

THESE QUESTIONS ARE ATTACHED FOR YOUR INFORMATION ONLY. RESPONSES TO THESE QUESTIONS SHOULD BE PROVIDED THROUGH THE ONLINE TOOL.

**Attachment VIII
Online Automated Data Collection Questions**

***U.S. Office of Personnel Management
2015 Technical Guidance***

The automated data collection (ADC) tool you are about to complete will allow you to enter and submit your answers electronically. You will have the opportunity to provide more detailed information and explanations in your proposal. **Your answers to the ADC questions should only address your Federal Employees Health Benefits (FEHB) Program population and NOT your entire book of business.**

Please note: You will receive an email with unique link(s) from TG_ADC@opm.gov (TG_ADC) that will guide you to the online ADC tool. Each contract number will have an individualized link. We ask that you complete the ADC online by May 31, 2014. If you have technical questions while completing the ADC, you will be able to submit questions to TG_ADC@opm.gov. If you have content related questions, please contact your contract specialist.

I. PRESCRIPTION DRUGS

Prescription Drug Cost Trends

Please refer to Call Letter Initiatives, Section I.A.1 of the technical guidance document for information regarding prescription drug cost trends.

1.1 Please provide your overall prescription drug cost trend rate (include all categories of drugs and all distribution channels).

- 2013 ____ (actual) Please enter “N/A” if you were not in FEHB in 2013.
- 2014 ____ (projected)
- 2015 ____ (projected)

1.2 Please provide your overall PMPY (per member per year) prescription drug cost trend rate (include all categories of drugs and all distribution channels). Use actual or estimated total enrollment on December 31 of each year.

- 2013 ____ (actual) Please enter “N/A” if you were not in FEHB in 2013.
- 2014 ____ (projected)
- 2015 ____ (projected)

1.3 Please provide your specialty drug cost trend rate, excluding oncology drugs. (OPM has provided a list of specialty drugs, excluding oncology drugs.)

- 2013 ____ (actual) Please enter “N/A” if you were not in FEHB in 2013.
- 2014 ____ (projected)
- 2015 ____ (projected)

1.4 Please provide your drug cost trend rate for specialty oncology drugs. (OPM has provided a list of specialty oncology drugs.)

- 2013 ____ (actual) Please enter “N/A” if you were not in FEHB in 2013.
- 2014 ____ (projected)
- 2015 ____ (projected)

1.5 Please provide your generic dispensing rate. (Generic dispensing rate = the total number of generic prescriptions divided by the total number of prescriptions reimbursed, both generic and brand.)

- 2013 ____ (actual) Please enter “N/A” if you were not in FEHB in 2013.
- 2014 ____ (projected)
- 2015 ____ (projected)

Utilization Management (2014 & 2015)

Please refer to Call Letter Initiatives, Section I.A.2 of the technical guidance document for information regarding utilization management.

1.6 Please check the box to indicate which of the following quality assurance and utilization management measures you currently employ in benefit year 2014 and those you intend to employ in benefit year 2015

QUALITY ASSURANCE AND UTILIZATION MANAGEMENT MEASURES	2014	2015
Cost-Share Tiers		
Distinct member cost-share tier for generic drugs		
Distinct member cost-share tier for preferred brand-name drugs		
Distinct member cost-share tier for non-preferred brand-name drugs		
Distinct member cost-share tier for preferred specialty drugs		
Distinct member cost-share tier for non-preferred specialty drugs		
Step Therapy		
Step therapy requires that in selected categories, a generic or preferred brand must be tried before a non-preferred drug may be reimbursed.		
Step therapy required for sleep medications		
Step therapy required for ACE/ARB anti-hypertensives		
Step therapy required for nasal steroids		
Step therapy required for statin anti-cholesterol drugs		
Step therapy required for SSRI antidepressants		
Members on a step therapy drug are exempted (grandfathered) when		

