
**FEHB Program Carrier Letter
All Experience Rated HMO Carriers**

**U.S. Office of Personnel Management
Healthcare and Insurance**

Letter Number 2021-14(b)

Date: August 13, 2021

Fee-for-service [n/a]

Experience-rated HMO [12]

Community-rated HMO [n/a]

**Subject: Changes to the Standard Contract for
Contract Year 2022**

Please review Attachment A, which details the proposed Standard Contract changes for Federal Employees Health Benefits Program Experience-Rated HMO Carriers for Contract Year 2022. If you have comments, please provide them as soon as possible or no later than September 10, 2021.

The proposed amendments are as follows:

- 1.** Section 1.7 Statistics and Specials Studies - modified subsection (e) to this section to provide reasonable guidance to the Carrier should they receive a third-party request about FEHB program related data that is unrelated to the administration of the contract.
- 2.** Section 1.28 Standards for Arrangements with Pharmacy Benefit Managers - modified to update pharmacy benefit manager standards.
- 3.** Section 1.37 Procedures for Information Security Incident and Data Breach Reporting - section (d) was updated to provide clarity to the carriers to send their security incident and data breach report to the Health Insurance Specialist.
- 4.** Section 2.7 Debarment and Other Sanctions - technical edits were made to this section.
- 5.** New Section 2.17 Medicare Part D Creditable Coverage- added this new Section 2.17 to state the requirement for carriers to provide Medicare for clarity of Part D creditable coverage.

- 6.** New Section 2.18 Surprise Billing - added this new Section 2.18 to state the requirements for carriers to comply with the No Surprises Act.
- 7.** Section 5.71 Combating Trafficking in Person - added definitions that were inadvertently omitted.
- 8.** Appendix F FEHB Plan Performance Assessment - Appendix F was amended to reflect the updated years for the Plan Performance Assessment measures and contributions to performance areas and scores.
- 9.** Global Technical Edit - remove the typographical character § for consistency.

Please email your comments to FEHBcontramend@opm.gov, with a copy to your OPM Health Insurance Specialist.

We look forward to working with you on your contract.

Sincerely,

Laurie Bodenheimer
Director
Healthcare and Insurance

Encl: Attachment A Proposed Changes to Standard 2022 Experience Rated HMO Health Benefits Contract

Attachment A
Proposed Changes to Standard 2022 Experience Rated HMO Health Benefits Contract

NOTE: New and revised language is *italicized in blue* and language to be deleted is ~~struck out in red~~.

1. Section 1.7 Statistics and Specials Studies

We modified subsection (e) to this section to provide reasonable guidance to the Carrier should they receive a third-party request about FEHB program related data that is unrelated to the administration of the contract.

SECTION 1.7 STATISTICS AND SPECIAL STUDIES (JAN ~~2009-2022~~)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish *to* OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under Chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under Chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Health Insurance Specialist (Contracts) immediately upon a change in the name or address of the Carrier's contracting official(s).

(e) *If a third party requests FEHB Program data and the Carrier determines that the data request is not reasonably necessary for administration of the FEHB contract, ~~The~~ the Carrier shall notify the OPM Health Insurance Specialist within ~~3~~ *three (3)* business days from the date ~~the Carrier makes the determination.~~ ~~of request if a third party requests FEHB program data for any purpose not related to administration of the contract.~~ *The Carrier must not distribute the data prior to receiving approval from the Contracting Officer.**

2. Section 1.28 Standards for Arrangements with Pharmacy Benefit Managers

This section was modified to update pharmacy benefit manager standards.

SECTION 1.28 STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN ~~2021-2022~~)

The Carrier will ensure and report that the following standards are included in new, renewing or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to Enrollees and family members effective on or after January 1, 2022. Notwithstanding the foregoing, the revisions to Section 1.28 shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January ~~2024~~ *2025*. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.28.

If the Carrier’s PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.28 shall be deemed to be references to the Underwriter.

(a) Definitions. Under this section

(1) “Expedited request” means a request initiated by the Prescriber, member, or member’s representative when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient’s life, health, or ability to regain maximum function.

