October 25, 2005

Behavioral Health and EAP Benefit Administration Services
RFP # F10R6200070

Questions Set #2.

11. What rates has the State paid for BH and EAP services over the past five years? Please express in terms of Per Employee Per Month (PEPM) values.

Answer: At this point, this information is not disclosable.

12. Please describe how the State's current EAP and BH services are integrated.

Answer: EAP operates independently, as far as the referral process as described in the RFP. However, the EAP professional may recommend that the State employee seek additional services from a mental health practitioner. The BH vendor would provide these services for those enrolled in a POS or PPO plan (in accordance with the BH plan design and cost-sharing provisions). However, if the employee is enrolled in an HMO, the employee must go back to the HMO PCP and obtain BH services through the HMO.

Also, the BH vendor provides BH services for all enrollees in a PPO or POS plan, including Actives, Satellites, Direct Pays, and Retirees. The EAP is only for Active Employees, and includes all active employees, regardless of any medical plan enrollment.

13. Who is the State's current disease management vendor?

Answer: The State currently does not have a disease management vendor. The State is requesting by this RFP that if the State chooses to procure disease management services in the future, the selected offeror will agree to cooperate and provide data to the disease management vendor.

14. How much is the fee to support operation of eMaryland Marketplace?

Answer: The eMaryland Marketplace fee for this procurement is $7,500.

15. Regarding the State's BH utilization reports, please confirm that the monthly claims data represented in these exhibits are irrespective of the claims incurred date. Also, what services are included under ANS?

Answer: The monthly paid claims are the claims paid regardless of the incurred date (i.e. date of service). ANS refers to ancillary services and was only used through 2003. Ancillary services are now included under the Outpatient category.

16. Please provide the following historical EAP information:

a. Total number of employees who accessed EAP services (i.e., with at least one face-to-face visit) in 2003, 2004 and YTD 2005

b. Total number of EAP visits in 2003, 2004 and YTD 2005

c. Total number of employees who were eligible for EAP services in 2003, 2004 and YTD 2005

Answer: For a and b above, see the Attached Adobe file. For c above: The total number of authorized positions in the State of Maryland FY 2006 Budget Book for fiscal year 2004 was 77,941 and 78,089 for FY 2005. These figures reflect total employees but it is highly unlikely that all will need an EAP service.

17. Will the Contractor provide the initial EAP assessment?

Answer: Yes, the Contractor provides the initial EAP assessment as part of the required services.

18. Please clarify whether the EAP pricing and annual fees are to be based on 70,000 active employees (Section 3.1.2), or on 88,417 active and retiree employees, as stated on Attachment M-4.

Answer: EAP pricing is part of the total administrative fee to be paid for mental health and EAP services. One monthly administrative fee will be paid for both services. EAP services will not be paid based on the number of State employees but the total administrative fee will be based on enrollment in the PPO and POS plans during the term of the contract. The 88,417 reflects employees, retirees, satellite employee and Direct Pay enrollees who were enrolled in a PPO or POS as of July 2005 and is not to be seen as a guaranteed number for enrollment. Individuals have the opportunity to change plans with each open enrollment.

19. Does the State expect the Contractor to provide home mailings to the State's participants? If so, who will be responsible for the costs of these mailings? What items are to be mailed? (Section 3.5.3 (3 and 5)).

Answer: The contractor is expected to assume part of the cost of the Open Enrollment mailing to all participants. This amount has averaged $13,000 to $15,000 each year. In addition, the contractor is expected to provide mailings as noted in the Compliance Checklist, including the HIPAA mailings (Notice of Privacy Practices to be mailed by the Contractor) and if a member requests a hard copy of the Summary of Coverage.

20. How is the State's EAP to be funded – fully insured or administrative services only (ASO)? (Section 3.5.4)

Answer: The administrative and claims costs for the EAP services must be built into the PEPM administrative fee charged for the BH plan. See question # 18 above.

The entire administrative fee paid by the State will be measured using BH plan enrollment, derived from the PPO and POS plan enrollment. Claims payments for EAP services (capped at the 3 hour of EAP treatment) must be made by the Contractor from the administrative fee paid. The Contractor may subcontract the EAP as a fully-insured component and pay premiums that are built into the monthly administrative fee paid by the State or may assume the risk of the EAP claims itself.

