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# Attachment T-1: Proposal Request

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions**: The State of Maryland is requesting proposals for an Employee Assistance Program. Please complete each item with the requested information for your proposed **EAP**. Items in the response column with the words **"Choose an item"** contain a drop down list of options. Please select a response from those options as applicable.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **I.** | **GENERAL PLAN INFORMATION** | | | | | | | |
|  |  | **Response** | | | | | | |
| 1. | Offeror's Legal Name | Click here to enter text. | | | | | | |
| 2. | Plan Name | Click here to enter text. | | | | | | |
| 3. | Proposed Plan Type | **EAP** | | | | | | |
| 4. | Address | Click here to enter text. | | | | | | |
| 5. | City | Click here to enter text. | | | | | | |
| 6. | State | Click here to enter text. | | | | | | |
| 7. | Zip | Click here to enter text. | | | | | | |
| 8. | Web Address | Click here to enter text. | | | | | | |
| 9. | Operational Date | | | | Click here to enter a date. | | | |
| 10. | Corporate Tax Status | | | | Choose an item. | | | |
| 11. | Federal Employer Identification Number | | | | Click here to enter text. | | | |
| 12. | Ownership/Controlling Interest | | | | Click here to enter text. | | | |
| 13. | Year Network Organized | | | | Click here to enter text. | | | |
| 14. | EAP membership totals as of 1/1/2019 | | | | Click here to enter text. | | | |
|  | EAP membership totals as of 1/1/2020 | | | | Click here to enter text. | | | |
| 15. | Amount of professional liability insurance maintained | | | | Click here to enter text. | | | |
| **II.** | **PLAN DESIGN** | |  | | |  |  | |
|  | Offerors must adhere to the proposed plan features shown in **"Attachment T-3: EAP Plan"** in preparing the quote. | | | | | | | |
|  |  | |  |  | | | | **Response** |
| 1. | Offerors agree to adhere to the proposed plan features shown in **"Attachment T-3: EAP Plan”** in preparing the quote and administering the EAP during the contract term. | | | | | | | Choose |
| 2. | Confirm that the proposal is issued in accordance with the specifications, assumptions and information included in this Request for Proposal, accompanying attachments and standard services addressed in the Information Questionnaire. If "No,” indicate deviations in **"Attachment T-2: Explanation and Deviations."** | | | | | | | Choose |
| 3. | Review and detail deviations from the proposed plan features shown in **"Attachment T-3: EAP Plan."** | | | | | | | Choose an item. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **III.** | **EAP NETWORK** | |  |  |
|  |  |  |  | **Response** |
|  | Complete the two (2) charts in **"Attachment T-5: EAP Providers.”** For the counties shown, list the total number of participating providers by specialty. Also indicate the number of providers accepting new patients, by specialty. For the states listed, provide the total number of participating providers. | | | Choose an item. |

**Members’ Access to Providers**

The State would like to determine the availability of key providers to its employee population. Please prepare GeoAccess® GeoNetworks® report(s) for the EAP that you are proposing using census data provided by the State and the parameters in the table below. **Provide the reports using the population eligible under the current EAP.** Note that it is important that you follow the exact parameters. The report should show the availability by specialty for each zip code (or community). Report output is required for those with access and those without access, based upon the stipulated parameters. The report output should show the average distance to each provider group. See "**Attachment T-4: Access**" for the required format of the output. Hard copy reports need only contain the aggregated provider access information. In addition to the hard copy report, the data must be supplied in electronic format that has read/write capabilities (i.e. Microsoft Excel). Do not send the data in a read-only file.

Use only providers accepting new patients in your GeoAccess® GeoNetworks® provider file. The census you need to perform this mapping will be available via secure FTP upon execution of the confidentiality agreement (see Section 1.30). Label the completed GeoAccess® GeoNetworks® report as **"Response Attachment T-1: GeoAccess GeoNetworks Report."**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Practice Specialty** |  | **Number of Providers Available** | **Miles from Employees Residence** |
|  | Clinical Psychologist | | 2 | 10 |
|  | Licensed Clinical Social Worker | | 2 | 10 |
|  | Family Therapist | | 2 | 10 |
|  | Psychiatrist | | 2 | 10 |
|  |  |  |  |  |
|  |  |  |  | **Select Response** |
| 2. | Has the GeoAccess® GeoNetworks® reporting been completed using the requested parameters? | | | Choose an item. |
| 3. | Please note the Geo-mapping method used: | | | Choose an item. |
| 4. | Which GeoAccess® GeoNetworks® Release was used to create the Accessibility Analysis? | | | Click here to enter text. |
|  |  |  |  |  |

**IV. ADMINISTRATIVE AND OPERATIONAL ISSUES**

**Other Services**  

|  |  |  |
| --- | --- | --- |
| 1. | List the location(s) of your service centers (separately identify billing and customer service centers if in different locations) that would be servicing the State's members and the corresponding geographic areas/regions covered by the respective location. Use **"Attachment T-2: Explanations and Deviations"** if you need more space. | |
|  | **Service Center Location(s)** | **Geographic Region(s) Covered** |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |
|  | Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | |  | |  | | **Response** |
| 2. | Please attach copies of your standard report suite, including monthly utilization reports, which would be provided to the State at no additional cost. At a minimum, your package should include the report format for the reports requested in the Reporting Section of the Compliance Checklist. In addition, please provide the frequency of each of your standard reports. Label these reports **"Attachment T-1: Management Reporting Package"** in your proposal. | | | | | | Choose an item. |
|  |  | |  | |  | |  |
| **V.** | **REFERENCES** | |  | |  | |  |
|  | Please complete the following tables with the requested reference information. | | | | | | |
|  |  | |  | |  | |  |
| 1. | Please provide three of your current employer client references of a minimum of 5,000 covered lives offering EAP services in the area that will be serving most of the State's employees. | | | | | | |
|  | **Information** | **Reference #1** | | **Reference #2** | | **Reference #3** | |
|  | Organization Name | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |
|  | Contact Person | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |
|  | Title | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |
|  | Telephone # | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |
|  | E-mail Address | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |
|  | # EAP Members | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |
|  | Effective date of contract | Click here to enter a date. | | Click here to enter a date. | | Click here to enter a date. | |
|  | Description of services provided | Click here to enter text. | | Click here to enter text. | | Click here to enter text. | |

| 2. | Please provide two of your terminated employer clients of a minimum of 5,000 covered lives that offered EAP services. | | | |
| --- | --- | --- | --- | --- |
|  | **Information** | **Reference #1** | **Reference #2** | **Reference #3** |
|  | Organization Name | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Contact Person | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Title | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Telephone # | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | E-mail Address | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | #EAP members at date of termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  | Effective date of contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Termination date of contract | Click here to enter a date. | Click here to enter a date. | Click here to enter a date. |
|  | Reason for termination | Click here to enter text. | Click here to enter text. | Click here to enter text. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **VI.** | **CONTACT INFORMATION** | |  |  |
|  | **Primary contact of person authorized to execute this proposal** | | | |
|  | Name | Click here to enter text. | | |
|  | Title | Click here to enter text. | | |
|  | Address | Click here to enter text. | | |
|  | City | Click here to enter text. | | |
|  | State | Click here to enter text. | | |
|  | Zip Code | Click here to enter text. | | |
|  | Telephone # | Click here to enter text. | | |
|  | Cell Phone # | Click here to enter text. | | |
|  | E-mail Address | Click here to enter text. | | |
|  | | | | |

# Attachment T-2: Explanations and Deviations

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** All deviations from the specifications of the Request for Proposal (RFP) must be clearly defined below. Explanations must be numbered to correspond to the question number and section number to which it pertains. If additional space is required, submit a separate attachment labeled **“Attachment T-2b: Explanations and Deviations”** using the same table format. **Most importantly, keep all explanations brief.** In the absence of any identified deviations, your organization will be bound to the terms of the RFP.

| **Section # / Question #** | **Indicate "Explanation" or "Deviation"** | **Offeror Response** |
| --- | --- | --- |
| Click here | Choose | Click here to enter text. |
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| Click here | Choose | Click here to enter text. |
| Click here | Choose | Click here to enter text. |

Please indicate if **Attachment T-2b: Explanations and Deviations** is provided. **Choose an item.**

