length of stay increased from x.x days in 2013 to x.x days in 2014 while the admissions/1000 increased from x.x admissions/1000 in 2013 to x.x admissions/1000 in 2014 (see Chart A).

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Chart A: Mental Health Inpatient and Alternate Levels of Care (ALOC) for the Empire Plan MHSA Program: 2012-2014 Comparison

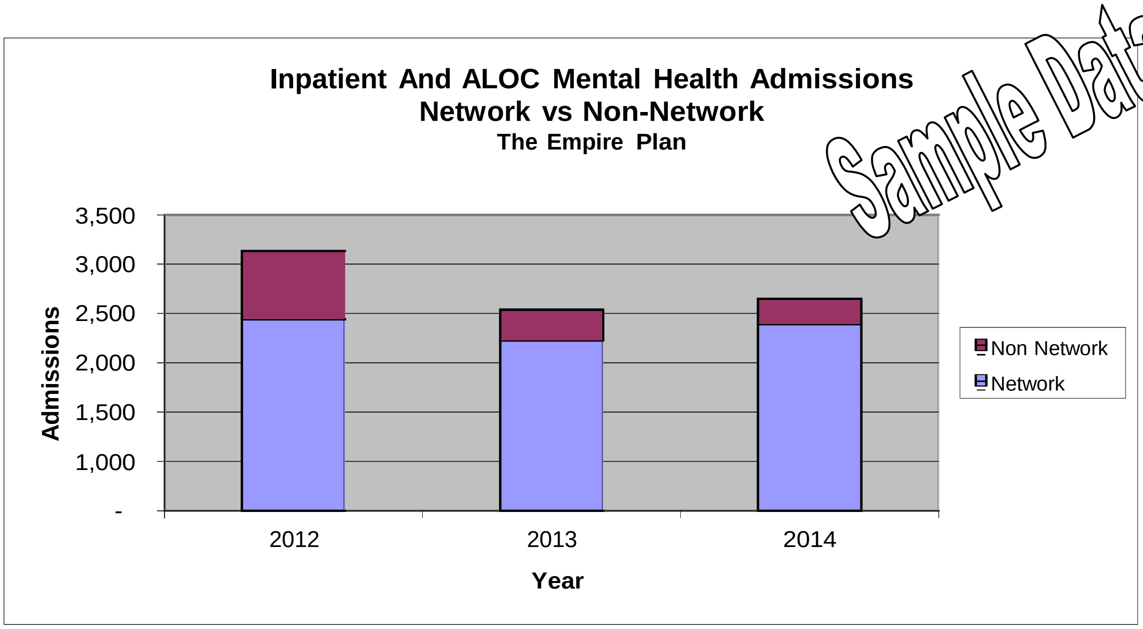
	Mental Health Inpatient and ALOC		
	2012 Empire MHSA Program	**2013 Empire MHSA Program**	**2014 Empire MHSA Program**
Admissions/1,000 Lives	x.x	x.x	x.x
Days/1000 Lives	x.x	x.x	x.x
Average Length of Stay (days)	x.x	x.x	x.x

Optum has worked with Facilities and Providers in making informed utilization decisions on a case by case basis. Care Advocates engaged in case shaping from the onset of the case. This proactive approach allowed members to be cared for at the necessary level of care, with the appropriate medications, treatment and discharge planning in an effort to help reduce readmissions starting from the date of admission. The Care Advocates evaluated Estimated Lengths of Stay throughout the episode of care, ensuring individuals were served optimally at one level of care before moving to a lower level of care, thus affecting utilization at all levels. While Non-Network Inpatient did have a significant amount of utilization, the Empire Plan was successful in referring members to network facilities and providers.

Other interventions included case consultation on High Risk Cases, Eating Disorder Cases, and High Utilizing Members with our Regional Medical Director. Additionally, members continued to opt into our Disease Management Programs at an increased rate in 2014.

A major goal for Optum in 2015 is to develop additional utilization review protocol and resources for Out of State facilities, cases with repeat admissions, complicated psychosocial issues, and eating disorder cases.

Chart B: Network vs. Non-Network Mental Health Inpatient and Alternate Levels of Care (ALOC) Admissions for the Empire Plan MHSA Program: 2012-2014 Comparison



Sample Data

Network vs. Non-Network Utilization for Mental Health Inpatient and ALOC Services:

In 2014, Non-Network Mental Health Inpatient and ALOC admissions continued to decline (see Chart B) as a percentage of total care. The Non-Network admissions dropped from x in 2013 to x in 2014. The Non-Network usage rate dropped from x% in 2013 to x% in 2014. The Care Advocates focused on referring members to Network facilities to ensure effective transitions to lower levels of care and aftercare planning.

This decline in Non-Network utilization occurred as a result of the successful recruitment efforts and robust Network options along with the CRL staff directing members to the available Network options. Behavioral Network Services continues to seek opportunities to enhance the Network with additional facilities, programs and practitioners. Optum believes that this ongoing initiative has contributed to the increase in Network usage.

Substance Abuse Inpatient and Alternate Levels of Care:

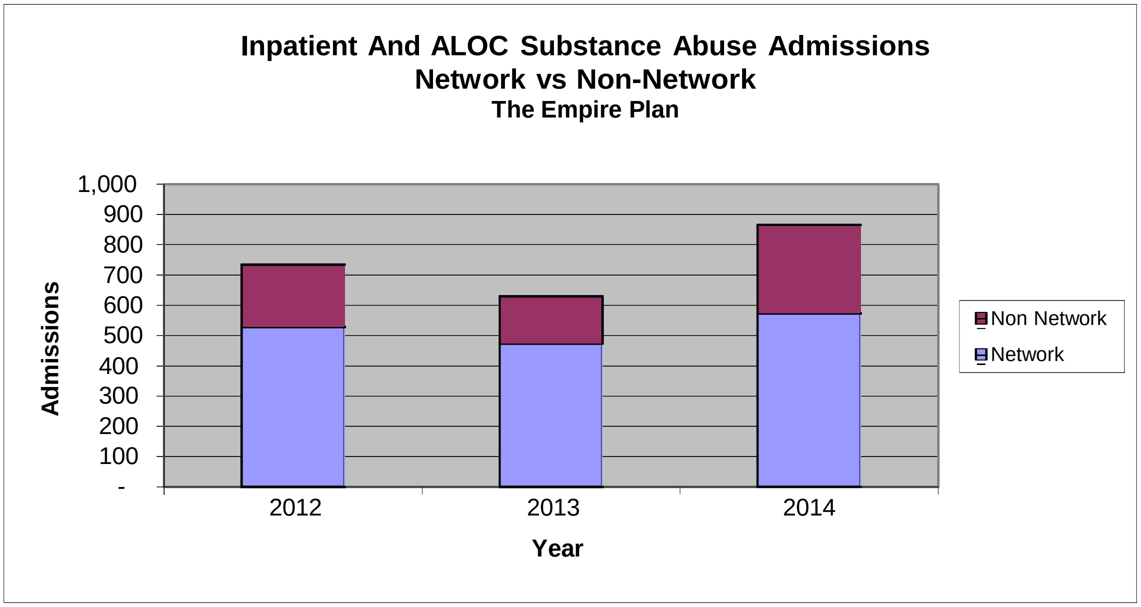
In 2014, the Substance Abuse Inpatient and ALOC admissions/1000 and days/1000 increased. The average length of stay (ALOS) decreased slightly from x days in 2013 to x days in 2014.

This data is a result of the Clinical Operations Department partnering with both our Behavioral Network Services team and our Network Substance Abuse facilities to develop an enhanced range of services. These services include ambulatory detoxification programs and sub-acute services within the facility. This allows the Empire Plan enrollees and covered dependents to step down to lower levels of care within the same facility. These services are designed to provide greater flexibility of service delivery with the goal of increased compliance with the treatment plan however; this can result in longer lengths of stay.

Chart C: Substance Abuse Inpatient and Alternate Levels of Care (ALOC) for the Empire Plan MHSA Program: 2012-2014 Comparison

	Substance Abuse Inpatient and ALOC		
	2012 Empire MHSA Program	**2013 Empire MHSA Program**	**2014 Empire MHSA Program**
Admissions/1,000 Lives	x.x	x.x	x.x
Days/1000 Lives	x.x	x.x	x.x
Average Length of Stay (days)	x.x	x.x	x.x

Chart D: Network vs. Non-Network Substance Abuse Inpatient and Alternate Levels of Care (ALOC) Admissions for the Empire Plan MHSA Program: 2012-2014 Comparison



Network vs. Non-Network Utilization for Substance Abuse Inpatient and ALOC Services:

In 2014, Substance Abuse Inpatient and ALOC Non-Network services increased throughout the year. There were xx admissions in 2013 compared to xx admissions in 2014 (see Chart D). The percentage of Non-Network services increased from x% in 2013 to x % in 2014. This significant increase can be attributed to the 18 to 26 year old dependents accessing service out of State and predominantly in XXXX in 2014. Behavioral Network Services continues to seek opportunities to enhance the Network with additional facilities, programs and practitioners that would be beneficial to the Empire Plan MHSA Program enrollees.

Mental Health Outpatient Care:

Mental Health Outpatient utilization increased in 2014 compared to 2013, with the Long Island and Hudson River region continuing to have the highest overall utilization. In 2014, the Mental Health Outpatient visits/1000 were xx visits compared to xx visits in 2013. The average number of visits per member was xx in 2013 compared to xx in 2014 (see Chart E).

The increase in utilization in 2014 is reasonable as a number of Disease Management and Aftercare programs were in place 2014. These programs proved to be effective in facilitating the engagement of at risk enrollees in outpatient treatment. At the time of discharge from Inpatient Care, Optum utilized Discharge Specialists and Care Advocates for standard and high risk cases. Care Advocates followed inpatient cases to provide input and support for discharge planning and transitional care. Care Advocates followed up with the member and provider after discharge from an inpatient admission to verify whether or not an enrollee kept their scheduled appointment for ongoing outpatient services. The ultimate goal is to encourage the member to successfully complete their treatment.

Some contributing factors for this increase include the added coverage of young adults to age 26, the increase in bullying and socio-economic factors. Optum has seen an increase in the number of members, particularly children and adolescents, presenting for outpatient treatment due to the focus on bullying, which includes being bullied or being identified as the bully. Additionally, when a child enters treatment, it is clinically indicated that the parents/family also attend sessions as part of the treatment plan. There has also been an increase in requests for outpatient treatment for members where the initial reason for seeking treatment was financial stress and/or occupational difficulties. Stress related to economic worries has impacted our members and resulted in the diagnosis of depression and/or anxiety. These kinds of issues are typically treated on an outpatient basis. Treatment is with both an outpatient therapist and frequently an outpatient psychiatrist when medications are clinically indicated.

Chart E: Mental Health Outpatient Services for the Empire Plan MHSA Program: 2012-2014 Comparison

Chart E

Network vs. Non-Network Utilization for Outpatient Mental Health Services:

The Non-Network Mental Health Outpatient utilization increased from xx visits in 2013 to xx visits in 2014. The Network Mental Health Outpatient utilization also increased from x visits in 2013 to x visits in 2014. (See Chart F below).

Non-Network utilization is an unavoidable occurrence as members have the option to choose their providers, however Optum continues to have an enhanced working relationship with four key Network Outpatient groups located in close proximity to our four highest volume Mental Health facilities. These Network groups are positioned in areas of high case presentation for Outpatient services and the groups have the type of services (treatment for Depression, Adolescent services, family therapy, etc.) that are in demand by the Empire Plan MHSA Program membership. Periodic meetings are held with each group to facilitate collaboration between them and discharging facilities in their geographic area. These groups have been providing excellent aftercare services throughout 2014.

In addition, the Clinical Referral line (CRL) continues to direct enrollees to the appropriate network providers to effectively treat members. They provide referral information, coordinate and encourage quality care. The staff also provides insight and guidance to appropriate choices that allow for successful case management for the combination of treatment options and support services to develop effective treatment plans for the members.

Chart F: Network vs. Non-Network Mental Health Outpatient Visits for the Empire Plan MHSA Program: 2012-2014 Comparison

Chart F

Substance Abuse Outpatient Care:

In 2014, Outpatient Substance Abuse visits/1000 were x as compared to x in 2013 (see Chart G). The 18 to 26 year old dependents represent the highest increase in utilization in this area for the reasons sited above. The increase in the outpatient substance abuse utilization is a direct correlation to the increase in inpatient and ALOC for substance abuse. As members are discharged from inpatient and ALOC they are transitioning into the lower levels of care as expected, thus increasing outpatient utilization.

Chart G: Substance Abuse Outpatient Services for the Empire Plan MHSA Program: 2012-2014

Comparison

	Substance Abuse Outpatient Services		
	2012 Empire MHSA Program	**2013 Empire MHSA Program**	**2014 Empire MHSA Program**
Visits/1000 Lives	x.x	x.x	x.x
Average number of visits per member seen	x.x	x.x	x.x

Network vs. Non-Network Utilization for Substance Abuse Outpatient Services:

In 2014, there were x Non-Network Substance Abuse Outpatient visits compared to x in 2013. The Network Substance Abuse visits also increased compared to 2013. (See Chart H) and the percentage of overall care increased from x% to x%.

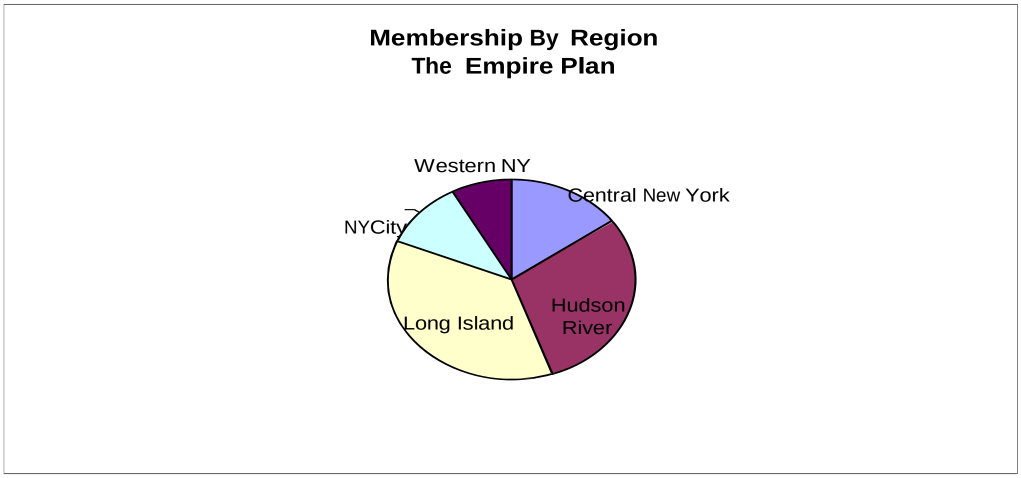
Chart H: Network vs. Non-Network Substance Abuse Outpatient Visits for the Empire Plan MHSA Program: 2012-2014 Comparison

Chart H

Regional Observations by Level of Care:

This section highlights details on the Empire Plan membership by Region. The overall breakout by regions for all covered lives in New York State is represented below (See Chart I).

Chart I: Membership by Region for the Empire Plan MHSA Program



Mental Health Inpatient and Alternate Levels of Care (ALOC):

In 2014, Long Island and Hudson River regions continued to have the highest Mental Health Inpatient and ALOC utilization, rates of admission and average length of stay as expected due to the higher membership in these areas. The Central and Western regions continued to have lower admissions compared to Long Island and Hudson River as they did in 2013. This comes as no surprise and matches the lower levels of outpatient utilization for these areas as well.

Substance Abuse Inpatient and Alternate Levels of Care (ALOC):

Substance Abuse Inpatient and ALOC utilization across the various regions of New York State was consistent with the Mental Health data. The Long Island and Hudson Valley regions have higher utilization due their large membership. As noted above, this pattern of utilization is consistent with what we saw in 2013.

Mental Health Outpatient Care:

The Long Island and Hudson River regions continue to have the highest outpatient utilization which is consistent with the membership for that region. This pattern for 2014 is also consistent with historical pattern of utilization for the Empire Plan MHSA Program.

Substance Abuse Outpatient Care:

The Substance Abuse Outpatient visits per enrollee were consistent with last year's data with some slight variations. The Hudson River region had x% of the visits for 2014, which is a slight decrease from x% in 2013. Long Island's visits increased from x% in 2014 to x% in 2014. The Central Region decreased slightly with x% of visits in 2014 compared to x% in 2013. However, these changes are substantial and therefore we find Substance Abuse Outpatient service delivery to be comparable year over year.

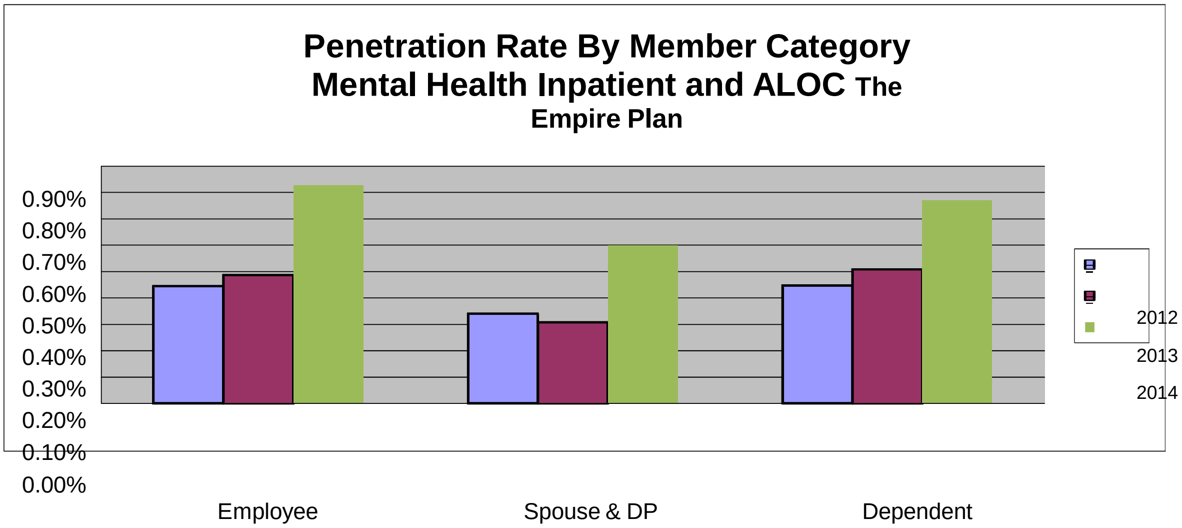
Utilization by Employee/Spouse /Dependent and Age Category:

In 2014, presentation rates increased for all three groups for all levels of care. Employees and dependents had higher presentation rates for Mental Health Inpatient and ALOC services than their spouses.

Mental Health Inpatient and Alternate Levels of Care (ALOC):

The employee and dependents have the highest percentage of utilization Inpatient Mental Health and ALOC. One interesting trend is the percentage of utilization by employees and dependents significantly increased from 2013 to 2014 for Mental Health Inpatient (see Chart N (i)). It should be noted that the most prevalent diagnostic cluster for this group is mood Disorders and substance-related disorder.

Chart N (i): Penetration Rates for Employee/Spouse/Domestic Partner/Dependent for Mental Health Inpatient and ALOC for the Empire Plan MHSA Program: 2012-2014 Comparison



Substance Abuse Inpatient and Alternate Levels of Care (ALOC):

In the area of Inpatient and ALOC Substance Abuse services, the employee and dependent accessed services at a higher rate than the spouse.

Also as noted above, there was a significant increase for the dependents accessing Substance Abuse Inpatient and ALOC from x% in 2013 vs. x% in 2014, which is consistent with the increase in Mental Health Inpatient and ALOC increased for 2014.

Mental Health Outpatient Care:

There was an increase in unique members seeking Mental Health Outpatient care in all member categories in 2014. The employee continued to have the highest percentage of utilization in 2014.

Substance Abuse Outpatient Care:

The dependent group had the highest percentage of utilization for Substance Abuse Outpatient care in 2014(x%) compared to 2014 (x %). This is attributed to the fact that when dependents access care they do so episodically rather than for chronic substance use/abuse which can result in more outpatient visits. Optum will continue to monitor this group over the coming year to identify if there are specific programming needs for this population.

Utilization by Employee/Spouse /Dependent (over 65 years of age)

Utilization data for the over 65 age group reflects a lower rate for Substance Abuse and Mental Health Outpatient services as compared to the under 65 age group.

However, Acute Inpatient Mental Health services for this age group actually accounts for over x% of the total Inpatient days for the Plan. This is attributed to the longer length of stays for the elderly Medicare population. The number of admissions is actually lower for the under 65 age group and this pattern of utilization is consistent with 2013 data. As a result of the Empire Plan having a significant percentage of retirees within its membership, there tends be a number of very lengthy geriatric Inpatient cases. Due to the complexity of the co-morbid presentation of these cases, the longer lengths of stay are appropriate. This, however, does then lead to a disproportionate amount of Inpatient days for this age group.

Top Diagnostic Trends

A diagnostic analysis of the Empire Plan MHSA Program population who accessed services in 2014 was conducted. Similar to the diagnostic patterns in 2013, the top three diagnostic categories for the Plan members receiving Inpatient and ALOC services were Mood Disorders, Substance-Related Disorders and Schizophrenia and Other Psychotic Disorders. The top three diagnostic categories for Outpatient care were Mood Disorders, Anxiety Disorders, and Adjustment Disorders. This type of analysis is useful when considering new programs and services that might be helpful for the membership. The Inpatient diagnostic analysis supports the continuation of the Individualized Case Management services incorporated into the Depression Disease Management Program. The Outpatient analysis also supports the Depression Disease Management program and the ADHD Program. The Depressive diagnoses are included in the Mood Disorders Category. ADHD is a top diagnosis in the "Disorders Usually Diagnosed in infancy, childhood or adolescence. The top categories are illustrated in Charts R and S below.