21. Please provide information/background about the State's current EAP model – how long has it been in place, what level of utilization has been achieved, is the State open to other models such as telephonic intake, etc.? (Section 3.5.4)

Answer: The current EAP model has been in place for approximately the past 5-6 years. The level of EAP utilization, according to our current minority sub-contractor, has averaged approximately 300 employee participants per year. The State is not open to other models at this time.

22. Will the audited financial statements requested by the State be made available to the public as part of the RFP process? (Section 4.4.3 and Attachment L-3, #17)

Answer: Please refer to RFP Section 1.19. The Maryland Public Information Act (State Government Article Sections 10-611 et. seq.) prohibits the Department from disclosing records to the extent those records are confidential, commercial information.

23. Please confirm that bidders are not expected to submit Attachments M-1, N-1, N-2, N-3 and N-4. Note that these attachments appear to consist solely of instructions and data to be used by vendors in preparing their RFP responses. (Section 4.5)

Answer: Confirmed. Offerors are not expected to submit Attachments M-1, N-1, N-2, N-3 and N-4.

24. Will the winning vendor be able to bill for administrative fees in advance or only in arrears? (Attachment A, Section 4.2)

Answer: See CC 100 & 101 in Attachment L-6. The State will pay the vendor as outlined in compliance checklist items 100 & 101. The selected offeror will not submit an invoice for administrative fees. The State will pay the selected offeror once a month based on enrollment in the PPO and POS plans. Administrative fees are not paid in advance. The payment is usually made towards the end of the month in which services are provided. For example, July's administrative fee payment will be based on estimated enrollment and should be received near the 27th of July.

25. Please clarify which Contractor personnel must be assigned to the State account for the term of the contract? Will the Contractor be permitted to reassign staff as needed? (Attachment A, Section 5)

Answer: The contractor must provide an Account Services Manager who must be on-site for the first 6 months, and then at a mutually agreed upon schedule, but at least one time per week. The Employee Benefits Division will provide the Account Services Manager with a private office. Staff can be reassigned, as long as the State agrees and accepts any staffing replacements and such staffing is compliant with the requirements of the RFP.

26. What, if any, termination rights will the Contractor have as part of the contract? (Attachment A, sections 14 and 15)

Answer: The contract terms referenced (Attachment A, Sections 14 and 15) are required by Maryland law. COMAR 21.07.01.11 and 21.07.01.12. There are no provisions granting a contractor termination rights.

27. Attachment L-6, CC-13. Will the State accept use of the Contractor's own satisfaction survey?

Answer: The State is requesting that the Contractor agree to assume the cost of a State specific survey conducted by the State or it's designee. The Contractor may be requested to participate in the distribution of the satisfaction survey but will not develop the satisfaction survey itself. The Contractor may continue its own internal satisfaction surveys with regard to the State's enrollment.

28. Attachment L-6, CC-88. When will monthly reports be due to the State?

Answer: As specified in CC-87, unless required differently by a performance guarantee, monthly reports should be submitted by the 10th business day of the month following the month being reported.

29. Attachment L-7, Q-7. Does this question pertain to the EAP or BH benefit?

Answer: This question pertains to both the EAP or BH benefit.

30. Attachment L-16. Will the State accept a timetable in Excel format instead of a written description of our proposed implementation plan?

Answer: Yes, the State will accept a timetable in Excel format instead of a written description of the proposed implementation plan.

31. Attachment M-7. For what licensure should the Contractor provide this information (e.g., M.D., Ph.D., master's-level)?

Answer: The Contractor should provide this information for all licensure (e.g., M.D., Ph.D., master's-level).

32. The RFP states that all pages of the proposal volumes should be consecutively page numbered. Should we include any attachments in our consecutive page numbering?

Answer: RFP attachments like L-1, L-2, etc., that the State is asking offerors to fill out, should be consecutively numbered. Attachments, such as Financial Statements, need not be included in your consecutive page numbering. However, they should be in a marked, separate Section. This Section should be identified in your Table of Contents and can be referred to in your Technical Proposal.

33. Is it acceptable to provide attachments in addition to those requested in the RFP?

Answer: Yes, however, they should be marked and they should be listed in the Table of Contents of your Technical Proposal. Offerors are encouraged to provide concise but complete proposals that fully inform the State of all aspects of the technical proposal.

34. Please provide current PEPM or fixed fee rate that the State is experiencing broken out by actives and retirees.

Answer: At this point, this information is not disclosable.

