1. INTRODUCTION

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I. OBJECTIVES

The State of Wisconsin Group Insurance Board intends these "Terms for Comprehensive Medical Plan Uniform Benefits and Contract with Group Insurance Board to Participate under the State of Wisconsin Group Health Benefit Program" (hereinafter referred to as "Guidelines") to accomplish the goals and objectives stated below. Use of the term "Guidelines" is an historical anachronism and does not imply that the benefits and agreements stated herein are advisory rather than binding terms. Further, all parties contracting with the Group Insurance Board (BOARD) agree that these terms shall always be interpreted consistent with the objectives stated herein.

The BOARD's objective with alternate health care programming is: to encourage the growth of alternate health plans which are able to deliver health care benefits in an efficient and economical fashion and to limit and discourage the growth of plans which do not; to provide employees the opportunity to choose from more than one comprehensive health benefit plan.

By statute, the Group Insurance Board has the authority to negotiate the scope and content of the group health insurance program(s) for employees and retired employees of the State of Wisconsin, as well as local units of government.

The BOARD is committed to the concept of providing employees with comprehensive health benefit programs and ensuring that such benefits are delivered in an efficient and economical manner. The intent is to provide employees with the opportunity to be covered by health benefit program(s), which will provide benefits, and services, which are substantially similar to those provided under the standard, fee-for-service, group health insurance program. Therefore, the BOARD has developed these Guidelines by which alternate health plans may be evaluated for possible inclusion under the State of Wisconsin's Group Health Benefit Program on a "dual-choice" basis.

EMPLOYEES also have the option to opt-out of Group Health Insurance coverage. An EMPLOYEE who opts out of State Group Health Insurance, and is also not a covered DEPENDENT of the State Group Health Insurance Program, is eligible for a $2,000 opt-out payment from their EMPLOYER if they become enrolled in other group health insurance coverage. Graduate Assistants are not eligible for the opt-out incentive and nor are EMPLOYEES who opted out in 2015.

"DUAL-CHOICE" refers to a program where eligible employees, ANNUITANTS under Wis. Stat. § 40.51 (16), and currently insured other retirees and CONTINUANTS have the opportunity to choose between at least two competing health benefit plans, the Standard Plan and one or more alternate health plans. The mechanics of "DUAL-CHOICE" are relatively simple. Once an alternate health plan receives approval from the BOARD on the benefit structure, its proposed premium rate is submitted as a sealed bid. The bid will be reviewed for reasonableness, considering plan utilization, experience and other relevant factors. Bids are subject to negotiation by the BOARD. The BOARD reserves the right to reject any proposal, which fails to include adequate documentation on the development of premium rates. These Guidelines provide a detailed explanation of the required documentation.

The current program requires alternate health plans to submit their premium rate quotations for the following calendar year. The BOARD reserves the right to change to a fiscal year or to some other schedule that it deems appropriate.

The BOARD determines the premium rate for its self-insured Standard Plan (fee-for-service, group health benefit). This premium is established after review of claims experience, secular trends, etc., and after consultation with the BOARD's actuary. The State of Wisconsin's current contribution toward the total premium for active employees (non-retired) for both single and family contracts is based on a tiered structure. Under the tiered structure, the Division of Personnel Management in the Department of Administration has determined the Standard Plan to be placed in Tier 2 for purpose of determining premium contribution share for those subscribers who are active employees assigned to work out of state.

The tiered premium structure is based on recommendations from the BOARD's appointed actuary whereby each alternate health plan's claims experience will be reviewed to determine which of the three premium contribution tiers each plan will be placed. This placement will be based on a risk-adjusted assessment of the plan's efficiency as determined by the BOARD's actuary. The most efficient plans will be placed in Tier 1, which will have the lowest employee premium contribution level. The moderately efficient plans will be placed in Tier 2. The least efficient plans will be placed in Tier 3, which will have the greatest employee premium contribution level. The employee premium contribution will be a fixed amount per tier, as determined by the non-represented compensation plan or collective bargaining agreement. The employer shall contribute the balance of the total premium. Plans are determined to be qualified on a county by county basis. Plans become "qualified" by meeting the requirements in Addendum 2; number of providers and years of operation. The BOARD reserves the right to make enrollment and eligibility decisions as necessary to implement this program, including whether to make a Tier 1 plan available in those counties in which otherwise no qualified health plan in Tier 1 exists and/or a Tier 2 plan available in any county. The DEPARTMENT may take such action as necessary to implement this intent.

Effective January 1, 2009, local governments seeking to participate in the health insurance program are subject to group underwriting and may be assessed a surcharge based on their risk, which is passed on to the health plan and prescription drug plan. Administration of the underwriting process is done by the Standard Plan administrator and actual assessment of the surcharge is determined by the BOARD's actuary.

Local governments must meet a 65% level of participation unless they are a small employer as defined under Wis. Stat. § 635.02 (7). Local governments that are small employers must meet a participation level in accordance with Wis. Adm. Code § INS 8.46 (2) to participate wherein eligible employees who have other qualifying health insurance coverage are excluded when calculating the participation level. The BOARD also may offer an optional deductible benefit and/or copayment and coinsurance benefit structure that mirrors the State program for local governments.

Local employers must pay at least 50% but not more than 105% of the lowest cost / 88% of the average cost "qualified" plan in the employer's area or may contribute under a tiered structure in accordance with Wis. Adm. Code § ETF 40.10. If there is no "qualified" alternate health plan, the BOARD reserves the right to designate the State Maintenance Plan (SMP) as the lowest / average cost "qualified" plan in those counties where it meets the minimum standards defined in Addendum 2.

In the event that the contribution is based on a percentage of the lowest / average cost qualified plan, if an alternate health plan submits a premium rate, which is less than the employer contribution rate, the employer contribution (dollar amount) could represent 100% of the total

alternate health plan premium and the employee will pay no out-of-pocket premium contribution. Conversely, if a plan submits a premium rate, which is substantially higher than the employer contribution rate, the employee contribution will be the difference between the total premium rate and the employer contribution rate in the plan's area.

