FEHB Program Carrier Letter
Health Maintenance Organizations (New)

U.S. Office of Personnel Management
Healthcare and Insurance

Letter No. 2012-12(b) **Date: April 19, 2012**

Fee-for-service [n/a] Experience-rated HMO [11] Community-rated HMO [11]

Subject: 2013 Technical Guidance and Instructions for Preparing Benefit and Service Area Proposals for New HMOs

Enclosed are the technical guidance and instructions for preparing your benefit proposals for the contract term January 1, 2013 through December 31, 2013. Please refer to our annual Call Letter (Carrier Letter 2012- 09) dated March 29, 2012 for policy guidance. Benefit policies from prior years remain in effect unless otherwise noted. The Guidance and instructions are in three parts:

- Part One: Preparing Your Benefit Proposal
- Part Two: Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program
- Part Three: Benefits for Newly-Approved HMOs

This year's deadlines are as follows:

- **No later than May 11, 2012:** Please send your community benefit package and non-Federal group benefit package we purchased.
- **No later than May 31, 2012:** Please send your complete proposal for benefit changes and clarifications to your contract specialist on a CD-ROM (or other electronic means) in addition to a hard copy. Your proposal should include corresponding language describing all proposed brochure changes. Your OPM contract specialist will discuss your proposed benefits and finalize negotiations in a close-out letter.
- **Within five business days following receipt of close-out letter or by date set by your contract specialist:** Please send him/her an electronic version of your fully revised 2013 brochure. See Attachment V-Preparing Your 2013 Brochure.

Carriers are strongly encouraged, as always, to follow our guiding principles of affordability and value based benefit design when preparing proposals. This year you will see an increased focus on quantitative data which we need to measure each plan's overall performance. For some items, we ask for historical data to establish a baseline for performance reviews. In addition, we appreciate your continued timely efforts to submit benefit and rate proposals and to produce and distribute brochures.

Enclosed is a checklist (Attachment XIII) showing all the information to include with your benefit and rate proposals. Please return a completed checklist with your submission.

Rate instructions for community-rated plans and experience-rated plans will be provided under separate cover. Keep in mind that FEHB rate submissions are the cornerstone of our financial relationship with HMOs. We may audit your FEHB rates and their supporting documentation to ensure they are accurate and reasonable. If you misrepresent your FEHB Program rates, we may take criminal or civil legal

actions against the carrier or its officials. We, with the support of the Inspector General's Office and the Justice Department, will aggressively pursue any misrepresentation.

In keeping with the spirit of the Call Letter, we remain extremely price sensitive. Although we do not limit HMOs to zero-cost benefit trade-offs, we prefer that benefits remain consistent with your benefit package purchased by the greatest number of your subscribers.

Our experience is that a plan with less than four years experience in the FEHB Program is most at-risk for dropping out of the program. Newer plans that drop out are more likely to cite insufficient FEHB enrollment as the reason for no longer wishing to participate. The FEHB Program is a mature, managed-care market. Your ability to differentiate yourself in terms of pricing, benefits, service, or provider panel will go a long way in determining your program success. Keep your lines of communication open with your OPM contract specialist. Don't hesitate to call if you have any questions about the Call Letter or the material enclosed in this letter.

We look forward to working closely with you on these essential activities to ensure a successful Open Season again this year.

Sincerely,

John O'Brien
Director
Healthcare and Insurance

2013 FEHB Proposal Instructions

Part One - Preparing Your Benefit Proposal

Experience-rated Plans

Please send the following by May 11, 2012,

- A copy of a fully executed employer group contract (i.e., *certificate of coverage*) that non-Federal subscribers purchased in 2012.

Please send the following by May 31, 2012:

- You must file your proposed benefit package and the associated rate with your state, if required. If you have made changes since your application, submit a copy of the new benefits description and answer the questions below.

- Attach a chart displaying the following information:

    - Benefits that are covered in one package but not the other

    - Differences in co-insurance, co-pays, numbers of days of coverage and other levels of coverage between one package and the other

    - The number of subscribers/contract holders who currently purchase each package.

Community-rated Plans

We will continue to allow HMOs the opportunity to adjust benefits payment levels in response to local market conditions (as indicated in the *Call Letter for the 2009 contract year*). If you choose to offer an alternate community package, you should clearly state your business case for the offering. We will only accept an alternate community package if it is in the best interest of the Government and FEHB consumers. You should also identify each of the differences between your current benefit package and the proposed offering, and include the impact on your community-rated price proposal.

The alternate benefit package may include greater cost sharing for enrollees in order to offset premiums.

The alternate benefit package may not exclude benefits that are required of all FEHB plans, and may not exclude state mandated benefits. However, other benefits may be reduced or not covered if there is an impact on premiums.

Proposals for alternative benefit changes that would provide premium offset of only minimal actuarial value will not be considered.

Please consult with your contact in the Office of the Actuaries regarding the alternate community package and requirements for the use of Similarly Sized Subscriber Groups (SSSGs) in the rating process.

- Submit a copy of a fully executed community benefit package by May 11, 2012 (a.k.a. master group contract or subscriber certificate), including riders, co-pays, co-insurance, and deductible amounts (e.g. prescription drugs and durable medical equipment) that non-Federal subscribers purchased in 2012. The material must show all proposed benefits for FEHB for the 2013 contract term, except for those still under review by your state. We will accept the community-benefit package that you *project* will be sold to the majority of your non-Federal subscribers in 2013. If you offer a "national plan" then you need to send us copies of your community-benefit package for each state you cover.

Note: Your FEHB rate must be consistent with the community package on which it is based. Benefit differences must be accounted for in your proposal or you may end up with a defective community rate.

All HMOs

Your benefit proposal must be complete. The timeframes for concluding benefit negotiations are firm and we cannot consider late proposals. Your benefit proposal should include:

- Benefit package documentation
- A plain language description of each proposed benefit
- A signed contracting official's form (see attached)
- Describe your state's filing process for obtaining approval of benefit packages and changes. Provide a copy of your most recent state submission that applies to the benefit package you sent to us and a copy of the state's approval document. We usually accept proposed benefit changes if you submitted the changes to your state prior to **May 31, 2012,** and you obtain approval and submit approval documentation to us by **June 30, 2012**. Please let us know if the state grants approval by default; i.e., it does not object to proposed changes within a certain period after it receives the proposal. The review period must have elapsed without objection by June 30, 2012.

