

**Attachment A**  
**Changes to Standard 2006 Experience-Rated HMO Health Benefits Contract**

1. Section 1.9 PLAN PERFORMANCE—EXPERIENCE-RATED HMO CONTRACTS (JAN 2006) We are amending 1.9 (b) to eliminate reference to ORYX and to correct the reference to URAC.

<b>Current §1.9</b>	<b>Proposed §1.9</b>
<p>(b) <u>Clinical Care Measures</u>. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Health Plan Employer Data and Information Set (HEDIS) or ORYX™, or similar measures developed by accrediting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or the American Accreditation Healthcare Commission/URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier’s responsibility and are allowable administrative expenses, subject to the administrative cost limitation.</p>	<p>(b) <u>Clinical Care Measures</u>. The Carrier shall measure and/or collect data on the quality of the health care services it provides to its members as requested by OPM. Measurement/data collection efforts may include performance measurement systems such as Health Plan Employer Data and Information Set (HEDIS), or similar measures developed by accrediting organizations such as the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier’s responsibility and are allowable administrative expenses, subject to the administrative cost limitation.</p>

2. Section 1.9 PLAN PERFORMANCE—EXPERIENCE-RATED HMO CONTRACTS (JAN 2006). We are removing Section 1.9(g) (8) Appointments. This standard is not captured in the Quality Assurance Report and should not be included in the contracts. We are also renumbering the following sections in 1.9 to maintain consistency with the section.

- (h) Quality Assurance Plan.
- (i) Reporting Compliance.
- (j) Correction of deficiencies.
- (k) 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 (i).

3. Section 1.19 CERTIFICATION UNDER P.L. 104-191 (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996) (JAN 1998) We are clarifying that everyone enrolled in the plan will receive a certification of coverage and we are correcting the reference below.

The Carrier will issue a certification of coverage for members in accordance with the regulations issued by the Department of Health and Human Services.

4. Section 1.25 DISCLOSURE NOTICE UNDER P.L. 108-173 (MEDICARE MODERNIZATION ACT OF 2003) (JAN 2006). We are adding this section to indicate the required disclosure notice under the Medicare Modernization Act of 2003.

The Carrier will issue, as part of its FEHB benefits brochure, a disclosure notice concerning creditable prescription drug coverage in accordance with the regulation at 42 CFR §423.56 issued by the Department of Health and Human Services.

5. Section 2.13 BENEFITS PAYMENTS WHEN MEDICARE IS PRIMARY (JAN 2006) We are adding language to indicate that copayments will be also reimbursed to Members. We are deleting the last sentence “This provision does not apply to debarred providers (see Section 2.7).”

When a Member who is covered by Medicare Part A, Part B, or Parts A and B on a fee-for-service basis (a) receives services that generally are eligible for coverage by Medicare (regardless of whether or not benefits are paid by Medicare) and are covered by the Carrier, and (b) Medicare is the primary payer and the Carrier is the secondary payer for the Member under the order of benefit determination rules stated in Appendix D of this contract, then the Carrier shall limit its payment to an amount that supplements the benefits payable by Medicare (regardless of whether or not Medicare benefits are paid). When emergency services have been provided by a Medicare nonparticipating institutional provider and the provider is not reimbursed by Medicare, the Carrier shall pay its primary benefits. Payments that supplement Medicare include amounts necessary to reimburse the Member for Medicare deductibles, coinsurance, copayments and the balance between the Medicare approved amount and the Medicare limiting charge made by non-participating providers. This provision does not apply to debarred providers (see Section 2.7).

6. Section 2.16 COORDINATION OF PRESCRIPTION DRUG BENEFITS WITH MEDICARE (JAN 2006) We are adding this section to indicate CMS’s coordination of benefits requirements and procedures.

(a) The Carrier shall comply with the Center for Medicare and Medicaid Services’ (CMS) Part D Coordination of Benefits Guidance when the mechanisms and systems indicated in this guidance are in place and functioning properly. This guidance provides the requirements and procedures for coordination of benefits between Part D plans and other providers of prescription drug coverage.

(b) For Medicare Part B covered prescription drugs, the Carrier will coordinate benefits with Medicare except when such prescription drugs are purchased from retail or mail order pharmacies. The Carrier may pay its benefits on retail pharmacy or mail order drugs eligible for Medicare Part B coverage.

7. Appendix B SUBSCRIPTION RATES, CHARGES, ALLOWANCES, AND LIMITATIONS. We are updating this section to reflect the way the Contractual Expense Limitation is computed.

**Item**

**Amount**

(i) Administrative Expenses

Actual, but not to exceed the Contractual Expense Limitation for 2006,\* 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."  
Actual (except that premium taxes as defined are not allowable).

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(ii) Taxes

(iii) Service Charge

8. Appendix B SUBSCRIPTION RATES, CHARGES, ALLOWANCES, AND LIMITATIONS.

We are changing the 12 month period so that carriers can compute their precise administrative expense ceiling earlier in the year. This change will also help complete the required fiscal year accounting reports.

\*The Contractual Expense Limitation for 2006 is the Contractual Expense Limitation for 2005 (\$\_\_\_), plus or minus adjustments for inflation and enrollment changes. The base shall be adjusted by percentage changes in enrollment (from OPM's March 2005 to March 2006 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, 2005 to the 12 month period ending on June 30, 2006.

Changes to:  
PART V Clauses

9. Section 5.12 FACILITIES CAPITAL COST OF MONEY (JUN 2003) (FAR 52.215-16). We are eliminating this section because it conflicts with the revised FEHBAR 1631.205-10 Cost of Money.

[RESERVED]

10. Section 5.13 WAIVER OF FACILITIES CAPITAL COST OF MONEY OCT 1997) (FAR 52.215-17)

We are eliminating this section because it conflicts with the revised FEHBAR 1631.205-10 Cost of Money.

[RESERVED]