

1609.7001

48 CFR Ch. 16 (10-1-03 Edition)

any of the offenses enumerated in subdivision (a)(2) of this clause.

(4) The Carrier has () has not (), within a 3-year period preceding this certification, had one or more contracts terminated for default by any Federal agency.

(b) *Principals*, for the purposes of this certification, means officers; directors; owners; partners; and persons having primary management or supervisory responsibilities within a business entity (e.g., general manager; plant manager; head of a subsidiary, division, or business segment, and similar positions).

This certification concerns a matter within the jurisdiction of an agency of the United States and the making of a false, fictitious, or fraudulent certification may render the Carrier subject to prosecution under section 1001, title 18, United States Code.

(c) The Carrier shall provide immediate written notice to the Contracting Officer if, at any time, the Carrier learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

(d) A Carrier's certification that any of the actions mentioned in the certification exists will not necessarily result in termination of the contract. However, the certification, or the Carrier's failure to provide such additional information as requested by the Contracting Officer, will be considered in connection with a determination of the Carrier's responsibility under subpart 1609.70, Minimum Standards for Health Benefits Carriers.

(e) Nothing contained in the certification shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by this section. The knowledge and information of the Carrier is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

(f) The certification in this section is a material representation of fact upon which reliance is placed by the Contracting Officer. If it is later determined that the Carrier knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the contract for default.

Carrier Name: _____

Name of Chief Executive Officer _____

Date signed: _____

(End of Certificate)

Subpart 1609.70—Minimum Standards for Health Benefits Carriers

1609.7001 Minimum standards for health benefits carriers.

(a) The carrier of an approved health benefits plan shall meet the requirements of chapter 89 of title 5, United States Code; part 890 of title 5, Code of Federal Regulations; chapter 1 of title 48, Code of Federal Regulations, and the following standards. The carrier shall continue to meet the requirements of chapter 89 of title 5, United States Code, and the standards cited in this paragraph while under contract with OPM. Failure to meet these requirements and standards is cause for OPM's withdrawal of approval of the health benefits carrier and termination of the contract in accordance with 5 CFR 890.204.

(1) It must be lawfully engaged in the business of supplying health benefits.

(2) It must have, in the judgement of OPM, the financial resources and experience in the field of health benefits to carry out its obligations under the plan.

(3) It must keep such reasonable financial and statistical records, and furnish such reasonable financial and statistical reports with respect to the plan, as may be requested by OPM.

(4) It must permit representatives of OPM and of the General Accounting Office to audit and examine its records and accounts which pertain, directly or indirectly, to the plan at such reasonable times and places as may be designated by OPM or the General Accounting Office.

(5) It must accept, subject to adjustment for error or fraud, in payment of its charges for health benefits for all enrollees in its plan, the enrollment charges received by the Employees Health Benefits (EHB) Fund less amounts set aside for the administrative and contingency reserves prescribed in 5 CFR 890.503. OPM makes available or pays the amounts within 30 days of receipt by the EHB Fund.

(6) A carrier that is an employee organization must continue coverage, without requirement of membership, of any eligible survivor annuitants, former spouses continuing coverage with the carrier under 5 CFR 890.803, children temporarily continuing coverage with the carrier under 5 CFR 890.1103(a)(2), or former spouses temporarily continuing coverage with the carrier under 5 CFR 890.1103(a)(3).

(7) It must timely submit to OPM a properly completed and signed novation or change-of-name agreement in accordance with subpart 1642.12 of this chapter.

(b) In addition to the standards in paragraph (a) of this section, the carrier must perform the contract in accordance with prudent business practices. A carrier's sustained poor business practice in the management or administration of a health benefits plan is cause for OPM's withdrawal of approval of the health benefits carrier and termination of the carrier's contract. Prudent business practices include, but are not limited to, the following:

(1) Timely compliance with OPM instructions and directives.

(2) Legal and ethical business and health care practices.

(3) Compliance with the terms of the FEHB contract, regulations and statutes.

(4) Timely and accurate adjudication of claims or rendering of medical services.

(5) A system for accounting for costs incurred under the contract, when required, which includes segregating and pricing FEHB medical utilization and allocating indirect and administrative costs in a reasonable and equitable manner.

(6) Accurate accounting reports of actual, allowable, allocable, and reasonable costs incurred in the administration of the contract.

(7) Application of performance standards for assuring contract quality as required by 1646.270(d).

(8) Establishment and maintenance of a system of internal control that provides reasonable assurance that:

(i) The provision and payments of benefits and other expenses are in com-

pliance with legal, regulatory, and contractual guidelines;

(ii) FEHB funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and,

(iii) Data are accurately and fairly disclosed in all reports required by OPM.

