

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

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

Current §1.9	Proposed §1.9
<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.</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), or URAC. Costs incurred by the Carrier for collecting or contracting with a vendor to collect quality measures/data shall be the Carrier’s responsibility.</p>

2. Section 1.9 PLAN PERFORMANCE—COMMUNITY-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.

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 the following section.

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.

6. Section 2.15 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. Section 3.9 HIGH DEDUCTIBLE HEALTH PLANS (HDHP) WITH SIMILARLY SIZED SUBSCRIBER GROUPS (SSSGS) (JAN 2006). We are adding this section to indicate the new rules for High Deductible Health Plans and Similarly Sized Subscriber Groups.

If separate SSSGs are needed for a High Deductible Health Plan (HDHP) because it is rated separately from the Carrier's traditional HMO's or the Carrier has no other plans in that region, the two SSSGs will be chosen based on size. If the Carrier's HDHPs are rated Adjusted Community Rated (ACR) and the groups closest in size are rated differently, that will be acceptable if that is the Carrier's current policy and it is done in a consistent matter. All other rules for choosing SSSGs will be consistent with the current rules for choosing SSSGs for traditional plans. If either of the SSSGs is given a discount, that discount should only be passed to the insurance portion and not the pass through.