U.S. Office of Personnel Management

2014 Multi-State Plan Program Application

Applicant Information

Legal Name	
Street Address	
City ST ZIP Code	
Federal Employer Identification Number (EIN)/ Federal Tax Identification Number	
NAIC Company Code	

Contact Information

Name	
Title	
Phone	
E-Mail Address	

Authorized Contracting Official

Name	
Title	
Phone	
E-Mail Address	
Signature	
Date	

Table of Contents

Appendix A: Plan Information Chart

- Section I: State Status
- Section II: MSP Information
- Section III: Service Areas
- Section IV: Appeals

Appendix B: Roles and Responsibilities Matrix

Appendix C: Network Adequacy Guidance

Appendix D: Benefits and Rates Submission (to be released at a later date)

Appendix E: Application Evaluation Criteria

Introduction

Background

The U.S. Office of Personnel Management (OPM) is charged with implementing the Multi-State Plan Program (MSPP) as authorized by Section 1334 of the Affordable Care Act. Specifically, OPM is responsible for contracting with at least two health insurance issuers to offer individual and small group coverage through multi-State plans (MSPs) made available on the Affordable Insurance Exchanges (Exchanges). MSPP Issuers may phase in MSPs over four years, eventually offering MSPs on Exchanges in all States and the District of Columbia. In the first year of the MSPP contract, MSPs must be offered in at least 60 percent of the States (31 States). In the second year, they must be offered in at least 70 percent of the States (36 States). In the third year, they must be offered in at least 85 percent of the States (43 States). In all subsequent years, the MSPP issuer must offer MSPs in all States and the District of Columbia. We also intend to allow MSPs to participate in part rather than all of the state initially. The MSPP will provide consumers in every Exchange with a choice of two high quality products thereby promoting competition in the Exchanges.

For more than 50 years, OPM has administered the Federal Employees Health Benefits Program (FEHBP), which provides health insurance coverage to approximately 8 million Federal employees, annuitants, and family members. OPM contracts with health insurance carriers to offer a wide variety of coverage options throughout the country. In the MSPP, consumers will benefit from OPM's experience. OPM will negotiate contracts with MSPP issuers, including rates and benefits, in consultation with States and Exchanges. In addition, OPM will monitor MSPP Issuers' performance, and oversee their compliance with legal requirements and contractual terms.

In administering the MSPP, OPM is advancing several objectives:

- To ensure a choice of at least two high-quality products to consumers participating on each Exchange;
- To promote competition in the health insurance marketplace to the benefit of all consumers;
- To provide strong, effective contractual oversight of the MSPP issuers; and
- To work cooperatively with States and the U.S. Department of Health and Human Services (HHS) to ensure a level playing field for Qualified Health Plans (QHPs) and MSPs and avoid disruption of State health insurance markets.

The MSPP will expand the health insurance choices available throughout the country. In administering the MSPP, OPM intends to draw on its experience with the FEHB while recognizing the importance of integrating MSPs into Exchanges.

Our approach

The Affordable Care Act directs OPM to implement the MSPP "in a manner similar to the manner in which the agency implements the contracting provisions with respect to carriers" under the FEHBP. The Affordable Care Act also provides that OPM may enter into MSPP contracts without regard to competitive bidding laws, similar to the authority given to OPM in regard to the FEHBP. Under the FEHBP, health insurance carriers may apply to enter the Program subject to timeframes and criteria established at the discretion of OPM. OPM may accept all such plans that, in its judgment, are qualified to participate. Upon agreement on benefits and rates for the upcoming plan year, OPM and the accepted health insurance carriers sign contracts.

OPM intends to follow a similar process for the MSPP, and thus is now soliciting applications for the MSPP. OPM may enter into contract negotiations with any Applicant who submits a complete, responsive application that demonstrates to OPM's satisfaction that the Applicant is able and willing to meet the requirements to become an MSPP Issuer. OPM will sign contracts with issuers upon successful completion of contract negotiations, thereby designating them as MSPP Issuers. MSPP issuers must accept enrollments beginning October 1, 2013 for coverage beginning as early as January 1, 2014.

We seek Applicants with extensive experience in providing innovative and affordable health insurance benefits. Successful Applicants must have, or be capable of developing, the capacity to offer coverage in all States. We encourage Applicants to study this application and the references below carefully in preparing their submissions.

