STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: April 17, 2020

To: Group Insurance Board

From: Renee Walk, Lead Policy Advisor
Molly Heisterkamp, Disease Management & Wellness Program Manager
Tricia Sieg, Program Manager
Office of Strategic Health Policy

Subject: 2021 Program Agreement Changes

The Department of Employee Trust Funds (ETF) requests the Group Insurance Board (Board) approve the following changes for the 2021 program year:

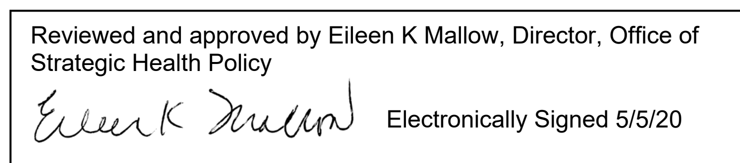
1. **Modifications to health plan administrative service requirements as described in Attachments A, B, and C;**
2. **Addition of coverage for biofeedback services for urinary incontinence, as well as language clarifications to Uniform Benefits described in Attachment A;**
3. **Addition of eHealth Solutions for prescribers and members to the pharmacy benefit;**
4. **Continuation of all pilot programs for 2021;**
5. **Addition of one new acupuncture pilot program from Network Health Plan (Network);**
6. **Adoption of Option 1 of the biometric screening options, replacing the current required screening with four "health check" options; and**
7. **Prohibition of non-Medicare Advantage plans from offering wellness incentives to GHIP members.**

Background

ETF presented initial change concepts to the Board for benefit year 2021 (Ref. GIB | 02.05.20 | 6C) at the February meeting. This early initial review is designed to provide ample opportunity for multiple stakeholders to provide input on changes.

Following the February meeting, ETF reviewed potential program changes with employer groups, health plans, and the Board's actuary, Segal. Through this process, ETF developed a final set of proposed contract and benefit language revisions for the Board to review.

Reviewed and approved by Eileen K Mallow, Director, Office of Strategic Health Policy



Electronically Signed 5/5/20

Board	Mtg Date	Item #
GIB	5.13.20	5A

Proposed Health Program Agreement Changes
The Health Program Agreement (Agreement) is comprised of four main sections; the first three sections (Sections 000, 100, and 200) discuss the administrative services provided by health plans to Group Health Insurance Program (GHIP) members. Section 300 summarizes the performance standards and penalties to which health plans are held. Section 400 contains Uniform Benefits.

The proposed revisions that ETF recommends for the administrative services sections of the contract in 2021 include:

- Section 150 Data Requirements: Clarifications of what detail health plans must submit to IBM Watson Health, the Board's data warehouse vendor, as well as clarifications to the penalties that apply if data is incomplete or inaccurate.
- Section 205 Enrollment: Changes to the timing of when plans are required to produce identification cards, to allow for later revisions made by employers, and clarifications regarding how plans should verify continued eligibility of disabled dependents.
- Section 240 Grievances: Additional requirement that plans provide ETF with a redacted copy of the full language from the written decision in member cases that have gone to external medical review.

If approved, concurrent changes would also be made to the parts of Section 300 that provide for performance standards and penalties related to these items.

ETF does not recommend the proposed administrative change to Section 215 Medical Management, which asked for the Department Initiatives related to low back surgery and shared decision-making to be removed. ETF reviewed utilization data from DAISI, the Board's data warehouse, and GHIP plans were inconsistent in their steerage of members away from unnecessary services related to low back pain. ETF recommends keeping this requirement in place and working with plans to improve outreach efforts and adoption of Choosing Wisely or other shared decision-making protocols.

A complete list of all changes, as well as an estimate of each change's impact to the Triple Aim are provided in Attachment A of this memo.

Proposed Health Benefit Changes
As noted above, Section 400 of the Agreement contains Uniform Benefits, the document that serves as the certificate of coverage for GHIP members. ETF recommends the following changes proposed for Section 400:

- I. Definitions: Clarification of the definition of usual and customary charges, to note that services that are not approved by the plan for payment may be subject to costs outside of what is covered by the plan. For the regional health maintenance organizations (HMOs) serving the GHIP, this means any out of network services that have not been authorized for in-network payment may be subject to additional costs to the member. In terms of the preferred provider organization (PPO) serving the GHIP, this means services that are not normally

covered as in-network or out-of-network or were not prior-authorized if such authorization is required, may be subject to additional member costs. The proposed language change is not intended to change benefits, only to clarify.

- II. Schedule of Benefits: Changes to the schedule of benefits include adding language to clarify when cost sharing applies for emergency room visits and services, as well as that members who receive non-preventive services during a preventive exam may need to pay cost sharing related to those services. Similar to the change to Definitions, these changes are meant to clarify existing policy, not to change what is covered by the policy.
- III. Benefits and Services: Adds language to clarify that plans can review utilization of physical therapy (PT), occupational therapy (OT) and speech therapy (ST) during the initial allowed 50 visits to make sure that members are making progress in treatment. ETF also proposed clarifying language in the ambulance services section regarding air ambulance availability, reiterating that air ambulance transportation should only be for services to transport members to the nearest facility that is able to appropriately address their medical condition, not necessarily to the site nearest the member's home. Lastly, ETF proposes language to clarify that members who need urgent care out of network will be held harmless from additional charges, similar to how emergency rooms are treated under the benefit. All three of these are also clarifications of existing policy, not changes to policy.
- IV. Exclusions and Limitations: Adding to the allowable biofeedback services treatment of urinary incontinence. This adds the ability of plans to cover biofeedback for this diagnosis; biofeedback is currently an acceptable treatment for urinary incontinence and may help members avoid less-effective and potentially more harmful treatments such as opioids or other therapies. Segal projected that this would have little to no cost impact to the plan.

ETF also received other suggested changes to benefits, including a request to consider coverage for dependents living out of the plan's immediate network area. This coverage would most commonly be used by college students. While the anticipated cost would be relatively low, adding such coverage to all health plans would cause an estimated $0.75 per member per month (PMPM) increase in premiums, which ETF cannot recommend without offsetting costs. Also, adding out-of-area coverage could negatively impact the long-term viability of the Access Plan, which is intended to provide broad network coverage for members who might need services statewide or nationwide. Other requests that ETF does not recommend include adding specific conditions to the non-covered services in the Exclusions and Limitations. ETF does not recommend these changes because they would already be non-covered as not medically necessary per plan report.