The BOARD is convinced that the development of "constructive competition" among providers of health care services will have a positive impact on improving the health care delivery system. A health care plan with efficient, highly qualified providers, who effectively practices peer-review and utilization review, will draw patients away from inefficient providers by offering better service and/or lower premium costs. The eventual goal is to have comprehensive, alternate health plans available to all public employees within the geographic confines of the State of Wisconsin.

The following Guidelines describe the requirements, which an organization must satisfy in order to secure approval from the BOARD to participate under the State of Wisconsin's Group Health Benefit Program. They have been developed to explain and clarify the general requirements set forth under Wis. Stats. Subchapter IV of Chapter 40, and Chapters ETF 10 and 40, Wisconsin Administrative Code, Rules of the Department of Employee Trust Funds. Further, they set forth requirements, which are complementary to the statutory provisions contained in Wis. Stats. Chapters 150, 185 (185.981-.985), 600-646, and Public Laws 93-222 (the HMO Assistance Act of 1973) and 94-460 (Health Maintenance Organization Amendments of 1976) and other applicable state/federal health benefit law provisions.

Participation in the program is not limited exclusively to organizations, which are considered "qualified" by the federal government as a health maintenance organization (HMO). The BOARD is interested in providing public employees with the opportunity to enroll in any comprehensive health benefit program, which is able to demonstrate financial responsibility, a successful operating experience, and meets the requirements outlined in these Guidelines.

II. GENERAL REQUIREMENTS

A. Statutory Authority to Contract

Wis. Stats. Subsection 40.03 (6) (a), provides:

> "(6) GROUP INSURANCE BOARD. The group insurance board:
>
> (a) 1. Shall, on behalf of the state, enter into a contract or contracts with one or more insurers authorized to transact insurance business in this state for the purpose of providing the group insurance plans provided for by this chapter; or
>
> 2. May, wholly or partially in lieu of sub. 1, on behalf of the state, provide any group insurance plan on a self-insured basis in which case the group insurance board shall approve a written description setting forth the terms and conditions of the plan, and may contract directly with providers of hospital, medical or ancillary services to provide insured employees with the benefits provided under this chapter."

To be harmonious with the rest of the Guidelines and the requirement under section II below, that plans have broad-based community support, the BOARD will contract with only those plans which have received Commissioner of Insurance approval. CONTRACTS once approved, must be renegotiated annually if the plan is to be offered in succeeding years.

An organization interested in participating under the State of Wisconsin Group Health Benefit Program must meet the requirements of Wis. Stat. § 40.03 (6) (a) and these Guidelines before the BOARD will consider the plan.

B. Operating Experience

Any organization which is eligible to contract with the Group Insurance BOARD, must have at least one (1) year of operating experience and must be able to demonstrate that the organization has broad-based community support. In determining the operating experience requirements, the BOARD shall consider the period of time elapsing from the date the organization first opens its door to the general public to render health care services to the date that such coverage would be effective for public employees.

To document the community support requirement, the plan must submit to the BOARD information on current enrollments, projected growth and historical data that would support the fact that the plan has experienced steady growth since its inception. The plan must provide a current listing of employer/employee groups participating under the program or actively sponsoring participation in the plan. If the plan is so large that providing a listing of each and every participating employer/employee group would be an inconvenience, the BOARD will accept a representative listing of 20 such organizations.

The BOARD may waive the one year operating experience and community support requirement(s) in those health service areas where the BOARD has determined there is a need for the promotion of innovative approaches to the delivery of health care such as the concept of direct provider contracting.

C. Financial Requirements

Any organization determined to be eligible to contract with the Group Insurance BOARD must be able to demonstrate that the plan has the financial resources necessary to carry out its obligations to public employees and dependents who choose to be covered under the program.

The BOARD prefers to approve only those plans, which have reached the "break even point" and are now operating at a level where program income equals expenses. However, the BOARD will consider plans, which are not yet self-sufficient, if the plan provides evidence that it can meet its short and long-term financial obligations.

In determining financial stability, the BOARD will consider:

1. Financial soundness of arrangements for health care services.

2. Adequate working capital (both current and projected).

3. Insolvency protection for subscribers. Consisting of, for example: financial bonds, third party guarantees, reinsurance, deposits, automatic conversion rights, or other arrangements which are adequate to the satisfaction of the BOARD to provide for continuation of benefits until the end of the month in which insolvency is declared; for those persons hospitalized on or before the date of insolvency, benefits must continue until 12 months from the date of insolvency, the attending physician determines confinement is no longer medically necessary, discharge, or the contract maximum has been reached, whichever occurs first.

Such documentation of financial stability may include one or more of the following:

1. Federal qualification under Public Law 93-222 (Health Maintenance Assistance Act of 1973), or subsequent amendments.

2. Incorporation and regulation under the provisions of Chapter 185 and/or 600 through 646 of the Wisconsin Statutes pertaining to insurance plans.

3. Posting financial bond guaranteeing benefit payments in the event the plan fails to meet the continuing requirements for inclusion under the state program and is terminated, or the plan ceases operation. The size of the performance bond required will be based on the number of enrollees and premium income involved.

4. The plan has sponsors who are incorporated under Chapter 613 of the Wisconsin Statutes or otherwise possess an appropriate certificate of authorization to transact insurance business under Wis. Stat. § 601.04, and will guarantee future benefit payments.

5. Other documentation such as reinsurance as provided by Chapter 627 of the Wisconsin Statutes and as authorized by the Commissioner of Insurance. Terminations will be handled in a manner consistent with the intent of Wis. Adm. Code § INS 6.51 (6) and (7), Rules of the Commissioner of Insurance (register date December 1984).

6. The BOARD reserves the right on a case by case basis to request additional documentation of financial stability of a kind and in a form as appropriate.

