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Delaware Department of Insurance

2020 Medical Issuer QHP Submission Guide

For Coverage Year 2020

Published April 13, 2019

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1. General Information and Background

1.1 *Purpose*

The purpose of this document is to provide guidance to health insurance Issuers regarding the certification standards for individual and/or Small Business Health Options Program (SHOP) Qualified Health Plans (QHPs) offered through the federal Health Insurance Marketplace. This document is for informational purposes and has no legal force or effect; Issuers should refer to applicable Delaware State Code and federal statute, rules, and regulations (located in House Bill 162 as incorporated into Delaware Insurance Code), as well as state-specific QHP Certification Standards for a more comprehensive and thorough understanding of requirements related to qualified health plans offered in the Marketplace. Federal statute and regulations referenced in this document may not be final, and the citations to the same will be updated in future versions of this document when such regulations are made final. Please refer to the Federal Register for updated federal statute and regulations (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf).

PLEASE NOTE: This document is for Medical Issuers only. Stand-Alone Dental Issuers have a separate 2020 SADP Issuer QHP Submission Guide

1.2 *Background*

Effective January 1, 2014, the Health Insurance Marketplace offered Issuers a state-wide marketplace to make it easier for individuals and small employers and their employees to compare plans and buy health insurance. The Marketplace is the only distributional channel through which individuals and small employers will be able to purchase coverage that will be eligible for certain affordability subsidies, including:

- Advanced premium tax credits and/or cost-sharing reductions available to households purchasing coverage in the individual market
- Affordability tax credits available to eligible employers offering coverage in the small group market

In order to comply with certain aspects of the Affordable Care Act (ACA), Delaware has chosen to implement and operate a health insurance marketplace through the Federal Facilitated Marketplace State Partnership Option (FFM/SPO). To be certified as a QHP on the Delaware Marketplace, all Issuers and their health plans must meet all pertinent federal and state statutory requirements and standards. Operating in partnership with the US Department of Health and Human Services (HHS), the Delaware Department of Insurance (DOI) will review and recommend certification of QHPs to the federal Department of Health and Human Services (HHS) for ratification of the certification

recommendation, allowing for participation in the Marketplace. The ACA authorizes QHP certification as well as other operational standards for the Marketplace in following sections: 1301-1304, 1311-1312, 1321-1322, 1324, 1334, 1401-1402, 1411, and 1412. Federal standards for QHP Issuers are codified in 45 CFR 155 and 156. Furthermore, the state of Delaware has approved additional QHP certification standards to be applied to those plans sold within the Delaware Marketplace. See ***Attachment 7.***

The Delaware Marketplace will collect data from Issuers as part of QHP certification and recertification and monitor compliance with QHP certification standards on an ongoing basis. QHP Issuer and plan data will also support additional operational activities, including the calculation of each individual's advance payment of the premium tax credit, the display of plan information on the Marketplace web site, and managing the ongoing relationships between QHP Issuers, the DOI, and the Marketplace. Much of the information collected for QHP certification purposes will support these ongoing operational activities.

Consistent with the previous year's submission, CMS will again ask Issuers to complete a Plan ID Crosswalk Template. The information collected in the template will facilitate enrollment transactions from CMS to the Issuers, presumably in mid-December 2018 for the new plan year. Delaware requests that Issuers forward to the state a copy of their Plan ID Crosswalk, includeng any updates, at the time it submits them to CMS.

An individual or SHOP health insurance plan certified during the 2018 review cycle will be offered through the Delaware Marketplace beginning November 1, 2018. Health insurance Issuers will offer certified QHPs for a term of one year beginning January 1, 2020 and ending December 31, 2020. In addition, Federal regulations allow for the offering of Multi-state Plans (MSPs) that are reviewed and approved by the federal Office of Personnel Management (OPM). The guidance contained in this document does not address these plans. Issuers who wish to submit MSPs should refer to OPM's website (http://www.opm.gov/healthcare-insurance/multi-state-plan-program/) and the Multi-State Plan Program Final Rule. Issuers who wish to learn more about MSPs are encouraged to contact OPM or HHS directly.

Please Note: In accordance with federal guidance and regulations, ancillary insurance products and health plans that are not certified QHPs, e.g., stand-alone vision plans, disability or life insurance products will not be offered on the Delaware Marketplace.

1.3 *General Marketplace Participation Requirements*

To be certified for participation in the Marketplace, a QHP must:

- Meet the legal requirements of offering health insurance in Delaware
- Satisfy the certification criteria as established by the State
- Satisfy the minimum federal requirements of a QHP as outlined in 45 CFR Parts 155 and 156

- Sign and submit to CMS a QHP Privacy and Security Agreement and a Senior Officer Acknowledgement; and
- Be recommended for certification by the Delaware DOI, have the recommendation ratified by HHS, and enter into a Certification Agreement with HHS.
- Issuers are expected to utilize the CMS Review tools, including the Data Integrity Tool, prior to submitting data to the state. The DOI will leverage the CMS Review Tools during its application review process.

1.3.1 Required Use of CMS Review Tools and Data Integrity Tool

The Delaware Department of Insurance requires that Issuers attest that CMS QHP Review Tools and CMS Data Integrity Tool have been run, as appropriate, against the Issuer's data, and that errors identified by the tools have been resolved prior to submission of data templates. DE DOI requires that Issuers submit the attestation as part of its initial SERFF Plan Management Binder submission to the State. The DOI will not review the Issuer's data template submissions review until such time as attestations are received noting satisfactory results.

1.3.2 Alignment of Data Template information with Form filing documentation, including Summary of Benefits and Coverage (SBCs)

QHP Issuers are required to provide the Summary of Benefits and Coverage (SBC) in a manner compliant with the standards set forth in in 45 C.F.R. 147.200, which implements section 2715 of the PHS Act, as added by the Affordable Care Act. Specifically, issuers must fully comply with the requirements of 45 C.F.R. 147.200(a)(3), which requires issuers to "provide an SBC in the form, and in accordance with the instructions for completing the SBC, that are specified by the Secretary in guidance."

QHP Issuers are required to provide SBCs that accurately represent plan variations in a manner consistent with the requirements set forth at 45 C.FR. 147.200, and provide adequate notice, in the form of a new SBC, to enrollees after receiving notice from the Exchange of the enrollee's assignment into a new plan variation (or standard QHP without cost-sharing reductions). In accordance with these new regulations, beginning no later than November 1, 2020, QHP Issuers must provide separate SBCs for each plan variation and therefore may not combine information about multiple plan variations in one SBC. Issuers offering plan variations should include a separate URL linking to the SBC created for each plan variation as part of the QHP data submission. All URL links included on the SBC must be readily obtainable (that is, without requiring logging on to a website, entering a policy number, clicking through several web pages, or creating user accounts, memberships, or registrations) to consumers, including shoppers, and link directly to the information referenced on the SBC.

Any changes in the Issuer's network made after submission of the filing must be reported to the Department immediately, and Issuers shall make appropriate updates **to all applicable state and federal templates and supporting documentation, such as Summary of Benefits and Coverage (SBCs), at the time they report a network change. The Department will only process changes**

that are received through SERFF and after such time as Issuer has update all applicable documents to reflect a change to a network.

In addition, to participate in the Delaware Marketplace an Issuer must:

- Submit at least one silver plan and one gold plan per 45 CFR 156.200(c)(1), as well as submit at least one bronze plan per Delaware approved standards.
- Provide a child-only option for each metal tier for which the Issuer offers a QHP (45 CFR 156.200(c)(2), or permit child-only enrollment.
- Submit three variations to each silver plan reflecting reduced cost-sharing on the essential health benefits (45 CFR 156.420(a))

1.4 *Timetable*

The following table provides dates for the QHP certification process in 2020. Please note that dates are subject to change based on several factors, including many beyond the control of the DOI such as delays in federal guidance, federal timelines, and SERFF enhancements. Issuers are expected to adhere to the QHP certification timeline. Issuers that fail to meet deadlines or do not follow the process outlined within this Guide may have their QHP application denied.

Issuers will be kept informed of delays through regular communications by the DOI, HHS and NAIC, as well as through stakeholder meetings and other existing communication mechanisms.

DE QHP Submission Timeline for Plan Year 2020

Activity		Proposed Dates *
QHP Application Submission and Review Process	Initial QHP Applications submission period begins.	4/25/2019 – 6/19/2019
	Deadline for Issuers to submit an initial and complete Issuer QHP Application (Binders) through SERFF. QHP Issuers are also required to submit a complete Rate and Form filing by **6/19/2019**. **Issuers are directed to reference Delaware Rate Filing Requirements through SERFF.** (QHP applications must include all required data templates and supporting documentation in order to be considered 'complete'. Any late or incomplete submissions may not be considered for certification by the State)	**6/19/2019**
	CMS reviews initial QHP applications as of 6/19/2019.	6/20/2019 – 8/2/2019
	CMS releases first Correction Notices.	8/9/2019
	Service area data change request deadline.	8/12/2019
	Deadline for issuers to change QHP application.	**8/21/2019**
	CMS reviews QHP applications as of 8/21/2019	8/22/2019 – 9/9/2019
	CMS posts QHP agreements and QHP plan lists	9/16/2019
	CMS sends final correction notice to Issuers with the Agreements for signature and plan lists for confirmation	9/16/2019
	Issuers send signed Agreements, confirmed plan lists and final Plan Crosswalks to CMS.	9/16/2019 – 9/24/2019
	Delaware sends CMS final recommendations for QHP Certification	**9/16/2019 – 9/24/2019**
	Limited data correction window: Issuers submit corrections; CMS reviews and finalizes data for open Enrollment.	9/19/2019 – 9/20/2019
	CMS sends Certification notices to Issuers	10/3/2019 – 10/4/2019
Open Enrollment		11/01/2019 – 12/15/2019

**Dates are subject to change based on future guidance from CMS and/or NAIC..*

1.5 *Contact Information*

For questions, please contact Jan Brunory, QHP Analyst, Delaware Department of Insurance, as follows:

E-mail: janet.brunory@delaware.gov
Phone: 302-674-7374
Mailing Address: 841 Silver Lake Blvd., Dover, DE 19904

The DOI will notify Issuers regarding application status, findings, objections and other QHP Review related topics through SERFF or via other existing communication mechanisms.

1.6 *Document Naming Convention and Location*

When submitting a QHP application, Issuers are required to adhere to the following document naming convention for all files related to a plan. This will help identify each document to a plan and binder in SERFF. Delaware is implementing the document naming convention below for all Issuers.