The last request received that ETF does not recommend pertains to a request to modify the Alternate Care Provision, which is in Subsection VI. Miscellaneous Provisions. This provision is intended to allow plans to cover services that are not normally covered by Uniform Benefits but could be the most cost-effective means of treating a particular

member. The request received would have narrowed that language and potentially also coverage. ETF recommends leaving the provision more general so that it might be best adapted to member needs.

A complete listing of the changes considered, as well as Triple Aim analyses, is included in Attachment A of this memo.

Proposed Pharmacy Administrative Changes
At the February 2020 Board meeting, ETF presented a series of administrative services additions to the pharmacy benefit. After further review, ETF recommends moving forward with the following changes:

- eHealth Solutions: This is a suite of online tools that can be used by prescribers and members to access benefit information at the site of care. Electronic prescribing is very common in the marketplace and allows prescribers to submit prescriptions securely online. It also provides access to the information Navitus has on members' benefit information and prescription history. Similarly, electronic prior authorization (ePA) allows prescribers to submit requests electronically. Each of these tools will expedite members' ability to receive review and approval of needed medications. Finally, eHealth Suite is an electronic tool that can be coordinated with a doctor's electronic health record to provide real-time feedback on a member's benefits and formulary, to help doctor's select the most cost-effective drugs for members during the course of a doctor visit. Navitus has estimated that these tools together will cost $0.05 per member per month.
  - *Triple Aim Analysis:* ETF expects this will have a positive impact on health if members are able to obtain drugs as quickly as possible in order to begin treatments. ETF also expects these changes will have a positive effect on quality, since prescribers will be more able to find the best drug for the best price for the member. The cost will be offset by better utilization of cost-effective alternatives, a possible increase in generic prescribing, reduced occurrence of unfilled prescriptions (20% of paper prescriptions do not make it to the pharmacy[1]), increased 1st fill and future fill adherence[2] , and lower drug spend due to increased formulary compliance.

Navitus has also proposed possible channel management, site of care management, and medical rebate tools that will help ensure that drugs are being received at the most cost-effective sites of care and for the best possible price. ETF recommends these changes be tabled for now and considered in the context of the Board's Specialty Drug Site of Care initiative, which was approved for review in February 2021.

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[1] American Journal of Pharmacy Benefits 2016:8(4)84-91
[2] *Ibid.*

Proposed Pharmacy Benefit Changes
Navitus also offered two possible changes to the pharmacy benefits. ETF recommends that the Board defer consideration of these changes until the 2022 contract year, given current world events. While the proposed Copay Max program could save the Board's programs money, implementation could also result in changes to member experience in receiving specialty medications and ETF does not recommend complicating this process at the present time. ETF also recommends postponing implementation of the pharmacogenomics program for consideration in 2022, so that ETF can further examine how costs of that program would be handled.

Current Pilot Program Performance
Over the past two years, the Board has approved a total of seven pilot programs offered by four participating health plans. Pilot results to date are summarized below by plan offering.

Dean Health Plan (Dean):

- *Living Healthy Plus*. Started in 2019, this pilot adds on to the value-based insurance design program offered to all members through Navitus and The StayWell Company (StayWell), the Board's wellness program vendor. Dean members who participate in StayWell's health coaching are not only eligible for copay and coinsurance reductions from Navitus for their diabetes-related medications, they also are eligible for cost sharing reductions on labs and office visits through Dean. To date, Dean has reported 19 members active in the program, which is below their targeted participation rate. Dean will increase promotion of the program in 2020 to promote participation.
    - *Triple Aim Analysis:* Impacts to be determined; participation is currently too small. Anticipated positive impact on health if adherence increases and on quality if member experience and guidelines adherence improves. Costs, by definition, will increase. Future analysis should consider whether the costs of copay waivers are offset by reduced healthcare costs.
- *Acupuncture Benefit*. Dean began this pilot at the start of 2020, and utilization is limited. Dean notes that the majority of use has been among Dean Health Plan members, versus Prevea360, its alternate network. Dean attributes this to the limited network availability for acupuncturists and is gradually developing its network. To date, the Board's members have received 18 acupuncture visits with a total cost of $2,161. ETF recommends continuing this program in 2021 to serve as a comparison population for Network Health, who is proposing to add a similar pilot program.
    - *Triple Aim Analysis*: Impacts to be determined, program has only been in effect for a few months. Anticipated positive impact on health and quality if members are better able to manage pain and particularly if they forego prescriptions. Costs per service are relatively low and may be offset by reduced use of other, more intensive pain management services.

Network Health Plan

- *Prevent T2.* Network was scheduled to begin recruiting for its Prevent T2 program in early 2020. Prevent T2 is a Centers for Disease Control and Prevention (CDC) certified diabetes prevention program (DPP). Members enrolled in the DPP participate in a CDC-approved educational curriculum, which includes group counseling to help address behaviors that can contribute to or prevent Type 2 diabetes. Since the meetings occur in person traditionally, Network has opted to delay recruitment for this program until more is known about the current public health outbreak.
    - *Triple Aim Analysis:* Impacts to be determined, program has only been in effect for a few months. CDC DPPs have demonstrated the ability to improve health and lower costs in other settings, and ETF expects that the same will be true of Network's program.
- *Delta EBICP Partnership.* Network has begun working with Delta Dental to help members take advantage of the Evidence-Based Integrated Care Program (EBICP) offered by Delta Dental. Network is focusing on members who have diabetes or a high-risk pregnancy. Network and Delta will work together to monitor the number of members who are contacted and then ultimately take advantage of the enhanced dental benefit. Utilization information will be available at the May 2021 GIB meeting. Given the reduction in dental claims experience so far in 2020, ETF expects that an extra year will be needed to determine the actual impact of the program.
    - *Triple Aim Analysis:* Impacts to be determined. While ETF expects positive impacts to health, quality, and cost, these effects will likely be limited due to the current pandemic's effect on ability to receive dental care.

