

**DEPARTMENT OF INSURANCE
OFFICE OF THE COMMISSIONER**

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

FINAL

REGULATORY IMPLEMENTING ORDER

1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

I. SUMMARY OF THE EVIDENCE AND INFORMATION SUBMITTED

A. Proposal 1

In the January 1, 2022 edition of the *Register of Regulations* at 25 **DE Reg.** 684, the Commissioner of the Delaware Department of Insurance (Commissioner) published a proposal which included a notice of intent to codify proposed new Regulation 1322 relating to Requirements for Mandatory Minimum Payment Innovations in Health Insurance (Proposal 1). The proposed new regulation would implement the requirements established pursuant to Senate Substitute 1 for Senate Bill 120 (SS1 for SB 120), through the expanded regulatory authority provided to the Delaware Department of Insurance (the Department) as more fully described in the January proposal. The Department solicited written comments from the public for 30 days as mandated by the Administrative Procedures Act at 29 **Del.C.** §10118(a). The Department did not hold a public hearing on the proposal. The Department received comments from 10 commenters, which are on file with the Department. Two commenters endorsed the Commissioner's proposed regulation wholesale. The other eight commenters offered comments that suggested substantive changes that required further public comment.

B. Proposal 2

In response to the comments received on Proposal 1, the Department published its re-proposed Regulation 1322 (Proposal 2) to affect the same purposes as Proposal 1, taking into consideration comments received on Proposal 1. The Department provided a summary of the comments received in connection with Proposal 1 in a separate section of the introduction to Proposal 2 (see at 25 **DE Reg.** 828 (03/01/2022)), along with the Department's responses and determinations related to the comments received. As with Proposal 1, the Department solicited written comments on Proposal 2 from the public for 30 days as mandated by the Administrative Procedures Act at 29 **Del.C.** § 10118(a). The Department did not hold a public hearing on Proposal 2. The Department received comments on Proposal 2 from two commenters, which are on file with the Department.

C. Summary of Public Comment and Responses on Proposal 2

1. Comments related to Section 3.0 - Scope

One commenter requested the Department again clarify that the regulation applies to the fully insured market only and remove language related to self-insured plans.

2. Comments related to Section 4.0 - Definitions

One commenter requested several changes to the definition of "primary care services" or "primary care" in Section 4.0 of the regulation as points of clarification as follows: (i) add clarifying language to specify that categories of Current Procedure Terminology (CPT) codes are provided by way of example and may expand in the future; (ii) clarify that administrative overhead expenses for primary care services be included without limitation based solely on parent/subsidiary status of the primary care provider or parent entity of the primary care provider; and (iii) include outpatient office-based behavioral health services as a category of "primary care."

One commenter requested the Department include primary care services paid on a non-claims-based basis in its definition of primary care.

Apart from the comments received by the Department, the Department is taking the opportunity to make minor technical corrections to the regulatory text that do not alter the substance of the regulation.

II. FINDINGS OF FACT

1. Proposed new Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

- implements the requirements of SS1 for SB 120 (83 Del. Laws., c. 237 (2021)).
2. The Commissioner finds that the Department responses and determinations related to the comments received on Proposal 1 are appropriate for the reasons set forth in the public notice for Proposal 2.
 3. The Commissioner determines that the following revisions add clarity to the text of the regulation without changing the substantive meaning of the regulation and are therefore permitted pursuant to the Administrative Procedures Act at 29 **Del.C.** § 10118(c), which allows non-substantive changes to a proposal to be made on adoption as a result of public comments:
 - a. The sentence in Section 1.0 of the regulation (Authority) regarding the Department's authority to set affordability standards will be deleted since the original Section 9.0 from Proposal 1 was deleted in Proposal 2 in response to public comments received.
 - b. As stated in the Department's response to comments on Proposal 1, the Department recognizes the need to allow flexibility for the regulation to keep up with rapid advances in the field of primary care. The Commissioner agrees with modifying the definition of "primary care services" in Section 4.0 to clarify that the identified list of procedures and CPT codes is not an exhaustive list of the types of services that may be included in the definition of "primary care services."
 - c. The language in subsection 5.2 of the regulation related to "services not provided to Delaware residents on a fee-for-service basis" should be clarified to read "services provided to Delaware residents on a non-fee-for service basis," which is consistent with the terminology used in subsection 5.2.3 of the regulation and better reflects the intent of the original language without the potential for misinterpretation.
 4. The Commissioner declines to further clarify that the regulation applies only to fully-insured plans, as requested by one commenter. As the commenter points out in its letter, the Department has already clarified, both in the public notice to Proposal 2 and the re-proposed regulation, that it has no jurisdiction to require self-insured plans to comply with the regulation or the statute. Because the proposed regulation at Section 3.0 is clear that it applies only to the fully-insured market, no further changes to the proposed regulation are necessary, and the Department cannot delete or remove language that was published in public notice related to Proposal 2.
 5. The Commissioner declines to adopt the suggestion that language be added to the definition of "primary care services" to clarify that reimbursement for services include administrative overhead expenses without limitation based solely on the parent/subsidiary status of the primary care provider or parent entity of the primary care provider. The Commissioner assumes that investments in primary care will, in part, reimburse for some administrative overhead expense associated with primary care delivery. However, since the purpose of SS1 for SB 120 is to develop a robust system of primary care by 2026, it is critical that dollars are paid to primary care providers, care teams and organizations, and then those providers determine how the dollars are spent to create the most effective and efficient care delivery for patients and meet the requirements of the carriers' programs.
 6. The Commissioner declines to adopt the suggestion of one commenter to include outpatient office-based behavioral health services in the definition of primary care. The Commissioner agrees with the commenter that there is a deficiency in behavioral health services and that incentives should be in place to encourage the expansion of behavioral health services. As such, the Department has already included behavioral health clinicians in its definition of primary care providers and included integrated behavioral health in its definition of primary care services. No additional changes are required to the regulation in response to this request.
 7. The Commissioner declines to adopt the suggestion of one commenter to include primary care services paid on a non-claims-based basis in its definition of primary care. The Commissioner determines that the regulation already includes several non-exclusive categories of non-claims-based services in the proposed definition of "primary care," including the specific services noted in the commenter's response, and, therefore, no additional changes are required to the regulation in response to this request.

III. DECISION TO ADOPT

For the foregoing reasons, the Commissioner concludes that it is appropriate to adopt proposed new 18 **DE. Admin. Code** 1322 as further amended by this order.

IV. EFFECTIVE DATE OF ORDER

The effective date of the Regulation shall be ten (10) days from the date this Order is published in the *Delaware Register of Regulations*, pursuant to 29 **Del.C.** § 10118 and 29 **DE Admin. Code** 101-5.1.

IT IS SO ORDERED.

The 18th day of April, 2022.

Trinidad Navarro
Commissioner

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 **[non-exhaustive list of]** categories of Current Procedure Terminology (CPT) codes **[, which is intended for guidance purposes only and is not intended to be an all-inclusive list of the types of services that may be included in the definition of "primary care services" or "primary care,"]** 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 [non-]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. 1028 (05/01/22) (Final)