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Department of Employee Trust Funds
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Correspondence Memorandum

Date: January 23, 2017

To: Group Insurance Board

From: Renee Walk, Strategic Health Policy Advisor
Office of Strategic Health Policy

Subject: Health Benefit Program Agreement & Uniform Benefits for the 2018 Plan Year

The Department of Employee Trust Funds (ETF) staff requests that the Group Insurance Board (Board) approve the changes to the Health Benefit Program Agreement (Agreement) that are detailed in this memo and grant ETF staff the authority to make additional technical changes as necessary.

Background

As the Board considers changes related to the overall structure of the State Group Health Insurance Program (GHIP), ETF staff presents to the Board additional program enhancements and clarifications that will further the goals of the broader program structure changes.

The Board typically considers and approves health insurance benefit and contract changes at its May meeting. Staff is presenting 2018 recommendations at the February Board meeting this year for the following reasons:

- Enables staff to incorporate 2018 contractual changes in the negotiation process;
- Allows early implementation and promotion of changes to the wellness incentive; and
- The Board expressed an interest in minimizing changes for 2018, affording an expedited process for analysis.

The following recommendations include technical and administrative changes, as well as benefits parameters and programmatic changes designed to position the GHIP for a more member-centric, Total Health Management approach as proposed by the Board's actuary, Segal Consulting (Segal). The recommendations are presented in the context of the new Agreement as established by the Self Insuring Request for Proposals (RFP), and build upon the changes proposed in the August 2016 memo, Potential 2018 Health Benefit Program Contract Changes (Ref. GIB | 8.16.16 | 8C). The changes presented in

Reviewed and approved by Lisa Ellinger, Director, Office of Strategic Health Policy

Lisa Ellinger

Electronically Signed 1/31/17

Board	Mtg Date	Item #
GIB	2.8.17	8B

August will be incorporated to the extent that they are appropriate for the overall program structure decided upon by the Board.

Key Recommended Changes

Wellness Incentive Design

ETF staff recommends transitioning the current $150 cash incentive into an incentive that is embedded in the benefit design in the form of reduced participant cost sharing.. By reducing cost sharing through a $150 annual premium reduction for wellness participation, members will be able to avoid the taxability issue that currently exists for the cash incentive. Reducing or eliminating the tax on the incentive increases the total incentive dollar amount actually received by participants without necessarily increasing the State's contribution. Incorporating the incentive as a premium reduction is easier to implement due to the enhanced administrative capabilities of the Board's wellness vendor, StayWell.

Additional consideration will need to be given to the incentives as they relate to certain subpopulations of the GHIP. Depending upon the incentive mode chosen, groups such as Medicare retirees, high deductible health plan (HDHP) participants, and/or Wisconsin Public Employer participants may need other incentive options.

Upon Board approval, staff will investigate the feasibility of a 2018 implementation with state employee payroll centers. If payroll system constraints warrant a delayed implementation, staff will bring a revised recommendation to the Board at the May meeting.

Data Reporting Requirements

Following the initial year of data reporting from the health plans, ETF staff will further refine requirements related to health plan data submissions to the Data Warehouse vendor (Truven) in the 2018 Agreement. New Agreement language will include requirements around overall data quality, participation in quality control processes, and pass-through of monetary penalties for poor data quality as negotiated in the Truven contract. Specific language is included in Attachment A of this memorandum, 2017 Guidelines Contract and Uniform Benefit Changes.

Performance Standards & Quality Measurement

The health plan performance standards proposed in the Self Insuring RFP will be incorporated into the 2018 Agreement as requirements. These standards which pertain to implementation, customer service, and other service level requirements will apply without regard to the ultimate structure of the GHIP.

In addition to performance standards, quality measures are currently being developed in partnership with Bailit Health, whose expertise was obtained by ETF staff through a Robert Wood Johnson Foundation grant in mid-2016. These measures will be incorporated into the contract once finalized and will serve as the foundation for understanding health plan quality, defining pathways to improvement, and developing

future rewards and penalties. Appendix 11 of the Self Insuring RFP is currently incorporated as a placeholder for these quality measures. Finalized performance measures will be presented to the Board in greater detail at the May 2017 Board meeting.