Quartz:

- *MobileBack*. Quartz originally implemented MobileBack, powered by Kiio, in early 2019. The program is an app that guides members who have acute low back pain through a series of physical therapy exercises to help alleviate back pain. In 2019, Quartz reported 353 ETF members taking advantage of the program, out of a potential 10,753 members who had a low back pain claim reported during the same year, for a participation rate of 3.3%. The program costs $62 per participant, and the total cost to Quartz for offering the program in 2019 was $21,886. Quartz has begun to experience positive results from members in the program. Members reported a 56% improvement in overall function (higher than the target 45%) and a 40% average reduction in pain (below the target 45%). 84% of members reported being very satisfied with the program and would recommend to others.
    - *Triple Aim Analysis*: As reported above, Quartz has seen positive member reports on the impact of the program to both health and satisfaction. ETF will work with Quartz over the coming year as DAISI data becomes more complete to determine whether there has been a concurrent change in low back claims data, which would offset the costs of the program.

WEA Trust:

- *Kiio*. WEA Trust implemented Kiio at approximately the same time that Quartz implemented Kiio, and the program functions in the same way. WEA Trust had 420 members who participated in Kiio in 2019, or 5.7% of eligible members. 84% of WEA Trust participating members who finished the program reported a reduction in pain; those members also reported a 57% reduction in average pain from baseline. WEA Trust reported an estimated 64% decrease in medical costs related to back pain for members who participated in the program, including a reduction in emergency and urgent care visits, injections, and imaging. The cost to provide this to members reported by WEA Trust was $11,240.
    - *Triple Aim Analysis:* WEA Trust's implementation of Kiio and the data reported appears to satisfy the Triple Aim, in that it has improved members' reported health and satisfaction, reduced the use of non-necessary or more acute services, and reduced costs as reported by WEA. ETF will work with WEA Trust to validate this reporting via the data available in DAISI as complete 2019 claims become available.
- *Livongo*. WEA Trust also offers a diabetes management program to the Board's members. Through Livongo, members receive a smart diabetes meter and strips, as well as access to diabetes coaching through Livongo. Livongo's meters provide feedback and surveying tools through the meter to try to engage members to better control their blood sugar. 350 members participated in Livongo in 2019, or 16.7% of those eligible. WEA Trust estimates that the program has resulted in a $55 per participant per month reduction in spending on diabetes related services. WEA Trust also reported improvements in blood sugar control for members in the program. The cost to provide this program was $172,720.
    - *Triple Aim Analysis*: It appears that participation in Livongo overall has contributed to improved self-reported patient health and quality outcomes, and improved costs at WEA Trust's book of business level. ETF will work with WEA Trust to validate this within the Board's own book of business via the data available in DAISI as complete 2019 claims become available.

Overall, ETF recommends that pilot programs be allowed to continue through 2021, primarily to provide continuity of services to GHIP members during this uncertain time. ETF will plan to report on outcomes again in May of 2021 and will provide recommendations for which of the first pilots (begun in 2019) should be either broadened or ended.

Proposed Pilot Program

Network Health has proposed adding a pilot acupuncture benefit to its offering for 2021. This benefit will allow members to receive ten acupuncture treatments in a calendar year. Network estimates that, of 4,000 potential eligible members, there will be a 1% participation rate. Network proposes working with ETF to determine impacts, and in particular whether members who use acupuncture are more or less likely to seek other care or prescriptions to manage pain.

- *Triple Aim Analysis:*
  - *Health*: Some research indicates that acupuncture can be effective in managing pain, and members may find it to be a less-invasive or less-severe form of pain management. The risks of negative outcomes related to acupuncture, such as infections at the needle site, are relatively low.
  - *Quality*: ETF has been asked about acupuncture coverage before, and member satisfaction in the program may increase if the service is more widely available. That said, creating a reliable means for allowing payment to qualified providers is important, and a pilot program would allow ETF and plans to explore the best ways to do so.
  - *Cost*: There is no cost of pilot programs to the Board.

ETF recommends allowing Network to offer this pilot program starting in 2021.

Pilot Program Guidelines
The health plans that offer pilot programs to GHIP members have said there is confusion about when and how they can promote pilot programs to those members. Historically, ETF has asked plans not to promote pilots during open enrollment out of concern that members might disrupt their main physician care relationships to seek an additional benefit for which they are not guaranteed enrollment (due to pilot program size or eligibility determination). ETF recognizes, though, that a blanket ban may undermine other health plan marketing campaigns that target existing members who are known to be eligible for a program. ETF has developed a set of guidelines for promoting health plan pilot programs that clarify when and how plans can promote pilots to members. That guidance is provided as Attachment D of this memo.

Well Wisconsin Program Changes
2021 will mark the eighth year of the Board offering a $150 wellness incentive to members who complete a health screening, health assessment, and well-being activity.

Participants have a variety of well-being activity options to choose from including the following tentatively planned for 2021:

- Complete three health coaching calls or virtual meetings;
- Complete three disease management calls;
- Complete at least one million steps in the Million Steps Challenge;
- Complete at least three education, skill building, and goal setting sessions;
- Track servings of fruits and vegetables or strength training minutes for at least 21 days;
- Track 21 days of participation in the Sleep, Hydration, or Mindfulness Challenge;
- Listen in to at least one monthly interview on Well Wisconsin Radio;
- Participate in an employer-sponsored wellness-supporting activity; or
- Participate in another GHIP vendor’s wellness-supporting activity such as disease management, health coaching, etc.

To complete the health screening requirement, participants may participate in an onsite biometric screening where their cholesterol, glucose and blood pressure are tested, or they may complete the health care provider form attesting to being up-to-date on their preventive care and include, at a minimum, their most recent blood pressure, height and weight. GHIP adults have comparable preventive visit rates to the total U.S. population (per DAISI, 459 visits per 1,000 in 2019).