# Attachment T-3: EAP Plan Design

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete each item with the requested information. Items in the response column with the words **"Choose,”** contain a drop down list of options. Please select a response from those options as applicable. All "No" responses must be addressed in **"Attachment T-2: Explanations and Deviations.”**

|  |  |  |
| --- | --- | --- |
| **SERVICES OFFERED** | | **Offeror Response** |
| PD-1 | Both remote and in-person counselor networks consisting licensed, credentialed providers in a variety of cognitive health specialties, with a core concentration located in the state of Maryland, supplemented by counselor presence in all 50 United States. | Choose |
| PD-2 | 24-hour/7-day 1-800 telephone access to live MA-Level intake staff for self-referrals and crisis interventions. | Choose |
| PD-3 | Clinical assessment and referral to short-term in-person or remote counseling (up to 5 sessions per person per episode). Referral to the State Health Plan networks for continued clinical care for chronic issues. Intake counselors are familiar with employee benefits and community resources. | Choose |
| PD-4 | Secure portal and mobile access for self-referrals. This includes access to electronic EAP provider search tools (available for in-person or remote counseling sessions), access to other work/life resources, employee health benefit information, and community resources. | Choose |
| PD-5 | Electronic directories of providers available to provide both in-person and remote counseling sessions. | Choose |
| PD-6 | Critical Incident Response and Stress Debriefing Support and on-site training of State Manager/Supervisor personnel upon request. | Choose |
| PD-7 | Familiarity with the State of Maryland employee benefit programs, health plan networks, and community resources. | Choose |
| PD-8 | Remote and mobile access to tools for cognitive behavior therapy/self-directed awareness training, self-assessments, and assistance with navigating further care options. | Choose |
| PD-9 | Print and make available hard copy and electronic co-branded educational materials about the value of the EAP services, program descriptions, and user instructions | Choose |
| PD-10 | Print and make available hard copy and electronic co-branded educational materials − mental health topics, substance use/recovery, relationships, legal, financial, parenting, eldercare, health, etc. | Choose |
| PD-11 | Access to financial planning, career coaching, mediation, and legal services on a prepaid basis, including one 30-minute consultation with a credentialed professional per service (separate from counseling) and access to sample forms or other resources. | Choose |
| PD-12 | Attendance at meetings, health fairs, and wellness fairs as requested by the State (see minimum services required in **Section 2.3.7.1** and **Attachment B**). | Choose |

# Attachment T-4: EAP Provider Network Access

**Instructions:** Provide the following access information for each type of available provider listed in the access request (Clinical Psychologists, Licensed Clinical Social Workers, Family Therapists, and Psychiatrists). **Provide access for all employees currently eligible for the EAP program based on home address (entire census population).** *(Please note that the total number of employees excludes those employees located in Guam, Puerto Rico, Virgin Islands, countries other than the United States and APO addresses.)*

**All employees eligible for EAP program**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Type** | **Access Criteria** | **Average Distance to Providers** | **Total Number of Employees** | **Employees Matched** | | **Employees Not Matched** | |
| **Number** | **Percent** | **Number** | **Percent** |
| Clinical Psychologist | 2 in 10 | Click here | 59,555 | Click here | Click here | Click here | Click here |
| Licensed Clinical Social Worker | 2 in 10 | Click here | 59,555 | Click here | Click here | Click here | Click here |
| Family Therapist | 2 in 10 | Click here | 59,555 | Click here | Click here | Click here | Click here |
| Psychiatrist | 2 in 10 | Click here | 59,555 | Click here | Click here | Click here | Click here |

# Attachment T-5: EAP Providers

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** For the counties shown below, list the total number of participating in-network providers by specialty. Also, indicate the number of providers accepting new patients, by specialty.

| **County/**  **Metro Area** | **Category** | **Clinical Psychologist** | **Licensed Clinical Social Worker** | **Family Therapist** | **Psychiatrist** | **Total Providers** |
| --- | --- | --- | --- | --- | --- | --- |
| **Remote Access** | |  |  |  |  |  |
| Remote Network Providers (Online / Mobile / Other) | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| **Central Maryland** | |  |  |  |  |  |
| Anne Arundel County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Baltimore City | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Baltimore County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Carroll County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Harford County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Howard County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| **Eastern Shore** | |  |  |  |  |  |
| Caroline County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Cecil County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Dorchester County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Kent County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Queen Anne's County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Somerset County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Talbot County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Wicomico County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Worcester County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| **Southern Maryland** | |  |  |  |  |  |
| Calvert County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Charles County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| St. Mary's County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| **Washington Metro** | |  |  |  |  |  |
| District of Columbia | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Montgomery County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Prince George's County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| **Western Maryland** | |  |  |  |  |  |
| Allegany County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Frederick County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Garrett County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |
| Washington County | # of providers | Click here | Click here | Click here | Click here | Click here |
| # accepting new patients | Click here | Click here | Click here | Click here | Click here |

**Instructions:** For the states and locations shown below, list the total number of participating providers by specialty.

| **State** | **Clinical Psychologist** | **Licensed Clinical Social Worker** | **Family Therapist** | **Psychiatrist** | **Total Providers** |
| --- | --- | --- | --- | --- | --- |
| Alabama | Click here | Click here | Click here | Click here | Click here |
| Alaska | Click here | Click here | Click here | Click here | Click here |
| Arizona | Click here | Click here | Click here | Click here | Click here |
| Arkansas | Click here | Click here | Click here | Click here | Click here |
| California | Click here | Click here | Click here | Click here | Click here |
| Colorado | Click here | Click here | Click here | Click here | Click here |
| Connecticut | Click here | Click here | Click here | Click here | Click here |
| Delaware | Click here | Click here | Click here | Click here | Click here |
| District of Columbia | Click here | Click here | Click here | Click here | Click here |
| Florida | Click here | Click here | Click here | Click here | Click here |
| Georgia | Click here | Click here | Click here | Click here | Click here |
| Hawaii | Click here | Click here | Click here | Click here | Click here |
| Idaho | Click here | Click here | Click here | Click here | Click here |
| Illinois | Click here | Click here | Click here | Click here | Click here |
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| North Carolina | Click here | Click here | Click here | Click here | Click here |
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| Oregon | Click here | Click here | Click here | Click here | Click here |
| Pennsylvania | Click here | Click here | Click here | Click here | Click here |
| Rhode Island | Click here | Click here | Click here | Click here | Click here |
| South Carolina | Click here | Click here | Click here | Click here | Click here |
| South Dakota | Click here | Click here | Click here | Click here | Click here |
| Tennessee | Click here | Click here | Click here | Click here | Click here |
| Texas | Click here | Click here | Click here | Click here | Click here |
| Utah | Click here | Click here | Click here | Click here | Click here |
| Vermont | Click here | Click here | Click here | Click here | Click here |
| Virginia | Click here | Click here | Click here | Click here | Click here |
| Washington | Click here | Click here | Click here | Click here | Click here |
| West Virginia | Click here | Click here | Click here | Click here | Click here |
| Wisconsin | Click here | Click here | Click here | Click here | Click here |
| Wyoming | Click here | Click here | Click here | Click here | Click here |
| **Total** | **Click here** | **Click here** | **Click here** | **Click here** | **Click here** |

# Attachment T-6: Compliance Checklist

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete each item with the requested information. Items in the response column with the words **"Choose an item,”** contain a drop down list of options. Please select a response from those options as applicable. All "No" responses must be addressed in **"Attachment T-2: Explanations and Deviations.”**

