

DEPARTMENT OF INSURANCE
OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311, 334, 2503, 3342B and 3556A, and 29 Delaware Code, Chapter 101 (18 **Del.C.** §§311, 334, 2503, 3342B & 3556A; 29 **Del.C.** Ch. 101)

PROPOSED

PUBLIC NOTICE

1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

A. Type of Regulatory Action Required

Re-proposal of proposed new Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.

B. Synopsis of Subject Matter of the Regulation

On January 1, 2022, the Delaware Department of Insurance (the Department) published its proposed new Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance (Proposal 1). See 25 **DE Reg.** 684 (01/01/22). The purpose of the proposed new regulation is to implement Senate Substitute 1 for Senate Bill 120 (SS1 for SB 120), which expanded the regulatory authority of Department's Office of Value Based Health Care Delivery (OVBHCD) as described in Proposal 1.

C. Summary of Public Comment and Responses

The Department accepted written comment on Proposal 1 for 30 days as required under the Administrative Procedures Act. The Department appreciates the thoughtful and thorough comments submitted, which are summarized below. In addition to the specific revisions discussed in the next sections, the Department is also taking the opportunity of re-proposing to make minor technical corrections to the regulatory text.

1. Comments related to Section 4.0 - Definitions

Several commenters objected to the mechanism proposed by the Department to supplement the proposed definition of "primary care services." As proposed, the Department would codify the definitions of primary care services and would further augment the definition by means of a Department-issued bulletin or other official communication as the understanding of these terms evolves in the quickly evolving healthcare space. Commenters objected to the use of this mechanism as contravening the Administrative Procedures Act requirements for transparency and public comment on regulatory initiatives that are substantive in nature.

The Department's definition of "primary care services" is based on an extraordinarily transparent, multi-stakeholder process undertaken in collaboration with the Primary Care Reform Collaborative (PCRC) and its technical subcommittee in 2020. The definition was included in the inaugural report authored by the Department's Office of Value Based Health Care Delivery (OVBHCD) entitled **Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality and Value**. For the last two years, the Department has used the definition to measure and report on primary care investment in Delaware. Each year, the Department has made minor changes to reflect new and expired Current Procedural Terminology (CPT) codes and continued conversations at the PCRC. The definition will continue to evolve to reflect changing code sets, new carrier programs and the Delaware Primary Care Model (DPCM), when the DPCM is developed.

While the Department recognizes the need to allow flexibility for the regulation to keep up with rapid advances in the field of primary care, in the interest of time and to further support health insurance carriers in timely complying with SS 1 for SB 120, the Department proposes to modify the definition to now include extensive detail on the services, providers and care settings that will be used to determine compliance with primary care investment requirements.

Two commenters sought clarification on what plans are included in the definition of "health benefit plan."

The regulatory definition of "health benefit plan" matches the statutory definition in 18 **Del.C.** §§3342A(a)(3)a. and 3559(a)(3)a. The Department notes that the term as defined in 18 **Del.C.** §§ 3342A(a)(3)a. and 3559(a)(3)a. does not apply to self-funded plans. The Department did not, nor did it intend to, expand the scope of that term through its use in the proposed regulation. The Department does not seek to regulate self-insured plans or any other insurance product not under its jurisdiction. The Department has attempted to clarify this in Section 2.0 of the re-proposed regulation.

The Department does agree with one commenter's suggestion that self-insured plans should encourage all carriers to have one fee schedule for fully insured and self-insured clients and that carriers should discuss the components of SS 1 for SB 120 immediately with self-insured clients. For its part, the Department has extended an open invitation to self-insured employers to attend PCRC meetings as one way for self-insured employers to keep abreast of the changes in the fully-insured market.

One commenter requested that the Department clarify that behavioral health and substance use disorder services are

not part of the definition of "inpatient hospital services" and therefore are excluded from the inflation-indexed caps on hospital inpatient and outpatient rate increases. The Department accepts the request to now include the clarification in the definition.

While the Department received other comments suggesting that the proposal should be reissued with clearer defined terms for other key provisions, the definitions are consistent with those used by carriers for the rate review process. These definitions are published annually by CMS' Center for Consumer Information and Insurance Oversight (CCIIO) in the Unified Rate Review Template instructions which may be viewed at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2021-URR-Instructions.pdf>. Therefore, the Department has determined that no additional revisions to any other definitions are required.