Top Mental Health/Substance Abuse Diagnoses by Level of Care

Chart R: Top 5 Categories/Inpatient- for the Empire Plan MHSA Program 2014

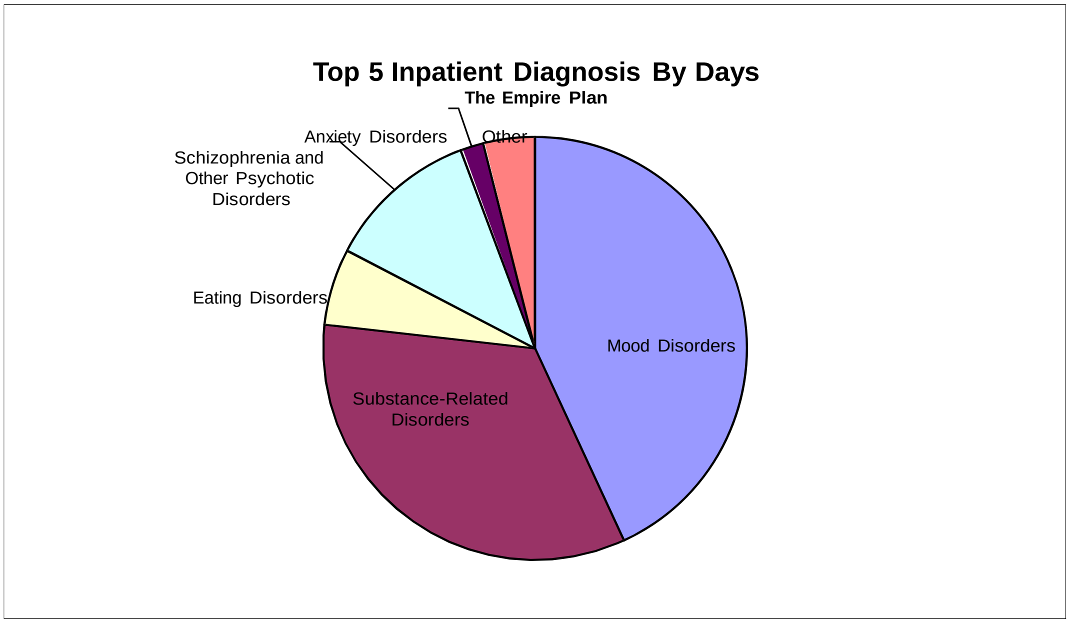


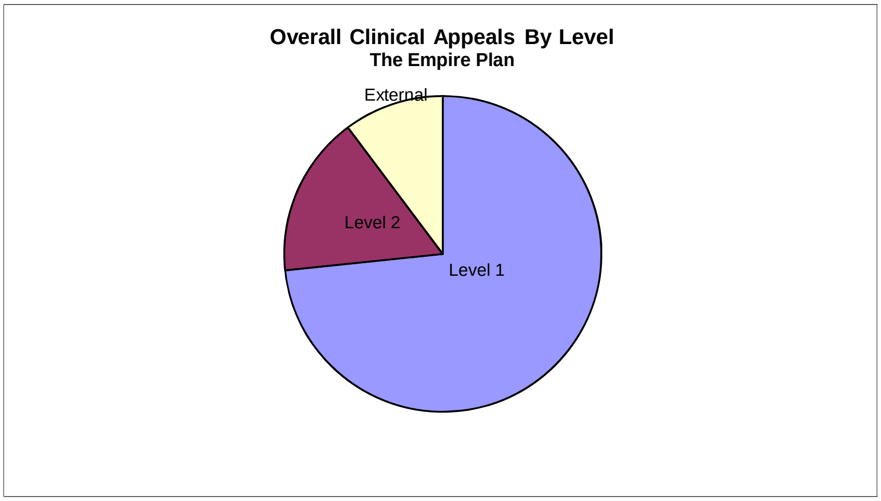
Chart S: Top 5 Categories/Outpatient- for the Empire Plan MHSA Program 2014

Chart S

Clinical Appeals:

In 2014, there were a total of x clinical appeals requested. This volume includes Level One (total x) and Level Two (total x) appeals as well as the External (total x) appeals requested for the Empire Plan MHSA Program in 2014 (see Chart T (i) below). These clinical appeals include Inpatient and Outpatient levels of care for both pre-service, concurrent and post service.

Chart T (i): Total Overall Clinical Appeals for the 2014 Empire Plan MHSA Program



The Charts below show the Clinical Appeal Outcomes by Level of Care (Inpatient/Outpatient) for Level One and Level Two Appeals.

Chart T (ii): Level 1 Clinical Appeal Outcome for the 2014 Empire Plan MHSA Program

Chart T (ii)

2014 Level One Appeals

Appeal Level 1

Appeal Outcome	Inpatient	Outpatient	Total
Overturned	x	x	x
Upheld	x	x	x
Total	xx	xx	xx

__Chart T (iii):__ Level Two Clinical Appeal Outcome for the 2014 Empire Plan MHSA Program

Chart T (iii)

2012 Level Two Appeals

Appeal Outcome	Inpatient	Outpatient	Total
Overturned	x	x	x
Upheld	x	x	x
Total	xx	xx	xx

Additionally, x appeals went for an external review. Out of the x external review appeals, x (x%) were upheld by the external agent who agreed with Optum's determination with the remaining x (x %) appeals modified or overturned in the member's favor.

Operational Overview of the Empire Plan MHSA Program Dedicated Service Center

Optum hosted the Annual Joint Committee Labor meeting in Albany, NY in June 2014. Optum presented the 2013 Empire Plan MHSA Program Annual Report including an overview of the program and highlights of the various operational departments in the dedicated service center. Presentations were also given on the Substance Abuse Treatments and Management Overview, and updates on the Federal Mental Health Parity Legislation and the Empire Plan. Empire Operational, Account and Clinical Management staff was available to answer questions.

Optum partnered with the Empire Plan Medical and Hospital vendors in order to be compliant with Federal Mental Health Parity Regulations effective for the Empire Plan on 1/1/2012. Optum, UHC and BCBS worked closely together with DCS and GOER to complete the necessary quantitative analysis review and worked collaboratively to develop the most efficient process for implementing the shared accumulator process for Non Network inpatient and outpatient cost-sharing (dollar value of deductible and coinsurance) among the three programs.

Behavioral Network Services

Network Recruitment

Optum continued to exceed the 95% access threshold within the twelve prescribed access standards for having a Network practitioner/facility throughout 2014.

At the close of the first quarter, phase 3 recruitment concluded. The Phase 3 recruitment effort consisted of non network providers who were treating 5 or more Empire enrollees. x % of providers targeted were successfully recruited into the network.

In addition to the Phase 3 Recruitment efforts, Optum added 3 acute care facilities in the down state region.

Additionally, two practitioners in the rural communities of Clinton County, where access to behavioral health services is limited, were added to the Empire Plan network. We will continue to seek opportunities to supplement the current Network of practitioners and facilities throughout 2014.

Provider Outreach/Communication Initiatives

Behavioral Network Services (BNS), in coordination with the Clinical Operations team, conducted x partnership meetings with key facilities and Outpatient providers in 2014. Meeting topics focused on the Empire Plan MHSA Program policies and procedures, as well as quality initiatives related to our Facility Quality Measure (FQM) Program. FQM is a program intended to improve the partnership between Optum and our Network facilities. The program provides facilities with a quarterly scorecard measuring their relative performance in key quality and efficiency metrics.

The focus of the facility partnership meetings was to discuss key quality and efficiency metrics including readmission rates, seven-day follow up appointments scheduled and kept, and actual length of stay as compared to the expected length of stay. The meetings also provided an opportunity for Optum to hear from providers on how we can improve service. We have found these meetings to be instrumental in strengthening our relationship with our Network providers.

The Outpatient partnership meetings focused primarily on educating practitioners on key areas including utilization management protocols, Network participation requirements, claim submission and our online functionality. The meetings also provided us an opportunity to better understand the needs of the community in which the providers serve.

On March 3, 2014, Optum met with representatives of the National Association of Social Workers (NASW), New York Chapter. The agenda included:

- ALERT online
- Federal Mental Health Parity
- Determining Medical Necessity with OTR
- Disease Management Programs
- Discharge Appointment Attestation
- Empire Practitioner Satisfaction Survey

Optum exhibited at National Association of Social Worker's (NASW's) annual conference in March and the New York State Psychological Association's (NYSPA) annual conference in New York City in June. Attendance at both conferences provided an opportunity for a face to face interaction with the provider community. Information was shared on the Empire Plan MHSA Program's Disease Management programs, general education on the Empire Plan MHSA Program specific policies and procedures and the functionality of our online provider portal.

On October 5, 2014, Optum met with representatives of NYSPA to discuss:

- Health Care Reform
- ALERT
- Empire Plan Updates

In 2014, our semi-annual provider publication, Network Notes contained the following articles in the dedicated New York State regional supplement:

Spring 2014:

- Disease Management Programs
- Fraud, Waste and Abuse Reminders
- Network Requirements Reminders

Sample

Fall 2014:

- Federal Mental Health Parity Updates for the Empire Plan
- Recovery and Resiliency

Throughout 2014, Optum conducted monthly webinars to educate network providers on the wide range of functionality available on the provider portal, www.ubhonline.com. These webinars were created to increase Network Provider awareness of the online functionalities available to them to streamline administrative processes including electronic claim submission and payment and enhanced online services.

Optum held two Network Clinician Advisory Council (NCAC) meetings in 2014. The NCAC includes practitioners of all licensure categories and a variety of specialties in New York and other Northeastern states. The Committee reviews key documents, makes recommendations and provides feedback to the Quality Improvement Program. The agenda included the following topics:

- Clinician Satisfaction Survey Results: Review of annual satisfaction survey.
- Clinical Quality Initiatives Website: www.ubhonline.com has a new Clinical Quality Initiative section.
- Provider Leading Edge Engagement Workgroup: Optum is making provider engagement a priority. We conducted blind focus groups,

visited providers and facility sites to evaluate what it is like to work with Optum.

- Recovery and Consumer Driven Care Presentation

Quality Improvement

In 2014, Optum offered three Disease Management programs for the Empire Plan MHSA Program membership to provide education, support and resources on Depression, Eating Disorders and Attention Deficit Hyperactivity Disorder (ADHD).

The **Depression Management** program provides screenings, access to web-based educational articles via www.liveandworkwell.com , access to a licensed practitioner and resources for adult members who may be depressed. These members receive educational mailings about depression, its cause, potential treatment interventions and resources on a quarterly basis. Members can opt out at any time.

There are two parts to this program: educational resources and Individualized Case Management (ICM). Members who have been treated for depression receive educational materials sent directly to their home to help manage their depression. ICM is offered to those members who have been recommended for and agree to participate in the voluntary program. ICM includes telephonic support, coordination of care with the treating behavioral health providers, and referrals to community resources. During 2014 the Depression Management ICM program focused on expansion.

- During 2014, the Clinical Care Advocate team invited x members into the ICM Program, a nearly four fold increase from the previous year.

- Of the members invited to ICM, x members opted into and were either active or completed the ICM program.

Optum sent depression educational materials to x NYS Empire Plan members during 2014. In an effort to expand the ICM services, more members were directly invited to the program based on behavioral health reports on treatment for depression and readmissions to acute level of care. Optum Clinical Care Advocates reached out telephonically to those members who did not respond to the initial letter. As a result, more members opted into the program in 2014 and were offered assistance from Clinical Care Advocates.

Member surveys are incorporated with the educational mailing to obtain member feedback on the current educational materials and other aspects of the program. The survey is ongoing and provides continuous feedback. In 2014, x completed surveys were received and the majority indicated satisfaction with the educational materials.

Of those surveyed, x% indicated that overall they were satisfied with the materials received.

The **Eating Disorder** program is strictly voluntary and primarily provides Individualized Case Management ICM) for enrollees 13 years of age and older diagnosed with anorexia and/or bulimia. The program includes telephonic support, coordination of care with the treating behavioral health providers and referrals to community resources. This program also offers access to web-based educational articles via www.liveandworkwell.com .

- During 2014, the Clinical Care Advocate team invited x members to participate in the Eating Disorder Individualized Case Management Program
- x Empire Plan MHSA Program members actively participated.

Every member who opted into the ICM Program received two sets of educational materials by mail that included information on eating disorders, potential treatment interventions and resources.

The **Attention Deficit Hyperactivity Disorder (ADHD**) program is designed to provide education, support and resources for enrollees and their covered dependents that may have ADHD. Members have access to resources and materials on www.liveandworkwell.com . These materials include self assessment tools and educational materials. All members newly diagnosed with ADHD are sent educational articles on the diagnosis and treatment of ADHD. Members are told they can opt out of the program and discontinue receiving educational materials at anytime by calling the NYSHIP toll-free number. ADHD educational mailings were sent to x members during 2014. Optum's provider newsletter "Network Notes" National Behavioral Health Quality Measures published information in both the spring and fall 2014 editions reminders for the ADHD Condition Centers on liveandworkwell.com and on the ADHD program and ADHD clinical practice guidelines available on www.ubhonline.com . An article entitled "Effective Treatment of ADHD" also appeared in this section during 2014.

Quality Improvement Initiatives

Optum seeks to improve member outcomes by keeping the question "How can the member experience the greatest gain from mental health services?" in mind. To determine this we evaluate alternative ways to provide appropriate and optimal care for members. This approach to improving quality and performance requires data collection, aggregation, and analysis. We refer to these activities as clinical quality improvement initiatives. Two clinical quality initiatives were started in 2014 as part of the Empire Plan MHSA Program: 1) Reducing Unnecessary Hospitalizations and 2) Improving Follow-up Appointments kept after Hospitalization.

The purpose of the "Reducing Unnecessary Re-hospitalizations" quality improvement initiative is to reduce unnecessary hospitalizations for members who are admitted to a hospital with a primary psychiatric diagnosis, as measured by a 30-day re-hospitalization rate. The goal of reducing unnecessary readmissions is x% or less. We improved our readmission rate from x% in 2013 to x% in 2014.

In order to achieve this rate the focus is on preventing re-hospitalization where appropriate. Several interventions contributed to this reduced rate in 2014. Clinical staff increased communication and coordination for enrollees who were referred to more than one clinical program, simultaneously, in order to deliver an improved customer service experience. We invited and assisted more members for the Depression Disease Management program in 2014 which also decreases the likelihood of readmissions. Those who adhere to their aftercare plans are less likely to require unnecessary readmissions. Family participation in aftercare planning is critical since they serve as the member's support network.

The purpose of the second quality improvement initiative, "Improving Follow-Up after Hospitalization (FUH)", is to improve the continuity and coordination of care for enrollees and their covered dependents as they move through the continuum of behavioral healthcare treatment. One aspect of improving the continuity and coordination of care is ensuring that enrollees and covered dependents obtain mental-health aftercare within seven days post discharge from treatment for mental illness. In 2014, x% of members followed-up within seven days of their hospital stay with a behavioral health provider.

The 2014 re-measure rate was x% a slight increase over 2013. 2014 re-measurement data will not be available until June 2015. Interventions have been implemented to improve upon the baseline rate of x%. The goal for follow-up appointments kept within seven days of inpatient discharge is x%.

In 2014, several changes were put into place to verify if enrollees and covered dependents were connecting with behavioral health providers after discharge from an inpatient hospitalization. Providers can now verify enrollees kept appointments by faxing an "attestation" form to Optum. In addition, our Behavioral Network Services unit outreaches to those providers who are not responding to our request to verify. These measures will increase the accuracy of appointment data.

Optum Care Advocates continue to reach out to members within 1 business day of discharge to provide referrals and assistance. In 2014, web based training was conducted with inpatient facilities to educate them on the many ways we can assist them in making after care appointments with network providers. The web based training was designed to facilitate follow-up appointment scheduling and to positively impact enrollee and covered dependents quality of care, improve the seven day follow-up rate and reduce the readmission rate.

Member Satisfaction

In 2014, the Center for the Study of Services (CSS) conducted an Annual Member Satisfaction Survey of the Empire Plan MHSA Program on behalf of Optum. Members who incurred services and were eligible for MHSA services at the time of the survey and who granted permission to have mail sent to their address on record were surveyed. Surveys were mailed to x members, resulting in a x% response rate. The findings are used to monitor service quality and access to care from the member perspective.

The overall satisfaction rate for the Empire Plan members with services received in 2014 was x%. Some areas of strength included:

- x% of members reported the treatment received from clinicians helped them better manage their overall health
- x% are satisfied with the overall experience of finding an available clinician
- x% are satisfied with the process of getting authorizations
- x% of members rated their experience with counseling or services positively
- x% were satisfied with the assistance they received when they called about claims

The survey also provides us data to measure areas where we can enhance our current service performance. 2014 saw a marked improvement and continued positive trend in the percentage of members satisfied (x%) with the time it took to resolve claims concerns from 2013 (x%).

Customer Service

The Customer Service team performed exceedingly well in 2014. The team focused on first call resolution, continuous refresher trainings, and increasing call quality initiatives. Customer Service Representatives also had the opportunity to shadow staff in the Clinical, Appeals and Claim departments as part of an initiative to allow staff to cross train with all areas to have a comprehensive understanding of the overall member experience. This enabled them to better service the Empire Plan members and providers.

The total incoming call volume for 2014 was x and the overall team quality score was x%. The Customer Service team met all Call Center performance metrics for 2014 (see statistics below).

Customer Service 2014 Phone Statistics for 2014:

Customer Service Phone Statistics for 2014		
Metric	**2014**	**Performance Guarantee**
Telephone line operational and available	100%	100%
Telephone Blockage Rate	0%	0%
Total Incoming Call Volume	xxx	Not Applicable
Percent of Calls Answered within 30 seconds	xx%	90%
First Call Resolution	xx%	Not Applicable
Call Quality (team) Annual Score	xx%	Not Applicable
Abandonment Rate	xx%	3%
Average Speed of Answer (seconds)	xx%	90% in 30 seconds

Claims Processing

Throughout 2014, the Empire Claim team continued to work on quality improvement initiatives focusing on accurate claim payment and reducing adjustments. The Claim team continued to meet with the Customer Service team to provide feedback and to look for process improvements to optimize service for the Empire membership. These initiatives focused on identifying the root cause for incoming calls and adjustments and identified refresher training to better service the Empire Plan members.

These ongoing claim initiatives and system enhancements allowed the team to adjudicate claims in a timely and accurate manner. Although the claim team did not meet the 2014 quarterly Non-Network turnaround time, there were continual quarterly improvements throughout the year. The Claim team is committed to meeting this metric and continues to identify process improvements to better serve the membership.

The total incoming claim inventory for 2014 was x receipts. During 2014, the claim team focused on continual quality improvement and system enhancements. The system enhancements reduced manual processes and increased claims auto adjudication throughout the year. The 2014 auto adjudication rate was x%.

III Future Initiatives 2014

New York State Autism Insurance Reform was signed November 1, 2011 to take effect in 12 months or next plan year. This legislation requires an insurer to cover certain health care services within their benefit plans for autism spectrum disorder. New York insurance companies that were not covering the screening, diagnosis and treatment for autism spectrum disorders will now be mandated to do so.

Optum Account Management Team will assist DCS/GOER in establishing:

1. Specialty provider network to include previous non-covered providers who perform Applied Behavioral Analysis (ABA) services.
2. Language changes for Certificate of Coverage and other documents explaining the new benefit for ABA services.
3. Process for intensive, specialized case management for Autism Treatment Plans.

Regional Medical Director Interface

TheOptum MHSA Regional Medical Director for the Empire Plan MHSA Program will continue to meet with key facility Medical Directors. These meetings foster open communication to discuss best practices, emerging treatments and are a forum for discussing complex situations.

Continuing to identify opportunities for integration between the Behavioral Health, Medical, Disease Management and Pharmacy Programs.

1) The Medical Directors will continue to lead the Behavioral Health, Medical, Disease Management and Pharmacy Synergy Initiative (BMPS) in an effort to improve the coordination of care of the Empire Plan MHSA Program enrollees across program lines. This Initiative gives us an opportunity to better serve the more complex cases by sharing data and collectively identifying the best approach to treatment.

2) Building on our accumulating positive experience with the BMPS Initiative we would like to expand our ability to utilize patient data across all UHICNY programs. Having access to pharmacy data as well as medical data would allow us to manage behavioral health conditions more effectively. This would also allow for better management of medical conditions.

Claims Performance

The claims team will continue to focus on meeting all Claim performance guarantees for 2015. The team continues to streamline processes to create efficiencies for prompt and accurate claim payment through both manual and system enhancements.

Practitioner Electronic Payment and Statements (EPS):

Targeted outreach will be made to Network practitioners not currently enrolled in EPS. This effort will focus on practitioners with 100+ claims in the most recent one-year look back period who are not currently enrolled in EPS. The second wave of outreach will focus on the volume level of 50-100 claims. This service is free for practitioners.

Regional Network Clinician Advisory Council (NCAC)

The Regional council will continue to meet in 2015 to review key documents, make recommendations to the Quality Improvement program and provide vital input to the Empire Plan MHSA Program.

Disease Management

As we enter the fourth year of the Disease Management Program's maturity, Optum plans to implement a member survey to obtain member satisfaction and feedback with the Individualized Case Management program. Surveys will be mailed confidentially to those who have completed the ICM program. Members may choose to complete the survey and return the results directly to Optum. The results will be used to improve member experience with the program.

Member Communications

In 2015, the Clinical Operations and Quality Improvement teams are developing specific condition based educational materials that can be used by the CRL Care Advocates as an adjunct to their telephonic conversations with members and www.liveandworkwell.com. The focus of the brief, educational pieces are supplemental treatments for anxiety and substance use treatment geared toward parents of adolescent or adult children seeking treatment.

We will be launching an exciting new provider campaign in 2015 focusing on www.ubhonline.com through email communications, webinars and provider meetings as well as individual education from the Behavioral Network Service representatives. The goal is to encourage providers who are not registered users of www.ubhonline.com to register for a secure login and begin benefiting from all our online functionality has to offer.

Enhanced Empire Plan Customized www.liveandworkwell.com website (LAWW)

The Empire customized website launched a major site refresh during second quarter 2012. The customized site was updated with some exciting enhancements. The "refreshed" site includes more engaging presentations, easier organization and navigation, as well as more customization capabilities.

State of New York - Empire Plan

MHSA Program

2014 Yearend Financial Summary Report

March 15, 2015

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SECTION I
CURRENT FULL YEAR PROJECTED EXPERIENCE
2014 Yearend Financial Summary Report
In Thousands

COMBINED	Projected at Renewal	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report	Final Report
1. Premium Equivalents	$0	$0	$0	$0	$0	$0
2a. Paid Claims	$0	$0	$0	$0	$0	$0
2b. Surcharges and Assessments	$0	$0	$0	$0	$0	$0
2c. Open & Unreported as of 12/31/2014	$0	$0	$0	$0	$0	$0
2d. Open & Unreported as of 12/31/2013	$0	$0	$0	$0	$0	$0
2e. Incurred Claims (2a + 2b +2c- 2d)	$0	$0	$0	$0	$0	$0
2f. Network Pricing Guarantee Adjustment (if needed)	$0	$0	$0	$0	$0	$0
2g. Adjusted Incurred Claims (2e-2f)	$0	$0	$0	$0	$0	$0
3a. Administrative Expenses	$0	$0	$0	$0	$0	$0
3b. Audit/Performance Adjustment and Other Credits	$0	$0	$0	$0	$0	$0
3c. Total Retention (3a-3b)	$0	$0	$0	$0	$0	$0
4. Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0	$0	$0	$0	$0

Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION II
PAID CLAIMS RECONCILIATION
2014 Yearend Financial Summary Report
In Thousands

	Total Projected Incurred Claims	Claims Paid Through 12/31/2013	Claims Paid Through 12/31/2014	Outstanding Reserve at 12/31/2014
2014	$0	$0	$0	$0
2013	$0	$0	$0	$0
2012	$0	$0	$0	$0
2011	$0	$0	$0	$0
TOTAL	$0	$0	$0	$0
	(3)		(1)(3)	(2)

Note 1)	Ties to Schedule of Paid Claims (I.) before application of adjustments.
Note 2)	Ties to Open and Unreported Reserve calculation.
Note 3)	Incurred Claims and Paid Claims are reported before adjustments and include manual checks.