| **Compliance Checklist** | | **Offeror's Response** |
| --- | --- | --- |
| **Yes or No** |
| **Customer Service** | |  |
|  | Offeror agrees to permit all eligible members, as determined by the State, to obtain EAP benefits. | Choose |
|  | Offeror agrees to no loss/no gain provision: All members eligible under the prior plan as of June 30, 2021, will be covered as of July 1, 2021. | Choose |
|  | Offeror agrees to establish and provide a dedicated, state-of-the-art customer service operation (including a toll-free line) that is available to plan Participants (both in-state and out of state) 24 hours a day, seven days a week, staffed by live, credentialed (MA-level) EAP specialists. | Choose |
|  | This dedicated toll-free EAP benefit line will be staffed with live licensed professionals who answer incoming calls within 30 seconds and respond to Participant needs and back-up supported by an automated voice-response system 24 hours a day, seven days a week. Participants (both in-state and out-of state) can access this system directly to request and receive live intake assessments, referrals, and other pertinent information. This operation should be in accordance with PG-1 and PG-2 on **"Attachment T-9: Performance Guarantees.”** | Choose |
|  | An Automated back-up call answer system will provide estimated wait time until live operator pick-up to Participant. This is a back-up, not a primary call answer system. | Choose |
|  | Offeror agrees to provide and administer a dedicated website, mobile and online access for the exclusive use of eligible Employees to locate cognitive behavior therapy tools, online educational materials, modules and webinars on topics, including but not limited to conflict resolution, parenting, eldercare, stress management, substance use, recovery, trauma, domestic violence, legal, financial, and other work/life topics. | Choose |
|  | Offeror agrees to accurately convert State data files, which are transmitted in HIPAA 834 format. This includes the State master eligibility file and any other relevant files to the Offeror's data system. The verification of eligibility and timing of file exchanges will be determined by the State and agreed upon by the Offeror as part of the Operational Readiness Review process. | Choose |
|  | Offeror agrees to offer co-branded promotional and educational materials, on-site support services during the Open Enrollment, and attendance at wellness events, including up to 60 Open Enrollment events and 60 wellness events per year during the contract term. Offeror will provide services in accordance with PG-3 on **"Attachment T-9: Performance Guarantees.”** | Choose |
|  | Offeror must arrive at least 15 minutes in advance of all Open Enrollment and Health Fairs Meetings and be fully prepared including having their table and materials set up prior to meeting start time. Display must be organized and include appropriate covering of table. Representative must have detailed plan knowledge, interact with members, and exhibit professional appearance and behavior. | Choose |
|  | Offeror will use a unique case identification number that is not a social security number on all Participant communication. | Choose |
|  | Self-Referral and Supervisor-Referral EAP intake and utilization data will be transmitted according to the Reporting requirements (see CC-33 through CC-39 below and Section 2.3.10). Self-referral data will be de-identified for privacy and confidentiality and used only to confirm eligibility and to audit the services provided. All data will be held securely and considered the property of the State. | Choose |
|  | In order to verify that individuals accessing core-counseling services are eligible, the Offeror shall request that each individual accessing services provide their name (or the name of the State employee to whom they are related (if dependents are covered) or with whom they reside (if household members are covered) before referral sessions begin. Offeror will cross check the name received with the monthly eligibility file received from the State, and contact the State EAP representative if necessary, to confirm eligibility. | Choose |
| **Network Compliance** | |  |
|  | Offeror agrees to notify the State in writing with at least 60 days advance notice in the event that the contract for a provider terminates for any reason. | Choose |
|  | Offeror has a procedure in place to allow the State and/or plan Participants to nominate providers to be considered for inclusion in the network panel, and if included, made available to Participants. | Choose |
|  | Offeror agrees to notify the State immediately if the Offeror loses any licenses, certificate of insurance, liability insurance coverage or certificate of authority from the Maryland Insurance Administration or any other state insurance department. | Choose |
| **Audits** |  |  |
|  | Offeror agrees to provide the State or its designated representative the right to audit the performance of the plan and services provided (including quality of care and HIPAA compliance). Offeror will make available all services, records and access to the auditors at no extra charge. Offeror will be given two months’ written advance notice of an impending audit. | Choose |
| **HIPAA** | (Terms herein shall have meaning provided in 45 CFR, Parts 160, 162 and 164.) |  |
|  | The Offeror agrees to comply with HIPAA security regulations, 45 CFR Part 164, subpart C. | Choose |
|  | The Offeror agrees to comply with HIPAA privacy standards, 45 CFR Parts 160 and 164. | Choose |
|  | The Offeror shall comply with 45 CFR 164.508(a)(4) and §13405(d)(1) and (2) of the HITECH Act as if it were a covered entity in connection with the benefits plan administered by the Offeror pursuant to this RFP and Contract. The Offeror shall prohibit its business associates, agents and subcontractors who receive, use, disclose, create, retain, maintain, or transmit PHI from receiving remuneration in exchange for PHI on the same terms. | Choose |
|  | The Offeror shall comply with the limitations on marketing and fundraising communications provided in 45 CFR 164.508(a)(3) and §13406 of the HITECH Act as if it were a covered entity in connection with the benefits plan. | Choose |
|  | **Data Breach Responsibilities** |  |
|  | a.) A breach shall be treated as discovered in the terms described in 45 CFR §164.410. | Choose |
|  | b.) Notice to the Department |  |
|  | (1) The Business Associate shall promptly notify the Department of a breach of unsecured PHI in its possession following the first day on which the Offeror (or Offeror's employee, officer, agent or subcontractor) knows of such breach or following the first day on which Offeror (or Offeror's employee, officer, agent or subcontractor) should have known of such breach. Such notice shall occur without unreasonable delay and in no event more than 30 days following discovery of the breach. Such notice shall occur even if the breach is not of a Member of the State's Plan. | Choose |
|  | (2) In the event that Offeror determines that there is no risk of an unauthorized access, acquisition, use, or disclosure compromises the security or privacy of the PHI of a Participant, Offeror shall promptly notify the Department of the event and the basis for that determination. Such notice shall occur as soon as is reasonable but in no event more than 30 days following discovery of the unauthorized access, acquisition, use or disclosure of PHI of a Participant. Such determination shall be in writing and signed by an appropriate officer or employee of Offeror. | Choose |
|  | (3) Offeror's notice to the Department pursuant to this section concerning breaches shall include, at a minimum: |  |
|  | (i) the number of individuals overall affected by the breach and the number of Participants in the State's Plan affected by the breach; | Choose |
|  | (ii) if applicable, the identification of each State Plan Participant whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, used, disclosed, or otherwise the subject of the breach; | Choose |
|  | (iii) a description of what happened, the date of the breach, if known, and the date of the discovery of the breach; | Choose |
|  | (iv) a brief description of the types of unsecured PHI that were involved in the breach (such as name, social security number, date of birth, claims or health care services information, etc.); | Choose |
|  | (v) identification of an individual who can provide additional information concerning the breach; and | Choose |
|  | (vi) a brief description of the steps Offeror is taking to mitigate the breach, investigate the breach, and to protect against further breaches. | Choose |
|  | (4) Offeror's notice to the Department pursuant to this section may be provided on a rolling basis, with information provided to the Department as it becomes available. | Choose |
|  | c.) Notice to Participants. |  |
|  | (1) Business Associate shall provide notice to affected members and to the media in the form, content, manner, method, and timing required to meet the requirements of §§13400-13402 of the HI TECH Act and 45 CFR §§164.404 and 164.406, applied as if Business Associate were a covered entity in connection with the group plan(s) administered by Business Associate pursuant to the Underlying Agreement. | Choose |
|  | (2) The notice(s) required by this section may not be issued until the Department has reviewed and approved the notice(s). Such approval may not be unreasonably delayed or withheld. | Choose |
|  | d.) Offeror may delay the notice(s) required pursuant to sections 164.404(b) and 164.406(b) only if permitted pursuant to 45 CFR §164.412. | Choose |