2. Comments related to Section 6.1 - Primary Care Spending Requirements for Rate Filings

Members of the Delaware General Assembly and the PCRC Co-Chair commented that the "annual designations in the Proposed Regulation depart from the statutory language of SS1 for SB120 and would have the effect of delaying by one year the phase-in of statutorily mandated minimum levels of critical primary care investments." These same commenters clarified the intent behind SS1 for SB120 regarding the enforceability of the 7 percent spending requirement for 2022 (the current plan year) and noted that that particular spend requirement "had been a provision included in SS1 for SB120 should the legislation have become effective prior to the operative deadline for rate filings in 2021 (that would apply in 2022). As SS1 for SB120 did not become effective until October 1, 2021, we understand that the 7 percent figure became nonbinding for 2022."

Similarly, the Medical Society of Delaware opined that "the proposed regulation does not comport with the requirements of SS 1 for SB 120 with regard to implementation of the legislation." The comment goes on to encourage the Department "to see what can be done outside of the regulations to implement increases in calendar year 2022, so as to encourage or 'advise' the payers to move to the bill's goal of 7% payment."

The Department sought to operationalize the General Assembly's goal of gradually increasing primary care investment and offsetting those increases with limits on aggregate unit price growth for non-professional services and implementation of other Affordability Standards to improve care value. As commenters point out, SS1 for SB 120 was not signed into law until October 1, 2021, past the rate filing deadlines and determinations for plan year 2022. Therefore, the primary care spending requirement of 7 percent for 2022 could not be implemented. Given the nature of the comments submitted, including the clarification of the General Assembly's intent, the Department is now proposing to revise proposed subsection 6.1 to comport with the statutory primary care spending requirements of 8.5 percent, 10 percent, and 11.5 percent by 2023, 2024, and 2025, respectively.

A carrier requested clarification on "whether the mandated PCP spend percentage is calculated at the entity total level or entity and size segment level" and whether the Department would "consider revising the regulation to allow for an adjustment to counter the effect of including [any] catastrophic claims and . . . to explicitly allow carriers that have not met the Delaware Primary Care spend requirement in a given year, to make up the shortfall by giving grants to PCPs to fund initiatives for the practice"

The Department is unclear as to the commenter's reference to "entity total level" and "entity and size segment level." The Department can confirm that, in alignment with the rate review process, the mandated primary care spending percentage will be calculated at the market segment level, that is, by individual, small group and large group markets. Questions on catastrophic claims and providing grants to primary care practices to bolster primary care spending should be brought to the Department during or prior to the rate filing period for review and approval as noted in subsections 6.2.1 and 6.2.2.2 of the proposed new regulation.

One commenter requested that additional programs developed by the Accreditation Association for Ambulatory Health Care be included in the list of eligible activities described in subsection 6.2.2.3. The Department will review this program and discuss the recommendation with stakeholders. If the Department decides to add the program, it will communicate it an upcoming annual notice to carriers as discussed in subsection 6.2.2.3.4.

3. Comments related to Section 7.0 - Price Growth Limits for Non-Professional Services

The Department received several comments in support of proposing to use a 3-year lookback methodology for calculating Core CPI. In contrast, two hospital stakeholders objected, one of whom described the Department's proposed methodology as "inconsistent with the plain language of the statute and will be grossly inadequate in the current inflationary environment," and another who opined that, "There is no reason to interpret Core CPI for the year beginning on 1/1/23 to be anything other than the Core CPI calculation for calendar year 2023, which will be published in December 2022."

The Department appreciates the articulated support of this methodology and acknowledges others' objections. The Department further points out that the commenter's characterization of Core CPI is inaccurate. The Consumer Price Index (CPI) is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The "Core" CPI is this average excluding food and energy. CPI and Core CPI are retrospective measures that are updated monthly. Contrary to the commenter's assertion, there is no forward-looking Core CPI for 2023 published in December 2022.

Since the measure is an "average change over time" and the General Assembly did not provide statutorily for the time

period over which to measure the average change, the Department has determined that its selection of a 3-year lookback period is a proper exercise of its regulatory authority. The Department determined that a 3-year lookback period would provide stability and consistency and furthers the stated goal of SS1 to SB 120. This approach is consistent with a similar policy approach in Rhode Island, the state model off which the General Assembly and PCRC based SS1 to SB120. See [Rhode Island Health Insurance Bulletin 2021-05](#).

