# Draft Recommendations for QHP Standards for Plan Year 2016

As prescribed in the Patient Protection and Affordable Care Act (PPACA), all Issuers and plans participating in the Marketplace must meet federal certification standards for Qualified Health Plans. Additionally, Delaware requires Issuers and plans who participate in Delaware's Health Insurance Marketplace to comply with state codes and regulations, as well as state-specific QHP standards approved by the Delaware Health Care Commission. The state followed a number of guidelines in developing its state standards, including:

- All QHP Certification Standards will apply to both Individual and Small Group (SHOP) plans sold inside the Marketplace. However, all plans, both inside and outside of the Marketplace, must comply with Essential Health Benefits benchmarks established by the state, with certain exceptions for stand-alone pediatric dental plans.
- All QHPs must comply with existing federal standards and regulations, including those in and out of the ACA, such as Mental Health Parity.
- The state-specific QHP Standards do not attempt to modify any federal standard, but augment federal requirements for QHP certification to include state regulations, codes and standards that promote state compliance, value to consumers and clarify state expectations for commercial plans offered to Delawareans through the Exchange.
- Delaware QHP Standards do not duplicate requirements clearly outlined in Federal regulation.

The current standards were approved for implementation in Plan Years 2014 and 2015, with a minor clarification implemented for 2015 regarding reimbursement for federally-qualified health centers (FQHC).

**Attached is a comprehensive list of all current and proposed Qualified Health Plan Standards for Plan Year 2016.**

**A public comment period for 2016 QHP Standards will be open from September 4, 2014 to September 18, 2014. Comments can be sent by email to QHPstandards@choosehealthde.com.**

| # | Status | Delaware QHP Standard |
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| | | General Standards |
| 1 | Current | Issuers are required to offer at least one QHP at the Bronze level, as well as the Silver and Gold as required by the federal standard. |
| 2 | Current | All stand-alone dental plans must be compliant with Title 18, Chapter 38: Dental Plan Organization Act. |
| 3 | Current | The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities. |
| 4 | Current | The QHP issuer must provide for reimbursement of a licensed nurse midwife subject to 16 Del.C§122, and as outlined in 18 Del.C. §3336 and§3553. |
| 5 | Current | The QHP issuer must permit the designation of an obstetrician-gynecologist as the enrollee's primary care physician subject to the provisions of Delaware Insurance code 18Del.C.§§3342 and 3556. |
| 6 | Current | Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval. |
| 7 | Current | The QHP Issuer must comply with the following state regulations in the event that it withdraws either itself or a plan(s) from the Exchange:<br>1. Issuers withdrawing plans for Individuals must comply with 18 Del.C. §§3608(a)(3)a, and 3608(a)(4)<br>2. Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5),7206(a)(6) and 7206(b), Renewability of coverage. |
| | | Accreditation |
| 8 | Current | The state will follow the proposed federal standards for accreditation, including requiring that those QHP issuers without existing accreditation must schedule the accreditation within the first year of participation in the exchange, and to be accredited on QHP policies and procedures by the end of the second year of certification. The state will also require in the third year of operation, that all QHP issuers must be accredited on the QHP product type. While all Issuers must comply with existing state and federal codes and regulations, Issuers of stand-alone dental plans are exempt from the state's Accreditation standard until such time as accreditation standards, entities and processes are available through federal guidance. |
| | | Continuity of Care |
| 9 | Current | Continuity of Care: A QHP issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan must include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. In such instances, the new plan is responsible for executing the Transition plan. Transition plans are not applicable for individuals who **voluntarily** disenroll in a QHP, do not enroll in another QHP, but are still not eligible for Medicaid/CHIP. |
| 10 | Current | For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the QHP issuer/plan must cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care. |
| 11 | Current | A continuity/transition period of at least 60 days must be provided for medications prescribed by a provider. If the QHP uses a tiered formulary, the prescribed medication must be covered at tier comparable to the plan from which the individual was transitioned |