I. Gross Claims/Payments (Statistical)		$0
Add:	Claims Pending 12/31/2013	$0
Less:	Claims Pending 12/31/2014	$0
Gross Claims/Payments (Financial)		$0
II. Less:	a) Financial Adjustment (2014)	$0
III. Net Paid Claims (Financial)		$0

Net Incurred Claims (Statistical)

	Gross Amount	Adjustments	Net Amount
2014 Claims Incurred	$0	$0	$0
2013 Claims Incurred	$0	$0	$0
2012 Claims Incurred	$0	$0	$0
2011 Claims Incurred	$0	$0	$0
2014 Claims Incurred/Paid	$0	$0	$0

Please note that totals may differ due to rounding

SECTION III
DETERMINATION OF 12/31/2014 OPEN & UNREPORTED RESERVE
2014 Yearend Financial Summary Report
In Millions

I.	2014 Claims Incurred (1)	$0.0	
II.	2014 Claims Incurred Paid Through 12/31/2014(1)	$0.0	
III.	12/31/2014 Runout due to 2014 Incurrals		$0.0
	Remaining 2013 Runout as of 12/31/2014	$0.0	
	Remaining Runout prior to 2013	$0.0	
	Claims Subtotal		$0.0
IV.	Reserve for Surcharges and Assessments	$0.0	
V.	Medicare Reclamation & Provider Litigation Risk	$0.0	
	Subtotal		$0.0
VIa.	Claim Base Adjustment	$0.0	
VIb.	Claims Pending 12/31/2014	$0.0	
	Total Open & Unreported Reserve		$0.0

	Claim Base Adjustment	
A	Total Reserve (Statistical Data)	$0
B	Stat Paid Claims (Sect IIIB)	$0
C	Reserve as % of Stat Paid (A/B)	0.0%
D	Financial Net Paid Claims (Sect IIIB)	$0
E	New Reserve = C*D	$0
F	Claim Base Adjustment = E - A	$0

(1) Statistical and Net of Adjustments

Please note that totals may differ due to rounding

SECTION IV
ADMINISTRATIVE EXPENSE SUMMARY
2014 Yearend Financial Summary Report

	Charge
Administrative Fee (Excludes Shared Communication Expense)	$0.00
Audit/Performance Adjustment and Other Credits	$0.00
Administrative Fee Expenses (Net of PG)	$0.00
Communication Expenses (Shared Expenses)	$0.00
Total Retention	$0.00

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION V
Average Number of Contracts - 2014
2014 Yearend Financial Summary Report

	PERSONAL	DEPENDENT
Core	0	0
NY Medical Enhancement	0	0
PA Medical Enhancement	0	0
SEHP	0	0
Excelsior Plan	0	0

Contracts represent actual contracts thru March 2014 with contracts projected April thru December 2014.

SECTION VI
2014 Claims Incurred
2014 Yearend Financial Summary Report
Triangle Report

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Jan-14	$0												$0
Feb-14	$0	$0											$0
Mar-14	$0	$0	$0										$0
Apr-14	$0	$0	$0	$0									$0
May-14	$0	$0	$0	$0	$0								$0
Jun-14	$0	$0	$0	$0	$0	$0							$0
Jul-14	$0	$0	$0	$0	$0	$0	$0						$0
Aug-14	$0	$0	$0	$0	$0	$0	$0	$0					$0
Sep-14	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Oct-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
Nov-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
Dec-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
													$0
													$0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Completion Factor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Incurred Claims	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0												
2014 Projected Claims	$0												
Network Pricing Guarant	$0												
2014 Adjusted Claims	$0												

PLEASE NOTE: Actual Reports will include Current Year INN, Prior Year INN, Current Year OON, and Prior Year OON

SECTION VII
Trend Statistics
2014 Yearend Financial Summary Report

2014

	In & Out of Network Total	**In Network** Total	**Out of Network** Total
# of Charges	0	0	0
$ Claims Incurred	$0	$0	$0
# of Contracts	0	0	0
Cost/charge	$0.00	$0.00	$0.00
# Charges/1000 Contracts	0	0	0
Cost/Contract	$0.00	$0.00	$0.00

2013

	In & Out of Network Total	**In Network** Total	**Out of Network** Total
# of Charges	0	0	0
$ Claims Incurred	$0	$0	$0
# of Contracts	0	0	0
Cost/charge	$0.00	$0.00	$0.00
# Charges/1000 Contracts	0	0	0
Cost/Contract	$0.00	$0.00	$0.00

% Change 2014 over 2013

	In & Out of Network Total	**In Network** Total	**Out of Network** Total
Cost/Charge	0.00%	0.00%	0.00%
# Charges/1000 Contracts	0.00%	0.00%	0.00%
Cost/Contract	0.00%	0.00%	0.00%

Note: In Network vs Out-of-Network based on the contracted status of the Provider.

SECTION VIII
CORE NY AND CORE PA EXPERIENCE
2014 Yearend Financial Summary Report

In Thousands

		CORE NY ONLY	CORE PA ONLY	CORE COMBINED
1.	Premium Equivalents	$0	$0	$0
2a.	Paid Claims	$0	$0	$0
2b.	Surcharges and Assessments	$0	$0	$0
2c.	Open & Unreported as of 3/31/2014	$0	$0	$0
2d.	Open & Unreported as of 12/31/2013	$0	$0	$0
2e.	Incurred Claims (2a+2b+2c-2d)	$0	$0	$0
2f.	Network Pricing Guarantee Adjustment (if needed)	$0	$0	$0
2g.	Adjusted Incurred Claims (2e-2f)	$0	$0	$0
3a.	Administrative Expenses	$0	$0	$0
3b.	Audit/Performance Adjustment and Other Credits	$0	$0	$0
3c.	Total Retention (3a-3b)	$0	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0	$0

Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

Attachment 8-38
May 20, 2014

State of New York - Empire Plan

MHSA Program

2015 Annual Renewal

September 1, 2014

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SECTION I
2014 YEAR TO DATE EXPERIENCE
2015 Annual Renewal
Current Quarter and Year to Date

In Thousands

		COMBINED		
		Estimated Prior Qtr YTD	Estimated Current Qtr	Estimated YTD
1.	Premium Equivalents	$0	$0	$0
2a.	Paid Claims	$0	$0	$0
2b.	Surcharges and Assessments	$0	$0	$0
2c.	Open & Unreported as of 3/31/2014	$0	$0	$0
2d.	Open & Unreported as of 12/31/2013	$0	$0	$0
2e.	Incurred Claims (2a+2b+2c-2d)	$0	$0	$0
2f.	Network Pricing Guarantee Adjustment (if needed)	$0	$0	$0
2g.	Adjusted Incurred Claims (2e-2f)	$0	$0	$0
3a.	Administrative Expenses	$0	$0	$0
3b.	Audit/Performance Adjustment and Other Credits	$0	$0	$0
3c.	Total Retention (3a-3b)	$0	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0	$0

Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION IIA
2014 PROJECTED FULL YEAR EXPERIENCE
2015 Annual Renewal
In Thousands

		COMBINED	
		Renewal	Financial
1.	Premium Equivalents	$0	$0
2a.	Paid Claims	$0	$0
2b.	Surcharges and Assessments	$0	$0
2c.	Ending O&U 12/31/2013	$0	$0
2d.	Beginning O&U 12/31/2012	$0	$0
2e.	Incurred Claims (2a+2b+2c-2d)	$0	$0
2f.	Network Pricing Guarantee Adjustment	$0	$0
2g.	Adjusted Incurred Claims (2e-2f)	$0	$0
3a.	Administrative Expenses	$0	$0
3b.	Audit/Performance Adjustment and Other Credits	$0	$0
3c.	Total Retention (3a-3b)	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	1st Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	2nd Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	3rd Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	4th Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

*Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION IIB
2015 PROJECTED FULL YEAR EXPERIENCE
2015 Annual Renewal
In Thousands

		COMBINED	
		Renewal	Financial
1.	Premium Equivalents	$0	$0
2a.	Paid Claims	$0	$0
2b.	Surcharges and Assessments	$0	$0
2c.	Ending O&U 12/31/2013	$0	$0
2d.	Beginning O&U 12/31/2012	$0	$0
2e.	Incurred Claims (2a+2b+2c-2d)	$0	$0
2f.	Network Pricing Guarantee Adjustment	$0	$0
2g.	Adjusted Incurred Claims (2e-2f)	$0	$0
3a.	Administrative Expenses	$0	$0
3b.	Audit/Performance Adjustment and Other Credits	$0	$0
3c.	Total Retention (3a-3b)	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0
2c.	1st Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0
2c.	2nd Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0
2c.	3rd Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0
2c.	4th Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

*Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION IIIA
2014 PAID CLAIMS RECONCILIATION
2015 Annual Renewal
In Thousands

	Total Projected Incurred Claims	Claims Paid Through 12/31/2013	Claims Paid Through 12/31/2014	Outstanding Reserve at 12/31/2014
2014	$0	$0	$0	$0
2013	$0	$0	$0	$0
2012	$0	$0	$0	$0
2011	$0	$0	$0	$0
TOTAL	$0 (3)	$0	$0 (1)(3)	$0 (2)

Note 1)	Ties to Schedule of Paid Claims (I.) before application of adjustments.
Note 2)	Ties to Open and Unreported Reserve calculation.
Note 3)	Incurred Claims and Paid Claims are reported before adjustments and include manual checks.

I. Gross Claims/Payments (Statistical)		$0
Add:	Claims Pending 12/31/2013	$0
Less:	Claims Pending 12/31/2014	$0
Gross Claims/Payments (Financial)		$0
II. Less:	a) Financial Adjustment (2014)	$0
III. Net Paid Claims (Financial)		$0

Net Incurred Claims (Statistical)

	Gross Amount	Adjustments	Net Amount
2014 Claims Incurred	$0	$0	$0
2013 Claims Incurred	$0	$0	$0
2012 Claims Incurred	$0	$0	$0
2011 Claims Incurred	$0	$0	$0

2014 Claims Incurred/Paid	$0	$0	$0

Please note that totals may differ due to rounding

SECTION IIIB
2015 PAID CLAIMS RECONCILIATION
2015 Annual Renewal
In Thousands

	Total Projected Incurred Claims	Claims Paid Through 12/31/2014	Claims Paid Through 12/31/2015	Outstanding Reserve at 12/31/2015
2015	$0	$0	$0	$0
2014	$0	$0	$0	$0
2013	$0	$0	$0	$0
2012	$0	$0	$0	$0
TOTAL	$0 (3)	$0	$0 (1)(3)	$0 (2)

Note 1)	Ties to Schedule of Paid Claims (I.) before application of adjustments.
Note 2)	Ties to Open and Unreported Reserve calculation.
Note 3)	Incurred Claims and Paid Claims are reported before adjustments and include manual checks.

I. Gross Claims/Payments (Statistical)		$0
Add:	Claims Pending 12/31/2014	$0
Less:	Claims Pending 12/31/2015	$0
Gross Claims/Payments (Financial)		$0
II. Less:	a) Financial Adjustment (2015)	$0
III. Net Paid Claims (Financial)		$0

Net Incurred Claims (Statistical)

	Gross Amount	Adjustments	Net Amount
2015 Claims Incurred	$0	$0	$0
2014 Claims Incurred	$0	$0	$0
2013 Claims Incurred	$0	$0	$0
2012 Claims Incurred	$0	$0	$0
2014 Claims Incurred/Paid	$0	$0	$0

Please note that totals may differ due to rounding

SECTION IVA
DETERMINATION OF 12/31/2014 OPEN & UNREPORTED RESERVE
2015 Annual Renewal
In Millions

I.	2014 Claims Incurred (1)	$0.0	
II.	2014 Claims Incurred Paid Through 12/31/2014(1)	$0.0	
III.	12/31/2014 Runout due to 2014 Incurrals		$0.0
	Remaining 2013 Runout as of 12/31/2014	$0.0	
	Remaining Runout prior to 2013	$0.0	
	Claims Subtotal		$0.0
IV.	Reserve for Surcharges and Assessments	$0.0	
V.	Medicare Reclamation & Provider Litigation Risk	$0.0	
	Subtotal		$0.0
VIa.	Claim Base Adjustment	$0.0	
VIb.	Claims Pending 12/31/2014	$0.0	
	Total Open & Unreported Reserve		$0.0

	Claim Base Adjustment	
A	Total Reserve (Statistical Data)	$0
B	Stat Paid Claims (Sect IIIB)	$0
C	Reserve as % of Stat Paid (A/B)	0.0%
D	Financial Net Paid Claims (Sect IIIB)	$0
E	New Reserve = C*D	$0
F	Claim Base Adjustment = E - A	$0

(1) Statistical and Net of Adjustments

Please note that totals may differ due to rounding

SECTION IVB
DETERMINATION OF 12/31/2015 OPEN & UNREPORTED RESERVE
2015 Annual Renewal
In Millions

I.	2015 Claims Incurred (1)	$0.0	
II.	2015 Claims Incurred Paid Through 12/31/2015(1)	$0.0	
III.	12/31/2015 Runout due to 2015 Incurrals		$0.0
	Remaining 2014 Runout as of 12/31/2015	$0.0	
	Remaining Runout prior to 2014	$0.0	
	Claims Subtotal		$0.0
IV.	Reserve for Surcharges and Assessments	$0.0	
V.	Medicare Reclamation & Provider Litigation Risk	$0.0	
	Subtotal		$0.0
VIa.	Claim Base Adjustment	$0.0	
VIb.	Claims Pending 12/31/2015	$0.0	
	Total Open & Unreported Reserve		$0.0

	Claim Base Adjustment	
A	Total Reserve (Statistical Data)	$0
B	Stat Paid Claims (Sect IIIB)	$0
C	Reserve as % of Stat Paid (A/B)	0.0%
D	Financial Net Paid Claims (Sect IIIB)	$0
E	New Reserve = C*D	$0
F	Claim Base Adjustment = E - A	$0

(1) Statistical and Net of Adjustments

Please note that totals may differ due to rounding

SECTION VA
2014 ADMINISTRATIVE EXPENSE SUMMARY
2015 Annual Renewal

	Charge
Administrative Fee (Excludes Shared Communication Expense)	$0.00
Audit/Performance Adjustment and Other Credits	$0.00
Administrative Fee Expenses (Net of PG)	$0.00
Communication Expenses (Shared Expenses)	$0.00
Total Retention	$0.00

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION VB
2015 ADMINISTRATIVE EXPENSE SUMMARY
2015 Annual Renewal

	Charge
Administrative Fee (Excludes Shared Communication Expense)	$0.00
Audit/Performance Adjustment and Other Credits	$0.00
Administrative Fee Expenses (Net of PG)	$0.00
Communication Expenses (Shared Expenses)	$0.00
Total Retention	$0.00

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION VIA
Basic/Par
2015 Annual Renewal
In Thousands

		Normalized 2014 Claims Inc	2015 Trend	2015 Claims Inc	2015 Adjustments	2015 Net Claims Incurred	2015 Fee Schedule & Plan Changes	2015 Adjusted Claims Inc	Surcharges & Assessments	Expenses	2015 Premium Equivalent	2014 Premium Equivalent	2015 % Change
Core	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
NY Enhancement	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
PA Enhancement	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Subtotal	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
SEHP	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Total	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%

Please note that totals may differ due to rounding

SECTION VIB
Enrollee/Dependent
2015 Annual Renewal
In Thousands

		Normalized 2014 Claims Inc	2015 Trend	2015 Claims Inc	2015 Adjustments	2015 Net Claims Incurred	2015 Fee Schedule & Plan Changes	Normalized 2015 Claims Inc	Surcharges & Assessments	Expenses	2015 Premium Equivalent	2014 Premium Equivalent	2015 % Change
Core	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
NY Enhancement	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
PA Enhancement	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Subtotal	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
SEHP	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Total	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%

Please note that totals may differ due to rounding

SECTION VII
Estimated Premium Equivalents Effective January 1, 2015
2015 Annual Renewal

		MONTHLY PREMIUM EQUIVALENTS (2014)		
		EMPLOYEE	DEPENDENT	FAMILY
Core		$0.00	$0.00	$0.00
NY Medical Enhancement		$0.00	$0.00	$0.00
PA Medical Enhancement		$0.00	$0.00	$0.00
SEHP		$0.00	$0.00	$0.00
Excelsior Plan		$0.00	$0.00	$0.00
Estimated Premium Equivalents Effective January 1, 2015				
Core	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
NY Medical Enhancement	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
PA Medical Enhancement	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
SEHP	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
Excelsior Plan	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00

Assumptions:

1. Level Enrollment
2. Increase

Core	0.0%
NY Enhancement	0.0%
PA Enhancement	0.0%
SEHP	0.0%
Excelsior Plan	0.0%

Please note that totals may differ due to rounding

SECTION VIII
Estimated Number of Contracts - 2015
2015 Annual Renewal

	PERSONAL	DEPENDENT
Core	0	0
NY Medical Enhancement	0	0
PA Medical Enhancement	0	0
SEHP	0	0
Excelsior Plan	0	0

Contracts represent actual contracts thru March 2014 with contracts projected April thru December 2014.

SECTION IX
2014 Claims Incurred
2015 Annual Renewal
Triangle Report

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Jan-14	$0												$0
Feb-14	$0	$0											$0
Mar-14	$0	$0	$0										$0
Apr-14	$0	$0	$0	$0									$0
May-14	$0	$0	$0	$0	$0								$0
Jun-14	$0	$0	$0	$0	$0	$0							$0
Jul-14	$0	$0	$0	$0	$0	$0	$0						$0
Aug-14	$0	$0	$0	$0	$0	$0	$0	$0					$0
Sep-14	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Oct-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
Nov-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
Dec-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
													$0
													$0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Completion Factor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Incurred Claims	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0												
Seasonality Factor	0.0												
2014 Projected Claims	$0												
Network Pricing Guarant	$0												
2014 Adjusted Claims	$0												

PLEASE NOTE: Actual Reports will include Current Year INN, Prior Year INN, Current Year OON, and Prior Year OON

SECTION X
Trend Statistics
2015 Annual Renewal
(PROJECTED FOR THE YEAR END)

	In & Out of Network Total	**In Network** Total	**Out of Network** Total
2014			
# of Charges	0	0	0
$ Claims Incurred	$0	$0	$0
# of Contracts	0	0	0
Cost/charge	$0.00	$0.00	$0.00
# Charges/1000 Contracts	0	0	0
Cost/Contract	$0.00	$0.00	$0.00
2013			
# of Charges	0	0	0
$ Claims Incurred	$0	$0	$0
# of Contracts	0	0	0
Cost/charge	$0.00	$0.00	$0.00
# Charges/1000 Contracts	0	0	0
Cost/Contract	$0.00	$0.00	$0.00
% Change 2014 over 2013			
Cost/Charge	0.00%	0.00%	0.00%
# Charges/1000 Contracts	0.00%	0.00%	0.00%
Cost/Contract	0.00%	0.00%	0.00%

Note: In Network vs Out-of-Network based on the contracted status of the Provider.

State of New York - Empire Plan

MHSA Program

2014 First Quarter Financial Report

April 15, 2014

		Page(s)
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SECTION I
EXPERIENCE OF CURRENT QUARTER AND YEAR TO DATE 2014
2014 First Quarter Report
Current Quarter and Year to Date

In Thousands

		COMBINED		
		Estimated Prior Qtr YTD	Estimated Current Qtr	Estimated YTD
1.	Premium Equivalents	$0	$0	$0
2a.	Paid Claims	$0	$0	$0
2b.	Surcharges and Assessments	$0	$0	$0
2c.	Open & Unreported as of 3/31/2014	$0	$0	$0
2d.	Open & Unreported as of 12/31/2013	$0	$0	$0
2e.	Incurred Claims (2a+2b+2c-2d)	$0	$0	$0
2f.	Network Pricing Guarantee Adjustment (if needed)	$0	$0	$0
2g.	Adjusted Incurred Claims (2e-2f)	$0	$0	$0
3a.	Administrative Expenses	$0	$0	$0
3b.	Audit/Performance Adjustment and Other Credits	$0	$0	$0
3c.	Total Retention (3a-3b)	$0	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0	$0

Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION II
RECONCILIATION OF EXPERIENCE PROJECTIONS FOR PRIOR YEAR
2014 First Quarter Report
In Thousands

		COMBINED	
		Renewal	Financial
1.	Premium Equivalents	$0	$0
2a.	Paid Claims	$0	$0
2b.	Surcharges and Assessments	$0	$0
2c.	Ending O&U 12/31/2013	$0	$0
2d.	Beginning O&U 12/31/2012	$0	$0
2e.	Incurred Claims (2a+2b+2c-2d)	$0	$0
2f.	Network Pricing Guarantee Adjustment	$0	$0
2g.	Adjusted Incurred Claims (2e-2f)	$0	$0
3a.	Administrative Expenses	$0	$0
3b.	Audit/Performance Adjustment and Other Credits	$0	$0
3c.	Total Retention (3a-3b)	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	1st Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	2nd Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	3rd Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

2c.	4th Quarter ending O&U	$0	$0
4.	Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0

*Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION IIIA
CURRENT FULL YEAR PROJECTED EXPERIENCE
2014 First Quarter Report
In Thousands

COMBINED	Projected at Renewal	1st Q Report	2nd Q Report	3rd Q Report	4th Q Report
1. Premium Equivalents	$0	$0	$0	$0	$0
2a. Paid Claims	$0	$0	$0	$0	$0
2b. Surcharges and Assessments	$0	$0	$0	$0	$0
2c. Open & Unreported as of 12/31/2014	$0	$0	$0	$0	$0
2d. Open & Unreported as of 12/31/2013	$0	$0	$0	$0	$0
2e. Incurred Claims (2a + 2b +2c- 2d)	$0	$0	$0	$0	$0
2f. Network Pricing Guarantee Adjustment (if needed)	$0	$0	$0	$0	$0
2g. Adjusted Incurred Claims (2e-2f)	$0	$0	$0	$0	$0
3a. Administrative Expenses	$0	$0	$0	$0	$0
3b. Audit/Performance Adjustment and Other Credits	$0	$0	$0	$0	$0
3c. Total Retention (3a-3b)	$0	$0	$0	$0	$0
4. Premium Equivalents Surplus (Deficit) (1 - 2G -3c)*	$0	$0	$0	$0	$0

Please note that totals may differ due to rounding

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION IIIB
PAID CLAIMS RECONCILIATION
2014 First Quarter Report
In Thousands

	Total Projected Incurred Claims	Claims Paid Through 12/31/2013	Claims Paid Through 12/31/2014	Outstanding Reserve at 12/31/2014
2014	$0	$0	$0	$0
2013	$0	$0	$0	$0
2012	$0	$0	$0	$0
2011	$0	$0	$0	$0
TOTAL	$0 (3)	$0	$0 (1)(3)	$0 (2)

Note 1)	Ties to Schedule of Paid Claims (I.) before application of adjustments.
Note 2)	Ties to Open and Unreported Reserve calculation.
Note 3)	Incurred Claims and Paid Claims are reported before adjustments and include manual checks.