After further review of the CPI calculation in Proposal 1, the Department now proposes to refine the calculation for the Core CPI average as reflected in the re-proposal. The Department will publish the limit in an annual Bulletin.

With regard to the comment concerning the "inflationary environment," the Department notes Delaware hospitals have received more than \$339 million in federal relief funds and another round of support was announced in February 2022. This does not include state aid to offset increased labor and other costs, which Delaware hospitals have also received.

4. Comments related to Section 8.0 - Alternative Payment Model Adoption

Two commenters objected to the use of Diagnosis Related Groups (DRG) and Ambulatory Patient Classification (APC) methodologies as appropriate alternative payment model arrangements, stating that they are inappropriate for pediatrics because they are Medicare methodologies, and that they are not contemplated in the statute and are therefore beyond the scope of the Department's statutory authority to establish Affordability Standards for primary care. One commentator sought clarification on the Department's authority to define minimum risk requirements for alternative payment model arrangements seeking to be counted toward carriers' statutory requirement.

The Department rejects any contention that the lack of specific reference to DRGs and APCs in the enabling statute prohibits the Department from defining these methodologies as permissible alternative payment models. The Department is mandated under the law to "[e]stablish, through regulations adopted under [18 Del.C. §334(c)(2)], mandatory minimums for payment innovations, including alternative payment models" See 18 Del.C. §334(c)(2) (*emphasis added*). It is clear through the plain language of the statute that the General Assembly provided the OVBHCD broad regulatory authority to define and establish appropriate alternative payment models as reflected in Proposal 1.

In addition, 18 Del.C. §334(b)(1) provides that affordability standards, which the Department is directed to define in regulation, may include, "effective strategies carriers can use to maintain close control over administrative costs and enhance the affordability of products and encourage delivery of high quality, efficient healthcare services."

Given the amendments to 18 Del.C. §334 noted above, the Department proposes to make no change to subsection 8.1 other than to clarify that DRGs and APCs are provided by way of example. Carriers may choose to implement other fixed payment, episode-based or population-based methodologies.

5. Comments related to Section 9.0 - Affordability Standards

Two hospital stakeholder commenters questioned whether the proposed regulations concerning setting affordability standards exceeded the Department's regulatory authority in light of the sunset provision contained in SS1 to SB 120 (the bill). The Department notes that the sunset provision in SS1 to SB 120 applies only to certain identified sections within the bill. Notably, the sunset provision does not apply to Section 7 of the bill, which amended 18 Del.C. §334 to expand the OVBHCD's authority, giving it express regulatory authority to establish "mandatory minimums for payment innovations, including alternative payment models, provider price increase, carrier investment in primary care, and other activities deemed necessary to achieve the purpose of [18 Del.C. §334]." While the OVBHCD's original enabling legislation, 82 Del. Laws c. 189, s. 3, did not allow for the Department's regulations to establish mandatory or enforceable requirements, SS1 to SB 120 deleted those regulatory restrictions and expressly authorized the OVBHCD to establish mandatory and enforceable requirements as more fully set forth in 18 Del.C. §334(c)(2).

Establishing mandatory minimums in primary care spending and price growth limits for years 2026 and beyond are within the Department's regulatory authority under 18 Del.C. §334(c)(2), which contains no temporal restrictions, notwithstanding the sunset of other provisions in SS 1 to SB120. While the Department's regulatory authority under the statute is clear, the Department has determined to delete Section 9.0 in its entirety to allow carriers to focus on the more time-sensitive requirements of the statute and regulation. The Department will revisit the implementation of additional affordability standards and payment innovations in future regulations.

6. Comments related to Section 10.0 - Enforcement

Two hospital stakeholder commenters objected to the use of the rate review process as an enforcement tool, because the rate review process only involves the Department and the carriers. Accordingly, in the commenters' opinion, the rate review process "lacks transparency and an opportunity for stakeholders to weigh in on the methods ultimately used for enforcement of the requirements set out in the regulation."

The Department notes the General Assembly tasked the OVBHCD with collecting data to monitor and evaluate whether carriers are complying with primary care reimbursement requirements and whether primary care spending is increasing as required by law. Section 10.0 of the proposed regulations identifies various methods of collecting the necessary data for the OVBHCD to complete its statutorily-mandated functions.