35. Just to verify, the State is requiring a composite rate for Actives and Retirees?

Answer: The administration fees in M-4 should be a composite rate for all groups covered by this RFP, to include actives, retirees, satellite account employee and direct pay enrollee. This administrative fee is the amount that will be paid for all groups enrolled in a PPO or POS plan. The estimated claims in M-5 should be provided as requested in the attachment.

36. Attachment L-6, Compliance Checklist CC-11: What is meant by "on-site" account manager? Will this person be expected to provide any clinical services?

Answer: The "on-site" account manager will provide the administrative services of an account manager, but not clinical services. This person will assist both the Office of Personnel Services and Benefits (EAP and BH benefits) as well as assist members with claims questions and other questions. The Account Manager is responsible for the smooth running of the account as required contractually.

37. Attachment L-3, VI, Administrative and Operational Issues, #2: Would the state prefer requested attachments/responses, such as the "Management reporting package" to be included in a separate exhibits section or included directly behind the tab, in which the question is asked, for the hard copies of the proposal?

Answer: The State would prefer having requested attachments in a separate exhibits section.

38. Attachment M-6 BH Book of Business Member Profile, Geographic Distribution of Profile Members table: In the "outside Maryland" row, would the State like for us to include our membership profile in the

additional Maryland counties not included in the table or our membership profile for the rest of the United States?

Answer: The table already includes all of the Maryland counties plus Baltimore City and the District of Columbia. The "Outside Maryland" row should include any location not shown in the rows above it.

39. Attachment M-6 Book of Business, Member Profile, Age Distribution table: When completing this table, should we include a break down of our membership in the counties specified in the Geographic Distribution of Profile Members table or for our entire book of business in the United States?

Answer: The Age/Sex Distribution chart should be based on the Maryland Counties plus Baltimore City and the District of Columbia.

40. RFP Section 4.5 Volume II-Financial Proposal: Should we return the historical enrollment and paid claims information (Attachment N1-N4) as part of our financial proposal to the state?

Answer: No. Do not return them.

41. Is the State willing to accept double sided pages for the hard copies submission of the proposal?

Answer: Either single-sided or double-sided pages for the hard copies submission of the proposal is acceptable.

42. Section 3.1.2 Employee Assistance Program (EAP): How do employees with drug/alcohol violations identify a substance abuse program to enroll in?

Answer: Each HMO member must go back to his or her respective PCP to secure covered services through the HMO. PPO and POS members must contact the BH contractor in order to secure such services through the BH plan. The EAP does not pay the cost of such substance abuse programs.

43. Section 3.1.2 Employee Assistance Program (EAP): Does the counseling contractor have any assess and refer involvement with substance abuse cases?

Answer: The counseling contractor only has assessment and referral involvement with substance abuse EAP-referrals and when EAP cases referred for mental health counseling result in a diagnosis of substance abuse during a routine EAP assessment. See questions #42 above as well.

44. Section 3.1.2 Employee Assistance Program (EAP): If an employee's drug/alcohol violation does not result in a diagnosis for which benefit-covered treatment is available, is the employee responsible for the cost of alternative treatment recommendations?

Answer: Yes, the employee is responsible for the cost of alternative treatment recommendations. See questions 42 and 43 above.

45. Section 3.1.2 Employee Assistance Program (EAP): For non-substance abuse violations is there any communication with the State EAP Coordinator other than notification of appointment time and notification if the appointment is not kept? Does the vendor EAP monitor continued compliance for these cases?

Answer: The State does not understand the term "non-substance abuse violations" and therefore, cannot answer the question. The communications required between the Contractor and the State's EAP Coordinator are outlined in the RFP.

46. Attachment L-6, Compliance Checklist CC-59: Please provide details about policies, amendments, contracts, required State filings, and development booklet/certificate formats that the state would expect the Offeror to preparation and filing of.

Answer: Any licensure or regulatory requirements that must be met by a self-funded/self-insured plan of the type described in the RFP must be met by the Contractor. At this time, the self-insured plan operated by the State for its employees is not regulated under ERISA or Maryland Insurance Administration regulations. If that status changes, the Contractor will be required to prepare and file all necessary documentation to maintain the compliance of the plan. However, the plan is designed to be compliant with Maryland insurance and mental health benefits mandates and the Contractor is required to monitor such mandates and administer the plan consistent with those requirements.

47. Attachment L-6, Compliance Checklist CC-39g: Please clarify if the State expects the Offeror to send the State's Notice of Privacy Practices to all

individuals enrolled in the health plan in compliance with 45 CFR §164.520, in addition to the Offeror's Notice of Privacy Practices to all individuals enrolled in the health plan in compliance with 45 CFR §164.520.