The cost of the onsite health screenings is $57 each, costing approximately $1.7M in 2019 alone. The US Preventive Services Task Force (USPSTF) does not currently recommend annual screenings; rather, cholesterol screenings should be done only every four to six years, depending upon personal health risks. Blood pressure screening is only recommended every three to five years for people ages 18 to 40 who do not have other health risks. Blood pressure screening is only recommended annually for people over age 40 or at high risk. Screening for diabetes should be targeted to people who are between ages 40 and 70 and who are also overweight or obese. The are other activities participants can complete to promote positive lifestyle changes that would be more effective than requiring the health screening each year.

At the February Board meeting, ETF proposed removing the screening as a required component of receiving the $150 incentive, and instead making it an optional activity. The Board asked ETF to return with additional options to compare approaches to changing the required Well Wisconsin activities.

Screening Options

Option 1: Replace screening with a choice of "health check." Participants can choose from one of four choices, all of which provide an opportunity for participants to engage in conversations with a health professional to check-in on their health status:

1. Onsite biometric screening;
2. Health care provider form attesting to being up to date on preventive care;
3. One preventive dental exam; or
4. One health coaching call, which includes assessing current health stage, specific goal setting, and referral to providers or other programs as needed.

Triple Aim Analysis

Program Quality: This option provides the most flexibility, allowing participants to choose the activity that most meets their needs and interests. It would be an easy transition with no changes to incentive requirements between years. This option would result in more members having regular conversations with a health professional (screener, doctor, dentist, or coach), providing them with a good opportunity to commit to healthy behaviors. It also helps support the Board's Uniform Dental Benefit program by encouraging participants to take advantage of those benefits.

Health: This option could result in an increase in health coaching utilization, an activity that has been proven to positively impact health outcomes in the GHIP

population. 2017 health coaching participants improved health by 10% and 2018 participants improved health by 6% as measured on the health assessment. Adding the preventive dental exam as one of the options for fulfilling the health check could increase utilization of this service, allowing for prevention of oral health-related conditions and early identification of health concerns.

Cost: If participants choose to leverage the health coaching call or the preventive dental exam to fulfill the "health check" requirement, the GHIP would save money on Well Wisconsin. The cost of one biometric screening is $57, compared to the cost of one health coaching call which is $47.50. The cost to process the health care provider form is $15, though may of course be associated with physician visit costs, and dental visits would be subject to provider costs as well. Additionally, in the July 9, 2019 report from Delta, 36% of subscribers did not receive a routine dental cleaning and the total cost per member with at least one oral exam is $267 less than a member who did not have an exam, which recoups the cost of the exam itself. Lastly, if health is being positively impacted via a coaching call or an oral cleaning, there is potential for even more cost savings in the future with prevention or early identification and slower progression of disease.

Option 2: Adjust the health screening requirement to be a bi-annual activity. Participants complete the health assessment, health screening, and one well-being activity in even years; complete health assessment and two well-being activities in odd years.

Triple Aim Analysis
Program Quality: This option could result in confusion among program participants as incentive requirements would change every other year. Members may forget what needs to be completed or think they've done the activity and later find out it was the previous year that they completed the activity.

Health: There is potential to positively influence health since participants would have to complete two well-being activities every other year which focus on knowledge, skills, and abilities related to healthy behaviors.

Cost: Eliminating screening costs every other year would result in the greatest cost savings in the short term (approximately $1.7M every other year).

Option 3: Status Quo. Maintain the current incentive design whereby participants complete the health assessment, health screening (biometric screening or health care provider form), and one well-being activity each year.

Triple Aim Analysis
Program Quality: Continuing the current incentive program requirements will be easiest from a participant perspective. However, suggesting annual biometric

screenings is not in line with USPSTF recommendations. 50% of StayWell's clients do not require a health screening as part of their incentive design.

Health: Participants will be aware of their current health status each year and be provided with opportunities to connect with a health coach as part of the well-being activity if they choose. However, the three-call minimum with a coach may seem daunting to someone who hasn't ever spoken with one. Members can still access their preventive dental services via Uniform Dental Benefits, and this could be added as one of the well-being activity options as well.

Cost: Continuing with the existing program design will have no impact on costs.

A fourth option deemed not feasible was to use DAISI to identify members who have completed a preventive care visit with their health care provider. The three to four-month lag in data received by DAISI from the health plans makes this extremely difficult, given the Board's program year timeline. There is likely an even longer lag time between when the appointment occurs and when the claim is submitted to the health plan and paid. Furthermore, a member could schedule a preventive exam and then have it coded differently because of concerns that arise and are discussed at the appointment . This visit may risk being missed for credit toward the incentive. DAISI is instead best utilized as an assessment and evaluation tool.

A fifth option not recommended was to require everyone to have an annual or biannual preventive exam to fulfill the screening requirement. There are many individuals who are encouraged to see their health care provider less frequently, based on their overall health. Requiring everyone to see a provider could burden health care professionals who could otherwise be treating those who have chronic conditions. Lastly, as indicated earlier, DAISI suggests that GHIP adults have comparable preventive visit rates as compared to the U.S. generally (459/1,000 for both GHIP and U.S. in 2019), and ETF is not sure that requiring visits would change that behavior substantially.

ETF recommends Option 1, to replace the current biometric screening requirement with the choice of one of four "health check" options (onsite biometric screening, health care provider form, one health coaching call, or a preventive dental exam).

Health Plan-Issued Wellness Incentives

A second change to the wellness policy proposed by ETF includes prohibiting non-Medicare Advantage health plans from offering wellness incentives that do not qualify as a medical expense under the Internal Revenue Service (IRS) Code 213 (d). The Board's current policy allows health plans to offer members wellness incentives, like gym membership or community supported agriculture (CSA) share reimbursements. Currently, three non-Medicare Advantage health plans are issuing wellness incentives. All of them support ending their incentive programs for ETF members, given the difficulty of administering them under the program guidelines. The guidelines require plans to report all incentives to ETF three times per year (up from two times per year

historically) and to withhold taxes from retirees and continuants beginning in 2019, due to updated guidance from the IRS. ETF processes health plans' reports and passes along information to employers for tax reporting. ETF is responsible for tax reporting for retirees and continuants.