Technical Changes/Clarifications

Attachment A describes additional proposed changes or clarifications that are technical in nature and are intended to clarify provisions of the Agreement and/or Uniform Benefits. Certain provisions have been added as placeholders for the "Additional Changes" described below. Comprehensive language will be provided to the Board at future Board meetings.

Attachment A includes section references to both the new language and structure as included in the 2018 Agreement and the 2017 Guidelines Contract, to the extent that each are available.

Other proposed changes include:

- Mental Health Parity coverage clarifications, and
- Out of network lab work notification requirements.

Additional Changes to Discuss at May Board Meeting

The above changes have been presented for approval with the goal of incorporating them into 2018 health plan contract negotiations. ETF staff will bring additional technical changes to the Board at the May Board meeting. These changes will include, but are not limited to:

- Changes to the pharmacy benefit program resulting from the pharmacy RFP;
- Changes to requirements for certain individuals to carry a health savings account when enrolled in a high deductible health plan.

Staff will be available at the Board meeting to answer questions.

Attachment A: 2017 Guidelines and Uniform Benefits Changes

2017 Guidelines Contract and Uniform Benefits Changes

Ref #	Color key:	Placeholder = gray	State contract specific change = blue	Local contract specific change = green	Guidelines/Uniform Benefits = white	Text key: Red text = the new 2018 language Blue text = references or language that will be added at a later date	
	Topic	**2017 Contract/ Uniform Benefits Reference**	**2018 Agreement/Uniform Benefits Reference**	**Description of change**	**2017 Contract Language**	**2018 Agreement Language from RFP**	**2018 Agreement Proposed Language**
1	Wellness	1. II. D. 12 1. II. D. 6 4. I. p. 4-5 - 4-17	400 I.	Adjustment of employee incentive payments to premium reduction, deductible, or other plan-integrated design			
2	Quality Measures	1. II. D. 8-9	Appendix 11	Quality measures developed in partnership with Bailit Health, with associated rewards/penalties			
3	Pharmacy	4. D.	400 D	Medication Therapy Management, Mail Order Pharmacy promotion, and other modifications resulting from the PBM RFP			
4	Perfor-mance Standards	N/A	155B 315	Specific contract performance standards pertaining to Implementation, Account management, claims processing, customer service, data management, enrollment, and miscellaneous other provisions.	N/A	See Exhibit 1 of SI RFP for full text	RFP Language as originally proposed.
5	Data	1. 2. D. (11), p. 1-9 3. 2.4. (6), p. 3-10 Addendum 1, Table 13	150 (5)(a) - (f)	Data submission requirements added as a result of Truven negotiations	(11) HEALTH PLANS must submit claims data for all PARTICIPANTS, for all claims processed for dates of service from January 1, 2014 through December 31, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Claims Data Specifications document (Addendum 3). HEALTH PLANS must also submit provider data for providers under contract any time from January, 2014 through December 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Provider Data Specifications document (Addendum 4). HEALTH PLANS that submit incomplete data may be subject to sanction by the BOARD, as described in Section 2.4 (5) of the State Contract. (6) HEALTH PLANS must submit claims data for all PARTICIPANTS for all claims processed for dates of service from January 1, 2014 through December 31, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the most recent Claims Data Specifications document (Addendum 3). HEALTH PLANS must also submit provider data for providers under contract anytime from January 2014 through December, 2017, to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT in the Provider Data Specifications document (Addendum 4). The DEPARTMENT will specify and communicate a schedule of deliverables and due dates once the data warehouse vendor is under contract. Plans must also submit claims for dates of service in 2017 durign a six (6) month run-out period from January 1, 2018 - June 30, 2018. The DEPARTMENT will withhold 25% of the December, 2017 premium, to be paid not later than April 1, 2018, unless there are issues receiving timely run-out claims data in 2018. In the event of issues receiving run-out claims per the DEPARTMENT'S timeline, the DEPARTMENT will withhold the final 25% premium payment until all run-out claims are received.	See Exhbit 1, section 150 of the SI RFP for full text.	See P. 3 of Attachment A for full text