Each plan must submit to the BOARD on an annual basis, information on its current financial condition including a balance sheet, statement of operations, financial audit reports (i.e., an annual audited financial statement by a certified public accountant in accordance with generally accepted accounting principles), and utilization statistics. (This information shall remain confidential insofar as permitted by Wisconsin Law.) Failure to file annual financial statements (prior to July 1 following the end of the preceding contract period) shall constitute sufficient grounds for the BOARD to deny future renewals, or consider the plan to be non-qualifying.

D. Comprehensive Health Benefit Plans Eligible for Consideration

1. The BOARD will only consider those plans, which provide benefit payments, or services which are, in whole or substantial part, delivered on a prepaid basis or which meet the requirement for preferred provider plans. The BOARD reserves the right not to contract with any plan whose premium is not satisfactory to the BOARD.

2. Plans that will be considered under these program Guidelines to be allowed in any service area include any of the following types of Organizations defined in Wis. Stats. § 609.01 (2) and (4):

   a. Independent practice association HMO (IPA's).

   b. Prepaid group practice HMO.

   c. Staff model HMO.

   Plans that will be considered under these Guidelines to be offered in any county also include:

   d. Point of service HMO (POS-HMO).

   e. Preferred Provider Plan (PPP).

   Plans that embrace the characteristics of one or more of the type of organization models described above may be considered by the BOARD as meeting the definition of a comprehensive health benefit plan. Insuring organizations may not offer more than one of the above listed plan types in any geographic location. This allows organizations sufficient flexibility to develop innovative alternative plans while recognizing the BOARD'S need for administrative efficiency and protection of the competitive environment.

3. Each plan will offer health care coverage through a High Deductible Health Plan (HDHP) to all eligible PARTICIPANTs who have enrolled in a State sponsored Health Savings Account that meets all applicable state or federal requirements.

4. Plans must provide for the Wisconsin State Employees' and Wisconsin Public Employers' Program benefits and services listed in Section 4 – Uniform Benefits.

5. The BOARD strongly encourages HEALTH PLANS to adopt a system by which upon enrollment in the State of Wisconsin Group Health Benefit Program, SUBSCRIBERS and DEPENDENTS shall be required to select a primary care physician (PCP). Under such a system, the PCP furnishes primary care-related services, arranges for and coordinates referrals for all medically necessary specialty services, and is available for urgent or emergency care, directly or through on-call arrangements, 24 hours a day, 7 days a week. Primary care includes ongoing responsibility for preventive health care, treatment of illness and injuries, and the coordination of access to needed specialist providers or other services. The PCP shall either furnish or arrange for most of the PARTICIPANT'S health care needs, including well check-ups, office visits, referrals, out-patient surgeries, hospitalizations, and health-related services. The BOARD will reward plans that establish a well-documented and efficient PCP process that effectively leads to better care and lower cost by providing credit to a plan's composite score during annual negotiation at a level determined by the BOARD.

6. HEALTH PLANS must receive written approval from the DEPARTMENT prior to offering any financial incentive or discount programs to PARTICIPANTS. HEALTH PLANS must participate in collaboration efforts between the DEPARTMENT, its wellness and disease management vendor and the HEALTH PLANS. HEALTH PLANS must accept PARTICIPANT level data transfers from the DEPARTMENT'S wellness and disease management vendor. HEALTH PLAN must demonstrate, upon request by the DEPARTMENT, their efforts in utilizing the PARTICIPANT level data from DEPARTMENT'S wellness and disease management vendor to identify PARTICIPANTS appropriate for complex/chronic case management and enroll PARTICIPANTS in such HEALTH PLAN programs.

   HEALTH PLANS must provide incentive payment information as specified by the DEPARTMENT for payroll tax purposes. Provider obtained biometric screenings as required by the DEPARTMENT'S wellness program shall be provided by the HEALTH PLAN at the PARTICIPANT'S request, for no cost to the PARTICIPANT, and at a minimum test: 1) glucose level; 2) body mass index (BMI); 3) cholesterol level; 4) blood pressure. Glucose and cholesterol screenings may be administered as non-fasting and in accordance with current U.S. Preventive Services Task Force (USPSTF) guidelines.

7. 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.

8. 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 Healthcare Effectiveness Data and Information Set (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.

9. Plans must provide the results of their annual Consumer Assessment of Healthcare Providers and Systems (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.

10. Plans are expected to fully incorporate available pharmacy claims data into data reporting, including, but not limited to, HEDIS data, Wisconsin Health Information Organization (WHIO) claims data, information requested on the disease management survey and catastrophic claims data, and information received from health risk assessments. Where appropriate, such as for the catastrophic claims data report, plans are expected to separate out pharmacy claims from the DEPARTMENT'S pharmacy benefit manager from any pharmacy claims that are paid by the plan.

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 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). HEALTH PLANS that submit incomplete data maybe subject to sanction by the BOARD, as described in Section 2.4 (5) of the State Contract.

12. Plans must demonstrate effective and appropriate means of monitoring and directing PARTICIPANT'S care by participating physicians, such as Utilization Review (UR), chronic care/disease management, prior authorizations for high-tech radiology and low back surgery, and wellness/prevention. Each plan shall report annually to the BOARD its utilization and disease management capabilities and effectiveness in improving the health of PARTICIPANTS and encouraging healthy behaviors, demonstrating support for technology and automation (e.g., automated diabetic registry, electronic medical records, etc.) in the format as determined by the DEPARTMENT. Plans shall also include a report detailing the State of Wisconsin group experience by disease and risk categories, place of services along with comparisons to aggregate benchmarks and any other measures the plan believes will be useful to DEPARTMENT staff and the BOARD in understanding the source of cost and utilization trends in a format as determined by each plan.

    Examples of the minimum UR procedures that participating alternate health plans should have in place include the following:

- Written guidelines that physicians must follow to comply with the plan's UR program for IPA model HMOs.