The complicated administrative requirements leave the Board's programs vulnerable to error. In 2019, ETF learned that one health plan incorrectly reported more than 350 incentives that were considered medical expenses from 2016 – 2018. These incentives should not have been reported or taxed. This resulted in ETF and employers making corrections to W-2s over multiple years and notifying impacted members that they may need to amend their tax filings. Another health plan incorrectly withheld taxes from more than 100 members in 2019 and had to issue refunds. A third health plan indicated they did not have the means to withhold taxes from the incentive and therefore, opted to exclude retirees and continuants. However, they made an error in their exclusion requirement and almost 500 payments were made to retirees and continuants without having the appropriate taxes withheld. These also had to be corrected by ETF and employers.

Lastly, GHIP members often don't understand why some of their peers can receive health plan wellness incentives and some do not. Those who receive an incentive often forget it is considered taxable income and that tax deductions are not immediate, and are surprised when their paychecks are reduced several months later. This causes additional work for employers, ETF, and the health plans who respond to member inquiries.

Triple Aim Analysis
Program Quality: The current policy is complex to administer and prone to error. Inconsistencies in availability across plans detract from the quality of the GHIP our members and employers expect.

Health: There are mixed results regarding health. Removing these incentives may hinder participants (2,111 unique members earning a gross amount of $264,087 in 2019) from being able to afford gym memberships or CSAs, which could negatively impact member health. ETF proposes sending communications to affected participants, redirecting them to Well Wisconsin and suggesting they utilize the Well Wisconsin incentive to subsidize their gym membership or CSA share.

Cost: Removing these incentives will save employers (including ETF) approximately $20,200 combined in taxes annually. Additionally, ETF and employers would save staff time processing reports, making corrections, answering member questions, etc.

With the above analysis in mind, ETF recommends the Board discontinue non-Medicare Advantage health plan-issued incentives for 2021 and continue to streamline all

wellness incentives through StayWell. Medicare Advantage plans should still be allowed to offer incentives since those incentives are considered in the plan’s star rankings which contribute to lower premiums for members.

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

Attachment A: 2021 Health Benefit and Contract Changes
Attachment B: 2021 Program Agreement Changes 150D Requirements
Attachment C: 2021 Program Agreement Changes 205C Requirements
Attachment D: 2021 Guidelines for Pilot Program Evaluation & Promotion memo

Contract Section	Contract Sub-Section	Contract Sub-Section Reference	Description of Change Requested	Proposed Language	Comments	Triple Aim Analysis: How will this change impact cost, quality/experience, and health?
Section 000		*(none)*	*Include list of State of Wisconsin holidays*	*No contract change: ETF will include this list in existing guidance documentation; no change to the agreement is required.*		*n/a*
Section 100	*130 Premiums*	*130B Rate-Setting Process*	*Process change*	*No contract change: ETF's process is to have final drafts of all contract language changes ready for the Board's review and approval at the May Board meeting.*		*n/a*
Section 100	*135 Financial Administration*	*135B Included Services, 3) Pilot Programs*	*Modification and application of contract*	*No contract change: ETF will create a guidelines document for health plans regarding acceptable means of promoting pilot programs.* *ETF expects plans to remain in regular contact regarding their pilot programs, including providing ETF with advanced notice of marketing campaigns related to the pilot program*		*n/a*
Section 100	*150 Data Requirements*	*150D Data Warehouse File Requirements, 1) Data Submission Requirements, b)*	*Submission requirements clarification*	*No contract changes at this time; if ETF adds future requirements for non-claims-based payments, contract language will be adjusted.*		*n/a*
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 3) Submission Timeline, a)	Clarify data submission timeline	3) a) All claims paid for the previous month shall be submitted to the DEPARTMENT'S data warehouse in the correct file layout on the date approved by the DEPARTMENT of the month following the date of payment to the provider, or another time period approved by the DEPARTMENT.		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 4) Data Dictionary	Clarify data dictionary requirement	4) Data Dictionary The CONTRACTOR shall submit documentation on its data files including a data dictionary. The data files must use the valid values specified in the data dictionary. ~~During the ongoing operation of the DEPARTMENT'S data warehouse, the DEPARTMENT shall charge the CONTRACTOR a penalty for any failure to communicate to the DEPARTMENT'S data warehouse vendor within ten (10) BUSINESS DAYS before the next data file submissions deadline a change to the valid values or data fields in the CONTRACTOR'S next data file submission.~~		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, 6) Data Quality	Clarify data quality requirement	Proposed language captured in Attachment B		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 100	150 Data Requirements	150D Data Warehouse File Requirements, f)	Provider NPI requirement clarification	"...National Plan and Provider Enumeration System (NPPES), if applicable."		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 100	155 Miscellaneous General Requirements	155A Reporting Requirements and Deliverables, 3)	Due date to comply with changes	"...The CONTRACTOR must comply with such changes within forty-five (45) calendar DAYS, or an agreed upon timeframe reasonable to the change being requested."		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 100	*155 Miscellaneous General Requirements*	*155D Information Systems Security Audit*	*Maintain language*	*No contract change requested*		*n/a*
Section 200	205 Enrollment	205A Identification (ID) Cards	Clarify language within section to specify how days are determined.	"...The CONTRACTOR shall issue ID cards within five (5) BUSINESS DAYS of the generation date of the enrollment file containing the addition or enrollment change, or at least ten (10) BUSINESS DAYS prior to the ...."		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 200	205 Enrollment	205C Over-Age Disabled Child Eligibility	Only require families of members the Health Plan deems permanently disabled to confirm support and marriage questions on an annual basis. Drop the requirement to file a physician's review.	Proposed langauge captured in Attachment C		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 200	215 Medical Management	215B Department Initiatives, 3) Low Back Surgery and 4) Shared Decision Making	Modify administrative requirement for low back surgery	Change not recommended: available data shows that, while Wisconsin as a state performs well in these areas, there is inconsistency year over year in terms of low back surgery approvals. ETF will work with plans to establish monitoring criteria moving forward and to further develop initiatives as appropriate.		n/a