(2) “Licensed pharmacist” means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction’s laws and regulations.

(3) “Manufacturer payment” means any and all compensation, financial benefits, or remuneration the PBM or (any Third Party) receives from a pharmaceutical manufacturer for any dispensing or distribution channel, including but not limited to, discounts, credits, rebates (regardless of how categorized), market share incentives, chargebacks, commissions, administrative or management fees, patient assistance and any fees received for sales of utilization data to a pharmaceutical manufacturer.

(4) “Network pharmacy,” means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.

(5) “Pass-Through Transparent Pricing” means drug pricing in which the Carrier receives the full value of all discounts, rebates, credits or other financial guarantees or adjustments including any true up or reconciliation.

(6) “Pharmacy Benefit Manager” or “PBM” means the combination of

(i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with Network pharmacies, and controlling the cost of covered prescription drugs; and

(ii) all entities that have a majority ownership interest in, or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).

(7) “Prescriber” means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.

(8) “Third Party” means any consultant, partner, administrator, intermediary or other entity outside the scope of the relationships between or among the PBM and the FEHB enrollee, Carrier, and/or OPM. It does not include wholesalers, distributors, or pharmacies.

(9) “Total Product Revenue” means the total dollar sales of prescription drugs at the prescription price negotiated with clients and associated administrative fees, either through retail Networks or PBM-owned or controlled mail order pharmacies, with respect to the PBM’s entire client base, for the reporting period.

(10) *“Mid-year formulary change” is any change that occurs to the formulary during the plan year. Positive formulary changes enhance formularies by adding drugs or placing a drug on a lower costs sharing tier or removing or relaxing utilization management (UM) requirements for drugs. Restrictive formulary changes negatively impact formularies by removing drugs, moving drugs to higher tiers, or tightening UM requirements for drugs.*

(11) *“Impacted member” is any member who is on a prescription drug that undergoes a mid-year formulary change.*

(12) *“Written notice” means notification to each impacted member by U.S. mail, secure e-mail or text message (if approved by the member).*

(b) Transparency Standards

(1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

(2) The PBM shall agree to provide Pass-Through Transparent Pricing as defined above for the following categories:

(3) Retail Pharmacies: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.

(i) Mail Order or Specialty Pharmacies not owned or affiliated with the PBM: The PBM shall charge the Carrier no more than the amount as determined by Pass-Through Transparent Pricing paid to the pharmacy for each drug plus a dispensing fee.

(ii) Mail Order or Specialty Pharmacies owned or affiliated with the PBM: The PBM shall charge the Carrier the cost of the drugs based on the pharmacy’s actual acquisition cost, plus a dispensing fee. Costs shall not be based on industry benchmarks or set pricing including, but not limited to, Average Acquisition Cost (AAC), Maximum Allowable Charge (MAC), Average Wholesale Price (AWP), and Wholesale Acquisition Cost (WAC).

~~(iii) The PBM must commit to minimum annual aggregate pharmacy claim discount guarantees, based on Average Wholesale Price (AWP) or other recognized industry benchmark, and maximum annual aggregate dispensing fee guarantees. PBM must reconcile Carrier claim costs to these guarantees no less frequently than annually. PBM must pay to the Carrier any shortfall in meeting these pricing guarantees, with the Carrier receiving any payment for under performance of the pricing guarantees to credit its’ FEHB Program reserves.~~

(4) The PBM or any other Third Party that negotiates or collects Manufacturer Payments allocable to the Carrier agree to credit to the Carrier either as a price reduction or by cash refund the value of all Manufacturer Payments properly allocable to the Carrier.

(5) The PBM must identify sources of profit to the Carrier and OPM as it relates to the FEHB contract.

(6) All of the PBM’s fees, including, but not limited to, administrative or dispensing fees, must be clearly identified to retail claims, mail claims, specialty claims, and clinical or other programs, if applicable. The PBM must agree to disclose each fee to the Carrier and OPM.