- Formal UR program consisting of preadmission review, concurrent review, discharge planning and individual case management.

- Established procedures for review determinations, including qualified staff (e.g., primary reviewer is licensed nurse), physician reviews all program denials and patient appeals procedure.

- Authorization procedure for referral to non-plan providers and monitoring of physician referral patterns.

- Procedure to monitor emergency admissions to non-plan hospitals.

- Retrospective UR procedures to review the appropriateness of care provided, utilization trends and physician practice patterns.

- If PARTICIPANTS are required to select a primary care provider or primary care clinic, have a process to allow a PARTICIPANT to change providers in a reasonable time and to communicate to the participant how to make this change. Plans will assist in location of a provider and facilitate timely access, as necessary.

- If PARTICIPANTS are identified as having a disease and/or condition that would place them into a moderate or high risk category as determined by the HEALTH PLAN, have a process to enroll the PARTICIPANTS into the appropriate wellness, disease management, or chronic care management programs. The HEALTH PLAN must coordinate this effort with the program(s) offered by the DEPARTMENT'S wellness and disease management vendor.

- Prior authorization procedures for referrals to orthopedists and neurosurgeons associated directly or indirectly with the plan for PARTICIPANTS with a history of low back pain who have not completed an optimal regimen of conservative care. Such prior authorizations are not required for PARTICIPANTS who present clinical diagnoses that require immediate or expedited orthopedic, neurosurgical or other specialty referral.

- Prior authorization procedures for high-tech radiology tests, including MRI, CT scan, and PET scans.

In its report, the plan must certify that these (or equivalent) procedures are in place. Failure to provide effective UR may be grounds for non-qualification or non-participation.

13. 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 or a vendor to do so. Plans must utilize Patient Decision Aids (PDA) according to International Patient Decision Aids Standards (IPDAS). The SDM process must also include an opportunity for members to discuss a particular intervention with their primary care provider, care manager, health educator or a vendor who is trained to have a discussion after the member has reviewed the PDA. Upon

request by the DEPARTMENT, plans must report annual patient utilization rates and program impacts in accordance with DEPARTMENT guidance. Plans are required to administer a patient satisfaction survey to all SDM participants, based on requirements provided by the DEPARTMENT. Upon request by the DEPARTMENT, plans must report the number of surveys administered as well as the results of the survey, including verbatim comments/feedback as applicable.

14. HEALTH PLANS and their contracting providers must provide a credible ADVANCE CARE PLANNING program that includes hospice care and a palliative care consultation in a manner that is consistent with the Disease Management initiatives of the DEPARTMENT. HEALTH PLANS must offer ADVANCE CARE PLANNING and/or a palliative care consultation to members with a serious disease and/or a likely survival of less than twelve months.

15. With the intent of reducing hospital admissions, plans must demonstrate, upon request by the DEPARTMENT, their efforts at contacting PARTICIPANTS 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, within 3-5 business days after the PARTICIPANT is initially discharged from the hospital. Plans may coordinate with a hospital or provider group in order to contact these PARTICIPANT.

16. Plans must cover emergency and urgent care and related catastrophic medical care received from plan or non-plan providers at the in-plan level of benefits. The emergency room copayment is applicable if the PARTICIPANT is not admitted to the hospital. This out-of-service area care may be subject to usual and customary charges while holding the PARTICIPANT harmless as described in Section II., E., 5. unless the PARTICIPANT accepted financial responsibility, in writing, for the specific treatment or services (i.e., diagnosis and/or procedure code(s) and related charges) prior to receiving services. Plans shall make every effort to settle claim disputes in a reasonable time frame. Plans affiliated with larger nationwide networks may offer coverage through affiliated plan networks as long as there is no additional cost to the plan or PARTICIPANT for doing so.

17. Plans must provide SUBSCRIBER written notification of how to enroll in a conversion policy set forth in Wis. Stat. §632.897 and/or Marketplace plan in the event of termination of employment.

18. Plans must agree to participate in the regular "DUAL-CHOICE" enrollment offering. A regular DUAL-CHOICE enrollment offering is scheduled approximately 90 days prior to the end of each contract period. During such DUAL-CHOICE enrollments the plan will accept any individual (active employee, CONTINUANT or retiree) who transfers from one health plan to another without requiring evidence of insurability, or waiting periods, or exclusions for pre-existing conditions as defined in Wis. Adm. Code § INS 3.31 (3) and any eligible employee or state retiree under Wis. Stat. § 40.51 (16) who enrolls. In certain situations, for example, when the Centers for Medicare and Medicaid Services does not allow an enrollment due to an individual's residence in a given area, a plan is not required to accept the individual. Any individual who is confined as an inpatient at the time of such transfer shall become the liability of the succeeding plan unless the facility in which the PARTICIPANT is confined is not part of the succeeding plan's network. In

this instance, the liability will remain with the previous insurer. The new plan shall assume liability for any subsequent services as provided for in 3.18 (3) of the Contract.

However, if a plan becomes insolvent, experiences a significant loss of primary physicians and/or hospitals or no longer meets the minimum criteria for qualification in that county, or if the BOARD so directs due to an unapproved change of ownership, merger or acquisition, the DEPARTMENT may close the plan to new enrollments, authorize a special enrollment period so that SUBSCRIBERS in that service area may change to another plan without waiting periods for pre-existing conditions, or both. The special enrollment period authorized by the BOARD may either require all employees insured by the plan to elect coverage under another plan or allow all employees insured by the plan the option to continue to be insured by the plan or to elect coverage under another plan.

19. 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.