I. Gross Claims/Payments (Statistical)		$0
Add:	Claims Pending 12/31/2013	$0
Less:	Claims Pending 12/31/2014	$0
Gross Claims/Payments (Financial)		$0
II. Less:	a) Financial Adjustment (2014)	$0
III. Net Paid Claims (Financial)		$0

Net Incurred Claims (Statistical)

	Gross Amount	Adjustments	Net Amount
2014 Claims Incurred	$0	$0	$0
2013 Claims Incurred	$0	$0	$0
2012 Claims Incurred	$0	$0	$0
2011 Claims Incurred	$0	$0	$0

2014 Claims Incurred/Paid	$0	$0	$0

Please note that totals may differ due to rounding

SECTION IIIC
DETERMINATION OF 12/31/2014 OPEN & UNREPORTED RESERVE
2014 First Quarter Report
In Millions

I.	2014 Claims Incurred [1]	$0.0	
II.	2014 Claims Incurred Paid Through 12/31/2014[1]	$0.0	
III.	12/31/2014 Runout due to 2014 Incurrals		$0.0
	Remaining 2013 Runout as of 12/31/2014	$0.0	
	Remaining Runout prior to 2013	$0.0	
	Claims Subtotal		$0.0
IV.	Reserve for Surcharges and Assessments	$0.0	
V.	Medicare Reclamation & Provider Litigation Risk	$0.0	
	Subtotal		$0.0
VIa.	Claim Base Adjustment	$0.0	
VIb.	Claims Pending 12/31/2014	$0.0	
	Total Open & Unreported Reserve		$0.0

	Claim Base Adjustment	
A	Total Reserve (Statistical Data)	$0
B	Stat Paid Claims (Sect IIIB)	$0
C	Reserve as % of Stat Paid (A/B)	0.0%
D	Financial Net Paid Claims (Sect IIIB)	$0
E	New Reserve = C*D	$0
F	Claim Base Adjustment = E - A	$0

(1) Statistical and Net of Adjustments

Please note that totals may differ due to rounding

SECTION IIID
ADMINISTRATIVE EXPENSE SUMMARY
2014 First Quarter Report

	Charge
Administrative Fee (Excludes Shared Communication Expense)	$0.00
Audit/Performance Adjustment and Other Credits	$0.00
Administrative Fee Expenses (Net of PG)	$0.00
Communication Expenses (Shared Expenses)	$0.00
Total Retention	$0.00

Actual Reports will include breakouts for Combined, Core, NY Enhancement, and PA Enhancement

SECTION IVA
Basic/Par
2014 First Quarter Report
In Thousands

		Normalized 2014 Claims Inc	2015 Trend	2015 Claims Inc	2015 Adjustments	2015 Net Claims Incurred	2015 Fee Schedule & Plan Changes	2015 Adjusted Claims Inc	Surcharges & Assessments	Expenses	2015 Premium Equivalent	2014 Premium Equivalent	2015 % Change
Core	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
NY Enhancement	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
PA Enhancement	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Subtotal	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
SEHP	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Total	basic	$0	0.0%	$0	$0	$0	$0	$0	$0				
	par	$0	0.0%	$0	$0	$0	$0	$0	$0				
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%

Please note that totals may differ due to rounding

SECTION IVB
Enrollee/Dependent
2014 First Quarter Report
In Thousands

		Normalized 2014 Claims Inc	2015 Trend	2015 Claims Inc	2015 Adjustments	2015 Net Claims Incurred	2015 Fee Schedule & Plan Changes	Normalized 2015 Claims Inc	Surcharges & Assessments	Expenses	2015 Premium Equivalent	2014 Premium Equivalent	2015 % Change
Core	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
NY Enhancement	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
PA Enhancement	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Subtotal	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
SEHP	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
Total	ee	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	dep	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%
	total	$0	0.0%	$0	$0	$0	$0	$0	$0	$0	$0	$0	0.0%

Please note that totals may differ due to rounding

SECTION IVC
Estimated Premium Equivalents Effective January 1, 2015
2014 First Quarter Report

		MONTHLY PREMIUM EQUIVALENTS (2014)		
		EMPLOYEE	DEPENDENT	FAMILY
Core		$0.00	$0.00	$0.00
NY Medical Enhancement		$0.00	$0.00	$0.00
PA Medical Enhancement		$0.00	$0.00	$0.00
SEHP		$0.00	$0.00	$0.00
Excelsior Plan		$0.00	$0.00	$0.00
Estimated Premium Equivalents Effective January 1, 2015				
Core	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
NY Medical Enhancement	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
PA Medical Enhancement	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
SEHP	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00
Excelsior Plan	Realistic	$0.00	$0.00	$0.00
	Pessimistic	$0.00	$0.00	$0.00
	Optimistic	$0.00	$0.00	$0.00

Assumptions:
1. Level Enrollment
2. Increase

Core	0.0%
NY Enhancement	0.0%
PA Enhancement	0.0%
SEHP	0.0%
Excelsior Plan	0.0%

Please note that totals may differ due to rounding

SECTION V
Estimated Number of Contracts - 2015
2014 First Quarter Report

	PERSONAL	DEPENDENT
Core	0	0
NY Medical Enhancement	0	0
PA Medical Enhancement	0	0
SEHP	0	0
Excelsior Plan	0	0

Contracts represent actual contracts thru March 2014 with contracts projected April thru December 2014.

Attachment 8-65
May 20, 2014

SECTION VI
2014 Claims Incurred
2014 First Quarter Report
Triangle Report

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Jan-14	$0												$0
Feb-14	$0	$0											$0
Mar-14	$0	$0	$0										$0
Apr-14	$0	$0	$0	$0									$0
May-14	$0	$0	$0	$0	$0								$0
Jun-14	$0	$0	$0	$0	$0	$0							$0
Jul-14	$0	$0	$0	$0	$0	$0	$0						$0
Aug-14	$0	$0	$0	$0	$0	$0	$0	$0					$0
Sep-14	$0	$0	$0	$0	$0	$0	$0	$0	$0				$0
Oct-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0			$0
Nov-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
Dec-14	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
													$0
													$0
Total	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

Completion Factor	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Incurred Claims	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0												
Seasonality Factor	0.0												
2014 Projected Claims	$0												
Network Pricing Guarant	$0												
2014 Adjusted Claims	$0												

PLEASE NOTE: Actual Reports will include Current Year INN, Prior Year INN, Current Year OON, and Prior Year OON

SECTION VII
Trend Statistics
2014 First Quarter Report
(PROJECTED FOR THE YEAR END)

2014

	In & Out of Network Total	In Network Total	Out of Network Total
# of Charges	0	0	0
$ Claims Incurred	$0	$0	$0
# of Contracts	0	0	0
Cost/charge	$0.00	$0.00	$0.00
# Charges/1000 Contracts	0	0	0
Cost/Contract	$0.00	$0.00	$0.00

2013

	In & Out of Network Total	In Network Total	Out of Network Total
# of Charges	0	0	0
$ Claims Incurred	$0	$0	$0
# of Contracts	0	0	0
Cost/charge	$0.00	$0.00	$0.00
# Charges/1000 Contracts	0	0	0
Cost/Contract	$0.00	$0.00	$0.00

% Change 2014 over 2013

	In & Out of Network Total	In Network Total	Out of Network Total
Cost/Charge	0.00%	0.00%	0.00%
# Charges/1000 Contracts	0.00%	0.00%	0.00%
Cost/Contract	0.00%	0.00%	0.00%

Note: In Network vs Out-of-Network based on the contracted status of the Provider.

Attachment 8-67
May 20, 2014

SECTION VIII
Trend Analysis - YTD 2014 - Provider Status
2014 First Quarter Report

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
In and Out of Network (Provider Status)													
Inpatient Services													
Mental Health	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Substance Abuse	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Alcohol Rehab***	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Alternate Levels of Care	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Weighted Average Facility Charge	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
% of Total	0.0%	0.0%											
Outpatient Services													
Professional Inpatient Services													
Physician	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Psychologist	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Other Health Professional	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
					0.0%					0.0%			0.0%
Outpatient Visits													
Physician	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Psychologist	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Other Health Professional	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Other Services Not Included Above	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Weighted Average Professional Charge	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
% of Total	0.0%	0.0%											
Total Combined	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/2014 (average members: 0,000,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/2014 (average members: 0,000,000)
***Include zero paid claims

Actual Reports will include In Network, Out Of Network, and Total by Provider Status

SECTION IX
Trend Analysis - YTD 2014 - Benefit Level
2014 First Quarter Report

	Days or Services***		Days/Visits Per 1000			Amount Paid		Average Unit Cost			Cost PMPM		
	2013*	2014**	2013*	2014**	% Change	2013*	2014**	2013*	2014**	% Change	2013*	2014**	% Change
In and Out of Network (Provider Status)													
Inpatient Services													
Mental Health	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Substance Abuse	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Alcohol Rehab***	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Alternate Levels of Care	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Weighted Average Facility Charge	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
% of Total	0.0%	0.0%											
Outpatient Services													
Professional Inpatient Services													
Physician	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Psychologist	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Other Health Professional	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
					0.0%					0.0%			0.0%
Outpatient Visits													
Physician	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Psychologist	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Other Health Professional	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Substance Abuse and Structured Outpatient Programs and Clinics (SOPS)	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Other Services Not Included Above	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
Weighted Average Professional Charge	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%
% of Total	0.0%	0.0%											
Total Combined	0	0	0.00	0.00	0.0%	$0	$0	$0.00	$0.00	0.0%	$0.00	$0.00	0.0%

*Incurred 1/1/13 - 12/31/13, claims paid through 3/31/2014 (average members: 0,000,000)
**Incurred 1/1/14 - 3/31/14, claims paid through 3/31/2014 (average members: 0,000,000)
***Include zero paid claims

Actual Reports will include In Network, Out Of Network, and Total by Benefit Level

Empire Plan Quarterly Coordination Of Benefit Report

2014 Q1	Other Insurance Code	Other Insurance Description	Alternate ID	Member Last Name	Member First Name	Member Birthdate	Provider Charge Amount	COB Savings Amount
1	M	Medicare Paid Primary	890XXXXXX	Sample Member 1	Sample Member 1	MM/DD/CCYY	$0000.00	$0000.00
2	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 2	Sample Member 2	MM/DD/CCYY	$0000.00	$0000.00
3	B	Both Medicare and OI Commercial Paid Primary (Tertiary)	890XXXXXX	Sample Member 3	Sample Member 3	MM/DD/CCYY	$0000.00	$0000.00
4	M	Medicare Paid Primary	890XXXXXX	Sample Member 4	Sample Member 4	MM/DD/CCYY	$0000.00	$0000.00
5	M	Medicare Paid Primary	890XXXXXX	Sample Member 5	Sample Member 5	MM/DD/CCYY	$0000.00	$0000.00
6	M	Medicare Paid Primary	890XXXXXX	Sample Member 6	Sample Member 6	MM/DD/CCYY	$0000.00	$0000.00
7	M	Medicare Paid Primary	890XXXXXX	Sample Member 7	Sample Member 7	MM/DD/CCYY	$0000.00	$0000.00
8	M	Medicare Paid Primary	890XXXXXX	Sample Member 8	Sample Member 8	MM/DD/CCYY	$0000.00	$0000.00
9	M	Medicare Paid Primary	890XXXXXX	Sample Member 9	Sample Member 9	MM/DD/CCYY	$0000.00	$0000.00
10	M	Medicare Paid Primary	890XXXXXX	Sample Member 10	Sample Member 10	MM/DD/CCYY	$0000.00	$0000.00
11	M	Medicare Paid Primary	890XXXXXX	Sample Member 11	Sample Member 11	MM/DD/CCYY	$0000.00	$0000.00
12	M	Medicare Paid Primary	890XXXXXX	Sample Member 12	Sample Member 12	MM/DD/CCYY	$0000.00	$0000.00
13	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 13	Sample Member 13	MM/DD/CCYY	$0000.00	$0000.00
14	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 14	Sample Member 14	MM/DD/CCYY	$0000.00	$0000.00
15	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 15	Sample Member 15	MM/DD/CCYY	$0000.00	$0000.00
16	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 16	Sample Member 16	MM/DD/CCYY	$0000.00	$0000.00
17	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 17	Sample Member 17	MM/DD/CCYY	$0000.00	$0000.00
18	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 18	Sample Member 18	MM/DD/CCYY	$0000.00	$0000.00
19	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 19	Sample Member 19	MM/DD/CCYY	$0000.00	$0000.00
20	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 20	Sample Member 20	MM/DD/CCYY	$0000.00	$0000.00
21	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 21	Sample Member 21	MM/DD/CCYY	$0000.00	$0000.00
22	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 22	Sample Member 22	MM/DD/CCYY	$0000.00	$0000.00
23	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 23	Sample Member 23	MM/DD/CCYY	$0000.00	$0000.00
24	O	OI Commercial Paid Primary	890XXXXXX	Sample Member 24	Sample Member 24	MM/DD/CCYY	$0000.00	$0000.00
25	B	Both Medicare and OI Commercial Paid Primary (Tertiary)	890XXXXXX	Sample Member 25	Sample Member 25	MM/DD/CCYY	$0000.00	$0000.00
26	B	Both Medicare and OI Commercial Paid Primary (Tertiary)	890XXXXXX	Sample Member 26	Sample Member 26	MM/DD/CCYY	$0000.00	$0000.00
27	B	Both Medicare and OI Commercial Paid Primary (Tertiary)	890XXXXXX	Sample Member 27	Sample Member 27	MM/DD/CCYY	$0000.00	$0000.00
28	B	Both Medicare and OI Commercial Paid Primary (Tertiary)	890XXXXXX	Sample Member 28	Sample Member 28	MM/DD/CCYY	$0000.00	$0000.00
Total	Total	Total	Total	Total	Total	Total	$0000.00	$0000.00

Attachment 8-70
May 20, 2014

OPTUM/EMPIRE SIU
4th Qtr-2012

TIN	**Prov Name/Group Under Investigation**	**PPA Status**	**Total $**	**Why is the provider being investigated?**	**What prompted the review of the provider?**	**3rd Quarter Status**	**4th Quarter Status**
TIN removed to protect confidentiality	TIN removed to protect confidentiality	Provider was participating with plan, contract has been terminated	N/A	Provider is suspected of misrepresenting services when submitting claims to the Optum Health/Empire Plan Mental Health program.	Member complaint regarding services billed. States provider misrepresenting services, billing for individual therapy, when actually receiving family counseling.	No cases were reviewed in the 3rd quarter. Case is still being investigated by NYS Department of Financial Services, Fraud Bureau. Provider remains on OptumInsight review. ***Case is pended at this time.***	No cases were reviewed in the 4th quarter. Case is still being investigated by NYS Department of Financial Services, Fraud Bureau. Provider remains on OptumInsight review. ***Case is pended at this time.***
		Provider is participating with Optum Health	$0.00	Provider suspected of up coding, misrepresentation of services and billing for non covered provider types.	Contacted by Optum Health Customer Service that it appeared provider was billing too many units of cpt code 90801, 90806 and 90808.	Provider continues to be non-compliant with overpayment request. Awaiting response from OptumHealth Legal Unit regarding possible civil action. OptumHealth/Empire Plan SIU working with OptumHealth National SIU building a case.	Provider continues to be non-compliant with overpayment request. Awaiting response from OptumHealth Legal Unit regarding possible civil action. OptumHealth/Empire Plan SIU working with OptumHealth National SIU building a case.
		Provider is participating with Optum Health	$0.00	Provider suspected of up-coding.	Optum Health Compliance Department notified SIU of a patient complaint alleging provider may be up-coding / billing for longer sessions than what actually occurred.	Awaiting response from provider regarding overpayment letter.	Provider has been non compliant with refund request. Claims to adjusted and future benefits offset.
		Provider is participating with Optum Health	N/A	Provider suspected of billing for services not rendered, up-coding & misrepresentation of services.	Member complaint stating provider was billing for dates of service that did not occur.	Case is still being investigated by the NYS Department of Financial Services, Frauds Bureau. Optum Health SIU assists as requested. SIU case file subpoenaed by NYS Office of Professional Discipline. SIU continues working with DFS and NYS OPD in case building.	Case is still being investigated by the NYS Department of Financial Services, Frauds Bureau. Optum Health SIU assists as requested. SIU case file subpoenaed by NYS Office of Professional Discipline. SIU continues working with DFS and NYS OPD in case building.
		Provider is participating with Optum Health	$0.00	Provider suspected of billing for non covered provider types. Review of claim data shows provider may be mis-using cpt code 90801.	Referral received from Optum Clinical Services Department that provider has an excessive number of authorization on file and maybe billing for other non-covered provider types in the office. Review of claim data also shows provider maybe mis-using cpt code 90801.	Optum Health/Empire SIU continues to work with assist Department of Health, Office of Professions in building a case. No update at this time.	Optum Health/Empire SIU continues to work with assist Department of Health, Office of Professions in building a case. No update at this time.
		Provider is participating with Optum Health	$0.00	Provider suspected of up-coding and mis-use of cpt code 90807	Enrollee complaint that provider billed for a date of service she never saw member. Review of claim data showed a high usage of 90807.	NYS Office of Professions has confirmed that provider is not certified as a psychiatric nurse practitioner. SIU Calculating overpayment and preparing complaint to NYS Office of Professions.	Working with SIU Investigator Michael Strong in case building.
		Provider is participating with Optum Health	$0.00	Provider is suspected of Contract manipulation, billing for services that were not rendered and misrepresentation of services or diagnosis. This is a NY provider who is contracted individually, but billing upwards of 25 units of cpt 90806 sessions/day.	Received several member complaints that provider's office manager was trying to make members pay up front for services, because the Empire Plan cancelled the providers contract. Data analytics was performed and revealed provider billing excessive units of cpt code 90806 for one day.	OptumHealth/Empire SIU working jointly with National SIU, as well as working with NYS Department of Financial Services and Office of the Professions building a case. No update at this time.	OptumHealth/Empire SIU working jointly with National SIU, as well as working with NYS Department of Financial Services and Office of the Professions building a case. No update at this time.

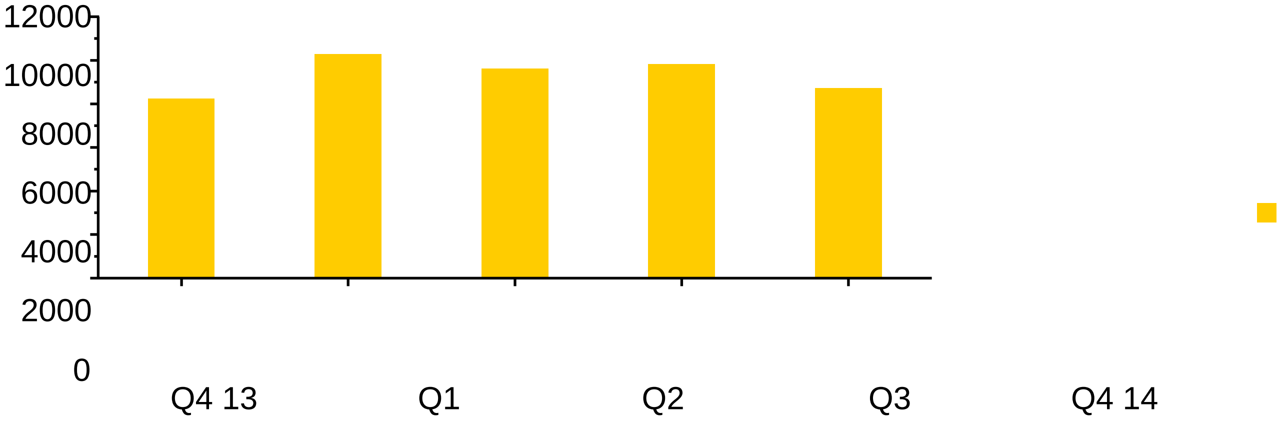
Attachment 8-71
May 20, 2014

liveandworkwell
liveandworkwell.com

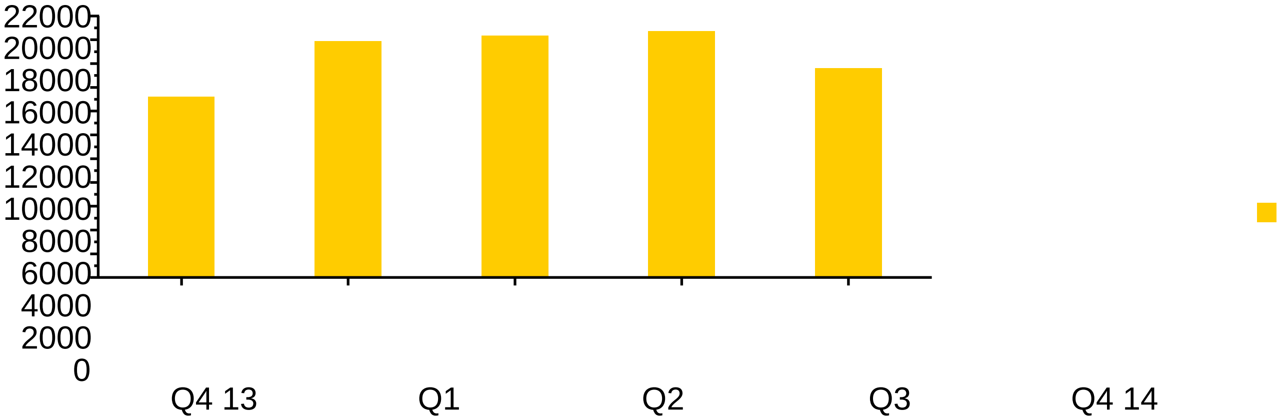
Empire Plan - New York State
1/01/2014 - 12/31/2014 - SAMPLE

SUMMARY INFORMATION

Visitor Sessions - 8717



Page Views - 17612



	Views
Materials	**11042**
Resources	**8276**
Spotlights	**97**

Spotlights

Coping With Your Loss and Grief	22
Autism	15
Wellness Monthly Newsletter	11
You Can Quit Smoking	10
October is National Bullying Prevention Month	3
A Child's Guide to Cultural Holidays	1
Special Alert : After the Storm	1
Spotlight Total	**63**

Top Centers

Committed Relationships	266
Separation & Divorce	111
Alcoholism	93
Depression (Adult)	72
Anxiety	62
Children : Preteen & Teen	61
Exercise & Fitness	48
Drug Use	47
Dating	45
Controlling Anger	36
Other 'Addictions'	33
Family Communication	27
Sexual Problems	27
Eating Disorders (Adult)	26
Procrastination	24
Special Needs : Adult	23
Bipolar Disorder (Adult)	18
Recovery & Resiliency	18
Sleep	18
Children : Adult	17
Stress Management	17

Coping & Peace of Mind	16
Obsessions & Compulsions	16
Responses to Trauma	16
Grief & Loss	15
Healthy Eating	14
Stress	14
Coworkers	13
ADHD (Youth)	12
Personality Disorders	10
Centers Total	**1323***

**Please note: Total hits may be higher than the total of utilization shown because it incorporates page views for all content.*

Top Articles

Coping with Your Loss and Grief	22
Managing Differences in Healthy Relationships	21
The Art of Romance	14
Codependence	11
You Can Quit Smoking	10
Alcoholism and Recovery	7
Kids, Divorce, and School Success	7
Set-Up Family Boundaries Before the Marriage	7
Alcoholism as Part of a Dual Diagnosis	6
FAQs About Divorce	6
Anorexia Nervosa	5
Helping Your Child Through a Divorce	5
It's Good to Ask for What You Need: Communication and Sexuality	5
A Stress-Relief Checklist	4
If Someone Close Has a Problem with Alcohol or Other Drugs	4
Insomnia	4
Principles of Attraction: Why We Like Who We Like	4
Resiliency Skills for Handling the Emotional Side of Job Loss and Job Search	4
Screening for Alcohol Abuse and Dependence	4
Bipolar Disorder (Manic-Depressive Illness)	3
Addressing Divorce in the Workplace	3

Family Therapy	3
Female Sexual Arousal Disorder	3
Health Insurance Basics	3
Intervention before Divorce Can Help Children through the Bad Times	3
Personal Finance: Advice for Couples Before the Wedding	3
Recognizing the Signs and Symptoms of Obsessive-Compulsive Disorder (OCD)	3
Recognizing the Warning Signs of Addiction	3
The Myth of Sex as a Spontaneous Act	3
When a Co-Worker Dies	3
Articles Total	**342***

**Please note: Total hits may be higher than the total of utilization shown because it incorporates page views for all content. English and Spanish content listed as separate line items.*

Top Resources

Clinician Search	8102
American Association for Marriage & Family Therapy	37
Relationship Help Helpguide	17
Addictions Helpguide	10
Anxiety Helpguide	9
Anxiety Disorders Association of America	7
Controlling Anger Before it Controls You	6
Abuse and Bullying Helpguide	6
HealthFinder - Everyday Health and Wellness	6
Children & Adults with Attention Deficit/Hyperactivity Disorder (CHADD)	5
Depression Helpguide	4
Depression & Bipolar Support Alliance (DBSA)	3
Eating Disorder Helpguide	3
Adult Survivors of Sexual Abuse	3
National Eating Disorders Association (NEDA)	3
Substance Abuse and Mental Health Administration (SAMHSA) Resource Locator	3
Al-Anon / Alateen	2
Anorexia Nervosa & Related Eating Disorders (ANRED)	2
Drug Facts	2
Divorce - MedlinePlus	2
Family Caregiver Alliance - Family Care Navigator	2

Get Your Angries Out	2
Guide to Physical Activity	2
HealthFinder - Nutrition and Fitness	2
It Gets Better Project®	2
National Clearinghouse for Alcohol & Drug Information (NCADI)	2
National Institute for the Prevention of Workplace Violence	2
National Institute of Mental Health (NIMH)	2
The Balanced Mind Foundation	2
GirlsHealth.gov - Teen Relationships	1
Resources Total	**8251***

**Please note: Total hits may be higher than the total of utilization shown because it incorporates page views for all content. English and Spanish content listed as separate line items.*

Self-Help Programs

Tobacco Cessation Plan	10
Moving Through Depression Personal Empowerment Program	5
Manage Your Weight Online Health Education Resource	5
Medication Safety Online Health Education Resource	1
Men's Health Online Education Resource	1
ADHD Online Health Education Resource	1
Are You Ready to Quit Smoking?	1
Depression Online Health Education Resource	1
Whole Health Tracker - Part One: Introduction and First Week	1
Women's Health Online Health Education Resource	1
Self-Help Programs Total	**27**

My Claims & Coverage

My Claims & Coverage	2331
My Claims & Coverage Total	**2331**

Forums

Relationships	7
Depression	4
Anxiety	2
Divorce	2
Children and Parenting	1
Forums Total	**16**

Multimedia

Videos	2
Multimedia Total	**2**

Admin Toolbox

Resources	3
Admin Toolbox Total	**6**

Prevention Program

Prevention Center Landing Page

Landing Page	1
Prevention Center Landing Page Total	**1**

Prevention Program for ADHD

Landing Page	272
Article Listing	18
Prevention Program for ADHD Total	**290**

Prevention Program for ADHD - Physicians' Corner

Landing Page	16
Prevention Program for ADHD - Physicians' Corner Total	**16**

Prevention Program for Depression

Landing Page	795
Article Listing	69
Prevention Program for Depression Total	**864**

Prevention Program for Depression - Physicians' Corner

Landing Page	107
Prevention Program for Depression - Physicians' Corner Total	**107**

Prevention Program for Eating Disorders

Landing Page	147
Article Listing	41
Prevention Program for Eating Disorders Total	**188**

Prevention Program for Eating Disorders - Physicians' Corner

Landing Page	56
Prevention Program for Eating Disorders - Physicians' Corner Total	**56**

Glossary of Terms

Visitor Session: A Visitor Session measures an individual visit to a specific web site only once per web site visit, and is captured by company access code.