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| 12 | Current | For mental health diagnosis, a continuity/transition period of at least 90 days must be provided by the QHP for medications prescribed by the treating provider for the treatment of the specific mental health diagnosis. The prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned. |
| | | Network Adequacy |
| 13 | Current | QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence.<br>*(Note: This standard will be replaced by new standard #20 if adopted)* |
| 14 | Current | Each QHP issuer that has a network arrangement must meet and require its providers to meet state standards for timely access to care and services as outlined in the table, titled **Appointment Standards,** found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services. |
| 15 | Current | Issuers must establish mechanisms to ensure compliance by providers, monitor providers regularly to determine compliance and take corrective action if there is a failure to comply with Network Standards. |
| 16 | Current | QHP networks must be comprised of hospitals, physicians, behavioral health providers, and other specialists in sufficient number to make available all covered services in a timely manner. |
| 17 | Current | Each primary care network must have at least one (1) full time equivalent Primary Care Provider for every 2,000 patients. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2500 patients. |
| 18 | Current | The Delaware Exchange requires that each health plan, as a condition of participation in the Exchange, shall (1) offer to each Federally Qualified Health Center (as defined in Section 1905(I)(2)(B) of the Social Security Act (42 USC 1369d(I)(2)(B)) providing services in geographic areas served by the plan, the opportunity to contract with such plan to provide to the plan's enrollees all ambulatory services that are covered by the plan that the center offers to provide and (2) reimburse such centers the relevant state-approved FQHC prospective payment system (PPS) rate for the items and services that the FQHC provides to the QHP enrollee, regardless of whether or not the QHP Issuer and the FQHC have previously contracted at a lower rate for the same items and services. |
| 19 | Current | Issuers of stand-alone dental plans are exempt from the state's network adequacy standards for medical and mental health providers. However, Stand-alone dental plans must comply with SSA 1902(a)(30)(A), and assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. |