The document naming convention includes the following for each file:

1. A three or four letter abbreviation identifying the Issuer company name.
   - Example: ABC
2. The name of the file.
   - Examples:
     - QHP-Network-Access-Plan-Cover-Sheet
     - Plan-and-Benefits-Data-Template
3. The version number of the document (increase the file version number by one number each time the file is re-uploaded to SERFF, starting with version #1).
   - Example: v1
4. The date the file was uploaded to SERFF
   - Example: 06272014

Separate each of the four naming convention requirements with a hyphen (-). An example of a complete document name loaded to SERFF is:

- ***ABC-QHP-Network-Access-Plan-Cover-Sheet-v1-06272014.pdf***

The DOI has developed a list of required, optional, and 'on-request' documentation for the QHP submission and review cycle. To make the intake and review process more efficient, Issuers are asked to upload and re-upload their documentation in the appropriate SERFF Tab/Section, including the Rate and/or Form Filing as indicated in the Summary of Submission Requirements document. Should an Issuer have a question about where to upload additional supporting documentation, they should contact the State prior to upload. See ***Attachment 1.***

2. Specifications for QHP Certification

This section outlines the various Issuer- and plan-level components that the DOI will require in the QHP submission. *Please note* that prior to completing a *Plans and Benefits Template*, Issuers must register their HIOS Product IDs via CCIIO's Health Insurance Oversight System (HIOS). Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review. Each Product ID will come with fifty Plan IDs, each of which is made up of the Standard Component ID and a Variance ID. Issuers must also have a HIOS Issuer ID issued by HHS for Rate Review.

QHP data and information will be submitted by Issuers to the DOI in SERFF using the methods numbered below.

1. Built-in Onscreen SERFF Data Entry Fields - *E.g., Plan Binder Name, Plan Year, Market Type*

2. CCIIO Standard MS Excel Data Templates (as attachments) - *E.g., Administrative Data Template, Plan and Benefits Template , Rate Data Template, Prescription Drug Template, Accreditation Templates (NCQA and URAQ)*
   - At the time of publication this guide, the CCIIO MS Excel Data Templates can be found at the following location: http://www.serff.com/plan_management_data_templates_2018.htm

3. Supporting Documentation (as attachments) - *E.g., QHP Network Access Plan and QHP Network Access Plan Cover Sheet template, PPACA Uniform Compliance Summary, Continuity of Care Plan, Actuarial Memorandum*

4. Attestations (as PDF attachments under Supporting Documentation in the Plan Management tab) - *E.g., "Issuer will adhere to all requirements contained in 45 CFR 156, applicable law and applicable guidance"*
   - State-specific attestations:
     - *Delaware Marketplace QHP Attestations & Compliance Form template*
   - Federal attestations
     - *Program Attestations for SPM/FFM Issuers template*
     - *Statement of Detailed Attestation Responses* (only required if Issuer does not fully attest to all attestations in the Program Attestations)

For each QHP certification requirement included in this section, the primary proposed method Issuers will use to submit supporting data information is listed. However, this may change prior to the opening of the QHP submission window subject to new guidance and information from CCIIO and the NAIC SERFF teams. As permitted by the ACA, Issuer and plan data and information required for QHP certification and ongoing monitoring will be forwarded by the DOI securely and directly to HHS through SERFF.

Additional instructions and helpful information can be found at the following link:
http://www.serff.com/plan_management_instructions.htm

2.1 *Data Submission Templates*

The 2020 QHP data templates can be found on SERFF at the following link:
http://www.serff.com/plan_management_data_templates_2020.htm

Questions and comments about the templates should be directed to CMS per their comment procedures.

2.2 *Uniform Modification of Coverage*

The Delaware Department of Insurance (DOI) has elected to adopt the federal standards for uniform modifications to certify plans, as referenced in the Final Letter to Issuers, Chapter 2, section 3, "Recertification for 2020" and ***45 CFR 147 Final Rule***:

2.3 *Issuer Administrative Information*

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related QHP application submissions.

Statutory/Regulatory Standard

Not applicable

DOI/HHS Approach to Certification

The QHP filing process requires submission of certain general administrative data that will be utilized for operational purposes. This basic information is required to identify Issuers and to facilitate communications between the DOI and the Issuers.
(See 508 Appendices A1 and A4 of Paperwork Reduction Act package, CMS Form Number CMS10433, for additional information.)

Each Issuer submitting QHP applications must also submit the *QHP Issuer Compliance and Organizational Chart Cover Sheet,* which can be found under Supporting Documentation in the Plan Management Tab in SERFF.

Please see the *Administrative Data Template* for detail on the data elements to be collected and complete all fields indicated with a red asterisk.

Primary data submission method(s): CCIIO MS Excel Data Templates, Supporting Documentation

2.4 *Licensure, Solvency, and Standing*

This information will be Issuer-specific and will only need to be submitted once, per Issuer, for all related initial QHP application submissions.

Statutory/Regulatory Standard

An Issuer must be licensed, meet State solvency requirements, and have unrestricted authority to write its authorized lines of business in the State of Delaware in order to be considered "in good standing" and to offer a QHP through the Exchange. Good standing means that the Issuer has no outstanding sanctions imposed by the DOI (45 CFR 156.200(b)(4)).

DOI/HHS Approach to Certification

The DOI's Bureau of Examination, Rehabilitation & Guaranty (BERG) will review and confirm Issuers submitting QHPs meet these standards, leveraging existing information and data sources to review the status of an Issuer's license, solvency, and standing.

- Issuers must provide one of the following supporting documents as part of the QHP Application: state license, certificate of authority, certificate of compliance, or an equivalent form or document for the product(s) in the service area(s) in which the Issuer intends to offer a QHP.
- Issuers applying for QHP certification must be able to demonstrate state licensure by no later than 90 days prior to open enrollment.

Issuers that are not currently licensed will be required to complete the Delaware licensing process, which is handled by the DOI's BERG unit. Delaware is a NAIC Uniform Certificate of Authority Application (UCAA) participant state; therefore, Delaware accepts the UCAA Primary and Expansion Applications. To obtain a license in Delaware, insurers and stand-alone dental plans must follow the procedures outlined in the UCAA Primary and Expansion Applications.

Primary data submission method(s): Attestations/Supporting Documents

2.5 *Benefit Standards and Product Offerings*

This information will be QHP-specific and will need to be included for each submitted QHP in the Issuer's application. With the exception of Section 2.5.7 (Mental Health Parity and Addiction Equity Act)

Plan-specific information not captured in other sections will be collected in the *Plan and Benefits Template*, including data elements such as Plan ID, whether or not the plan is offered in the individual or SHOP market and/or off of the Marketplace, and plan effective date.

Additionally, Issuers must submit benefits information for each QHP. QHP Issuers must ensure that each QHP complies with the benefit design standards (specified in the ACA and subsequent rules (45 CFR §156.200(3)), including:

- Federally approved State-specific essential health benefits (EHB)
- Federally approved State-specific QHP standards, *as applicable*
- Cost-sharing limits
- Actuarial value (AV) requirements
- Non-discriminatory benefit design
- Mental health parity

Sections 2.5.1 – 2.5.6 provide additional requirements related to Benefit Design standards.

2.5.1 Essential Health Benefits

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Exchange must cover a core set of "essential health benefits" as defined by HHS. Coverage must be substantially equal to the coverage offered by a benchmark plan, and the plan must cover at least the greater of one drug in every USP category and class or the same number of drugs in each category and class as benchmark plan (45 CFR 156.110, 156.115, 156.1207).

Delaware has selected the state's *Highmark BCBSD Inc. - Small Group Shared Cost EPO $2000/100 Plan*. At the time of approval, the BCBS EPO plan had the largest enrollment in the Small Group plan currently available in Delaware. The state has also decided to include the following supplements for pediatric dental, pediatric vision, and pediatric habilitative services to augment the *Highmark BCBSD Inc. - Small Group Shared Cost EPO $2000/100 Plan*.

Pediatric Dental

- Delaware has selected the state's Medicaid/CHIP Dental Plan as a supplement to its EHB benchmark plan to cover pediatric dental benefits.

Pediatric Vision

- Delaware has selected the Federal Employee Program Blue Vision Plan (FED Blue Vision) as a supplement to its EHB benchmark plan to cover pediatric vision benefits.

Habilitative Services

- As provided under existing federal guidance, Delaware will require that coverage for habilitative services be at parity with those for rehabilitative services as outlined in the state's Essential Health Benefit (EHB) benchmark. As it relates to habilitative devices and services for the State's EHB, the DOI interprets "parity" to mean both separate and equal to rehabilitative devices and services.

Delaware requests that Issuers include information indicating how frequently the Issuer updates its formularies, as well as information on the Issuer's process for providing the state with advance notification of such updates.

Delaware EHB Benchmark Plan: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/delaware-ehb-benchmark-plan.pdf

Delaware State-Required Benefits: http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/de-state-required-benefits.pdf

DOI/HHS Approach to Certification

In its review, the DOI and its third party Actuary will confirm the following:

- Issuer offers coverage that is substantially equal to the benchmark plan
- Issuer has demonstrated actuarial equivalence of substituted benefits if the Issuer is substituting benefits
- Issuer provides required number of drugs per category and class

EHB substitutions will require an actuarial certification to support that the substitutions are compliant and actuarially equivalent substitutions (45 CFR 156.115(b)(2)). Data will be collected on health benefits, including covered drugs, and Issuers will submit Summary of Benefits and Coverage (SBC) Scenario results. Please see the *Plans and Benefits Template* and *Prescription Drug Template* for additional detail on the data elements to be collected.

If the plan includes substitutions of any essential health benefit included in Delaware's benchmark plan, the Issuer must submit an *EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification*. *If the substitution is related to pharmacy benefits,* Issuers will be required to complete and submit a *Formulary – Inadequate Category/Class Count Supporting Documentation and Justification.* Both of these documents can be found under Supporting Documentation in the Plan Management tab in SERFF.

The Issuer must also complete and submit a *Delaware Issuer Essential Health Benefits (EHB) Crosswalk and Certification for Plan Year 20*20 template as part of their form filing. This template can be found at the end of this Issuer Submission Guide in ***Attachment 3.***

2.5.2 Annual Cost-Sharing Limitations

Statutory/Regulatory Standard

All small group and individual health benefit plans sold inside and outside of the Marketplace must meet the following annual cost-sharing limits in 2020 (45 CFR 156.130):

- Out-of-Pocket Limits: The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2020 shall

not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2020. The annual limitation on cost sharing (commonly referred to as a maximum out-of pocket limit) for 2020 is $7,900 for self-only coverage and $15,800 for other than self-only coverage. This affects the allowable maximum out-of-pocket value for Essential Health Benefits for all plans submitted in a QHP application. It also affects the allowable deductible value for catastrophic plans.

- Although the individual and family maximum out-of-pocket (MOOP) for Plan Year 2020 have been set for both individual and SHOP at $7,900 and $15,800, federal regulation stipulates that the MOOP paid for any individual cannot exceed the individual MOOP of $7,900, even if the family as a whole is subject to the $15,800 MOOP.

- Finally, beginning in 2020, all of the cost-sharing limits will be indexed to per-capita growth in premiums in the United States as determined by HHS.