(c) The following types of activities are examples of poor business practices which adversely affect the health benefits carrier's responsibility under its contract. A pattern of poor conduct or evidence of misconduct in these areas is cause for OPM to withdraw approval of the carrier:

(1) Presenting false claims by charging expenses to the contract which according to the contract terms are not chargeable to the contract;

(2) Using fraudulent or unethical business or health care practices or otherwise displaying a lack of business integrity or honesty;

(3) Repeatedly and knowingly providing false or misleading information in the rate setting process;

(4) Repeated failure to comply with OPM instructions and directives;

(5) Having an accounting system that is incapable of separately accounting for costs incurred under the contract and/or that lacks the internal controls necessary to fulfill the terms of the contract; and

(6) Failure to assure that the plan provides properly paid or denied claims, or providing medical services which are inconsistent with standards of good medical practice.

(7) Entering into contracts or employment agreements with providers, provider groups, or health care workers that include provisions or financial incentives that directly or indirectly create an inducement to limit or restrict communication about medically necessary services to any individual covered under the FEHB Program. Financial incentives are defined as bonuses, withholds, commissions, profit sharing or other similar adjustments to basic compensation (e.g., service fee, capitation, salary) which have the effect of limiting or reducing communication about appropriate medically necessary

services. Providers, health care workers, or health plan sponsoring organizations are not required to discuss treatment options that they would not ordinarily discuss in their customary course of practice because such options are inconsistent with their professional judgment or ethical, moral or religious beliefs.

(d) The Director or his or her designee will determine whether to propose withdrawal of approval and hold a hearing based on the seriousness of the carrier's actions and its proposed method to effect corrective action.

[57 FR 14359, Apr. 20, 1992. Redesignated and amended at 59 FR 14764, 14765, Mar. 30, 1994; 63 FR 42586, Aug. 10, 1998]

Subpart 1609.71—Performance Evaluation

SOURCE: 63 FR 55337, Oct. 15, 1998, unless otherwise noted.

1609.7101 Policy.

At the end of each contract period, the contracting officer will determine each community-rated carrier's responsiveness to the Program requirements in 1609.7101-1.

1609.7101-1 Community-rated carrier incentive performance elements.

(a) Customer Service. This element is intended to assist OPM in achieving the goal of providing customer service that meets or exceeds the expectations of Federal enrollees. The Customer Service category will represent 70 percent of the total calculation and will be based on the carrier's compliance with the following items:

(1) *Timely Closure on Rates and Benefits Consistent with Policy Guidelines.* In order for information to be available to our customers in time for the annual Open Season, carriers must work with OPM to conclude benefits and rate negotiations by the established time frames. The contracting officer will evaluate this item based on the carrier's demonstrated record in providing its rate reconciliation and benefits information within the time frames prescribed by and in the format required by OPM.

(2) *Customer Information.* Enrollees must have accurate information and adequate time to make informed Open Season choices in selecting a health plan. In evaluating this item, the contracting officer will consider the carrier's timeliness and accuracy of information.

(3) *Meeting Customer Service Performance Standards.* Compliance with this item is essential so that OPM can ensure that the carrier is providing quality health care and other services to enrollees. The contracting officer will evaluate this item based on the carrier's submission of the Consumer Assessment of Health Plans Study (CAHPS) survey results and other measures as required contractually between OPM and the carrier. (This element will be implemented beginning with contract year 2000).

(4) *Cooperation in Surveys.* FEHB enrollees rely on feedback from the consumer assessment survey in selecting a health plan. The contracting officer will evaluate this item based on the carrier's record in cooperating with OPM and/or its designated representative in administering a consumer assessment survey or providing comparable survey results as specified in the FEHB contract and OPM guidance.

(5) *Paperless Enrollment/Enrollment Reconciliation—(i) Paperless Enrollment.* The requirement to cooperate in the OPM designated system for paperless enrollment is under the section entitled "Enrollment Instructions" in the FEHB Supplemental Literature Guidelines in the FEHB contract. The contracting officer will evaluate this item based on the carrier's ability to accept electronic data transmission from the OPM designated electronic enrollment system and issue ID cards timely.

(ii) *Enrollment Reconciliation.* The requirement for carriers to reconcile their enrollment records on a quarterly basis with those provided by Federal Government agencies is in the *Records and Information to be Furnished by OPM* clause of the contract, as well as 5 CFR 890.110 and 5 CFR 890.308. The contracting officer will evaluate this item based on the carrier's demonstrated record of initiating reconciliation procedures with applicable agency payroll