(7) The PBM, or any Third Party that negotiates or collects Manufacturer Payments allocable to the Plan, will provide the Carrier with quarterly and annual Manufacturer Payment Reports identifying the following information. This information shall be presented for both the

total of all prescription drugs dispensed through the PBM, acting as a specialty and/or a mail order pharmacy, and its retail Network and in the aggregate for the 25 brand name drugs that represent the greatest cost to the Carrier or such number of brand name drugs that together represent 75 percent of the total cost to the Carrier, whichever is the greater number:

- (i) the dollar amount of Total Product Revenue;
- (ii) the dollar amount of total drug expenditures for the Plan;
- (iii) the dollar amount of all Manufacturer Payments earned by the PBM for the reporting period;
- (iv) the Manufacturer Payments that have been (1) earned but not billed (2) billed and (3) paid to the PBM based on the drugs dispensed to the Plan members during the past year.
- (v) the percentage of all Manufacturer Payments earned by the PBM for the reporting period that were Manufacturer Formulary Payments, which are payments the PBM receives from a manufacturer in return for formulary placement and/or access, or payments that are characterized as “formulary” or “base” rebates or payments pursuant to the PBM’s agreements with pharmaceutical manufacturers;
- (vi) the percentage of all Manufacturer Payments received by the PBM during the reporting period that were Manufacturer Additional Payments, which are all Manufacturer Payments other than Manufacturer Formulary Payments.

(8) The PBM agrees to provide the Carrier, at least annually, with all financial and utilization information requested by the Carrier relating to the provision of benefits to eligible enrollees through the PBM and all financial and utilization information relating to services provided to the Carrier, including but not limited to, a reasonable sample of retail pharmacy remittance advices, as selected by the Carrier.

(9) The Carrier shall provide any information it receives from the PBM, including a copy of its contract with the PBM to OPM. At OPM’s request, the Carrier must obtain from the PBM any reasonable information on reports and provide it to OPM. A PBM providing information to a Carrier under this subsection may mark that information as confidential commercial information. The Carrier, in its contract with the PBM shall effectuate the PBM’s consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential under 5 C.F.R Part 294.112.

(10) The Carrier will require that its PBM:

- (i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;
- (ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and
- (iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(11) In accordance with FEHBAR 1652.204-74, FAR 52.215-2 and FEHBAR 1652.246-70, all contracts and other documentation that support amounts charged and credited to the Carrier contract are fully disclosed to and auditable by the OPM Office of Inspector General (OPM OIG). The PBM must provide the OPM OIG upon request complete copies of all PBM records including, but not limited to:

Attachment A – Experience Rated HMO Proposed 2022 Changes

- (i) All PBM contracts with Participating Pharmacies, including invoices, receipts and credits;
- (ii) All PBM contracts with Pharmaceutical Manufacturers, including invoices, receipts, and credits;
- (iii) All PBM contracts with Third Parties or other entities purchasing or using claims data;
- (iv) All PBM transmittals in connection with sales of claims data to Third Parties and other entities;
- (v) All PBM records relating to patient assistance maximizer programs, optimizer programs, or similar arrangements with Third Parties; and
- (vi) All PBM records pertaining to arrangements with Third Parties, including Group Purchasing Organizations (GPOs).

(12) *The Carrier at the minimum must perform an annual check to ensure that the PBM adheres to the pricing standards outlined in (b)(2)(i), (ii), and (iii).*

(c) Integrity Standards

- (1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association, for their employed pharmacists.
- (2) The Carrier will require that its PBM be licensed as required by the appropriate jurisdiction's laws and regulations.
- (3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.
- (4) The PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.
- (5) A PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.
- (6) A PBM, or Carrier, shall not enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:
 - (i) The cost of a prescription medication to the member; or
 - (ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and submit reports to the Carrier on their performance. PBMs must meet, at minimum, the member inquiry, customer service, claims processing, and other applicable standards set for Carriers at Section 1.9(g). All other standards discussed below will have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business. Agreed to standards shall be provided to OPM for its review and comment. If OPM has concerns about a particular standard, the Carrier agrees to

present OPM’s concerns to the PBM and either revise the standard as requested by OPM or revise the standard to the extent feasible and present to OPM information demonstrating the problems associated with making the requested revisions in full.