Section 200	*225 Quality*	*4)*	*Modify rate setting process and modify quality incentives program for transparency, alignment and consistency*	*No change to contract language. ETF will provide a guidance document explaining the quality measure methodology and allocation process prior to 2021 negotiations.*		*n/a*
Section 200	240 Grievances	240G	Add requirement to pass through detailed clinical results from Independent Medical Review	Within thirty (30) calendar DAYS of the CONTRACTOR'S receipt of the final external review determination language, the CONTRACTOR shall send a copy of the detailed report provided from the external reviewer to the DEPARTMENT. The CONTRACTOR shall redact all member-identifying information from this copy before sending to the DEPARTMENT.	Noted this is a minor change to current plan process; not a significant administrative lift	Health - Provides an additional avenue to ETF to ensure we are current with best clinica/treatment practices Quality - Goal to ensure that health plan clinical review staff are not enforcing out of date certificate language and/or incurring more review requests than necessary Cost - may result in additional cost of coverage, but may also reduce review and future IRO if resulting in change to coverage
Section 300	*305 General Deliverable Standards*	*305A Deliverable Requirements*	*Notification to health plans regarding discontinuation of deliverables due throughout the contract year*	*No change to contract language. ETF already provides this information via weekly notice emails.*		*n/a*
Section 300	310 Administrative Deliverables	2d	Request to modify ID card processing timeline	The CONTRACTOR shall issue ID cards by December 15 (or a later date as approved by the DEPARTMENT) for enrollment additions or changes effective the following January 1 calendar year, as submitted on enrollment files generated on the first DAY of the IT'S YOUR CHOICE OPEN ENROLLMENT period through December 5. Any enrollments received after December 5 will be mailed within 10 BUSINESS DAYS of receipt of the enrollment file. CONTRACTOR will confirm each ID cards mailing date and if any delays or changes to the mailing dates occur or are expected. Specific deliverable dates may be defined by the DEPARTMENT. (See Section 205A.)		Health - none; internal administrative change only Quality - none; internal administrative change only Cost - none; internal administrative change only
Section 300	325 Data Warehouse	325A Data Warehouse Deliverable Requirements, 1) & 2)	Data Warehouse Deliverable Requirement timeline	ETF has updated the reference to indicate Section 150D instead of 150E. Language in 150D has been updated to clarify timeline. See Attachment B. Penalties language has also been updated in Section 325B to clarify "two-chance rule" and remove penalties associated with data dictionary delivery		n/a
Section 400	I. Definitions	(none)	Modify language for Usual and Customary Charge	…In some cases the amount the HEALTH PLAN determines as reasonable may be less than the amount billed. In ~~these~~ situations where the service is provided by an IN-NETWORK PROVIDER or an approved OUT-OF-NETWORK PROVIDER, the PARTICIPANT is held harmless for the difference between the billed and paid CHARGE(s), other than the COPAYMENTS or COINSURANCE specified on the SCHEDULE OF BENEFITS, unless he/she accepted financial responsibility, in writing, for specific treatment or services (that is, diagnosis and/or procedure code(s) and related CHARGES) prior to receiving services. HEALTH PLAN approved REFERRALS or PRIOR AUTHORIZATIONS to OUT-OF-NETWORK PROVIDERS are not subject to USUAL AND CUSTOMARY CHARGES; PARTICIPANTS may be responsible for costs beyond USUAL AND CUSTOMARY CHARGES for services obtained from OUT-OF-NETWORK PROVIDERS if the services are non-EMERGENCY or non-URGENT, or if they are not previously approved for reimbursement by the HEALTH PLAN. EMERGENCY or ~~urgent~~ URGENT services from an…		Health - none; clarifying language Quality - may improve quality if members are better able to understand the nuances of when they may be balance billed for services. Cost - none; the intent is to clarify language and not to change coverage so cost should not change
Section 400	II. Schedule of Benefits	(none)	Consolidate Schedules of Benefits	No changes made. ETF recommends holding substantial changes to the format of the Schedule of Benefits until 2022 in order to give adequate time for review.		n/a
Section 400	II. Schedule of Benefits	(none)	Definition of telemedicine	ETF does not recommend changing this language at this point in time. ETF was intentionally broad in the initial definition of telehealth, and feels this is still the most appropriate means of approach at this time.		n/a
Section 400	II. Schedule of Benefits	(none)	DME when Medicare is Primary: - If Medicare covers, plan pays Medicare patient portion - if Medicare does not cover, patient pays 20% coinsurance toward $500 DME OOPL	ETF does not recommend making this change as it would result in an increase to program costs and would require a concurrent reduction.		n/a

