Delaware and Vermont Network Adequacy Regulations

Delaware

Managed Care Organizations:

Delaware Administrative Code Title 14 Health Insurance Specific Provisions 1403 Managed Care Organizations 11.3 Provider Network Adequacy 11.3.1 Primary, Specialty and Ancillary Providers 11.3.1.1 The MCO shall maintain an adequate network of primary care providers, specialists, and other ancillary health care resources to serve enrollees at all times.

11.3.1.2 If a plan has an insufficient number of providers that are geographically accessible and available within a reasonable period of time to provide covered health services to enrollees, the MCO shall cover non-network providers, and shall prohibit balance billing.

11.3.1.3 The MCO shall allow referral to a non-network provider, upon the request of a network provider, when medically necessary covered health services are not available through network providers, or the network providers are not available within a reasonable period of time. The MCO shall make acceptable service arrangements with the provider and enrollee, and shall prohibit balance billing.

11.3.4 The MCO shall submit evidence of network adequacy to the Department upon request. If the Department receives a complaint regarding an MCO's network adequacy, the burden shall be on the MCO to prove network adequacy to the satisfaction of the Department.

Exchange:

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(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 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.

Vermont

Managed Care Organizations:

Department of Financial Regulation

Reg-H-2009-03 Consumer Protection and Quality Requirements for Managed Care Organizations Section 2.3 Access to and Continuity of Care Generally

(A) Managed care organizations shall ensure that their policies and procedures facilitate the provision of health care services to their members in a manner informed by generally accepted medical or scientific evidence consistent with prevailing standards of medical practice as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition, and shall take into account the unique needs of each individual patient and each presenting situation.

(B) Each managed care organization shall ensure timely access to effective, medically necessary care and shall monitor and take action, as necessary, to improve coordination

and continuity of care for its members across service providers. For purposes of this section, ”coordination and continuity of care” means that a member’s health care services are managed by the managed care organization(s) in a manner that facilitates collaborative and effective treatment of a condition, illness or other medical condition, including but not limited to ensuring that the managed care organization:

1. manages the benefits available for treatment of mental health and substance abuse conditions in a manner that allows for the effective provision of medically necessary care in urgent, medically complex, and unique situations, including but not limited to situations involving children and adolescents;

2. has authorized covered benefits necessary for a medically safe and appropriate discharge or transition plan developed after consultation with the treating health care provider or the provider’s designee before the managed care organization renders a decision that will result in discharge or transfer from a facility; and

3. collaborates with health care providers to monitor and improve coordination between mental health and other health care.

Exchange:

Please confirm that the provider networks of each QHP submitted for review includes essential community providers as described in 45 CFR §156.235.

Please confirm that the provider networks of each QHP submitted for review maintains a network that is sufficient in number and type of providers including those that specialize in mental health and substance abuse services.

Please confirm that the provider networks of each QHP submitted for review is consistent with the network adequacy provisions of section 2702 of the Public Health Service Act and Vermont Rule H-2009-03.

Please confirm that you will make the provider directory for each QHP available to the Vermont Health Connect for publication online, and to potential enrollees in hard copy upon request.

Please confirm that the provider directory for each QHP identifies those providers who are not accepting new patients.