QHP Network Access Plan Cover Sheet Template For Plan Year 2017

Section 1: Overview

As part of the Delaware QHP Application process, the Delaware Department of Insurance will conduct a review and analysis of Plan Provider Networks to ensure compliance with State and federal regulations, standards, and to confirm there is adequate access to all providers and facilities without unreasonable delay or the need to travel an unreasonable distance. The process also accounts for differences in provider availability, capacity to treat patients, provider types (specialties, including mental health and substance abuse providers, dental providers, etc.), facilities, practice referral patterns, continuity of care, among others.

In addition to federal QHP submission requirements, Issuers applying for certification of health plans and stand-alone dental plans on the Delaware Marketplace for Plan Year 2017 are required to submit for review by the Delaware DOI a Network Access Plan, including a completed Cover Sheet template, and other supporting documentation, as described below. Issuers must also document that their proposed network meets additional Delaware-specific QHP Standards.

(Note: Delaware required supporting documentation must be submitted in addition to any template/supporting documentation required by CMS/CCIIO. The DOI understands that there may be some overlap in information provided; however, the State's additional submission requirements for Network Adequacy/Access are needed to support the State's independent review for compliance with federal and state standards and regulations.)

The Delaware Network Adequacy standards for Plan Year 2017 are provided in the table below. A complete list of the Delaware QHP Standards for Plan Year 2017 may be found at the following URL: http://dhss.delaware.gov/dhcc/files/healthplanstandards.pdf

Delaware Network Adequacy Standards for Qualified Health Plans for Plan Year 2017

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,** in the Delaware Medicaid and Managed Care Quality Strategy document relating to General, Specialty, Maternity and Behavioral Health Services. ***(This standard does not apply to stand-alone dental plans)***
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.
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**. *(This standard does apply to stand-alone dental plans with regard to covered dental services)***
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. ***(This standard does not apply to stand-alone dental plans)***

A. For QHP medical Issuers: 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.

B. For QHP Stand-Alone Dental Issuers: The Delaware Exchange requires that each stand-alone dental 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 pediatric dental services that are covered by the plan that the center offers to provide and (2) reimburse such centers the relevant state-approved Medicaid/CHIP fee for service (FFS) rate as outlined in schedule (http://www.dmap.state.de.us/downloads/hcpcs/fee.schedule.2014.pdf) 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.

Issuers of stand-alone dental plans are exempt from the state's network adequacy standards for medical and mental health providers unless otherwise indicated. 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.

A. Qualified Health Plan Provider Networks must meet the GEO Access Standards for the practice areas listed below for all services covered by the plan.

- If a plan's network does not have a geographically accessible provider with appropriate expertise to treat a patient's medical (or dental) condition, after notifying the issuer, 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 covered 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.
- In the event that the Issuer and the out-of-network provider cannot agree upon the appropriate rate, the provider shall be entitled to those charges and rates allowed by the Insurance Commissioner or the Commissioner's designee following an arbitration of the dispute. The Issuer will pay the benefits directly to the out-of-network provider.

Practice Area	Miles from Resident Urban / Suburban*	Miles from Resident Rural*
PCP	**15**	**25**
OB/GYN	**15**	**25**
Pediatrician	**15**	**25**
Specialty Care Providers**	**35**	**45**
Behavioral Health/Mental Health/Substance Abuse Providers***	**35**	**45**
Acute-care hospitals	**15**	**25**
Psychiatric hospitals	**35**	**45**
Dental	**35**	**45**

**"Urban / Suburban" is defined as those geographic areas with greater than 1,000 residents per square mile. "Rural" is defined as those geographic areas with less than 1,000 residents per square mile.*

***Examples of Specialty Care Providers include, but are not limited to, Home Health Specialists, Cardiologists, Oncologists, OB/GYN, Pulmonologists, Endocrinologists, Chiropractors, Skilled Nursing Facilities, Rheumatologists, Ophthalmologists, Urologists, Neurologists, and telemedicine sites*

****Examples of Behavioral Health/Mental Health/Substance Abuse Providers include, but are 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 Drug and Alcohol Counselors, 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.*

B. Restricted Broad Network (i.e., HMO and EPO) and Value Network Plans must comply with the following standard for adequate and timely access to Out-of-Network Providers

- If the Plan's network is unable to provide necessary services, covered under the contract, the Issuer must adequately and timely cover these services out of network for the member, for as long as the Issuer is unable to provide them.
- Requires Issuer to coordinate with the out-of-network providers with respect to payment and ensures that cost to the member is no greater than it would be if the services were furnished within the network.