<table>
<tr>
<td>20</td>
<td>Proposed</td>
<td>Plans must meet the GEO Access Standards for the practice areas listed below.<br><br>If a plan's network does not have a geographically accessible provider with appropriate expertise to treat a patient's medical condition, the patient can obtain services from an out of network provider. The health plan will work with the patient to identify a provider. The plan will pay all medically necessary expenses directly related to the treatment of the patient's medical condition. The patient will be responsible for the plans copayments and cost-sharing based on in network benefits. The plan may apply any case management, preauthorization protocols that would be applied to an in network provider.<br><br>
<table>
<tr><th>Practice Area</th><th>Miles from Resident Urban</th><th>Miles from Resident Suburban</th><th>Miles from Resident Rural</th></tr>
<tr><td>PCP</td><td>8</td><td>15</td><td>25</td></tr>
<tr><td>OB/GYN</td><td>8</td><td>15</td><td>25</td></tr>
<tr><td>Pediatrician</td><td>8</td><td>15</td><td>25</td></tr>
<tr><td>Specialty Care Providers*</td><td>30</td><td>35</td><td>45</td></tr>
<tr><td>Behavioral Health/Mental Health/Substance Abuse Providers**</td><td>30</td><td>35</td><td>45</td></tr>
<tr><td>Acute-care hospitals</td><td>10</td><td>15</td><td>25</td></tr>
<tr><td>Psychiatric hospitals</td><td>30</td><td>35</td><td>45</td></tr>
<tr><td>Dental</td><td>30</td><td>35</td><td>45</td></tr>
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<br>*Including but not limited to Home Health Specialists, Cardiologists, Oncologists, OB/GYN, Pulmonologists, Endocrinologists, Skilled Nursing Facilities, Rheumatologists, Ophthalmologists, Urologists, Neurologists, and telemedicine sites<br>**Including but not limited to advanced-degree behavioral health practitioners (MD or DO in General or Pediatric Psychiatry), mid-level professionals (Licensed Psychologists, Psychiatric Nurse Specialists, Licensed Clinical Social Workers, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists), certified peer counselors or certified alcohol and drug counselors (when supervised by an appropriately-related licensed provider or facility), in-patient and outpatient facilities, and telemedicine sites.</td>
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<td>21</td>
<td>Proposed</td>
<td>1. QHP Provider Directories are required to include a listing of the plan's providers including, but not limited to:<br>a. Primary Care Providers (primary care physicians in pediatrics, family medicine, general internal medicine or advanced practice nurses working under Delaware's Collaborative Agreement requirement);<br>b. Specialty Care Providers (including, but not limited to: Hospitals, Home Health Specialists, Cardiologists, Oncologists, OB/GYN, Pulmonologists, Endocrinologists, Skilled Nursing Facilities, Rheumatologists, Ophthalmologists, Urologists, Neurologists, Psychiatric and State-licensed Psychologists,);<br>c. Behavioral Health, including mental health and substance abuse disorder providers and facilities, clearly identifying specialty areas;<br>d. Habilitative autism-related service providers, including applied behavioral analysis (ABA) services.<br>2. Issuer/Plans must update their online Provider Directory quarterly and notify members within 30 days if their PCP is no longer participating in the Plan's network.</td>
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<td>22</td>
<td>Proposed</td>
<td>Each plan's network must have at least one (1) full time equivalent advanced-degree behavioral health practitioner (MD or DO in General or Pediatric Psychiatry), or mid-level professional (licensed psychologists, psychiatric nurse specialists, Licensed Clinical Social Workers, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists) supervised by an advanced-degree behavioral health practitioner, for every 2,000 members. The QHP issuer must receive approval from the Insurance Commissioner for capacity changes that exceed 2,500 patients.</td>
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| 23 | **Proposed** | In order to meet provider-to-patient ratios, an issuer's QHP network must include ratios calculated on a count of all patients served by the provider across all of the health plans marketed by the issuer. |
| 24 | **Proposed** | 1. Reimbursement for services provided through telemedicine must be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and patient.<br>2. In order for telemedicine services to be covered, healthcare practitioners must be:<br>a. acting within their scope of practice;<br>b. licensed (in Delaware or the State in which the provider is located if exempted under Delaware State law to provide telemedicine services without a Delaware license) to provide the service for which they bill; and are<br>c. located in the United States. |
| | | Rating Area |
| 25 | Current | Delaware will permit one rating area. |
| | | Service Area |
| 26 | Current | The entire geographic area of the State is in the service area of an Exchange, or multiple Exchanges consistent with §155.140(b) The State of Delaware will require Qualified health plan(s) offered by an issuer to be available in all three counties of Delaware. |
| | | Quality Improvement Strategy |
| 27 | Current | Issuers will be required to participate in state quality improvement workgroups intended to standardize QHP quality improvement strategies, activities, metrics and operations, including payment structures to improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes. |
| 28 | Current | Issuers, with the exception of those who provide stand-alone dental plans only, will be required to participate in and utilize the Delaware Health Information Network (DHIN) data use services and claims data submission services, at prevailing fee structure, to support care coordination and a comprehensive health data set as a component of state quality improvement strategy. |
| 29 | **Proposed** | 1. Beginning January 2016, payers must make available to eligible PCPs at least one Pay for Value (P4V, with bonus payments tied to quality and utilization management for a panel of patients) and one Total Cost of Care (TCC, with shared savings linked to quality and total cost management for a panel of patients) payment with at least one model with some form of funding for care coordination for chronic disease management, whether in the form of per member per month fees or payments for non-visit based care management.<br>2. Payers must indicate how payment is tied to the common scorecard for all models, with a minimum percentage (consistent with the levels recommended by the Delaware Center for Health Innovation) linked to common measures and the rest linked to performance on payer-specific measures.<br>3. Payers must support reporting for the common provider scorecard and overall scorecard consistent with the recommendations of the Delaware Center for Health Innovation. |

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| 30 | **Proposed** | Each health plan shall establish and implement policies and processes to support integration of medical health and behavioral health services. Policies and processes for integration of care must address integration of primary care and behavioral health services, including but not limited to substance abuse disorders. |
| | | Quality Rating |
| 31 | Current | The state will adopt the Quality Rating standards as provided in federal guidance. |
| | | Marketing and Benefit Design |
| 32 | Current | Issuers and QHPs must comply with state laws and regulations regarding marketing by health insurance issuers, including Delaware Insurance Code Title 18§23 Unfair Methods of Competition and Unfair or Deceptive Acts and the requirements defined in 18 Del Admin Code§ 1302 Accident and Sickness Insurance Advertisements. |