Further, as stated in proposed new Regulation 1322, the OVBHCD will provide an annual public report with all methodologies and results listed by payer. The template and process used to assess carrier compliance will be similar to

the process and publicly available template that the Department has used for two years to assess carriers' investment in primary care, Delaware price and utilization trends, and alternative payment model adoption. While the rate review process includes confidential data, the Department regularly shares information and data, as appropriate, on its website and with public workgroups and committees including the PCRC.

One commenter inquired whether the word "rate" should be inserted before the word "year" in Proposal 1 subsection 10.4.4.2. This adjustment has been made in Proposal 2.

D. Notice and Public Comment - Proposal 2

Proposal 2, revised as appropriate in response to the public comments received on Proposal 1, appears below and may also be viewed on the Department's website at <http://insurance.delaware.gov/information/proposedregs/>. The Department will not be holding a public hearing on Proposal 2.

Any person may file written comments, suggestions, briefs, and compilations of data or other materials concerning Proposal 2. Any written submission in response to this notice and relevant to the proposed amendments must be received by the Department of Insurance no later than 4:30 p.m. EDT, the 31st day of March 2022 and should be directed to:

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1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

1.0 Authority

This regulation is promulgated and adopted pursuant to the authority granted in 18 Del.C. §§311, 334, 2503, 3342B and 3556A, and in accordance with 29 Del.C. Ch. 101. Subsection 9.0 is codified under the Department's express authority under 18 Del.C. §334 to set affordability standards, which do not include a sunset date.

2.0 Purpose

The purpose of this regulation is to establish a process through which carriers must demonstrate compliance with requirements for mandatory minimum payment innovations, including alternative payment models, provider price increases, carrier investment in primary care, and other activities deemed necessary to support a robust system of primary care by January 1, 2026, pursuant to 18 Del.C. §334.

3.0 Scope

This regulation applies to insurers, health service corporations, and managed care organizations that deliver or issue for delivery in this State individual and group insurance policies or plans subject to regulation under Title 18 of the Delaware Code.

4.0 Definitions

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

"Accountable care organization" means an organization formed when a group or groups of doctors, hospitals, and other health care providers come together voluntarily to give coordinated high-quality care to their patients.

"Ambulatory Payment Classification" or "APC" means the classification system described in 42 CFR 419.31 that is the basis of Medicare's reimbursement system for outpatient hospital services.

"Annual notice" means the bulletins issued by the Commissioner that establish the format and supporting information that carriers must use to comply with the reporting requirements of this regulation. Such notices will be issued not later than 90 days prior to annual premium rate filing deadlines established under 18 Del.C. §2503.

"Capitated Services" means services paid through a fixed amount of money per patient per unit of time paid in advance for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided.

"Carrier" has the meaning set forth in 18 Del.C. §334(b)(2).

"Chronic care management services" means the specific services included in the Chronic Care Management Services program, as administered by the Centers for Medicare and Medicaid Services (CMS) and includes Current Procedural Terminology ("CPT") codes 99487, 99489, and 99490.

"Commissioner" means the Commissioner of the Delaware Department of Insurance.

"Comprehensive Primary Care Plus" or "CPC+" means the national advanced primary care medical home model contemplated by Section 3021 of the Patient Protection and Affordable Care Act that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation.

"Comprehensive Primary Care Plus Track 1" or "CPC+ Track 1" means the version of the CPC+ program in which providers are reimbursed the full Medicare Physician Fee Schedule as well as a risk-adjusted care management fee, with an opportunity to earn a performance-based incentive payment.

"Comprehensive Primary Care Plus Track 2" or "CPC+ Track 2" means the version of the CPC+ program in which providers are reimbursed less than the full Medicare Physician Fee Schedule in exchange for receiving higher non-fee-for-service payments than in CPC+ Track 1.

"Core CPI" means the Consumer Price Index for All Urban Consumers, All Items Less Food & Energy as developed by the United States Bureau of Labor Statistics.

"Delaware Health Information Network Health Care Claims Database" or "DHIN HCCD" means the data base in which health care claims data that are collected from commercial and public payers under regulations promulgated pursuant to 16 Del.C. §10306 are stored.

"Department" means the Delaware Department of Insurance.

"Diagnosis Related Groups" or "DRGs" means the patient classification scheme set forth in 42 CFR 412.60.