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	Topic	**2017 Contract/ Uniform Benefits Reference**	**2018 Agreement/Uniform Benefits Reference**	**Description of change**	**2017 Contract Language**	**2018 Agreement Language from RFP**	**2018 Agreement Proposed Language**
6	Laboratory Services	1. 2. D. 29	220I	Add notification requriement or other clarification for member notification of OON labs	If the PARTICIPANT received anesthesiology, radiology or pathology (includes all lab tests) services at a plan clinic or hospital, it will be covered at the in-plan level of benefits even if that care is not provided by a plan provider. Theo nly exception is when the PARTICIPANT knowingly elects to receive such care through a non-plan provider.	220I Ancillary Services If the PARTICIPANT receives anesthesiology, radiology or pathology (includes all lab tests) services at an IN-NETWORK clinic or HOSPITAL, it will be covered at the IN-NETWORK level of benefits even if that care is not provided by an IN-NETWORK provider. The only exception is when the PARTICIPANT knowingly elects to receive such care through an OUT-OF-NETWORK provider.	220I Ancillary Services If the PARTICIPANT receives anesthesiology, radiology or pathology (includes all lab tests) services at an IN-NETWORK clinic or HOSPITAL, it will be covered at the IN-NETWORK level of benefits even if that care is not provided by an IN-NETWORK provider. ~~The only exception is when the PARTICIPANT knowingly elects to receive such care through an OUT-OF-NETWORK provider.~~
7	Mental Health/ AODA		400 II. C. 1)	Clarify coverage of services are all as required by Mental Health Parity and Addiction Equity Act.		C. Other Medical Services 1) Mental Health Services/Alcohol and Drug Abuse PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA. a) Outpatient Services Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. The outpatient services means non-residential services by PROVIDERS as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37. This benefit also includes services for a full-time student attending school in Wisconsin but out of the SERVICE AREA as required by Wis. Stat. § 609.655. b) Transitional Services Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. Transitional care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by the federal Mental Health Parity and Addiction Equity Act. c) Inpatient Services Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS and as required by Wis. Stat. §632.89 and Wis. Adm. Code § INS 3.37. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by an OUT-OF-NETWORK PROVIDER, if provided as required by an EMERGENCY detention or on an EMERGENCY basis and the PROVIDER notifies the TPA within 72 hours after the initial provision of service.	400 II C. 1) C. Other Medical Services 1) Mental Health Services/Alcohol and Drug Abuse PARTICIPANTS should contact the TPA prior to any services, including testing or evaluation, to determine if PRIOR AUTHORIZATION or a REFERRAL is required from the TPA. a) Outpatient Services Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. ~~The o~~ "Outpatient services" means non-residential services by PROVIDERS as defined and set forth under Wis. Stat. § 632.89 (1) (e) and as required by Wis. Adm. Code § INS 3.37 and the federal Mental Health Parity and Addiction Equity Act (MHPAEA). This benefit also includes services for a full-time student attending school in Wisconsin but out of the SERVICE AREA as required by Wis. Stat. § 609.655. b) Transitional Services Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS. Transitional care is provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services as required by Wis. Stat. § 632.89 and Wis. Adm. Code § INS 3.37 and as required by ~~the federal Mental Health Parity and Addiction Equity Act~~ MHPAEA. c) Inpatient Services Covers MEDICALLY NECESSARY services provided by an IN-NETWORK PROVIDER as described in the SCHEDULE OF BENEFITS and as required by Wis. Stat. §632.89~~, and~~ Wis. Adm. Code § INS 3.37 and MHPAEA. Covers court-ordered services for the mentally ill as required by Wis. Stat. § 609.65. Such services are covered if performed by an OUT-OF-NETWORK PROVIDER, if provided as required by an EMERGENCY detention or on an EMERGENCY basis and the PROVIDER notifies the TPA within 72 hours after the initial provision of service.
8	Mental Health/ AODA		400 IV. A. 11) k)	Clarify coverage of exclusion for residential services by changing "or" to "and."		A. Exclusions… k) Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 or as required by the federal Mental Health Parity and Addiction Equity Act.	400 Iv A. Exclusions... k) Residential care except residential care for Alcohol and Drug Abuse and transitional care as required by Wis. Stat. § 632.89 and Wis. Admin Code § INS 3.37 ~~or~~ and as required by the federal Mental Health Parity and Addiction Equity Act.