DOI/HHS Approach to Certification

The DOI will review plan data for compliance with ACA cost-sharing limitations. Benefit cost sharing (e.g., quantitative limits, co-payments, and co-insurance by benefit), plan cost-sharing (e.g., in–network and out–of–network deductibles), and pharmacy benefit cost-sharing data elements will be collected; please see the *Plans and Benefits Template* and *Prescription Drug Template* for additional detail on required data elements. The DOI will conduct this review using the *CMS Cost Sharing Tool*. **Issuer are expected to utilize the *CMS Cost Sharing Tool* prior to submitting data to the state.**

To ensure appropriate alignment of information between the information shown on Healthcare.gov and the information included in consumer packets, Issuers shall make appropriate updates to all applicable state and federal templates and supporting documentation, such as Summary of Benefits and Coverage (SBCs), at the time they update cost-share changes within the cost share tab of the Plan and Benefits template. Issuers must indicate what documents have been updated when responding to the data change requests. Failure to notify the State or to update all relevant documents may result in a delay of review.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documentation

2.5.3 Actuarial Value

Statutory/Regulatory Standard

Except for the impact of cost-sharing reduction subsidies and a *de minimis* variation of +/- 2 percentage points, each plan in a metal tier must meet the specified AV requirements based on the cost-sharing features of the plan (45 CFR 156.140):

- Bronze plan – AV of 60 percent
- Silver plan – AV of 70 percent
- Gold plan – AV of 80 percent
- Platinum plan – AV of 90 percent
- Catastrophic plan – N/A *(Please see ACA §1302(e) for details on catastrophic plans and individuals eligible for them.)*

Issuers must use an actuarial value calculator, provided by HHS for use within the SERFF application, to produce computations of a QHP's metallic level based upon benefit design features. The AV calculator *may* also be used by Issuers informally for plan design. For unique plan designs for which the calculator does not provide an accurate summary of plan generosity, an actuarial certification is required from the Issuer indicating compliance with one of the calculation methods described in 45 CFR 156.135(b)(2).

DOI/HHS Approach to Certification

The DOI and its third party Actuary will review and confirm that the AV for each QHP meets specified levels and review unique plan designs and the accompanying actuarial certification, if applicable.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documentation

2.5.4 Non-Discrimination

Statutory/Regulatory Standard

An Issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125). In addition, QHPs must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation (45 CFR 156.200(e)) and must not have benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs (45 CFR 156.225(b)).

2.5.5 Discriminatory Benefit Design

For purposes of QHP certification, DOI will assess compliance with this standard by collecting an attestation that Issuers' QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation, consistent with 45 C.F.R. 156.200(e). DOI will continue to work with CMS to assess compliance through Issuer monitoring and compliance reviews, including analysis of appeals and complaints.

Issuers must use Delaware's 2020 benchmark plans when designing their plans. The DOI reminds Issuers that CMS cautioned issuers in its 2020 Letter to Issuers cautioned "…that age limits may potentially be discriminatory when applied to services that have been found clinically effective at all ages." Since Delaware's EHB benchmark includes coverage of hearing aids for members up to the age of 24, CMS may consider this restriction to be discriminatory based on age.

In addition to complying with EHB non-discrimination standards, QHPs must not employ market practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs pursuant to 45 C.F.R. 156.225. As in prior QHP certification review cycles, DOI will perform an outlier analysis on QHP cost sharing (e.g., co-payments and coinsurance). The outlier analysis will compare benefit packages with comparable cost-sharing structures to identify cost-sharing outliers with respect to specific benefits.

2.5.6 Non-Discrimination in relation to Prescription Drug Coverage.

A review of each QHP's formulary drug list will be performed to ensure non-discrimination in QHP prescription benefit design. For Plan Year 2020 it is required that issuers' formulary drug lists be up-to-date, accurate, and include a complete list of all covered drugs. The formulary drug list must include any tiering structure that the plan has adopted and any restrictions on the manner in which a drug can be obtained. A formulary drug list is considered to be complete, when the formulary drug list includes and lists all drugs that are EHB, and list all drug names that are currently covered by the plan at that time. The formulary drug list does not have to list every covered formulation for each covered drug, but the issuer should be prepared to provide information on the specific formulations upon request. Issuers must also include accurate information on any restrictions on the manner in which an enrollee can obtain the drug, including prior authorization, step therapy, quantity limits, and any access restrictions related to obtaining the drug from a brick and mortar retail pharmacy. The formulary drug list must be up-to-date, which means that the formulary drug list must accurately list all of the health plan's covered drugs at that time.

The formulary drug list must be published in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Marketplace, HHS, OPM, and the general public. A formulary drug list is easily accessible when it can be viewed on the plan's public web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and if an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan. Issuers must make this information publicly available on their websites in a machine-readable file and format specified by HHS, to allow the creation of user-friendly aggregated information sources. These requirements are to enhance the transparency of QHP formulary drug lists and to help consumers make more informed decisions about their health care coverage.

There are also requirements for the prescription drug exception process, under which an enrollee can request and gain access to a drug not on the plan's formulary. These provisions include a requirement that an issuer must notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage decision no more than 72 hours following the receipt

of a standard exception request, as well as a requirement that the issuer must have a process for the enrollee or the enrollee's designee or the prescribing physician (or other 40 prescriber) to request that the denied exception request be reviewed by an independent review organization. As part of these requirements, in the event that an exception request is granted, the plan must treat the excepted drug(s) as an EHB, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing under 45 C.F.R. 156.130, and that a health plan that grants a standard exception request must provide coverage of the excepted non-formulary drug for the duration of the prescription, including refills (or in the case of an expedited request, a health plan that grants an exception must provide coverage of the excepted non-formulary drug for the duration of the exigency). Issuers must update their policies and procedures to reflect these requirements. In addition to the above standards, issuers are encouraged to temporarily cover non-formulary drugs, as well as drugs that are on an issuer's formulary but require prior authorization or step therapy, as if they were on formulary or without imposing prior authorization or step therapy requirements, during the first 30 days of coverage when an enrollee is transitioning to a new plan.

Based on data submitted by issuers in the prescription drug template, a review will analyze the availability of covered drugs recommended by nationally-recognized clinical guidelines used in the treatment of the following medical conditions: bipolar disorder, breast and prostate cancer, diabetes hepatitis C., HIV, multiple sclerosis, rheumatoid arthritis, and schizophrenia. The purpose of the analysis is to ensure that issuers are offering a sufficient number and type of drugs needed to effectively treat these conditions, and on some first line drugs, are not restricting access through lack of coverage and inappropriate use of utilization management techniques. Other conditions, including HIV, may be considered as part of future reviews.

Finally under guaranteed renewability requirements and the definitions of "product" and "plan," issuers generally may not make plan design changes, including changes to drug formularies, other than at the time of plan renewal. However, it is recognize that certain mid-year changes to drug formularies related to the availability of drugs in the market may be necessary and appropriate. Such changes generally would not affect a QHP's certification.

DOI/HHS Approach to Certification

The DOI will review Issuer forms and supporting policy/procedure documentation to identify deficiencies or areas of non-compliance with the new regulations. Additionally, Issuers will be required to attest to non-discrimination on these factors for both federal and state standards. In addition, the DOI will conduct outlier tests to identify potentially discriminatory benefit designs using CMS-develop tools, including *CMS Cost Share Tool, Drug Class/Count Tool, Non-discrimination Formulary Clinical Appropriateness Tool and the Non-Discrimination Formulary Outlier Tool*.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations

2.5.7 Mental Health Parity and Addiction Equity Act

Statutory/Regulatory Standard

All individual and small group plans sold inside and outside of the Exchange are required to comply with the Mental Health Parity and Addiction Equity Act (ACA § 1311(j)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.c§3578.

DOI/HHS Approach to Certification

The DOI will review benefits and cost-sharing for compliance with this standard, including ensuring that financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

The Issuer must also complete and submit a *Delaware Mental Health Parity and Addiction Equity Act Issuer Checklist and Certification – Plan Year 2020* template as part of their Form filing. This template can be found at the end of this Issuer Submission Guide in ***Attachment 4.***

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestations, Supporting Documentation

2.5.8 Continuity of Care

Delaware QHP Certification Standards

Delaware specific certification standards regarding Continuity of Care include:

- 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 these 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.
- For treatment of a medical condition or diagnosis that is in progress or for which a preauthorization for treatment has been issued, the QHP Issuer/plan must cover the service for the 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 is required for medications prescribed by a provider. If the QHP uses a tiered formulary, the prescribed medication must be covered at a tier comparable to the individual's previous plan.

- For a mental health diagnosis, a continuity/transition period of at least 90 days is required by the QHP for medications prescribed by the provider for the treatment of the specific mental health diagnosis. The prescribed medication must be covered at a tier comparable to the individual's original plan.

Issuers must submit a Continuity of Care Plan to the Department of Insurance for review/approval.

DOI/HHS Approach to Certification

The DOI will review Issuer transition plans for compliance with continuity of care standards, as well as Issuer attestations.

Primary data submission method(s): Attestations, Supporting Documentation

2.5.9 Withdrawal from the Marketplace

Delaware QHP Certification Standards

Delaware specific certification standards regarding withdrawal from the marketplace include:

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

    (a) An individual health benefit plan shall be renewable with respect to an enrollee or dependents at the option of the enrollee, except in the following cases:

    (3) A decision by the individual carrier to discontinue offering a particular type of health benefit plan in the state's individual insurance market. A type of health benefit plan may be discontinued by the carrier in the individual market only if the carrier:

    a. Provides notice of the decision not to renew coverage to all affected individuals and to the Commissioner in each state in which an affected insured individual is known to reside at least 90 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the Commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected individuals;

    (4) The carrier elects to discontinue offering and to nonrenew all its individual health benefit plans delivered or issued for delivery in the state. In that case, the carrier shall provide notice of its decision not to renew coverage to all enrollees and to the Commissioner in each state in which an enrollee is known to reside at least 180 days prior to the nonrenewal of the health benefit plan by the carrier. Notice to the Commissioner under this paragraph shall be provided at least 3 working days prior to the notice of the enrollees;

- Issuers withdrawing Small Group plans must comply with 18 Del.C. §§7206 (a)(5),7206(a)(6) a,b and 7206(b), Renewability of coverage, which states:

  (a) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees or dependents, at the option of the small employer, except in any of the following cases:

  (5) Repeated misuse of a provider network provision;

  (6) The small employer carrier elects to nonrenew all of its health benefit plans delivered or issued for delivery to small employers in this State. In such a case the carrier shall:

  a. Provide advance notice of its decision under this paragraph to the commissioner in each state in which it is licensed; and

  b. Provide notice of the decision not to renew coverage to all affected small employers and to the commissioner in each state in which an affected insured individual is known to reside at least 180 days prior to the nonrenewal of any health benefit plans by the carrier. Notice to the commissioner under this subparagraph shall be provided at least 3 working days prior to the notice to the affected small employers;

  (b) A small employer carrier that elects not to renew a health benefit plan under subsection (a)(6) of this section shall be prohibited from writing new business in the small employer market in this State for a period of 5 years from the date of notice to the Commissioner.