"Episode-based payments" means a discounted payment or pre-determined price against which actual payments are retrospectively reconciled that is specific to conditions for a discrete timeframe and that are initiated by combinations of diagnoses, procedures, and drugs furnished to a patient.

"Facility" means a place where healthcare is delivered, including by way of example only, a hospital, outpatient clinic or nursing home.

"Health benefit plan" has the meaning set forth in 18 Del.C. §§3342A(a)(3)a. and 3559(a)(3)a.

"Inpatient hospital services" means non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility and categorized as such as part of development of the Unified Rate Review Template, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.

"Medicare Shared Savings Program Pathways to Success" or "MSSP Pathways" means the CMS alternative payment model program adopted by the Federal Centers for Medicare & Medicaid Services in the "Pathways to Success" Final Rule, 83 FR 67816 (December 31, 2018), and codified in 42 CFR 425.

"Nonprofessional services" means services categorized as such as part of development of the Unified Rate Review Template as inpatient hospital, outpatient hospital, and other medical services.

"Other medical services" means non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, and the facility component of vision exams, dental services, and other services when billed separately from professional services and categorized as such as part of development of the Unified Rate Review Template, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.

"Outpatient hospital services" means non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility and categorized as such as part of development of the Unified Rate Review Template, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.

"Population-based payment" means an arrangement in which a provider entity accepts responsibility for delivering covered services to a group of patients for a predetermined payment amount.

"Primary Care First" or "PCF" means the CMS five-year alternative payment model program established under the authority of Section 1115A of the Social Security Act that aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.

"Primary Care Place of Service" means a care delivery location where primary care services are frequently provided, including by way of example only, each of the following locations as defined by their CMS place of service code:

<u>Place of Service Code Description</u>	<u>Place of Service Code</u>
<u>Telehealth Provided Other than in Patient's Home</u>	<u>02</u>

<u>School</u>	<u>03</u>
<u>Telehealth Provided in Patient's Home</u>	<u>10</u>
<u>Office</u>	<u>11</u>
<u>Home</u>	<u>12</u>
<u>Walk-In Retail Clinic</u>	<u>17</u>
<u>Place of Employment – Worksite</u>	<u>18</u>
<u>Urgent Care Facility</u>	<u>20</u>
<u>Federally Qualified Health Center</u>	<u>50</u>
<u>Public Health Clinic</u>	<u>71</u>
<u>Rural Health Clinic</u>	<u>72</u>

"Primary Care Provider" or "PCP" means an individual licensed under Title 24 of the Delaware Code to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist. This definition includes family practice, pediatrics, internal medicine, and geriatrics, including by way of example only, the following taxonomy codes:

<u>Taxonomy Code Description</u>	<u>Taxonomy Code</u>
<u>Family Medicine</u>	<u>207Q00000X</u>
<u>Family Medicine, Adult Medicine</u>	<u>207QA0505X</u>
<u>Family Medicine, Geriatric Medicine</u>	<u>207QG0300X</u>
<u>General Practice</u>	<u>208D00000X</u>
<u>Internal Medicine</u>	<u>207R00000X</u>
<u>Internal Medicine, Geriatric Medicine</u>	<u>207RG0300X</u>
<u>Pediatrics</u>	<u>208000000X</u>
<u>Federally Qualified Health Center</u>	<u>261QF0400X</u>
<u>Clinic/Center, Rural Health</u>	<u>261QR1300X</u>
<u>Clinic/Center, Primary Care</u>	<u>261QP2300X</u>
<u>Nurse Practitioner</u>	<u>363L00000X</u>
<u>Nurse Practitioner, Adult Health</u>	<u>363LA2200X</u>
<u>Nurse Practitioner, Pediatrics</u>	<u>363LP0200X</u>
<u>Physician Assistant</u>	<u>363A00000X</u>
<u>Physician Assistant, Medical</u>	<u>363AM0700X</u>
<u>Nurse Practitioner, Family</u>	<u>363LF0000X</u>
<u>Nurse Practitioner, Gerontology</u>	<u>363LG0600X</u>
<u>Nurse Practitioner, Primary Care</u>	<u>363LP2300X</u>
<u>Nurse Practitioner, Community Health</u>	<u>363LC1500X</u>
<u>Nurse Practitioner, School</u>	<u>363LS0200X</u>
<u>Behavioral Health & Social Service Providers</u>	<u>1041C0700X</u>

"Primary care services" or "primary care" means the provision of integrated, accessible health care services by primary care providers and their health care teams who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.

