
**FEHB Program Carrier Letter
All Community Rated HMO Carriers**

**U.S. Office of Personnel Management
Healthcare and Insurance**

Letter Number 2021-14(a)

Date: August 13, 2021

Fee-for-service [n/a]

Experience-rated HMO [n/a]

Community-rated HMO [12]

**Subject: Changes to the Standard Contract for
Contract Year 2022**

Please review Attachment A, which details the proposed Standard Contract changes for Federal Employees Health Benefits Program Community-Rated HMO Carriers for Contract Year 2022. If you have comments, please provide them as soon as possible or no later than September 10, 2021.

The proposed amendments are as follows:

- 1.** Section 1.7 Statistics and Specials Studies - modified subsection (e) to this section to provide guidance to the Carrier should they receive a third-party request about FEHB program-related data that is unrelated to the administration of the contract.
- 2.** Section 1.29 Standards for Arrangements with Pharmacy Benefit Managers - modified to update pharmacy benefit manager standards.
- 3.** Section 1.37 Procedures for Information Security Incident and Data Breach Reporting - section (d) was updated to provide clarity to the carriers to send their security incident and data breach report to the Health Insurance Specialist. Section (f) (1) was updated with a technical edit to remove "and breach."
- 4.** Section 2.7 Debarment and Other Sanctions - technical edits were made to this section.
- 5.** Section 2.16 - added as reserved to maintain consistency within all contracts.

- 6.** New Section 2.17 Medicare Part D Creditable Coverage - added this new Section 2.17 to state the requirement for carriers to provide Medicare Part D creditable coverage.
- 7.** New Section 2.18 Surprise Billing - added this new Section 2.18 to state the requirements for carriers to comply with the No Surprises Act.
- 8.** Appendix F FEHB Plan Performance Assessment - Appendix F was amended to reflect the updated years for the Plan Performance Assessment measures and contributions to performance areas and scores.
- 9.** Global Technical Edit - remove the typographical character § for consistency.

Please email your comments to FEHBcontramend@opm.gov, with a copy to your OPM Health Insurance Specialist.

We look forward to working with you on your contract.

Sincerely,

Laurie Bodenheimer
Director
Healthcare and Insurance

Encl.: Attachment A Proposed Changes to Standard 2022 Community Rated HMO Health Benefits Contract

Attachment A
Proposed Changes to Standard 2022 Community Rated HMO Health Benefits Contract

NOTE: New and revised language is *italicized in blue* and language to be deleted is ~~struck out in red~~.

1. Section 1.7 Statistics and Special Studies

Modified subsection (e) to this section to provide reasonable guidance to the Carrier should they receive a third-party request about FEHB program-related data that is unrelated to the administration of the contract.

SECTION 1.7 STATISTICS AND SPECIAL STUDIES (JAN ~~2021-2022~~)

(a) The Carrier shall maintain or cause to be maintained statistical records of its operations under the contract and shall furnish *to* OPM, in the form prescribed by the Contracting Officer, the statistical reports reasonably necessary for the OPM to carry out its functions under chapter 89 of title 5, United States Code.

(b) The Carrier shall furnish such other reasonable statistical data and reports of special studies as the Contracting Officer may from time to time request for the purpose of carrying out its functions under chapter 89 of title 5, United States Code.

(c) The Carrier shall furnish the routine reports in the required number of copies in a format to be determined by the Contracting Officer as instructed by OPM.

(d) The Carrier shall notify the OPM Health Insurance Specialist immediately upon a change in the name or address of the Carrier's contract administrator(s).

(e) *If a third party requests FEHB Program data and the Carrier determines that the data request is not reasonably necessary for administration of the FEHB contract, ~~The~~ the Carrier shall notify the OPM Health Insurance Specialist ~~within 3~~ *three (3)* business days from the date ~~the Carrier makes the determination.~~ ~~of the request if a third party requests FEHB program data for any purpose not related to administration of the contract.~~ *The Carrier must not distribute the data prior to receiving approval from the Contracting Officer.**

2. Section 1.29 Standards for Arrangements with Pharmacy Benefit Managers

This section was modified to update pharmacy benefit manager standards.

