# Annual Review of Carrier Progress Towards Meeting Affordability Standards

**FEBRUARY 2023**

OFFICE OF VALUE-BASED HEALTH CARE DELIVERY
DELAWARE DEPARTMENT OF INSURANCE

# *Fellow Delawareans –*

We face rising costs in nearly every area of life. At the Department of Insurance, we are working to make healthcare coverage affordable and accessible so that Delawareans can focus on their health.

This year, Delaware consumers have more Health Insurance Carriers and plans to choose from than ever before. We remain optimistic that this increased competition will lead to lower rates and higher care quality over time.

It is no coincidence that this increase in consumer choice occurred in the same year that laws limiting hospital price growth to appropriate, inflation-conscious levels became enforceable. Insurers nationally are requesting steep increases due to inflation, increasing costs of care, and rising drug prices. We have worked hard to shield Delawareans from many of these impacts.

The hospital price growth law, for the first time in our state's history, gave insurers leverage to negotiate lower costs for consumers, while still ensuring that hardworking healthcare providers receive their fair share. Other new statutes and regulations – all enforceable for the first time this year – require commercial health insurance companies to make meaningful increases in primary care investment and create new partnerships with providers to improve quality and value.

These concepts were recommended by our Office of Value-Based Health Care Delivery in our 2021 inaugural report, "An Integrated Approach to Improve Access, Quality and Value." We are grateful to have worked with legislators and the Primary Care Reform Collaborative to build on those recommendations and develop policy that requires compliance with these important goals. Following an in-depth data review, we are pleased to announce that commercial health insurance companies are on track to be compliant for the 2023 plan year. Refocusing Delaware's healthcare system on primary care and improving value requires commitment and collaboration with primary care providers and their care teams, hospitals and health systems, commercial health insurance companies, employers, and even patients. More about their strategies to meet the requirements and the market conditions that enable these are described in this report.

Commercial health insurance companies have spent the last year designing programs and adjusting agreements with providers. Our Office has supported them with more than two dozen discussions on compliance with the laws and policies and will be continuing to support them throughout the year. We look forward to providers engaging in these programs, so they have the resources necessary to offer the best care to their patients.

Sincerely yours,

**TRINIDAD NAVARRO**
Delaware Insurance Commissioner

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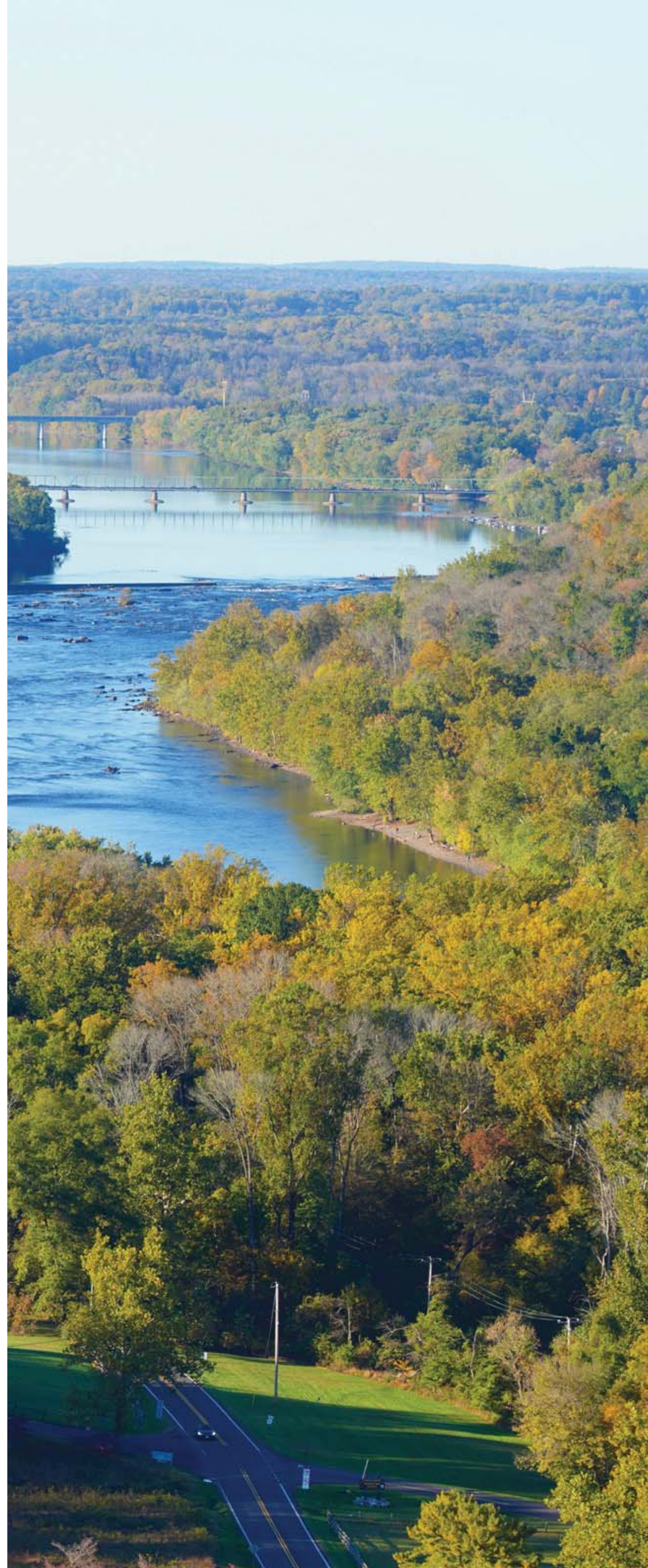

