Delaware QHP Certification Standards: Final Draft for HCC Approval

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

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

General Requirements	
Federal Minimum Standard for Certification	Must comply with the minimum Federal QHP Certification Standards described in 454 CFR 155 and 156 plus CMS guidance rules. **Subpart C—Qualified Health Plan Minimum Certification Standards § 156.200 QHP issuer participation standards** (a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. (b) *QHP issuer requirement.* A QHP issuer must— (1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis; (2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter; (3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20 (4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage; (5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

	(6) Pay any applicable user fees assessed under § 156.50; and (7) Comply with the standards related to the risk adjustment program under 45 CFR part 153. (c) *Offering requirements.* A QHP issuer must offer through the Exchange: (1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and, (2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21. (d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs (e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation Comply with all minimum federal QHP certification standards as specified in 45 CFR Part 156 and consistent with CMS guidance including, but not limited to: • 45CFR 156.20- General requirements related to QHP issuer participation • 45 CFR 156.225-Compliance with marketing and benefit design guidelines • 45 CFR 156.230-Compliance with network adequacy standards • 45 CFR 156.275- Accreditation requirements Comply with QHP certification requirements in 45 CFR Part 156 subpart c regarding benefit design standards and accreditation Comply with standards in the best interest of the consumer, as established by the FFE(Federally Facilitated Exchange), including • Meaningful difference among QHPs offered for certification within the same metal level. • Comply with Federal and State law pertaining to plan rating rules, factors, and/or tables to determine rates • Ensure that rates are based on an analysis of the plan rating assumptions and rate increase justifications in coordination with the Department of Insurance • Submit updated rates for QHP plans participating in FFE-SHOP
State Standards	• 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. • All stand-alone dental plans must be compliant with Title 18, Chapter 38: Dental Plan Organization Act. • Continuity of Care: A QHP issuer must have a transition plan for continuity of care for those individuals who become eligible or lose eligibility for public health programs. The Continuity of Care Transition Plan must include a transition period for prescriptions, including how the plan specifically addresses mental health pharmacy. In such instances, the new plan is responsible for executing the Transition plan. Transition plans are not applicable for individuals who **voluntarily** disenroll in a QHP, do not enroll in another QHP, but are still not eligible for Medicaid/CHIP. • For treatment of a medical condition or diagnoses that is in progress or for which a preauthorization for treatment has been issued, the QHP issuer/plan must cover the service for a lesser of: a period of 90 days or until the treating

	provider releases the patient from care. • 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. • 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. • 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 and3556 • The QHP issuer must make appropriate provider directories available to individuals with limited English proficiency and/or disabilities. • Withdrawal from Exchange: 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: o 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) 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.* • Issuers must submit a withdrawal and transition plan to the Department of Insurance for review/approval.
Accreditation	
Federal Standard	QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience. HHS intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification. By the fourth year of certification, all QHP issuers must be accredited on the QHP product type having fulfilled the requirements to submit performance data to the accrediting entity.
State Standard	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.
Network Adequacy	
Federal Standard	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-* • Includes essential community providers in accordance with§156.235; • 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; and, • Is consistent with the network adequacy provisions of section 2702© of the PHS Act, • (b) Access to provider directory. A QHP issuer must make its provider director

	for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients. Must have sufficient number of and geographic distribution of essential community providers where available to ensure reasonable and timely access to a broad range of such providers for low income and medically underserved individuals in QHP service area.
State Standard	Additional Delaware specific certification standards regarding Network Adequacy include: • QHP network arrangement must make available to every member a Primary Care Provider (PCP) whose office is located within 20 miles or no more than 30 minutes driving time from the member's place of residence. • Each QHP issuer that has a network arrangement must meet and require its providers to meet state standards for timely access to care and services as outlined in the table, titled **Appointment Standards,** found on page 27 of 84 in the Delaware Medicaid and Managed Care Quality Strategy 2010 document relating to General, Specialty, Maternity and Behavioral Health Services. • 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 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 for such services as provided in Section 1302(g) of the Patient Protection and Affordable Care Act (Publ. L.111-148) as added by Section 10104(b)(2) of such Act. • Issuers of stand-alone dental plans are exempt from the state's network adequacy standards for medical and mental health providers. However, Stand-alone dental plans must comply with SSA 1902(a)(30)(A), and assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.
Rating Area	
Federal Standard	As it applies to QHPs the ACA defines a "Rating Area" as a geographic area established by a state that provides boundaries by which issuers can adjust premiums (156.255)

	Rating Area- *(A)* In General-Each State shall establish 1 or more rating areas with that State for purposes of applying the requirement of this title(PHS SEC.2701 (2)(A)
State Standard	Delaware will permit one rating area Note: The size of the population base and actuarial review shows little difference in geographic areas. The DOI has found that this is generally in line with current Issuer practices in Delaware. .
Service Area	
Federal Standard	Service area is the geographic area in which an individual must reside or be employed in order to enroll in a QHP in accordance with §155.30 and§155.70.
State 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.
Quality Rating Standards	
Federal Standard	….the Affordable Care Act directs the Secretary to develop and administer a rating system and an enrollee satisfaction survey system, the results of which will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements. QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience The National Committee for Quality Assurance (NCQA) and URAC – would be recognized as accrediting entities on an interim basis subject to conditions. In phase two, we would adopt an application and review process for the recognition of additional accrediting entities. HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that State-based Exchanges may adopt a similar approach prior to final regulatory standards. For example, HHS intends to propose that reporting requirements related to all QHP issuers will start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges.
State Standard	The state will adopt the Quality Rating standards as provided in federal guidance
Quality Improvement Standards	
Federal Standards	**Per 45 CFR, 156.20, a QHP issuer 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 (I) 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) • 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; • The implementation of activities 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; • The implementation of activities 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; • The implementation of wellness and health promotion activities; • The implementation of wellness and health promotion activities; The implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings.
State Standard	• 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.
Marketing and Benefit Design	
Federal Standard	Non-Discrimination: A QHP may not employ .marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs.
State Standard	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.