Answer: A Notice of Privacy Practices that explains the BH and EAP plan, and provides all information and complies with 45 CFR §164.520 must be sent by the Contractor to all enrollees in the BH plan. The State sends a general Notice of Privacy Practices as part of its annual open enrollment materials but does not provide any information specific to each medical plan offered by the State to its employees and retirees as part of that Notice.

48. Attachment M-7a and M-7b - 90806AH: AH is a modifier for Clinical Psychologist. Is the State requesting our rate for this code for only Clinical Psychologists and not a blended rate?

Answer: Please disregard the AH modifier and respond for 90806.

49. Attachment M-7a and M-7b - Code 90862: The definition listed is not pharmacologic management (this code actually appears on page 1, 2nd code down). The definition is for code is 90812. Perhaps this is a typo? Should we provide the blended rates for 90812?

Answer: Code 90862 is "Pharmacologic Management" and code 90812 is for "Individual psychotherapy, in an office or outpatient facility, approximately 45 to 50 minutes face to face with patient", which is the second to last code in the chart.

50. Attachment M-7a and M-7b - Code 90801AH: AH is a modifier for Clinical Psychologist. Is the State requesting our rate for this code for only Clinical Psychologists and not a blended rate?

Answer: Please disregard the AH modifier and respond for 90801.

51. Attachment M-7a and M-7b - 90806AJ: AJ is a modifier for Clinical Social Worker. Is the State requesting our rate for this code for only Clinical Social Workers and not a blended rate?

Answer: Please disregard the AH modifier and respond for 90806.

52. Attachment M-7a and M-7b - 90847AJ: AJ is a modifier for Clinical Social Worker. Is the State requesting our rate for this code for only Clinical Social Workers and not a blended rate?

Answer: Please disregard the AJ modifier and respond for 90847.

53. Attachment M-7a and M-7b - 90847AH: AH is a modifier for Clinical Psychologist. Is the State requesting our rate for this code for only Clinical Psychologists and not a blended rate?

Answer: Please disregard the AH modifier and respond for 90847.

54. In Attachment L-17, PG-1: Please clarify the difference in standard A and Standard B, both standards/goals appear to ask for "percent of telephone calls are answered by a live service representative (with knowledge of State of Maryland account) within 60 seconds. The representative must be able to address the member's issue/question".

Answer: Telephone systems have different measuring capabilities. The selected offeror will indicate which goal it will be able to measure. Standard A) How long did it take to answer 90% of calls? (for example – 90% of calls were answered by a live service representative (with knowledge of State of Maryland account) within 50 seconds would meet the standard while within 75 seconds would not). Standard B) How many calls were answered within 60 seconds? (for example – 85% of calls were answered by a live service representative (with knowledge of State of Maryland account) within 60 seconds would not meet the standard while 93% of calls would). The selected offeror must agree to either A or B

55. Attachment M-2, Financial Compliance Checklist, F-4: F-4 states that "Offeror agrees to accept payment of fees solely based on enrollment in the behavioral health component of the plan as payment of all services in the RFP". Although a paragraph on page 10 of the RFP indicates that members who elect PPO or POS plan medical coverage are automatically enrolled to receive mental health and substance abuse benefits coverage through the Behavioral Health plan, the statement above would imply that there might be a portion of the 88,417 PPO/POS members listed on page 10 of the RFP that may not have a behavioral health benefit. Please clarify.

Answer: Administrative fee payments are made based on those employees, retirees etc. for whom a PPO or POS deduction is taken. Anyone who enrolls in a PPO or POS plan will receive his/her mental health coverage through the selected vendor. The 88,417 were individuals enrolled in a PPO & POS plan as of July 2005 but is not a guarantee of any future enrollment. These individuals would have been eligible for mental health coverage through the current mental health provider as long as they had the proper medical premium deducted from their payroll check,

pension check or by "Direct Pay" payment. If no deduction is taken, no administrative fee will be paid.

56. Attachment M4, Admin Fees: Lines 1f and 1g refer to inclusion of the cost for "*vendor's share* of State-conducted member satisfaction surveys and *vendor's share* of State's annual open enrollment costs". Please state what constitutes the vendor's responsibilities for these activities and what constitutes the State's responsibilities for these activities.