20. Contracting organizations must participate in both the state group and the local public employer group.

21. The BOARD may allow plans that have substantially but not completely met the requirements of these Guidelines to participate as a health care plan provider, but not be considered "qualifying" for purposes of establishing the employer contribution toward premium when the contribution is based on a percentage of the lowest / average cost qualified plan. The reasons a plan may be considered "non-qualifying" shall include, but not be limited to:

    1. Failure to submit required information in the format specified by the department,

    2. Insufficient provider coverage in a service area (determined by the BOARD),

    3. Failure to provide the benefit level as described in Section II. D., 3,

    4. Failure to substantiate premium rate proposals, or

    5. Failure to comply with the contract.

22. Non-qualifying plans. This section applies only to those for whom contributions are based on a percentage of the lowest / average cost qualified plan. Local government employers must pay at least 50% but not more than 105% of the lowest cost / 88% of

the average cost qualified plan in the employer's area (except for eligible employees who work less than half-time for whom the minimum contribution shall be at least 25% of premium). Local government employers who determine the employee premium contribution based on the tiered structure established for state employees must do so in accordance with Wis. Adm. Code § ETF 40.10. The county of the employer is considered the service area for local employers. At the request of a participating employer, the Department will review the service area used to determine the least / average cost qualified plan used for determining the employer's maximum premium contribution. If the Department reviews the service area, the least / average cost plan will either be based on the zip code locations that include at least 80% of the covered employees of the participating employer, or, when an employer has offices in multiple counties, the least / average cost plan is determined by the county office to which the employee reports to work. Once the Department has made such an assessment, that service area will determine the least / average cost plan until it is demonstrated that there has been a significant change in employee residency and the area no longer meets the 80% criteria. A non-qualifying plan approved by the BOARD for participation in the State of Wisconsin Group Health Benefit Program may market its plan in any area. However, only the lowest / average cost qualified plan's premium rate would be used in the above calculations. No plan may qualify for determining employer contributions in its first year of operation under the BOARD's program. Preferred Provider Plans (PPP) are not qualified in areas served by SMP. The service area for PPPs will be considered the subscriber's county of residence.

The Standard Plan premium rates for state employees will be the same statewide. However, premium rates for the Standard Plan for the local government program will depend upon the geographic location of the municipality. The ratio is to be determined annually by the BOARD's actuary.

23. Subscriber premium payments will be arranged through deductions from salary, accumulated sick leave account (state employees only), or annuity. For all other subscribers, premiums will be paid directly to the plan and plans must notify the Department of subscribers terminating or reinstating coverage as described in Section II., J.

24. In order to maintain family coverage that is in effect at the time of a subscriber's death, the Department may split sick leave credits between multiple surviving insured dependents upon request by the surviving spouse or a surviving dependent.

25. Plans will provide and receive all reasonable requests for data and other information as needed in a file format as identified by the Department after seeking input from plans. This includes requests for the pharmacy benefit manager to administer the pharmacy benefit program. Data file requests containing personal health identifiers must be submitted via the Department's secure FTP site, unless otherwise directed by the Department.

26. Each plan must submit all medical and prescription drug claims (except Medicaid) data to the Wisconsin Health Information Organization (WHIO) for the plan's commercial and Medicare lives residing in Wisconsin at a minimum. Claims shall be submitted to WHIO in a manner compliant with WHIO requirements.

27. Plans shall not recoup any payments it has made for prescriptions filled by participants on and after January 1, 2004.

28. PPPs and Point of Service plans (POS) may have different copayment and deductible schedules for out-of-plan providers, except in the case of emergency, urgent care or when the service is not reasonably available from a plan provider. If the PARTICIPANT resides in a plan's qualified county, the PPP and POS must consider the PARTICIPANT'S physical capability to travel the necessary distance to see a specialty plan provider when determining if that plan provider is reasonably available.

29. If the PARTICIPANT receives 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. The only exception is when the PARTICIPANT knowingly elects to receive such care through a non-plan provider.

30. The plans shall comply with Wis. Stat. § 628.46 with regard to any interest due for late payment of claims submitted by a non-plan provider.

31. The plans shall comply with and abide by the Patient's Rights and Responsibilities as printed in the annual Dual-Choice brochure. Plans that have their own Patient's Rights and Responsibilities may also use them unless there is a conflict. In that case the Patient's Rights and Responsibilities which is more favorable to the PARTICIPANT will apply.

32. The plans shall comply with all state and federal laws regarding patient privacy and shall assist the BOARD in complying with all requirements of the Early Retiree Reinsurance Program as specified in 45 C.F.R. 149.35.

E. Provider Agreements

Any organization seeking approval under these Guidelines must provide the following information:

1. If professional services are provided through contractual arrangements, such as an Independent Practice Association (IPA), a sample copy of the actual contractual agreement established between the organization and the participating physicians who will be providing professional services. If more than one type of contract is used then include a sample of each.

2. Detailed explanation of any relationship between the plan and hospitals which would be involved under the State of Wisconsin Group Health Benefit Program. Each applicant must specify whether there is a contractual relationship between the plan and the hospital(s) involved or if the relationship is limited only to the extent that physicians providing services under the program have staff privileges with the hospital(s).

3. Detailed explanation of how physicians and hospitals are compensated under the program including a description of any and all incentives involved. If physicians are salaried, a detailed explanation of how salaries are established, reviewed and changed, and who is the authorizing party for such action. The intent is to secure information on how a plan reimburses its providers; the BOARD is not interested in specific fees or salary information.

4. Detailed explanation of medical specialties associated directly or indirectly with the plan. For those plans where medical specialists are used as referral physicians rather than primary care, the plans must submit documentation to demonstrate that the referral physician(s) has, in fact, agreed to accept such referrals. If there is a contractual arrangement where an organization has contracted with a clinic/individual practitioner to provide either primary or referral care, such contractual agreements must be identified and included with the proposal.

5. Except for those benefits which require the enrollee to satisfy a deductible or be subject to copayment, the contract for professional or hospital services must contain a provision whereby the physician and/or hospital and/or health care provider (as defined under Wis. Stat. § 655.001 (8)) agrees to accept the payments provided by the plan as full payment for covered services. Each plan must certify that it will "hold harmless" the enrollee from any effort(s) by third parties to collect payments for medical/hospital services.