We will contact the state about benefits as necessary. Please provide the name and phone number of the state official responsible for reviewing your plan's benefits. If your plan operates in more than one state, provide the information for each state.

- Please highlight and address any state mandated benefits. State-mandated benefits should be reported if finalized by May 1, 2012.

If you anticipate significant changes to your benefit package, please discuss them with your OPM contract specialist before you prepare your submission.

Part Two - Changes in Service Areas or Plan Designation Since You Applied to the FEHB Program

Unless you inform us of changes, we expect your proposed service area and provider network to be available for the 2013 contract term. We are committed to providing as much choice to our customers as possible. Given consolidations in the managed-care industry, there are geographic areas where our customers have more limited choices than in other areas.

Please consider expanding your FEHB service area to all areas in which you have authority to operate. This will allow greater choice for our customers. **You must submit in electronic format all ZIP Codes for your existing service area and any new service area expansion that you propose.**

We will provide detailed instructions for submitting your ZIP Code file in September. However, please note that we will ask you to provide your ZIP Codes in a comma delimited text file format and we will provide instructions for uploading your files to our secure web portal.

- **Service Area Expansion** - You must propose any service area expansion by May 31, 2012. We may grant an extension for submitting supporting documentation to us until June 30, 2012.

- **Service Area Reduction** - Explain and support any proposed reduction to your service area. If this reduction applies only to the Federal group, please explain. Please provide a map and precise language to amend the service area description for both expansions and reductions.

Important Notices

- The information you provide about your delivery system must be based on **executed** contracts. We will not accept letters of intent.

- All provider contracts must have "hold harmless" clauses.

Service Expansion Criteria

We will evaluate your service area proposal according to these criteria:

- Legal authority to operate
- Reasonable access to and choice of quality primary and specialty medical care throughout the service area
- Your ability to provide contracted benefits

Please provide the following information:

- **A description of the proposed expansion area in which you are approved to operate:**

Provide the proposed service area expansion by ZIP Code, county, city or town (whichever applies), and provide a map of the old and new service areas. Provide the exact wording of how you will describe the service area change in the brochure.

- **The authority to operate in proposed area:**

  Provide a copy of the document that gives you legal authority to operate in the proposed expansion area, and the name and telephone number of the person at the state agency who is familiar with your service area authority.

- **Access to providers:**

  Provide the number of primary care physicians, specialty physicians, and hospitals in the proposed area with whom you have **executed** contracts. Also, please update this information on August 31, 2012. The update should reflect any changes (non-renewals, terminations or additions) in the number of executed provider contracts that may have occurred since the date of our initial submission.

Service and Additional Geographic Areas:

Federal employees and annuitants who live within the service area we approve are eligible to enroll in your plan. If you enroll commercial, non-Federal members from an **additional** geographic area that surrounds, or is adjacent to, your service area, you may propose to enroll Federal employees and annuitants who live in this area. In addition, if the state where you have legal authority to operate permits you to enroll members who **work** but do not reside within your commercial service area, and/or any additional geographic area, you may propose the same enrollment policy for your FEHB Program enrollees. We will provide model language for stating your policy in your brochure.

Benefits may be restricted for non-emergency care received outside the service area. Your proposal must include language to clearly describe any additional geographic area as well as your service area.

Federal Employees Health Benefits Program Statement about Service Area Expansion

(COMPLETE THIS FORM ONLY IF YOU ARE PROPOSING A SERVICE AREA EXPANSION)

We have prepared the attached service area expansion proposal according to the requirements found in the Technical Guidance for 2013 Benefits and Service Area Proposals. Specifically,

1. All provider contracts include "hold harmless" provisions.

2. All provider contracts are fully executed at the time of this submission. I understand that letters of intent are not considered contracts for purposes of this certification.

3. All of the information provided is accurate as of the date of this statement.

_____
Signature of Plan Contracting Official

_____
Title

_____
Plan Name

_____
Date

Part Three – Benefits for Newly-Approved HMOs

The policies established in prior years remain in effect unless we have stated otherwise. You should work closely with your contract specialist to develop a complete benefit package for 2013. For guidance in preparing your proposal for High Deductible Health Plans (HDHP), Health Savings Accounts (HSA), and Health Reimbursement Arrangements (HRA), please refer to *Call Letter* (Carrier Letter 2008-06) dated March 11, 2008. The FEHB policies include the following:

We expect that you cover state-mandated benefits even if your community package does not specifically reference them.

As stated in the 2013 Call Letter, our three primary initiatives this year are:

- Implementing additional requirements under the Affordable Care Act;
- Improving the delivery and cost efficiency of prescription drugs; and
- Advancing quality of care principles.

I. CALL LETTER INITIATIVES

A. Implementing the Affordable Care Act

1. Lifetime and Annual Limits on Essential Health Benefits

FEHB plans have historically not imposed lifetime limits and we will continue to enforce this requirement.

In addition, FEHB plans are expected to eliminate annual limits on essential health benefits (EHB), regardless of grandfathered plan status.

On December 16, 2011, the Department of Health and Human Services (HHS) released a Bulletin (http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) describing its approach to define EHB under the Affordable Care Act. On February 17, 2012, HHS issued a FAQ (http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf) to provide additional guidance on the subject.

Information Required for Proposal: Attachment II- Lifetime and Annual Limits on Essential Health Benefits

2. Clinical Trial Coverage

FEHB plans are expected to comply with certain coverage requirements for clinical trials next year, in advance of required implementation for 2014, regardless of grandfathered status. The requirements are described in detail in Attachment V.