SECTION 1.29 STANDARDS FOR ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS (JAN ~~2021-2022~~)

The Carrier must ensure and report that the following standards are included in new, renewing, or amended contracts with Pharmacy Benefit Managers (PBMs) providing services to enrollees and family members effective on or after January 1, 2022. Notwithstanding the foregoing, the revisions to this section 1.29 shall not take effect before the expiration of the Carrier's current contract (including the exercise of an existing option to extend the term by not more than one year at a time) but not later than January ~~2024~~ *2025*. The PBM includes all entities that have a majority ownership interest in or majority control over the PBM. The PBM also includes any other subsidiary of the entity that has majority ownership or control over the PBM.

All PBMs must adhere to the provisions of this Section 1.29.

If the Carrier's PBM arrangement is with an Underwriter rather than with the Carrier, then all references to the Carrier and Plan appearing in this Section 1.29 shall be deemed to be references to the Underwriter.

(a) Definitions. Under this section

- (1) "Expedited request" means a request initiated by the Prescriber, member or member's representative when the time limit for standard utilization management review for the prescribed medication could seriously jeopardize the patient's life, health, or ability to regain maximum function.
- (2) "Licensed pharmacist" means an individual currently licensed by the appropriate jurisdiction to engage in the practice of pharmacy consistent with that jurisdiction's laws and regulations.
- (3) "Network pharmacy" means any retail, mail order, specialty, or licensed pharmacy provider that contracts with the PBM.
- (4) "Pharmacy Benefit Manager" or "PBM" means the combination of
 - (i) a business or other entity that, pursuant to a contract with the Carrier, either directly or through an intermediary, manages the prescription drug benefit provided by the Carrier including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with Network pharmacies, and controlling the cost of covered prescription drugs; and
 - (ii) all entities that have a majority ownership interest in or majority control over, the business or other entity that is in contract with the Carrier referenced in (i).
- (5) "Prescriber" means any licensed, certified or otherwise legally authorized health care professional authorized by law to prescribe a prescription drug.
- (6) "Third Party" means any consultant, partner, administrator, intermediary or other entity outside the scope of the relationships between and among the PBM and the FEHB enrollee, Carrier, and OPM. It does not include wholesalers, distributors, or pharmacies.
- (7) *"Mid-year formulary change" is any change that occurs to the formulary during the plan year. Positive formulary changes enhance formularies by adding drugs or placing a drug on a lower costs sharing tier or removing or relaxing utilization management (UM) requirements for drugs. Restrictive formulary changes negatively impact formularies by removing drugs, moving drugs to higher tiers, or tightening UM requirements for drugs.*
- (8) *"Impacted member" is any member who is on a prescription drug that undergoes a mid-year formulary change.*
- (9) *"Written notice" means notification to each impacted member by U.S. mail, secure e-mail or text message (if approved by the member).*

(b) Ownership and Reporting Standards

- (1) The PBM shall not be majority-owned or majority-controlled by a pharmaceutical manufacturing company. The PBM must disclose to the Carrier and OPM the name of any entity that has a majority ownership interest in or majority control over the PBM.

- (2) The PBM must agree to provide the Carrier with reasonable financial and utilization information requested by the Carrier relating to the provision of benefits to eligible enrollees through the PBM and reasonable financial and utilization information relating to services provided to the Carrier for the purposes of determining the Carrier's Health and Human Services (HHS) and FEHB medical loss ratio (MLR) requirements.
- (3) At OPM's request, the Carrier must obtain reasonable formulary, aggregate cost and utilization, and other information from the PBM and provide it to OPM. A PBM providing information to a Carrier under this subsection may mark that information as confidential and proprietary commercial information. The Carrier, in its contract with the PBM, shall effectuate the PBM's consent to the disclosure of this information to OPM. OPM shall treat such designated information as confidential under 5 C.F.R 294.112.
- (4) The Carrier will perform the following or require that its PBM do so:
 - (i) Provide information to physicians, pharmacists, other health care professionals, consumers, and payers about the factors that affect formulary system decisions, including: cost containment measures; the procedures for obtaining non-formulary drugs; and the importance of formulary compliance to improving quality of care and restraining health care costs;
 - (ii) Provide consumer education that explains how formulary decisions are made and the roles and responsibilities of the consumer; and
 - (iii) Disclose the existence of formularies and have copies of the current formulary readily available and publicly accessible.