|  | e.) In the event of an unauthorized use or disclosure of PHI or a breach of Unsecured PHI, Offeror shall use reasonable efforts to mitigate any harmful effects of said disclosure that are known to it. | Choose |
|  | f.) Notices to Maryland Department of Health (MDH). |  |
|  | (1) In the event of a breach described in 45 CFR §164.408(b), Offeror shall provide to Department all information required by that subsection to be submitted to the Secretary of MDH. The information shall be provided without unreasonable delay and in no event more than 30 days following discovery of the breach. Upon request, Offeror shall submit the required breach notice to the Secretary of MDH on behalf of the Department, the State, the group plan(s), and the Program. | Choose |
|  | (2) Offeror shall maintain a log of breaches described in 45 CFR §164.408(c) and that affect members and the group plan(s) administered by Business Associate pursuant to the Underlying Agreement. | Choose |
|  | g.) In fulfilling its obligations pursuant under this Contract in connection with 45 CFR §164.530, Business Associate shall address the provisions of 45 CFR Part 164, subpart D in the manner provided in 45 CFR §164.414, as if Offeror were a covered entity in connection with the benefits plan administered by the Offeror pursuant to this Contract and RFP. | Choose |
|  | h.) Business Associate agrees to review any guidance from MDH specifying the technologies and methodologies that render PHI unusable, unreadable, or indecipherable to unauthorized individuals. BA further agrees, to the extent practical, appropriate and reasonable, to incorporate such guidance into its administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of PHI. | Choose |
|  | i.) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by the Offeror, agrees to provide notice of a breach and the information necessary for the Offeror to comply with its notice requirements in sections (a) through (h) above. | Choose |
|  | **Electronic Health Records** |  |
|  | a.) Offeror shall notify the Department if and when Offeror uses or maintains electronic health record(s) with respect to PHI. | Choose |
|  | b.) As of the applicable effective date identified in HITECH §13405(c)(4), when complying with the obligations to respond to requests for an accounting under 45 CFR §164.528, Offeror shall respond to requests for an accounting of disclosures of PHI, in compliance with the requirements of §13405( c)(1) and (3) of the HITECH Act and any regulations promulgated by the Secretary of MDH pursuant to §13405( c)(2) of the HITECH Act. The requirements of this section shall apply if Offeror uses or maintains an electronic health record with respect to PHI. | Choose |
|  | c.) When complying with the obligation to provide access to PHI under 45 CFR §164.524, Offeror shall respond to requests for access to PHI in compliance with the requirements of §13405(e) of the HITECH Act. The requirements of this section shall apply if Offeror uses or maintains an electronic health record with respect to PHI. | Choose |
|  | The Offeror confirms that its proposal, and plan design offered, is in compliance with all federal and state laws and regulations that pertain to employee benefit plans. | Choose |
|  | The Offeror understands, has the necessary systems capability and complies with HIPAA's administrative simplification standards related to electronic data interchange (EDI), including the code set/transactions requests of 45 CFR Part 162. | Choose |
|  | The Offeror requires any agents/subcontractors it brings onto the project(s) covered by this RFP to comply with the HIPAA standards for EDI. | Choose |
| **Special Provisions** | |  |
|  | The Offeror will have a fully functioning program in place and operable on July 1, 2021. | Choose |
|  | Offeror shall provide for a comprehensive operational readiness review (pre-implementation review by the State), at least 60 days prior to the go-live date, Such review by the State, may include, but not be limited to, an onsite review of the Offeror’s operational readiness for all services required in this Agreement (e.g., member services, training, and website development). All IT processes including but not limited to the website, mobile apps, electronic provider directory, and call center automated voice response system will be fully tested prior to this readiness review 60 days prior to go-live, with corrective action plans already initiated | Choose |
|  | Offeror will provide at least 6 months’ notice to the State of Maryland for any planned systems upgrades or changes (to include claims, customer service, eligibility, corporate operating system). | Choose |
|  | Member service operations must include an information system capable of electronically transmitting, receiving, and updating Participant profile information regarding demographics, coverage, and other information (e.g. eligibility, change of address, etc.). | Choose |
|  | Offeror agrees to have a process in place for resolving complaints operable on the date of contract commencement. The State expects an expeditious, written resolution will normally be mailed within 10 workdays of receipt of the complaint. | Choose |
|  | Offeror agrees to notify the Contract Manager if a subcontractor is removed or added. | Choose |
| **Reporting** | |  |
|  | Offeror agrees to deliver the required management information reporting in the format specified by the State that provides utilization data by subgroup to the State of Maryland. | Choose |
|  | The State requires a number of regular monthly, quarterly, and annual utilization reports. The Offeror will deliver these reports in an electronic and hard copy formats following the end of each month and quarter to both the State’s Contract Manager and the State's benefit consultant. | Choose |
|  | **Monthly reports include** |  |
|  | Reporting of plan utilization and activity data, including but not limited to utilization by department/agency: number of self-referrals, source, presenting issues, open cases, closed cases, number of sessions per self-referral (of the 5 sessions available per episode per year), number of sessions for ineligible participants, and the average number of sessions per episode. For Supervisor referrals, number of sessions per supervisor referral (of the 2 sessions per year),location of EAP counseling sessions, timeliness of appointment scheduling, Agency, city and zip code of EAP Counselor, substance abuse referrals by drug class, and referral outcome. Report shall be submitted to the Contract Manager within seventy five (75) calendar days following the end of the preceding month. This report shall be in the form and format approved by the Contract Manager after contract commencement. (See Section 2.3.10) | Choose |
|  | **Quarterly reports include:** |  |
|  | Reporting of plan utilization and activity data, including but not limited to utilization breakdowns by department/agency: number of self-referrals, number of self-referral sessions (of the 5 sessions available per episode per year), source, presenting issues, open cases, closed cases, number of sessions for ineligible participants, and the average number of sessions per self-referral. For Supervisor referrals, number of supervisor-referrals, location of EAP counseling sessions, timeliness of appointment scheduling, gender of employees, age ranges, marital status, Agency, city of EAP Counselor, substance abuse referrals by drug class, and referral outcome. Report shall be submitted to the Contract Manager within seventy five (75) calendar days following the end of the preceding quarter. This report shall be in the form and format approved by the Contract Manager after contract commencement. See PG-7 in **“Attachment T-9: Performance Guarantees.”** | Choose |
|  | Offeror must self-report on each of the Performance Guarantee measurements as defined in the Quarterly Plan Performance Measurement Report Card to the State on a calendar quarter basis, in the format requested. See PG-6 in **"Attachment T-9: Performance Guarantees."** This report shall be in the form and format approved by the Contract Manager after contract commencement. | Choose |
|  | Provide quarterly reports and real-time online updates of provider directories to reflect EAP Counselor status, location, licensing, or name changes, additions, or terminations. For each new EAP Counselor, the quarterly report should be updated to reflect, at minimum the EAP Counselor name, office address, county, phone number, expiration date (if applicable), specialty (if applicable), effective date of network participation, and type of professional license, availability for new patients, and remote access capabilities. For each EAP Counselor removed, the quarterly report shall reflect, at minimum, the EAP Counselor name, the office address, county, phone number, expiration date (if applicable), specialty (if applicable), effective date, end date, and reason for removal from the network. This report shall be submitted to the Contract Manager by email by the 15th day of the following month after each quarter. | Choose |
|  | A report describing network development activities for the previous quarter and a network development plan for the upcoming quarter. | Choose |
|  | **Annual reports include:** |  |
|  | A rate renewal report, as required by PG-8 on **"Attachment T-9: Performance Guarantees**,**”** including, but not limited to: |  |
|  | a.) Projection of utilization for renewal year; | Choose |
|  | b.) Complete documentation of the methodology and assumptions used to develop the projected utilization; | Choose |
|  | c.) Substantiation of any proposed increase in rates or fees via a thorough analysis of activities and costs covered by those rates or fees; | Choose |