Information Required for Proposal: Attachment III- Clinical Trial Coverage

3. Preventive Services

Last year, we requested FEHB plans to eliminate cost-sharing for all recommended in-network preventive services, immunizations, screenings, tobacco cessation services and medications. Please check the latest posting by the Advisory Committee on Immunization Practices (ACIP) at http://www.cdc.gov/vaccines/pubs/ACIP-list-by-date.htm for the full list of required vaccinations as some have changed. Note that, unless otherwise specified, plans must cover these requirements no later than the start of the plan year which follows the year in which the recommendation becomes effective.

Plans must submit proposals that cover preventive services, including birth control, with no cost-sharing, regardless of grandfathered status. The Affordable Care Act adds new preventive services requirements for 2013 that go beyond recommendations of the United States Preventive Services Task Force. See http://www.hrsa.gov/womensguidelines/.

Information Required for Proposal: Attachment IV- Preventive Services

4. 2013 Brochure

FEHB plans are required to provide a "Summary of Benefits" for 2013, in advance of required implementation for 2014, regardless of grandfathered status. To evaluate our "Going Green" goals to help reduce FEHB administrative costs, please provide your cost savings information on the worksheet provided. You will receive additional guidance in a forthcoming carrier letter.

Information Required for Proposal: Attachment V-Preparing Your 2013 Brochure

B. Improving the Delivery & Cost Efficiency of Prescription Medications

OPM continues to explore innovative methods to reduce pharmacy spending and to develop effective prescription drug management without cost shifting or burdening members. The rate proposal, which you will receive separately, has our pharmacy data request.

Information Required for Proposal:

- Describe effective prescription drug management without cost shifting or burdening enrollees;
- Describe proposals to implement specialty drug programs that manage these cost;
- Describe how you are managing the control of drug administrative cost such as dispensing fees; and
- Complete Attachment VI for four issues below:

(1) Generic Medications

OPM's target for 2013 is to achieve an overall FEHB average generic dispensing rate of at least 75 percent**.** The Generic Dispensing Rate (GDR) is defined as the percentage of total prescriptions filled with generic drugs.

(2) Specialty Pharmacy

OPM's target is to stabilize the growth and cost of specialty drugs by keeping cost trends below the industry average of 14 to 20 percent.

(3) Pharmacy Benefit Managers Accreditation

FEHB plans should provide the highest quality pharmacy services to Federal employees, retirees and their families as demonstrated by the accreditation status of their pharmacy benefit managers (PBMs) or pharmacy components.

(4) Control of Dispensing Fees

Carriers will provide OPM with baseline data on the administrative fees in their current PBM contracts and describe how they intend to mitigate inflation in those fees. Examples are dispensing fees for generic drugs, brand name drugs, and for specialty drugs.

C. Advancing Quality of Care

1. Quality

OPM supports enhanced care coordination and the principles underlying patient centered medical homes (PCMH). To the greatest extent possible, we encourage participation in pilots offered by states or other Federal agencies, including the Comprehensive Primary Care (CPC) initiative sponsored by the Centers for Medicare and Medicaid Innovation Center. Read about this important initiative at http://www.innovations.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/index.html We invite you to propose arrangements through which your FEHB members can participate in the new CPC activities.

> Information Required for Proposal: Attachment VII-Quality of Care: PCMH

Additionally, we support the goals of the HHS' *Partnership for Patients, Better Care, Lower Costs* to reduce hospital readmissions by 20 percent and decrease preventable hospital acquired conditions by 40 percent when compared with 2010. We expect that you will make concerted efforts to improve the quality and safety of health care by addressing both those concerns.

> Note: Plans will receive separate guidance in a forthcoming Carrier Letter describing how to measure applicable rates for FEHB populations.

We seek to eliminate elective deliveries before 39 weeks' gestation to reduce prematurity and adverse neonatal outcomes. We encourage you to describe initiatives supporting this goal in your benefit proposal, including those in place through your plan, participating hospitals or network providers.

> Note: The forthcoming Carrier Letter regarding readmission and preventable conditions will include data requests reflecting maternity care and prematurity.

2. Wellness

In your proposal, please describe all wellness programs you intend to offer - including any quantitative data or other measures of their effectiveness - that can improve employee productivity, enhance healthy lifestyles and lower long-term healthcare costs.

FEHB plans are expected to continue programs to manage obesity as part of their focus on members' health and wellness. Your 2013 benefit proposal should update weight management coverage to ensure that enrollees receive all appropriate support to achieve and sustain a healthier weight.

Information Required for Proposal: Narrative information on all wellness programs with outcome data and Attachment VIII-Weight Management

II. BENEFITS & SERVICES

A. New Guidance: Coverage of Applied Behavior Analysis (ABA)

The OPM Benefit Review Panel recently evaluated the status of Applied Behavior Analysis (ABA) for children with autism. Previously, ABA was considered to be an educational intervention and not covered under the FEHB Program. The Panel concluded that there is now sufficient evidence to categorize ABA as medical therapy. Accordingly, plans may propose benefit packages which include ABA.

Information Required for Proposal: Describe what benefit package you intend to offer and describe how you will deliver these services through appropriate providers.

B. Continued Focus from Previous Years

1. Health & Wellness

We encourage you to offer financial incentives to enrollees who (a) complete a health risk assessment or biometric assessment or (b) participate in wellness activities or treatment plans to improve their health status.

Information Required for Proposal: Attachment IX-Health & Wellness

2. Increase FEHB providers

We encourage you to increase the number of health care providers in FEHB plan networks who are board certified or have training in geriatrics.

Information Required for Proposal: Attachment X-Geriatric Providers

3. Affinity Products

We encourage you to add products on the "non-FEHB" page of your plan brochure that may be of interest to members and ineligible family members, especially individual policies for domestic

partners as well as for members who may seek additional insurance products, such as short-term disability.

Information Required for Proposal: Attachment XI-Affinity Products

4. Organ/Tissue Transplants

We have updated the guidance on organ/tissue transplants which we provided in last year's technical guidance. When a carrier determines that a transplant service is no longer experimental, but is medically accepted, you may begin providing benefits coverage at that time. Carriers are not obligated to wait for the next contract year before they begin providing such benefits. We have updated the following table in Attachment XII:

- Table 1– OPM's required list of covered organ/tissue transplants. Although we no longer require coverage for autologous transplants for breast cancer, plans may continue to offer it.