# EXECUTIVE SUMMARY:

For more than three decades, Delaware healthcare costs and cost growth have ranked among the highest in the nation. Since its inception in 2020, the Delaware Department of Insurance's Office of Value-Based Health Care Delivery (the "Office") has worked to improve healthcare access and affordability in the state.

Following extensive data analysis and with input from stakeholders across Delaware, the Office made three recommendations to address commercial premiums in Delaware.

These recommendations have informed a series of recent statutory and regulatory changes including Senate Bill 120 and related regulations and statutes. This report outlines Delaware commercial Health Insurance Carriers' ("Carriers") projected compliance with these requirements and provides additional information on healthcare cost, utilization and market trends in Delaware.

This report provides an overview of the first year of implementation, including Carriers projected compliance with each requirement for 2023.

## *Requirements for Fully-Insured Commercial Health Plans and Key Findings*

### REQUIREMENT

Reimburse at least as much as Medicare for primary care and chronic care management services, and offer a non-Fee-for-Service component to reimburse for services such as creating care plans and checking in with patients between visits.

**Key Findings:** All carriers were materially in compliance. Carriers typically reimbursed primary care and chronic care management services at the Delaware Medicare rate or higher. Many have adjusted reimbursement processes and provider contracts to meet this requirement. They either offer or have plans to offer non-fee-for-service reimbursement for these services to providers.

### REQUIREMENT

Increase primary care investment as a percent of total medical spending to reach annual, minimum thresholds for providers in care transformation activities.

**Key Findings:** All carriers project they will meet the 2023 plan year requirement to invest at least 8.5% of total medical expense in primary care. The Office calculates compliance based on primary care spending for Delawareans who are "attributed to" or regularly visit Delaware primary care providers. The primary care provider also must be participating in care transformation activities, such as those listed in Appendix 2. Participation can occur through a carrier program or by earning National Committee for Quality Assurance Patient-Centered Medical Home Recognition. The required level of investment increases by 1.5 percentage points annually until reaching 11.5% in 2025.

For Delawareans attributed to Delaware primary care providers engaged in care transformation, carriers project they will spend 10% of total medical expense or an estimated $67 per member, per month on primary care services in 2023. This is a projected 63% increase over the previous year.

The statute does not require carriers pay primary care providers equally or spread the 8.5% increase in any specific manner. Carriers have made it clear that primary care providers will receive different payment amounts based on the contracts that are implemented. The statute also does not define how carriers should structure their value-based programs. The Office continually recommends carriers to meet the increased investment through a combination of increased fee-for-service payments, prospective care management payments and when appropriate, some component of shared risk for cost and outcomes.

### REQUIREMENT

Target 75% of primary care providers participating in care transformation activities by 2026.

**Key Findings:** There is not a compliance requirement for the 2023 plan year. Carriers project 35% of fully-insured members will be attributed to a primary care provider in a care transformation program in 2023. To achieve this projection, carriers are developing new programs that include substantial non-fee-for-service payments.

These payments will support care management, expanded access, integrated behavioral health, and other care transformation activities.

### REQUIREMENT

Limit price growth for hospital and other non-professional services to better align with growth in the overall economy.

**Key Findings:** All carriers project compliance with unit price growth limits for inpatient, outpatient and other medical services for plan year 2023. Carriers expect commercial prices for inpatient and outpatient hospital and other non-professional services will continue to increase 3% to 5% per year, on average, in 2023. This rate of growth is consistent with previous trends. The limits on price growth for non-professional services help Delaware avoid the steep commercial hospital price growth being reported in some states for 2022 and 2023. The Office estimates these limits saved Delawareans $2 million to $12 million in 2023, depending on the price increases hospitals would have otherwise negotiated.