|  | d.) Explanations for any unusual trend results (high/low relative to the market). | Choose |
|  | A report summarizing the outcomes of the Offeror's Quality Management initiatives (as detailed in the Quality Assurance section below) for the prior plan year and areas of focus for the upcoming plan year. | Choose |
|  | **Other reporting requirements include:** |  |
|  | Provide weekly reports of all scheduled supervisor-referred appointments for the previous work week by secure electronic transmission on Monday by 5:00 pm Local Time. This report shall be submitted to the State EAP Coordinator and Contract Manager. | Choose |
|  | Offeror will provide online access by approved Personnel to monthly, quarterly and annual aggregate utilization reports. The data used to prepare these reports will be de-identified and will include gender, relationship status, zip code, agency, previous contact with EAP and/or counseling, insurance information (Health Plan), employee type, time type, pay group, union information (including bargaining unit), eligibility status (employee, dep, household member), referral source (self, state employee, supervisor), presenting issues, type of Specialist/provider to which the caller was referred, setting (telephonic/chat/email/in-person), distance to in-person provider, number of sessions scheduled, number of sessions completed, number of sessions missed, number of sessions for ineligible participants, type of referral beyond EAP, satisfaction results. | Choose |
| **Implementation Schedule** | |  |
|  | Offeror agrees to comply with the implementation schedule as described in the RFP Section 2.3.7, Implementation Schedule, including an Operational Readiness Review. | Choose |
| **Payment Specifications** | |  |
|  | Offeror agrees to accept premium payments in accordance with the payment procedures described in RFP Section 3.3, PaymentTerms***.*** | Choose |
|  | Offeror agrees to accept payment processed through normal State transmittal process (i.e., transmittal sent to Annapolis, EFT transfer to Offeror.) (See Section 4.31 Non-Disclosure Agreement of the RFP document.) | Choose |
|  | Ensure that the EAP Counselor does not charge the Active Employee or the State any fees. Offeror agrees that the only compensation to be received by or on behalf of its organization in connection with this Plan shall be that which is paid directly by the State. | Choose |
| **Account Management/Customer Service** | |  |
|  | Upon request by the State, the Offeror agrees to change the designated account manager for any reason at any time. | Choose |
|  | Offeror will provide a dedicated (but not exclusive) account management team for the State. | Choose |
|  | Offeror will provide a succession plan upon request for the account management team. | Choose |
|  | Offeror will provide a dedicated (but not exclusive) customer service team for the State. | Choose |
|  | Offeror will provide a designated senior eligibility contact for the State. | Choose |
|  | Offeror will provide a designated senior IT/Systems contact for the State. | Choose |
|  | Offeror will provide a designated senior reporting contact for the State. | Choose |
|  | Offeror will provide a designated senior billing contact for the State. | Choose |
|  | Offeror will provide complete contact information for the contacts indicated in items CC-48 through CC-55 above. | Choose |
|  | Acknowledge and respond to the applicable State representative within 24 hours of a verbal or email request. | Choose |
|  | Offeror will attend quarterly calls/meetings to discuss plan administration and any other concerns the State may have. Meetings will be set with the State in advance on a designated day each quarter. Meeting reporting content will include but not be limited to financial performance, performance guarantee results, utilization, customer services issues, book of business services and financial comparisons, process, improvements, upcoming and revised regulations to federal, state, and local law Offeror will attend meetings in accordance with PG-3 on **"Attachment T-9: Performance Guarantees.”** | Choose |
|  | In addition to providing co-branded EAP brochures, the Offeror agrees to review two drafts each year of the plan description contained in the State's Open Enrollment booklet and / or the State’s online Benefit Guide, upon request by the State, and at no extra cost. | Choose |
|  | Offeror agrees to meet or exceed established performance standards as described in **"Attachment T-9: Performance Guarantees.”** | Choose |
| **Core EAP Services** | |  |
|  | Promote and provide a (new) self-referred Employee Assistance Program benefit to be used as a confidential resource by eligible employees who wish to access up to five prepaid session hours of assessment and counseling (in-person or via remote access) by a licensed professional in an appropriate specialty to help address short-term behavioral and emotional health needs on a self-referral basis. Services include confirming eligibility, assessment, counseling, and referral, as well as follow up on contact with resources beyond the EAP if recommended. | Choose |
|  | As a new offering to participants on a self-referred basis, provide an EAP assessment and short-term counseling, if appropriate, by a specialist for up to five sessions per episode per plan year. Provide referrals to other state benefit programs, health plan resources, and community resources available to employees. | Choose |
|  | Administer the current Supervisor referral EAP program to provide up to five (currently three) prepaid hours of assessment, short-term counseling, and potential referral to services within the health plan by a licensed professional in an appropriate specialty to State employees experiencing adverse conditions in their personal lives that may negatively impact (or have negatively impacted) their job performance on a Supervisor-referred basis. | Choose |
|  | Schedule all supervisor-referred EAP appointments within 48 hours of receipt of referral via email from the State EAP Coordinator. | Choose |
|  | Ensure all appointments for supervisor referrals occur within 15 calendar days after the email submission of the EAP Supervisory Referral Form by the State EAP Coordinator. | Choose |
|  | Accept only Supervisor referrals made by the State EAP Coordinator, Contract Manager, or designee. Should the Offeror receive a call requesting a referral to counseling by someone other than the State EAP Coordinator, Contract Manager, or designee, the Offeror shall immediately contact the State EAP Coordinator notifying him/her of the request. | Choose |
|  | For supervisor-referred EAP services, provide at least 24 hours advance notice of appointment cancellation via email to the Active Employee, State EAP Coordinator, and Contract Manager. | Choose |
|  | For supervisor-referred EAP services, within three (3) business days of the missed appointment(s), notify the State EAP Coordinator and the respective Agency EAP Representatives of all Active Employees: who fail to (i) contact the EAP provider at least three (3) business days before the EAP counseling session, and (ii) appear for initial assessment appointments | Choose |
|  | Provide Critical Incident Response and Debriefing services to Active Employees within 48 hours of the Authorization date, or the date specified in the Authorization, if later. | Choose |
| **Provider Contracting/ Relations** | |  |
|  | Ensure the licensure of all its EAP Counselors to whom employee referrals are made. Provide line listing report [to include the EAP Counselors name, office address, email address, county, phone number, expiration date (if applicable), specialty (if applicable), remote access capability, effective date of network participation, and type of professional license, with supporting licensure of each EAP Counselor. This report shall be submitted to the Contract Manager to include licensures no later than ten (10) Business Days of NTP and annually thereafter on the contract anniversary date. | Choose |
|  | Acknowledge its continuing obligation to provide proof of current licenses to the Contract Manager prior to any new network EAP Counselor Contractor Personnel providing service on the State of Maryland account. | Choose |
|  | Provide in-person or remote access to a provider network, including a sufficient number of licensed professional EAP Counselors in appropriate locations, to deliver services. | Choose |
|  | The Offeror(s) agrees to the Responsibilities and Tasks as described in Section 2.3. | Choose |
|  | The Offeror(s) agrees to the **Contract Initiation Requirements** as defined in Section 3.1 | Choose |
|  | The Offeror(s) agrees to the **End of Contract Transition** as defined in Section 3.2 | Choose |
|  | The Offeror(s) agrees to the **Invoicing** as defined in Section 3.3 | Choose |
|  | The Offeror(s) agrees to the **Liquidated Damages** as defined in Section 3.4 | Choose |
|  | The Offeror(s) agrees to the **Disaster Recovery and Data** as defined in Section 3.5 | Choose |
|  | The Offeror(s) agrees to the **Insurance Requirements** as defined in Section 3.6 | Choose |
|  | The Offeror(s) agrees to the **Security Requirements** as defined in Section 3.7 | Choose |
|  | The Offeror(s) agrees to the **Problem Escalation Procedure** as defined in Section 3.8 | Choose |
|  | The Offeror(s) agrees to the **SOC 2 Type 2 Audit Report** as defined in Section 3.9 | Choose |
|  | The Offeror(s) agrees to the **Experience and Personnel** as defined in Section 3.10 | Choose |
|  | The Offeror(s) agrees to the **Substitution of Personnel** as defined in Section 3.11 | Choose |
|  | The Offeror(s) agrees to the **No-Cost Extensions** as defined in Section 3.14 | Choose |