The Issuer is responsible for making timely payment, in accordance with state regulation, to out-of -network providers for medically necessary, covered services, up to their fee maximum for contracting providers.

1. QHP Provider Directories are required to include a listing of the plan's providers including, but not limited to:
    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);
    b. Specialty Care Providers (including, but not limited to: Hospitals, Home Health Specialists, Cardiologists, Oncologists, OB/GYN, Pulmonologists, Endocrinologists, Chiropractors, Skilled Nursing Facilities, Rheumatologists, Ophthalmologists, Urologists, Neurologists, Psychiatric and State-licensed Psychologists,);
    c. Behavioral Health, including mental health and substance abuse disorder providers and facilities, clearly identifying specialty areas;
    d. Habilitative autism-related service providers, including applied behavioral analysis (ABA) services.
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.

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.

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.

For the purposes of the standard, *"**Telehealth**" means the mode of delivering health care services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.*

*"**Telemedicine**" means a form of telehealth which is the delivery of clinical health care services by means of real time two-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care by a health care provider practicing within his or her scope of practice as would be practiced in-person with a patient, and legally allowed to practice in the state, while such patient is at an originating site and the health care provider is at a distant site. Telemedicine facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers."*

1. An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact. Payment for telemedicine interactions shall include reasonable compensation to the originating or distant site for the transmission cost incurred during the delivery of health care services
2. Telehealth/medicine services covered under policies shall not be subject to deductibles, copayment or coinsurance requirements which exceed those applicable to the same services provided via face-to-face contact between a health care provider and patient.
3. In order for telehealth/medicine services to be covered, healthcare practitioners must be:
    a. Acting within their scope of practice;
    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
    c. Located in the United States.

The Delaware benchmark plan includes coverage of mental health and substance abuse (MHSA) services. Federal law requires that these services be offered at parity with medical and surgical services. Final rules for the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) went into effect on January 13, 2014 and the interim final rule went into effect starting in 2010. As such, the DOI will review each Issuer's Network Access Plan to ensure parity related of mental health providers with other specialty provider types with respect to adequacy, access and referral procedures.

Section 2: Instructions for Submitting Network Adequacy and Access Plan Information

The DOI instructs Issuers to submit, as supporting documentation within each applicable SERFF Binder, an electronic copy of the Issuer's' *Network Access Plan*. To facilitate the DOI's review, Issuers are also instructed to provide, in addition to their *Network Access Plan*, information related to the Issuer's Provider Network policies and Network Access Plan using the two templates described below.

DE Network Access Plan Cover Sheet template:

Section 3 of this document provides a template (MS Word) for Issuers to provide information and page references related to their *Network Access Plan*. If the Issuer's access plan addresses an element, mark 'Yes' in the Included in Access Plan column. Then, in the Page Number for Supporting Documentation column, provide a reference to the applicable page number in the issuer's *Network Access Plan* that addresses the specific element. If the Issuer has multiple networks, reference the pages that are applicable to each network, or indicate whether the particular page is applicable to multiple networks. ***(Note: If the information is referenced within an additional supporting document other than the Issuer's Network Access Plan, the Issuer should submit a copy of that document, and reference the document name and applicable page numbers accordingly.)***

DE Network Adequacy Detailed Analysis Template

Documentation that the Issuer's network(s) meet State Network Adequacy Standards should include a completed DE Network Adequacy Detailed Analysis Template (MS Excel), available through SERFF. The template instructs Issuers to provide a comprehensive list of the network's providers (practitioners and facilities), including, but not limited to provider's name, location (address and county), provider type/specialty, and languages spoken. The Excel template collects provider information for both medical and dental provides, and will be used by the DOI to support its evaluation of the Issuer's network compliance with federal and state regulations and standards, including new standards being implemented in Plan Year 2017. Examples of the provider types are listed below.