Information Required for Proposal: Attachment XII: 2013 Organ/Tissue Transplants and Diagnoses

5. Describing Prescription Drug Co-Pays in the Guide to Federal Benefits

Plans that use levels or tiers to denote different prescription drug co-pays must clearly describe the coverage and difference between each level or tier in the 2013 brochure. The *2013 Guide to Federal Benefits* will illustrate the prescription drug co-pays at the following levels.

- Level I – generally includes generic drugs, but may include some brand formulary or preferred brands. Usually represents the lowest co-pays.
- Level II – generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I. Usually represents brand or middle-range co-pays.
- Level III – may include all other covered drugs not on Levels I and II, i.e. non-formulary or non-preferred and some specialty drugs.

If your plan has more than three co-pay levels for prescription drug coverage, please work with your OPM Contract Specialist to ensure that we accurately reflect your coverage in the *2013 Guide to Federal Benefits.*

6. Point of Service Product

We will consider proposals to offer a Point of Service (POS) product under the FEHB Program. Your plan's proposal must demonstrate experience with a private sector employer who has already purchased the POS product.

7. Infertility Treatment

We require you to cover diagnosis and treatment of infertility including at least one type of artificial insemination. **This requirement does not include related prescription drugs.** Your

brochure language must indicate if you cover or exclude fertility drugs in both the infertility benefit section and the prescription drug benefit section.

8. Reduce Health Disparities

We encourage you to submit proposals that aim to reduce disparities, such as racial and ethnic disparities, in both health status and healthcare. Please provide us with a description of the specific goals and processes you are undertaking or plan to implement in order to reduce health disparities.

9. Actuarial Value

We are requesting additional information on the medical loss ratio for FEHB plans. Please refer to the medical loss ratio defined in both the Affordable Care Act (Public Laws 111-148 & 111-152) and the interim final regulation published by the Department of Health and Human Services on December 1, 2010 (75 FR 74864). We are also requesting your best estimate of the actuarial value for each of your FEHB plan options.

10. Facility Fee for an Office Visit

We would like to clarify that if an enrollee visits a doctor whose office is located in a facility (such as a hospital), the enrollee should only be charged the doctor's co-payment. We have been informed that some enrollees are charged the hospital co-payment in addition to the doctor's copayment. Please ensure that this does not occur.

11. Smoking Cessation

Carriers must offer smoking cessation programs without co-payments or co-insurance and which are not subject to deductibles, annual or lifetime dollar limits. The programs must include at least two quit attempts per year with up to four smoking cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling and individual counseling. In addition to the smoking cessation programs, drugs (over-the-counter (OTC) and prescribed) approved by the FDA to treat tobacco dependence for smoking cessation should be available with no co-payments or co-insurance and not subject to deductibles, annual or life time dollar limits (a list of covered OTC drugs is attached). Plans should include OTC drugs in their smoking cessation programs.

Plans must follow the FDA guidelines for all approved drugs. Enrollees who use drugs with multiple purposes, such as Zyban which may be used to treat smoking cessation or depression, must be carefully monitored by a health care professional.

For further information regarding tobacco cessation treatment, please reference the Clinical Practice Guideline, Treating Tobacco Use and Dependence 2008 Update, U.S. Department of Health and Human Services Public Health Service, May 2008. Here is a link to the Guideline: http://www.surgeongeneral.gov/tobacco/treating_tobacco_use08.pdf

12. Donor Testing Services

We are enhancing benefits related to donor testing services for bone marrow and stem cell

transplants and encourage proposals that include testing for up to four bone marrow transplant donors per year. We encourage proposals that include testing for up to four potential bone marrow transplant donors per year from individuals unrelated to the patient, in addition to testing of family members.

13. Assistive Technologies

We encourage you to review your benefits on assistive technologies, including hearing aids, speech generating devices, and prescription drug readers. We also encourage you to offer auditory osseointegrated implants / bone anchored hearing aid (BAHA). Please note that the BAHA benefit should be listed under orthopedic/prosthetic devices in your plan brochure. For those plans which offer these benefits with dollar limitations, we are encouraging proposals to increase those dollar amounts.

14. Coordination of Benefits

When FEHB Program plans pay secondary COB claims, including those with **Medicare**, they pay the lesser of their allowance or the difference between their allowance and what is paid by the primary plan. You may continue to charge the member co-payments or co-insurance on secondary COB claims. If your benefit design includes co-insurance, it should be based on the remaining charge, not on your allowance. In the following example Medicare is primary and your health plan is secondary. The plan design requires the member to pay 10% co-insurance.

DOS 02/01/10 billed:	$10,000
Medicare allowance:	$9,000
Medicare payment:	$7,200 (80% of allowance)
Balance after Medicare payment:	$1,800
Member responsibility:	$1,800 x 10% = $180
Plan pays:	$1,800 x 90% = $1,620

If your brochure language does not correctly describe this process currently, please work with your contract specialist to ensure that your 2013 Federal brochure correctly describes this process.

15. Catastrophic Limitations

We expect carriers to fully describe their catastrophic limitations for all benefits as well as balance billing for the services of out-of network providers to ensure FEHB enrollees receive appropriate coverage for medically necessary services. We encourage proposals to mitigate any gaps you may have in the catastrophic coverage that you offer.

Please provide a full description of your catastrophic limit(s):

1. Describe the expenses that fall under each of these categories: medical, surgical, mental health and prescription drug benefits.
2. Please indicate completely what expenses are still the member's responsibilities after the member has reached the limit.
3. If you have an out-of-network benefit, please include any payments that members could be responsible for after they have met the catastrophic limit, including provider balance billing. We will consider cost neutral proposals that mitigate the potential for high cost

sharing.

4. Given your catastrophic limits, what is the maximum out of pocket expense a member may pay for covered services?

16. Preventable Medical Errors

We encourage you to review your coverage guidelines with respect to preventable medical errors and to revise your policies as long as you have arrangements in place to protect your members from balance billing.

