MARYLAND HEALTHBENEFIT EXCHANGE

2017 Proposed Plan Certification Standards

November 23, 2015

2017 Proposed Plan Certification Standards

- MHBE will release a draft annual letter to Maryland Health Connection issuers setting forth proposal for the 2017 Carrier and Plan Certification Standards shortly after the November Board meeting
  - Comment period of 3 weeks

- NA/ECP Workgroup was reconvened to review NA/ECP proposed standards

- After a comment period, MHBE's Board will adopt final plan certification standards at its February meeting, and MHBE will release a final 2017 Letter to Maryland Health Connection Issuers in early March.

- Rules and standards included in the CMS 2017 Final Letter to Issuers may be included in MHBE 2017 Final Letter to Issuers

Service Area

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
1. Issuers may serve an area smaller than one county if they demonstrate that boundaries are not designed to discriminate against individuals excluded from the service area.	Issuers may serve an area smaller than one county if they demonstrate that boundaries are not designed to discriminate against individuals excluded from the service area. Issuers servicing an area smaller than one county must submit a Partial County Service Area Justification
2. Will permit service area changes after initial data submission by petition for limited reasons, e.g., issuer's inability to secure enough providers or MHBE request to serve an unmet need.	Will permit service area changes after initial data submission by petition for limited reasons, e.g., issuer's inability to secure enough providers or MHBE request to serve an unmet need.
3. No service area changes permitted after final data submission unless they constitute an expansion rather than contractions of service area.	No service area changes permitted after final data submission unless they constitute an expansion rather than contractions of service area.

Network Adequacy/Provider Directory

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
4. MHBE should continue current requirements that plans submit provider lists to CRISP. The provider list should be current (produced at least twice a month), accurate, and complete. Issuers must also provide the directory information on their websites in a machine-readable file and format.	4a. MHBE will continue current requirements that plans submit provider files to CRISP. The provider list must be current (produced at least twice a month), accurate, and complete. • Issuers must also provide, in a form and manner to be defined by MHBE, information on "Accepting New Patients" status. • Issuers must also provide the directory information on their website without requiring login. 4b. MHBE will further address provider director accuracy through multi-step process: • 2016: Carrier assesses directory accuracy in preparation for 2017 application • With 2017 plan certification application: Carrier provides accuracy information to MHBE, including carrier-selected method of assessment and steps taken to improve accuracy (*e.g.* provider contracting requirements) • During 2017: MHBE, with EIAC input, proposes to Board standard assessment method, baseline target, and requirements for accuracy improvements; Board adopts standards for 2018 plan certification standard. • 2017-8: Carrier uses standard assessment method and meets baseline target and/or requirements for accuracy improvement; includes information in 2018

NA/ECP Workgroup Comments – Directory Accuracy

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- Consensus suggestions:
  - Carriers should remove inactive providers from directory
  - Ensure easy method for providers to update information

- Concerns from some carriers that:
  - Accuracy/updates rest with providers not carriers
  - Information may be misleading to consumers and prejudicial
  - Non-compliance doesn't serve consumer since provider penalty is dismissal from network
  - Should first review metrics then set baseline

- Support from some consumer advocates and additional requests:
  - Penalties for non-compliance; Preferred provider listing for compliance
  - Carriers must conduct secret shopper audits

Network Adequacy/Provider Directory

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
5. Plans will be required to attest to and describe how their networks will provide access to services for all enrollees without unreasonable delay. MHBE will: -work with Hilltop to analyze any data that can help assess the network adequacy -obtain input from the Standing Advisory Committee and Medicaid -develop metrics for network adequacy standards for 2017 plans	Carriers must include the following metrics in a plan's SBC to provide consumers with information about the plan's network: 1. Average wait time for PCPs and MH providers 2. Average drive distance to PCPs and MH providers 3. Percent of PCPs and MH providers in network accepting new patients 4. CAHPS scores 5. OPTIONAL: Additional metrics for any other specialist categories of the carrier's choosing

NA/ECP Workgroup Comments – Metrics

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- Concerns from some carriers that:
  - Time and distance metrics aren't applicable for HMO or comparable for small v. large carriers
  - Information considered to be proprietary; already shared with MIA and of little assistance to consumers
- Some carriers suggests alternatives for educating consumers such as:
  - Indicating that provider is in network, which is already provided
  - Include date of last contact with provider