requirement is implemented		
Quantity Limits		
Quantity limits for narcotics		
Quantity limits for sleep medications		
Quantity limits for stimulants		
Prior Approval		
Prior approval required for Incivek, Victrelis, Sovaldi		
Prior approval required for Tysabri		
Prior approval required for Herceptin		
Prior approval required for Avastin		
Prior approval required for Actiq		
Prior approval required for Provigil, Nuvigil		
Prior approval required for testosterone		
Oncology		
Clinical pathway or guideline program		
Decision support tools		
Outlier analysis		
Expert review		
Bundled payments that include drugs		
Other		
Retrospective drug utilization review (DUR)		
Medication therapy management for selected patients		
Narrow or preferred pharmacy network		
Fraud and Abuse monitoring		
Medicare Part B COB for drugs and supplies – retail pharmacy		
Medicare Part B COB for drugs and supplies – mail-service pharmacy		
Limit some or all specialty drugs to 30 day supply		
Limit reimbursement of one or more specialty drugs to pharmacy benefit (disallowed under medical benefit)		
Prescription drug cost calculator		
Optimized distribution channels – member and plan incentives are aligned		
Zero co-pay for SELECTED generic drugs		
Zero co-pay for ALL generic drugs		
Non-Covered Drugs		
Does your benefit plan EXCLUDE coverage of drugs in these categories?		
Drugs for weight loss		
Drugs for cosmetic purposes		
Drugs for sexual dysfunction		
Other categories (please describe in Attachment VII – Rx Supplemental Information)		

Member Cost-Share for 2015

Please refer to Call Letter Initiatives, Section I.A.3 of the technical guidance document for information regarding member cost-share for 2015.

1.7 Please indicate if you intend to increase member cost-share in 2015:

- Increase member cost-share for generic drugs
- Increase member cost-share for preferred brand-name drugs
- Increase member cost-share for non-preferred brand-name drugs
- Increase member cost-share for preferred specialty drugs
- Increase member cost-share for non-preferred specialty drugs
- No increase in member cost-share in any of the above categories

II. WELLNESS PROGRAMS

Health Risk Assessment and Biometric Screening

Please refer to Call Letter Initiatives, Section I.B.1 of the technical guidance document for information regarding Health Risk Assessments and Biometric Screening requirements.

2.1 What percent of FEHB covered adults completed a Health Risk Assessment (HRA) as of April 1, 2014?

- _____%

2.2 What is your goal for completion of HRAs in 2015 (as a % of FEHB covered adults)?

- _____%

2.3 Do you offer a member incentive for HRA completion?

- Yes
- Not for 2014, but intend to propose for 2015
- No current or proposed incentive

2.4 Please check the box that most accurately describes the incentive you provide for purchasing health related goods and services that members may earn for completing an HRA:

- Incentive that is less than or equal to \$50
- Incentive that is less than or equal to \$100 but greater than \$50
- Incentive that is less than or equal to \$200 but greater than \$100
- Incentive that is less than or equal to \$250 but greater than \$200
- Incentive that is greater than \$250
- No incentive

2.5 Enrollees may also earn a cash or gift card incentive that does not have to be limited to health care services of up to \$75 per individual or \$250 per family for completing an HRA. Please check the box that best describes the maximum FAMILY cash incentive available for HRA completion:

- Incentive that is less than or equal to \$50
- Incentive that is less than or equal to \$100 but greater than \$50
- Incentive that is less than or equal to \$200 but greater than \$100
- Incentive that is less than or equal to \$250 but greater than \$200
- Incentive that is greater than \$250
- No incentive

2.6 What percent of FEHB covered adults completed biometric screening as of April 1, 2014?

- _____%

2.7 What is your goal for completion of biometric screening in 2015 (as a % of FEHB covered adults)?

- _____%

2.8 Do you offer a member incentive for completion of biometric screening?

- Yes
- Not for 2014, but intend to propose for 2015
- No current or proposed incentive

2.9 Please check the box that most accurately describes the incentive you provide for purchasing health related goods and services that members may receive for completion of biometric screening:

- Incentive that is less than or equal to \$50
- Incentive that is less than or equal to \$100 but greater than \$50
- Incentive that is less than or equal to \$200 but greater than \$100
- Incentive that is less than or equal to \$250 but greater than \$200
- Incentive that is greater than \$250
- No incentive

2.10 Enrollees may also earn a cash or gift card incentive that does not have to be limited to health care services of up to \$75 per individual or \$250 per family for completion of biometric screening. Please check the box that best describes the maximum FAMILY cash incentive available for completion of biometric screening:

- Incentive that is less than or equal to \$50
- Incentive that is less than or equal to \$100 but greater than \$50

