

Attachment A
Proposed Changes to Standard 2019 Experience-Rated Health Benefits Contract

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

1. Section 1.9 Plan Performance – Experience-Rated HMO Contracts

We amended Subsection (g) to align quality assurance standards among Carriers and to provide clarity for the measures and standards. Subparagraph (g)(2) *Coordination of Benefits* was moved to its own subsection in Section 1.9(k) because it is a more appropriate location for the requirement. Subsections (k) and (l) were renamed (l) and (m) respectively and references to them were changed accordingly. In amended Subparagraphs (g)(2) *Claims Timeliness* and (g)(4) *Member Inquiries*, the time period for reporting was clarified. In amended Subparagraph (g)(5)(i) *Call Answer Timeliness*, the required standard is set at 85% of calls answered by a live voice (during operating hours) within 30 seconds. In amended Subparagraph (g)(6) *Responsiveness to FEHB Member Requests for Reconsideration*, the reportable calculation is described. The required quality assurance standards are otherwise unchanged in these amendments. Subparagraph (g)(2) *Coordination of Benefits* was moved to its own subsection in Section 1.9(k) because it is a more appropriate location for the requirement; the language was also edited for clarity.

SECTION 1.9 PLAN PERFORMANCE--EXPERIENCE-RATED HMO CONTRACTS
(JAN ~~2018~~2019)

* * * * *

(g) Contract Quality Assurance The Carrier shall develop and apply a quality assurance program specifying procedures for assuring contract quality. At a minimum the Carrier shall meet the following standards and submit an annual report to OPM on these standards by July 1 of the following contract period.

(1) *Claims Processing Accuracy* - the number of FEHB claims processed accurately divided by the total number of FEHB claims processed ~~for the given time period, expressed as a percentage~~.

REQUIRED STANDARD: The Carrier shall accurately process at least~~An average of~~ 95 percent of FEHB claims ~~must be processed accurately~~.

~~(2) *Coordination of Benefits (COB)*—the Carrier must demonstrate that a statistically valid sampling technique is routinely used to identify FEHB claims prior to or after processing that require(d) coordination of Benefits (COB) with a third party payer. As an alternative, the Carrier may provide evidence that it pursues all claims for COB.~~

(~~3~~2) *Claims Timeliness* - the ~~average~~ number of FEHB claims adjudicated (paid, denied or a request for further information is sent out) within 30 working days from the date the Carrier

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receives ~~an FEHB claim to the date it adjudicates~~ it divided by the total number of FEHB claims received between 30 days prior to the beginning of the contract year through 30 days prior to the end of the contract year ~~(paid, denied or a request for further information is sent out), for the given time period, expressed as a cumulative percentage.~~

REQUIRED STANDARD: The Carrier shall adjudicate 95 percent of claims within 30 working days.

(43) *Processing ID cards on change of plan or option* - the number of calendar days from the date the Carrier receives the enrollment from the Enrollee's agency, Tribal Employer, or retirement system to the date it issues the ID card.

REQUIRED STANDARD: The Carrier shall issues ~~all the~~ ID cards within fifteen15 calendar days after receiving the enrollment from the Enrollee's agency, Tribal Employer, or retirement system except that the Carrier ~~will~~shall issue ID cards resulting from an open season election within fifteen15 calendar days or by December 15, whichever is later.

(54) *Member Inquiries* - the number of written inquiries responded to within 15 working days divided by the total number of inquiries received between 15 days prior to the beginning of the contract year through 15 days prior to the end of the contract year ~~taken to respond to an FEHB Member's written inquiry, expressed as a cumulative percentage, for the given time period.~~

REQUIRED STANDARD: The Carrier shall responds to at least 90 percent of inquiries within 15 working days ~~(including internet inquiries).~~

(65) *Telephone Access* - the Carrier shall report on the following statistics concerning telephone access to the member services department (or its equivalent) for the given time period. Except that, if the Carrier does not have a computerized phone system, report results of periodic surveys on telephone access.

(i) *Call Answer Timeliness* – the percentage of calls answered by a live voice (during operating hours) within 30 seconds.

REQUIRED STANDARD: The Carrier shall answer 85% of members' telephone calls by a live voice (during operating hours) within 30 seconds.

(ii) *Telephone Blockage Rate* - the ~~percentage of time that callers~~ number of calls receiving a busy signal when calling the Carrier divided by the total number of calls received.

REQUIRED STANDARD: The Carrier shall ensure that Nno more than 5 percent of callers receive a busy signal.

(iii) *Telephone Abandonment Rate* - the number of calls attempted but not ~~completed~~ connected to a representative ~~(presumably because callers tired of waiting to be~~

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~~connected to a Carrier representative) divided by the total number of calls attempted (both completed and not completed), expressed as a percentage.~~

REQUIRED STANDARD: The Carrier shall ensure that ~~On average, Enrollees abandon the effort~~ no more than 5 percent of ~~the time~~ calls are abandoned before connection to a representative.