(c) Integrity Standards

- (1) The Carrier will require that its PBM agree to adopt and adhere to a code of ethics promulgated by a national professional association, such as the Code of Ethics of the American Pharmacists Association, for their employed pharmacists.
- (2) The Carrier will require that its' PBM be licensed as required by the appropriate jurisdiction's laws and regulations.
- (3) The Carrier will require that its PBM only employ or contract with licensed pharmacists for roles that require such a license under the appropriate jurisdiction's laws and regulations.
- (4) The Carrier will require that its PBM shall perform its duties with care, skill, prudence, diligence, and professionalism.
- (5) The Carrier will require that its PBM shall notify the Carrier in writing of any activity, policy, or practice of the PBM that directly or indirectly presents any conflict of interest with the duties imposed in this subsection.
- (6) A Carrier, shall not, and will require that its PBM shall not, enter into a contract with a pharmacy or pharmacist that prohibits or penalizes a pharmacy or pharmacist for disclosure of information to a member regarding:
 - (i) The cost of a prescription medication to the member; or
 - (ii) The availability of any therapeutically-equivalent alternative medications or alternative methods of purchasing the prescription medication, including but not limited to, paying a cash price that is less expensive to the member than the cost of the prescription under the Plan.

(d) Performance Standards

The Carrier will require that its' PBM contractors develop and apply a quality assurance program specifying procedures for ensuring contract quality on the following standards at a minimum and

submit reports to the Carrier on their performance. The Carrier will require that its PBM meet all applicable required standards set for Carriers at Section 1.9(g). All other standards discussed below must have specific target goals the PBM is expected to achieve. Carriers may permit PBMs to measure compliance using statistically valid samples for the PBMs book of business.

- (1) Point of Service (POS) system response time. The PBM's network electronic transaction system provides rapid response to Network pharmacies.
- (2) POS system availability. The PBM's network electronic transaction system generally is available to, and accessible by, Network pharmacies.
- (3) Licensing. The PBM verifies the appropriate licensing of its Network pharmacies. This includes DEA registration for U.S. pharmacies, and the equivalent, if one exists, for pharmacies outside of the U.S.
- (4) Dispensing accuracy – The PBM dispenses its prescriptions to the correct patient and for the correct drug, drug strength and dosage in accordance with the prescription not less than 99.9 percent of the time.
- (5) Mail service pharmacy turnaround time – The PBM promptly dispenses and ships at least 98 percent on average of all prescriptions not requiring intervention or clarification within 3 business days or meets an equivalent measure approved by OPM.
- (6) Specialty pharmacy shipment stability. The Carrier or PBM's specialty pharmacy must have policies and procedures in place to promote effective shipping practices and monitor cold chain packaging. Specific areas to be addressed include achievement of internal and external metrics and the identification and appropriate use of best practices.
- (7) Quality of Drug Therapy. The quality assurance program implemented by a Carrier's PBM contractor must include a process to measure the quality of its drug therapy provided to enrollees. Specific areas to be addressed include achievement of quality targets measured by both internal and external metrics; identification and appropriate use of best practices; and application of evidence-based medicine, as appropriate.

(e) Mid-Year Formulary Changes may not become effective until an itemized list is provided to OPMPharmacy@OPM.gov and your Contracting Officer.