- Incentive that is less than or equal to \$200 but greater than \$100
- Incentive that is less than or equal to \$250 but greater than \$200
- Incentive that is greater than \$250
- No incentive

2.11 What happens when a member has an abnormal blood pressure reading during a biometric screening? Check all that apply:

- Member counseled at the screening site
- Member contacted by health coach or counselor
- Member referred to primary care provider
- Results transmitted to primary care provider
- Results entered into data portal or electronic record available to member's health care provider
- Member notified in writing about abnormal results
- Other
- No follow up

2.12 What happens when a member has a body mass index of 35 kg/m² during a biometric screening? Check all that apply:

- Member counseled at the screening site
- Member contacted by health coach or counselor
- Member referred to primary care provider
- Member referred to dietician or nutrition specialist
- Member referred to commercial weight loss program
- Member referred to medically supervised comprehensive weight loss program (including diet, lifestyle, and behavior modification)
- Results transmitted to primary care provider
- Results entered into data portal or electronic record available to member's health care provider
- Member notified in writing about abnormal results
- Other
- No follow up

Tobacco Cessation

The next 5 questions relate to the FEHB tobacco cessation benefit as described in Carrier Letter 2011-01 and referenced in Call Letter Initiatives, Section 1.B.2 of the technical guidance document.

2.13 How do you identify FEHB members who use tobacco? Check all that apply:

- Member self-identification
- Questions on enrollment form
- Health Risk Assessment or survey

- Biometric or Health screening
- Intake information from Disease Management or similar programs
- Provider referral
- Claims data
- Electronic Medical Record
- Other
- No identification process in place

2.14 How does your plan promote the FEHB tobacco cessation benefit to members? Check all that apply:

- Email, postal mail, or newsletter with general information about coverage and/or incentives
- Internet or website posting with general information about coverage and/or incentives
- Newspaper or other advertisement with general information
- Health fair
- Personal outreach to tobacco using member via secure email, postal mail, or patient portal message
- Tobacco using member contacted by health coach or counselor
- Explanation of Benefits text box
- Outreach through affiliated pharmacy or laboratory
- Other
- The benefit is not promoted to members

2.15 How does your plan promote the FEHB tobacco cessation benefit to providers? Check all that apply:

- Email or postal mail with general information about coverage and incentives
- Secure email or postal mail with information about specific patients that could benefit from the plan's tobacco cessation programs
- Outreach through electronic health record or provider portal
- Provider newsletter
- Academic detailing
- Presentations/conferences
- Other
- The benefit is not promoted to providers

2.16 How do you track the utilization of the tobacco cessation benefit by FEHB members? Check all that apply:

- Plan tracks counseling utilization and/or quit attempts
- Plan or Pharmacy Benefits Manager tracks cessation medication utilization
- Other tracking method (please describe in your proposal)
- No tracking

2.17 How do you use incentives to encourage tobacco free living? Check all that apply:

- Cash or gift card for participation/completion of tobacco cessation program
- Reduce deductible for participation/completion of tobacco cessation program
- Eliminate out of pocket cost for tobacco cessation counseling and cessation medications
- Reduce deductible or cost sharing for non-users of tobacco
- Other incentive (please describe in your proposal)
- No incentive for 2014, but intend to propose for 2015
- No current or proposed incentive

III. ADVANCING QUALITY AND VALUE OF CARE

Patient Centered Medical Homes

The next 5 questions refer to OPM recognized Patient Centered Medical Homes (PCMH), as defined in Carrier Letter 2013-01 and Call Letter Initiatives, Section I.C.1 of the technical guidance document.

3.1 Using OPM's criteria for PCMH, how many FEHB covered members are enrolled in a PCMH practice affiliated with your plan? (as of April 1, 2014)

- _____ (number)

3.2 How many FEHB covered members are enrolled in a plan-affiliated practice participating in the CMS Comprehensive Primary Care Initiative? (as of April 1, 2014)

- _____ (number)

3.3 In which states do you provide PCMH to FEHB members?

- PCMH is available in all 50 states and DC
- PCMH is available in some states
- Plan does not offer PCMH to FEHB members
- Other
- N/A I am a new plan in the FEHB program

(If option 2, "PCMH is available in some states" is selected, participant will view question 3.3.a)

3.3a Please select the states in which you currently offer PCMH. Check all that apply.