Page View: A Page View records a single view of a particular page every time the page is accessed during a single Visitor Session. For example, if the same web page is accessed 12 times during one Visitor Session, it will record 12 Page Views. **Please note:** Page views here reflect content viewed solely from liveandworkwell.com servers. Page views from licensed/third party professional sources are not available at an account level.

Case: A Case is recorded by submitted Intake Forms only.

Materials: Materials are measured by Page Views. For example, if a user views an article 10 times during one Visitor Session, it will record 10 page views.

Resources: Resources are measured by Page Views. For example, if a user views a school resource 5 times during one Visitor Session, it will record 5 page views.

B_7_B_1_Copy of Sample - Adhoc DEAS Dependent Deletes Report
001 - Empire Plan

SSN	BEA_ALTID	BENEFIT_PROGRAM	LAST_NAME	FIRST_NAME	BENEFIT_PLAN	DEAS_DEP_LAST_NAME	DEAS_DEP_FIRST_NAM	DEPENDENT_BENEF	BEA_BIRTHDATE	REASON_CD	NET_PAID_AMOUNT (UHC Medical)	NET_PAID_AMOUNT (Optum Behavioral)	NET_PAID_AMOUNT (UHC Pharmacy)	NET_PAID_AMOUNT (Combined)
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	01	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	01	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	01	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	01	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
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000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
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000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	01	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	01	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00
000000000	890000000	R01	SAMPLE	SAMPLE	001	SAMPLE	SAMPLE	02	12-31-9999	99	$0.00	$0.00	$0.00	$0.00

Sample Adhoc Request

Request Number 1

Number of acute Inpatient denials/adverse benefits determinations for clinical reasons
For <Insert Collective Bargaining Unit Name> Members Only, this includes partial denials, and both pre-service and concurrent denials.

	Acute Inpatient
Prior Year	0
Current Year	00
Total	***00***

Request Number 2:

All denials for <Insert Collective Bargaining Unit Name> Members.
Includes administrative and clinical, all levels of care

	Prior Year		**Current Year**		**Total**
	SA	**MH**	**SA**	**MH**	
Acute Inpatient	0	0	0	0	**0**
Alternate Levels of Care (ALOC)	0	0	0	0	**0**
Outpatient	0	0	0	0	**0**
Total	***0***	***0***	***0***	***0***	***0***

Request Number 2:
Number of new providers by county contracted for the previous 2 years

Practitioners

State	**County**	**Previous year**	**Current year**
NY			
NY	Albany	0	0
NY	Allegany	0	0
NY	Bronx	0	0
NY	Broome	0	0
NY	Cattaraugus	0	0
NY	Cayuga	0	0
NY	Chautauqua	0	0
NY	Chemung	0	0
NY	Chenango	0	0
NY	Clinton	0	0
NY	Colonie	0	0
NY	Columbia	0	0
NY	Cortland	0	0
NY	Delaware	0	0
NY	Dutchess	0	0
NY	Erie	0	0
NY	Essex	0	0
NY	Franklin	0	0
NY	Genesee	0	0
NY	Greene	0	0
NY	Herkimer	0	0

NY	Jefferson	0	0
NY	Kings	0	0
NY	Lewis	0	0
NY	Livingston	0	0
NY	Madison	0	0
NY	Monroe	0	0
NY	Montgomery	0	0
NY	Nassau	0	0
NY	New York	0	0
NY	Niagara	0	0
NY	Oneida	0	0
NY	Onondaga	0	0
NY	Ontario	0	0
NY	Orange	0	0
NY	Orleans	0	0
NY	Oswego	0	0
NY	Otsego	0	0
NY	Putnam	0	0
NY	Queens	0	0
NY	Rensselaer	0	0
NY	Richmond	0	0
NY	Rockland	0	0
NY	Saint Lawrence	0	0
NY	Saratoga	0	0
NY	Schenectady	0	0
NY	Seneca	0	0
NY	Steuben	0	0
NY	Suffolk	0	0
NY	Sullivan	0	0
NY	Tioga	0	0
NY	Tompkins	0	0
NY	Ulster	0	0
NY	Warren	0	0
NY	Washington	0	0
NY	Westchester	0	0
NY	Wyoming		
TOTAL		**0000**	**0000**

Facilities

State	County	Prior Year	Current Year
NY	Albany	0	0
NY	Bronx	0	0
NY	Chautauqua	0	0
NY	Chemung	0	0
NY	Dutchess	0	0
NY	Kings	0	0
NY	Monroe	0	0
NY	Nassau	0	0
NY	New York	0	0
NY	Orange	0	0
NY	Queens	0	0
NY	Saint Lawrence	0	0
NY	Suffolk	0	0
NY	Tompkins	0	0
NY	Wayne	0	0
NY	Westchester	0	0
TOTAL		**00**	**00**

Groups

State	County	Prior Year	Current Year
NY	Albany	0	0
NY	Allegany	0	0
NY	Bronx	0	0
NY	Cattaraugus	0	0
NY	Cayuga	0	0
NY	Chautauqua	0	0
NY	Chemung	0	0
NY	Chenango	0	0
NY	Clinton	0	0
NY	Columbia	0	0
NY	Cortland	0	0
NY	Dutchess	0	0
NY	Erie	0	0
NY	Essex	0	0
NY	Franklin	0	0
NY	Genesee	0	0
NY	Greene	0	0
NY	Hamilton	0	0
NY	Herkimer	0	0
NY	Jefferson	0	0
NY	Kings	0	0
NY	Lewis	0	0
NY	Livingston	0	0
NY	Monroe	0	0
NY	Nassau	0	0
NY	New York	0	0
NY	Niagara	0	0
NY	Oneida	0	0
NY	Onondaga	0	0
NY	Ontario	0	0
NY	Orange	0	0

NY	Orleans	0	0
NY	Oswego	0	0
NY	Otsego	0	0
NY	Putnam	0	0
NY	Queens	0	0
NY	Rensselaer	0	0
NY	Richmond	0	0
NY	Rockland	0	0
NY	Saint Lawrence	0	0
NY	Saratoga	0	0
NY	Schenectady	0	0
NY	Schoharie	0	0
NY	Schuyler	0	0
NY	Seneca	0	0
NY	Steuben	0	0
NY	Suffolk	0	0
NY	Sullivan	0	0
NY	Tioga	0	0
NY	Tompkins	0	0
NY	Ulster	0	0
NY	Warren	0	0
NY	Washington	0	0
NY	Wayne	0	0
NY	Westchester	0	0
NY	Wyoming	0	0
NY	Yates	0	0
TOTAL		**00**	**00**

Attachment 8-83
May 20, 2014

Empire Plan Consolidated Toll Free Service
877-7NYSHIP
OptumHealth Clinical Referral Line and Customer Service Detail

Clinical Referral Line (CRL)

Month/Year	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD
Totals Calls Received																	
Calls Abandoned																	
Percentage Abandoned																	
Average Handle Time in Seconds																	
Average Speed of Answer in Seconds																	

Customer Service (CS)

Month/Year	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD
Totals Calls Received																	
Calls Abandoned																	
Percentage Abandoned																	
Average Handle Time in Seconds																	
Average Speed of Answer in Seconds																	

Performance Metrics

Month/Year	Performance Guarantee Standard	Jan	Feb	Mar	Q1	Apr	May	Jun	Q2	Jul	Aug	Sep	Q3	Oct	Nov	Dec	Q4	YTD
Non Network Claim 18 Business Day Turnaround Time**	**99.5%**																	
Customer Call Center Speed to Answer	**90% within 30 seconds**																	
Customer Call Center Abandonment Rate	**Less than 3%**																	
Call Blockage Rate	**0%**																	
Customer Call Quality	**N/A**																	
First Call Resolution (Lag by 1 Month)	**N/A**																	
LAWW usage	**N/A**																	

*The guarantee excludes claims subject to the terms of a Provider Agreement that allows for a turnaround time of greater than 18 business days.

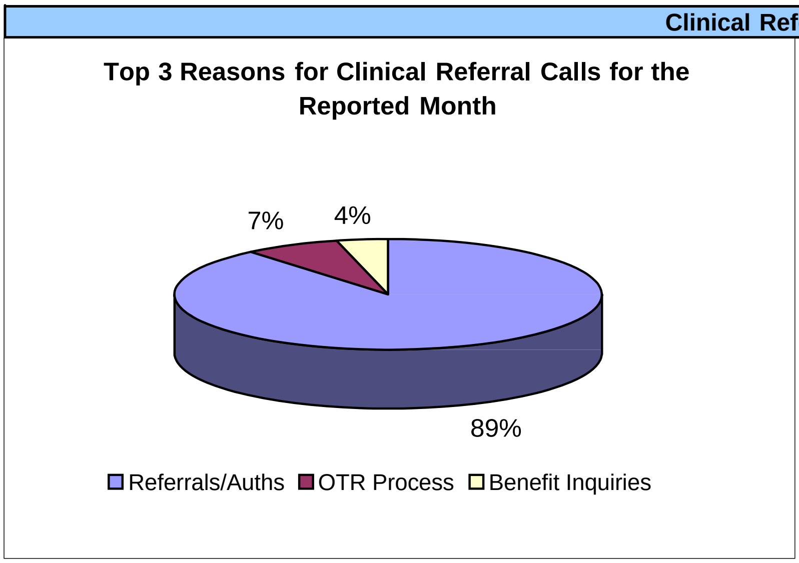
**Turnaround times based on monthly pre-audit claim inventory report to be finalized, post-audit.

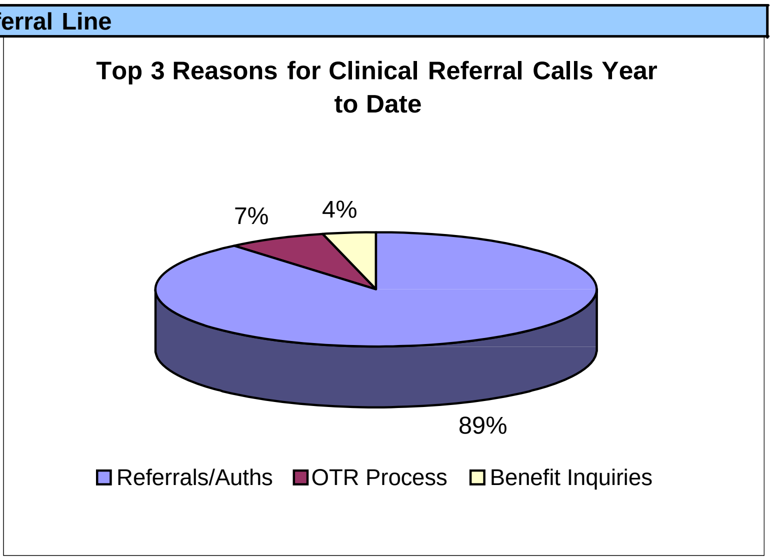
Attachment 8-85
May 20, 2014

OptumHealth Clinical Referral Line and Customer Service Graphs

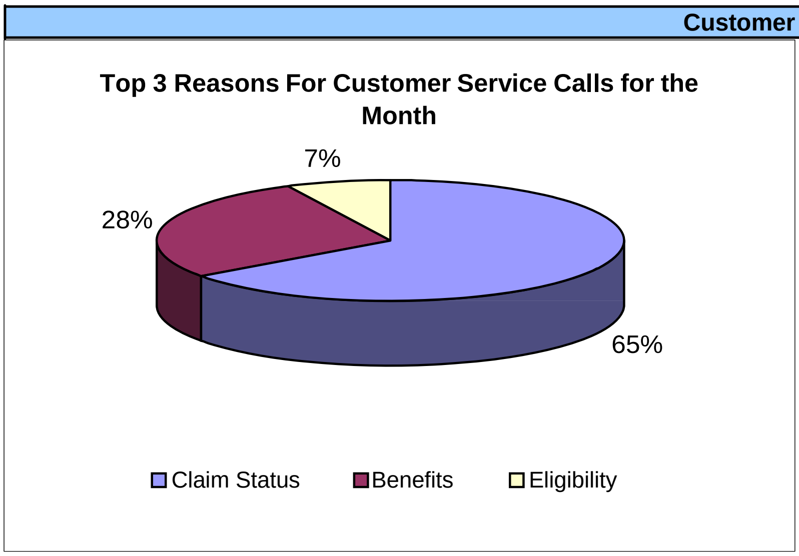
Monthly | **Year To Date**

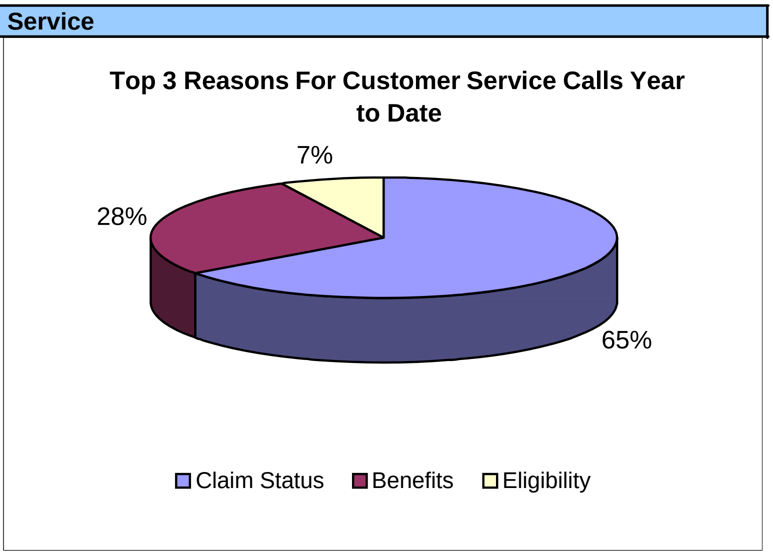
Clinical Referral Line


Top 3 Reasons for Clinical Referral Calls for the Reported Month


Top 3 Reasons for Clinical Referral Calls Year to Date

Customer Service


Top 3 Reasons For Customer Service Calls for the Month


Top 3 Reasons For Customer Service Calls Year to Date

Business Name	UBH Field Name	FIELD TYPE	LENGTH	START	END
A Customer Account Structure Policy Number	POLICY_NUMBER	Alphanumeric	9	1	9
Plan Variation Code	PLAN_VAR_CD	Alphanumeric	5	10	14
Report Code	REPORT_CD	Alphanumeric	5	15	19
Alternate ID	ALTID_NUMBER	Alphanumeric	9	20	28
Filler		Alphanumeric	6	29	34
B Employee/ Member Information Employee ID	SUBSCRIBER_ID	Alphanumeric	9	35	43
Member First Name	MBR_FIRST_NAME	Alphanumeric	25	44	68
Member Last Name	MBR_LAST_NAME	Alphanumeric	25	69	93
Dependent Number	MEMBER_NUMBER	Alphanumeric	2	94	95
Member Relationship Code	MBR_REL_CODE	Alphanumeric	4	96	99
Member Date (CCYYMMDD) of Birth	MBR_DOB	Numeric Date (CCYYMMDD)	10	100	109
Member Sex	MBR_GDR_CD	Alphanumeric	1	110	110
Employee Sex	SBSCR_GDR_CD	Alphanumeric	1	111	111
Employee Date (CCYYMMDD) of Birth	SBSCR_BTH_DT	Numeric Date (CCYYMMDD)	10	112	121
Employee ZIP Code	SBSCR_ZIP_CD	Alphanumeric	5	122	126
Employee Status	SUBSCRIBER_STATUS	Alphanumeric	5	127	131
Patient Number	PTNT_ACCT_NBR	Alphanumeric	10	132	141
Member Product Code	PRDCT_CD	Alphanumeric	5	142	146
Filler		Alphanumeric	5	147	151
C. Claim Information Claim Reference Number	CLAIM_NUMBER	Alphanumeric	20	152	171
Date (CCYYMMDD) Processed	PROC_DT	Numeric Date (CCYYMMDD)	10	172	181
Electronic Billing Indicator	CLM_ORIG_CD	Alphanumeric	5	182	186
Date (CCYYMMDD) Claim Received	BIL_RECV_DT	Numeric Date (CCYYMMDD)	10	187	196
Transaction Type		Alphanumeric	3	197	199
Filler		Alphanumeric	5	200	204
D Provider Information Provider Type	PROV_TYP_CD	Alphanumeric	5	205	209
Provider Full Name	PROVIDER_FULL_NAME	Alphanumeric	70	210	279
Provider Tax ID	PROVIDER_TAX_ID	Alphanumeric	9	280	288
Provider ZIP Code	PROVIDER_ZIP_CODE	Alphanumeric	5	289	293
Provider Specialty Code	PROV_DISCIPLINE	Alphanumeric	3	294	296
MPIN	PROVIDER_NUMBER	Alphanumeric	8	297	304
Provider Network Participating Ind.	PAR_IND	Alphanumeric	5	305	309
Filler		Alphanumeric	5	310	314
E Clinical Information Auth Number - Empire Custom Field		Alphanumeric	8	315	322
Hospital DRG	SYS_DRG_CD	Alphanumeric	5	323	327

Discharge Status	DSCHRG_STS_CD	Alphanumeric	5	328	332
Primary Surgical Procedure Code	PROC_1_CD	Alphanumeric	5	333	337
Place of Service	PLACE_OF_SERVICE	Alphanumeric	5	338	342
Service Code	PROC_CD	Alphanumeric	5	343	347
Service Code Modifier	PROC_MOD_CD	Alphanumeric	5	348	352
Date (CCYYMMDD) of Service From	FDOS	Numeric Date (CCYYMMDD)	10	353	362
Date (CCYYMMDD) of Service To	LDOS	Numeric Date (CCYYMMDD)	10	363	372
Service Count	QTY_BILLED	Numeric	8	373	380
Primary Diagnosis	DIAG_1_CD	Alphanumeric	5	381	385
Secondary Diagnosis		Alphanumeric	6	386	391
Tertiary Diagnosis	DIAG_3_CD	Alphanumeric	7	392	398
Filler		Alphanumeric	5	399	403
F Payment Information Billed Amount	SUBMITTED_AMT	Numeric (-999999999.99)	13	404	416
Not Covered Amount	NOT_COVERED_AMT	Numeric (-999999999.99)	13	417	429
Charge Level Remark Code	REASON_FOR_DENIAL	Alphanumeric	10	430	439
Discount Amount	DISCOUNT_AMT	Numeric (-999999999.99)	13	440	452
Allowable Expense	AMT_ALLOWED	Numeric (-999999999.99)	13	453	465
Deductible	AMT_DEDUCT	Numeric (-999999999.99)	13	466	478
Copay	COPAY_AMT	Numeric (-999999999.99)	13	479	491
Coinsurance	COINS_AMT	Numeric (-999999999.99)	13	492	504
Other Insurance Amount	OTHER_INS_AMT	Numeric (-999999999.99)	13	505	517
Other Insurance Type	STD_COB_TYP_CD	Alphanumeric	5	518	522
Net Paid	NET_AMT_PAID	Numeric	13	523	535
Service Order	DTL_LN_NBR	Alphanumeric	2	536	537
Filler		Alphanumeric	5	538	542
G Additional Claim Information Revenue Code-1	PYMT_RVNU_CD	Alphanumeric	6	543	548
NPI Number	SRVC_PROV_NPI_NBR	Alphanumeric	15	549	563
DEA number	DEA_NBR	Alphanumeric	20	564	583
Procedure Modifier Two Code	PROCEDURE_MODIFIER_CODE_(2)T	Alphanumeric	5	584	588
Derived Level of Care - Empire Custom Field	Derived Field	Alphanumeric	25	589	613
Data Load Date		Numeric Date (CCYYMMDD)	8	614	621

Attachment 8-88
May 20, 2014

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Attachment 8-91
May 20, 2014

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OPTUMHealth™

Attachment 8-95
May 20, 2014

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Jay Ewing

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with the same calculation used in historical reports.