<u>DOI/HHS Approach to Certification</u>

The DOI will review Issuer transition plans for compliance with QHP certification standards, as well as Issuer attestations.

Primary data submission method(s): Attestations, Supporting Documentation

2.6 *Rating Factors and Rate Increases*

This Section addresses how the rate review and rate increase process will affect plans that are certifying as QHPs for participation in the Delaware Marketplace will be addressed.

The following will be considered regarding rate increases:

- Issuers' data and actuarial justification provided in the Unified Rate Review Template (URRT);

- Other information submitted as part of a filing under an Effective Rate Review program; and

- Patterns or practices of excessive or unjustified rate increases and whether or not an Issuer should be excluded from participation in the Marketplace;

- Any excess of premium rate growth outside the Marketplace as compared to growth inside the Marketplace

To align with CMS guidance for effective rate review systems, the DOI will consider the following factors in its premium rate analysis, especially with regard to Issuer requests for rate increases.

- Medical cost trend changes by major service categories
- Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits) by major service categories
- Cost-sharing changes by major service categories
- Changes in benefits
- Changes in enrollee risk profile
- Impact of over- or under-estimate of medical trend in previous years on the current rate
- Reserve needs
- Administrative costs related to programs that improve health care quality
- Other administrative costs
- Applicable taxes and licensing or regulatory fees
- Medical loss ratio
- The issuer's capital and surplus
- The impacts of geographic factors and variations
- The impact of changes within a single risk pool to all products or plans within the risk pool; and
- The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

<u>Statutory/Regulatory Standard</u>

Issuers offering non-grandfathered health insurance coverage in the individual and small group markets starting in 2014 must limit variation in plan premiums to age, tobacco use (subject to wellness program requirements in the small group market), family size, and geography (45 CFR 147.102; 45 CFR 156.255). The Federal rule prohibits the use of other rating factors such as health status, medical history, gender, and industry of employment to set premium rates. All rate increases are to be made at the plan level. Federal rules related to rate-setting are listed below:

- *Tobacco Use*. Rates based on tobacco use may vary by up to 1.5:1.

- *Family Composition*. Issuers must add up the premium rate of each family member to arrive at a family rate. However, the rates of no more than the three oldest family members who are under age 21 would be used in computing the family premium.
- *Geography*. A state must have a maximum of seven rating areas. The rating area factor must be actuarially justified for each area.
- *Age*. Issuers must use a uniform age rating curve that specifies the distribution of relative rates across all age bands and is applicable to the entire market. The federal government's proposed age curve anchors the premium amount to age 21, and is expressed as a ratio, for all ages between ages 0 and 64, inclusive, subject to the following:
    - Children: single age band covering children 0 to 14 years of age, where all premium rates are the same
    - Adults: one-year age bands starting at age 15 and ending at age 64
    - Older adults: a single age band covering individuals 64 years of age and older, where all premium rates are the same
    - Rates for adults age 15 and older may vary within a ratio of 3:1

In addition, Delaware has established, as part of its QHP Standards, *a single rating area* to be applied to the entire state.

Furthermore, Issuers must:

- Set rates for an entire benefit year, or for the SHOP, plan year;
- Charge the same premium rate without regard to whether the plan is offered through the Marketplace or directly from the Issuer through an agent and is sold inside or outside of the Marketplace;
- Submit rate information to the Marketplace at least annually;
- Submit a justification for a rate increase prior to the implementation of the increase; and
- Prominently post the justification on its Web site (45 CFR 156.210).

Rate increases for QHPs are subject to the reporting and review requirements in 45 CFR 154.215 related to the submission of a Rate Filing Justification, inclusive of:

- An HHS standardized Unified Rate Review data template – Issuers seeking to offer QHPs must submit the URRT to the state (via SERFF) <u>and to</u> CMS (via HIOS), on the same timeline as the submission of the QHP Application, "Part I"
- If the State requires an Issuer to make changes in the rate filing and the rate filing is altered, causing a change to the URRT, the issuer must revise its URRT in HIOS, ensuring that both the State and CCIIO have matching URRTs.
- A Consumer Narrative Justification (for increases subject to the review threshold), "Part II"
- An actuarial memorandum providing the reasoning and assumptions that support the data submitted in the data template and an actuarial attestation, "Part III"

DOI/HHS Approach to Certification

The DOI and its third party Actuary will review rates for compliance with rating standards, as well as Issuer attestations. For rate increases, a review of the Rate Filing Justification, including Actuarial Memorandum, will be performed. Please see the *Rate Data Template*, *Unified Rate Review Template*, and *Rating Business Rules Template* for detail on the data elements to be collected.

The DOI will, at its sole discretion, implement additional data collections to its rate filing requirements. It may also conduct an outlier test on QHP rates to identify rates that are relatively high and low compared to other QHP rates in the same rating area.

Primary data submission method(s): CCIIO MS Excel Data Templates, Attestation, Supporting Documentation

2.7 *Accreditation Standards*

This information will be Issuer-specific and will only need to be submitted once, per plan year, per Issuer, for all related initial QHP application submissions

Statutory/Regulatory Standard

During an Issuer's initial year of QHP certification (e.g., in 2013 for the 2014 coverage year), a QHP Issuer must have an existing commercial, Medicaid, or Exchange health plan accreditation in Delaware granted by a HHS recognized accrediting entity or must have scheduled, or plan to schedule, a review of QHP policies and procedures with a recognized accrediting entity (45 CFR 155.1045).

Per 45 CFR 155.1045, prior to a QHP Issuer's second and third year of QHP certification (e.g. in 2014 for the 2015 coverage year), a QHP Issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products or must have commercial or Medicaid plan accreditation granted by a recognized accrediting entity for the same state in which the Issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the administrative policies and procedures used in connection with the QHP.

Delaware will follow the final 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.

The accrediting organization will evaluate local performance in the following categories based on (45 CFR 156.275):

- Clinical quality measures, such as the HEDIS
- Patient experience ratings on a standardized CAHPS survey
- Consumer access
- Utilization management
- Quality assurance
- Provider credentialing
- Complaints and appeals
- Network adequacy and access
- Patient information programs

DOI/HHS Approach to Certification

Data verifying accreditation status is received directly in SERFF from the NCQA, URAC and AAAHC. Issuers meeting accreditation standards in the initial year must authorize the release of accreditation survey data to the DOI and Marketplace. An accreditation data file will be received by the NAIC from accrediting entities, loaded into SERFF, and made available for display as part of the plan submission (data will also be sent to HHS). In addition, Issuers, regardless of accreditation status, must provide attestations including acknowledgment that, prior to 2016, CAHPS® data may be used on the Marketplace Internet website and the website may display that a QHP Issuer is accredited if that Issuer is accredited on its commercial, Medicaid or Marketplace product lines.

Plans must be accredited in their 3rd year of participation in the Delaware Marketplace. Therefore, those plans seeking recertification for a second time are required to be accredited no later than (http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf).
August 23, 2016 (final data transfer from SERFF to CMS). Those who are seeking initial recertification need to be accredited in July 2018, and those plans that are seeking first certification must be accredited by July 2020 if they wish to be recertified. Please refer to Delaware State-Specific Standards for Plan Year 2020, ***Attachment 7.*** In addition, CMS Accreditation templates (one for NCQA and one for URAQ) are being implemented in Plan Year 2020 submission cycle.

Primary data submission method(s): Built-in SERFF Fields, Delaware State-Specific Standards for Plan year 2020, *Attestations*

2.8 *Network Adequacy and Provider Data*

This information may be Issuer or QHP-specific. If the provider network in the service area is consistent across all products and plans sold by the Issuer, the Issuer may provide required information and attestations only once. If there is any variation in the provider networks across QHPs, information will need to be provided for each product and/or plan (with the exception of 2.8.3, Mental Health and Substance Abuse Services).

2.8.1 General

Statutory/Regulatory Standard

Per 45 CFR 155.1050, the Exchange must ensure that enrollees of QHPs have a sufficient choice of providers. A QHP's provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay (45 CFR 156.230(a)(2)).

Issuers and QHPs must meet the following certification standards for Network Adequacy as specified in CFR 156.230, which state that a *QHP Issuer must ensure that the provider network of each of its QHPs is available to all enrollees and meets the following standards:*

- Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay;
- Includes essential community providers in accordance with§156.235; and is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

Issuers must have a sufficient number of and a reasonable geographic distribution of essential community providers who are available to ensure reasonable and timely access to a broad range of network service providers for low income and medically underserved individuals in the QHP service area.

Additional Delaware specific certification standards regarding Network Adequacy include:

- 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.
- 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.
- 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.

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

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, the patient can obtain services from an out of network provider after notifying the Issuer. 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.
   - Issuer is required to coordinate with the out-of-network providers for payment and ensure 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.

<u>Telehealth</u>

*"**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;

a. Licensed (in Delaware or Country 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.

Value Network

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

a) 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.
b) Issuers must make available a Value Network Plan in each of the three counties in Delaware (New Castle, Kent and Sussex).
c) 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.
d) 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.
    1. 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.
    2. 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.
e) Issuers of Value Network Plans are required to 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.
f) 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.
g) 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.
h) 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).

DOI/HHS Approach to Certification

To fulfill the network adequacy requirement, an Issuer must be accredited with respect to network adequacy by an HHS-recognized accrediting entity and attest to complying with the following standards to demonstrate it has an adequate range of providers for the intended service areas:

- Issuer will maintain a provider network that is sufficient in number and types of providers to assure that all services are accessible without unreasonable delay, as specified in 45 CFR 156.230(a)(2)
- Issuer's network meets applicable Delaware network adequacy requirements as defined above.
- Issuer's network reflects executed contracts for the year in which the Issuer is applying.

Issuers are required to complete and submit the *Delaware QHP Network Access Plan Cover Sheet Template.* This template can be found at the end of this Issuer Submission Guide in ***Attachment 5.***

Issuers are also required to complete and submit the Delaware Issuer Network Adequacy Detailed Analysis Template which will be available for download by Issuers in SERFF.

The DOI will monitor network adequacy, for example, via complaint tracking and/or gathering network data from any QHP Issuer at any time to determine whether the QHP's network(s) continues to meet federal and state certification requirements.

Primary data submission method(s): Attestations, Supporting Documentation, Delaware State-Specific QHP Standards for Plan Year 2020.

2.8.2 Essential Community Providers

Statutory/Regulatory Standard

Issuers must ensure that the provider network for a QHP has a sufficient number and a geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of network service providers for low-income, medically underserved individuals in the QHP's service area (45 CFR 156.235).

ECPs are defined in section 340B(a)(4)of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care.

Additionally, 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 Medicaid 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.

DOI/HHS Approach to Certification

The state will follow the proposed federal standards for Essential Community Provider.

In this section, Issuers must denote the ECP's with which they have contracts for each network in which they plan to provide coverage.

Based on an HHS-developed ECP list, the DOI will verify one of the following:

- Contracts with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network;
- Offers contracts in good faith to at least one ECP in each ECP category in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the Issuer plan type.
- Issuer complies with additional Delaware standards regarding Federally Qualified Health Centers as defined above.
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission.

