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 2021.

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 <u>prior to submission of data templates</u>.

			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*