- Support from some consumer advocates and additional requests for:
  - Breakdown specialist category with MH and SUD categories
  - Include whether provider is accepting new patients
  - Include ratios for routine v. urgent care visit wait time
  - Need quantitative standards to assess "unreasonable delay"

Essential Community Providers & Discriminatory Benefit Design

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
6. Plans will be required to attest to and describe how they ensure adequate ECP participation. MHBE should: - work with Hilltop to analyze any data that can help assess the sufficiency of ECP engagement - seek input from Standing Advisory Committee and Medicaid - develop recommended metrics for ECP engagement adequacy standards for plans offered on MHC in 2017	6a. Definition of ECP: Federal definition at 45 CFR 156.235(c), with addition of local health departments, outpatient mental health centers and substance use disorder treatment providers, as described at COMAR 10.09.80.03.B(1) & B(3), licensed or approved by DHMH as programs or facilities, and school-based health centers • Providers must be able to meet carrier credentialing standards 6b. Plan network must meet threshold standard: 1. Contract with at least 30% of available ECPs in each plan's service area • Allow write in option and alternative standard • Offer contracts in good faith to: • all available Indian Health Care Providers in service area, • any willing Local Health Dept. in service area, and • At least one ECP in each ECP category in each county in service area, where an ECP in that category is available and provides medical or dental services by issuer plan type (except if not applicable for dental).

NA/ECP Workgroup Comments – Definition

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- Most comments related to MH/SUD expansion

- Concerns from some carriers that:
  - State-specific standard increases complexity and cost to be passed on to consumers
  - Need more information on need to include MH/SUD providers and scope of group
- Some carriers suggests alternatives such as:
  - Collect information from consumers on underserved areas

- Support from some consumer advocates and additional requests for:
  - Credentialing standards must be objective, transparent and comply with Parity Act
  - Include all MH providers, specifically in-network psychiatrists

NA/ECP Workgroup Comments – Minimum Threshold

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- General support for use of federal threshold standard

- Concerns from some carriers that:
  - CMS master list is inaccurate
  - Should not include any separate categories for MH/SUD providers
  - Federal alternative standard doesn't accommodate broad range of providers/services at one location

- Support from some consumer advocates and additional requests for:
  - Inclusion of separate 30% category for MH/SUD providers
  - Use Value Options list as guidance

Discriminatory Benefit Design

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
7. MHBE should require plan attestation that it does not discriminate on the basis of any factors set forth above and prohibited by federal regulation.	MHBE will require plan attestation that it does not discriminate on the basis of any factors set prohibited by federal and state regulation.

Prescription Drugs

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
8. Drugs covered under plan's medical benefit must be identified in plan's filings.	8. Drugs covered under plan's medical benefit must be identified in plan's filings.
9. Drug formulary Internet link provided by plans must link directly to list of covered drugs without requiring further navigation, and must include tiering and cost-sharing information. The formulary drug link must be up-to-date, accurate, and complete. Issuers must make the formulary drug list available on their website in a standard machine readable format as specified by HHS.	9. Drug formulary Internet link provided by plans must link directly to the list of covered drugs without requiring further navigation, and must include tiering and cost-sharing information. The tier category (i.e. generic, preferred brand, etc.), must be made clear for each drug, a legend is acceptable with MHBE approval. The formulary drug link must be up-to-date, accurate, and complete. Issuers must make the formulary drug list available on their website in a standard machine readable format as specified by HHS.

Prescription Drugs

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard. (Red connotes substantially different text)
10. Issuers have the option of identifying a drug as a "preventive drug" covered at zero cost.	Issuers have the option of identifying a drug as a "preventive drug" covered at zero cost.
11. Defer proposal regarding continuity of care to afford time to evaluate the efficacy of the Maryland Health Progress Act's continuity of care policies.	MHBE will develop a time horizon, to evaluate the efficacy of the Maryland Health Progress Act's continuity of care policies and to develop, if determined to be of need, a continuity of care proposal.

Prescription Drugs

MARYLAND HEALTHBENEFIT EXCHANGE

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard. (Red connotes substantially different text)
12. Issuers must create a drug exception process for standard situations (in contrast to exigent circumstances) by which an enrollee can request access to a drug not on the plan's formulary. The issuer must notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception request. Issuers must have an external review process by an independent review organization for denied requests. The external review organization must complete its review and provide a decision within 72 hours of receiving the review request.	Issuers must create a drug exception process for standard situations (in contrast to exigent circumstances) by which an enrollee can request access to a drug not on the plan's formulary. The issuer must notify the enrollee of its coverage decision no more than 72 hours after receipt of the exception request. Issuers must have an external review process by an independent review organization for denied requests. The external review organization must complete its review and provide a decision within 72 hours of receiving the review request. The Issuer will keep account of, and report on, member drug exceptions processed and provide summary metrics to MHBE determine compliance. MHBE will provide guidance to meet this requirement.