17. Preventive Care

As stated in last year's *Call Letter*, we encourage your review of your current preventive benefits for adults and compare them to the United States Preventive Services Task Force (USPSTF) recommendations and propose benefit changes to address any gaps between the two. The USPSTF guidelines are at http://www.ahrq.gov/clinic/uspstfix.htm.

18. Mental Health Parity

The Department of Health and Human Services, Department of Labor, and Department of Treasury released interim final regulations for the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Under these rules, health plans cannot have separate deductible and out-of-pocket maximum requirements that are applicable only with respect to mental health or substance use disorders. This means plans must accrue member expenses toward the same deductibles and out-of-pocket maximums for both medical and surgical benefits and mental health and substance use disorder benefits. In addition, if a health plan has a lower copayment for Primary Care Physician visits, the Plan must use the same copayment level for outpatient visits to providers of mental health or substance use disorder services.

These regulations require parity between medical/surgical and mental health/substance use disorder benefits with respect to financial requirements (copayment, co-insurance, deductibles, and out-of-pocket maximums) or treatment limitations (visit or treatment limit) in the following six classifications: (1) inpatient, in-network, (2) inpatient, out-of-network, (3) outpatient, in-network, (4) outpatient, out-of-network, (5) emergency care, and (6) prescription drug benefits. A financial requirement or treatment limitation must be compared only to a financial requirement or treatment limitation of the same type (co-payments, co-insurance, etc.). For instance, co-payments are compared only to other co-payments; co-payments cannot be compared to co-insurance and vice versa.

In addition, the regulations state a health plan that provides both medical/surgical benefits and mental health or substance use disorder benefits may not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant (level of type of financial requirement applied to more than one half) financial requirement or treatment limitation of that type that is applied to substantially all (at least two-thirds) medical/surgical benefits in the same classification. In other words, if co-payments are identified as the financial requirement applied to substantially all medical/surgical benefits (measured by plan costs) in that classification and there are multiple levels of co-payments, the level that applies to more than one half would be considered the

"predominant" financial requirement for that classification. Similarly, if a single level applies to at least two-thirds of medical/surgical benefits in a classification, then that level is considered the predominant level that applies to mental health/substance use benefits in that classification. Example: Plan A co-payments apply to at least two-thirds of inpatient/in-network classification and there are two levels of co-payments ($20 & $30); however, the $30 copayment applies to more than one-half of the benefits in that classification, in this case the $30 copayment would be the predominant level.

The regulations prohibit discrimination in the application of non-quantitative treatment limitations, such as medical management standards, prescription drug formulary design, determinations of usual, reasonable and customary amounts, step therapy, and requiring benefits be subjected to a condition such as completing a course of treatment. Any elements used in non-quantitative treatment limitations for mental health benefits must be comparable to those used for medical and surgical benefits. The regulations allow variations to this rule to the extent that recognized clinically appropriate standards of care permit a difference; therefore, concurrent review of mental health care can be required even if the same is not required for medical surgical care.

For further guidance refer to carrier Letter No. 2008-17 and Letter No. 2009-08 as well as the Interim Final Rules implementing the Act: http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf

19. Maternity and Mastectomy Admissions

All plans must provide for maternity benefits. Benefits must be for coverage of admissions of at least 48 hours after a regular delivery and 96 hours after a cesarean delivery, at the mother's option. Similarly, all plans must provide a mastectomy patient the option of having the procedure performed on an in-patient basis and remaining in the hospital for at least 48 hours after the procedure.

20. Immunizations for Children

All FEHB plans must provide coverage for childhood immunizations, including the cost of inoculations or serums.

21. Dental, Vision and Hearing Benefits

All plans must cover medically necessary treatment of conditions and diseases affecting eyes and ears, such as glaucoma, cataracts, ruptured ear drums, etc. Beyond treatment for medical conditions by appropriate providers, we will consider dental care (preventive, restorative, orthodontic, etc.), vision care (refractions, lenses, frames, etc.), or hearing care benefits from community-rated plans when these benefits are a part of the core community benefit package that we purchase. It is important that your 2013 brochure language clearly describes your coverage.

22. Physical, Occupational and Speech therapy

You must provide coverage for no less than two consecutive months per condition. You may provide a richer benefit, such as 60 visits per condition, if that is your community benefit. You may apply co-pays or co-insurance of up to 50 percent if that is your community benefit. All

plans must provide **speech** therapy when medically necessary. If your community package limits speech therapy coverage to rehabilitation only, you must remove that limit for the FEHB Program.

Federal Preemption Authority

The law governing the FEHB Program gives OPM the authority to pre-empt state laws regarding the nature or extent of coverage or benefits, including payments with respect to benefits. We do not pre-empt state laws that increase our enrollees' benefits unless the state mandate conflicts with Federal law, FEHB regulations, or Program-wide policy.

Department of Health and Human Services (HHS) Benefits

All HMOs *must* offer certain benefits that the Department of Health and Human Services (HHS) requires for Federally-qualified plans, **without limits on time and cost,** except as prescribed in the Public Health Service Act and HHS regulations. These required benefits include:

- Non-experimental bone marrow, cornea, kidney, and liver transplants
- Short-term rehabilitative therapy (physical, occupational, and speech), if significant improvement in the patient's condition can be expected within two months
- Family planning services include all necessary non-experimental infertility services such as artificial insemination with either the husband's or donor sperm. You do not have to cover the cost of donor sperm if it is not in your community package. You may exclude benefits for conception by artificial means or assisted reproductive technology to the extent permitted by applicable state law and excluded in your community package
- Pediatric and adult immunizations, in accordance with accepted medical practice
- Allergy testing, treatment and allergy serum
- Well-child care from birth
- Periodic health evaluations for adults
- Home health services
- In-hospital administration of blood and blood products (including "blood processing")
- Surgical treatment of morbid obesity, when medically necessary
- Implants – you must cover the surgical procedure, but you may exclude the cost of the device

if the device is excluded in your community package

Federally-qualified, community-rated plans offer these benefits at no additional cost, since the cost is covered by the community rate. Community-rated plans that are not Federally-qualified should reflect the cost of any non-community benefits on Attachment II of their rate calculation. If there is no additional cost, the cost entry should be zero.