REMINDER: All "No" responses must be addressed in **"Attachment T-2: Explanations and Deviations.”**

# Attachment T-7: Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please provide a response to each of the following questions. Items in the response column with the words **"Choose an item**,**”** contain a drop down list of options. Please select a response from those options as applicable. **NOTE: Answers that are not concise and directly relevant may receive a lower score.**

| **Question** | | **Offeror's Response** |
| --- | --- | --- |
| **GENERAL** | |  |
|  | Briefly describe your company's experience in providing EAP benefits. | Click here to enter text. |
|  | How long have you offered EAP programs to Maryland based clients? | Click here to enter text. |
|  | Is your organization compliant with all applicable HIPAA administrative simplification rules? | Choose an item. |
|  | a.) Will your organization be involved in any acquisitions or mergers within the next 12 months? | Choose an item. |
|  | If yes, please describe. | Click here to enter text. |
|  | b) Has your organization been involved in any recent acquisitions or mergers? | Choose an item. |
|  | ● Within the last 12 months? | Choose an item. |
|  | ● 1-2 years ago? | Choose an item. |
|  | ● 2-5 years ago? | Choose an item. |
|  | ● None in the last five years | Choose an item. |
|  | If yes, please describe. | Click here to enter text. |
|  | Confirm that your organization has Errors and Omissions Insurance and Commercial General Liability Insurance. | Please submit a copy of your certificate(s) of insurance indicating coverage limits and label as **"Response Attachment T-7: Certificates of Insurance.”** |
|  | ● E & O | Choose an item. |
|  | ● Commercial General Liability | Choose an item. |
|  | On average, by what percentage have premium rates for your EAP programs increased over the last three years? | Click here to enter text. |
|  | Is your EAP program accredited and does it follow the guidelines of the Employee Assistance Professionals Association (EAPA)? | Click here to enter text. |
|  | Provide a list of other pertinent professional accreditations or distinctions | Click here to enter text. |
|  | What is your average EAP utilization rate across all active accounts, as defined as the percentage of employees and families members where one or more members are seen by an EAP clinician one or more times? | Click here to enter text. |
| **NETWORK MANAGEMENT** | |  |
|  | Please provide an electronic copy of your most recent provider directory by specialty, indicating state(s) in which the provider is licensed and if the provider is accepting new patients for face-to-face counseling. Additionally, provide a comprehensive list of virtual access providers by specialty and the state(s) in which they are licensed. | Please submit response and label as **"Response Attachment T‑1: Provider Directory.”** |
|  | For your proposed network for the State of Maryland, what percentage of participating providers in your proposed network were not accepting new patients during the following calendar years? | Click here to enter text. |
| **Calendar Year 2018** | |
| ● Clinical Psychologist | Click here to enter text. |
| ● Licensed Clinical Social Worker | Click here to enter text. |
| ● Family Therapist | Click here to enter text. |
| ● Psychiatrist | Click here to enter text. |
| **Calendar Year 2019** | |
| ● Clinical Psychologist | Click here to enter text. |
| ● Licensed Clinical Social Worker | Click here to enter text. |
| ● Family Therapist | Click here to enter text. |
| ● Psychiatrist | Click here to enter text. |
|  | Please provide a network development plans relevant to this Request for Proposal. Please include details such as number, locations, and specialty of providers being recruited and target completion dates. | Click here to enter text. |
|  | Describe your current network of EAP affiliates and other contracted providers (e.g. remote counselor networks, Financial and Legal services) and the method used to develop those networks. | Click here to enter text. |
|  | List the criteria for EAP clinicians to be included in your network. Describe how credentials are verified. | Click here to enter text. |
|  | How would you identify and refer to the appropriate specialist within the State Health Insurance provider networks for continued care to treat a chronic issue? | Click here to enter text. |
|  | List all active EAP affiliates providing core-counseling services. How long have these contractual relationships existed? If an employee preferred to receive EAP counseling in another state or remotely, for example, how would that member access the affiliate? | Click here to enter text. |
|  | List the office locations that your EAP (or parent organization) owns and operates in Maryland and in other locations. List the locations of any network affiliates. | Click here to enter text. |
|  | Do you or an affiliate have experience matching marginalized communities with compatible licensed therapists based on their unique experiences and identities across race, gender identity, class, sexuality, ethnicity, and ability? | Choose an item. |
|  | If yes, please describe. | Click here to enter text. |
|  | Do you conduct provider satisfaction surveys? | Choose an item. |
|  | If yes, please provide a sample survey and copy of the results of your latest survey. | Please submit response and label as **"Response Attachment T‑7: Provider Satisfaction Survey.”** |
|  | If yes, what percentage of providers are currently satisfied? | Click here to enter text. |
| **INTAKE, 24-HOUR ACCESS, AND INTERVENTION** | |  |
|  | Please describe your process for confirming eligibility. Please include verification process and procedures for employees, dependents, and household members. | Click here to enter text. |
|  | Provide a description of the intake process and applicable phone tree chart and script. Describe variations for emergency (life-threatening), urgent and routine responses. | Click here to enter text. |
|  | Describe what would happen if one of our employees accessed the EAP at 3:00 a.m. with symptoms of suicidal ideation requesting to meet with an EAP clinician immediately. | Click here to enter text. |
|  | Under what circumstances would you provide telephonic or remote counseling in lieu of in-person services? Is this based solely on client preference? | Click here to enter text. |
| **CLINICAL ASSESSMENT AND SHORT-TERM COUNSELING** | |  |
|  | Describe how clinician appointments are scheduled and the timeframes. Include in your answer the process that is used to schedule an employee or family members for face-to-face, telephonic, and web- based assessment when a specific preference is expressed (e.g., request for a clinician of a specific gender, age, ethnicity, religious affiliation, etc.). | Click here to enter text. |
|  | What personal and behavioral health issues do your EAP clinicians handle? What other personal work/life services do you offer (e.g., relocation, financial/credit, career, mediation, legal). Is this provided online, by a professional, both? | Click here to enter text. |
|  | What percentage of EAP cases is handled within your EAP, and what percentage is given referrals beyond the EAP for long-term counseling or specialized care? What is your average number of sessions provided per case In a 5-session model of care? | Click here to enter text. |
|  | Could you identify first responder cases at intake and provide expertise? | Click here to enter text. |
| **SYSTEMS** | |  |
|  | Are there any electronic system changes planned for the contract term? | Choose an item. |
|  | If yes, please describe. | Click here to enter text. |
|  | Is there a contingency plan(s), procedure, and system in place to provide backup service in the event of strike, natural disaster or backlog? | Choose an item. |
|  | If yes, please describe. | Click here to enter text. |
|  | How often are the systems backup and disaster recovery systems tested? | Click here to enter text. |
|  | When were the systems last tested and what were the results? | Click here to enter text. |
|  | What system down time have you experienced during the most recent 12 months? | Click here to enter text. |
|  | How long are records maintained? | Click here to enter text. |
|  | How quickly can the State's services be reinstated in the event of permanent disaster to both the hardware and software? | Click here to enter text. |
| **PROFESSIONAL QUALIFICATIONS AND REFERRAL COORDINATION** | |  |
|  | What are the qualifications of staff at intake, for core counseling, and for EAP specialists addressing first responder issues? | Click here to enter text. |
|  | How do you determine that a referral beyond the EAP is indicated? What is the EAP clinician’s role in facilitating appropriate clinical referrals? How would you match clients with resources within the State’s employee benefit programs and community-at-large? | Click here to enter text. |
|  | If a participant is comfortable with an EAP Specialist, can they return to them for a new episode or ongoing support? Explain tracking of unique episodes in one year. | Click here to enter text. |
| **WORKPLACE ASSISTANCE** | | |
|  | Describe your ability to offer consultation to supervisors attempting to manage employees with job performance problems caused by unresolved personal or behavioral/medical problems. | Click here to enter text. |
|  | Do you offer training and educational materials to promote a recovery-friendly workplace? Could you offer eligible families substance use education webinars or workshops through the EAP? | Click here to enter text. |
|  | Do your network providers within the State of Maryland have experience with Medication Assisted Treatment? How would you refer a client to MAT resources within the Health Plan network? | Click here to enter text. |
|  | Describe your training program for teaching managers/supervisors on how to promote the self-referred EAP benefit and conduct job performance-based EAP referrals for marginally performing employees. | Click here to enter text. |
|  | Do you offer workshops that help prevent or mitigate the occurrence of behavioral and organizational health problems? If so, list examples of workshops you can provide as part of the core EAP offering. | Click here to enter text. |
|  | What organizational consultation services can you provide which fall within the role and expertise of an EAP and support the human resource development efforts of companies? Does this consultation include expertise in helping to design policies and programs to address substance abuse, harassment, or aggression in the workplace? | Click here to enter text. |
|  | Indicate your experience and services for handling critical incidents, trauma in the workplace, periods of public unrest. | Click here to enter text. |
|  | Indicate your experience providing training and program development. | Click here to enter text. |
| **QUALITY AND EVALUATION** | |  |
|  | In order to ensure members receive consistent high-quality service for remote access sessions, have you adopted the American Telemedicine Association (ATA) Practice Guidelines for Videoconferencing-based Telemental Health? If not adopted, what equivalent standards do you follow? | Click here to enter text. |
|  | Specify EAP related quality indicators that your program is capable of measuring and monitoring. Do you have a formal quality management structure and program? If yes, describe. | Click here to enter text. |
|  | Provide any value assessment data your program has analyzed for other groups and describe process for ensuring the integrity of the data. How would you work with the State to measure the effectiveness of your services? | Click here to enter text. |
|  | Identify external audits (including SOC 2 Type II) that were recently conducted on your EAP services and share any findings that led to implementing changes. | Click here to enter text. |
|  | How do you typically evaluate the success of your EAP? | Click here to enter text. |
| **OTHER SERVICES** | | |
|  | Describe the legal consultation benefits offered with the EAP. | Click here to enter text. |
|  | Describe the financial consultation benefits offered with the EAP. | Click here to enter text. |
|  | Does the EAP provide access to advocates for clients in recovery? Clients experiencing domestic violence? Clients with PTSD? Parents of autistic children? Clients with eating disorders? Other chronic conditions? How do you link to resources within the local community of the client? How do you ensure successful matches of clients to resources beyond the EAP benefit, and provide any client follow up? | Click here to enter text. |
| **IMPLEMENTATION PROGRAM / TRANSITION** | | |
|  | Please discuss your procedures and processes for handling the employee communications regarding the EAP changes during the initial transition period. | Click here to enter text. |
|  | **Implementation Plan** |  |
|  | Please provide the Name and Title of the person with overall responsibility for planning, supervising and implementing the program for the State. | Click here to enter text. |
|  | What other duties, if any, will this person have during implementation? Please include the number and size of other accounts for which this person will be responsible during the same time period. | Click here to enter text. |
|  | What percentage of this person's time will be devoted to the State during the implementation process? | Click here to enter text. |
|  | Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for implementing the State of Maryland account. | Please submit organization chart and label as "**Response Attachment T-7: Implementation Team Organizational Chart.”** |
|  | Provide a detailed implementation plan that clearly demonstrates the Offeror's ability to meet the State's requirements to have a fully functioning program in place and operable on July 1, 2021. This implementation plan should include a list of specific implementation tasks/transition protocols and a time-table for initiation and completion of such tasks, beginning with the contract award and continuing through the effective date of operation (July1, 2021). Included in the Plan, the Offeror shall provide for a comprehensive operational readiness review (pre-implementation review by the state), at least 60 days prior to the go-live date, i.e. by April 1, 2021. Such review by the state, may include, but not be limited to, an onsite review of the Bidder’s operational readiness for all services required in this Agreement (e.g., member services, training, and website development).  All IT processes including but not limited to the website, mobile apps, electronic provider directory, and call center automated voice response system will be fully tested prior to this readiness review 60 days prior to go-live, with corrective action plans already initiated.  The implementation plan should be specific about requirements for information transfer as well as any services or assistance required from the State during implementation. The implementation plan should also specifically identify those individuals, by area of expertise, responsible for key implementation activities and clearly identify their roles. | Please submit the Offeror's description of account management support and label as "**Response Attachment T-7: Implementation Plan.”** |
|  | Do you anticipate any major transition issues during implementation? | Choose an item. |
|  | If yes, please describe. | Click here to enter text. |
| **ACCOUNT MANAGEMENT AND COMMUNICATION** | | |
|  | ● Please provide the Name and Title of the person with overall responsibility for planning, supervising and performing account services for the State. | Click here to enter text. |
|  | ● What other duties, if any, does this person have? Please include the number and size of other accounts for which this person is responsible. | Click here to enter text. |
|  | ● What percentage of this person's time will be devoted to the State? | Click here to enter text. |
|  | ● Please provide an organizational chart identifying the names, functions and reporting relationships of key people directly responsible for account support services to the State. It should also document how many account executives and group services representatives will work full-time on the State's account and how many will work part-time on the State's account. | Please submit organization chart and label as "**Response Attachment T-7: Account Management Team Organizational Chart.”** |
|  | ● Describe account management support, including the mechanisms and processes in place to allow State personnel to communicate with account service representatives, hours of operation; types of inquiries that can be handled by account service representatives; and a brief explanation of information available on-line. The State requires identification of an account services manager to respond to inquiries and problems, and a description of how the Offeror's customer service and other support staff will respond to subscriber or client inquiries and problems. The management plan should include the names, resumes and description of functions and responsibilities for all supervisors and managers that will provide services to the State with respect to this contract. | Please submit the Offeror's description of account management support and label as "**Response Attachment T-7: Account Management Support.”** |
|  | Given that the State will be offering a new self-referral EAP benefit, what communication resources are included in your proposal for the initial benefit launch in Year 1? Annually, thereafter? | Click here to enter text. |
|  | What do you see as the responsibilities of the State with regard to the launch campaign for the new self-referred EAP benefit? | Click here to enter text. |
|  | Do you have a dedicated website for the EAP? If so, please provide a link to a demo with sample login information. | Choose an item. |
|  | Describe content and ability to co-brand with the State. As part of the core premium, can the website be customized by the State and used to distribute information. | Click here to enter text. |
|  | Provide examples of your ongoing EAP promotional materials and employee outreach. | Click here to enter text. |
|  | Do you offer mobile apps and push technology/messaging and other electronic means for periodic outreach? How would you regularly promote cognitive health and other resources available through the EAP on a customized, individual basis? | Click here to enter text. |
|  | Describe outreach, education, and virtual session features which address support during the current COVID 19 pandemic. What sources are used to keep information and processes current as circumstances change? | Click here to enter text. |
|  |  |  |