- (1) Positive formulary changes may be effective at any time after the itemized list of Mid-year formulary changes is provided as set forth above.*
- (2) FEHB Carriers must notify their Contracting Officer at least 70 days prior to making any Restrictive Formulary Change effective during the plan year that results in any Impacted Member.*
- (3) FEHB Carriers must provide Impacted members with written notice of a Restrictive mid-year formulary change at least 60 days prior to the date the formulary change becomes effective.*
- (4) FEHB Carriers have the option to grandfather Impacted members of a restrictive formulary change for coverage and cost-sharing for the remainder of the plan year. In such cases, impacted member notification is not required. However, FEHB Carriers must notify OPMPharmacy@OPM.gov and their Contracting Officer at least 10 days prior to making any restrictive mid-year formulary change that has no member impact.*
- (5) Carriers may immediately remove from their formulary drugs deemed unsafe based on new information on a drug's safety or efficacy or removed from the market by their manufacturer without meeting the advance notice requirement specified above. In such cases, FEHB Carriers must provide retrospective notice of any such formulary changes to impacted members and OPM as soon as possible.*

(e) Alternative Drug Options

The Carrier will require that its PBMs, at a minimum, utilize the following protocols for PBM initiated drug interchanges (any change from the original prescription) other than generic substitutions:

- (1) The PBM must treat the Prescriber, and not itself, as the ultimate decision-maker. Furthermore, to the extent appropriate under the circumstances, the PBM must allow the patient input into that decision-making process. At a minimum, the PBM must provide the patient with a written notice in the package sent to the patient that the drug interchange has occurred with the approval of the Prescriber.
- (2) The PBM will obtain authorization for a drug interchange only with the express, verifiable authorization from the Prescriber as communicated directly by the Prescriber, in writing or verbally, or by a licensed medical professional or other physician's office staff member as authorized by the Prescriber.
- (3) The PBM must memorialize in appropriate detail all conversations with patients and Prescribers in connection with drug interchanging requests, including the identity of the contact person at the Prescribers office and the basis for ~~his or her~~ *their* authority.
- (4) The PBM will only interchange a patient's drug from a lower priced drug to a drug with a higher cost to the patient or Plan when authorized by the Carrier or the Plan.
- (5) The PBM will permit pharmacists to express their professional judgment to both the PBM and Prescribers on the impact of drug interchanges and to answer Prescribers' questions. PBMs will not require pharmacists to, and will not penalize pharmacists for refusing to, initiate calls to Prescribers for drug interchanges that in their professional judgment should not be made.
- (6) The PBM will offer to disclose, and if requested, will disclose to Prescribers, the Carrier, and patients (i) the reason(s) why it is suggesting a drug interchange and (ii) how the interchange will affect the PBM, the Plan, and the patients financially.

(f) Utilization Management Timeframe

- (1) The PBM must promptly review and respond to requests for prior approval for specific drugs and any other utilization management edits following receipt of all required information.
 - (i) For Expedited requests, the PBM must review and respond within 24 hours.
 - (ii) For other, non-expedited requests, the PBM must review and respond within 72 hours.
- (2) *For expiring prescription prior authorizations (PAs), the PBM must:*
 - (i) *have in place a process to review all expiring PAs; and*
 - (ii) *must notify members at least 45 days before the expiration of a PA for a maintenance medication.*

(g) Patient Safety Standard

The Carrier must require that its PBM establish drug utilization management, formulary process, and procedures that have distinct systems for identifying and rectifying consumer safety issues including:

- (1) A system for identifying and communicating drug and consumer safety issues at point-of-service;
- (2) A system of drug utilization management tools, such as prospective and concurrent drug utilization management that identifies situations which may compromise the safety of the consumer.

- (3) A system/process for error reporting; and
- (4) A system/process for identifying/managing risk.

(h) Safety and Accessibility for Consumers

The Carrier will require that its PBM meet the following standards related to pharmacy Network management and consumer access to medications.