   This provision shall be considered as satisfied if arrangements have been made which prevent the enrollee from being held liable for hospital or professional charges except for those benefits which require the enrollee to satisfy a deductible; be paid on a copayment basis; or in those instances where the individual failed to comply with published requirements for seeking medical care. Unauthorized referrals or the use of non-participating hospitals or medical personnel in violation of published plan requirements shall not be subject to the "hold-harmless" provision.

6. Provider agreements for transplants are expected to specify that re-transplantation due to immediate rejection that occurs within the first 30 days of a transplant shall be covered and is not subject to the Uniform Benefits exclusion on re-transplantation.

7. Plans are expected to incorporate into hospital and provider agreements the guidelines as described by Medicare that limit reimbursement for adverse events and preventable errors.

8. Plans are expected to incorporate into hospital and provider agreements the hospital readmissions reduction program and the community-based care transitions program as described by Medicare and that are conducted under the authority of Sections 3025 and 3026.

F. Capital Equipment and Expenditures

Each applicant must provide in its proposal a detailed explanation of how capital equipment and expenditures for the facility are authorized. If your organization is not specifically providing services but rather, functioning as a sponsor, include within your proposal the following statement:

> "Item F. of the Guidelines is not applicable to this organization. The purchase of capital equipment, etc., is not subject to review by either the state or federal health agencies."

If the approval of capital equipment and expenditures is subject to review by state and/or federal agencies, the applicant should provide information on all reporting requirements.

G. Enrollment and Reporting

If an organization submits a proposal to participate under the State of Wisconsin Group Health Benefit Program and the proposal receives approval by the BOARD, the plan will be offered to active and retired public employees at a time established by the BOARD (dual-choice enrollment) subject to the following:

1. Any plan, which receives approval from the Group Insurance Board, must:

    a. Secure a minimum of 100 subscriber contracts (state/local employees enrolled; this number does not include any dependents covered under the plan) or;

    b. Demonstrate that 10% of the eligible employees within the area to be serviced by the plan have opted to participate in the program.

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.

    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.

3. Each organization must demonstrate to the BOARD's satisfaction its ability to provide the following:

    a. The specified level of services to enrollees.

    b. An adequate mechanism for maintaining records on each enrolled employee and covered dependents, including but not limited to, initial determination of eligibility for dependents for disabled and full-time student status.

    c. Effective methods for containing costs for medical services, hospital confinements or any other benefit to be provided. Particular emphasis should be placed on the presence of an effective peer review mechanism and utilization review mechanism for monitoring health care costs. The BOARD is also particularly interested in COB (Coordination of Benefit) provisions such as third party requests, dual-coverage under different plans, etc.

    d. An effective mechanism for handling complaints and grievances made by enrollees.

        1) This includes a formal grievance procedure, which at a minimum complies with Wis. Adm. Code § INS 18.03, whereby the individual is provided the opportunity to present a complaint to the organization and the organization will consider the

complaint and advise the enrollee of its final decision. Enrollees must be advised of the grievance process when a claim or referral is denied or if the enrollee expresses, in writing, dissatisfaction with the administration or claims practices or provision of services by the plan. In all final grievance decision letters, the HEALTH PLAN shall cite the specific Uniform Benefit contractual provision(s) upon which the HEALTH PLAN bases its decision and relies on to support its decision.

2) When necessary, the BOARD intends to take a proactive approach in resolving complaints. The plan will be expected to cooperate fully with the efforts of the DEPARTMENT in resolving complaints. Adverse decisions are subject to review by the BOARD for contractual compliance if the employee is not satisfied with the plan's action on the matter.

3) The plan must retain records of grievances and file an annual summary (see schedule in Section II., J.) with the BOARD of the number, types of grievances received and the resolution or outcome. The annual summary report will contain data and be in a format established by the Department of Employee Trust Funds.

e. Statistical report(s) showing utilization and claims data on the plan as a whole (if community rated), or specifically the state/local employees and DEPENDENTS covered thereunder if experience rated. If the plan premium is community-rated then the plan should give some indication of the percentage the state and local employee groups represent of the total covered community. The BOARD will require each plan to provide an explanation of rate methodology and the rate calculation developed by the HEALTH PLAN'S actuary or consultant along with supporting documentation deemed necessary by the BOARD's actuary. The BOARD will also require enrollment information on state enrollees by age, sex, single or family coverage of PARTICIPANTS. Such information will be required once each year (per Section II., C.) and shall be treated as confidential by the BOARD in accordance with Wisconsin and federal law.

f. An adequate mechanism for handling medical costs and services provided to an enrolled individual in the event of an emergency, which occurs out of the service area.

g. Compliance with state and federal regulations pertaining to mandated or minimum benefits which may be applicable to the plan (under insurance statutes or otherwise).

h. Unless a benefit is being changed or added to the plan to comply with state or federal law, no benefit changes shall occur during the contract period unless the BOARD initiates the proposed changes.

i. A written description which will provide state and local employees with a clear explanation of pre-authorization and referral requirements. Such brochure shall be prepared and set forth in lay language for ease of understanding, and in a form and content acceptable to the BOARD and will be provided to the employee within 30 days of the effective date of coverage or the date the plan receives the employee's application, whichever is later.

j. Provide at least annually the names of individuals in the organization who are considered "key contacts." Key contacts are the names and telephone numbers of the chief executive officer and the liaison person with the Department of Employee Trust Funds. Also those persons who should be contacted by the various state agencies and local employers regarding claims problems, complaints and grievances and ordering supplies. Further, each plan must identify one person who will be designated as a "key contact" for the Employee Assistance Program Coordinators to ensure proper assessment, coordination and treatment for PARTICIPANTS who request referral to a facility for alcohol, drug and/or mental health problems.

k. Notification of significant event:

1) Each plan shall notify the BOARD in writing of any "Significant Event" within ten (10) calendar days after the plan becomes aware of it. (In the event of insolvency, the BOARD must be notified immediately.) As used in this provision, a "significant event" is any occurrence or anticipated occurrence that might reasonably be expected to have a material effect upon the plan's ability to meet its obligations under the State of Wisconsin Group Health Benefit Program , including, but not limited to, any of the following: disposal of major assets; loss of 15% or more of the plan's membership; termination or modification of any contract or subcontract if such termination or modification will have a material effect on the plan's obligations under the State of Wisconsin Group Health Benefit Program ; the imposition of, or notice of the intent to impose, a receivership, conservatorship or special regulatory monitoring; the withdrawal of, or notice of intent to withdraw, state licensing or certification, United States Department of Health and Human Services (HHS) qualification or any other status under state or federal law; default on a loan or other financial obligations; strikes, slow downs or substantial impairment of the plan's facilities or of other facilities used by the plan in the performance of this CONTRACT.