Application process/instructions to Applicants

Individual and SHOP coverage

This application is intended to cover your participation in the Affordable Insurance Exchanges and the Small Business Health Options Programs (SHOPs). If your answers to the application questions differ based on your individual or small group lines of business, please indicate so and provide separate answers to the questions.

Definitions

For purposes of this application, the following definitions apply:

"Applicant" means an issuer or group of issuers that is applying to contract with OPM to be an MSPP Issuer.

"Group of issuers" means (1) a group of health insurance issuers who are affiliated either by common ownership and control or by common use of a nationally licensed service mark or (2) an affiliation of health insurance issuers and an entity that is not an issuer but that owns a nationally licensed service mark.

"Multi-State Plan" or "MSP" means a health plan that is offered under a contract with OPM pursuant to section 1334 of the Affordable Care Act.

"Multi-State Plan Program Issuer" or "MSPP Issuer " means a health insurance issuer or group of issuers that has a contract with OPM to offer health plans pursuant to section 1334 of the Affordable Care Act.

"Nationally licensed service mark" means a word, name, symbol, or device, or any combination thereof, that an issuer or group of issuers uses consistently nationwide to identify itself.

"State-level MSP issuer" means a health insurance issuer designated by the Applicant to offer MSPs on the Applicant's behalf. The State-level MSP issuer may offer coverage in all or part of one or more states.

Application structure

This application requests information about the Applicant, State-level MSP issuers, and the relationship between them.

The "Applicant information" sections solicit information about the Applicant, its managerial structure, financial stability, oversight and control over State-level MSP issuers, and about standardized systems, processes, and procedures used by the MSPP Issuer and State-level MSP issuers.

The "State-level MSP issuer information" section solicits information on each of the Applicant's State-level MSP issuers. When systems and processes are nationally standardized, as Applicants will indicate in Appendix B, one joint response to this section is sufficient. When systems and processes vary between State-level MSP issuers, individual responses to this section are required.

We anticipate that Applicants' organizational structures and affiliations will vary. Possible Applicant structures include, but are not limited to:

- a group of one or more State-level MSP issuers affiliated by common ownership and control or by the use of a nationally licensed service mark;
- an entity that owns a nationally licensed service mark and an affiliation of State-level MSP issuers;
- a health insurance issuer with wholly-owned subsidiaries that serve as State-level MSP issuers in some or all States; and
- a health insurance issuer that subcontracts with State-level MSP issuers to offer coverage in States in which the health insurance issuer is not currently licensed.

Other organizational structures are possible.

Accreditation

Applicants may offer accreditation status as proof of compliance with parts of this application. Accordingly, sections/questions marked with a "*" are not required with NCQA accreditation. Sections/questions marked with a "#" are not required with URAC accreditation.

Questions and answers about the application

OPM intends to provide guidance and assistance during the application process. Our website, [Link TBD], will provide up-to-date information, frequently asked questions, and notifications of interest to potential applicants.

Notice of intent to apply

Potential Applicants must submit a notice of intent to apply no later than [Date TBD] to gain access to OPM's online application portal. The notice of intent to apply is not binding; however, you cannot apply without first submitting a notice of intent. Further instructions will be provided.

Application submission

We will specify the process and timeline for submitting applications at a later date. We anticipate a staged submission process in which the deadline for submitting benefits and rates will be different from the deadline for submitting other information required in the application.

We will acknowledge receipt of your application within one business day. If you have questions or problems with your submission, or you do not receive a confirmation email, contact MSPP@opm.gov.

Application evaluation

OPM will evaluate each application we receive in order to determine whether it is in the best interest of the MSPP to enter into contract negotiations with the Applicant. OPM may enter into contract negotiations with any Applicant submitting a complete, responsive application that demonstrates to OPM's satisfaction that the Applicant is able and willing to meet the requirements to become an MSPP Issuer. These requirements include those set forth in sections 1324 and 1334 of the Affordable Care Act, in rulemaking for the MSPP, and in the evaluation criteria found in Appendix E. However, OPM reserves the right to limit the number of applicants with whom it will enter into contract negotiations during any given application cycle, if it determines in its sole discretion that such a limitation is in the best interests of the MSPP. OPM's decision whether to enter into a contract with an Applicant is final.