Section 400	II. Schedule of Benefits	(none)	Emergency Room Visit cost sharing	PARTICIPANT may be responsible for other charges in addition to the visit COPAYMENT. See Illness/Injury related services below		Health - none; change to language is only for clarification and should not impact actual benefits received. Quality - potential improvement to quality and satisfaction in the program due to increased clarity of benefits and cost sharing requirements. Cost - no change to cost; language chane is not intended to increase costs.
Section 400	II. Schedule of Benefits	(none)	Preventive Care vs. Diagnostic Care clarity	Services (diagnostic or otherwise) for specific conditions during an annual exam may be subject to cost sharing	Plans indicated a need for additional clarity, though some asked for even more specific definitions of preventive and diagnostic. ETF prefers to defer to HHS for these definitions as the remainder of the certificate language does.	Health - none, language clarification only Quality - added language should help clarify coverage and marginally improve member experience Cost - non, language clarification only
Section 400	II. Schedule of Benefits	(none)	Vision Services - Provide greater clarity of covered benefit	ETF recommends holding substantial changes to the format of the Schedule of Benefits until 2022 in order to give adequate time for review.		n/a
Section 400	III. Benefits and Services	A. Medical /Surgical Services, 12) Outpatient Rehabilitation, Physical, Speech, and Occupational Therapy	Modify language as it relates to rehabilitation (ST, PT, OT)	As determined by the health plan, those services deemed medically necessary for habilitation or rehabilitation services and treatment as a result of Illness or Injury, provided by an IN-Network provider. Therapists must be registered and must not live in the patient's home or be a family member. For those services deemed medically necessary by the payor, members are allowed up to 50 visits per Participant for all therapies combined per calendar year. Health Plans may review utilization and clinical information during the initial 50 visits to verify medical necessity. Additional medically necesasry visits may be authorized when prior authorized by the health plan, up to a maximum of 50 addtional visits per therapy per PARTICIPANT per calendar year.	Plans indicated that this is not a change from their current administration, only a clarification	Health - no change, language clarification only Quality - possible improved understanding of how benefit is administered, leading to fewer issues with plan coverage Cost - no change, language clarification only
Section 400	III. Benefits and Services	A. Medical/Surgical Services, 10) Ambulance Services	Modify language for Ambulance Services to define when professional air ambulances are allowed	Ambulance Service Covers licensed professional ambulance service (or comparable EMERGENCY transportation if authorized by the HEALTH PLAN) when MEDICALLY NECESSARY to transport to the nearest HOSPITAL where appropriate medical care is available when the conveyance is an EMERGENCY or URGENT in nature and medical attention is required en route. This includes licensed professional air ambulance when another mode of ambulance service would endanger the PARTICIPANT'S health. EMERGENCY Air Ambulance services are limited to only those services necessary for transport to the nearest medical facility equipped to handle the EMERGENCY. Ambulance services include MEDICALLY NECESSARY transportation and all associated supplies and services provided therein. If the PARTICIPANT is not in the HEALTH PLAN'S SERVICE AREA, the HEALTH PLAN or IN-NETWORK PROVIDER should be contacted, if possible, before EMERGENCY or urgent transportation is obtained.		Health - no change, language clarification only Quality - possible improved understanding of how benefit is administered, leading to fewer issues with plan coverage Cost - no change, language clarification only
Section 400	III. Benefits and Services	A. Medical/Surgical Services, 2) EMERGENCY Care, c)	Out of area dependent coverage	ETF recommends against language changes; plans should determine coverage on a case-by-case basis, based on necessity of remaining with the out of network provider.	Plans indicated that adding out-of-area dependent expanded coverage could result in a cost increase to the plan.	n/a
Section 400	III. Benefits and Services	A. Medical/Surgical Services, 3) Urgent Care	Urgent Care Services	PARTICIPANTS must receive URGENT CARE from an IN-NETWORK PROVIDER if the PARTICIPANT is in the SERVICE AREA, unless it is not reasonably possible. If a PARTICIPANT is out of the SERVICE AREA, the PARTICIPANT should go to the nearest appropriate medical facility unless they can safely return to the SERVICE AREA to receive care from an IN-NETWORK PROVIDER. If the PARTICIPANT must go to an OUT-OF-NETWORK PROVIDER for care, it is recommended that they contact the HEALTH PLAN by the next BUSINESS DAY or as soon as possible and tell the HEALTH PLAN where the PARTICIPANT received URGENT CARE; this will expedite claims payment. ~~URGENT CARE from OUT-OF-NETWORK PROVIDERS may be subject to USUAL AND CUSTOMARY CHARGES.~~ PARTICIPANTS will be held harmless as described in UNIFORM BENEFITS. Non-urgent follow-up care must be received from an IN-NETWORK PROVIDER unless it is PRIOR AUTHORIZED by the HEALTH PLAN or it will not be covered. PRIOR AUTHORIZATIONS for the follow-up care are at the sole discretion of the HEALTH PLAN.	Plans indicated this was a positive clarification over original language.	

Section 400	IV. Exclusions and Limitations	2) Medical Services, 4) Therapies, d)	Add coverage of biofeedback for treatment of urinary incontinence	Biofeedback, except that provided by a physical therapist for treatment of headaches, ~~and~~ spastic torticollis, and urinary incontinence.	The majority of plans expressed this would be a positive change in line with current best practices for some members.	Health - Postiive for members impacted; may result in reduced use of other, less effective treatments. Quality - Positive for members impacted; would result in the most appropriate type of care being received. Cost - Neutral; nearly all plans indicated no cost, and the one that noted a possible cost indicated it would be less than 0.1% of premium.
Section 400	IV. Exclusions and Limitations	A. Exclusions	Add language for alopecia treatment	ETF does not recommend the changes proposed. The rationale for the requst and the volume of services requested were unclear in the initial submission. It appears that this can be appropriately handled by existing medical necessity language.		n/a
Section 400	IV. Exclusions and Limitations	A. Exclusions	Add language for Continuous Passive Motion (CPM) machine and cold therapy machine	ETF does not recommend the changes proposed. Several plans indicated that, while rare, CPM machines can be appropriate for some members. Plans should continue to review on a case-by-case basis for medical necessity.		n/a
Section 400	IV. Exclusions and Limitations	A. Exclusions, 10) General, aj)	Modification of marriage and family therapy exclusion	ETF does not recommend the language change proposed; it would substantially broaden coverage and could potentially extend coverage to people who are not members of the plan		n/a
Section 400	*IV. Exclusions and Limitations*	*A. Exclusions, 10) General, x) Orthoptics*	*Benefit modification to Orthoptics*	*No change to contract after follow up from the original requestor.*		*n/a*
Section 400	IV. Exclusions and Limitations	B. Limitations	Modify language related to bariatric surgery for treatment of GERD	ETF does not recommend the changes proposed. Plans should determine need for surgeries case-by-case.		n/a
Section 400	*IV. Exclusions and Limitations*		*Clarification of extraction responsibility for wisdom teeth*	*ETF provides the following clarification to coverage: given the benefit cap on Uniform Dental, it is ETF's intent that health plans continue to cover third molar ("wisdom tooth") removal under the health plan's benefit.* *No change to contract language required.*		*n/a*
Section 400	VI. Miscellaneous Provisions	C. Case Management/Alternate Treatment	Modify administrative requireemnt for Case Management / Alternative Treatment	ETF rejects the request to change the Alternative Treatment provision of the contract. The specificity offered by the requesting plan would substantially limit the benefit's intent.		n/a

150D Data Warehouse File Requirements, 6) Data Quality

The quality of CONTRACTOR'S data submissions shall be assessed by the DEPARTMENT'S data warehouse vendor for timeliness, validity and completeness. If the DEPARTMENT'S data warehouse vendor determines that the data submitted by CONTRACTOR fails to meet the DEPARTMENT'S data warehouse vendor's thresholds for data quality, the CONTRACTOR shall cooperate with the DEPARTMENT'S data warehouse vendor in submitting corrected data.