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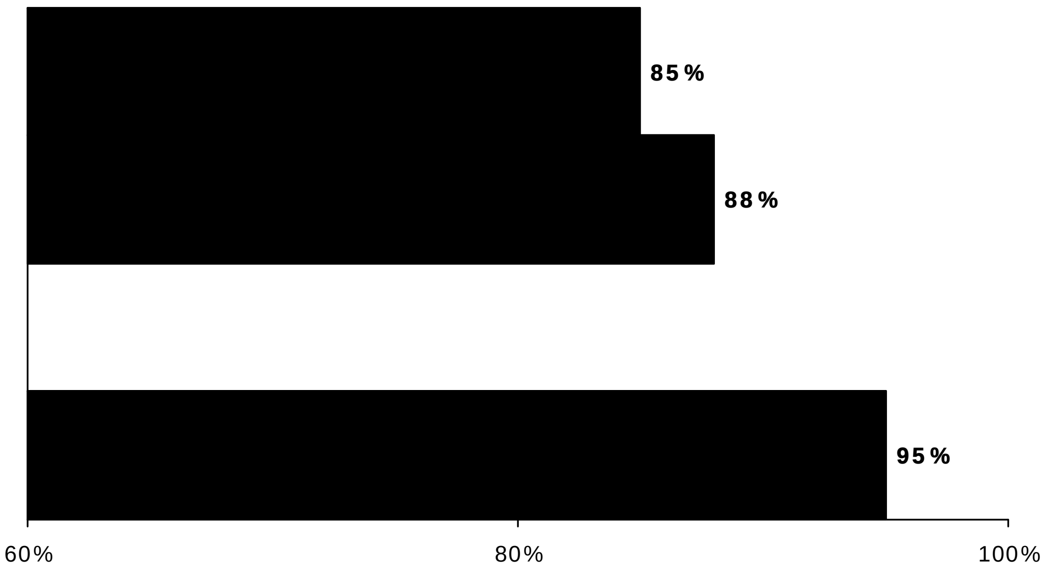
Overall Satisfaction – Concluding Evaluation (n=376)

Top Two Box Scores



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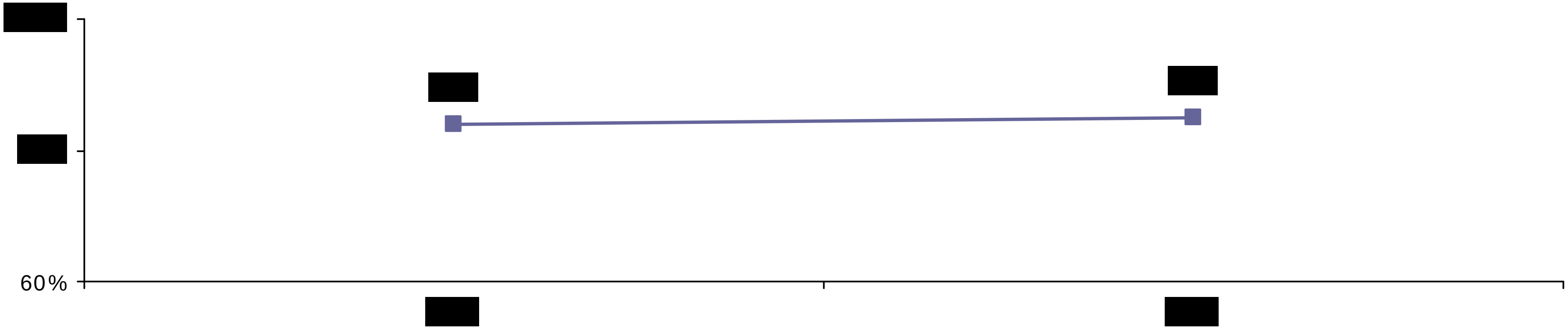

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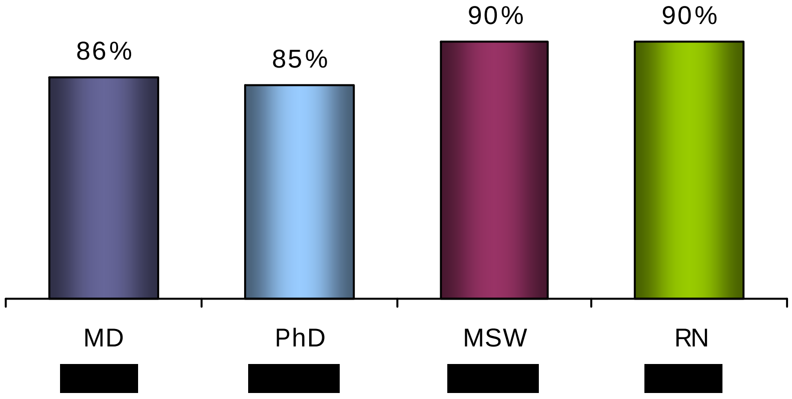

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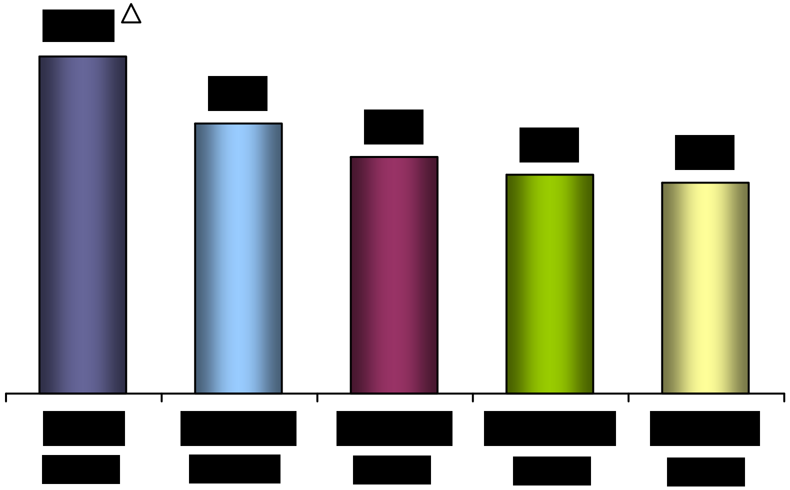

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Attachment 8-104
May 20, 2014

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[redacted]nts - Interpretation

Attachment 8-105
May 20, 2014

[redacted]

Attachment 8-106
May 20, 2014

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Attachment 8-107
May 20, 2014

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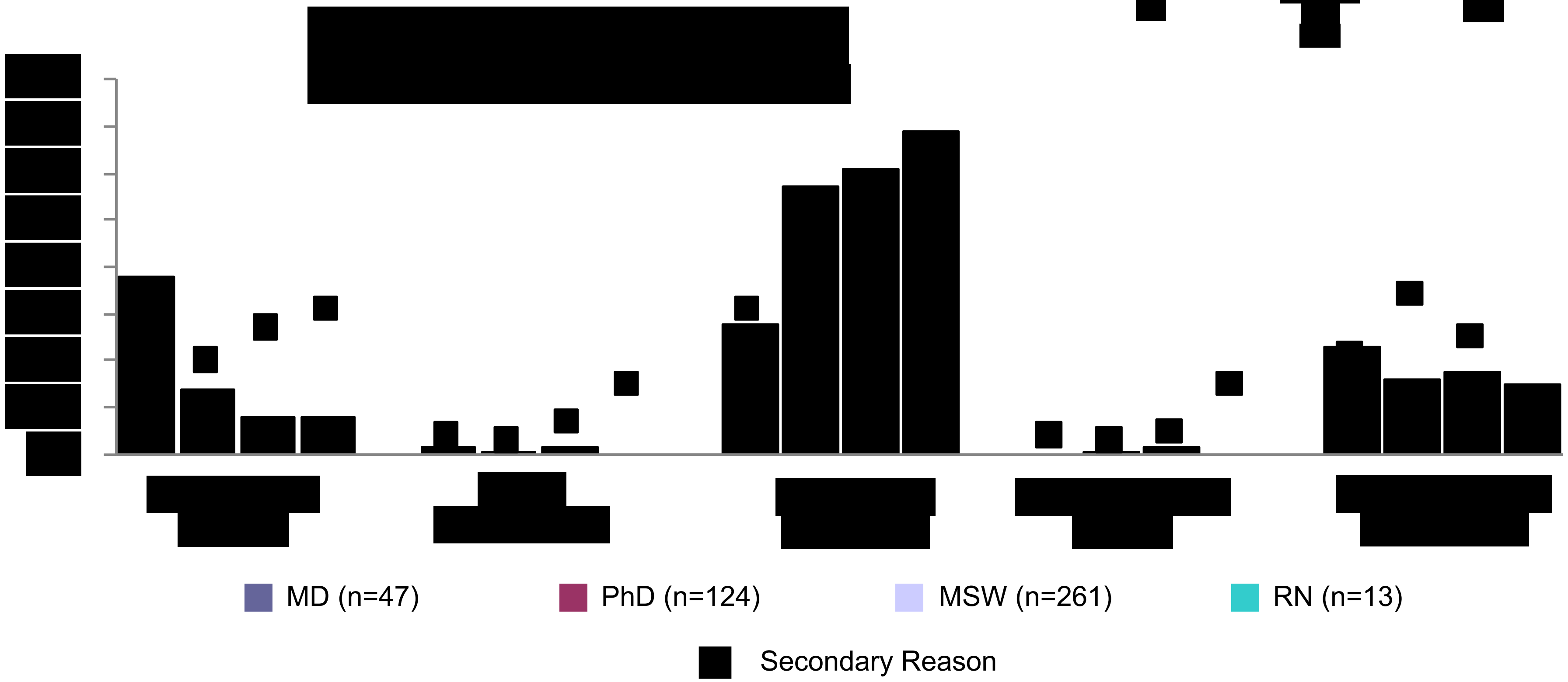

Reason “Terminating treatment “excluded due to low n size

Results with low n sizes should be interpreted with caution

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↑↓ *indicates a significant increase or decrease from 2010*

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May 20, 2014

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May 20, 2014

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May 20, 2014

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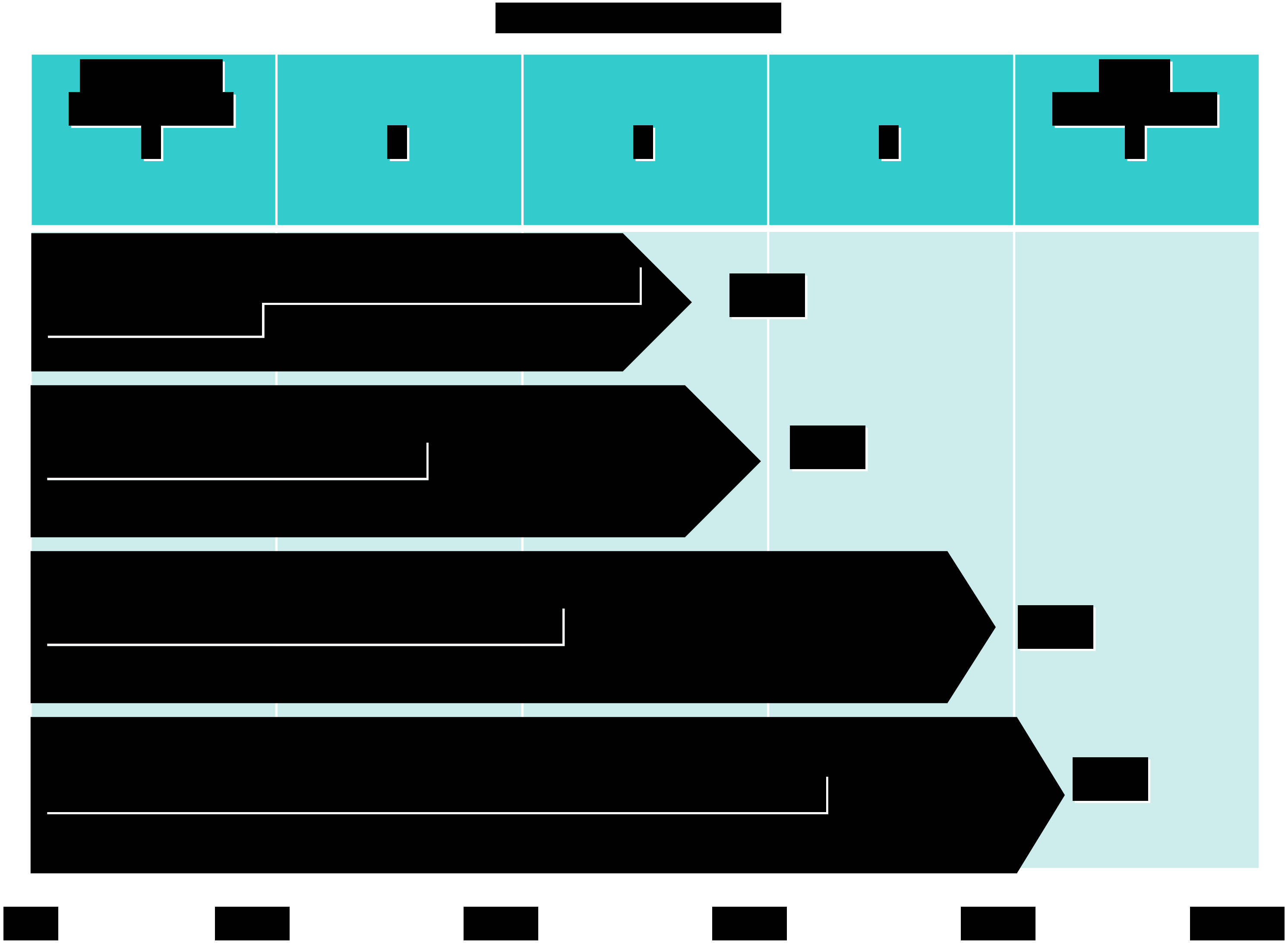

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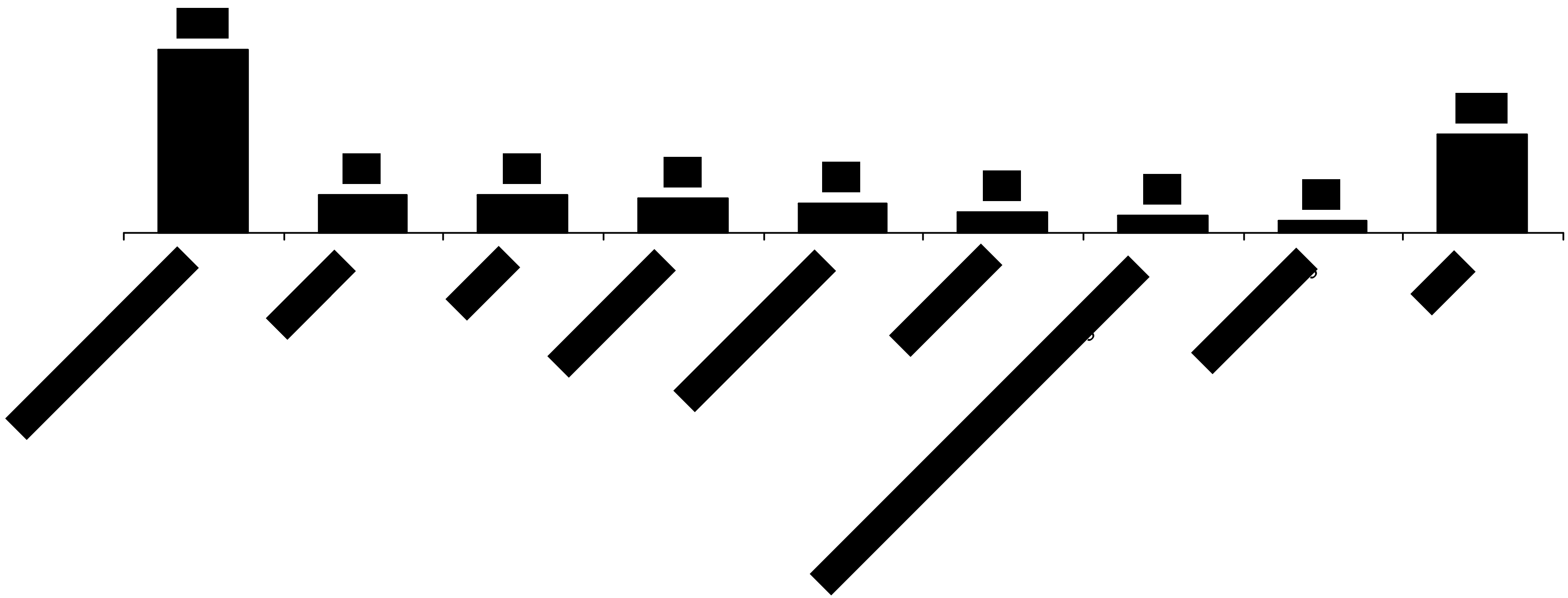

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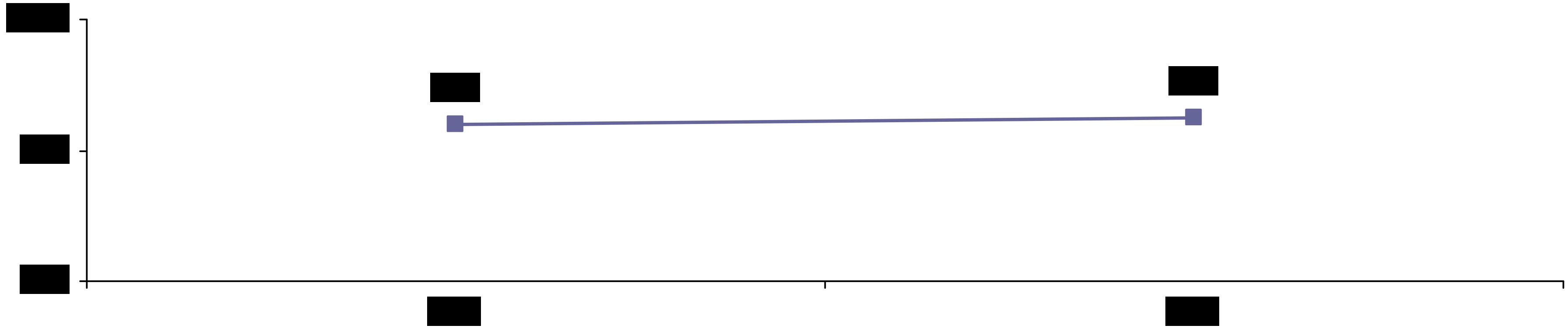

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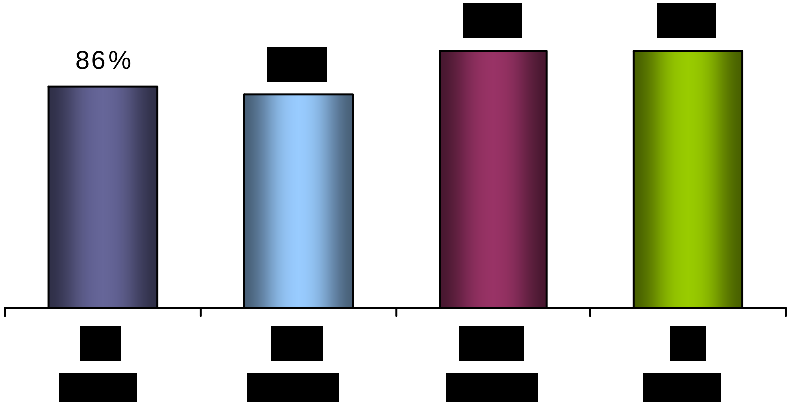

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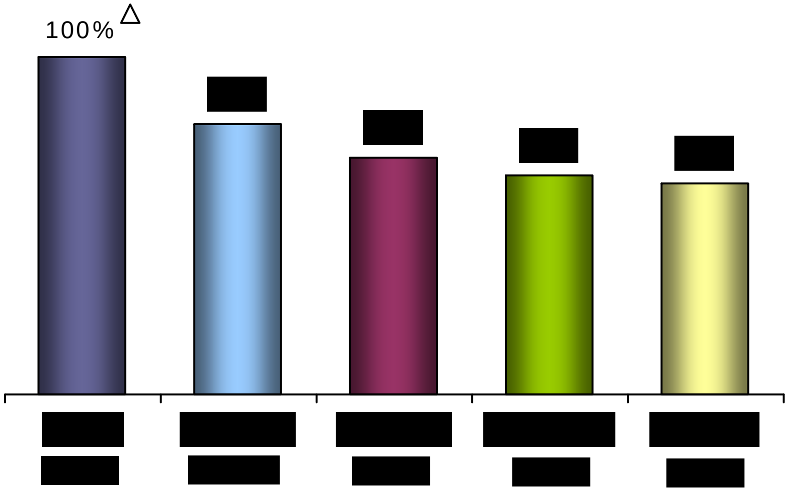

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Attachment 9 - Sample Data Sharing Agreement

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Attachment 10 - New York ABA Providers by County

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May 20, 2014

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Attachment 10-2
May 20, 2014

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Attachment 10-3
May 20, 2014

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Attachment 10-4
May 20, 2014

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Attachment 10-5
May 20, 2014

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Attachment 10-6
May 20, 2014

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Attachment 11 - Exhibit I.Y.2 - Proposed MHSA Network

We have provided Exhibit I.Y.2 in our electronic Technical Proposal only, per instructions.

Attachment 12 - Exhibit I.Y.3 - MHSA Network Pre-requisite Worksheet

Exhibit I.Y.3

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

Offeror's Proposed MHSA Provider Network Access Prerequisite

Psychiatrists

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban	[redacted]	[redacted]	[redacted]	[redacted]%
Suburban	[redacted]	[redacted]	[redacted]	[redacted]
Rural	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Psychologists

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban	[redacted]	[redacted]	[redacted]	[redacted]
Suburban	[redacted]	[redacted]	[redacted]	[redacted]
Rural	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Master's Level Clinicians

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban	[redacted]	[redacted]	[redacted]	[redacted]
Suburban	[redacted]	[redacted]	[redacted]	[redacted]
Rural	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Exhibit I.Y.3

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

Offeror's Proposed MHSA Provider Network Access Prerequisite Worksheet

Inpatient, ALOC, and Outpatient Clinic Groups - Mental Health

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban	[redacted]	[redacted]	[redacted]	[redacted]
Suburban	[redacted]	[redacted]	[redacted]	[redacted]
Rural	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Inpatient, ALOC, and Outpatient Clinic Groups - Substance Abuse

Location Column (1)	# of Empire Plan Enrollees With Access Column (2)	# of Empire Plan Enrollees Without Access Column (3)	Total Empire Plan Enrollees Column (4)	% With Access Column (5)
Urban	[redacted]	[redacted]	[redacted]	[redacted]
Suburban	[redacted]	[redacted]	[redacted]	[redacted]
Rural	[redacted]	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]	[redacted]

Exhibit I.Y.3

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

Offeror's Proposed MHSA Provider Network Access Prerequisite

Instructions:

A. Include facility or practitioner type based on the following specifications and categorizations from I.Y.2:

1) Psychiatrists should only include Licensed Psychiatrists (PSYI)

2) Psychologists should only include Licensed Psychologists (PSYCH)

3) Master's Level Clinicians should only include Licensed Clinical Social Workers who qualify for the "R" designation in New York and Master's level clinicians with the highest level of licensure in other states (MLC)

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

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

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

7) Provider types CBA, ABA, and MHSAPO should not be included in the prerequisite worksheet

B. Enter the number of Empire Plan Enrollees who are within the Program's minimum access requirements from your GeoAccess Accessibility Summaries (column 2)

C. Enter the number of Empire Plan Enrollees who are not within the Program's minimum access requirements from your GeoAccess Accessibility Summaries. (column 3)

D. Column (4) equals Column (2) plus Column (3).

E. Column (5) equals Column (2) divided by Column (4).

F. The Offeror's proposed MHSA provider network access %'s in column (5) must equal the Program's minimum mandatory access requirements, set forth in Section III of this RFP, for each of the five categories in order for their proposal to be evaluated.

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

Attachment 13 - Exhibit I.Y.4 - Comparison of Current Program Providers to Offeror's MHSA Network

We have provided Exhibit I.Y.4 in our electronic Technical Proposal only, per instructions.

Attachment 14 - Substance Abuse Professional Clinician List

Clinician Name	Clinician Type	Address1	Address2	City	County	State	ZIP	Phone	SAP
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Clinician Name	Clinician Type	Address1	Address2	City	County	State	ZIP	Phone	SAP
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Attachment 15 - Master's Level Therapist Licenses

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Attachment 16 - Base Provider Network Contracts

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Attachment 17 - Audit and Fraud and Abuse Language

Fraud, Waste and Abuse

In this section we review both Medicare-specific requires and information, as well as more general Fraud, Waste and Abuse information.

Code of Conduct and Conflict of Interest Policy Awareness

All Providers and Affiliates working on Medicare Advantage, Part D or Medicaid programs – including contracted providers – must provide a copy of our Code of Conduct to employees and contractors.