Justifications submitted by Issuers that fail to achieve any standard will undergo stricter review by the DOI.

Issuers that provide a majority of covered services through employed physicians or a single contracted medical/dental group must comply with the alternate standard established by the Exchange (45 CFR 156.235(b)), as follows:

- Issuer has at least the same number of providers located in designated low-income areas
- Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its QHP submission
- Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its submission
- Dental plans that are embedded within Issuer's health plans will be held to the same standards as Stand Alone Dental Plans (SADPs).

Failure to comply with these standards will be a basis for not certifying a plan as a QHP. To assist Issuers in identifying these providers, CMS has published a non-exhaustive list of available ECPs based on data maintained by CMS and other federal agencies, and will include identifying and

contact information for each provider. In addition, the DOI has provided Issuers with a list of dental providers currently under contract with the state's CHIP program.

Issuers will indicate which ECPs are included in their provider network(s) by populating a template as part of the QHP application. Please see the *Essential Community Providers Template* for more detail on the data elements to be collected. Issuers will be permitted to write in ECPs not on the CMS-developed list for consideration as part of the DOI's review. DOI will use the *CMS ECP Tool* as part of this review.

If applicable, the Issuer must complete and submit the *ECP Supplemental Response* template, which can be found under Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): Attestation, CCIIO MS Excel Data Templates, Supporting Documentation

2.8.3 Mental Health and Substance Abuse Services

Statutory/Regulatory Standard

Issuers must ensure that the provider network for the QHP has a sufficient number and type of providers that specialize in mental health and substance abuse services to assure that mental health and substance abuse services will be accessible without unreasonable delay (45 CFR 156.230(a)(2)).

Additionally, Issuers are reminded that the state requires plans offered in the Individual Exchange market to comply with Delaware Insurance code 18Del.C §3343, and plans offered in the small group market to comply with 18 Del.C §3578 **as amended by Del. S.B. 230/Del. S.A. 1, 149th Gen. Assem. § 1 (2018.)**

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DOI/HHS Approach to Certification

Issuers must establish a standard to ensure that the QHP network complies with the Federal standard. A copy of this standard must be included in this application, and the Issuer must certify that the provider network for this QHP meets this standard.

Primary data submission method(s): Attestation, Supporting Documentation, Mental Health Parity Addiction and Equity Act Issuer Checklist and Certification Template

2.8.4 Service Area

Statutory/Regulatory Standard

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.

Delaware does not allow plans with Partial Services Areas.

DOI/HHS Approach to Certification
Data elements such as service area ID and name will be collected from Issuers using the CCIIO standard data template and reviewed by the DOI for compliance with the State standard. Please note that the standard SERFF template used includes a field to indicate whether or not the service area is a partial county; this does not apply in Delaware. Please see the *Service Area Template* for additional detail on the data elements to be collected.

Primary data submission method(s): CCIIO MS Excel Data Template, Attestation

2.8.5 Provider Directory

Statutory/Regulatory Standard
A QHP Issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request (45 CFR 156.230 (b)).

The Issuer's Provider Directory must be updated, at a minimum, on a monthly basis and must be easily accessible to the general public. As such, the public should be able to view all of the current providers contracted with a plan on the Issuer's public website through a clearly identifiable link or tab. The public should be able to view all of this information without needing to enter a policy number or create an account. The general public should be able to easily discern which providers participate in which plan(s) and provider network(s) and if they are accepting new patients. Furthermore, if the health plan issuer maintains multiple provider networks, the plan(s) and provider network(s) associated with each provider should be clearly identified on the website. An active provider link is required.

DOI/HHS Approach to Certification
Issuers will be asked to provide their network names, IDs, and active URL in the *Network Template.*

Primary data submission method(s): CCIIO MS Excel Data Templates

2.9 Marketing, Applications, and Notices

This information may be Issuer-specific or QHP-specific.

Statutory/Regulatory Standard
Issuers must not employ marketing practices that will discourage individuals with significant health needs from enrolling in their QHP (45 CFR 156.225). In addition, all QHP enrollee applications and notices must comply with Federal standards in 45 CFR 155.230 and 156.250, including being provided in plain language and language that is accessible to people with Limited English Proficiency and disabilities.

Issuers must also comply with Delaware 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.

DOI/HHS Approach to Certification

Issuers will be asked to attest to compliance with the ACA requirements related to nondiscrimination in marketing practices. Issuers must also submit a copy of all marketing materials, application, and notices for DOI review and approval as either a URL in the *Plan and Benefits Template* or as Supporting Documentation in the Plan Management tab in SERFF.

Primary data submission method(s): Attestation; Supporting Documentation

2.10 *Quality Standards*

This information may be Issuer-specific or QHP-specific.

Statutory/Regulatory Standard

A rating system has been developed that will rate QHPs offered through an Exchange at each benefits level on the basis of the relative quality and price (ACA § 1311(c)(3)) and an enrollee satisfaction survey system (ACA § 1311(c)(4)). In addition, Issuers must implement a Quality Improvement Strategy (QIS) that complies with the description in ACA § 1311(g)(1), i.e., uses provider reimbursement or other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, and implement wellness programs.

Consistent with 45 C.F.R. 156.200(b)(5), in order to demonstrate compliance with the quality reporting standards as part of the certification process for the 2020 coverage year, QHP Issuers will be required to attest that they comply with the specific quality reporting and implementation requirements related to the QRS and QHP Enrollee Survey.

Additionally, per federal regulation 45 CFR, §156.20, Issuers must:

- Implement and report on a quality improvement strategy or strategies consistent with standards of section 1311(g) of the Affordable Care Act, disclose and report information on healthcare quality and outcomes described in sections 1311(C) (1) (H) and (l) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable care Act; Strategies in ACA Section 1311(g);

- Develop a payment structure that provides increased reimbursement or other incentives for improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

- Implement policies and procedures to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and cost discharge reinforcement by an appropriate health care professional. (not applicable to Stand-alone Dental Plans);

- Implement policies and procedures to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

- Coordinate the implementation of wellness and health promotion activities; and

- Implement policies and procedures to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.

Delaware will also apply the following state-specific QHP Certification Standards with regard to Quality Improvement Strategy.

- Issuers will be required to participate in a state quality improvement workgroup 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 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. Beginning January 2020, 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.
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.

Payers must support reporting for the common provider scorecard and overall scorecard consistent with the recommendations of the Delaware Center for Health Innovation.

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.

DOI/HHS Approach to Certification

Issuers will be required to attest to compliance with various Federal and State quality requirements. In addition to the attestations, Issuers are required to submit a narrative describing the approach they will take to meet the new Quality Improvement Strategy Standards.

Issuers seeking re-certification in 2020 must attest that they have entered into a formal agreement with the DHIN.

Issuers will also be required to complete and submit a *Delaware Quality Improvement Strategy Workgroup Designation Form.* This template can be found at the end of this Issuer Submission Guide in ***Attachment* 6**.

Primary data submission method(s): Attestation, Supporting Documentation

2.11 *Meaningful Difference to Support Informed Consumer Choice*

In the 2020 Payment Notice Final Rule, CMS removed the meaningful difference requirement as part of QHP certification. Therefore, CMS no longer requires QHP issuers to demonstrate meaningful difference and no longer conducts meaningful difference reviews.

DOI/HHS Approach to Certification

Delaware intends to ensure that consumers can make an informed selection among plan choices that the consumer can readily differentiate and compare.

2.12 *Segregation of Funds for Abortion Services*

This information is QHP-specific.

Statutory/Regulatory Standard

In the case of Issuers that cover abortions for which federal funding is prohibited, the ACA bars the use of federal funds "attributable" to either the advance refundable tax credit or cost-sharing reduction under the Act for those abortions. The ACA requires Issuers to create allocation accounts that separate the portion of premiums/tax credits/cost-sharing subsidies for covered services *other* than non-excepted abortions from the premium amount equal to the actuarial value of the coverage of abortion services. Issuers must exclusively use funds from these separate accounts to pay for the services for which the funds were allocated (e.g., funds for services other than non-excepted abortions cannot be used to pay for non-excepted abortions).

Additionally, the ACA requires Issuers to provide a notice to enrollees of abortion coverage as part of the summary of benefits and coverage explanation at the time of enrollment; specifies that notices provided to enrollees, advertisements about qualified plans, information provided by Exchanges, and any other information specified by the Secretary, must provide information with respect to the total

amount of the combined premium/tax credit/cost sharing subsidy payments for services covered by the plan and in connection with abortions for which federal funding is prohibited; and prohibits qualified health plans from discriminating against any health care provider or any health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortion.

Issuers offering coverage for non-excepted abortion services must submit a segregation plan that details its process and methodology for meeting the requirements of Section 1303(b)(2)(C), (D), and (E) of the ACA. The segregation plan must describe the health plan's financial accounting systems, including appropriate accounting documentation and internal controls, which would ensure the segregation of funds required by the ACA. The plan should address items including the following:

- The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of non-excepted abortion services from those received for coverage of all other services, which may be supported by Federal premium tax credits and cost-sharing reduction payments
- The financial accounting systems, including accounting documentation and internal controls that would ensure that all expenditures for non-excepted abortion services are reimbursed from the appropriate account
- An explanation of how the health plan's systems, accounting documentation, and controls meet the requirements for segregation accounts under the law

DOI/HHS Approach to Certification

Issuers will be asked to annually attest that they will comply with Federal requirements related to segregation of funds for abortion services, as well as provide a segregation plan. The DOI will perform periodic financial audits of each QHP to assure compliance with Section 1303 of the ACA.

Primary data submission method(s): Attestation, Supporting Documentation

2.13 *Past Complaints/Compliance*

This review may be Issuer-specific or QHP-specific.

Statutory/Regulatory Standard

The Exchange may certify a health plan as a QHP if it determines it is in the interest of qualified individuals and qualified employers in the State to do so (155.1000 (c)(2)).

DOI/HHS Approach to Certification

As part of the "interest" standard, the DOI may perform an analysis of past compliance and complaints for existing insurers. Existing data sources will be used for this analysis, therefore Issuers are not required to complete or upload any specific data for this standard.

Primary data submission method(s): None

2.13.1 Transparency

Issuers seeking certification of a health plan as a QHP must make accurate and timely disclosures of certain information to the appropriate Marketplace, the Secretary of HHS, and the state insurance commissioner, and make it available to the public.

3. SHOP-specific Requirements

This information is QHP-specific.

Statutory/Regulatory Standard

SHOP QHPs will be required to comply with SHOP-specific criteria as outlined in 45 CFR §156.285 of the final federal rule.