- (1) Point of Service (POS) system response time. The PBM’s network electronic transaction system provides rapid response to Network pharmacies.
- (2) POS system availability. The PBM’s network electronic transaction system generally is available to, and accessible by, Network pharmacies.
- (3) Licensing. The PBM verifies the appropriate licensing of its Network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.
- (4) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.
- (5) Mail service pharmacy turnaround time – The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.
- (6) Specialty pharmacy shipment stability. The Carrier or PBM’s specialty pharmacy must have policies and procedures in place to promote effective shipping practices and monitor cold chain packaging. Specific areas to be addressed include achievement of internal and external metrics and the identification and appropriate use of best practices.
- (7) Quality of Drug Therapy. The quality assurance program implemented by a Carrier’s PBM contractor must include a process to measure the quality of its drug therapy provided to enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Mid-Year Formulary Changes may not become effective until an itemized list is provided to OPMPharmacy@OPM.gov and your Contracting Officer.

- (1) Positive formulary changes may be effective at any time after the itemized list of Mid-year formulary changes is provided as set forth above.*
- (2) FEHB Carriers must notify their Contracting Officer at least 70 days prior to making any Restrictive Formulary Change effective during the plan year that results in any Impacted Member.*
- (3) FEHB Carriers must provide Impacted members with written notice of a Restrictive mid-year formulary change at least 60 days prior to the date the formulary change becomes effective.*
- (4) FEHB Carriers have the option to grandfather Impacted members of a restrictive formulary change for coverage and cost-sharing for the remainder of the plan year. In such cases, impacted member notification is not required. However, FEHB Carriers must notify OPMPharmacy@OPM.gov and their Contracting Officer at least 10 days prior to making any restrictive mid-year formulary change that has no member impact.*
- (5) Carriers may immediately remove from their formulary drugs deemed unsafe based on new information on a drug’s safety or efficacy or removed from the market by their manufacturer without meeting the advance notice requirement specified above. In such cases, FEHB Carriers must provide retrospective notice of any such formulary changes to impacted members and OPM as soon as possible.*

(ef) Alternative Drug Options

The Carrier will require that its PBM contractors, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

- (1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.
- (2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other office staff member as authorized by the Prescriber.
- (3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescriber's office and the basis for ~~his or her~~ *their* authority.
- (4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.
- (5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.
- (6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(fg) Utilization Management Timeframe – The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.

~~(1i)~~ For Expedited requests, the PBM must review and respond within 24 hours.

~~(2ii)~~ For other, non-expedited requests, the PBM must review and respond within 72 hours.

(1) For expiring prescription prior authorizations (PAs), the PBM must:

(i) have in place a process to review all expiring PAs; and

(ii) must notify members at least 45 days before the expiration of a PA for a maintenance medication.

(gh) Patient Safety Standard - The Carrier will require that its PBM establish drug utilization management, formulary process and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

- (i) A system for identifying and communicating drug and consumer safety issues at point-of-service;

Attachment A – Experience Rated HMO Proposed 2022 Changes

- (ii) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.
- (iii) A system/process for error reporting; and
- (iv) A system/process for identifying/managing risk

(h) Safety and Accessibility for Consumers - The Carrier will require that its PBM meets the following standards related to pharmacy Network management and consumer access to medications.

- (1) The Carrier will require that its PBM define the scope of its services with respect to:
 - (i) The distribution channels offered (e.g. pharmacy Network, mail order pharmacies, or specialty pharmacies);
 - (ii) The types of pharmacy services offered within each distribution channel; and
 - (iii) The geographic area served by each distribution channel.
- (2) The Carrier will require that for each distribution channel provided by its PBM, the PBM:
 - (i) Establishes criteria and measures actual performance in comparison to those criteria:
and
 - (ii) Makes improvements where necessary to maintain the pharmacy network and meet contractual requirements.
- (3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:
 - (i) Quality and safety of drug distribution; and
 - (ii) Quality of service

(i) Fraud, Waste, and Abuse

- (1) The PBM must establish fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
 - (i) A system designed to detect and eliminate FWA
 - (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
 - (iii) A system/process for FWA reporting; and
 - (iv) A system/process for identifying/managing risk
- (2) Any third party or entity providing services or supplies related to the administration of payments or benefits must certify to the PBM that it has established fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
 - (i) A system designed to detect and eliminate FWA;
 - (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
 - (iii) A system/process for FWA reporting; and

(iv) A system/process for identifying/managing risk.