[List of 50 states, Washington, D.C., and U.S. Territories]

3.4 How does your anticipated PCMH coverage for 2015 differ from 2014?

- More states or more practices included for 2015
- Fewer states or fewer practices included for 2015
- Coverage is the same
- Plan does not offer PCMH to FEHB members

3.5 If OPM provided a PCMH logo or symbol, would your plan be able to incorporate it in provider directories for Open Season 2014?

- Yes
- No (Please describe barriers in your proposal)

Access to Care

The next 2 questions refer to Call Letter Initiatives, Section I.C.2 of the technical guidance document.

3.6 Check all tele-health or telemedicine encounter types covered by your plan:

- Primary care video, telephonic, or e-visits
- Urgent care video, telephonic, or e-visits
- Specialty consultation video, telephonic, or e-visits
- Mental health or counseling video, telephonic, or e-visits
- Video/tele-presence ICU or Emergency Room consultation
- None, but propose to add for 2015
- No current or proposed coverage

3.7 Does your plan cover condition monitoring visits conducted by non-provider personnel or provider extenders (e.g., blood pressure, diabetes, or weight control visits by nurses)?

- Yes
- No, but propose to add for 2015
- No current or proposed coverage

Patient Safety

The next question refers to Call Letter Initiatives, Section I.C.4 of the technical guidance document.

3.8 In response to the Choosing Wisely Campaign, most FEHB carriers chose to focus on early elective delivery, antibiotic overuse, or the appropriate use of imaging. Please indicate ways in which your plan addressed commonly overused tests, treatments, or procedures. Check all that apply:

- Established baseline utilization rates
- Established targets for optimal utilization
- Measured progress toward utilization goal

- Measured savings resulting from UM program
- Added language to hospital contracts
- Added or reinforced Radiology Benefits Management
- Added/updated pre-authorization or pre-certification
- Introduced academic detailing or outreach to providers
- Began/increased outreach to members
- Other
- No specific actions

Health Plan Accreditation

The next question refers to OPM's accreditation requirements in Section 1.9 of the FEHB standard contract and Carrier Letter 2001-19.

3.9 Please provide the source and details of your plan's most recent comprehensive health plan accreditation:

- National Committee for Quality Assurance (NCQA) [Expiration Date _____]
- URAC [Expiration Date _____]
- Accreditation Association for Ambulatory Health Care (AAAHC) [Expiration Date _____]
- Plan is not accredited as a comprehensive health plan, but provider network is fully accredited
- Plan is not accredited as a comprehensive health plan and provider network is not fully accredited
- None of the above

IV. MENTAL HEALTH PARITY

The next 5 questions refer to the Carrier Letter 2013-24 and Call Letter Initiatives, Section I.D of the technical guidance document. Carriers are required to comply with the provisions of 45 C.F.R. s 146.136(c).

4.1 Has your plan actuary performed a quantitative parity determination?

- Yes (include details in your proposal)
- No

4.2 Are all Mental Health outpatient visits billed at the primary care cost sharing formula?

- Yes
- No

4.3 Does your plan offer Residential Treatment Centers for alcohol/substance use disorder?

- Yes

- No

4.4 What is your cost sharing parity standard for Residential Treatment Centers?

- Inpatient care
- Home health care
- Outpatient/ambulatory care
- Skilled Nursing Facility care
- Hospice care
- Other standard
- Plan does not offer Residential Treatment Centers

4.5 Check all settings in which your plan covers intensive alcohol/substance use disorder treatment for members requiring more than outpatient counseling:

- Inpatient facility
- Residential Treatment Center
- Day or partial hospitalization
- Intensive outpatient program
- Other (please describe in your proposal)
- Plan does not cover intensive alcohol/substance use disorder treatment

V. ALIGNING THE FEHB PROGRAM WITH THE AFFORDABLE CARE ACT

Preventive Care

The next 3 questions refer to Affordable Care Act required preventive services. Please refer to Call Letter Initiatives, Section I.E.1 of the technical guidance document for details.