It is important that an Applicant provide adequate and specific information in its application. Assurance of experience, capability, qualifications, etc., without a clear demonstration to support the claim will adversely influence the evaluation of an application. OPM may verify information contained in an application and the readiness and ability to comply with MSPP requirements through in-person or telephone interviews with key personnel, on-site visits to facilities, oral presentations, or other evaluation techniques. OPM reserves the right to request clarification of potential misunderstandings and apparent inaccuracies contained within an application, provide additional written information, and conduct oral presentations.

We may use a private contractor to assist us in our review and evaluation of applications. If this is the case, the private contractor staff would be granted access to the information contained in the applications. The private contractor staff would be subject to the appropriate conflict of interest rules, standards of conduct, nondisclosure agreements and confidentiality restrictions. The private contractor would be precluded from assisting another entity in preparing an application to become an MSPP Issuer.

OPM's proposal to interact with the States during the benefits/rates review process

OPM intends to work closely with States when evaluating an Applicant's benefits and rate proposal. In coordinating with States during this benefits and rate review process, OPM aims to balance State and Federal regulatory interests in a manner that will enable MSPP Issuers to offer viable plans on Exchanges

and ensure a level playing field for MSPP and non-MSPP Issuers. OPM recognizes that each State has unique knowledge of its consumers and markets and plays a critical role in protecting consumers. Accordingly, OPM's benefits and rate review process will strive to balance State needs with OPM's statutory obligation to implement and oversee the MSPP.

Key references

- The Affordable Care Act (Pub. L. 111-148 as amended by Pub. L. 111-152). Of particular note is section 1334, Multi-State Plans, and section 1324, Level Playing Field.

- OPM's Notice of Proposed Rulemaking for the Multi-State Plan Program [forthcoming]

- Regulations, bulletins, and guidance issued by the Department of Health and Human Services on matters including, but not limited to :
    - Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers
    - Standards related to Reinsurance, Risk Corridors, and Risk Adjustment
    - Essential Health Benefits [forthcoming]
    - Actuarial Value and Cost-Sharing Reductions [forthcoming]
    - Market Rules [forthcoming]

Additional references

- FEHB statute
- FEHB Program regulations
- FEHB Acquisition Regulation (FEHBAR)

Timetable

(all dates are to be determined)

- Application available:
- Notice of Intent to Apply due:
- Applications due to OPM: (different dates for benefits and rates and all other information)
- OPM review of applications
- Benefit and rate negotiations, consultation with States:
- MSPP contracts signed and certifications issued by:

Application questions

Statement of intent and accuracy

Provide a written statement signed by an authorized contracting official of the Applicant's intent to contract with the U.S. Office of Personnel Management for the provision of health insurance through Exchanges in the individual and small group markets. In addition, this statement must attest to the accuracy of the information provided in this application.

Applicant overview

Provide an introductory overview of your organization. Explain how your organization's participation as an MSPP Issuer would benefit the MSPP and further OPM's objectives in administering the MSPP listed on page 4. What solutions, efficiencies, economies of scale, or unique approaches do you propose to bring to the MSPP and Exchanges?

Applicant information

Provide the following information about the Applicant:

1) Corporate structure and management. Provide copies of executed articles of incorporation or organization, bylaws, partnership agreement(s), and any other applicable organization documents.
2) The legal and organizational relationship between the Applicant and the State-level MSP issuers that will provide health insurance under this contract.
3) How the Applicant interacts with the State-level MSP issuers, including decision-making processes and lines of authority. How will the Applicant ensure that the State-level MSP issuers comply with the terms of its MSPP contract?
4) The Applicant's history of health insurance operations. Describe reorganizations, mergers, changes of ownership, and name changes that have taken place within the last 10 years.
5) Is the Applicant a non-profit entity? If so, explain and provide documentation.
6) Is the Applicant owned by, affiliated with, or sponsored by another organization that provides management and/or financial support to the Applicant? If so, provide details including legal relationship, administrative, management, financial or other services the other organization provides. In what ways, if any, is the other organization financially responsible for the Applicant?
7) Any significant legal actions or ongoing investigations that may impact the Applicant's financial stability or operational abilities.
8) Has the Applicant and/or any State-level MSP issuer been sanctioned or penalized for engaging in improper or fraudulent activity in any government program? If so, provide details.
9) Provide a signed opinion by legal counsel that the Applicant and State- level MSP issuers are not debarred, suspended, or ineligible to participate in federal Government contracting for any reason, including fraudulent health care practices in other Federal health care programs. This includes members of the board of directors, any key management or executive staff, major stockholders, affiliated companies, subsidiaries, subcontractors, and subcontractor staff.