(j) Contract Terms - The contract between the PBM and the Carrier must not exceed 3 years without re-competition unless the Contracting Officer approves an exception. The Carrier's PBM contract must allow for termination based on a material breach of any terms and conditions stated in the Carrier's PBM contract. The Carrier must provide sufficient written notice of the material breach to the PBM and the PBM must be given adequate time to respond and cure the material breach.

3. Section 1.37 Procedures for Information Security Incident and Data Breach Reporting

Section (d) was updated to provide clarity to the carriers to send their security incident and data breach report to the Health Insurance Specialist.

SECTION 1.37

PROCEDURES FOR INFORMATION SECURITY INCIDENT AND DATA BREACH REPORTING (JAN ~~2021~~ 2022)

- (a) The specific terms listed below are defined as stated for purposes of this Section.
- (1) Incident is defined by 44 U.S.C. § 3552(b)(2) and applicable OMB guidance.
 - (2) Breach is defined in HHS regulations 45 CFR Part 164 Subpart D.
 - (3) Compromise is defined in the current revisions of the glossary of NIST SP 800-32.
- (b) A Carrier must report to OPM incidents and breaches where the confidentiality, integrity, or availability of FEHB member protected health information (PHI) is compromised or if a Carrier notifies law enforcement of an incident or breach that: (1) compromises its systems that contain or process FEHB Program data or (2) compromises its systems operating in the same general information technology control environment as the information systems that process FEHB Program data.
- (c) The Carrier must report to OPM before any other external notifications are made (excluding notification to necessary parties for incident response), and in no case later than 24 hours after its incident response team determines the confidentiality, integrity, or availability of FEHB member PHI is compromised, or it has notified law enforcement of an incident or breach that meets the requirements stated in paragraph (b) of this Section.
- (d) The Carrier must submit reports to OPM via email to Cybersolutions@opm.gov or via phone to (844) 377-6109. *The Carrier must also notify their Health Insurance Specialist on its security incident and data breach reporting.*
- (1) Any data shared with OPM that relates to an incident or breach must be transmitted in a secure manner.
 - (2) The report should include the following:
 - i. A brief description of the nature of the incident or breach.
 - ii. An estimate of the number of affected FEHB members, if feasible.
 - iii. A brief description of the remedial steps that the Carrier has already taken and those they plan to take.
 - (3) The Carrier is responsible for providing additional detailed information as soon as it becomes available.

- (e) For a breach of PHI, the notice to FEHB enrollees will comport with 45 CFR § 164.404 for breaches as defined in this Section or OPM guidance. Notices must be coordinated with OPM before any communication with FEHB enrollees. All other notices must also be coordinated with OPM and the Carrier must follow OPM guidance to the extent practicable.
- (f) In case of subcontractor breach or incident the following applies.
 - (1) A subcontractor breach or incident must be reported to OPM by the Carrier no later than the calendar day following notice to the Carrier.
 - (2) Either the Carrier or its subcontractor may provide a notice of the breach to FEHB enrollees.
 - (3) If the subcontractor provides the notice, it must be in a form that allows the enrollee to easily identify the Carrier and FEHB plan. If specific identification is not practical under the circumstances, Carrier and FEHB plan identification shall be otherwise accomplished in a manner agreed upon with OPM.
 - (4) The Contracting Officer may direct the Carrier to issue a separate notice in order to avoid enrollee confusion.

4. Section 2.7 Debarment and Other Sanctions

Technical edits were made to this section.