2) In addition, any change in the ownership of or controlling interest in the plan, any merger with another entity or the plan's acquisition of another plan which participates in the State of Wisconsin Group Health Benefit Program is a "significant event." A change in ownership or controlling interest means any change in ownership that results in a change to or acquisition of majority (51%) interest in the plan or any transfer of 10% or more of the indicia of ownership, including but not limited to shares of stock. The plan agrees to provide to the BOARD at least 60 days advance notice of any such event. The BOARD may accept a shorter period of notice when it determines the circumstances so justify. If the BOARD determines that the change of ownership or control, merger or acquisition is not in the best interests of the State of Wisconsin Group Health Benefit Program and insured employees, the BOARD may do any of the following, including any combination of the following:

a) Terminate the plan's participation upon any notice it deems appropriate, including no notice.

b) Authorize a special enrollment period and require that each subscriber enrolled in that plan change to another plan. No plan may impose a waiting period for pre-existing conditions with respect to such special enrollment periods.

c) Authorize a special enrollment period so that a subscriber enrolled in that plan may voluntarily change to another plan. No plan may impose a waiting period for pre-existing conditions with respect to such special enrollment periods.

d) Close the plan to any new enrollments for the remainder of the contract period.

e) Require that prior to making a selection between plans, prospective subscribers be given a written notice describing the BOARD's concerns.

f) Take no action.

3) The BOARD requires the information concerning any change in ownership or controlling interest, any merger or any acquisition of another participating plan in order to fulfill the BOARD's responsibility to assess the effects of the pending action upon the best interests of the State of Wisconsin Group Health Benefit Program and insured employees. The BOARD pledges to keep the information disclosed as required under par. (b) temporarily confidential unless the plan waives confidentiality or a court orders the DEPARTMENT or BOARD to disclose the information or the DEPARTMENT or BOARD determines that under the particular circumstances, any harm to the public interest that would result from permitting inspection is outweighed by the public interest in immediate inspection of the records. The BOARD also agrees to notify the plan of a request to disclose the information as a public record prior to making such disclosure, so as to permit the plan to defend the confidentiality of the information. Information disclosed by a plan concerning any change in ownership or controlling interest, any merger or any acquisition of another participating plan will be treated as a public record beginning on the earliest of the following dates:

a) The date the pending change in ownership or controlling interest, any merger or any acquisition of another participating plan becomes public knowledge, as evidenced by public discussion of the action including but not limited to newspaper accounts.

b) The date such action becomes effective.

c) 60 days after the BOARD receives the information.

4) The BOARD shall reserve the right to institute action as it deems necessary to protect the interests of its employees and dependents, as the result of a "significant event."

l. Agree to utilize identification numbers (group and subscriber) according to the system established by the Department of Employee Trust Funds. Identification numbers must not correlate to Social Security numbers. Social Security numbers may be incorporated into the subscriber's data file and may be used for identification purposes only and not disclosed or used for any other purpose. Plans must always keep record of Social Security numbers for providing data and other reports to the

DEPARTMENT and track the 8-digit unique member identification number that is assigned by the DEPARTMENT.

m. The plan's provider network must comply with the access standards set forth in WI Adm. Code § INS 9.32.

n. Provide coverage for eligible children as required under the National Medical Support Notice, a State and Federal law providing for a special enrollment opportunity for eligible children in certain cases when ordered by a court.

H. Rate-Making Process

Each plan must include in its proposal to the BOARD a detailed explanation as to how initial premium rates were determined, and how premium rates will be determined for subsequent periods. The organization shall identify whether the rate which will be proposed represents a community rate (factored or not factored for different time periods or for different benefit provisions) or as a projection of claims/benefits based on expected experience of the state/local group or other groups, etc. This information will be treated confidential by the BOARD insofar as permitted by Wisconsin Law. Rates shall be uniform statewide, except that plans may submit different rates which result from mutually exclusive provider networks in separate geographic locations. Plans are encouraged to separate higher cost providers within geographic areas under the tiered structure into separate plans. The state and local groups must be separately rated in accordance with generally accepted actuarial principles. The local group is to be rated as a single entity for each plan. Plans shall provide rates for each of the program options for the local group. Plans shall not provide claims or other rating information to individual local employers participating in the program.

The proposal should also include an explanation of how adverse or favorable experience would be reflected in future rates. The DEPARTMENT reserves the right to audit, at the expense of the plan, the addendum and the other data the plan uses to support its bid. A bid based on data which an audit later determines is unsupported subject to re-opening and re-negotiating downward.

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 State of Wisconsin Group Health Benefit 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 State of Wisconsin Group Health Benefit Program. The BOARD limits plans to the following premium categories, and each plan to be qualified must provide coverage for each premium category:

- Individual (Employee Only)
- Family (Employee Plus Eligible Dependents)
- High Deductible Health Plan (HDHP) Option for eligible non-Medicare individual and family health insurance premium rates.