Group of issuers

If the Applicant is a group of issuers, provide the following additional information:

1) The managerial organization, control and decision-making structures for the group.
2) Any contractual, agency, fiduciary or other relationship between affiliated issuers that will ensure that the Applicant complies with the terms of its MSPP contract.
3) How conflicts between affiliated issuers are resolved.
4) If applicable, a copy of the contract or other documents relating to the use and ownership of the service mark.

Managerial capabilities

1) Provide the names, titles, and résumés (or summaries of relevant experience) of key personnel that would be assigned to this contract. Include key personnel who would be responsible for overall management of the MSPP contract and for coordination with State-level MSP issuers as well as those responsible for critical areas such as:
    - marketing
    - enrollment
    - claims
    - claims disputes
    - customer service
    - financial management
    - actuarial analysis
    - care management
    - IT systems
    - compliance
    - medical director
    - quality
    - premium administration

    Identify the percentage of time that each will dedicate to the MSPP.

2) Provide a chart of the Applicant's entire organizational structure, highlighting which parts of that structure would be involved in managing the MSPP contract. Identify where the key personnel listed in (1) reside in the organizational structure.
3) Identify the individual in the Applicant's organization who will serve as the point of contact for OPM with respect to day-to-day management and administration of the contract.

Financial solvency

1) Provide evidence of the financial ability of the Applicant to sustain operations in the future and to meet obligations under the MSPP. This includes audited financial statements for the last 3 years, including balance sheet, income statement, and statement of cash flow. Include any qualified opinions and steps taken to resolve them. Provide a projected balance sheet for the current fiscal year.

2) Provide evidence of adequate current and projected funding to operate in the States in which you are applying for participation in 2014, including any commitment from an outside entity. Describe financing available to cover shortages and agreements covering the financing arrangements.
3) Provide evidence of adequate projected funding to phase in operations to all 50 States and the District of Columbia by 2017.
4) Provide your current and two prior financial ratings from A.M. Best, Moody's Standard and Poors, and Weiss, as available. If rating(s) significantly changed within the last three years, explain why.
5) Describe provisions that would be implemented to prevent insolvency or in the event you became insolvent while you are an MSPP issuer.
6) Describe any fiduciary, agency, or trust relationship between the Applicant and the State-level MSP issuers. If a State-level MSP issuer becomes unable to fulfill its responsibilities under an MSPP contract, will the Applicant guarantee contract performance in that State, including full payment of claims? Specify the actions that the Applicant would take in the event of insolvency of a State-level MSP issuer.

Oversight, control, and consolidation of functions

1) Describe oversight and control over the State-level MSP issuers. Include a discussion of how you intend to oversee the delivery of a consistent level of performance.
2) Complete the Roles and Responsibilities Matrix (Appendix B).
3) For each of the functions that you have identified in Appendix B as being performed by the Applicant, describe your planned processes and procedures. Discuss coordination with State-level MSP issuers and provide detailed timelines for implementation.
4) Are your State-level MSP issuers operating on a consistent data platform? If not, describe how these systems will interact to share required information.
5) Describe your process for developing medical policy and deciding whether and when to provide benefits for a new procedure/technology.
6) Describe the standard policy you will establish for the termination of MSP enrollee coverage due to non-payment of premium as permitted by 45 CFR 155.430(b)(2)(ii). This policy for the termination of coverage:
    - Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in 45 CFR 156.270(d); and
    - Must be applied uniformly to enrollees in similar circumstances.

2014 Benefits package

Guidance forthcoming

State-level MSP issuer information

Complete the "State Status" worksheet in Appendix A.

You must propose to offer MSPs in at least 31 States for 2014. If you are not proposing to offer MSPs in all States and the District of Columbia in 2014, describe the strategy for offering MSPs in all 50 States and the District of Columbia by 2017.

Complete the remaining application information for each State for which you are proposing an MSP in 2014. When systems and processes are nationally standardized as indicated in Appendix B, one joint response is sufficient.

Sections/questions marked with a "*" are not required with NCQA accreditation. Sections/questions marked with a "#" are not required with URAC accreditation.

In the section below, "you" refers to the State-level MSP issuer(s).