Primary care services include the following categories of Current Procedure Terminology (CPT) codes when provided by primary care providers in a primary care place of service:

- Outpatient visits, including by way of example only 99201-99205 and 99211-99215
- Prevention services, including by way of example only 99381-99387 and 99391-99397
- Office consultations, including by way of example only 99381-99387 and 99391-99397
- Risk assessments and screenings, including by way of example only 99401-99404, 96160-96161 and G0442-G0444
- Home visits, including by way of example only 99341-99345 and 99347-99350
- Domicile services, including by way of example only 99339-99340
- Care management services, including by way of example only 99495-99498 and 99487-99489
- Prolonged services, including by way of example only 99354-99355 and G0513-G0514
- Telephonic communication, including by way of example only 99441-99444 and 99451-99350
- Immunization administration, including by way of example only 90460-90461 and G0008-G0010
- Procedures performed in primary care, including by way of example only 11300-11303, 81000-81001 and 81025
- Integrated behavioral health services, including by way of example only G2086-G2088 and 99446-99449

Primary care also includes services reimbursed via non-fee-for-service payments. Categories of non-fee-for-service payments are aligned with definitions developed for Delaware's Health Care Spending and Quality Benchmarks. The following categories of non-fee-for-service payments shall be included as primary care:

- Primary Care Incentive Programs: All payments made to primary care providers for achievement of specific, predefined goals for quality, cost reduction or infrastructure development, including by way of example pay for performance payments, performance bonuses and electronic medical record/health information technology adoption incentive payments.
- Primary Care Capitation: All payments made to primary care providers made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately and can be separately reported as Incentive Program. These payments are typically made monthly for the care of assigned beneficiaries.
- Primary Care, Case Management: All payments made to primary care providers for providing care management, utilization review and discharge planning.
- A portion of shared savings dedicated to primary care providers and their health care teams.
- Other non-fee-for-service payments for primary care delivery, including by way of example only community health teams, integrated behavioral health, and coordination of social services and health care.

"Professional services" includes services categorized as such as part of development of the Unified Rate Review Template including primary care, dental, specialist, therapy, the professional component of laboratory and radiology, and similar services, other than the facility fee component of hospital-based services.

"Total cost of medical care" means the sum of all payments by carriers, including fee-for-service and non-fee-for-service payments, for medical services paid to healthcare providers on behalf of patients and excludes spending on pharmaceutical products categorized as "pharmacy" as part of development of the Unified Rate Review Template.

"Unified Rate Review Template" means a form that summarizes the data used to determine rate increases for the entire single risk pool. The form and instructions to support its completion are released each year by CMS' Center for Consumer Information and Insurance Oversight (CCIIO).

"Year" means the calendar year in which rates are filed with the Department and applicable to the following plan year.

5.0 Coverage for Primary Care and Chronic Care Management Services

5.1 A carrier shall reimburse a contracted primary care provider, the provider's care teams and the provider's organizations for primary care and chronic care management services furnished to Delaware residents on a fee-for-service basis according to the following:

5.1.1 The reimbursement rate shall be greater than or equal to the non-facility Delaware Medicare fee schedule that is in effect at the time the service is billed and that can be found in the Medicare Physician Fee Schedule published online at [CMS.gov](https://www.cms.gov); and

5.1.2 A carrier shall not use business rules or any other mechanism to discount a reimbursement rate such that the resulting payment would be less than the Medicare payment that would have been made had the Medicare rate been utilized.

5.2 A carrier shall reimburse a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services not provided to Delaware residents on a fee-for-service basis by offering the primary care provider the opportunity to participate in one or more of the following primary care incentive programs:

5.2.1 A program in which non-fee-for-service reimbursement is greater than or equal to primary care incentive programs offered by Medicare (including by way of example only, Comprehensive Primary Care Plus (CPC+) Track 1) adjusted for the age, gender, and health status of the population, as defined by the contract. A carrier that offers a program under subsection 5.2.1 of this regulation shall ensure that the total reimbursement available to a primary care provider, the provider's care teams and organizations, is greater than or equal to the total reimbursement that would be provided according to the methodology of such program, as adjusted for the age, gender, and health status of the population;