SHOP QHPs will also be required to comply with the following federal and state regulations and standards:

- Federal regulation 45 CFR §155.725 describing Employer-defined contribution approach
- Delaware Insurance code 18 Del.C. §7205(4) regarding restrictions relating to premium rates
- Delaware Insurance code 13 Del.C. §201 regarding Civil Unions
- Delaware Insurance code 18 Del.C. §3513 regarding grace period for premium payment
- Delaware Insurance code 18 Del.C. §7206(a)(6)(a and b) regarding noticing requirements related to non-renewal of all its health benefit plans

The DOI also reminds Issuers and brokers/producers that, within the Individual Exchange and FF-SHOP, Issuers are required to pay the same commissions offered in the state outside the exchange for similar product offerings.

DOI/HHS Approach to Certification

Reviews of SHOP plans will be conducted through the same process, timelines and criteria as for Individual plans with the exception that SHOP plans will also be reviewed for compliance with the standards mentioned above.

Primary data submission method(s): Attestation, Supporting Documentation

4. Issuer Attestations

Documents including all attestations along with instructions will be available for download by Issuers in SERFF. Issuers will review, complete, provide an electronic signature, and upload back into SERFF. Issuers must comply with both Federal Program Attestations that were developed by HHS and Delaware state-specific Attestations.

4.1 HHS Requirements

HHS requires Issuers seeking certification and/or recertification of qualified health plans to complete and submit *a Statement of Detailed Attestations Responses*. CCIIO and the NAIC have indicated that Issuers will be able to download a PDF document with the attestations in SERFF, provide an electronic signature, and upload back into SERFF for submission to the State and HHS. Similar to last year, Delaware anticipates that if an Issuer does not fully attest to all attestations in the Program Attestations, an Issuer will be required to submit the *Statement of Detailed Attestation Responses* document, which allows Issuers to provide an explanation on non-compliance with an attestation. Detailed instructions regarding both documents will be available in the SERFF application prior to the opening of the submission window.

4.2 Delaware Requirements

Delaware specific standards require Issuers to complete and submit *Delaware Marketplace Attestations & Compliance Form. See* ***Attachment 2.***

ATTACHMENTS

2020 Medical Issuer QHP Submission Guide

Attachment 1: Summary of Submission Requirements
Delaware QHP Application
Submission Requirements Plan Year 2020

For certification of a plan as a QHP effective beginning in 2020, Issuers must submit a complete QHP application for all plans they intend to offer on the Delaware Marketplace, or offer as a certified SADP off the Marketplace. As a Plan Management Partnership State, Delaware DOI will conduct, in concert with CMS, a full review of all current and new Issuers applying for QHP certification in Delaware. ***Please note*** *that certification eligibility only applies to QHPs that are to be offered on Delaware's Marketplace/SHOP and to SADPs seeking certification for both On- and Off-Exchange. SERFF Binder submissions are NOT applicable to QHP medical plans to be offered exclusively OFF Marketplace.*

The Table below provides a list of templates and supporting documentation to support Issuer applications for certification of qualified health plans (QHPs) and stand-alone dental plans (SADPs) for Plan Year 2020. The requirements are grouped into two main categories: 1) Templates and Supporting Documentation requirements developed by CMS; and 2) Templates and Supporting Documentation requirements that have been developed and implemented by DOI to support its QHP review process. All templates (both CMS and Delaware-specific) will be available to Issuers through SERFF. Issuers may also review the CMS QHP Application instructions, templates, supporting documentation and justification documents located at http://cciio.cms.gov/programs/exchanges/qhp.html .

The Table indicates which type of template/supporting document is applicable for each type of QHP Application, (i.e., those applicable for QHP medical submissions and SADP submissions). It also identifies under which SERFF 'Filing tab' the Issuer is required to submit it (i.e., Form Filing, Binder, and/or Rate Filing). In some cases, Issuers are required to submit the same template in multiple 'tabs'. In these cases, it is the Issuer's responsibility to ensure that all applicable tabs contain the most current version of the completed template.

The Table also indicates the applicability of each template and supporting documentation, as follows:

- **Required**: template or supporting document must be included in the Issuer's initial QHP Application
- **Not Required**: template or supporting document is not to be included in the Issuer's QHP Application
- **Required Under Special Circumstances**: template or supporting documentation is must be included in the Issuer's initial QHP Application if the plans included in the submission meet certain criteria, for example, EHB substitution or unique plan design.
- **If Applicable**: template or supporting document must be included in the Issuer's initial QHP Application to provide justification for failing to meet QHP certification criteria, such as inadequate drug class/count or cost-share arrangements that exceed established limits.
- **If Requested**: template or supporting document must be submitted by the Issuer, following the initial QHP Application, following a formal request by DOI or CMS/CCIIO Plan Management QHP Review team.

For Plan Year 2020, both CMS and DOI have, in some areas, made significant changes to the type and content of template and supporting documentation required for QHP certification application. Issuers are strongly urged to review

each template and supporting document requirement carefully, and reach out to CMS or DOI with questions prior to submission. In most cases, but not all, a template has been provided to standardize the data collection across Issuers. In those instances where a template is not provided, Issuers are instructed to submit the information, as instructed, and include the Issuer's name, market (Individual/SHOP), and HIOS Plan IDs that the documentation supports.

PLEASE NOTE: The DOI instructs all Issuers to utilize the CMS Data Integrity Tool and all applicable CMS QHP Application Tools prior to submission of CMS emplates through SERFF and to submit full, clean and accurate information, as required/requested in its QHP Application. This includes both the initial submission and any subsequent submission of templates throughout the Review Cycle. Issuers are also instructed to ensure that templates and supporting documentation are submitted within the appropriate SERFF tab (i.e., Binder, Form Filing, Rate Filing), as indicated. Lastly, Issuers are instructed to notify the DOI, by email, of any re-submission of templates or supporting documentation prior to submission, whether or not the resubmission is requested by the CMS or DOI Plan Management team.

Delaware QHP Application Submission Requirements PY2020

Template / Supporting Document	SERFF Filing Submission Tab (Form, Binder, Rate)	QHPs & SADPs offered On or Both On/Off Marketplace		SADPs offered Off Marketplace Only
		Medical QHPs	SADPs	
Plan ID Crosswalk Template	**Binder** Templates	Required*	Required*	Not Required
State Authorization Form (Plan ID Crosswalk)	**Binder** Supporting Documents	Required	Required	Not Required
Compliance Plan and Organizational Chart Cover Sheet	**Binder** Supporting Documents	Required	Required	Required
Issuer Compliance Plan	**Binder** Supporting Documents	Required	Required	Required
Issuer Organizational Chart	**Binder** Supporting Documents	Required	Required	Required
SPM Statement of Detailed Attestations	**Binder** Supporting Documents	Required	Required	Required
Accreditation Templates NCQA, URAQ, AAAHC	**Binder** Templates	Required	Not Required	Not Required
Evidence of Issuer Licensure and Good Standing**	**Binder** Supporting Documents	Required	Required	Required
Network ID Template	**Binder** Templates	Required	Required	Required
Essential Community Provider/Network Adequacy Template	**Binder** Templates	Required	Required	Required
Supplementary Response: Inclusion of Essential Community Providers	**Binder** Supporting Documents	If Applicable	If Applicable	If Applicable

Template / Supporting Document	SERFF Filing Submission Tab (Form, Binder, Rate)	QHPs & SADPs offered On or Both On/Off Marketplace		SADPs offered Off Marketplace Only
		Medical QHPs	SADPs	
Plan and Benefits Template (plus Add-In)	**Binder** Templates	Required	Required	Required
Uniform Actuarial Value Plan Justification Form	**Binder** Supporting Documents	Required for Unique Plan Design	Not Required	Not Required
EHB Substituted Benefit Justification	**Binder** Supporting Documents	If applicable	If applicable	If applicable
Discrimination – Cost Sharing Outlier Justification	Binder Supporting Documents	If Requested	If Requested	If Requested
Limited Cost Sharing Plan Variation – Estimated Advance Payment Supporting Documentation and Justification	Binder Supporting Documents	Required	Not Required	Not Required
Cost Sharing – Supporting Documentation and Justification for Exceeding Annual Limitation on Small Group Deductibles	**Binder** Supporting Documents	If Applicable	If Applicable	If Applicable
Cost Sharing – Supporting Documentation and Justification for Exceeding Annual Limitation on out of Pocket Expenses ("Nesting" Justification)	**Binder** Supporting Documents	If Applicable	If Applicable	If Applicable
Cost Sharing – Supporting Documentation and Justification for Exceeding Limitation on Small Group Out of Pocket Maximums	**Binder** Supporting Documents	If Applicable	If Applicable	Not Required
Marketing Language Justification	**Binder** Supporting Documents	If Requested	If Requested	If Requested
Meaningful Difference Justification	**Binder** Supporting Documents	If Requested	Not Required	Not Required
SADP Actuarial Value	**Binder** Supporting Documents	Not Required	Required	Required
SADP Disclosure of Arbitration and Allocation Methods	**Binder** Supporting Documents	Not Required	Required	Required
Prescription Drug Template	**Binder** Templates	Required	Not Required	Not Required
Drug Formulary Inadequate Category/Class Count	**Binder** Supporting Documents	If Applicable	Not Required	Not Required

Template / Supporting Document	SERFF Filing Submission Tab (Form, Binder, Rate)	QHPs & SADPs offered On or Both On/Off Marketplace		SADPs offered Off Marketplace Only
		Medical QHPs	SADPs	
Support Documentation and Justification				
Discrimination—Formulary Outlier Review	**Binder** Supporting Documents	If Applicable	Not Required	Not Required
Discrimination—Formulary Clinical Appropriateness	**Binder** Supporting Documents	If Applicable	Not Required	Not Required
Discrimination—Formulary Treatment Protocol	**Binder** Supporting Documents	If Applicable	Not Required	Not Required
Quality Improvement Strategy (QIS) Implementation and Progress Report Form	**Binder** Supporting Documents	Required***	Not Required	Not Required
Service Area Template	**Binder** Templates	Required	Required	Required
Business Rules Template	**Binder** Templates	Required	Required	Required
Rate Data Template	**Binder** Templates	Required	Required	Required
Part I – Uniform Rate Review Template	**Rate Filing & Binder** Templates	Required	Not Required	Not Required
Part II – Consumer Preliminary Justification Narrative (reference Delaware General Instructions)	**Rate Filing & Binder** Supporting Documents	Required	Not Required	Not Required
Part III – Actuarial Memorandum (complete)	**Rate Filing & Binder** Supporting Documents	Required	Not Required	Not Required
Part III – Actuarial Memorandum (redacted)	**Rate Filing & Binder** Supporting Documents	Required	Not Required	Not Required
Summary of Benefits and Coverage **for each Plan Variation Level**	**Form Filing** Supporting Documents	Required	Not Required	Not Required
Delaware-specific Data Collection Templates and Supporting Documentation Requirements				
Delaware Marketplace QHP Attestation and Compliance Form – **Health**	**Binder** Supporting Documents	Required	Not Required	Not Required
Delaware Marketplace QHP Attestation and Compliance Form – **SADP**	**Binder** Supporting Documents	Not Required	Required	Required
Delaware Issuer EHB Crosswalk and Certification Form – **Health**	**Form Filing** Supporting Documents	Required	Not Required	Not Required