State:

Name of State-level MSP issuer(s):

For profit or non-profit

Indicate whether you are a for-profit or non-profit organization. If non-profit, provide documentation.

Enrollment experience

1) Describe your experience in providing health insurance in the individual, small group and large group markets, including your share in each market in this State.
2) Describe your experience, if any, with Federal and State government contracts, including Medicare, Medicaid, Children's Health Insurance Program, Federal Employees Health Benefits Program, Indian Health Service, TRICARE, State high risk pools, Pre-Existing Condition Insurance Plan, and special State subsidized health insurance programs.

Financial

1) Provide a copy of the most recent annual financial statement submitted to the State insurance commissioner (or equivalent) in each jurisdiction where you are licensed.
2) Describe State solvency standards, including reserve requirements and participation in guaranty funds. Demonstrate your compliance with these standards. Describe and document other insolvency protection measures, including insurance, reinsurance, stop loss provisions, bonding provisions, or other protections.

Accreditation status

1) Is the State-level MSP Issuer in this State currently fully accredited by URAC?
2) Is the product type the State-level MSP Issuer proposes to offer in this State (e.g., PPO, HMO, POS) currently fully accredited by NCQA?

3) Provide the most recent accreditation summary report for your MSP-proposed product type.
4) Are you currently submitting HEDIS and CAHPS data, and if so, to whom?
5) If your MSP-proposed product type is not accredited by NCQA or URAC, what is your timeline for gaining accreditation? If you have applied for but not received accreditation, provide documentation.
6) If accredited, provide authorization for the accrediting entity to release to OPM, the Exchanges and HHS a copy of your most recent accreditation survey, together with any survey-related information that may be required, such as corrective action plans and summaries of findings.

Claims

1) Detail your current and proposed claims payment system and processes, including:
    a. Claims system from intake through payment
    b. Timely processing standards
    c. Staffing level and location(s)
    d. Claims assessment and validation tools
    e. Prompt payment standards
    f. Overpayment collections
    g. Coordination of benefits
    h. Claims denials
2) Describe how you would comply with the internal claims and appeals processes applicable to group health plans and health insurance issuers under 45 CFR §147.136(b).
3) Are you currently using an Independent Review Organization (IRO) for external review and/or for coverage recommendations? If so, describe the relationship to your organization and processes in place.
4) Demonstrate adherence to applicable State law in negotiating the terms of payment in contracts with providers and in making payments to claimants and providers. Provide the number and dollar amount of penalties you have paid for the last 3 years for exceeding State-mandated prompt payment standards.
5) Complete the "Appeals" worksheet in Appendix A. Refer to 45 CFR Part 147 for definitions.

Member services

1) ***#**Describe your approach to providing excellence in customer service. Include a discussion of philosophy, best practices, staffing levels, training, and current service standards.
2) Describe member services that would be available by telephone and the plan website. Include self-service capabilities, self-management tools, health information, advice lines, access for urgent matters, premium payments, claims status, provider status, and other tools. Provide the URL to your member website.
3) *#Describe your capacity to provide customer service for individuals who are disabled or have limited English proficiency. Is your website section 508 compliant?
4) How long does it take to issue identification cards to enrolled individuals in your current plans? How long would it take for MSP enrollees?

5) **#Provide your member rights and responsibilities policy. How is this communicated to members and providers?
6) Describe your capacity to manage the anticipated increase in encounter volume with MSPP enrollment. How would your staffing levels change?
7) **# Describe sources of enrollee input and how you use that information to improve processes and performance.
8) #Describe the enrollee complaint process, including timelines for response.
9) *#Describe specific steps taken to ensure compliance with National Standards on Culturally and Linguistically Appropriate Services (CLAS).
10) *Describe health and wellness programs available to members, such as weight loss and tobacco cessation programs.
11) *#Describe health risk assessment tools.
12) Describe how you measure wellness programs and health risk assessment tools for effectiveness and the results of those programs in influencing enrollee behavior.