5.2.2 A primary care incentive program (including by way of example only, the Medicare Primary Care First Program or CPC+ Track 2) in which non-fee-for-service payments comprise a larger proportion of total provider reimbursement. A carrier that offers a program under subsection 5.2.2 of this regulation shall ensure that the total reimbursement made to a participating primary care provider, the provider's care teams and organizations, is greater than or equal to the total reimbursement that would be provided according to the methodology of such program, as adjusted for the age, gender and health status of the population, as defined by the contract;

5.2.3 A carrier-designed primary care incentive program that transitions a portion of fee-for-service payment to non-fee-for-service payment, provided that:

5.2.3.1 The total PCP reimbursement under the carrier-designed program is greater than or equal to what would be paid by Medicare, adjusted for age, gender, and health status; and

5.2.3.2 The carrier has applied for approval to use the program pursuant to subsection 5.2.4 of this regulation and the Department has granted its approval; or

5.2.4 Any other qualifying primary care incentive program as may be determined by the Department and communicated annually to carriers by annual notice.

6.0 Primary Care Spending Requirements for Rate Filings

6.1 No carrier shall submit a rate filing for a health benefit plan to the Department for approval unless the rate filing reflects the following primary care spending minimums for the applicable plan year to which the rate filing pertains:

6.1.1 In 2022, at least 8.5 percent of the total cost of medical care will be expended on primary care during plan year 2023.

6.1.2 In 2023, at least 10 percent of the total cost of medical care will be expended on primary care during plan year 2024.

6.1.3 In 2024, at least 11.5 percent of the total cost of medical care will be expended on primary care during plan year 2025.

6.2 Each carrier rate filing shall include the following:

6.2.1 A report on primary care expenses using a template supplied by the Department. The report shall include prospective and retrospective data on eligible fee-for-service and non-fee-for-service payments as well as other information as required by the Department. A carrier may submit a request to the Department for a determination on whether an expense qualifies as a primary care expense for purposes of fulfilling the reporting requirements of subsection 6.2.1 of this regulation;

6.2.2 A written demonstration of the carrier's compliance with the primary care spending minimums set forth in subsection 6.1 of this regulation that is based on eligible fee-for-service and non-fee-for-service payments for Delaware residents who are attributed patients of contracted primary care providers, care teams and organizations participating in care transformation activities, and in accordance with the following:

6.2.2.1 In 2022 rate filings for the 2023 plan year, a carrier shall file a plan per instructions issued in an annual notice that describes how the carrier will make progress towards achieving 75 percent of Delaware primary care providers and care team members with attributed patients participating in eligible care transformation activities by 2026;

6.2.2.2 In 2023 and 2024, rate filings for plan years 2024 and 2025, respectively, a carrier shall include a report on progress toward achieving 75 percent of Delaware primary care providers and care team members with attributed patients participating in eligible care transformation activities by 2026. A

carrier may submit a request to the Department for a determination on whether a care transformation activity meets the standards of programs in this subsection; and

6.2.2.3 Eligible activities under subsection 6.2.2 of this regulation include meeting the standards of:

6.2.2.3.1 A carrier primary care incentive program;

6.2.2.3.2 The Delaware Primary Care Model established by the Primary Care Reform Collaborative under the authority of 16 Del.C. §9903(a)(1);

6.2.2.3.3 The National Committee for Quality Assurance Patient-Centered Medical Home certification program as detailed at [NCQA.org](https://www.ncqa.org); or

6.2.2.3.4 Any other standards as may be added by the Department and communicated annually to carriers by annual notice.

7.0 Price Growth Limits for Non-Professional Services

7.1 No carrier shall submit a rate filing for a health benefit plan that includes aggregate unit price growth for nonprofessional services that exceeds the following:

7.1.1 In 2022, the greater of 3 percent or Core CPI plus 1 percent;

7.1.2 In 2023, the greater of 2.5 percent or Core CPI plus 1 percent; and

7.1.3 In 2024, 2025, and 2026, the greater of 2 percent or Core CPI plus 1 percent.

7.2 Each carrier rate filing for a health benefit plan for each plan year shall be based on fee schedules and reimbursement structures that include increases that are no greater than the limits set forth in subsection 7.1 of this regulation.

7.3 The Commissioner shall annually determine the Core CPI percentage increase based on an average of the previous three years of United States Department of Labor data ending January 31st of the applicable rate filing year and shall communicate this determination annually to carriers by Bulletin or other form of notice.