(iv) *Initial Call Resolution* – the number of initial calls that result in a resolution ~~percentage of issues resolved during the initial call~~ of the issue divided by the total number of initial calls for an issue.

REQUIRED STANDARD: The Carrier shall ~~On average, caller's issues must be resolved~~ resolve the issue during the initial call at least 80 percent of the time.

~~(76)~~ *Responsiveness to FEHB Member Requests for Reconsideration*– the number of times the Carrier responds (affirms the denial in writing to the FEHB member, pays the claim, provides or authorizes coverage of the service, or requests additional information reasonably necessary to make a determination) within 30 days to a request for reconsideration of a disputed claim divided by the total number of requests for reconsideration of disputed claims received between 30 days prior to the beginning of the contract year through 30 days prior to the end of the contract year.

REQUIRED STANDARD: The Carrier shall respond to ~~For~~ 100 percent of written FEHB disputed claim requests ~~received for the given time period,~~ within 30 days after receipt by the Carrier, ~~the Carrier shall affirm the denial in writing to the FEHB member, pay the claim, provide or authorize coverage of the service, or request additional information reasonably necessary to make a determination.~~

* * * * *

(k) The Carrier must demonstrate that it uses and shall use a statistically valid sampling technique to identify FEHB claims prior to or after processing that require coordination of benefits with a third party payer or the Carrier shall pursue and provide evidence that it pursues all claims for coordination of benefits.

~~(k)~~ *Correction of Deficiencies.* The Contracting Officer may order the correction of a deficiency in the Carrier's quality assurance program or fraud prevention program. The Carrier shall take the necessary action promptly to implement the Contracting Officer's order. If the Contracting Officer orders a modification of the Carrier's quality assurance program or fraud prevention program pursuant to this paragraph ~~(k)~~ after the contract year has begun, the costs incurred to correct the deficiency may be excluded from the administrative expenses -- for the contract year -- that are subject to the administrative expenses limitation specified at Appendix B; provided the Carrier demonstrates that the correction of the deficiency significantly increases the Carrier's liability under this contract.

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(~~m~~) In order to allow sufficient implementation time, the Contracting Officer will notify the Carrier reasonably in advance of any new requirement(s) under paragraphs (a) through (~~k~~).

2. Section 1.28 Standards for Pharmacy Benefit Management Company (PBM) Arrangements

We amended Subsection (c) to update the references to Section 1.9, Subsection (g).

SECTION 1.28 STANDARDS FOR PHARMACY BENEFIT MANAGEMENT COMPANY (PBM) ARRANGEMENTS (JAN ~~2014~~2019)

* * * * *

(c) 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, telephone customer service, paper claims processing, and other applicable standards set for Carriers at Section 1.9(g)(1), (~~3~~2), (~~5~~4) and (~~6~~5). 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 PBM's 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.

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3. Section 1.29 Health Information Technology Privacy and Security

We amended Subsection (d) to more clearly require Carriers to allow an authorized representative of the Contracting Officer to perform independent evaluations to ensure information systems that directly process FEHBP data and information systems that are in the same general IT control environment are securely configured and are up to date.

SECTION 1.29 HEALTH INFORMATION TECHNOLOGY PRIVACY AND SECURITY (JAN ~~2014~~2019)

(a) Any Carrier subcontractor, large provider, or vendor, that administers a personal health record or quality and cost or price transparency software applications for Members that collect, create, receive, store or transmit individually identifiable protected health information of Members that does not qualify as a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or regulations will be required by

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the Carrier to, at a minimum, comply with equivalent privacy and security policies as are required of a “covered entity” under the HIPAA Privacy and Security regulations.

(b) The Carrier will provide for consumer transparency including, but not limited to, the posting of the subcontractor’s, large provider’s, or vendor’s notice of privacy practices prominently at the point where the Member enters the subcontractor’s, large provider’s, vendor’s or other entity’s website or web portal.

(c) Notices of privacy practices disclosures must describe the uses of individually identifiable protected health information and any potential disclosure to other entities as described in the HIPAA Privacy Rule.

(d) ~~(H)~~ The Carrier must allow the ~~The~~ Contracting Officer or an authorized representative of the Contracting Officer may to independently perform credentialed vulnerability scans and configuration compliance audits (using administrator accounts) against the Carrier’s information systems and environments to determine whether the Carrier has controls in place to ensure its information systems are securely configured and up-to-date.

(1) use NIST SP 800-53 (or its current equivalent) ~~requirements~~ may be used as a benchmark for conducting audits of Carrier information systems. ~~and~~ The Contracting Officer or an authorized representative of the Contracting Officer may recommend that the Carrier adopt a best practice drawn from NIST SP 800-53 (or its current equivalent) to the following Carrier information systems:

(i) Information systems that directly process FEHBP data for contract purposes; and

(ii) All other information systems operating in the same general information technology control environment (i.e. any resources in the same physical or logical environment) as the information systems in subparagraph (i) above.