- (1) The Carrier will require that its PBM define the scope of its services with respect to:
 - (i) The distribution channels offered (e.g. pharmacy Network, mail order pharmacies, or specialty pharmacies);
 - (ii) The types of pharmacy services offered within each distribution channel; and
 - (iii) The geographic area served by each distribution channel.
- (2) The Carrier will require that for each distribution channel provided by its PBM, the PBM:
 - (i) Establishes criteria and measures actual performance in comparison to those criteria: and
 - (ii) Makes improvements where necessary to maintain the pharmacy Network and meet contractual requirements.
- (3) The Carrier will require that its PBM contractor establish a quality and safety mechanism for each distribution channel in order to identify and address concerns related to:
 - (i) Quality and safety of drug distribution; and
 - (ii) Quality of service.

(i) Fraud, Waste, and Abuse

- (1) The PBM must establish fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
 - (i) A system designed to detect and eliminate FWA
 - (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
 - (iii) A system/process for FWA reporting; and
 - (iv) A system/process for identifying/managing risk
- (2) Any third party or entity providing services or supplies related to the administration of payments or benefits must certify to the PBM that it has established fraud, waste and abuse detection processes and procedures, with distinct systems for identifying and rectifying FWA issues including:
 - (i) A system designed to detect and eliminate FWA;
 - (ii) A system that assesses its vulnerability to FWA to include, but not limited to, performing post-payment reviews and audits of providers identified either proactively or reactively;
 - (iii) A system/process for FWA reporting; and
 - (iv) A system/process for identifying/managing risk

3. Section 1.37 Procedures for Information Security Incident and Data Breach Reporting

Section (d) was updated to provide clarity to the carriers to send their security incident and data breach report to the Health Insurance Specialist and Contracting Officer. Section (f) (1) was updated with a technical edit to remove “and breach.”

SECTION 1.37 PROCEDURES FOR INFORMATION SECURITY INCIDENT AND DATA BREACH REPORTING (JAN ~~2021~~ 2022)

- (a) The specific terms listed below are defined as stated for purposes of this Section.
- (1) Incident is defined by 44 U.S.C. § 3552(b)(2) and applicable OMB guidance.
 - (2) Breach is defined in HHS regulations 45 CFR Part 164 Subpart D.
 - (3) Compromise is defined in the current revisions of the glossary of NIST SP 800-32.
- (b) A Carrier must report to OPM incidents and breaches where the confidentiality, integrity, or availability of FEHB member protected health information (PHI) is compromised or if a Carrier notifies law enforcement of an incident or breach that: (1) compromises its systems that contain or process FEHB Program data or (2) compromises its systems operating in the same general information technology control environment as the information systems that process FEHB Program data.
- (c) The Carrier must report to OPM before any other external notifications are made (excluding notification to necessary parties for incident response), and in no case later than 24 hours after its incident response team determines the confidentiality, integrity, or availability of FEHB member PHI is compromised, or it has notified law enforcement of an incident or breach that meets the requirements stated in paragraph (b) of this Section.
- (d) The Carrier must submit reports to OPM via email to Cybersolutions@opm.gov or via phone to (844) 377-6109. *The Carrier must also notify their Health Insurance Specialist on its security incident and data breach reporting.*
- (1) Any data shared with OPM that relates to an incident or breach must be transmitted in a secure manner.
 - (2) The report should include the following:
 - i. A brief description of the nature of the incident or breach.
 - ii. An estimate of the number of affected FEHB members, if feasible.
 - iii. A brief description of the remedial steps that the Carrier has already taken and those they plan to take.
 - (3) The Carrier is responsible for providing additional detailed information as soon as it becomes available.
- (e) For a breach of PHI, the notice to FEHB enrollees will comport with 45 CFR § 164.404 for breaches as defined in this Section or OPM guidance. Notices must be coordinated with OPM before any communication with FEHB enrollees. All other notices must also be coordinated with OPM and the Carrier must follow OPM guidance to the extent practicable.
- (f) In cases of subcontractor breach or incident the following applies.
- (1) A subcontractor breach or incident ~~and breach~~ must be reported to OPM by the Carrier no later than the calendar day following notice to the Carrier.
 - (2) Either the Carrier or its subcontractor may provide a notice of the breach to FEHB enrollees.
 - (3) If the subcontractor provides the notice, it must be in a form that allows the enrollee to easily identify the Carrier and FEHB plan. If specific identification is not practical under the circumstances, Carrier and FEHB plan identification shall be otherwise accomplished in a manner agreed upon with OPM.
 - (4) The Contracting Officer may direct the Carrier to issue a separate notice in order to avoid enrollee confusion.