Attachment A

Reference #4. Data.

2018 Agreement Proposed Language

Blue Text = Specific values to be determined

Section XX. Data Submission Requirements

CONTRACTOR shall cooperate with ETF's designated Data Warehouse and Visual Business Intelligence Solution Contractor ("DW/VBIS Contractor") by submitting to the DW/VBIS Contractor all of the following data on a schedule to be determined by ETF:

1. Data on payments made to providers of goods or services to [ETF's members] under the terms of this Contract. Payment data shall include claim payments made or denied, capitation or per-member payments, administrative payments, and payments made after coordinating responsibility with third parties (Coordination of Benefits); and,
2. Data on other financial transactions associated with claim payments, including charged amount, allowed amount, and charges to members as co-payments and deductibles; and,
3. Data on the providers of those goods and services; and,
4. Data on enrollment of ETF members.
5. [Add other data types and documents as may be applicable.]

CONTRACTOR shall comply with the DW/VBIS Contractor's specifications for submission of the required data elements in the standard formats listed below, as are applicable to the services CONTRACTOR provides to ETF's members:

[Cite here the specific formats that were listed as appendices to the DW/VBIS RFP]

To comply with the data submission requirement, CONTRACTOR must follow the specified data file layout and formatting of all data elements within it and the DW/VBIS Contractor's specifications for data filtering/extraction. CONTRACTOR must submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the data dictionary. The claim adjustment data CONTRACTOR submits must follow the logic CONTRACTOR defines in the documentation. A unique person/member identifier is required on all data files and the identifier must match the person identifier on ETF's eligibility file. On all provider and claim files, CONTRACTOR must supply the 10-digit National Provider Identifier (NPI) as issued by the US Centers for Medicare and Medicaid Services' National Plan and Provider Enumeration System (NPPES).

CONTRACTOR must designate a Data Steward, i.e., a person from CONTRACTOR that is knowledgeable of its data and the systems that generate it. The Data Steward shall attend data submission planning meetings scheduled by the DW/VBIS Contractor on ETF's behalf and shall be the key point of contact for the DW/VBIS Contractor on the submission of data and the correction of data errors should they occur.

CONTRACTOR shall follow the data transmission instructions provided by the DW/VBIS Contractor, which shall include industry-standard electronic transmission methods via secure Internet technology.

Attachment A

The quality of CONTRACTOR's data submissions will be assessed by the DW/VBIS Contractor for timeliness, validity, and completeness. If the DW/VBIS Contractor determines that the data submitted by CONTRACTOR fails to meet the DW/VBIS Contractor's thresholds for data quality, CONTRACTOR must cooperate with the DW/VBIS Contractor in submitting corrected data.

CONTRACTOR must submit data and corrected data when necessary by the dates indicated by the DW/VBIS Contractor, which dates shall not be unreasonably imposed.

CONTRACTOR agrees to the following financial penalties for failure to submit data in accordance with this Contract, which ETF will deduct from any payment owed CONTRACTOR in the payment period after the data submission failure:

- During the initial implementation of the DW/VBIS, CONTRACTOR will have two chances to submit acceptable data. ETF will charge CONTRACTOR a penalty of $X,XXX.XX for each data file submitted after the second submission not accepted by the DW/VBIS Contractor and a penalty of $X,XXX.XX for each data file submitted more than one (1) business day after the deadline for data file submission.
- During the ongoing operation of the DW/VBIS, ETF will charge CONTRACTOR a penalty of $X,XXX.XX for each data file submitted after the first submission not accepted by the DW/VBIS Contractor and a penalty of $X,XXX.XX for each data file submitted after the deadline for submission.
- During the ongoing operation of the DW/VBIS, ETF will charge CONTRACTOR a penalty of $XX,XXX.XX per occurrence for any failure to communicate to the DW/VBIS Contractor a change to the valid values or data fields in CONTRACTOR's next data file submission by ten (10) business days before the next data file submission deadline.