- Medicare Coordinated
  - Individual
  - Family 2 (all insureds under Medicare)
  - Family 1 (at least 1 under Medicare, at least 1 other not under Medicare)

- Graduate Assistants[1]:
  - Individual
  - Family

- Deductible, Coinsurance and HDHP Options for Local Program
  - Individual
  - Family

1. Family rates (regular coverage) must be 2.5 times the individual rate.

2. Medicare Coordinated Coverage: Individual rate must be justified by experience and may not exceed the calculated rate in Table 7 of Addendum 1 without written justification. It may not exceed 50% of the single rate for regular coverage, unless determined by the BOARD's actuary to be lower; Medicare family 2 eligible rate shall be 2 times the individual Medicare coordinated rate; Medicare family 1 rate (1 under Medicare, 1 or more not eligible), shall be the sum of the individual rate (regular coverage) and individual rate (Medicare eligible).

3. Graduate Assistants: Individual rate must be within a range of 65% to 75% of the individual regular coverage rate; family rate must be within a range of 65% to 75% of the family regular coverage rate. It may not exceed the calculated rate in Table 7 of Addendum 1 without written justification.

4. Deductible, Coinsurance and HDHP Options for Local Program: The ratio is to be determined annually by the BOARD's actuary based on the relative value of these plans to the Traditional plan.

5. Local Program: Rates must be no greater than 1.5 times the rate for the state program unless the local group is sufficiently large that the rate is justified by experience, as determined by the BOARD's actuary.

6. The BOARD will consider rate proposals outside of these standards if the variation is supported by evidence of genuine demographic differences other than age or sex, or is required by federal or state HMO regulations to be community-rated. Otherwise, aberrations will be adjusted by the BOARD upward or downward to the nearest within range percentage to conform with these Guidelines. The plan will then have the option of accepting the adjusted rates or withdrawing from the State of Wisconsin Group Health Benefit Program.

7. The BOARD will assess administration fees to cover expenses of the Department of Employee Trust Funds. This charge is added by the BOARD to the rates quoted by each

[1] Graduate Assistants and employees-in-training at the University of Wisconsin are covered by Wis. Stats. § 40.52 (3). Employees who are employed at least one-third of full-time are eligible for a contribution toward premium as determined by collective bargaining agreements.

alternate health plan and is collected prior to transmittal of the premiums to the alternate health plans.

8. Include completed Table contained in Addendum 1.

9. Plans shall not include in their rate any claims that they decide to pay outside the Uniform Benefits contract.

I. Submission of Proposals

Proposals to participate in the State of Wisconsin Group Health Benefit Program must be submitted to the BOARD and address each of the requirements in Section II of the Guidelines. In addition to requirements previously cited, each plan proposal must be received by April 15 and include:

1. Fifteen (15) copies.

2. Specific listing of the plan's pre-authorization and referral requirements.

3. A description of case management and disease management activities.

4. A list and count of providers under contract arranged by county of practice for state employees, and by zip code for local employees. An electronic version of the listing must also be made available. The BOARD will expect an updated listing by July 23 in order to determine what areas will constitute your service area.

5. A copy of your detailed contingency plan in the event of strike, disaster, etc. Such a plan must be in writing and address the method used for providing services and processing claims under such circumstances.

6. An organizational chart.

7. Statement of agreement to abide by all the terms and conditions set forth in the “Terms and Conditions for Comprehensive Medical Plan Participation in the State of Wisconsin Group Health Benefit Program and Uniform Benefits” document.

8. If a PPP, include a schedule of benefits.

> The Board will treat all proposals as confidential insofar as is permitted by applicable law, except as may be necessary for the proper evaluation of the proposal.

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

The time table is abbreviated and does not detail all due dates for the entire contract period. The due dates sent with the Key Dates Memo, issued to participating HEALTH PLANS on April 12, 2016, and revised and reissued on June 14, 2016 details required due dates for submittals. An additional time table with due dates for required submittals will be issued in early 2017.

(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. These are anticipated due dates and final due dates will be confirmed via the Key Dates Memo in 2017.)

Due Date (Receipt by Dept)	Information Due	Date Submitted
January 1, 2017	• Identification cards must be issued to all new PARTICIPANTS. Explanation of referral and grievance procedures must be included.	
January 13, 2017	• Issuance of new identification cards, if applicable, to continuing SUBSCRIBERS. Written notification to the DEPARTMENT confirming completion is also due.	
February 17, 2017	• 2016 Wellness Well participation and aggregate health assessment data due	
March 3, 2017	• 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.	
March 31, 2017	• A Quality Improvement plan in the format set forth by the DEPARTMENT.	
April 28, 2017	• 2016 ETF Initiative/Disease Management Data Advance Care Planning (ACP), Shared Decision Making (SDM), Low Back Pain (LBP), Radiology (RAD), Coordination of Care (COC)	
July 14, 2017	• Health Plan Issued Incentive/Reward/Reimbursement Payment Data (January – June Payments) • 2016 Status updates ETF Initiatives Advance Care Planning (ACP), Shared Decision Making (SDM), Low Back Pain (LBP), Radiology (RAD), Coordination of Care (COC)	
October 6, 2017	• Report on disease management capabilities and effectiveness. [Section II., D., 11.]	
November 9, 2017	• Final 2016 Health Plan Issued Incentive/Reward/Reimbursement Data (June – November). Payments earned after report must be postponed until 2017.	

Due Date (Receipt by Dept)	Information Due	Date Submitted
By Noon on Second Monday of Each Month, or as Directed by the Department	• HIPAA compliant Full File Compare Submissions. • 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.	
Monthly, or as Directed by the Department	• Submit the following data to the DEPARTMENT'S data warehouse in the file format and frequency specified by the DEPARTMENT: o Claims data for all Participants for all claims processed for dates of service from January 1, 2014 through December 31, 2017. o Provider data for providers under contract anytime from January 2014 through December 2017.	
Annually	• Verify eligibility of adult disabled children age 26 or older, which includes checking that the: 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 o Support and maintenance requirement is met, and o Child is not married.	