Attachment I: FEHB Carrier Contracting Official

The Office of Personnel Management (OPM) will not accept any contractual action from

_____ (Carrier),
including those involving rates and benefits, unless it is signed by one of the persons named below (including the executor of this form), or on an amended form accepted by OPM. This list of contracting officials will remain in effect until the carrier amends or revises it.

The people named below have the authority to sign a contract or otherwise to bind the Carrier

for _____ (Plan).

Enrollment code (s):_____

Typed name	Title	Signature	Date

By: _____
(Signature of contracting official) (Date)

_____
(Typed name and title)

_____ _____
(Telephone) (FAX)

_____
(Email)

Attachment II: Affordable Care Act – Lifetime and Annual Limits on Essential Health Benefits

Essential Health Benefits

The Secretary of Health and Human Services issued preliminary guidance on essential benefits and asked issuers to make a good faith effort to comply with a reasonable interpretation of the term "essential health benefits." Please read the two HHS documents on "essential health benefits" – citations for both appear earlier in this Technical Guidance.

We ask that you carefully consider whether a particular benefit is essential by taking into account medical evidence and best practices for your other health plan offerings.

Essential health benefits include items and services within the following 10 categories: 1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health and substance use disorder services, including behavioral health treatment, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive and wellness services and chronic disease management, and 10) pediatric services, including oral and vision care.

Lifetime Limits

Does your plan have any lifetime limits? Yes___No___.

If yes, please list each specific limit and its justification.

Annual Limits

Please complete the table below listing any services for which your plan now enforces annual limits.

LIST EACH SERVICE IN PLAN YEAR 2012 THAT HAS ANNUAL LIMITS

Attachment III: Affordable Care Act - Clinical Trial Coverage Requirement

Section 2709 of the Public Health Service Act, as amended by the Affordable Care Act, requires group health plans to provide coverage for approved clinical trials. Specifically, health plans may not deny the individual participation in certain clinical trials; may not deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and may not discriminate against an individual on the basis of that individual's participation in such trial.

Routine patient costs include all items and services consistent with the coverage provided in the plan (or coverage) that is typically covered for a qualified individual who is not enrolled in a clinical trial. An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

FEHB plans are expected to comply with these coverage requirements for clinical trials next year, in advance of required implementation for 2014, and regardless of grandfathered status.

Please indicate your plan policies regarding clinical trials in the table below:

CLINICAL TRIAL COVERAGE REQUIREMENT	YES	NO
Routine patient costs for individual participation in phase I, II, III or IV clinical trials conducted to prevent, detect or treat cancer that is Federally funded;** conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application.		
Routine patient costs for individual participation in phase I, II, III or IV clinical trial conducted to prevent, detect or treat life-threatening diseases or conditions* that are Federally funded;** conducted under investigational new drug application reviewed by FDA; or conducted as a drug trial exempt from the requirement of an investigational new drug application.		
Please describe the implementation process for any clinical trials you will cover.		

*Life threatening condition or disease means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

**Federally funded means that the study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

1) The National Institutes of Health
2) The Centers for Disease Control and Prevention
3) The Agency for Health Care Research and Quality
4) The Centers for Medicare and Medicaid Services
5) Cooperative group or center any of the entities described in 1-4 above or the Department of Defense or the Department of Veterans Affairs
6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
7) If the study or investigation has been reviewed and approved through a system of peer review that has been approved by the Secretary of HHS and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review, then the Department of Veterans Affairs, the Department of Defense or the Department of Energy.

Attachment IV - Affordable Care Act: Preventive Services

Last year, FEHB plans were requested to eliminate cost-sharing for all recommended in-network preventive services, immunizations, screenings, tobacco cessation services and medication. Please check the latest posting by the Advisory Committee on Immunization Practices (ACIP) at http://www.cdc.gov/vaccines/pubs/ACIP-list-by-date.htm for the full list of required vaccinations as some have changed. Plans are required to cover these requirements no later than the start of the plan year which follows the year in which the recommendation becomes effective.

The Affordable Care Act adds some new preventive service requirements for 2013 that go beyond recommendations of the USPSTF. The list of services is available at http://www.hrsa.gov/womensguidelines/.

FEHB plans are required to provide the following preventive services with **no cost sharing** for plan year 2013.

Please complete the effective date for each type of service listed below. If you are already offering it, list what year it began.

Preventive Service	HHS Guideline	Frequency	Effective Date
Well-woman visits	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713 of the Public Health Service Act.	Annual, although several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs and other risk factors. *	
Screening for gestational diabetes	Screening for gestational diabetes	In pregnant women between 24 and 28 weeks of gestation and at first prenatal visit for pregnant women identified to be at high risk for diabetes.	
Human papillomavirus testing	High-risk human papillomavirus DNA testing in women with normal cytology results	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.	
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women	Annual	
Counseling and screening for human immune-deficiency virus	Counseling and screening for human immune-deficiency virus infection for all sexually active women	Annual	

Contraceptive methods and counseling **	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed	
Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.	
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	Annual.	

* Refer to recommendations listed in the July 2011 IOM report entitled Clinical Preventive Services for Women: Closing the Gaps concerning individual preventive services that may be obtained during a well-woman preventive service visit.

** Group health plans sponsored by certain religious employers, and group health insurance coverage in connection with such plans, are exempt from the requirement to cover contraceptive services. A religious employer is one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a non-profit organization under Internal Revenue Code section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii). 45 C.F.R. §147.130(a)(1)(iv)(B). See the *Federal Register* Notice: Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act.

Attachment V - Preparing Your 2013 Brochure

Summary of Plan Benefits

The Affordable Care Act requires group health plans to provide a summary of plan benefits and coverage based on standards developed by the Secretary of the Department of Labor. We intend to start the process of implementing the summary requirements in this year's Brochure Creation Tool for the 2013 contract year. We will provide you more detailed information on how this process works as soon as it becomes available.

Going Green

We appreciate your efforts to support our "Going Green" goals to help reduce FEHB administrative costs. You may provide paper copies of plan brochures to new members or only upon request to current members and may send Explanations of Benefits, newsletters and other plan materials electronically.