You can obtain and review our **Code of Conduct**, at **www.unitedhealthgroup.com** > About > Ethics & Integrity, and provide this to your employees and contractors.

Fraud, Waste and Abuse & Compliance Training

All Providers and Affiliates working on Medicare Advantage, Part D or Medicaid programs must provide compliance program training and Fraud, Waste, and Abuse (FWA) training within 90 days of employment and annually thereafter (by the end of the year) to their employees and/or contractors. The training is subject to certain requirements, and may be obtained through OptumHealth or another source.

All Providers and Affiliates meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program are deemed by CMS rules to have met the training and education requirements. It is our responsibility to ensure that your organization is provided with appropriate training for your employees and applicable subcontractors. To facilitate that, we are providing training materials on the **Forms page** on **ubhonline**. Select the Fraud, Waste and Abuse link.

In compliance with federal regulations, you are required to administer the compliance and FWA training materials to your employees and/or contractors. If your organization has already completed a compliance and FWA training program – either on your own or through a Medicare plan – that meets CMS requirements, we will accept documentation of that training. You must maintain records of the training (e.g., sign-in sheets, materials, etc) in compliance with CMS requirements. Documentation of the training may be requested at anytime for verification that training was completed.

Exclusion/Sanction/Debarment Checks

All Providers and Affiliates must review federal exclusion lists (HHS-OIG and GSA) at the time of hire/contracting with their current employees/contractors, health care professionals, or vendors that work on Medicare Advantage, Part D or Medicaid programs to ensure that none are excluded from participating in Federal health care programs. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services – Office of the Inspector General (HHS-OIG) List of Excluded Individuals / Entities: **http://oig.hhs.gov/exclusions/index.asp**
- General Services Administration (GSA) List of Parties Excluded from Federal Procurement and Non-procurement programs: **https://www.epls.gov/**

What You Need to Do**:** Review applicable exclusion/sanction/debarment lists to ensure that none of your employees or contractors are excluded from participation in federal health care programs.

We have guidelines to address suspected fraud, waste and/or abuse by Providers. In accordance with your Agreement, you are required to cooperate with the review process to include any requests for medical records.

We are committed to the detection and investigation of potential fraud, waste and/or abuse. Such practices include, but are not limited to, filing fraudulent claims, fraudulent authorization of claims, misrepresentation of services provided, abuse of services in order to obtain a benefit (including personal or commercial gain) from UBH or a Payor to which an individual or entity is not entitled. This identification process includes, but is not limited to, examining claims of Providers to identify outlier practice patterns.

Once suspected fraud, waste and/or abuse is identified, appropriate interventions are implemented. Possible interventions may include, but are not limited to: outreach meetings and/or written correspondence to Providers, record review and/or site audit, individual case peer-to-peer reviews, and referral for further investigation. You are contractually required to cooperate in this process and participate in any activities related to the identification and correction of potential fraud, waste, and abuse.

Once an intervention has occurred, we continue to monitor the practice patterns of an identified Provider to ensure that the potential fraud, waste or abuse practice pattern has been corrected.

Some examples of fraud are as follows:

- Paying, soliciting, offering or receiving:
    - A kickback or bribe in connection with the furnishing of treatment, services or goods for which payment is or may be made in whole or in part under the Medicaid program
    - A rebate of a fee or charge made to a provider for referring a recipient to a provider
    - Anything of value, with intent to retain it, and knowing it to be in excess of amounts authorized or rates established under the Medicaid program, as a precondition of providing treatment, care, services or

  goods or as a requirement for continued provision of treatment, care, services or goods

- Providing the following with intent that a claim be relied upon for the expenditure of public money:
  - Treatment, services, or goods that have not been ordered by a treating provider
  - Treatment that is substantially inadequate when compared to generally recognized standards within the profession or industry
  - Merchandise that has been adulterated, debased, mislabeled or is outdated
- Presenting or causing to be presented for allowance or payments with intent that a claim be relied upon for the expenditure of public money, any false, fraudulent, excessive, multiple or incomplete claims

Examples of abuse include, but are not limited to:

- Inappropriate balance billing
- Inadequate resolution of overpayments
- Lack of integrity in computer systems
- Failure to maintain confidentiality of information/records
- High utilization of procedures or tests not medically necessary
- Providing services that are not medically necessary
- Providing poor quality medical services
- Unbundling/exploding charges (e.g., the unpacking and billing separately of services that would ordinarily be all-inclusive)
- Coding a service at a higher level than what was rendered (i.e., up-coding)
- Violation of Agreement by Provider
- Breaches of Agreement that result in Consumers being billed for amounts not allowed by the Agreement
- Failure to collect coinsurance and deductible amounts, as required by the Member’s Benefit Plan
- Excessive charges for services
- Inappropriate documentation of services rendered

In the event that we suspect fraud, waste and/or abuse, the allegation or complaint is forwarded for investigation. The investigation unit determines which claims are appropriate to review. In addition, suspicious billing patterns may be detected through established data tools and analysis. In general, identified claims, along with the Provider that submits these claims, are audited on a prospective basis. In accordance with our policy, audits of previously paid claims are completed on a retrospective basis.

All prospective reviews are completed in a timely manner, prior to a payment determination, to assess whether they validate the initial allegation. Any claim submitted by a Provider that matches suspected patterns under investigation may trigger a request for medical records. In some cases, additional investigative steps may be used in order to obtain accurate information related to a claim. Upon completion of the investigation the claim is adjudicated. Either timely payment is made or, in the event that a claim denial is issued, the denial notification includes the Provider’s standard appeal rights.

Findings of billing inconsistent with our policies by in-network Providers may result in such actions as clarification of proper procedure, a Corrective Action Plan (CAP), a change in network availability status, or may result in termination of your Agreement. In the case of retrospective review, UBH and our Payors reserve the right to pursue recoupment of funds paid. The Credentialing Committee may recommend termination. In that event, the Provider is notified in writing and provided with information about appeal rights, if applicable, and in compliance with state and federal laws.

As warranted, Providers will be reported to their respective State Department of Insurance, licensing board(s), and any other regulatory agencies based on the outcome of the investigation and as required by state and federal laws. Throughout this process, we adhere to state law, ERISA guidelines, and confidentiality standards.

Quality Improvement

Participation in the UBH Quality Improvement Program

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of Members and to meeting or exceeding customer expectations. Our Quality Improvement (QI) Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and Member satisfaction. The QI Program is comprehensive and incorporates the review and evaluation of all aspects of the managed behavioral health care delivery systems. If you have any feedback regarding QI projects and processes, please contact Network Management.

We have established committees that address concerns related to Members, clinicians, facilities, and UBH. These committees include Regional Quality Improvement Committees, Network Clinician Advisory Committees, and Peer Review Committees. Compliance with the QI Program is required in accordance with your Agreement, including cooperation with UBH and customers in their efforts to adhere to all applicable laws, regulations and accreditation standards.
The key components of the QI Program required of you as a participating provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary medical physician and other treating clinicians and/or facilities
- Cooperation with On-site Audits and requests for treatment records
- Cooperation with the Member complaint process (e.g., supplying information necessary to assess and respond to a complaint)
- Cooperation with the Campaign for Excellence (CFE) and Facility Quality Measure (FQM) programs (Please refer to the CFE and FQM sections for more information)
- Responding to inquiries by UBH Regional Quality Improvement Committee staff or UBH Corporate Quality Improvement staff
- Participation in UBH Regional Quality Improvement initiatives related to enhancing clinical care or service for Members
- Assisting UBH in maintaining various accreditations as appropriate and as requested by UBH
- Submission of information related to the UBH Patient Safety Program

- Helping to ensure Members receive rapid follow-up upon discharge from an inpatient level of care

Upon request, UBH makes information available about the QI Program, including a description of the QI Program and a report on our progress in meeting goals. Some of the activities that may involve you are described in more detail below.

Sentinel Events

Sentinel events are defined as unexpected occurrences involving death or serious physical or psychological injury, or risk thereof, which occur during the course of a Member receiving behavioral health treatment. If you are aware of a sentinel event involving a Member, you must notify UBH Care Advocacy within one business day of the occurrence.

UBH has established processes and procedures to investigate and address sentinel events. This includes a centralized Sentinel Event Committee, chaired by medical directors within UBH, and incorporates appropriate representation from the various behavioral health disciplines. You are required to cooperate with sentinel event investigations.

We support the Joint Commission's National Patient Safety Goals as they apply to behavioral health care. These Safety Goals are available on the Joint Commission web site at **www.jointcommission.org**.

Member Satisfaction Surveys

On at least an annual basis, we conduct a Member Satisfaction Survey of a representative sample of Members receiving outpatient and inpatient behavioral health services within the UBH network. The results of the survey are compared to performance goals. Improvement action plans are developed to address any areas not meeting standards. Both the survey results and action plans are shared as appropriate with Members, customers, clinicians, and facilities.

Clinician Satisfaction Survey

We regularly conduct a satisfaction survey of a representative sample of clinicians delivering behavioral health services to Members. This survey obtains data on clinician satisfaction with UBH services including intake, care advocacy, clinician services, and claims administration.

The results of the survey are compared to performance goals and to previous years for tracking and trending. Improvement action plans are developed to address any areas not meeting standards. Both the survey results and action plans are shared as appropriate with customers, clinicians, and facilities.

Preventive Behavioral Health Services

Our preventive behavioral health programs are selected and developed based on the demographic, cultural, clinical, and risk characteristics of Members. You may be enlisted to participate in the design and implementation of preventive behavioral health programs. UBH encourages all clinicians and facility-based clinical staff to review the content and process of UBH preventive health programs. These programs are described at **ubhonline®.** If you would like a paper copy of these programs please contact Network Management. We periodically communicate additional information about these programs, including modifications in program process and content, on ubhonline and in the newsletter, ***Network Notes***.

Practice Guidelines

UBH has adopted clinical guidelines from nationally recognized behavioral health organizations and groups. We also have Supplemental and Measurable Guidelines based on existing nationally recognized guidelines, additional literature review and clinician input. The development of these Supplemental and Measurable Guidelines is driven by quality initiatives aimed at improving clinical outcomes for Members. The adopted **Best Practice Guidelines** and the **Supplemental and Measurable Guidelines** are available through **ubhonline**. On the home page left sidebar “Quick Links” menu, select “Guidelines/Policies”. Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

Complaint Investigation and Resolution

You are required to cooperate with UBH in the complaint investigation and resolution process. If UBH requests written records for the purpose of investigating a Member complaint, you must submit these to UBH within 14 business days, or sooner as requested. Complaints filed by Members should not interfere with the professional relationship between you and the Member.

QI staff, in conjunction with Network Management staff, monitors complaints filed against all clinicians and facilities, and solicits information from them in order to properly address Member complaints. In general, resolution of most complaints is communicated to the Member when the complaint is received from, or on behalf of, the Member. QOC complaints do not generally include notification of resolution except as required by state law.

UBH requires the development and implementation of appropriate Corrective Action Plans (CAP) for legitimate problems discovered in the course of investigating complaints. Such action may include, but is not limited to, having UBH:

- Require you to submit and adhere to a CAP

- Monitor you for a specified period, followed by a determination about whether substandard performance or noncompliance with UBH requirements is continuing
- Require you to use peer consultation for specific types of care
- Require you to obtain specific additional training or continuing education
- Limit your scope of practice in treating Members
- Hold referrals of any Members to your care by changing your availability status to “unavailable” and/or reassigning Members to the care of another participating clinician or facility
- Terminate your participation status with UBH

Cooperation with an unavailable status associated with complaint, quality-of-care or sentinel event investigations may include:

- Informing Members of unavailable status at the time of an initial request for services, and identifying other network clinicians or facilities to provide services or referring the Member to UBH for additional referrals
- Informing current Members of status and their option to transfer to another network clinician or facility
- Assisting with stable transfers to another network clinician or facility at the Member’s request

Audits of Sites and Records

On-site and record-only audits may occur with any contracted provider. Both types of audits involve reviewing a sampling of treatment records. The on-site audit also involves a review of policies and procedures, including policies related to hiring and supervision of staff, discussion of services that are offered and a tour of the facility or office site.

UBH representatives conduct site visits at clinician offices, agencies such as community mental health centers (CMHCs), facilities, and group provider locations. On-site audits are routinely completed with high-volume clinicians, clinicians who have a clinical office in their home or who offer services in the homes of Members, and CMHCs and facilities without national accreditation. In addition, audits are completed to address specific quality of care issues or in response to Member complaints about the quality of the office or facility environment.

Facilities and CMHCs that hold national accreditation through organizations such as the Joint Commission, CARF, COA, HFAP, NIAHO, CHAP, and/or AAAHC receive credit for meeting those standards of care for the identified accredited services or programs without additional review prior to the initial credentialing process. Facilities and CMHCs that are not accredited will be required to participate in an on-site audit prior to credentialing and a recredentialing audit prior to their specified recredentialing timeframe. Any facility or CMHC, regardless of their accreditation status, may be subject to an on-site audit for any Member complaints or suspected quality of care concerns brought to the attention of UBH.

During on-site and record-only audits for all types of providers, chart documentation is reviewed, including (but not limited to) the assessment, diagnosis, treatment plan, progress notes, coordination of care activities, and discharge planning. This process also verifies that services were provided to Members. You are expected to maintain adequate medical records on all Members and document in the record all services that are provided. Prior to the audit, you will be notified of the specific types of charts that will be reviewed. Failure to adequately document services that are rendered and/or dates of services may lead to a request for a Corrective Action Plan (CAP). Please see the “Treatment Record Documentation Requirements” section of this manual for more information.

The audit tools are based on NCQA, the Joint Commission and UBH standards. These forms are used during audits and are available at **ubhonline** for reference.

Member Education

We offer a variety of Health and Wellness Tip sheets for Members. These are educational materials, written in common, everyday language. Topics include, but are not limited to general therapy issues, self-help, mood and anxiety disorders, and substance use disorders and address child, adult and elderly populations. You are encouraged to distribute these to Members as appropriate. **Health and Wellness Tips** are available at **ubhonline** or you can request paper copies by contacting Network Management.

Attachment 18 - Claims Process

Attachment 18-1
May 20, 2014

[redacted]

Attachment 18-2
May 20, 2014

[redacted]

Attachment 18-3
May 20, 2014

[redacted]

Attachment 19 - Sample Precertification Forms

"The rest of this Exhibit has been redacted."

Attachment 20 - Depression Management Communications Materials

OPTUMHealth™

THE EMPIRE PLAN

The Empire Plan and OptumHealth Behavioral Solutions is pleased to offer:

Depression Management Program

For Empire Plan Enrollees and their covered dependents

Web based educational and screening materials:

All Empire Plan enrollees can access a wide range of state-of-the-art materials on the **liveandworkwell.com (access code: Empire)** enrollee website. The depression program materials are scientifically based articles about the symptoms of depression, how to understand if you are depressed, and how to begin feeling better. We can also print the web based materials and send them to your home at your request.

Access to a licensed clinician:

You may speak with one of our licensed clinicians for a referral to a behavioral health network provider in your area 24 hours a day, 7 days a week, at **1-877-7NYSHIP**, Option 3.

Depression Management Program:

Mailings sent directly to your home:

If you have been treated for depression, you may receive educational materials sent directly to your home to help you manage your depression.

Individualized Case Management:

If you are recommended for, and agree to participate in the voluntary program, we will have a licensed mental health clinician call you at regular intervals to find out how you are doing and to see if there is anything we can do to help you. This Case Manager can help find you services, work with your clinicians to make sure they are sharing information, and recommend additional resources in your community.

Signs of depression

- Persistent sad, anxious or "empty" feelings
- Difficulty concentrating, remembering details and making decisions
- Feelings of hopelessness and/or pessimism
- Insomnia, early–morning wakefulness, or excessive sleeping
- Feelings of guilt, worthlessness and/or helplessness
- Overeating, or appetite loss
- Irritability, restlessness
- Thoughts of suicide, suicide attempts
- Loss of interest in activities or hobbies once pleasurable, including sex
- Unexplained aches and pains (even though nothing is physically wrong)
- Fatigue and decreased energy

If you have experienced one or more of these symptoms for 2 weeks or longer, you may want to talk with your doctor or call OptumHealth to speak with a licensed clinician by calling the number below.

Empire Plan Clinical Referral Line available 24 hours a day:

- **1-877-7NYSHIP (1-877-769-7447),** *press Option 3*
- **1-800-855-2881 (TTY)** *for impaired hearing*

Attachment 20-2
May 20, 2014

Depression Treatment

National Institute of Mental Health. Public domain.

Even in severe cases, depression is highly treatable. The first step is to visit a doctor. Your family doctor or a health clinic is a good place to start. A doctor can make sure that the symptoms of depression are not being caused by another medical condition. A doctor may refer you to a mental health professional. The most common treatments of depression are psychotherapy and medication.

Psychotherapy

Several types of psychotherapy-or “talk therapy”-can help people with depression. There are two main types of psychotherapy commonly used to treat depression: cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). CBT teaches people to change negative styles of thinking and behaving that may contribute to their depression. IPT helps people understand and work through troubled personal relationships that may cause their depression or make it worse.

For mild to moderate depression, psychotherapy may be the best treatment option. However, for major depression or for certain people, psychotherapy may not be enough. For teens, a combination of medication and psychotherapy may work the best to treat major depression and help keep the depression from happening again. Also, a study about treating depression in older adults found that those who got better with medication and IPT were less likely to have depression again if they continued their combination treatment for at least two years.

Medications

Medications help balance chemicals in the brain called neurotransmitters. Although scientists are not sure exactly how these chemicals work, they do know they affect a person’s mood. Types of antidepressant medications that help keep the neurotransmitters at the correct levels are:

- SSRIs (selective serotonin reuptake inhibitors)
- SNRIs (serotonin and norepinephrine reuptake inhibitors)
- MAOIs (monoamine oxidase inhibitors)
- Tricyclics

These different types of medications affect different chemicals in the brain. Medications affect everyone differently. Sometimes several different types have to be tried before finding the one that works. If you start taking medication, tell your doctor about any side effects right away. Depending on which type of medication, possible side effects include:

- Headache
- Nausea
- Insomnia and nervousness
- Agitation or feeling jittery
- Sexual problems
- Dry mouth
- Constipation
- Bladder problems

- Blurred vision, or
- Drowsiness during the day

Other therapies

St. John's wort

The extract from St. John's wort (Hypericum perforatum), a bushy, wild-growing plant with yellow flowers, has been used for centuries in many folk and herbal remedies. The National Institutes of Health conducted a clinical trial to determine the effectiveness of the herb in treating adults who have major depression. Involving 340 patients diagnosed with major depression, the trial found that St. John's wort was no more effective than a "sugar pill" (placebo) in treating major depression. Another study is looking at whether St. John's wort is effective for treating mild or minor depression.

Other research has shown that St. John's wort may interfere with other medications, including those used to control HIV infection. On February 10, 2000, the FDA issued a Public Health Advisory letter stating that the herb may interfere with certain medications used to treat heart disease, depression, seizures, certain cancers, and organ transplant rejection. The herb also may interfere with the effectiveness of oral contraceptives. Because of these potential interactions, patients should always consult with their doctors before taking any herbal supplement.

Electroconvulsive therapy

For cases in which medication and/or psychotherapy does not help treat depression, electroconvulsive therapy (ECT) may be useful. ECT, once known as "shock therapy," formerly had a bad reputation. But in recent years, it has greatly improved and can provide relief for people with severe depression who have not been able to feel better with other treatments.

ECT may cause short-term side effects, including confusion, disorientation and memory loss. But these side effects typically clear soon after treatment. Research has indicated that after one year of ECT treatments, patients show no adverse cognitive effects.

FDA warning on antidepressants

Despite the fact that SSRIs and other antidepressants are generally safe and reliable, some studies have shown that they may have unintentional effects on some people, especially young people. In 2004, the U.S. Food and Drug Administration (FDA) reviewed data from studies of antidepressants that involved nearly 4,400 children and teenagers being treated for depression. The review showed that 4% of those who took antidepressants thought about or attempted suicide (although no suicides occurred), compared to 2% of those who took sugar pills (placebo).

This information prompted the FDA, in 2005, to adopt a "black box" warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and teenagers taking antidepressants. In 2007, the FDA proposed that makers of all antidepressant medications extend the black box warning on their labels to include young patients up through age 24 who are taking these medications for depression treatment. A "black box" warning is the most serious type of warning on prescription drug labeling.

The warning also emphasizes that children, teenagers and young adults taking antidepressants should be closely monitored, especially during the initial weeks of treatment, for any worsening depression, suicidal thinking or behavior. These include any unusual changes in behavior such as sleeplessness, agitation, or withdrawal from normal social situations.

Results of a review of pediatric trials between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders. The study was funded in part by the National Institute of Mental Health.

La depresión es una enfermedad tratable, ¡no se cura por sí sola!

Por Dra. Francisca Azocar

OptumHealth Behavioral Solutions

(NAPSM)-La depresión puede trastornar nuestras vidas así como la vida de nuestros seres queridos, pero en la comunidad latina, la depresión sigue rodeada de misterio, temor y confusión. Generalmente identificamos los síntomas de la depresión como ataques de nervios y pánico, nostalgia o melancolía, cansancio o incluso una enfermedad física temporaria. Si esto nos afecta, tendemos a pensar que los síntomas de la depresión se pueden tratar en casa y que se disiparán y desaparecerán por sí solos. No reconocemos que estos síntomas necesitan evaluación médica.

Como resultado, miles de latinos con depresión generalmente no obtienen tratamiento profesional.

La depresión es una enfermedad tratable. No es un mal que se cura por sí solo. El tratamiento puede incluir terapia y medicamentos. Las nuevas medicinas antidepresivas y medicamentos para estabilizar su estado de ánimo han mejorado el tratamiento de la depresión, y la terapia puede ayudarle a lidiar con algunos de los problemas que contribuyen a la depresión.

Si usted ha sufrido cinco o más de los siguientes síntomas por dos semanas o mas, consulte con su doctor o diríjase a una clínica de la salud para una evaluación de depresión. Estos síntomas incluyen:

- Sentirse desesperanzado o triste la mayoría del tiempo
- Poco interés y placer en las actividades normales
- Aumento o disminución delapetito/peso
- Sentirse decaído o agitado
- Falta de energía constante
- Problemas de insomnio
- Dificultad en concentrarce, recordar o en tomar decisiones
- Impaciencia o irritabilidad
- Pensamientos de culpabilidad o sentirse inútil o inservible
- Pensamientos suicidas

Tambien la gente con depresión muchas veces se siente irritable, con dolores o achaques que no tienen razón médica y pierden el interés sexual.

¿Qué puede hacer?

El sentirse mejor toma tiempo, pero usted puede ayudarse a sí mismo tomando simples medidas diarias que le ayudarán a controlar su estado de ánimo. Usted puede ayudar a mejorar su condición mediante lo siguiente:

- Hacer ejercicio físico regularmente. El ejercicio relaja y mejora su sueño y su estado de ánimo.
- Mantener un horario diario regular. Una rutina consistente le ayudará a controlar sus actividades diarias.
- Descansar adecuadamente. Acostarse y levantarse a la misma hora todos los días ayuda a que su reloj interno esté dentro de un horario de descanso saludable.
- Reconocer las causas del estrés. Observe la vida en su hogar, en el trabajo y su vida social e identifique qué hace que usted se sienta tenso o irritable.
- Comer una dieta saludable. El comer una variedad de comidas bajas en grasas en porciones pequeñas durante el día mantendrá bajo el azucar sanguíneo y por lo tanto su nivel de energía será consistente.
- Evitar el alcohol. El alcohol es una sustancia depresiva.
- Obtener el apoyo de amigos y familiares. Pase tiempo con la gente que usted ama y en la cual confía; pida el apoyo que necesita.
- Mantenerse socialmente activo. Una buena compañía y apoyo pueden mejorar su humor.
- Aprender a pensar positivamente. Pida a su terapeuta que le hable sobre los trastornos cognitivos.