### REQUIREMENT

Expand meaningful alternative payment model adoption by requiring healthcare providers to be more accountable for spending and value.

**Key Findings:** The alternative payment model adoption requirement includes two components 1) Movement to Fixed, Episode-Based and Population-Based Payment Methodologies and 2) Increased, Shared Accountability for Total Cost of Care. There is no compliance requirement for either component in plan year 2023. Carriers reported they are working with providers to make the necessary contract adjustments to meet future years' compliance requirements.

**In summary, based on projections for 2023, the Office estimates the following:**

- **Primary care investment will increase approximately $8 million more in 2023 with the passage of SB 120 than it would have without passage of the legislation.**
- **A savings of $2 million to $12 million in 2023 due to limits on price growth for non-professional services.**

The Office will publish updated guidance via Bulletin and an updated 2024 ASDS template and instruction manual in March 2023.

The Office appreciates the extensive efforts of carriers and providers to implement SB 120 and its related regulations and statutes. For plan year 2023, carriers anticipate compliance with all requirements. Each year of implementation will bring new requirements, challenges and opportunities. The Office looks forward to continuing to work collaboratively with carriers and other stakeholders to achieve our shared goal of improving healthcare access and affordability in Delaware.

# INTRODUCTION

Healthcare costs and cost growth in Delaware have outpaced the nation for more than 30 years. Delaware ranked among the Top 10 states for highest health care spending per capita – typically 5th or 6th – from 1991 to 2020, based on data for all years available from the Kaiser Family Foundation.[1] Per capita health care costs in Delaware increased an average of 5.4% per year during the same period, ranking it among the Top 10 in growth as well.[2]

In 2019, the Delaware General Assembly established the Office of Value-Based Health Care Delivery (the "Office") within the Department of Insurance (DOI) as one component of a multi-faceted effort to address the state's long-standing high health care cost challenges (see box on page 7). Following extensive data collection and stakeholder engagement, the Office released "Delaware Health Care Affordability Standards: An Integrated Approach to Improve Access, Quality, and Value" in 2021.[3] In this report, the Office made three recommendations to address commercial premiums in Delaware.

1. Increase primary care investment
2. Limit price growth for hospital and other non-professional services
3. Expand meaningful adoption of alternative payment models

New statutes and regulations followed including Senate Bill 120, its companion regulation, Regulation 1322: Requirements for Mandatory Minimum Payment Innovations in Health Insurance, and SB 222. Together, they aim to be a catalyst in creating a robust primary care system by 2026 without increasing health care cost growth. In addition, limiting price growth for hospital and other non-professional services offsets the cost of increased primary care investment, while expanding meaningful alternative payment model adoption helps to better align all stakeholders for long-term value.

This report provides an overview of the first year of implementation, including commercial health insurance carriers' ("Carriers") projected compliance with each requirement for 2023.

To achieve success, providers and Carriers must work together by sharing accountability and aligning payment and care delivery strategies. Primary care providers must expand access and transform how care is delivered. Health systems must find new ways to provide care more equitably and efficiently. Carriers must develop programs that fairly compensate providers for primary care and other high-value services.

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1. Kaiser Family Foundation 2022
2. Kaiser Family Foundation 2022; Kaiser Family Foundation 2022
3. Office of Value-Based Health Care Delivery 2021

# REQUIREMENTS AND COMPLIANCE

## Requirements for Fully-Insured Commercial Health Plans

Through enacting these statutes and regulations, the State of Delaware has laid the foundational steps the healthcare landscape will need to begin building a robust primary care system that will increase access and improve health outcomes for patients. The Office focused its evaluation of Carriers' compliance with five requirements. The next section discusses each requirement and the Carriers' projected compliance with each requirement for plan year 2023.

1. Reimburse at least as much as Medicare for primary care and chronic care management services, and to additionally offer providers non-fee-for-service payments to offer value-added programs, such as creating care plans and checking in with patients between visits.
2. Increase primary care investment as a percent of total medical spending to reach annual, minimum thresholds for those providers engaged in care transformation activities.
3. Target 75% of primary care providers participating in care transformation activities by 2026.
4. Limit price growth for hospital and other non-professional services to better align with growth in the overall economy.
5. Expand meaningful alternative payment model adoption by requiring healthcare providers to be more accountable for spending and value.