Template / Supporting Document	SERFF Filing Submission Tab (Form, Binder, Rate)	QHPs & SADPs offered On or Both On/Off Marketplace		SADPs offered Off Marketplace Only
		Medical QHPs	SADPs	
Delaware Issuer EHB Crosswalk and Certification Form – **SADP**	**Form Filing** Supporting Documents	Not Required	Required	Required
Delaware Issuer MHPEA Checklist and Certification Form	**Form Filing** Supporting Documents	Required	Not Required	Not Required
DE Continuity of Care Plan – **NOTE: No template provided; narrative required**	**Binder** Supporting Documents	Required	Required	Not Required
DE Withdrawal Transition Plan – **NOTE: No template provided; narrative required**	**Binder** Supporting Documents	Required	Required	Not Required
Issuer's *Network Access Plan & Policies* – **NOTE: No template provided; narrative required**	**Binder** Supporting Documents	Required	Required	Not Required
DE Network Access Plan Cover Sheet Template	**Binder** Supporting Documents	Required	Required	Not Required
DE Network Adequacy Detailed Analysis Template	**Binder** Supporting Documents	Required	Required	Not Required
Delaware Quality Improvement Strategy Workgroup Member Designation	**Binder** Supporting Documents	Required	Required	Optional
Delaware content requirements and format guidelines for Part II Preliminary Justification (reference Delaware General Instructions)	**Rate Filing** Supporting Documents	Required	Not Required	Not Required

**** Applies to all Issuers that offered Individual Market QHPs/SADPs through the Delaware Marketplace in 2020.***

*****Issuers must provide one of the following supporting documents with their QHP Application: State license, certificate of authority, certificate of compliance, or an equivalent form or document for the product(s) the Issuer intends to offer on the Delaware Marketplace.***

******Issuers participating in a Marketplace for two or more consecutive years who are applying for QHP certification in the Delaware will submit QIS information during the 2020 QHP Application Period.***

Attachment 2: Delaware Marketplace QHP Attestations & Compliance Form – Medical Issuers

All Medical QHP Issuers are required to complete and submit the following Attestations sheet indicating compliance with Delaware rules, regulations and state-specific QHP Certification Standards for Plan Year 2020.

I, _____, _____ of
(Name) *(Title)*
_____, attest that the plan submission (_____)
(Company / NAIC Co-Code) *(HIOS Plan ID Number)*

is in compliance with all of the laws, regulations, rules, guidance, and standards outlined below.

Check (√) "Y", "N", or "NA" for each of the items below to indicate that the plan complies with each item. If supporting documentation is included, please indicate the appropriate the page number.

Y	N	N/A	
			1. Compliance with State Rules & Regulations
			a. Plan complies with Delaware Insurance Law - Chapters 33 and 36, Regulation 1304 - Individual Health Forms
			b. Plan complies with Delaware Insurance Law - Chapter 72, Regulation 1308; Forms & Rates Bulletins Nos. 11-13 - Small Employer
			c. Plan complies with Delaware Insurance Law - Chapter 35, Forms & Rates Bulletin 17 - Group & Blanket Health
			2. Accreditation
			Plan complies with federal and state accreditation standards, including provisions in 45 CFR §156.275; 45 CFR §155.1045, and the additional Delaware requirement that all QHP Issuers must be accredited on the QHP product type by the **third year of operation**.
			Note: The state will follow the final 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. Issuers are to be accredited before final approval.
			3. Network Adequacy
			a. Plan complies with requirement that QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located: in a urban/suburban area 15 miles; and for a rural area 25 miles From the member's place of residence.
			b. 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)
			c. Plan complies with requirement that 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 including oversight process regarding timely access to care and services.
			d. 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 Medicaid 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.
			e. Issuer has and will maintain a provider network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, dental providers (if applicable), Endocrinology, Infectious Disease, Oncology, Outpatient Dialysis, Primary care, Rheumatology and Hospital Systems to assure that all services will be accessible to enrollees without unreasonable delay.
			f. Each primary care network has at least one (1) full time equivalent Primary Care Provider for every 2,000 patients.
			g. Each plan's network has 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.
			h. Issuer's QHP network includes ratios calculated on a count of all patients served by the provider across all of the health plans marketed by the issuer.
			4. Rating Areas Attestation
			Plan rates do not vary by geographical rating area, as the state of Delaware permits only one rating area.
			5. Service Area Attestation
			Plan complies with requirement that 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.
			6. DHIN Quality Improvement Standards
			a. Plan Issuer implements a QIS in accordance with the State and Federal requirements. And §1311(c)(1)(E) of the Affordable Care Act.
			b. Plan Issuer will 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 improve health outcomes, medical home models and technology and data analytics to support coordination and improved quality and outcomes.
			c. Plan Issuer has entered into a formal agreement with the Delaware Health Information Network (DHIN), and will participate in and utilize the DHIN data use services and claims data submission services for all plans offered on the Delaware Marketplace, at prevailing fee structure, to

			support care coordination and a comprehensive health data set as a component of state quality improvement strategy, unless plan is a stand-alone dental plan.
			d. Plan Issuer has a QIS which includes activities related to at least one of the following: ● Improving Health Outcomes; ● Preventing Hospital Readmissions; ● Improving Patient Safety and Reducing Medical Errors; ● Promoting Wellness and Health; and/or ● Reducing Health and Health Care disparities.
			e. Plan Issuer adheres to guidelines, including the CMS QIS Technical Guidance and User Guide, established by the Secretary of HHS in consultation with experts in health care quality and stakeholders.
			f. Plan Issuer implements and reports on a QIS, including a payment structure that provides increased reimbursement or other market-based incentives in accordance with the health care topic areas in Section 1311(g)(1) of the Affordable Care Act, for each QHP offered in a Marketplace.
			g. Plan Issuer complies with 45 C.F.R. 156.1130 requiring a Plan Issuer to submit data annually in a manner and timeframe specified by the marketplace to support the evaluation of quality improvement strategies in accordance with §155.200(d).
			7. Marketing and Benefit Design
			Plan marketing and benefit design complies with and will continue to 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.
			8. Dental Compliance with Title 18, Chapter 38 (if applicable)
			Plan complies with Delaware Title 18, Chapter 38 (Dental Plan Organization Act) if plan is offering dental coverage, including embedded dental coverage. (If plan does not offer dental coverage, mark this item as N/A.)
			9. Actuarial Value
			Plan Issuer has separately offered or plans to offer in the same plan year at least one QHP at the Bronze level, as well as the Silver and Gold as required by the federal standard 45 CFR §156.225.
			10. Marketing Regulations and Transparency
			Plan complies with state and federal marketing and transparency regulations, including the Unfair or Deceptive Acts and Unfair Methods of Competition Act (Delaware Insurance Code Title 18§23; 18 Del Admin Code§ 1302) as well as federal regulations including, but not limited to, 45 CFR **§**156.220 which requires the publication of cost-sharing data on Issuer Internet web site.
			11. Market Reform Rules
			Plan complies with all state and Federal Market Reform rules including, but not limited to PHS 2701; PHS 2702; PHS 2703; PPACA §1302(e); PPACA §1312(c); PPACA §1402; 43 CFR §156; 42 CFR §147.
			12. Compliance with Essential Health Benefits
			a. Plan includes pediatric dental benefits that are substantially equal to benefits offered in the Delaware pediatric dental benchmark plan (CHIP). Note: If plan does not include dental benefits, mark this item as N/A.
			b. Plan includes medical benefits that are substantially equal to the benefits offered in the Delaware benchmark plan (BCBS EPO).
			c. Plan includes coverage of habilitative devices and services that are separate and equal to those offered for rehabilitative devices and services.

			d. Plan includes pediatric vision benefits that are substantially equal to the benefits offered in the Delaware vision benchmark plan (FEDVIP)
			13. Continuity of Care
			a. Plan Issuer has 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 includes a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. Plan Issuer is responsible for executing the Transition plan.
			b. Plan Issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c.18 subsection §3608 for Individual plans.
			c. Plan Issuer agrees to comply with withdrawal and transition plan requirements as stated in Del.c.18 subsection §7207 for Small Group plans.
			d. Plan Issuer has submitted a withdrawal and transition plan to the Department of Insurance for review/approval.
			e. For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, plan Issuer agrees to cover the service for a lesser of: a period of 90 days or until the treating provider releases the patient from care.
			f. Plan Issuer agrees to provide a continuity/transition period of at least 60 days for medications prescribed by a provider and agrees to cover the prescribed medication at a tier comparable to the plan from which the individual was transitioned.
			g. Plan Issuer agrees to provide a continuity/transition period of at least 90 for a mental health diagnosis and agrees to cover medications prescribed by the treating provider for the treatment of the specific mental health diagnosis for at least 90 days. Issuer agrees that the prescribed medication must be covered at a tier comparable to the plan from which the individual transitioned.
			14. Patient Safety Standards for QHP Issuers
			Issuer agrees that its QHPs are in compliance with patient safety standards, as outlined in 45 CFR 156.1110(a)(2), for network hospitals with more than 50 beds, and that the Issuer and QHP collect and maintain the required documentation from its network hospitals to verify that the hospital utilizes a patient safety evaluation system as defined in 42 CFR 3.20 and has implemented a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient
			15. Transparency
			Plan Issuer agrees to ensure that clear and plain language is used to communicate information to consumers and members regarding a plan's cost sharing, including, but not limited to, information published on the company's website, included in plan enrollee packets or provided as part of member notifications.
			16. Broker/Producer Compensation
			Plan Issuer agrees to ensure that commissions paid to brokers/producers for QHPs sold through the Individual Marketplace and FF-SHOP are the same as those paid for similar health plans offered in the State outside the Marketplaces.
			17. Required Use of CMS Review Tools and Data Integrity Tool
			Review Tools and CMS Data Integrity Tool have been run, as appropriate, against the Issuer's data, and that errors identified by the tools have been resolved prior to submission of data templates.

			18. Alignment of Data Template information with Form filing documentation, including Summary of Benefits and Coverage (SBCs)
			Issuer agrees to ensure accurate and appropriate alignment of all information included in the Issuer's QHP Application and related Form Filings, including all templates, supporting documentation, and the plan policy documentation, such as the plan's contract and policy documentation, Summary of Benefits and Coverage and Schedule of Benefits.

_____ _____

Printed Name/Title *Signature/Date*

Attachment 3: Delaware Issuer EHB Crosswalk and Certification Template – Health Care

Issuer Essential Health Benefits (EHB) Crosswalk and Certification For Plan Year 2020							
[INSERT ISSUER'S NAME]							
The benefits included in the State of Delaware's Benchmark, Including applicable supplements for pediatric vision and dental and habilitative devices and services, are Essential Health Benefits and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 C.F.R. §§147.150 & 156.100 et. Seq., unless otherwise noted. As allowed for in federal regulation, all Delaware state-mandated benefits enacted prior to January 1, 2012 are included in the State's Essential Health Benefit benchmark.							
The Issuer must complete and submit this EHB Crosswalk and Certification as a supplement to its Form Filings for each plan.							
Benefits	**EHB**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Exclusions**	**Description and Location of Benefit in Issuer's Policy Form**
Primary Care Visit to Treat an Injury or Illness	Yes	Covered	No				See Page ____ of _____.
Specialist Visit	Yes	Covered	No				See Page ____ of _____.
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	No				See Page ____ of _____.