Timeline: 2013 Brochure Process

We will continue to use the brochure process we implemented last year. This process is a web application that uses database software to generate a Section 508-compliant PDF. This year's deadlines and significant dates are:

DEADLINES	REQUIRED ACTIVITY
May 31	Plans submit Section 5 Benefits information with proposal if suggesting new option
July 2	Plans receive *2013 FEHB Brochure Handbook* via listserv
July 2	OPM will provide *2013 Brochure Creation Tool (BCT) User Manual*
July 2-August 31	OPM circulates updated FEHB Brochure Handbook pages by listserv
September 4	Plans must enter all data into Section 5 Benefits and update all plan specific information in the brochure tool. Plans will be unable to make changes after this date so that Contract Specialists can review PDF versions of plan brochures. If changes need to be made, we will unlock plan brochures on a case-by-case basis.
September 10	OPM sends brochure quantity form to plan after Contract Specialist approves brochure for printing as well as other related Open Season instructions.
August 24	OPM's deadline to finalize all language and shipping labels

In July, we will provide in-house training to refresh plans on the use of the Brochure Creation Tool with 10 individual sessions held at OPM. We will notify plans via the FEHB Carriers listserv about the training dates and times. Please send any comments or questions pertaining to the Brochure Creation Tool to Lionell Jones at lionell.jones@opm.gov or Angelo Cueto at angelo.cueto@opm.gov.

Attachment VI: Pharmacy
Table 1: Generic Dispensing Rate (GDR)

Remember to prepare your data worksheet to return to OPM actuaries.

Have you already reached our target GDR of at least 75%? Yes __No___. If yes, you may skip the rest of this worksheet.

If not, please describe what activities - beyond those currently in place - you will implement to reach this target for 2013? Please describe the three activities that are most likely to help you reach this goal.

Generic Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	
Generic Initiative	
Target Beneficiary Population	
Anticipated participation rate	

Expected beneficiary impact	
Projected results: each target population	
Generic Initiative	
Target Beneficiary Population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Attachment VI: Pharmacy
Table 2: Specialty

Remember to prepare your data worksheet to return to OPM actuaries.

Have you already reached our specialty pharmacy target of keeping cost trends below the industry average of 14 to 20 percent? Yes/No. If yes, you may skip the rest of this worksheet.

If not, please describe what activities - beyond those currently in place - you will implement to reach this target for 2013? Please describe the three activities that are most likely to help you reach this goal.

Specialty Initiative	
Target beneficiary population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	
Specialty Initiative	
Target beneficiary population	
Anticipated participation rate	

Expected beneficiary impact	
Projected results: each target population	
Specialty Initiative	
Target beneficiary population	
Anticipated participation rate	
Expected beneficiary impact	
Projected results: each target population	

Attachment VI: Pharmacy
Table 3: PBM Accreditation

Is your PBM separately accredited?	Yes/No
If yes, what is the accrediting organization?	
What was the accreditation effective date?	
What is the accreditation expiration date?	
If your PBM is not separately accredited, is it included in your overall accreditation?	Yes/No
What is the accrediting organization?	
What was the accreditation effective date?	
What is the accreditation expiration date?	
If you have a separate PBM that is not yet accredited, what are your plans to obtain that credential?	

Attachment VI: Pharmacy
Table 4: Control of Dispensing Fees

What are the average fees in your current PBM agreement?	
Generics	
Brand	
Specialty Drugs/Biologics	

Attachment -VII: Quality of Care – Patient Centered Medical Home (PCMH)

Requested Data Item	Data Response
What percentage of your in-network primary care practitioners were recognized as medical homes at the start of 2012 plan year?	
What percentage of your in-network primary care practitioners do you project will be recognized as medical homes at the start of the 2013 plan year?	
How many covered lives were enrolled/attributed to a PCMH practice in 2011?	
How many covered lives were enrolled/attributed to a PCMH practice in 2012?	
How many are projected for 2013?	

PCMH Narrative Responses

1. What criteria do you use to recognize a practice as meeting the definition of medical home or advanced primary care?

2. Describe all applicable provider or health system payment incentives, along with your evaluation of their effectiveness.

Attachment VII: Quality of Care – PCMH-Page 2

3. How are members invited to participate in a PCMH?

4. How will members learn about quality outcomes associated with the PCMH practices?

5. List the results of each specific outcome metric you use - exclusive of HEDIS and CAHPS - to evaluate the quality and continuity of care delivered in the PCMH practices (e.g. % decrease admissions; % decrease ER utilization, etc.).

6. Are you able to propose including an FEHB population in the Comprehensive Primary Care initiative? Yes/No___.

   If yes, what arrangements will you make for these members to participate?

Attachment VIII: Weight Management

List each covered service for weight management. In addition, list any specific exclusions that may limit access to weight management services, for both adults and children.

Requested Data Item	Adults (use 1 cell/response)	Children (use 1 cell/response)
Covered service/initiative		
Exclusions		

Describe SUSTAINED RESULTS from one recent initiative for adults and provide quantitative outcome data.

Initiative	
Target Population	Adults ages ___ - ___
Participation rate	
Outcome results	

Describe SUSTAINED RESULTS from one recent initiative for children and provide quantitative outcome data.

Initiative	
Target Population	Children ages ___ - ___
Participation rate	
Outcome results	

Attachment IX: Health/Wellness

What percentage of your enrollment has completed a health risk or biometric assessment in the last two years?
What do you think is your most effective financial incentive program to engage members in their own health management?
How has your financial incentive program helped to improve or change members' health outcomes?

1. Describe sustained results from one recent initiative for adults:

Describe Initiative	
Target Population	Adults ages ___ - ___
Participation rate	
Results	

2. Describe sustained results from one recent initiative for children:

Describe Initiative	
Target Population	Children ages ___ - ___
Participation rate	
Results	

Attachment X: Geriatric Providers

Plan Year	2012	2013
Do you have a mechanism to identify providers with geriatric training or certification (including those PCPs with these qualifications) in your FEHBP directory?		
How many enrollees do you have over age 65?		