Meaningful Difference

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
13. Board's limitation on the number of permissible plans should remain in effect. MHBE should examine going forward whether the Board's limitation on the number of permissible plans continues to be effective or whether meaningful difference review should supplement or replace the limitation approach in 2017	A given carrier's set of plans must meet the FFM meaningful difference standard and continue to meet the four benefit designs maximum per metal level requirement. The FFM meaningful difference standard will be applicable to all non-Zero, non-Limited plan variations.

Quality Reporting

2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
14. Certain QHP issuers must comply with standards and requirements related to quality reporting through the implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Issuers are also required to continue to provide quality data and Race, Ethnicity, Language, Interpreter Need, and Cultural Competency (RELICC) data to the Maryland Health Care Commission (MHCC).	Certain QHP issuers must comply with standards and requirements related to quality reporting through the implementation of the Quality Rating System (QRS) and the Enrollee Satisfaction Survey (ESS). Issuers are also required to continue to provide quality data and Race, Ethnicity, Language, Interpreter Need, and Cultural Competency (RELICC) data to the Maryland Health Care Commission (MHCC). MHBE will determine a final approach for the QHP Issuer quality reporting system.
15. MHBE encourages QHP issuers that have offered plans on MHC for two (2) years to submit a quality improvement strategy (QIS) for 2016. This is a voluntary.	QHP issuers that have offered plans on MHC for at least two (2) years will submit a quality improvement strategy (QIS) for 2017 in functional areas determined by MHBE oversight and compliance staff.

QHP Performance and Oversight, Employee Choice in SHOP & Consumer Support

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
16. MHBE will move forward with conducting some compliance reviews in 2016. The scope of this review will be limited to compliance with plan certification standards and will not extend to requirements enforced by MIA	MHBE will continue conducting compliance reviews in 2017. The scope of this review will be limited to compliance with plan and carrier certification standards and will not extend to requirements enforced by MIA
17. Qualified employers can offer employees a choice of all stand-alone dental plans offered or a single stand-alone dental plan.	Moved to SHOP Section.
18. MHBE should require plans to explain their strategies to provide meaningful access, and MHBE should incorporate into compliance oversight its approach to reviewing meaningful access.	To supplement QHP issuer annual submission of the Network Access Plan, MHBE will require plans to explain their strategies to provide meaningful access, MHBE will incorporate into compliance oversight its, to be determined, approach to reviewing meaningful access.

QHP Performance and Oversight, Employee Choice in SHOP & Consumer Support

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
No related requirement.	QHP issuers must make public, and provide to MHBE, for public release, their Standards for Network Management reported for 2016 NCQA Accreditation, in a form and manner described by MHBE.
No related requirement.	QHP Issuers will submit, as an expansion to their Summary of Benefits and Coverage Form Coverage Examples, Out-patient/Inpatient Substance Abuse Treatment Costs and Out-patient/Inpatient Mental Health Treatment Costs. The criteria and factors for determining these costs will be established by MHBE.
No related requirement.	QHP Issuers will, on their Summary of Benefits and Coverage forms, will submit a URL that links to each QHP's respective complete benefits or terms, via a policy contract or an in-depth plan document, without further navigation.

Small Business Health Options Program (SHOP)

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
Composite rating not permitted.	Carriers will be allowed to provide composite rating for small employers if the plan selection is limited to a single plan
Qualified employers can offer employees a choice of all stand-alone dental plans offered or a single stand-alone dental plan	Qualified employers can offer employees a choice of all stand-alone dental plans offered or a single stand-alone dental plan

Essential Health Benefits

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
Pediatric dental is embedded in QHPs.	Embedded-Pediatric Dental as an Essential Health Benefit for QHP Issuer plans is optional.

Stand-Alone Dental Plans

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2016 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
No related requirement.	Stand-Alone Dental Plans will accept Advance Premium Tax Credit for the portion of premium payable to the Embedded-Pediatric Dental Essential Health Benefit
No related requirement.	Stand-Alone Dental Plans will be subject to QHP rating rules applicable to dependent caps.