¿Dónde obtengo ayuda e información?

La depresión es tratable, tanto la psicoterapia como los medicamentos antidepresivos han demostrado ser efectivos, si uno sigue el tratamiento adecuado. Su doctor de cabecera puede evaluar su condición y referirlo a un terapeuta o sicólogo. Su terapeuta o sicólogo tendrá acceso a recursos a nivel comunitario, estatal y nacional que le pueden ser útiles.

Al hablar con su doctor sobre su condición, utilice un lenguaje claro y directo para expresar sus preocupaciones.

- Pida explicaciones si no comprende algo.
- Vaya acompañado por un miembro de su familia o un amigo en quien confía para que le ayuden a comprender el diagnóstico e instrucciones del doctor.
- Aprenda todo lo que pueda sobre la depresión.
- Considere costos, idioma, religión y cultura al seleccionar un terapeuta.
- Encuentre un grupo de ayuda para la depresión.
- Encuentre a alguien para que lo guíe a través del sistema de salud o consulte con una "promotora de salud" en su área.

También existe un recurso de tratamiento gratuito y confidencial sobre el bienestar de la familia, salud mental y abuso de drogas en www.mentesana-cuerposano.com.

DEPRESSION IS A TREATABLE ILLNESS, IT WILL NOT GO AWAY ON ITS OWN!

By Francisca Azocar

OptumHealth Behavioral Solutions

Depression can disrupt our lives as well as the lives of our loved ones, but for the Hispanic/Latino community, depression is still surrounded with mystery, fear and confusion. We often identify symptoms of depression as nerve and fright attacks, a nostalgic or melancholic disposition, tiredness, or even as a temporary physical illness. If we are affected by it, we tend to think that the symptoms of depression can be treated at home and it will dissipate and disappear on its own. In general, we don't recognize that these symptoms need a medical evaluation.

As a result, thousands of Latinos with depression often go without professional treatment.

Depression is a treatable illness. It is not an ailment that will go away on its own. Treatment may include therapy and medication. New antidepressant medications and mood-stabilizing drugs have improved the treatment of depression, and counseling can help you cope with some of the problems that contribute to depression.

If you are experiencing five or more of the following symptoms for two weeks or more, consult with your doctor or a health clinic about being assessed for depression. Symptoms include:

- Feeling desperate or sad most of the time
- Little interest and pleasure in normal activities
- Increase or lose of appetite/weight
- Feeling slow or feeling agitated
- Chronic pain or increase in ailments not related to illness or injury
- Sustained lack of energy
- Trouble sleeping, insomnia
- Difficulty remembering and making decisions
- Restlessness or irritability
- Thoughts of guilt or feeling useless or unfit
- Suicidal thoughts

Also, people suffering from depression often feel irritable, suffer from pains and aches that have no medical reasons and lose interest in sex.

What can you do about it?

Feeling better may take time, but you can help yourself by making daily choices that will help you control your mood. You can improve your condition by:

- Exercising regularly. Exercise can improve your mood and your sleep, and it relaxes you.
- Keeping a regular daily schedule. Having a consistent routine will help you control your daily activities.
- Getting adequate rest. Going to bed and getting up at the same time every day will help your body's internal clock stay on a healthy rest schedule.
- Recognizing reasons for stress. Take a look at your home life, work, and social life and identify what causes you to become tense or irritable.
- Eating a healthy diet. Eating a variety of low fat foods in small portions throughout the day will keep your blood sugar balanced and thus your energy level more consistent.
- Avoiding alcohol. Alcohol is a depressant.
- Getting support from friends and family. Spend time with people you love and trust; ask for the support you need.
- Staying socially active. Good company and support can boost your mood.
- Learning positive thinking. Ask your therapist to talk to you about cognitive distortions.

Where do I get help and information?

Depression is a treatable illness. Psychotherapy as well as antidepressants medications have shown to be effective, if appropriate treatment is followed. Your primary care physician can assess your condition and refer you to a therapist or psychologist. Your clinician will have access to resources at the community, state and national levels that can be useful to you.

When talking with your doctor about your condition, use clear, direct language to express your concerns.

- Ask for explanations if you don't understand something.
- Take a trusted member of your family, or a friend with you to help you understand the doctor's diagnosis and instructions.
- Learn all you can about depression.
- Consider costs, language, religion, and culture when selecting a counselor.
- Find a depression support group.
- Find someone to guide you through the system, or consult with a "promotora de salud" in your area.

A free, confidential, family well-being, mental health and substance abuse treatment resource is also available at www.liveandworkwell.com.

About OptumHealth

As one of the nation's largest health and well-being companies, OptumHealth makes health care easier and better for employers, health plans, public sector entities and the 58 million people with access to its services. The Company's goal is to optimize health, well-being and financial security, while lowering benefit costs and helping consumers make informed decisions about their health through standalone or integrated services. OptumHealth is a division of UnitedHealth Group (NYSE:UNH). More information about OptumHealth can be found at www.OptumHealth.com.

The Five Levels of Resiliency

By By Al Siebert, PhD © Practical Psychology Press. Used with permission

Last Reviewed: December 2012

Resilience is essential in today's world. In today's workplace everyone feels pressured to get more work done, of higher quality, with fewer people, in less time, with less budget. In our personal lives things are changing so rapidly everyone must learn how to be change proficient, cope with unexpected setbacks, and overcome unwanted adversities.

Resilience is the process of successfully adapting to difficult or challenging life experiences. Resilient people overcome adversity, bounce back from setbacks, and can thrive under extreme, on-going pressure without acting in dysfunctional or harmful ways. The most resilient people recover from traumatic experiences stronger, better, and wiser.

Everyone is born with the potential to develop these abilities. **The five levels of resiliency are:**

1. Maintaining Your Emotional Stability, Health, and Well-Being
2. Focus Outward: Good Problem Solving Skills
3. Focus Inward: Strong Inner "Selfs"
4. Well-Developed Resiliency Skills
5. The Talent for Serendipity

The **first** level is essential to sustaining your health and your energy.

The **second** level focuses outward on the challenges that must be handled, it is based on research findings that problem-focused coping leads to resiliency better than emotion-focused coping.

The **third** level focuses inward on the roots of resiliency--strong self-esteem, self-confidence, and a positive self-concept.

The **fourth** level covers the attributes and skills found in highly resilient people.

The information about educational or therapeutic approaches is provided for educational purposes only. Certain treatments may or may not be covered through your benefit plan. Coverage typically depends on your plan specifications and relevant guidelines maintained in relation to your benefit plan.

The **fifth** level describes what is possible at the highest level of resiliency. It is the talent for serendipity--the ability to convert misfortune into good fortune.

When faced with adversity it is useful to remember that:

- Your mind and habits will create either barriers or bridges to a better future.
- Resiliency can't be taught, but it can be learned. It comes from working to develop your unique combination of inborn abilities.
- The struggle to bounce back and recover from setbacks can lead to developing strengths and abilities that you didn't know were possible.

The information about educational or therapeutic approaches is provided for educational purposes only. Certain treatments may or may not be covered through your benefit plan. Coverage typically depends on your plan specifications and relevant guidelines maintained in relation to your benefit plan.

Attachment 21 - Eating Disorder Communications Materials

Attachment 21-1
May 20, 2014

OPTUMHealth™

THE EMPIRE PLAN

Resources and education on the Web: liveandworkwell.com (**access code: Empire**) provides scientifically based articles to identify and treat eating disorders. This is an easy, private way to learn about eating disorders. We can also print the web-based materials and send then to your home at your request.

Access to a licensed clinician:

OptumHealth is staffed by licensed clinicians 24 hours a day at **1-877—7NYSHIP (1-877-769-7447), option 3**, who are available to answer your questions about eating disorders or assist you in finding a behavioral health network provider in your area.

Mailings sent directly to your home:

If you choose, you can request to have educational materials mailed to your home to assist you in understanding eating disorders.

Individualized Case Management (ICM):

If you are recommended for and agree to participate in the ICM Program, you will receive mailings about eating disorders and offered individualized case management services. ICM includes a dedicated Case Manager who will work with you throughout your course of treatment, providing outreach and support as needed.

Some signs and symptoms of anorexia or bulimia may include the following:

- Do you make yourself sick (induce vomiting) because you feel uncomfortably full?
- Do you worry that you have lost control over how much you eat?
- Have you recently lost more than 14 lbs in a 3-month period?
- Do you think you are too fat, even though others say you are too thin?
- Would you say food dominates your life?

You may want to speak with you doctor or call OptumHealth to speak with a licensed clinician if you or your eligible dependent has experienced most of the above symptoms of an eating disorder.

Empire Plan Clinical Referral Line available 24 hours a day:

- **1-877-7NYSHIP (1-877-769-7447),** *press Option 3*
- **1-800-855-2881 (TTY)** *for impaired hearing*

The Empire Plan and OptumHealth Behavioral Solutions is pleased to offer:

Disease Management Program for Eating Disorders

(Anorexia Nervosa and Bulimia Nervosa)

For Empire Plan Enrollees and their covered dependents (13 years and older)

Recognizing the Signs and Symptoms of Anorexia and Bulimia

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February 2012

Did you know that the number of people with eating disorders and similar conditions is triple the number of people living with AIDS? *Eating disorders* refers to a pattern of attitudes, eating habits, and weight management practices about weight and body shape that are unhealthy. Eating disorders are extreme expressions of a variety of food and weight issues that can affect men and women of all ages. Anorexia nervosa, bulimia, and other eating disorders are serious problems that can have life-threatening consequences if left untreated.

Causes of Anorexia and Bulimia -
American culture today seems to be obsessed with thinness and beauty. Children and adolescents often feel that they cannot measure up to the media images they see and they may develop low self-esteem. The causes are not known, but a number of factors have been identified that can influence their development. People who feel that they have no control over their lives, are high achieving, strive for perfection, have a family history of eating disorders, and/or are victims of severe trauma are at risk for developing an eating disorder. These people feel that their lives are getting out of control. They come to believe that their weight is the only aspect of their lives over which they can exert complete control. However, these behaviors undermine physical health, self-esteem, and a sense of competence and control. Those who feel hopeless about life seem to not care about the harm and serious danger caused by binge

eating, food restriction, vomiting, over-exercising, and abuse of laxatives, diet pills, diuretics, and syrup of ipecac.

Early Diagnosis is Critical -
Identifying the stages of the disease is not easy. Serious symptoms indicating later stages are listed below and can help you determine if you or a loved one is developing an eating disorder. They can develop at any age, but they tend to begin in adolescence. It may not be possible to prevent the onset of an eating disorder, but it is important to recognize the early signs, and begin treatment as soon as possible. It also is important to note that each person who develops an eating disorder does not show all of these signs. Moreover, not everyone who shows some of these behaviors develops an eating disorder.

Signs of Anorexia -

- Menstrual cycle stops
- Increased preoccupation with food
- Isolates from friends and family and/or fights with family
- Perfectionism
- Eats alone
- Fatigue
- Increased facial and body hair, and decreased scalp hair
- Emaciated appearance (loss of 15-25% of body weight)
- Denial of problem, fear of food and gaining weight
- Malnutrition
- Sensitive to cold
- Slow heart beat and low blood pressure
- Joint pain

Signs of Bulimia -

- Eats alone
- Preoccupation with eating and food
- Tiredness, irritability, apathy
- Gastrointestinal problems

- Isolates from friends and family
- Lying, stealing food and money
- Tooth damage
- Chronic sore throat
- Difficulties in breathing and/or swallowing
- Possible rupture of esophagus/peritonitis
- Dehydration
- Suicidal tendencies or attempts

How to Get Help for an Eating Disorder -
There is help for people with eating disorders. First, schedule a complete physical exam. Collect information and find treatment resources such as your local Mental Health Association or school system. For someone you care about, tell the person what you have observed in a compassionate and nonjudgmental way, and suggest they seek appropriate physical and psychological help.

For additional information, please visit the following websites:

- National Association of Anorexia Nervosa and Associated Disorders:
  http://www.anad.org

- National Eating Disorders Association:
  http://www.nationaleatingdisorders.org

- Academy for Eating Disorders:
  http://www.aedweb.org

Attachment 22 - ADHD Communications Materials

Attachment 22-1
May 20, 2014

OPTUMHealth™

THE EMPIRE PLAN

Screening and education on the Web: liveandworkwell.com (access code: Empire) provides scientifically based articles to identify and treat ADHD. This is an easy, private way to learn about ADHD. We can also print the web based materials and send them to your home at your request.

Speaking with a licensed clinician: OptumHealth is staffed by licensed clinicians 24 hours a day, 7 days a week, at 1-877-7NYSHIP (1-877-769-7447), option 3, who are available to answer your questions about ADHD or assist you in finding a behavioral health network provider in your area.

Mailings sent to your home: The articles mailed to your home contain information and resources to help you understand and manage your child's ADHD. If your child is newly diagnosed with ADHD you may receive ADHD educational mailings

OptumHealth Behavioral Solutions outreach to behavioral health and medical practitioners: We may also send educational materials to your child's practitioners regarding new or best practices.

Children with ADHD often:

- Lose things
- Run or climb "excessively"
- Have difficulty waiting their turn
- Are easily distracted
- Are forgetful
- Interrupt or intrude on others
- Fidget with their hands or squirm in their seats
- Avoid tasks that require constant mental effort
- Are off in a "dream world"
- Make careless mistakes
- Do not finish school work or chores
- Have difficulty paying attention
- Do not seem to listen when spoken to directly
- Have difficulty being quiet or talk non-stop
- Blurt out the answer before the question is complete

If your child has exhibited 6 or more of the above behaviors for at least six months to the point of being disruptive, you may want to consider signing up for the Empire Plan **ADHD Educational Mailings**, talking with your child's doctor or calling OptumHealth at the number listed below.

Empire Plan Clinical Referral Line available 24 hours a day:

- **1-877-7NYSHIP (1-877-769-7447),** *press Option 3*
- **1-800-855-2881 (TTY)** *for impaired hearing*

The Empire Plan and OptumHealth Behavioral Solutions is pleased to offer:

Attention Deficit Hyperactivity Disorder (ADHD) Educational Materials

For Empire Plan Enrollees and their covered dependents (17 years and under)

Treatment Options for Your Child's ADHD

By Johns Hopkins Health Information

Last Reviewed: January 2013

Though there is no specific cure for ADHD, many treatment options are available, including medications and behavioral therapy.

Once your child has received a proper diagnosis of ADHD (attention-deficit/hyperactivity disorder), you can work with your pediatrician or a child psychiatrist to determine the best treatment plan. Doctors used to think that children outgrew ADHD over time, though now it is understood to often be a lifelong circumstance that requires frequent monitoring.

At the beginning of treatment, your pediatrician or child psychiatrist should set some realistic goals for your child's behavior, such as improved relationships with parents and teachers, better schoolwork or improved self-esteem. These targets should be easy to observe and measure with rating scales.

For most children, stimulant or other medications are a safe and effective way to relieve symptoms. These medications help children with ADHD focus their thoughts better and ignore distractions, enabling them to pay attention and control their behavior. The medications are available in short-, intermediate- and long-acting forms. It is important for your child to have regular medical checkups to monitor how well the medication is working.

Side effects, though rare, include decreased appetite or weight loss, sleep problems, headaches and stomach aches. Talk to your child's doctor if you observe any of these complications. Most side effects can be relieved through simple measures like changing medications or adjusting the dosage.

The information about educational or therapeutic approaches is provided for educational purposes only. Certain treatments may or may not be covered through your benefit plan. Coverage typically depends on your plan specifications and relevant guidelines maintained in relation to your benefit plan.

When medication isn't enough

For about half of children with ADHD, medications alone will bring about a huge improvement in behavior. The good news for parents of these children is they may not need to do anything else, and they'll see results quickly.

For other children, the medications may be complemented with behavior therapy. The basic tenets of behavior therapy include setting clear goals for your child, such as focusing on homework for a set period of time; providing specified rewards for good behavior; and specified consequences, like a "time-out," for bad behavior. Parents may need to practice behavior therapy for a long time to direct their child appropriately. Some parents benefit from working with a behavioral therapist for reinforcement.

The American Academy of Pediatrics recommends the following additional measures:

- Keep your child on a set daily schedule.
- Give the child a maximum of two to three choices when he is faced with making a decision.
- Cut out distractions like music or television while the child does homework.
- Avoid places like busy shopping malls that may be too stimulating.
- Organize your living environment to establish specific places for your child to keep schoolbooks, toys or clothes.
- Use calm discipline. Remove a child from a bad situation, but do not spank him or yell at him. Talk with him about the situation when you are both calm.
- Find activities at which your child can succeed, and reward his positive behavior.

A team approach

Your child's schoolteacher should be a key partner in behavior therapy efforts. For example, you can ask the teacher if it's possible to sit your child in the front of the room, on a corner, so there are other children on only two sides. Request that the teacher supervise your child closely and send home frequent reports noting the child's progress. Teachers also might implement a token system for rewards. If a child performs well, she can earn special privileges, but if she performs poorly, the privileges should be removed.

For older children, keep assignments short or break them into smaller sections.

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Parents, working together with a health care professional and school personnel, must continually monitor a child's behavior and medications to determine if the treatment plan is working. Is your child achieving the goals the pediatrician set initially?

Finally, as a parent, learn all you can about ADHD by reading about the condition and talking to other parents and professionals who understand it. This can help your day-to-day management of the disorder.

The information about educational or therapeutic approaches is provided for educational purposes only. Certain treatments may or may not be covered through your benefit plan. Coverage typically depends on your plan specifications and relevant guidelines maintained in relation to your benefit plan.

Medication Log

Child's Name:	**Date of Birth:**
Child's Health Care Provider:	**Phone Number:**
Child's Behavioral Health Provider:	**Phone Number:**
Emergency Contact:	**Phone Number:**
Medical Conditions:	
Known Medication Allergies:	**Other Allergies:**

Instructions: Use this medication log to keep track of the medicine your child takes. Bring this log to your child's healthcare visits. This information will be useful for your doctor in case there are any problems with the medicine. When medications or doses are changed, do not erase or black out the old information. Instead, draw a line through it and make a new entry to the list. This way you have a complete record.

Medication Name	**Dose** (How much/how often? Special instructions?)	**Prescribed By**	**Start Date**	**End Date**	**Notes on how the medicine is working or side-effects:**
[Example] Ritalin	10mg 2x day (give at breakfast and lunch)	Taylor	2/1/05		

Medication Log

Medication Name	**Dose** (How much/how often? Special instructions?)	**Prescribed By**	**Start Date**	**End Date**	**Notes on how the medicine is working or side-effects:**

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Attachment 23 - The Road to Recovery

As I changed jobs, I started drinking heavily throughout the week, even when by myself. I was late for work when my supervisor pulled me aside and told me he was aware that I was repeatedly late and that I needed to address the problem...

How to know when there is a problem?

1. Have you ever felt you should cut down on your drinking or drug use?
2. Have people annoyed you by criticizing or complaining about your drinking or drug use?
3. Have you ever felt bad or guilty about your drinking or drug use?
4. Have your ever had a drink or drug in the morning (eye opener) to steady your nerves or to get rid of a hangover?
5. Do you use any drugs other than those prescribed by a physician?
6. Has a physician ever told you to cut down or quit using alcohol or drugs?
7. Has your drinking/drug use caused family problems?
8. When drinking/using drugs, have you ever had a memory loss (blackout)?

If you answered "Yes" to two or more of the questions, you may have an alcohol or drug problem. Please discuss the results with your healthcare provider.

Where can I learn more?

Learn more on how to make healthy choices about alcohol and drug use. Information can be found on the following Web sites:

- liveandworkwell.com
  http://prevention.liveandworkwell.com
- National Institute on Drug Abuse
  http://www.nida.nih.gov

The information in this brochure is based on information found in:

- American Psychiatric Association, Treatment of Patients With Substance Use Disorders, Second Edition.
- National Committee for Quality Assurance, HEDIS® 2010 Technical Specifications.
- National Institutes on Alcohol Abuse and Alcoholism, *Rethinking Drinking: Alcohol and Your Health*, NIH Publication No. 10-3770, April 2010.

The text in this brochure is not meant to provide medical advice or other health services. It is not meant to replace professional advice or imply coverage of specific clinical services or products. The information is for educational purposes only and is not a substitute for professional health care. Consult your healthcare provider concerning your specific health needs. Certain treatments may not be covered in some benefit plans. Check with your health plan regarding your coverage of services.

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The Road to Recovery

I always enjoyed the occasional drink with friends on a Friday night to relax...

Attachment 23-2
May 20, 2014

From use to abuse; what are the signs and symptoms?

Behavior is an important clue to a possible problem with alcohol or drugs. Common signs of a problem include:

- Not enjoying parties or social events without using alcohol or drugs.
- Making excuses for alcohol or drug use
- Doing almost anything to get alcohol or drugs
- Having financial, legal, medical, family, and/or work problems
- Avoiding family and friends who are worried about your alcohol or drug use.

Recovering from an alcohol or drug problem?

Recovery means finding a way to stay sober while changing your attitudes and behaviors. Recovery occurs in three phases:

1. Admitting that there is a problem, and looking for help.
2. Getting help, such as, substance abuse treatment and/or going to support groups to learn skills.
3. Practicing the skills you have learned to prevent alcohol or drug use.

What Causes Alcohol & Drug Addiction?

It is not clear why some people develop alcohol and drug addiction and others do not. Experts know that the risk of addiction can be passed down in families.

Addiction is a medical condition that can have negative effects on your emotions and behavior. Experts believe that the negative effects from using alcohol or drugs can be improved only by dealing with your use.

I **was determined** to make some changes but I discovered that it was harder than I thought to stop drinking. I decided to visit a substance abuse provider and receive the treatment I needed. I began going to an outpatient treatment program.

Now I've been sober for several months. And I'm meeting with a peer support group as a way to keep my commitment to staying sober.

Be active in your recovery by following these tips:

- Get help from a provider who treats alcohol or drug problems
- Seek medical care for alcohol withdrawal or drug-related medical problems. There are medications that treat alcohol and drug addiction and that support relapse prevention.
- Work with family, friends and groups who can support your recovery
- Identify what triggers your substance use
- Create a recovery plan
- Manage your stress by exercising, eating right and getting enough sleep
- Use healthy rewards to recognize progress.

Getting help?

- Seek treatment from a substance abuse provider and attend appointments regularly for the first few weeks. This will support you in your recovery
- Talk about any concerns with your substance abuse provider
- Ask your substance abuse provider to work with you on a recovery plan
- Get help from free peer support groups.

Contact the mental health/substance abuse access line for a referral to a substance abuse provider. The phone number can be found on your health insurance card.

In case of emergency, call 911 or go to the nearest emergency room.

Get the support of others:

There are many support groups that provide assistance to people in recovery and their family members. Here are some examples; check them out on the Web or in your local phone book:

- Alcoholics Anonymous
  www.aa.org
- Narcotics Anonymous
  www.na.org
- SMART Recovery
  www.smartrecovery.org
- Al-Anon Family Groups
  www.al-anon.org
- Adult Children of Alcoholics
  www.adultchildren.org

Attachment 24 - Optum and Caremark Executed NDA

"The rest of this Exhibit has been redacted."

Attachment 25 - UBH GeoAccess Results

We have provided the UBH GeoAccess Results in our electronic Technical Proposal only, per instructions.