(2) In a written response to such a recommendation, the Carrier shall do one of the following:

(i) ~~agree~~ Agree to adopt the recommendation,

(ii) ~~explain~~ Explain that it is already in compliance with the recommendation, or

(iii) ~~explain~~ Explain why maintaining its current practice is compliant with Section 1.22, captioned Administrative Simplification -- HIPAA and is equally, if not more, appropriate for its business purposes than the recommended best practice from (1) above.

(3) Upon request of the Contracting Officer or an authorized representative of the Contracting Officer, the Carrier agrees to demonstrate to the requestor its compliance with either a recommended best practice from (1) or an alternative current practice from (2)(iii) that the Carrier has adopted. Evidence submitted pursuant to (2) that the Carrier and Contracting Officer

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agree is extremely sensitive may, at the Carrier’s request and the Contracting Officer’s concurrence, be reviewed on the Carrier’s premises.

(4) If the Carrier agrees to adopt a best practice recommendation made pursuant to (1) above, the Contracting Officer will allow reasonable time for the Carrier to implement the best practice before making any request under (3) above.

4. Appendix B Subscription Rates, Charges, Allowances and Limitations

We amended Appendix B to reflect the updated dates.

APPENDIX B

SUBSCRIPTION RATES, CHARGES, ALLOWANCES AND LIMITATIONS

Experience-Rated
Health Maintenance Organization Carrier

(Enter Carrier’s name)

CONTRACT NO. CS _____

Effective January 1, ~~2018~~2019

(a) Biweekly net-to-Carrier rates, with appropriate adjustments for Enrollees paid on other than a biweekly basis, are as follows:

Self Only \$ _____

Self Plus One \$ _____

Self and Family \$ _____

(b) The amount of administrative expenses and charges to be included in the Annual Accounting Statement required by Section 3.2 shall be as set out in the schedule below:

<u>Item</u>	<u>Amount</u>
(i) Administrative Expenses	Actual, but not to exceed the Contractual Expense Limitation for 2018 2019, * plus an amount sufficient to cover the costs needed to pay the Plan’s Independent Public Accountant to undertake the audits and agreed upon procedures required in the “FEHBP Experienced-Rated Carrier and Service Organization Audit Guide.”

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(ii) Taxes Actual (except that premium taxes as defined are not allowable).

(iii) Service Charge** \$ _____

*The Contractual Expense Limitation for ~~2018~~2019 is the Contractual Expense Limitation for ~~2017~~2018(\$_____), plus or minus adjustments for inflation and enrollment changes. The base shall be adjusted by percentage changes in enrollment (from OPM's March ~~2017~~2018 to March ~~2018~~2019 headcount) and by the percentage change in the average monthly Consumer Price Index for All Urban consumers (published monthly by the Bureau of Labor Statistics) from the 12-month period ending on June 30, ~~2017~~2018 to the 12-month period ending on June 30, ~~2018~~2019.

** The Service Charge for the ~~2018~~2019 contract year is based on the Overall Performance Score calculated in accordance with the ~~2017~~2018 Appendix F. The Service Charge for the ~~2019~~2020 contract year will be based on the Overall Performance Score calculated in accordance with the ~~2018~~2019 Appendix F.

5. Appendix F FEHB Plan Performance Assessment

We amended Appendix F to reflect the updated Plan Performance Assessment measures and contributions to performance areas and scores for 2019 Performance and 2020 Service Charge.

APPENDIX F

Measures and contributions to performance areas and scores for ~~2018~~ 2019 Performance and ~~2019~~ 2020 Service Charge

To be performed in accordance with the 2018 FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2017-15). The Service Charge for the ~~2019~~ 2020 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%

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

Performance Area	Measure	Priority Level	Measure Weight
Clinical Quality	Controlling High Blood Pressure Breast Cancer Screening	2 <u>1</u>	1.25 <u>2.50</u>
	Prenatal and Postpartum Care (Timeliness)	1	2.50
	Breast Cancer Screening	2 <u>2</u>	1.25 <u>1.25</u>
	Well Child Visits in the First 15 Months of Life (6 visits)	2	1.25
	Flu Vaccinations for Adults Ages (18-64)	2	1.25
	Cervical Cancer Screening	2	1.25
	Comprehensive Diabetes Care – HbA1C <8% - Control	2	1.25
	Asthma Medication Ratio	2	1.25
	Avoidance of Antibiotics in Adults with Acute Bronchitis	2	1.25
	Follow-up After Hospitalization for Mental Illness (7-day or 30-day)	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease (Adherence)	2 <u>2</u>	1.25 <u>1.25</u>
	Customer Service	Plan Information on Costs	3
Getting Needed Care Care Quickly		3	1.00
Getting Care Quickly Needed Care		3	1.00
Claims Processing		3	1.00
Overall Health Plan Rating		3	1.00
Coordination of Care		3	1.00
Overall Personal Doctor Rating		3	1.00
Customer Service		3	1.00
Resource Use	Plan All Cause Readmissions	1	2.50
	Emergency Department Utilization	2 <u>2</u>	1.25 <u>1.25</u>
	Use of Imaging Studies for Low Back Pain	2	1.25