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	No				See Page ____ of _____.
Outpatient Surgery Physician/Surgical Services	Yes	Covered	No				See Page ____ of _____.
Hospice Services	Yes	Covered	No			Private duty nursing; respite care; care not prescribed in the approved treatment plan; financial, legal or estate planning, and; hospice care in an acute care facility, except when a patient in hospice care requires services in an inpatient setting for a limited time.	See Page ____ of _____.
Routine Dental Services (Adult)	No	Not Covered	No				See Page ____ of _____.
Infertility Treatment	No	Not Covered	No				See Page ____ of _____.
Long-Term/Custodial Nursing Home Care	No	Not Covered	No				See Page ____ of _____.
Private-Duty Nursing	Yes	Covered	Yes	240	Hours per Year	This care isn't covered when done in special care units of the hospital, such as: self-care units; selective care units; intensive care units	See Page ____ of _____.
Routine Eye Exam (Adult)	No	Covered	Yes	1	Visit(s) per 2 Years		See Page ____ of _____.
Urgent Care Centers or Facilities	Yes	Covered	No				See Page ____ of _____.

Home Health Care Services	Yes	Covered	Yes	3/100	visits per week/visits per benefit period	Chronic condition care is not covered; drugs; lab tests; imaging services; inhalation therapy; chemotherapy and radiation therapy; dietary care; durable medical equipment; disposable supplies; care not prescribed in the approved treatment plan; volunteer care	See Page ____ of _____.
Emergency Room Services	Yes	Covered	No				See Page ____ of _____.
Emergency Transportation/Ambulance	Yes	Covered	No				See Page ____ of _____.
Inpatient Hospital Services (e.g., Hospital Stay)	Yes	Covered	No				See Page ____ of _____.
Inpatient Physician and Surgical Services	Yes	Covered	No				See Page ____ of _____.
Bariatric Surgery	Yes	Covered	No				See Page ____ of _____.
Cosmetic Surgery	No	Not Covered	No				See Page ____ of _____.
Skilled Nursing Facility	Yes	Covered	Yes	120	Days per Admission	Intermediate, rest and homelike care not covered	See Page ____ of _____.
Prenatal and Postnatal Care	Yes	Covered	No				See Page ____ of _____.
Delivery and All Inpatient Services for Maternity Care	Yes	Covered	No				See Page ____ of _____.

Mental/Behavioral Health Outpatient Services	Yes	Covered	No			Exclusions include “certain mental health and substance abuse services, including: aptitude tests, testing and treatment for learning disabilities, treatment for personality disorders, treatment [of] factitious disorders, treatment of sleep disorders, treatment of sexual and gender identity disorders, care beyond that needed to determine mental deficiency or retardation, marital/relationship counseling, and care at behavioral health facilities.”	See Page ____ of _____.

Mental/Behavioral Health Inpatient Services	Yes	Covered	No			Exclusions include “certain mental health and substance abuse services, including: aptitude tests, testing and treatment for learning disabilities, treatment for personality disorders, treatment [of] factitious disorders, treatment of sleep disorders, treatment of sexual and gender identity disorders, care beyond that needed to determine mental deficiency or retardation, marital/relationship counseling, and care at behavioral health facilities.” Methadone is not covered	See Page ____ of _____.
Substance Abuse Disorder Outpatient Services	Yes	Covered	No				See Page ____ of _____.
Substance Abuse Disorder Inpatient Services	Yes	Covered	No				See Page ____ of _____.
Generic Drugs	Yes	Covered	No				See Page ____ of _____.
Preferred Brand Drugs	Yes	Covered	No				See Page ____ of _____.
Non-Preferred Brand Drugs	Yes	Covered	No				See Page ____ of _____.
Specialty Drugs	Yes	Covered	No				See Page ____ of _____.

Outpatient Rehabilitation Services	Yes	Covered	Yes	30	Visit(s) per Benefit Period	OT and PT covered only when "needed to help your condition improve in a reasonable and predictable time",	See Page ____ of _____.
Habilitation Services	Yes	Covered	Yes	30	Visit(s) per Benefit Period	Speech therapy is not covered for attention disorders, behavior problems, conceptual handicaps, learning disabilities, developmental delays	See Page ____ of _____.
Chiropractic Care	Yes	Covered	Yes	30	Visit(s) per Benefit Period		See Page ____ of _____.
Durable Medical Equipment	Yes	Covered	No				See Page ____ of _____.
Hearing Aids	Yes	Covered	Yes	1	Item(s) per 3 Years	Hearing aids are excluded for members age 24 and over	See Page ____ of _____.
Imaging (CT/PET Scans, MRIs)	Yes	Covered	No				See Page ____ of _____.
Preventive Care/Screening/Immunization	Yes	Covered	No				See Page ____ of _____.
Routine Foot Care	No	Not Covered	No				See Page ____ of _____.
Acupuncture	No	Not Covered	No				See Page ____ of _____.
Weight Loss Programs	No	Not Covered	No				See Page ____ of _____.
Routine Eye Exam for Children	Yes	Covered	Yes	1	Exam(s) per Year		See Page ____ of _____.
Eye Glasses for Children	Yes	Covered	Yes	1	Item(s) per Year		See Page ____ of _____.
Dental Check-Up for Children	Yes	Covered	Yes				See Page ____ of _____.
Rehabilitative Speech Therapy	Yes	Covered	Yes	30	Visit(s) per Benefit Period		See Page ____ of _____.

Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Yes	30	Visit(s) per Benefit Period	OT and PT covered only when "needed to help your condition improve in a reasonable and predictable time", page 28.	See Page ____ of _____.
Well Baby Visits and Care	Yes	Covered	No				See Page ____ of _____.
Laboratory Outpatient and Professional Services	Yes	Covered	No				See Page ____ of _____.
X-rays and Diagnostic Imaging	Yes	Covered	No				See Page ____ of _____.
Basic Dental Care – Child	Yes	Covered	Yes	1	Visit every six months		See Page ____ of _____.
Orthodontia – Child	Yes	Covered	No			All pediatric orthodontic treatment is subject to Precertification by the Plan, and must be part of an approved written plan of care. To be eligible for pediatric orthodontic treatment, a Member must: - have been enrolled under this Agreement for twelve (12) consecutive months ("waiting period"), and must continue to be enrolled during the duration of treatment; and - have a fully erupted set of permanent teeth.	See Page ____ of _____.
Major Dental Care – Child	Yes	Covered	Yes				See Page ____ of _____.

Basic Dental Care – Adult	No	Not Covered	No				See Page ____ of _____.
Orthodontia – Adult	No	Not Covered	No				See Page ____ of _____.
Major Dental Care – Adult	No	Not Covered	No				See Page ____ of _____.
Abortion for Which Public Funding is Prohibited	No	Not Covered	No			"Elective abortions"	See Page ____ of _____.
Transplant	Yes	Covered	No				See Page ____ of _____.
Accidental Dental	Yes	Covered	No				See Page ____ of _____.
Dialysis	Yes	Covered	No				See Page ____ of _____.
Allergy Testing	Yes	Covered	No				See Page ____ of _____.
Chemotherapy	Yes	Covered	No				See Page ____ of _____.
Radiation	Yes	Covered	No				See Page ____ of _____.
Diabetes Education	No	Not Covered	No				See Page ____ of _____.
Prosthetic Devices	Yes	Covered	No				See Page ____ of _____.
Infusion Therapy	Yes	Covered	No				See Page ____ of _____.
Treatment for Temporomandibular Joint Disorders	No	Not Covered	No				See Page ____ of _____.
Nutritional Counseling	Yes	Covered	No				See Page ____ of _____.
Reconstructive Surgery after Mastectomy	Yes	Covered	No				See Page ____ of _____.

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Attachment 4: Delaware Mental Health Parity Addiction and Equity Act Issuer Checklist and Certification Template

Delaware Mental Health Parity and Addiction Equity Act Issuer Checklist and Certification (Plan Year 2020)

Company Name:	
Product Name:	
Plan:	
☐	Individual
☐	Small Group
☐	Large Group

YES: The plan should check this box if it meets the requirements.

NO: The plan should check this box if it does not meet requirements. The plan should provide detailed explanations for any "No" boxes that are checked.

Requirement	Yes	No
Federal Law		
Aggregate lifetime and annual dollar limit requirements for mental health and substance use disorder benefits ☐The plan complies with the aggregate lifetime and annual dollar limit requirements set forth in 45 CFR §146.136(b).	☐	☐
Explanation (if necessary):		

Financial requirements and quantitative and non-quantitative treatment limitation requirements for mental health and substance use disorder benefits ☐The plan complies with the financial requirements and quantitative and non-quantitative treatment limitation requirements set forth in 45 CFR §146.136(c).	☐	☐
Explanation (if necessary):		
Requirement	**Yes**	**No**
Availability of medical necessity criteria for mental health and substance use disorder benefits ☐The plan makes the criteria for medical necessity determinations with respect to mental health or substance use disorder benefits available to any current or potential participant, beneficiary, or contracting provider upon request in accordance with 45 CFR §146.136(d).	☐	☐
Explanation (if necessary):		
State Law		
☐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)**	☐	☐
Explanation (if necessary):		
☐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).**	☐	☐

Explanation (if necessary):	

I, on behalf of [INSERT ISSUER] ("Company"), hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) Company complies with, and will continue to comply with, the Mental Health Parity and Addiction Equity Act and 45 C.F.R. § 146.136 et. seq.

_____	_____	_____
Signature	***Title***	***Date***

Attachment 5: Delaware QHP Network Access Plan Cover Sheet Template

QHP Network Access Plan Cover Sheet Template
For Plan Year 2020

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 2020 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 2020 are provided in the table below. A complete list of the Delaware QHP Standards for Plan Year 2020 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 2020

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.

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.
    e.
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.
3.

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 2020. 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 Access Plan (Y/N)	Page number for 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?		

Attachment 6: Delaware Quality Improvement Strategy Workgroup Designation Form

Designation Information	
Company Name:	**Date:**

Primary Contact			
Name:		**Title:**	
Address:	**City:**	**State:**	**Zip:**
Phone Number:	**Email Address:**		

_____ _____ ***Primary Contact Signature*** ***Date***

Alternate Contact			
Name:		**Title:**	
Address:	**City:**	**State:**	**Zip:**
Phone Number:	**Email Address:**		

_____ _____

Alternate Contact Signature ***Date***

Attachment 7: Delaware State-Specific 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.

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 2020, 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, 2020.

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 2020.

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.

    1. 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.

    2. 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).