SECTION 2.7

DEBARMENT AND OTHER SANCTIONS (JAN ~~1999~~ 2022)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a, *or* 5 CFR *Part 919 970*, ~~or Public Law 103-123 (or other applicable appropriations law)~~, a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

5. New Section 2.17 Part D Creditable Coverage

Added this new Section 2.17 to state the requirement for carriers to provide Medicare Part D creditable coverage.

SECTION 2.17

PART D CREDITABLE COVERAGE

The Carrier shall offer prescription drug coverage that is considered creditable prescription drug coverage under 42 CFR § 423.56.

6. New Section 2.18 Surprise Billing

Added this new Section 2.18 to state the requirements for carriers to comply with the No Surprises Act in the Consolidated Appropriation Act of 2021 (Dec 27, 2020).

SECTION 2.18

SURPRISE BILLING (JAN 2022)

- (a) The Carrier shall comply with requirements described in the provisions of sections 2799A-1, 2799A-2, 2799A-3, 2799A-4, 2799A-5, 2799A-7, and 2799A-8 of the Public Health Service Act, sections 716, 717, 718, 719, 720, 722, and 723 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections.*
- (b) The Carrier's compliance with paragraph (a) will be concurrent and consistent with implementing regulations issued by the Departments of Health and Human Services, Labor, and the Treasury, subject to OPM regulation and FEHB contract terms.*
- (c) The Carrier's provider contracts must extend the provisions of sections 2799B-6, 2799B-8, and 2799B-9 of the Public Health Service Act to covered individuals in the same manner as such provisions apply to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer.*
- (d) Consistent with the preemption provision at 5 U.S.C. 8902(m)(1), the provisions of Public Health Service Act section 2723 as well as 45 CFR Part 150 are inapplicable to the Carrier with respect to the Plan.*

7. Section 5.71 Combating Trafficking in Persons

Added definitions that were inadvertently omitted.

SECTION 5.71

COMBATING TRAFFICKING IN PERSONS (JUN 2020) (FAR 52.222-50)

(1) Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or

(2) The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

“Sex trafficking” means the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act.

“Subcontract” means any contract entered into by a subcontractor to furnish supplies or services for performance of a prime contract or a subcontract.

“Subcontractor” means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor.

“United States” means the 50 States, the District of Columbia, and outlying areas.

(b) Policy. The United States Government has adopted a policy prohibiting trafficking in persons including the trafficking-related activities of this clause. Contractors, contractor employees, and their agents shall not—

8. Appendix F FEHB Plan Performance Assessment

Appendix F was amended to reflect the updated years for the Plan Performance Assessment measures and contributions to performance areas and scores.

APPENDIX F

Measures and contributions to performance areas and scores for ~~2021-2022~~ Performance and ~~2022-2023~~ Service Charge.

To be performed in accordance with the ~~2021-2022~~ FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2020-15). The Service Charge for the ~~2022-2023~~ contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS).

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures.

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure	CBP	HEDIS	1	2.50
	Comprehensive Diabetes Care (HbA1c <i>Control</i> <8.0%)	CDC	HEDIS	1	2.50
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	1	2.50
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB(18-64)	HEDIS	2	1.25
	Asthma Medication Ratio	AMR	HEDIS	2	1.25

Attachment A – Experience Rated HMO Proposed 2022 Changes

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Breast Cancer Screening	BCS	HEDIS	2	1.25
	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dep. (30 Day)	FUA30	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM30	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease <i>Statin Adherence 80% (Adherence)</i>	SPC	HEDIS	2	1.25
	Well Child Visits in the First 15 Months of Life (6 visits) <i>First 30 Months of Life – Well-Child Visits in the First 15 months: 6 or More Well-Child Visits</i>	W30(15)	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00

Attachment A – Experience Rated HMO Proposed 2022 Changes

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain	LBP	HEDIS	1	2.50
	<i>Plan All Cause Readmissions: Observed/Expected (O/E) Ratio</i>	PCR	HEDIS	2	1.25

9. Global Technical Edit

Remove the typographical character § for consistency.