4. Section 2.7 Debarment and Other Sanctions

Technical edits were made to this section.

SECTION 2.7 DEBARMENT AND OTHER SANCTIONS (JAN ~~1999~~ 2022)

(a) Notwithstanding 5 U.S.C. 8902(j) or any other provision of the law and regulations, if, under 5 U.S.C. 8902a *or*, 5 CFR *Part 919 970, or Public Law 103-123 (or other applicable appropriations law)*, a provider is barred from participating in the Program under 5 U.S.C. or the provider's services under 5 U.S.C. are excluded, the Carrier agrees that no payment shall be made by the Carrier pursuant to any contract under 5 U.S.C. (either to such provider or by reimbursement) for any service or supply furnished by such provider during the period of the debarment, except as provided in 5 CFR 970.200(b).

(b) The OPM shall notify the Carrier when a provider is barred from the FEHBP.

5. Section 2.16

Section 2.16 added as reserved to maintain consistency within all contracts.

*SECTION 2.16
[RESERVED]*

6. New Section 2.17 Medicare Part D Creditable Coverage

Added this new Section 2.17 to state the requirements for carriers to provide Medicare Part D creditable coverage.

SECTION 2.17 PART D CREDITABLE COVERAGE

The Carrier shall offer prescription drug coverage that is considered creditable prescription drug coverage under 42 CFR 423.56.

7. New Section 2.18 Surprise Billing

Added this new Section 2.18 to state the requirements for carriers to comply with the No Surprises Act.

*SECTION 2.18
SURPRISE BILLING (JAN 2022)*

(a) The Carrier shall comply with requirements described in the provisions of sections 2799A-1, 2799A-2, 2799A-3, 2799A-4, 2799A-5, 2799A-7, and 2799A-8 of the Public Health Service Act, sections 716, 717, 718, 719, 720, 722, and 723 of the Employee Retirement Income Security Act of 1974, and sections 9816, 9817, 9818, 9819, 9820, 9822, and 9823 of the Internal Revenue Code of 1986 (as applicable) in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage, as described in such sections.

- (b) The Carrier’s compliance with paragraph (a) will be concurrent and consistent with implementing regulations issued by the Departments of Health and Human Services, Labor, and the Treasury, subject to OPM regulation and FEHB contract terms.*
- (c) The Carrier’s provider contracts must extend the provisions of sections 2799B–6, 2799B–8, and 2799B–9 of the Public Health Service Act to covered individuals in the same manner as such provisions apply to an enrollee in a group health plan or group or individual health insurance coverage offered by a health insurance issuer.*
- (d) Consistent with the preemption provision at 5 U.S.C. 8902(m)(1), the provisions of Public Health Service Act section 2723 as well as 45 CFR Part 150 are inapplicable to the Carrier with respect to the Plan.*

8. Appendix F FEHB Plan Performance Assessment

Appendix F was amended to reflect the updated years for the Plan Performance Assessment measures and contributions to performance areas and scores.

APPENDIX F

Measures and contributions to performance areas and scores for ~~2021-2022~~ Performance and ~~2022-2023~~ Performance Adjustment

To be performed in accordance with the ~~2022-2023~~ FEHB Plan Performance Assessment Procedure Manual and the FEHB Plan Performance Assessment – Consolidated Methodology Carrier Letter (CL 2020-15). The Performance Adjustment for the ~~2022~~ 2023 contract year will be based on the Overall Performance Score calculated in accordance with this Appendix F.