REMINDER: All "No" responses must be addressed in **"Attachment T-2: Explanations and Deviations.”**

# Attachment T-8a: Subcontractor Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"Attachment T-8: Subcontractor Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

**Subcontractor's Name (if applicable)**  Click here to enter text.

**Subcontractor's MDOT Number (if applicable)**  Click here to enter text.

| **Question** | | **Offeror's Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: |  |
|  | ● Organization's legal name | Click here to enter text. |
|  | ● State of incorporation | Click here to enter text. |
|  | ● Date of incorporation | Click here to enter text. |
|  | ● Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: |  |
|  | ● Corporate/ Firm Management Office | Click here to enter text. |
|  | ● Customer Service Office | Click here to enter text. |
|  | ● Provider Service Office | Click here to enter text. |
|  | ● Account Management/ Client Services Office | Click here to enter text. |
|  | ● Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |
|  |  |  |

# Attachment T-8b: Subcontractor Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"Attachment T-8: Subcontractor Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

**Subcontractor's Name (if applicable)**  Click here to enter text.

**Subcontractor's MDOT Number (if applicable)**  Click here to enter text.

| **Question** | | **Offeror's Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: |  |
|  | ● Organization's legal name | Click here to enter text. |
|  | ● State of incorporation | Click here to enter text. |
|  | ● Date of incorporation | Click here to enter text. |
|  | ● Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: |  |
|  | ● Corporate/ Firm Management Office | Click here to enter text. |
|  | ● Customer Service Office | Click here to enter text. |
|  | ● Provider Service Office | Click here to enter text. |
|  | ● Account Management/ Client Services Office | Click here to enter text. |
|  | ● Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

# Attachment T-8c: Subcontractor Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"Attachment T-8: Subcontractor Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

**Subcontractor's Name (if applicable)**  Click here to enter text.

**Subcontractor's MDOT Number (if applicable)**  Click here to enter text.

| **Question** | | **Offeror's Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: |  |
|  | ● Organization's legal name | Click here to enter text. |
|  | ● State of incorporation | Click here to enter text. |
|  | ● Date of incorporation | Click here to enter text. |
|  | ● Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: |  |
|  | ● Corporate/ Firm Management Office | Click here to enter text. |
|  | ● Customer Service Office | Click here to enter text. |
|  | ● Provider Service Office | Click here to enter text. |
|  | ● Account Management/ Client Services Office | Click here to enter text. |
|  | ● Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

# Attachment T-8d: Subcontractor Questionnaire

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Instructions:** Please complete one **"Attachment T-8: Subcontractor Questionnaire"** for each subcontractor that the Offeror proposes to have perform any of the required functions under this contract. Clearly indicate if a proposed subcontractor is an MBE certified by the State of Maryland, if responding for a MBE subcontractor.

**Subcontractor's Name (if applicable)**  Click here to enter text.

**Subcontractor's MDOT Number (if applicable)**  Click here to enter text.

| **Question** | | **Offeror's Response** |
| --- | --- | --- |
|
|  |
| SQ-1 | Provide a brief summary of the history of the subcontractor's company and information about the growth of the organization on a national level and within the State of Maryland. | Click here to enter text. |
| SQ-2 | Specifically what roles will the subcontractor have in the performance of the Contract? | Click here to enter text. |
| SQ-3 | Explain the process for monitoring the performance of the subcontractor and measuring the quality of their results. | Click here to enter text. |
|  | List any services for which the subcontractor will be solely responsible and describe how the subcontractor will be monitored and managed. | Click here to enter text. |
| SQ-4 | Provide the following information about the subcontractor's company: |  |
|  | ● Organization's legal name | Click here to enter text. |
|  | ● State of incorporation | Click here to enter text. |
|  | ● Date of incorporation | Click here to enter text. |
|  | ● Insurance certification from the Maryland Insurance Administration | Click here to enter text. |
| SQ-5 | Describe any significant government action or litigation taken or pending against the subcontractor's company or any entities of the subcontractor's company during the most recent five (5) years. | Click here to enter text. |
| SQ-6 | Provide the addresses, including city and state, for the subcontractor's following activities: |  |
|  | ● Corporate/ Firm Management Office | Click here to enter text. |
|  | ● Customer Service Office | Click here to enter text. |
|  | ● Provider Service Office | Click here to enter text. |
|  | ● Account Management/ Client Services Office | Click here to enter text. |
|  | ● Technical Support Office | Click here to enter text. |
| SQ-7 | Does the subcontractor have contractual relationships with third party administrators/ organizations in which the subcontractor pays service fees or other fees that you (the Offeror) are directly or indirectly charged for? If so, identify the outside organizations that receive these service fees and explain the nature of the relationship. | Click here to enter text. |
| SQ-8 | What fidelity and surety insurance, general liability and errors and omissions or bond coverage does the subcontractor carry to protect its clients? Describe the type and amount of each coverage that would protect this plan. Please furnish a copy of all such policies for review. | Click here to enter text. |

# Attachment T-9: Performance Guarantees

**Representations made by the Offeror in this proposal become contractual obligations that must be met during the contract term.**

**Offeror will report results on all performance measurements quarterly per the requirements of the Report Card and separately for each plan type. Performance results will also be audited annually by the State's contract auditor.**

**Note:** It is critical to the success of the State's programs that services be maintained in accordance with the schedules agreed upon by the State. It is also critical to the success of the State's programs that the Contractor operates in an extremely reliable manner. It would be impracticable and extremely difficult to fix the actual damage sustained by the State in the event of delays or failures in claims administration, service, reporting, and attendance of Contractor personnel on scheduled work and provision of services to the citizens of the State. The State and the Offeror, therefore, presume that in the event of certain delay(s) or failure(s), the amount of damage which will be sustained from the delay or failure will be the amount set forth below, and the Offeror agrees that in the event of any such failure of performance, the Offeror shall pay such amount as liquidated damages and not as a penalty. The State, at its option for amount due the State as liquidated damages, may deduct such from any money payable to the Offeror or may bill the Offeror as a separate item.