Provider Types	Examples	
Primary Care/Pediatrics/OB-GYN	• General/Family Practitioners or Internal Medicine • Family Practitioners and Pediatricians • Pediatricians • OB-GYN	
Specialty Care-Medical	• Cardiologists • Oncologists • Pulmonologists • Endocrinologists • Anesthesiologist	• Rheumatologists • Ophthalmologists • Urologists • Other *(include provider type / facility type)*
Facilities-Medical	• Ambulatory clinics • Outpatient rehabilitations / habilitation centers • Skilled Nursing Facilities	• Home Health Agencies • Other *(include provider type / facility type)*
Mental/Behavioral Health Providers	• Advanced degree behavioral health practitioners *(MD or DO in General or Pediatric Psychiatry)* • Mid-level professionals *(licensed psychologists, Psychiatric Nurse Specialist, licensed clinical social workers, licensed professional counselors of mental health, licensed marriage and family therapists, etc.)* • Licensed Drug and Alcohol Counselors • Certified Peer Counselors and Certified Alcohol and Drug Counselors *(when supervised by an appropriately-related licensed provider or facility)* • Applied Behavior Analysis (ABA) Specialists • Other *(include provider type / facility type)*	
Mental/Behavioral Health Facilities	• In-patient Mental/Behavioral Health Facilities • Outpatient Mental/Behavioral Health Facilities	

	• In-patient Substance Abuse Facilities • Outpatient Substance Abuse Facilities • Other *(include provider type / facility type)*	
Pharmacy	• Retail Pharmacy • Mail Order Pharmacy	
Essential Community Providers	Federally Qualified Health Center (FQHC) Ryan White Provider Family Planning Provider Hospital School-Based Provider Other ECP *(include provider type / facility type)*	
Dental Providers	• General Dentistry • Pediatric Dentists • Endodontists • Periodontists	• Oral Surgeon • Orthodontist • Dental Hygienists
Telehealth Providers (include provider type		

Section 3: Network Access Plan Cover Template and Required Network Access Plan Elements

All Issuers are asked to complete all subsections, unless otherwise instructed. Stand-alone dental Issuers are asked to complete all subsections as they relate to dental provider networks for those plans seeking QHP certification for offer both on and off the Delaware Marketplace.

1. General Information

Issuer Name	
Issuer Contact for Network policies and practices *(include name, title, contact phone and email)*	
Delaware Health Plans served by the Network *(*include plan names and plan type (i.e., EPO, HMO, PPO, etc.)	
List of Issuer supporting documentation submitted (i.e., Network Access Plan, Issuer Provider Network Standards and Management policies, Provider Directory policies and practices, etc.)	

2. Standards for Network Composition:

Describe how the issuer establishes standards for the composition of its network to ensure that networks are sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services and pediatric dental (if applicable), to ensure that all services will be accessible without unreasonable delay. Standards must be specific, quantifiable, and measurable based on the anticipated needs of their membership. The standards must address provider-to-enrollee ratios and time and distance standards.

Evaluation Criteria	Included in Access Plan? (Y/N)	Page number for supporting documentation
Does the issuer have a documented process to establish standards for network composition?		
Does the issuer's standard address how the network will be sufficient in number, type of providers, including mental health and substance abuse services to comply with Delaware's QHP standards?		
Do the issuer's policies, standards and procedures regarding provider-to-patient ratios address Delaware standards for calculating said ratios based on a count of all patients served by the provider across all of the plans marketed by the issuer?		
Does the issuer's standard address how the network will be sufficient to address Delaware's network distance standards outlined in the state's QHP standards?		
Are the issuer's standard quantifiable and measurable?		
Do the issuer's network policies and procedures regarding the use of telehealth providers address Delaware's QHP Standards regarding Telehealth?		
What percentage of providers in the network participate as Telehealth providers?		
Does the issuer provide documentation or evidence that its proposed network meets its standards?		
Does the issuer subcontract any of its provider network management through a third-party administrator (TPA)		
Does the issuer subcontract its pharmacy benefits through a third-party administrator?		

3. Referral Policy

Describe the issuer's procedures for making referrals within and outside of its network.

Evaluation Criteria	Included in Access Plan? (Y/N)	Page number for supporting documentation
Does the issuer have a documented process for making referrals inside and outside the network?		
Does the process allow members to access services outside the network when necessary?		
Do the issuer's policies and procedures regarding referrals for mental health, behavioral health and substance abuse services align with those for medical/surgical referrals, including access to services		

outside the network when necessary?		
Do the issuer's policies and procedures address Delaware's standards for integration of primary care and behavioral health providers?		
Do the issuer's policies and procedures address Delaware's standards for telehealth providers, including, but not limited to referrals, access and reimbursement of such providers?		