Marketing

1) Describe your open enrollment strategy for the MSPP, including advertising, outreach to different demographic and socioeconomic subgroups, outreach to Navigators and in-person assistors, materials, website functionality, and call center staffing and hours of operation.
2) Describe how your marketing strategy will differ for times other than open enrollment.
3) Do you intend to use agents or brokers? If so, describe:
    - how you intend to use them,
    - your proposal for complying with laws, regulations, and rules set forth by a State and/or Exchange regarding the use of agents and brokers for products offered through an Exchange, and
    - your proposal for selection, training, oversight, and compensation of agents and brokers.
4) **#Describe how you ensure that marketing materials fairly and accurately describe plan benefits, exclusions, limitations, restrictions, cost-sharing requirements, procedures for obtaining benefits, and provider access. Provide examples.

Utilization/quality assurance

1) *Describe the management of patient care through the use of:
    i. #prospective review (e.g., pre-certification, preauthorization)
    ii. #concurrent review
    iii. #retrospective review
    iv. #case management
    v. #disease management
    vi. referrals/approval to access specialty care
    vii. care coordination
    viii. #patient-centered medical homes
    ix. medical necessity determinations
    x. clinical practice guidelines

xi. evidence-based medicine
xii. other programs/policies

2) *Describe the review of utilization of services by physicians and your program to correct utilization that does not fall within evidence-based clinical guidelines or treatment patterns.
3) *#How are prospective review decisions communicated to enrollees and providers? Are there expedited procedures for the review of urgent cases? Provide your definition of an urgent case.
4) *Describe your programs or procedures for ensuring appropriate utilization of emergency care services. Provide your definition of emergency care.
5) *#Describe your quality assurance program. Include a discussion of:
   i. data collection, analysis and use
   ii. how and when you provide information on health plan quality measures to enrollees , prospective enrollees, or others (e.g., employers)
   iii. pediatric quality measures established under section 1139A of the Social Security Act
   iv. any enrollee satisfaction surveys you conduct besides CAHPS, the results for the last 3 years, and how you publish and use that information
   v. quality strategies as articulated in section 1311(g) of the Affordable Care Act through market-based incentives or increased reimbursement available for:
      - Improving health outcomes
      - Implementation of activities to prevent hospital readmissions Implementation of activities to improve patient safety and reduce medical errors
      - Implementation of wellness and health promotion activities
      - Implementation of activities to reduce health and health care disparities
      - Use of health risk assessments and biometric assessments
6) Describe your fraud and abuse prevention programs, including compliance with Federal and State fraud and abuse laws. Do you intend to implement these same programs for the MSPP?
   i. Document savings from fraud/abuse prevention programs in the last 3 years
   ii. Describe processes and protocols for assessing vulnerability, preventing, detecting and eliminating fraud and abuse by employees, subcontractors, providers, and enrollees
   iii. Provide sample reports

IT Systems, security and confidentiality

1) Describe your current and proposed use and support of health information technology, including:
   i. electronic medical records
   ii. personal health records
   iii. e-prescribing
   iv. cost and quality transparency tools
   v. electronic referrals
2) You must collect and transmit data to and from OPM, Exchanges, HHS, Treasury, and reinsurance entities. OPM anticipates this will include transmitting line-level claims data to OPM. Describe your system infrastructure's capacity to securely interface with these entities for data transfers, including enrollment, reconciliation, claims/encounter data, and reports.

i. What do you anticipate to be the most significant challenges in data collection and reporting?
ii. How do you propose to mitigate those challenges?

3) Describe how your system would maintain statistical records regarding MSP enrollment and operations separate from other lines of business.
4) Describe your system infrastructure's capacity to manage the anticipated increase in enrollment, claims, and encounter volume.
5) Describe security and confidentiality measures, including your compliance with Federal privacy and information security standards. Include how your standards are consistent with the following principles:
    - Individual access. Individuals are provided with a simple and timely means to access and obtain their personally identifiable health information in a readable form and format;
    - Correction. Individuals are provided with a timely means to dispute the accuracy or integrity of their personally identifiable health information and to have erroneous information corrected or to have a dispute documented if their requests are denied;
    - Openness and transparency. There is openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable health information;
    - Individual choice. Individuals are provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable health information;
    - Collection, use, and disclosure limitations. Personally identifiable health information is created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;
    - Data quality and integrity. Reasonable measures are in place to ensure that personally identifiable health information is complete, accurate, and up-to-date to the extent necessary for intended purposes and is not altered or destroyed in an unauthorized manner.
    - Safeguards. Personally identifiable health information is protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and,
    - Accountability. These principles are implemented, and adherence assured, through appropriate monitoring and other means and methods to report and mitigates non-adherence and breaches.
6) Describe your operational, technical, administrative and physical safeguards, consistent with any applicable laws, to ensure that:
    - Personally identifiable information (PII) created, collected, used, and/or disclosed under the MSPP is protected against any reasonably anticipated threats or hazards to its confidentiality, integrity, and availability;
    - PII is only used by or disclosed to those authorized to receive or view it;