As needed, the DEPARTMENT, in consultation with its data warehouse vendor and the CONTRACTOR, shall develop a data improvement plan which will identify specific areas for the CONTRACTOR to improve the quality and completeness of its data submission, along with goals and timelines for improvement.

The CONTRACTOR agrees to financial penalties for failure to submit data in accordance with this AGREEMENT, and which are assessed by the DEPARTMENT'S data warehouse vendor on behalf of the DEPARTMENT. Charges or penalties that are the direct result of the CONTRACTOR'S failure to meet the DEPARTMENT'S data submission requirements, timelines, or other requirements in this AGREEMENT that impact the DEPARTMENT'S data warehouse vendor will either be invoiced to the CONTRACTOR and due within thirty (30) calendar DAYS or deducted from a future payment(s) owed the CONTRACTOR.

During the ~~initial~~ implementation of the DEPARTMENT'S data warehouse or a new CONTRACTOR, the CONTRACTOR will have two (2) chances to submit acceptable data. The DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the second submission not accepted by the DEPARTMENT'S data warehouse vendor. See Section 325.

During the ongoing operation of the DEPARTMENT'S data warehouse, if the DEPARTMENT's data warehouse vendor notifies the CONTRACTOR of an error on its initial data submission, as described in 3d above, the CONTRACTOR will have one opportunity to submit a corrected data file. If the CONTRACTOR requires additional submissions to correct identified errors, the DEPARTMENT will charge the CONTRACTOR a penalty for each data file submitted after the first corrected submission not accepted by the DEPARTMENT'S data warehouse vendor. See Section 325.

The penalties assessed in Section 150~~E~~D and Section 325 do not apply to the penalty maximum described in Sections 310, 315, 320, or 330. See Section 325 for data warehouse deliverable and penalty details.

205C Over-Age Disabled Child Eligibility
The CONTRACTOR shall notify the DEPARTMENT of individual over-age disabled child reviews per DEPARTMENT submission instructions. The CONTRACTOR may perform the annual individual reviews at any time of the year. If it is found that the child no longer meets the criteria for an over-age disabled child, termination of the child's coverage must be prospective. The DEPARTMENT must be copied on the notification of the CONTRACTOR'S review as described in the submission instructions.

In addition, the CONTRACTOR must report and certify to the DEPARTMENT ~~at least annually~~ the total results from its process to verify the eligibility of over-age disabled children age twenty–six (26) or older, which includes checking that the:

1. 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 (reviewed annually except if the child has Medicare Parts A and B, or has been found permanently disabled; if so, the medical review must be done at least once every 3 years), and

2. Support and maintenance requirement is met (reviewed annually), and

3. Child is not married (reviewed annually).

Attachment D

STATE OF WISCONSIN
Department of Employee Trust Funds
Robert J. Conlin
SECRETARY

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931
1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Correspondence Memorandum

Date: May 5, 2020

To: Group Health Insurance Program Participating Vendors

From: Office of Strategic Health Policy

Subject: Guidelines for Pilot Program Evaluation & Promotion

The Department of Employee Trust Funds (ETF) supports vendors who wish to provide innovative health programming to Group Health Insurance Program (GHIP) members. ETF also aims to provide standard Uniform Benefits (UB) to all GHIP members. In order to support both innovation and program consistency, ETF invites vendors to submit proposals annually to add pilot programs for ETF members.

Initial guidance for the submission of pilot programs to ETF (Proposal Guidelines) was provided via an ETF Council on Health Program Improvement meeting in 2018. Proposal Guidelines were sent again most recently in the ETF OSHP Weekly Notice Email no. 2019:50. In order to consider a pilot for provision to ETF membership, all elements discussed in the Proposal Guidelines must be included in the initial submission. ETF reserves the right to refuse a pilot program without review if the proposal is incomplete.

This document provides guidance for the promotion of approved pilot programs, as well as expectations regarding evaluation of programs in progress.

Pilot Program Evaluation

All vendors submitting pilot programs should also submit concepts for evaluating those pilot programs at the time of the pilot submission. Once accepted, vendors will work with ETF to finalize evaluation criteria and reporting.

Plans will be expected to report annually on pilot program outcomes, no later than April 15 of the year following the pilot's implementation, unless otherwise approved by ETF. Evaluation plans should at minimum describe the number of members impacted by the program and the cost of providing the program. A well-developed plan will include an analysis of health outcomes and cost changes resulting from the pilot program.

Pilot Program Promotion

Promotion during Open Enrollment: Following feedback from health plans, ETF will modify its prior policy on promoting pilot programs during Open Enrollment to allow vendors to include links to program information on their GHIP-dedicated websites. Any information on pilot programs should include the following:

- A clear reference in the description of the program that it is a pilot for ETF members for the current benefit year and may be changed or discontinued in future years;
- A description of any limitation to enrollment numbers, eligibility requirements, or other factors that would be relevant to the member being able to receive the benefits (e.g., availability to high-deductible health plan members, retirees versus active employees, etc.).

Vendors may not provide information at their benefit fair tables regarding pilot programs, but vendor representatives may provide information on pilot programs if specifically asked by a member. Any limitations in enrollment should be made clear to the member.

Promotion outside of Open Enrollment: Plans may include marketing materials related to pilot programs in new member welcome packets. Plans may also promote pilot programs to existing members outside of open enrollment. Materials should be submitted for review by the Office of Strategic Health Policy's Communications Manager, unless otherwise the plan is notified otherwise by the Communications Manager.

Incentives: Any incentives provided as a part of a pilot program must be approved by ETF before inclusion in the pilot program. ETF's outside counsel has interpreted all incentives as taxable that are not directly related to the care and treatment of a medical condition.