1. Performance Area Contributions to Overall Performance Score (OPS)

Performance Area	Contribution to Overall Performance Score
Clinical Quality, Customer Service, and Resource Use	65%
Contract Oversight	35%

2. Clinical Quality, Customer Service, and Resource Use (QCR) Performance Area Measures

Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Controlling High Blood Pressure	CBP	HEDIS	1	2.50

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Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
Clinical Quality	Comprehensive Diabetes Care (HbA1c <i>Control</i> <8.0%)	CDC	HEDIS	1	2.50
	Prenatal and Postpartum Care (Timeliness of Prenatal Care)	PPC	HEDIS	1	2.50
	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18-64)	AAB(18-64)	HEDIS	2	1.25
	Asthma Medication Ratio	AMR	HEDIS	2	1.25
	Breast Cancer Screening	BCS	HEDIS	2	1.25
	Cervical Cancer Screening	CCS	HEDIS	2	1.25
	Colorectal Cancer Screening	COL	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dep. (30 Day)	FUA30	HEDIS	2	1.25
	Follow-Up After Emergency Department Visit for Mental Illness (30 Day)	FUM30	HEDIS	2	1.25
	Flu Vaccinations for Adults (18-64)	FVA	CAHPS	2	1.25
	Statin Therapy for Patients with Cardiovascular Disease <i>Statin Adherence 80%</i> (Adherence)	SPC	HEDIS	2	1.25

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Performance Area	Measure	Abbrv	Measure Source	Priority Level	Measure Weight
	Well Child Visits in the First 15 Months of Life (6 visits) <i>First 30 Months of Life – Well-Child Visits in the First 15 months: 6 or More Well-Child Visits</i>	W30(15)	HEDIS	2	1.25
Customer Service	Coordination of Care	CoC	CAHPS	3	1.00
	Claims Processing	CP	CAHPS	3	1.00
	Getting Care Quickly	GCQ	CAHPS	3	1.00
	Getting Needed Care	GNC	CAHPS	3	1.00
	Overall Health Plan Rating	RHP	CAHPS	3	1.00
	Overall Personal Doctor Rating	RPD	CAHPS	3	1.00
Resource Use	Use of Imaging Studies for Low Back Pain	LBP	HEDIS	1	2.50
	<i>Plan All Cause Readmissions: Observed/Expected (O/E) Ratio</i>	PCR	HEDIS	2	1.25

3. Community Rated Adjustment (CRA)

The value of the CRA as outlined in Carrier Letter [2017-02](#) will be based on a combination of QCR and CO scores. The QCR portion of the calculation used to establish the CRA is set at 0.6. The CO portion of the calculation used to establish the CRA is set at 0.95. For ~~2021~~ 2022, the CRA is the complement (one minus the outcome) of the following calculation: 0.65 times 0.6, plus 0.35 times 0.95.

The Performance Adjustment Percentage (PAP) for individual community-rated FEHB Program carriers for ~~2021-2022~~ performance will be one percent minus the Performance Based Percentage (PBP). The PBP is the amount calculated by the OPS plus the CRA with this result then multiplied by one percent. The PAP is multiplied by the subscription income to arrive at the Performance Adjustment (PA).

Depending on a plan's PA result three things are possible:

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1. If the PA result is positive this amount will be withheld from a net-to-carrier premium disbursement on or about the second payment of March of the ~~2022~~ 2023 contract year and placed in the plan's contingency reserve.
2. If the PA result is negative a plan can elect to receive the absolute value of this amount from the plan's contingency reserve which will be paid out on or about the second payment of March of the ~~2022~~ 2023 contract year. The decision to receive this amount or to allow the amount to remain in the contingency reserve is at the sole discretion of the plan.
3. If the PA result is zero no adjustments will be made.

The calculations described above are shown in formulas below:

$$\text{CRA: } 1 - ((0.65 * 0.6) + (0.35 * 0.95)) = 0.2775$$

$$\text{PBP} = (\text{OPS} + \text{CRA}) * 1\%$$

$$\text{PAP} = 1\% - \text{PBP}$$

$$\text{PA} = \text{PAP} * \text{Subscription Income}$$

9. Global Technical Edit

Remove the typographical character § for consistency.