Attachment XI: Affinity Products

Please indicate yes/no in each column on the table below:

Product	2012-Yes/No	2013-Yes/No
Do you offer individual policies for domestic partners?		
Do you list individual policies for domestic partners on your non-FEHB page?		
Do you offer short-term disability coverage?		
Do you list short-term disability coverage on your non-FEHB page?		

Attachment XII: 2013 Organ/Tissue Transplants and Diagnoses:

Table 1: Required Coverage

I. Solid Organ Transplants: Subject to Medical Necessity	**Reference**
Cornea	Call Letter 92-09
Heart	Call Letter 92-09
Heart-lung	Call Letter 92-09
Kidney	Call Letter 92-09
Liver	Call Letter 92-09
Pancreas	Call Letter 92-09
Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas	Carrier Letter 2001-18
Lung: Single/bilateral/lobar	Carrier Letter 91-08
II. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. Plan's Denial is Limited to the cytogenetics, subtype or staging of the diagnosis (e.g. acute, chronic) as appropriate for the diagnosis.	
Allogeneic transplants for:	
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
Advanced Hodgkin's lymphoma – relapsed	
Advanced non-Hodgkin's lymphoma - relapsed	
Acute myeloid leukemia	
Advanced Myeloproliferative Disorders (MPDs)	
Amyloidosis	
Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	
Hemoglobinopathy	
Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)	
Myelodysplasia/Myelodysplastic Syndromes	
Paroxysmal Nocturnal Hemoglobinuria	
Severe combined immunodeficiency	
Severe or very severe aplastic anemia	
Autologous transplants for:	
Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	Call Letter 96-08B
Advanced Hodgkin's lymphoma – relapsed	Call Letter 96-08B
Advanced non-Hodgkin's lymphoma - relapsed	Call Letter 96-08B
Amyloidosis	
Neuroblastoma	Call Letter 96-08B

III. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity	
Allogeneic transplants for:	
Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	
Autologous transplants for:	
Multiple myeloma	Carrier Letter 94-23, Call Letter 96-08B
Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Carrier Letter 94-23, Call Letter 96-08B
IV. Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials.	
Autologous transplants for:	
Epithelial ovarian cancer	Carrier Letter 94-23 Call Letter 96-08B
Childhood rhabdomyosarcoma	
Advanced Ewing sarcoma	
Advanced Childhood kidney cancers	
Mantle Cell (Non-Hodgkin lymphoma)	
V. Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed under Section II): Subject to Medical Necessity	
VI. Tandem transplants: Subject to medical necessity	
Autologous tandem transplants for:	
AL Amyloidosis	
Multiple myeloma (de novo and treated)	
Recurrent germ cell tumors (including testicular cancer)	Call Letter 2002-14

Table 2: Recommended For Coverage. Transplants Under Clinical Trials

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2013?	
Blood or Marrow Stem Cell Transplants	**Yes**	**No**
Allogeneic transplants for:		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple myeloma		
Multiple sclerosis		
Sickle Cell		
Beta Thalassemia Major		
Chronic Inflammatory Demyelinating Polyneuropathy (CIDP)		
Non-myeloablative allogeneic transplants for:		
Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia		
Advanced Hodgkin's lymphoma		
Advanced non-Hodgkin's lymphoma		
Breast cancer		
Chronic lymphocytic leukemia		
Chronic myelogenous leukemia		
Colon cancer		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Multiple Myeloma		
Multiple Sclerosis		
Myeloproliferative Disorders		
Myelodysplasia/Myelodysplastic Syndromes		
Non-small cell lung cancer		
Ovarian cancer		
Prostate cancer		
Renal cell carcinoma		
Sarcomas		
Sickle Cell disease		
Autologous transplants for:		
Chronic myelogenous leukemia		
Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)		
Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		
Small cell lung cancer		

Autologous transplants for the following autoimmune diseases:		
Multiple sclerosis		
Systemic lupus erythematosus		
Systemic sclerosis		
Sclerodema		
Scleroderma-SSc (severe, progressive)		

Table 3: Recommended For Coverage

Technology and clinical advancements are continually evolving. Plans are encouraged to provide coverage during the contract year for transplant services that transition from experimental/investigational to being consistent with standards of good medical practice in the U.S. for the diagnosed condition. Please return this worksheet with your proposal.

	Does your plan cover this transplant for 2013?	
Solid Organ Transplants	**Yes**	**No**
Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis		
Blood or Marrow Stem Cell Transplants		
Allogeneic transplants for:		
Advanced neuroblastoma		
Infantile malignant osteopetrosis		
Kostmann's syndrome		
Leukocyte adhesion deficiencies		
Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)		
Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants)		
Myeloproliferative disorders		
Sickle cell anemia		
X-linked lymphoproliferative syndrome		
Autologous transplants for:		
Ependymoblastoma		
Ewing's sarcoma		
Medulloblastoma		
Pineoblastoma		
Waldenstrom's macroglobulinemia		

Attachment XIII: 2013 Technical Guidance Submission Checklist

Topic/Attachment Number	In Proposal Yes/No	Worksheet Completed Yes/No
FEHB Contracting Official (Attachment I)		
Annual limits for essential health benefits (Attachment II)		
New clinical trial coverage requirements (Attachment III)		
Expanded preventive services (Attachment IV)		
Pharmacy - Generic Medications (Attachment VI)		
Pharmacy - Specialty (Attachment (VI)		
Pharmacy - PBM (Attachment VI)		
Pharmacy - Control of Dispensing Fees (Attachment VI)		
PCMH (Attachment VII)		
Hospital readmissions & preventable hospital acquired conditions	Separate OPM guidance forthcoming	Not applicable
Early elective deliveries	Separate OPM guidance forthcoming	Not applicable
Weight management (Attachment VIII)		
Applied Behavior Analysis (ABA) services		None required
Health & Wellness (Attachment IX)		
Providers with geriatric expertise (Attachment X)		
Affinity products (Attachment XI)		
Organ/Tissue Transplants (Attachment XII)		
Technical Guidance Submission Checklist (Attachment XIII)	Not Required	

Please return this checklist with your CY 2013 benefit and rate proposal