**NOTE:** Items in the response column with the words **"Willing to Comply”** contain a drop down list of options including Yes or No. Please select a response from those options as applicable. All "No" responses must be addressed in **"Attachment T-2: Explanations and Deviations.”**

|  | **Performance Indicator** | **Standard/Goal** | **Reporting Measurement**  (subject to audit by State and/or contract auditors) | **Liquidated Damages\*** | **Willing to Comply** |
| --- | --- | --- | --- | --- | --- |
|  | Telephone Call Availability  Measurements must be State-specific or for only the service center handling the State account. | Average speed of answer **by a live service representative (with knowledge of State of Maryland account) is** 30 seconds or less. The representative must be able to address the member's issue/question.  Time over which standard is measured: Quarter | Plan Performance Measurement Report Card and supporting data (to be submitted by the Offeror).  Frequency of report: Quarterly | $1,500 for each second over 30. | Choose |
|  | Telephone Call Abandonment Rate  Measurements must be State-specific or for only the service center handling the State account. | Abandonment rate of less than 3%.  Time over which standard is measured: Quarter | Report Card and supporting data (to be submitted by the Offeror).  Frequency of report: Quarterly | $1,500 per percentage point over 3% per reporting period | Choose |
|  | Offeror attendance at State-sponsored annual Open Enrollment meetings and wellness meetings | Attendance by plan representative(s) trained on State of Maryland plan benefits at 100% of meetings requested by the State, for 100% of the meeting’s duration.  Representative must arrive at least 15 minutes in advance and be fully prepared including having their table and materials set up prior to meeting start time. Display must be organized and include appropriate covering of table. Representative must have detailed plan knowledge, interact with members, and exhibit professional appearance and behavior. | Sign-in sheets at Open Enrollment and Wellness event meetings  Frequency of report: Annually | $2,500 per scheduled meeting not attended or if timeliness and preparedness requirements are not met | Choose |
|  | Implementation | All administrative functions completed for a successful program implementation as of the effective date of the contract.  Overall rating of 4.5 or greater on a scale of 1 to 5 must be received. | One time measurement after the first quarter of the initial plan year by State of Maryland DBM staff using implementation evaluation | $50,000. Payment due within 30 days of invoice. | Choose |
| 1. 1 | Account Management | Plan representatives will return all messages received from the State (whether voice mail, e-mail or other communication method) promptly. Messages sent before 12 Noon will be replied to the same day. Messages received after 12 Noon will be replied to by 12 Noon of the following business day.  Time over which standard is measured: Quarter | Report Card - Contractor to maintain log for review by the State's contract auditor.  Frequency of report: Quarterly | $150 for each delayed response. | Choose |
|  | Delivery of Quarterly Plan Performance Measurement Report Card to the State | Delivery to the State by 6:00 pm on the following dates\*\*: | Date-stamp of receipt by the State.  Frequency of report: Quarterly | $1,500 for each week, or fraction thereof that Report Card is not received. | Choose |
|  | First Quarter  (Jul – Sep) **Due: December 15th** |
|  | Second Quarter  (Oct – Dec) **Due: March 15th** |
|  | Third Quarter  (Jan – Mar) **Due: June 15th** |
|  | Fourth Quarter  (Apr – Jun) **Due: September 15th** |
|  | Delivery of Quarterly Utilization Reports to the State | Delivery to the State by 6:00 pm on the following dates\*\*: | Documentation of receipt by State, i.e., date-stamp of mailing package for data information and verification of completeness. (All required fields must be filled in correctly.)  Frequency of report: Quarterly | $1,500 for each week, or fraction thereof that Quarterly Report is not received. | Choose |
| First Quarter  (Jul – Sep) **Due: December 15th** |
| Second Quarter  (Oct – Dec) **Due: March 15th** |
| Third Quarter  (Jan – Mar) **Due: June 15th** |
| Fourth Quarter  (Apr – Jun) **Due: September 15th** |
|  | Delivery of Rate Renewal Reports | Delivery to the State and to the State's actuarial consultant of reports required for annual rate renewal process by 6:00 PM May 31st of each contract year for the next contract year. At a minimum, the renewal reports must include (but not be limited to) the following\*\*: | Date-stamp of receipt by the State and verification of completeness of required documentation.  Frequency of report: Annually | $3,000 for each week, or fraction thereof, that the rate renewal reports are not received or are incomplete. | Choose |
| ● projection of utilization for renewal year | Choose |
| ● complete documentation of the methodology and assumptions utilized to develop the projected utilization | Choose |
| ● substantiation of any proposed increase in fixed costs via a thorough analysis of activities and costs covered by those fees | Choose |
|  | Timely Critical Incident Stress Management Services | 100% of the State’s requests for CISM are provided within 48 hours of the Authorization date or the extension date approved in writing by the DBM Employee Relations Officer or Contract Manager. | Report Card and State verification.  Frequency of report: Quarterly | $500 for each appointment not meeting criteria. | Choose |
| **SELF REFERRALS** | | | | |  |
|  | Timeliness of Scheduling appointments with counselors/specialists | 95% of urgent calls within 48 hours; 100% of routine care calls within 6 business days. | Report Card and supporting documentation to be submitted by the Offeror.  Frequency of report: Quarterly | $5,000 if performance is less than standards. | Choose |
|  | Participant Satisfaction | A 90% or higher member satisfaction rate, including 85% or higher percentage of respondents, on average, indicating a grade of satisfied or higher to survey question: “The treatment I received from my clinician(s) helped me better manage my problems.”  Time over which standard is measured: Annual | Survey results of the State’s annual Customer Satisfaction Survey.  Frequency of report: Annually | $5,000 if performance is less than standards. | Choose |
|  | Net Promoter Score | A 50% or higher percentage of respondents, on average, indicating yes to survey question: “Overall, would you recommend the EAP services?” | Company-wide independent reporting.  Frequency of report: Annually | $2,500 of PEPM fees if performance is less than standards. | Choose |
| **SUPERVISORY REFERRALS** | | | | |  |
|  | Timely EAP Services (Supervisory Referral) | 99% of supervisory referrals are seen within 15 calendar days after the e-mail submission of an EAP Supervisory Form by the State EAP Coordinator to the Contractor Account Executive | Report Card and supporting documentation to be submitted by the Offeror.  Frequency of report: Quarterly | $1,000 for each percent under 99% for the quarter under review. | Choose |
|  | Timely EAP Services (Supervisory Referral) | 99% of initial supervisor referred appointments are scheduled within 48 hours from the e-mail submission date of the EAP Supervisory Referral Form by the State EAP Coordinator to the Contractor Account Executive. | Report Card and supporting documentation to be submitted by the Offeror.  Frequency of report: Quarterly | $1,000 for each percent under 100% for the quarter under review. | Choose |
|  | Counseling Locations for Supervisor-Referrals | 100% of EAP Assessment appointments are scheduled within 30 miles of a referred Active Employee’s workplace or home address. | Report Card and State verification.  Frequency of report: Quarterly | $100 for each appointment not meeting criteria. | Choose |

\* Determination of results and any applicable damages will be conducted by the State's contract auditor and be based on actual administrative fees included in the total premium rates.

\*\* If due date falls on a state / contractor holiday or a weekend, Report Card and reports are due next business day.

REMINDER: All "No" responses must be addressed in **“Attachment T-2: Explanations and Deviations.”**