# GUIDELINES EXCERPTS – ATTACHMENT B(1)

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5. Plans must administer an annual health risk assessment (HRA) and biometric screening to at least 30% of its adult members. Plans may provide incentives up to $150.00 in value to encourage participation. Biometric screenings shall at a minimum test: 1) glucose level; body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings shall be administered as non-fasting in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines. Members may submit test results obtained from an annual physical in lieu of completing a biometric screening if the submission includes verification of results ~~from~~ for the four tests listed above and the results were obtained within ~~six months from the date on which the HRA is submitted~~ the timeframe allowed by current USPSTF guidelines. The Board will reward health plans that administer HRAs and biometric tests to more than 50% of the Participants described above by crediting the plan's composite score during annual negotiation. Plans must demonstrate, upon request by the Department, their efforts in utilizing the results to improve the health of members of the group health insurance program.

6. Plans must demonstrate, upon request by the Department, their efforts in encouraging and/or requiring network hospitals, providers, large multi-specialty groups, small group practices and systems of care to participate in quality standards and initiatives, including those as identified by the Department.

7. Plans must demonstrate, upon request by the Department, their support for the Department's initiatives in monitoring and improving quality of care, such as collecting HEDIS measures and submitting quality improvement plans as directed by the Department. This may include providing actual contract language that specifies provider agreement or terms to participate in or report on quality improvement initiatives/patient safety measures and a description of their link, if any, to provider reimbursement.

8. Plans must provide the results of their annual CAHPS survey to the Department as follows:

   a. Results must be based on responses from commercially insured adult Plan members in Wisconsin;

   b. Survey must be conducted by a certified CAHPS survey vendor;

   c. Results must utilize the current version of the CAHPS Health Plan survey as specified by the National Committee for Quality Assurance (NCQA) guidelines at the time the survey is administered;

   d. Results must be for each standard NCQA composite;

   e. Plans must submit timely results in a file format as specified by the Department;

   f. Plans must submit separate results for each of its service areas, if available.

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11. Plans must provide a credible Shared Decision Making (SDM) program for Low Back Pain surgery consistent with the Prior Authorization requirement to all participants and may collaborate with providers to do so. Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS). Upon request by the Department, plans must report annual patient utilization rates and program impacts in accordance with Department guidance.

~~11.~~12. With the intent of reducing hospital admissions, ~~P~~plans must demonstrate, upon request by the Department, their efforts at contacting members who have been discharged from an in-patient hospital stay greater than twenty-four (24) hours and who have been diagnosed with heart failure, myocardial infarction, pneumonia, or any other high-risk health condition as specified by current Disease Management Guidance as issued by the Department, ~~are at high risk for readmission to the hospital within 30 days. Plans must contact high risk members~~ within 3-5 business days after the member is initially discharged from the hospital. Plans may coordinate with a hospital or provider group in order to contact these members.

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16. Each plan will offer the uniform benefit level provided public employees under the standard health benefit coverage. Each plan must meet any and all applicable state or federal requirements concerning benefits and cost-sharing which may be imposed on the State of Wisconsin as an employer, the plan as an insurer, or a federally qualified health benefit program. Rate adjustments, if any, required for such mandated benefit payments will occur on January 1 after the next contract period begins unless otherwise mutually agreed to in writing.

    Each plan will offer the uniform benefit level to annuitants. With respect to annuitants eligible for Medicare, each plan will offer the uniform benefit and carve-out the benefits paid by Medicare so that annuitants on Medicare receive the same uniform benefit level as provided active employees except that premium for annuitants on Medicare is reduced.

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2. The Board may waive the minimum participation requirement set forth under Section II., G., 1., provided the organization submits a marketing plan which demonstrates that this minimum number of contracts will be obtained at some future date. The marketing proposal should include some evidence that the benefit plan has been accepted to a similar extent by employees of other groups and the location is convenient to potential subscribers. This marketing plan will be considered confidential by the Board insofar as permitted by Wisconsin Law.

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As stated previously, each plan so approved will be required to offer annually, a "dual-choice enrollment" opportunity. The Board establishes when such dual-choice enrollment periods will be held. Each plan will be required to prepare informational materials in a form and content acceptable to the Board and clearly indicate any changes from the previous year's materials when submitting draft materials to the Department.