- Return information, as such term is defined by Title 26 USC section 6103(b)(2), is kept confidential;
- PII is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and
- PII is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

i. Describe how you monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls. Describe how you ensure your workforce complies with these controls. Are applicable policies and procedures regarding PII in writing?

ii. Describe the utilization of secure electronic interfaces when sharing PII electronically.

7) Describe your current and proposed records retention policy and capacity.

Provider contracts

1) Describe current and proposed professional and institutional network and/or preferred provider arrangements. Discuss major contract terms and provisions, including hold harmless provisions, risk sharing arrangements, and any exclusivity clauses. In multi-provider group contracts, is there a requirement for the group to guarantee participation of all providers in that group?
2) Describe your current and proposed provider reimbursement method(s). Describe incentives (e.g., shared savings, pay for performance, care coordination fees, incentives for use of centers of excellence for high risk conditions or procedures, payment bundling, discounted fee-for-service, fee-for-service incentive withholds, hospital incentive pools, capitation rates, DRGs etc.) to lower claims costs without compromising patient care.
3) Will your provider reimbursement rates vary between your MSP and non-MSP products?
4) **#**Discuss recruitment of high-quality providers.
5) ***#**Describe your credentialing/recredentialing policies and processes.
6) ***#** Describe how you ensure the continued quality of your provider network(s) through such factors as accreditation, customer satisfaction surveys, and attainment of quality or efficiency recognition designations. What metrics do you collect from providers? Do you hold preferred providers to higher standards?
7) ***Describe ongoing education of providers, including training, best practices, and peer review.
8) ***#**Describe how you ensure provider compliance with contract terms and other requirements, including corrective action plans.
9) ***Describe your processes for provider contract termination, including enrollee notification and provisions for continuation of care.
10) Does your current and proposed MSP provider network include dental providers? If not, describe how you will deliver pediatric dental services required by section 1302 of the Affordable Care Act.

Enrollment, disenrollment, and termination

1) What is your projected MSP enrollment in this State for 2014 and 2015? Discuss contingency plans for enrollment significantly less than or greater than projections.
2) Describe your proposal to interact with Exchanges for enrollment issues.

3) Describe how you will comply with accessibility and readability standards established in 45 CFR 155.230(b).
4) Describe your planned policies and procedures for reconciling enrollment files with each Exchange no less than once a month.
5) Describe your proposal to facilitate continuity and portability in coverage across State lines or Exchange service areas, including:
    i. enrollees moving from one State to another
    ii. families with members living in different States
    iii. businesses with employees in more than one State

Disaster recovery/Business continuity

1) *Do you have a plan for providing continued medical coverage and prescription drug dispensing for MSP enrollees affected by a major disaster? If so, please describe it.
2) Describe your disaster recovery plan.
3) #Describe your business continuity plan.

Product information

Benefit proposal

1) For each proposed benefits package identified in Appendix A, use Appendix D to submit detailed benefit information, including cost sharing requirements and benefit limitations.
2) The Affordable Care Act requires that at least one MSP in a State offers coverage without abortion services. If you plan to offer coverage for abortion services for which public funding is prohibited, provide a plan that details your process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) ("segregation plan") of the Affordable Care Act. This segregation plan should describe:
    i. Your financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of these services from those received for coverage of all other services;
    ii. Your financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for these services are reimbursed from the appropriate account; and
    iii. An explanation of how your systems, accounting documentation, and controls meet the requirements for segregation accounts under the law.
3) Provide any analysis you have conducted to determine that your benefit design(s) will not have the effect of discouraging the enrollment of individuals with significant health needs in your MSP.
4) Describe your prescription drug benefit, including:
    i. What, if any, contract arrangements you propose to have with Pharmacy Benefit Managers (PBMs) and with retail and mail order pharmacies. Do you have a similar contract arrangement in place for your existing plans? Is the PBM separately accredited by NCQA or URAC, and if so, what is its accreditation status?

ii. What tools would be made available to the enrollees, physicians, or pharmacists to aid in understanding the prescription drug benefit;
iii. How you would differentiate, define, and tier generic drugs, preferred brands, non-preferred brands and specialty drugs;
iv. The process for the addition or deletion of formulary drugs and how these changes would be communicated to enrollees;
v. The processes or programs you would use to promote generic drug utilization; and
vi. If you do not contract with a PBM, or if the PBM is not separately accredited by NCQA or URAC, how you ensure quality and safety in pharmacy operations.