Answer: For the member satisfaction survey refer to question #27 above. For Open Enrollment, the State develops a Benefits Booklet which has a description of all the benefits plans, and include plan phone numbers, website addresses, etc. This Benefits booklet is distributed to all active employees, Satellite Account employees, direct pay enrollees and retirees by the State, either through the mail or at the worksite. The selected offeror will have to work with and submit to the State, a description of the plan's services to be included in the Open Enrollment booklet.

57. Attachment N-1, "BH Paid Claims", multiple sheet tabs: What is the definition for treatment type "ANS"?

Answer: ANS refers to ancillary services and was only used through 2003. Ancillary services are now included under the Outpatient category.

58. Attachment N-1, "BH Paid Claims", multiple sheet tabs: Is the paid claims data based on incurred date or paid date? If incurred, has an IBNR factor been applied?

Answer: The monthly paid claims are the claims paid regardless of the incurred date (i.e. date of service).

59. Attachment N-1, "BH Paid Claims", multiple sheet tabs: Does the designation "number paid" refer to individual units of service for each treatment type?

Answer: Yes. The designation "number paid" refers to individual units of service for each treatment type.

60. Attachment N-1, "BH Paid Claims", multiple sheet tabs: Does the designation "Total members" refer to unique users of service for each treatment type? Is the count of an individual member duplicated if their treatment episode spans more than one month?

Answer: Yes. The designation "Total members" refers to unique users of service for each treatment type. Yes. The count of an individual member is duplicated if their treatment episode spans more than one month**?**

61. Attachment N-1, "BH Enrollment ", multiple sheet tabs: Please confirm that the enrollment data for each year corresponds exactly to the paid claim data provided on the "BH Paid Claims" sheet tabs.

Answer: The enrollment data for each month is the number of members enrolled in the PPO and POS plans for that month. The monthly paid claims are the claims paid regardless of the incurred date (i.e. date of service).

62. Attachment N-1, "BH Large Claims ", multiple sheet tabs: Under the Member ID column, do all of the claims for an identified member (i.e. Member 2), correspond to one individual's utilization? And, for instance, is "Member 5" listed under the Large Claims for 2005 the same individual as "Member 5" listed under the Large claims for 2004?

Answer: Yes. All of the claims for an identified member (i.e. Member 2), correspond to one individual's utilization. Yes. "Member 5" listed under the Large Claims for 2005 is the same individual as "Member 5" listed under the Large claims for 2004.

63. Attachment N-1, "BH EAP Statistics ", multiple sheet tabs: Does this utilization reflect only referrals from management? i.e. is the desired EAP program structure description outlined in the RFP consistent with the historical program structure?

Answer: Yes, referrals can ONLY come from management.

64. Section 3.3, Background of the RFP indicates that the State conducted approx 100 Benefit Fairs throughout the State during the last annual enrollment period. Is it the State's desire that the vendor conduct approx this same number on an annual basis?

Answer: It is approximately this number every year, sometimes more, sometimes less. However, the BH vendor is required to have representative at each Benefits Fair to answer employee questions.

65. Section 3.5.3.5. Enrollment Services of the RFP indicates that the Vendor will "share in the cost of printing and mailing open enrollment materials."

Please clarify the vendor's responsibility for this activity and define "share" (i.e. a specific percentage of the cost?).

Answer: The cost of printing and mailing the booklets to be handled by the State is included in this cost. In addition, the booklets are mailed to all retirees and direct pay enrollees. They are distributed at the worksite to active employees and Satellite Account employees. After the printing and mailing costs are finalized, the costs are divided up between all the vendors. As indicated in the RFP, these costs have run between $13,000 to $15,000 each Open Enrollment. The selected offeror will have to work with and submit to the State, a description of the plan's services to be included in the Open Enrollment booklet.

66. Attachment L-6 Compliance Checklist CC-99: Please clarify as to the type of adjustments the Offeror must agree to accept based on the reconciliation of State's invoice amount and 100 character file. Applicable adjustments will be made to a subsequent invoice.

Answer: The 100 character file to be submitted as support for the weekly invoice will provide the State with claims data that will be matched against the State's eligibility file. This file listing individuals for whom the vendor has paid claims will be run against the State file to verify that the individual is in the State group, was enrolled in a PPO or POS plan, had a deduction taken for the time-period services were rendered and that his/her dependents were eligible for coverage. If after review any individual is deemed ineligible by this process, an adjustment can be made to a future invoice.