8.0 Alternative Payment Model Adoption

8.1 By 2023, each carrier rate filing for a health benefit plan shall reflect fee schedules and reimbursement structures for inpatient and outpatient hospital facility services delivered in Delaware that are based on a fixed payment, episode-based or population-based payment methodology (e.g., not a percent of charges), including, by way of example, but not limited to:

8.1.1 DRGs for inpatient hospital services; and

8.1.2 APCs for outpatient hospital services.

8.2 By 2023, each carrier's rate filing for a health benefit plan with more than 10,000 Delaware residents enrolled across all fully-insured products shall reflect 50 percent of total cost of care of those Delaware residents tied to an alternative payment model contract that qualifies as a Health Care Payment Learning and Action Network (HCP-LAN) Category 3 shared savings or shared savings with downside risk, with a minimum of 25 percent total cost of care of those Delaware residents covered by an alternative payment model contract that qualifies as HCP-LAN Category 3B, which includes only contracts with downside risk, and in accordance with the following:

8.2.1 For a program to qualify as HCP-LAN Category 3A in 2023 and 2024, the program must offer provider organizations the ability to receive shared savings at a minimum split of 30 percent to the accountable care organizations and 70 percent to the carrier. For a program to qualify as HCP-LAN Category 3A in 2025, it must offer provider organizations the ability to receive shared savings at a minimum split of 40 percent to the accountable care organizations and 60 percent to the carrier;

8.2.2 For a program to qualify as HCP-LAN Category 3B in 2023 and 2024, the program must require accountable care organizations to be responsible for at least 30 percent of losses, or 15 percent of losses if the accountable care organization would be considered low revenue by CMS. For a program to qualify as HCP-LAN Category 3B in 2025, it must require accountable care organizations to be responsible for at least 40 percent of losses, or 20 percent of losses if the accountable care organization would be considered low revenue by CMS; and

8.2.3 Program design elements regarding risk corridors (i.e., minimum shared savings rate and minimum loss rate) and loss sharing limits shall be consistent with the MSSP Pathways model. A carrier may submit a request to the Department for a determination on whether a program design element is consistent with the MSSP Pathways.

9.0 Enforcement

- 9.1 The Department shall monitor carrier compliance with the requirements of this regulation through an annual review of any or all of the following:
 - 9.1.1 Carrier-specific and Medicare fee-for-service data from the DHIN HCCD;
 - 9.1.2 Carrier-submitted templates that report information such as: fee-for-service payments, non-fee-for-service payments, and primary care incentive programs, requirements, numbers of participating providers, performance metrics, price, utilization and total cost trends and other information, as required in this regulation and as identified in annual notices. Carriers shall use templates supplied by the department to provide prospective and retrospective information to confirm carrier requirements were met; and
 - 9.1.3 As necessary, a market conduct exam of a carrier that may include a review of carrier contracts with healthcare providers and additional information as necessary. Any market conduct exam pursuant to this regulation shall be conducted in accordance with the provisions of 18 Del.C. §§318-321.
- 9.2 The Department may report on carrier compliance with this regulation by carrier and by market segment.
- 9.3 The Commissioner may deem carriers as non-compliant for failure to:
 - 9.3.1 Submit a rate filing that conforms to the requirements of this regulation;
 - 9.3.2 Timely remediate filing deficiencies; or
 - 9.3.3 Achieve any of the requirements of this regulation and as approved in annual rate filings.
- 9.4 The Commissioner may elect to take one or more of the following actions for non-compliant carriers:
 - 9.4.1 Return a rate filing to the carrier for amendments and correction of deficiencies;
 - 9.4.2 Require the carrier to submit a corrective action plan;
 - 9.4.3 Create carrier-specific, ongoing, additional reporting and monitoring requirements starting immediately and continuing through the following two plan years; and
 - 9.4.4 Impose administrative penalties, after notice and hearing as specified in 18 Del.C. Chapter 3 including but not limited to:
 - 9.4.4.1 Daily fines of up to \$10,000 per day for failure to submit initial, revised or final filing documents per established timelines or department instructions; and
 - 9.4.4.2 Fines equal to each plan year's value of the deficiency in reimbursement, payment and cost growth limits as set forth in Section 9.0 of this regulation.

10.0 Effective Date of Regulation

This regulation shall become effective on May 11, 2022.

25 DE Reg. 828 (03/01/22) (Prop.)