5.1 In 2015, which of the following will you cover as preventive services with no member cost sharing? Check all that apply:

- Screening for hepatitis C in an adult born in 1950
- Low-dose computed tomography screening for lung cancer in a 60 year old smoker with a 35 pack-year smoking history
- BRCA gene testing for a woman determined to be at high risk for breast cancer on the basis of multiple affected family members
- Varicella (chicken pox) vaccine for a 4 year old
- Screening for HIV infection in a 20 year old male
- Brand-name patch contraceptive (equivalent generic not available) for a woman using this method when other contraception methods are not indicated
- Brand-name vaginal ring contraceptive (equivalent generic not available) for a woman using this method when other contraception methods are not indicated

5.2 Check all locations at which your plan covers flu shots at no out of pocket cost to members:

- Provider office
- Retail clinic/urgent care
- Pharmacy
- Grocery or retail store
- Laboratory Service Center
- Health Fair
- Workplace Health Unit
- Government Health Clinic
- Other

5.3 Does your member health portal, patient portal, or personal health record track immunizations?

- Yes
- No
- No, but plan to add immunizations in 2015
- We don't offer a member health portal, patient portal, or personal health record

VI. MEDICARE POPULATION PROGRAMS AND BENEFITS

The Call Letter asks carriers to propose programs that allow members to maximize benefits under Medicare and the FEHB. These programs should be designed to encourage members to participate in both Medicare Part B and FEHB. These may include pass-through of some or all of the Part B premiums and reductions in cost sharing. We are aware that some carriers offer Medicare Part C (Medicare Advantage) to FEHB members – we are not collecting data on Medicare Part C so please only report on FEHB products.

6.1 For 2015, will you propose any new programs or benefits to encourage participation in both Medicare Part B and FEHB?

- Yes
- No

6.2 Please describe the changes you are proposing. Check all that apply.

- Not proposing any changes
- New benefit enhancements
- Premium pass-through
- Other (please describe in your proposal)

VII. CONTINUED FOCUS FROM PREVIOUS YEARS

For references or more information, please refer to Call Letter Initiatives, Section II.B.1 of the technical guidance document.

7.1 Do you offer Applied Behavior Analysis (ABA) for children with autism in your commercial packages?

- Yes
- No
- Plan does not offer commercial health insurance

7.2 In which states do you provide ABA to FEHB members?

- ABA is available in all 50 states and DC
- ABA is available in some states
- Plan does not offer ABA to FEHB members
- Other (please describe in your proposal)

(If option 2, “ABA is available in some states” is selected, participants will view question 7.2a)

7.2a Please select the states in which you currently offer ABA. Check all that apply.

[List of 50 states, Washington, D.C., and U.S. Territories]

7.3 How does your ABA coverage proposal for 2015 differ from 2014?

- 2015 proposal covers more states or wider service area
- 2015 proposal covers fewer states or smaller service area
- Coverage is the same
- Plan does not offer ABA to FEHB members

VIII. HABILITATIVE SERVICES

The next 2 questions refer to ACA required Essential Health Benefits. For references and additional information, please refer to Call Letter Initiatives, Section I.E.2 of the technical guidance document.

8.1 Which of the following are covered as habilitative services by your plan? Check all that apply:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Low vision/blind services or therapy
- Hearing aids or cochlear implants
- Applied Behavior Analysis
- Chiropractic
- Cognitive habilitation/rehabilitation

8.2 What are your plan's benchmarks for habilitative services? Check all that apply:

- State mandated benefits
- State benchmark health plan
- FEHB program benchmark
- Parity with your plan's rehabilitative benefits
- Other (please describe in your proposal)

IX. COST-SHARING LIMITS

9.1 What are your current (2014) out-of-pocket (OOP) maximums?

- Self Only medical services \$ _____
- Self and Family medical Services \$ _____
- Self Only for services provided by a third party vendor (e.g., prescription drugs or mental health services) \$ _____
- Self and Family for services provided by a third party vendor (e.g., prescription drugs or mental health services) \$ _____

9.2 Do you have a third party vendor for any health care services (e.g., for prescription drugs or mental health benefits)?

- Yes
- No

9.3 For 2015, will you propose any changes in your OOP maximums?

- No changes
- Yes, have one combined OOP maximum for multiple service providers
- Yes, have separate OOP maximums for multiple service providers. Combined amount will not exceed IRS guidelines.