Legacy – Rate Increase Notice

2014 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
That the carrier, for any premium rate increase for a qualified plan sold on the SHOP Exchange or Individual Exchange, will provide to the Maryland Health Benefit Exchange the associated Preliminary Justification Forms I and II filed with the Maryland Insurance Administration, and will notify the Maryland Health Benefit Exchange of the final disposition of the premium rate increase request at least 45 days before its effective date	That the carrier, for any premium rate increase for a qualified plan sold on the SHOP Exchange or Individual Exchange, will provide to the Maryland Health Benefit Exchange the associated Preliminary Justification Forms I and II filed with the Maryland Insurance Administration, and will notify the Maryland Health Benefit Exchange of the final disposition of the premium rate increase request at least 45 days before its effective date

Legacy – Accreditation

2014 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
That the carrier holds current and valid accreditation, ~~as follows, for years 2014 and 2015~~: (a) That the carrier, unless the carrier offers only dental or vision benefits, is accredited by National Committee for Quality Assurance (NCQA) or URAC as an accredited commercial or Medicaid carrier. (b) That the carrier, if offering only dental or vision benefits, holds a current and valid Maryland Insurance Administration Certificate of Authority. ~~(c) Non-accredited carriers:~~ ~~(i) Non –accredited carriers shall receive a one-year grace period to obtain accreditation in year 2014.~~ ~~(ii) Non-accredited carriers applying for certification shall apply for accreditation prior to July 1, 2013 to receive the one-year grace period set forth in subsection (i).~~	That the carrier holds current and valid accreditation, as follows, for years 2014 and 2015: (a) That the carrier, unless the carrier offers only dental or vision benefits, is accredited by National Committee for Quality Assurance (NCQA) or URAC as an accredited commercial or Medicaid carrier. (b) That the carrier, if offering only dental or vision benefits, holds a current and valid Maryland Insurance Administration Certificate of Authority.

Legacy – Transparency

2014 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
Transparency Data That the carrier will provide the transparency data required under 45 CFR §156.220(a) for 2014 qualified plan certification and thereafter as required for maintaining plan certification and recertification.	The carrier will provide the transparency data required under 45 CFR §156.220(a) for annual qualified plan certification and thereafter as required for maintaining plan certification and recertification.

Legacy – Service Area

2014 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
~~For 2014~~, a carrier holding carrier certification by the Maryland Health Benefit Exchange shall provide: (1) documentation of the service area of each qualified plan the carrier offers for sale through the SHOP Exchange or Individual Exchange; and (2) data on demographics of areas served by each qualified plan the carrier offers for sale within the SHOP Exchange or Individual Exchange, in accordance with 45 CFR §155.1055(b), except where the carrier provides a statewide service area.	A carrier holding carrier certification by the Maryland Health Benefit Exchange shall provide: (1) documentation of the service area of each qualified plan the carrier offers for sale through the SHOP Exchange or Individual Exchange through the Service Area Template developed by CCIIO; and (2) data on demographics of areas served by each qualified plan the carrier offers for sale within the SHOP Exchange or Individual Exchange, in accordance with 45 CFR §155.1055(b), except where the carrier provides a statewide service area.

Legacy – QHP Certification Process

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2015 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
Defer for presentation of 2015 QHP certification procedures at 4/18/14 Board meeting in time for 6/1/14 certification application deadline.	QHP certification procedures will be released annually in the MHBE Final Letter to Issuers.
Stand-alone dental plan application timeline and procedure will be released annually in the MHBE Final Letter to Issuers	Stand-alone dental plan application timeline and procedure will be released annually in the MHBE Final Letter to Issuers
Timeline and procedure for adjustments to Plan Display will be released annually in the MHBE Final Letter to Issuers.	Timeline and procedure for adjustments to Plan Display will be released annually in the MHBE Final Letter to Issuers.

Legacy – Discriminatory Benefit Design

2015 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
MHBE should defer any further action pending engagement with MIA to determine respective roles in protecting against discriminatory plan design.	MHBE will commence detailed analysis of plan benefits to determine if plan certification standards are needed to address discriminatory benefit design

Legacy – Primary Care

2015 Plan Certification Standard	MHBE Proposed 2017 Plan Certification Standard.
Defer pending federal guidance regarding 2016 approach to EHB, rate impact, and any additional preventive services required at no cost.	Board should direct MHBE to: - Determine if above State-EHB Primary Care benefits should be included in Plan Certification Standards for 2018 plans. - Seek input from Standing Advisory Committee and stakeholder groups. - Develop recommendations for Board's consideration