Rate proposal

1) Submit your proposed schedule or table of base premium rates with sufficient information and data as outlined in this section and Appendix D to allow OPM to conduct an actuarial review, and upon its review, to evaluate whether the proposed rate should be accepted, rejected, or modified based on whether the proposed rate is:
    i. Actuarially sound;
    ii. Not excessive, unjustified or unfairly discriminatory; and
    iii. Based on reasonable administrative expenses and/or profit loading.
2) In order to determine whether the proposed premium rates are reasonable and not excessive, unjustified or unfairly discriminatory, OPM may consider:
    i. Your financial position, including but not limited to profitability, surplus, reserves and investment savings;
    ii. Historical and projected administrative costs and medical and hospital expenses;
    iii. Historical and projected loss ratio between the amounts spent on medical services and earned premiums;
    iv. Your health care cost containment and quality improvement plans; and
    v. Whether the proposed rate is necessary to maintain rate stability and prevent excessive rate increases in the future.
3) All proposed rates and rating methodology submitted must adhere to adjusted community rating and use only the permissible rating factors as set forth in regulations implementing sections 2701, 2702, and 2703 of the Public Health Service Act. Your proposal must adjust premium base rates in accordance with State rating requirements, as needed.
4) Submit your proposed schedule or table of base premium rates and factors on a State-by-State basis for the individual market and the SHOP, for each MSP.
5) Submit, in the form of a cover letter, the minimum and maximum rate proposed by State and the name and contact information of the filer in the event additional information is needed to complete the review.
6) Submit an actuarial memorandum that includes:
    i. A discussion of assumptions, factors, calculations, rate tables, and any other information pertinent to the proposed rate; and
    ii. A dated signature from the qualified health actuary who reviewed the rate proposal.

Service area

Indicate the service area(s) for each Exchange that you are proposing for 2014, as defined by that Exchange, in the "Service Area" worksheet of Appendix A. If an Exchange permits issuers to define their service areas, you must obtain OPM's approval for your proposed service area(s). The service area must cover a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and small employers (as defined in 45 CFR 155.20), in the judgment of OPM. If you are proposing to cover less than an entire Exchange service area in 2014, provide your rationale for limiting the area. Complete a separate chart for each service area.

Provider network

1) Consistent with 45 C.F.R. §156.230 and State law, OPM will conduct a review of each State-level MSP issuer's provider network to determine network adequacy. See Appendix C for instructions.
2) #How often is the provider directory updated?
   i.#Does the directory indicate providers not accepting new patients?
   ii.#Do you provide printed copies upon request?
3) If you would require enrollees to select a primary care provider, what would the process be for changing a selection? Would you limit the number of times an enrollee can change primary care providers?
4) How does the provider directory indicate which primary care providers are recognized as Patient Centered Medical Homes?
5) Describe your planned procedures for providing notice to enrollees of provider terminations. Would an enrollee be allowed to continue care with the provider for a period of time, with the applicable provisions of the terminated provider contract applicable? Describe special provisions for continuity of care during pregnancy.
6) Describe provisions for adequate choice for enrollees who are American Indians and for ensuring covered services from the Indian Health Service, as applicable.
7) Describe provisions for access to care for covered services not available from participating providers, emergency care in and out of the service area, and access to care in medically underserved areas.
8) Describe your system for monitoring your provider network and your procedures to react to changes in your network that impair adequacy for MSP enrollees.
9) Describe your planned process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of the enrolled population, from an overall enrollee population standpoint and addressing the needs of those with special needs and those with limited English proficiency and literacy. Specify what services would be available to such enrollees.
10) Describe procedures for continuity of care for enrollees who may cycle in and out of enrollment due to a change in their eligibility for Medicaid or the Children's Health Insurance Program (CHIP).
11) Describe your approach to ensuring compliance with 45 CFR 156.235, regarding Essential Community Providers in your network.