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Any health plan approved by the Board will be subject to the provisions of Wis. Stats. Chapter 40, and the rules of the Department of Employee Trust Funds. **The Board reserves the right to reject any plan's bid when the Board believes it is not in the best interests of the group health insurance program.** The Board reserves the right to reopen the bid process after final bids are submitted when the Board determines that it is in the best interests of the group health insurance program. The Board limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

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**J. Time Table and Due Dates For Annual Information Submittals to the Department of Employee Trust Funds**

*(Note: Unless otherwise specified, if the "Due Date" listed below falls on a Saturday, materials should be received by the Department the previous Friday. If the "Due Date" falls on a Sunday, materials should be received by the Department the following Monday.)*

| Due Date (Receipt by Dept) | Information Due | Date Submitted |
|---|---|---|
| April 15, ~~2012~~2013 | • New plans only. Proposal to participate in the program addressing each of the requirements in Section II of the Guidelines (Section II., I, page 1-18). | |
| April ~~30~~29, ~~2012~~2013 | • Estimated premium rate proposal for next calendar year. | |
| May 14, ~~2012~~2013 | • For PPPs and POSs – Any change to the level of benefits for out-of-plan services for the next benefit year must be submitted. | |
| June 14, ~~2012~~2013 | • Documentation of financial stability (2 copies each):<br>1. Balance sheet<br>2. Statement of Operations<br>3. Annual audited financial statement<br>• Preliminary identification of planned service areas by county for the next calendar year.<br>• Plan Utilization and Rate Review Information (Addendum 1). This information is to be mailed directly to:<br>~~Julie Maendel~~Nichole Ramsey<br>Deloitte Consulting<br>50 South Sixth Street | |

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| Due Date (Receipt by Dept) | Information Due | Date Submitted |
|---|---|---|
| | Suite 2800<br>Minneapolis, MN 55402-1538<br>• Addendum 1Tables 8A and 8B describing catastrophic data.<br>• Initial data files of: (1) Addendum 2 provider counts and (2) primary physicians and specialty providers under contract by county (and zip code) for the next calendar year.<br>• Report detailing the State of Wisconsin group experience with comparisons to aggregate benchmarks. [Section II., D., 8.] | |
| June 15, ~~2012~~2013 | • HEDIS information is required for the prior calendar year in the format as determined by the Department. | |
| July ~~9~~1, ~~2012~~2013 | • Preliminary ~~P~~premium rate quotations for next calendar year. (Annually, ~~about July 1,~~ each plan will be provided with a rate quotation form about one week in advance of the due date.) | |
| July 6, ~~2012~~2013 | • If the plan offers dental coverage, final dental plan benefit description is due if the dental coverage is first being offered or if there is any benefit change to the dental benefit.<br>• Information of the plan's features, including objective documentation as requested, for use in the health plan features comparison summary in the Dual-Choice brochure. | |
| July 12, 2013 | • 1st Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group. | |
| July 13, ~~2012~~2013 | • The plan's address and telephone number as it should appear in the Dual-Choice brochure. | |
| July 23, ~~2012~~2013 | • Final data files of: 1) Addendum 2 and 2) providers under contract by county (and zip code) for the next calendar year. (Note: This date will be moved up by one week at the discretion of the Department's Data Manager for any individual plans for whom the June 1 data submission was unacceptable.) | |
| July 30, ~~2012~~2013 | • Text to be printed in the plan description section of the annual Dual-Choice brochures. Plans must use the format provided by the Department and list major providers and hospitals in its network for all counties the Board has determined the plan to be qualified. | |
| August ~~10~~2, ~~2012~~2013 | • Final best premium bid or withdrawal notice due.<br>• Due date for a plan to notify the Department that it is terminating its contract with the Board. | |
| August 13, ~~2012~~2013 | • Request for state employee home address labels (by zip code) for plan use during Dual-Choice Enrollment Period. Note this information can only be used for plans to send informational materials related to the Dual-Choice Enrollment Period. | |
| August 20, ~~2012~~2013 | • Complete list of the plan's key contacts as stated in Section II., G., 3., j. | |
| August ~~28~~27, ~~2012~~2013 | • Group Insurance Board meeting to set the Standard plans' premium rates (fee-for-service plan) and to open for the public alternate plan rate submittals. | |
| August 31, 2012 | • Proof copies of informational material that the plan intends to distribute to state/local employees during Dual-Choice | |