4. Ongoing Monitoring

Describe the issuer's process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of the population enrolled.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process for monitoring, on an ongoing basis, the sufficiency of the network to meet the needs of its members?		
Does the issuer include a both quantifiable and measurable approach to monitoring ongoing sufficiency of its network?		

5. Needs of Special Populations

Describe the issuer's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural or ethnic backgrounds, or with physical and mental disabilities.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities?		
Does the issuer s process identify the potential needs of special populations?		
Does the issuer s response describe how its process supports access and accessibility of services for special populations?		
If the issuers plans include the pediatric dental benefit, does the issuers response address compliance with Delaware regulations regarding access to all required provider services for severely handicapped children?		

6. Health Needs Assessment

Describe the issuer's methods for assessing the needs of covered persons and their satisfaction with services.

Evaluation Criteria	Included in	Page number for

	Access Plan (Y/N)	supporting documentation
Does the issuer have a documented method for assessing the needs of covered persons?		
Does the proposed method include a review of quantitative information?		
Does the proposed method assess needs on an ongoing basis?		
Does the proposed method assess the needs of diverse populations?		

7. Communication with Members

Describe the issuer's method for informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented method for informing covered persons of the plan's services and features, including, but not limited to, the plan s grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care?		
Does the method address the process for choosing or changing providers and access to emergency or specialty services?		
Does the process describe how it supports member access to care?		

8. Coordination Activities

Describe the issuer's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians; for covered persons using ancillary services, including social services and other community resources; and for ensuring appropriate discharge planning.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented process for ensuring coordination and continuity of care?		
Does the proposed process address specialty care referrals; ancillary services, including social services and community resources; and discharge planning?		
Does the response describe how the process supports member access to care?		

9. Continuity of Care

Describe the issuer's proposed plan for providing continuity of care in the event of contract termination between the health issuer and any of its participating providers or in the event of the issuer's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, issuer's insolvency, or other cessation of operations and how they will be transferred to other providers in a timely manner.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Does the issuer have a documented plan for ensuring continuity of care in compliance with federal and state QHP Standards?		
Does the issuer have a hold harmless provision in its provider contracts, prohibiting contracting providers from balance-billing enrollees in the event of the issuer s insolvency or other inability to continue operations?		
Does the Issuer's Network Access Plan, policies and procedures comply with federal regulation that requires issuers, when providers are terminated without cause, to allow an enrollee in active treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates. Active treatment is defined as an ongoing course of treatment for a (1) life-threatening conditions; (2) serious acute conditions; (3) the second or third trimester of pregnancy, through the postpartum period; and (4) health conditions for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes. Issuers are required, in these circumstances, to pay providers what was previously being paid under the same terms and conditions of the provider contract, including any protections against balance billing.		
Does the Issuer's Network Access Plan, policies and procedures address how the Issuer will comply with federal regulation to make a good faith effort to provide written notice of a discontinued provider, 30 days prior to the effective date of the change or as soon as practicable, to all enrollees who are patients seen on a regular basis by the provider or receive primary care from the provider. For example, does the Issuer's process address working with the provider to obtain the list of affected patients or to use their claims data system to identify		

enrollees who see the affected providers. Does the Issuer's procedures include notifying the enrollee of other comparable in-network providers in the enrollee's service area, including information on how an enrollee could access the plan's continuity of care coverage, and how the enrollee may contact the issuer with any questions?		

10. Provider Directory

Describe the issuer's policies and process for ensuring the network's provider directory is current and accessible to consumers and regulators as outlined in state standards and federal regulations.

Evaluation Criteria	Included in Access Plan (Y/N)	Page number for supporting documentation
Do the issuer's (medical and stand-alone dental) policies and procedures regarding the Plan's Provider Directory(ies) comply with federal and state regulations and standards, including, but not limited to the ability for consumers to easily access the Provider Directory to review provider's name, location, specialty, and languages without the need to establish an account with the issuer?		
Do the issuer's (medical and stand-alone dental) policies and procedures support compliance with federal and state regulations and standards regarding the monthly updates to its online Provider Directory, as well as the requirement to notify members within 30 days if their PCP is no longer participating in the Plan's network?		