QHP Standards for Plan Year 2020*

Delaware QHP Standards apply to both medical and stand-alone dental plans unless otherwise indicated.

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. *(This standard does not apply to stand-alone dental plans)*

All stand-alone dental plans must be compliant with Title 18, Chapter 38: Dental Plan Organization Act. *(This standard does not apply to medical plans)*

The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities.

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. *(This standard does not apply to stand-alone dental plans)*

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. *(This standard does not apply to stand-alone dental plans)*

The QHP issuer must comply with the federal Mental Health Parity and Addiction Equity Act of 2008, as described in the final rule at 45 CFR Parts 146 and 147, effective 1/13/2014.

The plan (if offered in the individual market) complies with 18 Del.C §3343 **as amended by Del. S.B. 230/Del. S.A. 1, 149th Gen. Assem. § 1 (2018).**

The plan (if offered as a group or blanket plan) complies with 18 Del.C §§3571U and 3578 **as amended by Del. S.B. 230/Del. S.A. 1, 149th Gen. Assem. § 1 (2018).**

Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval.

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:

1. Issuers withdrawing plans for Individuals must comply with 18 Del.C. §§3608(a)(3)a, and 3608(a)(4)

2. Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5),7206(a)(6) and 7206(b), Renewability of coverage. *(This standard does not apply to stand-alone dental plans)*

Accreditation

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. *(This standard does not apply to stand-alone dental plans)*

Continuity of Care

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 dis-enroll in a QHP, do not enroll in another QHP, but are still not eligible for Medicaid/CHIP. (This standard does apply to stand-alone dental plans with regard to covered dental services)

For treatment of a medical/dental 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.
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. (This standard does apply to stand-alone dental plans with regard to covered dental services)

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. (This standard does not apply to stand-alone dental plans)

Network Adequacy

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(l)(2)(B) of the Social Security Act (42 USC 1369d(l)(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(l)(2)(B) of the Social Security Act (42 USC 1369d(l)(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 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."

"Distant site" means a site at which a health care provider legally allowed to practice in the state is located while providing health care services by means of telemedicine or telehealth.

"Originating site" means a site in Delaware at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties. For example, an originating site may be a healthcare facility, provider office, clinic, a member's place of residence, day program, or alternate location in which the member is physically present and telemedicine can be effectively utilized.

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 telehealth/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. NOTE: No compensation for originating site transmission will be paid when the originating site is the member's home or other non-provider-based location.

2. Telehealth/telemedicine 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/telemedicine services to be covered, healthcare practitioners must be:

    a. Acting within their scope of practice;
    b. Licensed (in Delaware or the State or Country in which the provider is located if exempted under Delaware State law to provide telehealth/telemedicine services without a Delaware license) to provide the service for which they bill; and
    c. Must meet all federal and state requirements for utilizing telehealth within their specific discipline including the requirements for establishing a patient- or client-provider relationship in order to use telehealth and any other requirements.

Rating Area

Delaware will permit one rating area.

Service Area

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

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.

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.

1. By January 2017, payers shall make value based payment models available to primary care providers (PCPs) or accountable care organizations, networks, or systems with which they affiliate who are eligible based on a minimum set of criteria, meant to reward those providers for the quality and efficiency of care delivered to a population of attributed members spanning their interactions with the health care system. Each QHP should offer at least one pay-for-value model (with bonus payments tied to quality and utilization management for a panel of patients) and one total cost of care model (with shared savings linked to quality and total cost management for a panel of patients). Payers shall also provide a form of funding for care coordination for chronic disease management in at least one of the programs, whether in the form of per member per month fees or payments for non-visit based care management. Provider eligibility criteria (e.g., minimum quality requirements, minimum number of attributed members, ability to pool volume across other lines of business and/or with other providers), and the approach taken to provider outreach and enrollment should allow for the adoption of these models by providers sufficient to support of at least 60 percent of members to providers, with an effective date of January 1, 2017.

2. Payers shall include incentives for quality as a part of both pay-for-value and total cost of care models. At least 75% of quality and efficiency measures tied to payment will be linked to performance on the accountable measures of the Common Scorecard and the rest linked to performance on payer-specific measures.

3. Payers shall support reporting for the Common Scorecard by providing requested data according to the timelines and format specified by DCHI and DHIN. Payers shall also provide overall program dashboard information such as payment model availability adoption levels consistent with the recommendations of the DCHI.

4. Payers shall actively participate in DCHI including through representation on the DCHI Board of Directors and Committees if invited by the Board and through support of ongoing SIM initiatives.

5. Pursuant to 16 Del. Code §10311-§10315, all Qualified Health Plans are considered Mandatory Reporting Entities and as such are required to submit claims data on all fully insured Marketplace members to the Delaware Health Information Network (DHIN) for inclusion in the Delaware Health Care Claims Database. All QHPs shall

have in place the appropriate data submission and data use agreements that will allow for the submission of data to DHIN on the first reporting date that falls in Plan Year 2018.

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

The state will adopt the Quality Rating standards as provided in federal guidance.

Marketing and Benefit Design

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.

Value Network Plans

In addition to existing standards, the Delaware Exchange requires Issuers offering Value Network Plans to meet the following additional State standards:

1, Issuers who wish to offer Value Network Plans must also offer at least one broad network plan that meets the State's single Service Area in each of the following metal levels—Bronze, Silver and Gold.

2. Issuers must make available a Value Network Plan in each of the three counties in Delaware (New Castle, Kent and Sussex).

3. Issuers' marketing materials must provide consumers with clear and easy-to-understand language regarding the benefits covered and provider network restrictions and exceptions under the plans.

4. Value Network Plans must meet current network adequacy and access standards, including the requirement that Plans that do not have a skilled and experienced in-network hospital or clinician to perform a medically-necessary service are required to provide coverage for that service out-of-network, at no additional cost to the member.

a. 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.

b. The Issuer will pay directly to the out-of-network provider the highest allowable charge for any in-network provider for each covered service allowed by the Issuer during the full 12-month period immediately prior to the date of each medical service performed by the out-of-network provider.

5. Issuers of Value Network Plans are required to provide quarterly reports to the Insurance Commissioner regarding the number of consumer complaints and appeals related to network adequacy and access. These reports must provide sufficient detail to allow the Department of Insurance to perform timely monitoring of compliance with network standards.

6. Issuers of Value Networks must have policies and processes in effect for monitoring provider quality, adequacy and access to ensure that the Issuer can effectively deliver on the benefits promised under the plan.

7. If an Issuer offers broad network plans in both the individual and small group markets and chooses to offer Value Network Plans, then that Issuer must offer Value Network Plans in both markets.

8. Such other standards as are adopted by the Department of Insurance to address the following concerns: consumer protection; unaffordability of coverage; such other interests as are reflected in and consistent with the Insurance Code (Title 18, Delaware Code).