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| Due Date (Receipt by Dept) | Information Due | Date Submitted |
|---|---|---|
| | Enrollment period. | |
| September 14, ~~2012~~2013 | • Draft of dental benefit description that will be provided to members if the plan offers dental coverage. This must include the exclusions and limitations. Department approval, prior to September 21, is required.<br>• For plans not participating in the group health insurance program in ~~2013~~2014, a draft of the letter the plan will mail subscribers notifying them that the plan will not be offered in ~~2013~~2014. Department approval by September 21 is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24.**<br>• Draft of letter the plan will mail to current subscribers summarizing dental benefit, accessing the plan's health risk assessment tool, and provider network changes for the new calendar year, including a description of referral requirements. Provider network changes must include a list of providers, clinics and hospitals that will no longer be plan providers in the following calendar year, in the format established by the Department. Department approval, prior to September 21, is required. **THIS NOTICE MUST BE MAILED TO SUBSCRIBERS BY SEPTEMBER 24, WITH FORWARDING REQUESTED.** | |
| September 17, ~~2012~~2013 | • Put a PDF copy of your plan's provider directory for the upcoming benefit year on your plan's web site and provide ETF with the location. The PDF must remain on your plan's web site through the benefit year. | |
| September 26, ~~2012~~2013 | • Dual-Choice kick off meeting in Madison. | |
| September 30, ~~2012~~2013 | • Completed contract, signed and dated. This must include all applicable attachments, the "Vendor Information" and W-9 forms, and two (2) copies of the contract signature page.<br>• Provide four (4) copies of all informational materials in final form to the Department.<br>• Final dental benefit description that will be provided to members if the plan offers dental coverage. | |
| October ~~7~~1 – November ~~12~~6, ~~2012~~2013 | • Dual-Choice Enrollment Period. | |
| October ~~11~~ 3, ~~2012~~2013 | • Report on disease management capabilities and effectiveness. [Section II., D., 8.]<br>• ~~2~~2nd Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group.<br>• Confirmation to ETF that the letter to current subscribers summarizing changes for the new calendar year has been sent. | |

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| Due Date (Receipt by Dept) | Information Due | Date Submitted |
|---|---|---|
| January 1, ~~2013~~2014 | • Identification cards must be issued to all new Dual-Choice enrollees. Explanation of accessing the plan's health risk assessment tool and referral and grievance procedures must be included. | |
| January 10, 2014 | • 3rd Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group. | |
| January 14, ~~2013~~2014 | • Issuance of new identification cards, if applicable, to continuing subscribers. Written notification to the Department confirming completion is also due. | |
| March 1, ~~2013~~2014 | • Report summary of grievances received during previous calendar year period, by number, type and resolution/outcome [Section II., G., 3., d., (3.)] and a sample grievance decision letter to participants that incorporates Department administrative review rights. | |
| April 1, ~~2013~~ 2014 | • A Quality Improvement plan in the format set forth by the Department. | |
| April 11, 2014 | • 4th Quarter - Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group. | |
| By Noon on Second Monday of Each Month, or as Directed by the Department | • HIPAA compliant Full File Compare Submissions.<br>• Report direct pay terminations and reinstatements in the format as determined by the Department. | |
| Monthly | • Generate and process the reports identifying the Full File Compare discrepancies, contacting the Department regarding proposed resolutions for those discrepancies that you are unable to resolve. | |
| Annually | • Verify eligibility of adult disabled children age 26 or older, which includes checking that the:<br>o Child is incapable of self-support because of a disability that can be expected to be of long-continued or indefinite duration of at least one year, and<br>o Support and maintenance requirement is met, and<br>o Child is not married. | |
| Quarterly | • Report detailing the outcomes and cost-of-care savings for the disease management programs and/or interventions commitments for the State of Wisconsin group. Dates are specified above. | |