**Examples of other initiatives to improve healthcare quality and affordability in Delaware:**

- Spending and Quality Benchmark Program
- Primary Care Reform Collaborative
- State reinsurance program
- Essential Health Benefits Review
- Lifting reimbursement and other barriers to telemedicine
- Improvements in prescription drug affordability including limits on consumer cost sharing and prior authorization

Accountability for these requirements occurs through the annual rate review process. Carriers must complete the Affordability Standards Data Submission (ASDS), a set of detailed supplemental filings, in addition to their standard rate filing for each market segment. The ASDS includes an Excel template and an instruction manual to support completion. Carrier compliance is based on data submitted in the ASDS.

The statute assigns responsibility for other tasks to the Delaware Health Care Commission. These tasks include the continued convening of the Primary Care Reform Collaborative (PCRC), monitoring primary care and other providers' uptake of value-based care models, and developing a Delaware Primary Care Model.

The policy initiatives in Delaware are consistent with several states' efforts to control healthcare costs. Three other states – Rhode Island, Colorado, and Oregon – have passed laws to require increases in primary care investment. Delaware's approach is most similar to Rhode Island, which also funds the increased investment through limits on price growth for other services (e.g., hospital services) and requires movement to alternative payment models. More states appear to be on a similar path. At least 13 states now measure primary care investment. Eight states collect data on alternative payment models to evaluate progress towards value-based care implementation.

## *Requirement 1: Reimburse at least as much as Medicare for Primary Care and Chronic Care Management Services*

The Medicare parity requirement includes a fee-for-service component and a non-fee-for-service component. The fee-for-service component requires carriers to reimburse providers for primary care and chronic care management services at a rate no less than the Delaware Medicare Physician Fee Schedule (MPFS). The non-fee-for-service component requires carriers offer primary care providers the opportunity to receive non-fee-for-service payments for primary care services not typically reimbursed on a fee-for-service basis. Examples of these services include helping patients manage chronic conditions or coordinate care across a team of specialists or care settings.

### Data Collected to Assess Compliance

To demonstrate compliance with the fee-for-service component, carriers provided data on their lowest contracted fee, and lowest reimbursement for more than 182 Current Procedural Terminology (CPT) codes defined as primary care and chronic care management services. The Office developed the code set with input from the PCRC.

To demonstrate compliance with the non-fee-for-service component, carriers provided written documentation detailing an internal program. The documentation included examples of covered services, how payments were calculated and whether payments were adjusted to account for differences in patient needs. Carriers also were deemed compliant if they participated in the Centers for Medicare and Medicaid Services (CMS) Primary Care First (PCF) program. PCF is a voluntary, multi-state primary care payment model that rewards value and quality by offering an innovative payment structure to support the delivery of advanced primary care.

### Compliance

All carriers were materially in compliance with both components of the Medicare parity requirement. One carrier is working to identify a limited number of instances in which underpayment occurred and provide appropriate compensation to impacted providers.

Fee-for-service Medicare parity has been a statutory requirement since 2018. The Office previously assessed compliance for 2019 and 2020 and reported similar findings.[4] Carriers have adjusted reimbursement processes and/or amended provider contracts to comply with the law.

4. Office of Value-Based Health Care Delivery 2021

All carriers also reported they will continue or begin to offer non-fee-for-service reimbursement to primary care providers. For some carriers, these programs will begin as a pilot and expand to other primary care providers over the next two to three years.

## Additional Discussion

When the Office assessed compliance for 2019 and 2020, it initially compared carrier fee schedules to the MPFS. Then, it reviewed actual amounts paid using data from the carriers and from the Delaware Health Information Network (DHIN), the state's all-payer claims database. Through this review, the Office noted some carriers applied business rules that resulted in a lower final reimbursement than the MPFS but not necessarily lower than what Medicare would have paid under similar circumstances. The Office determined carriers may apply business rules so long as the resulting reimbursement is at least as much as Medicare would have paid.

This is the first year the Office is evaluating carriers' business rules as an aspect of compliance with Medicare parity requirements. More information on these business rules and how carriers apply them is provided below. The Office did not allow two of the four business rule explanations provided by carriers. If carriers had fully reimbursed for these services, Delaware primary care providers would have received an additional $360,966 across all providers in 2021. Carriers do not project any underpayment for 2023 nor in future years. The Office will provide additional guidance on allowable and non-allowable business rules as part of the Bulletin released with the 2023 ASDS for plan year 2024.

### Business Rule 1: Advanced Practice Practitioner provided the service

- **DOI Determination:** Allowed. In developing the original legislation, SB 226, the General Assembly discussed whether Advanced Practice Practitioners should be paid at least as much as the Medicare physician reimbursement or the discounted rate allowed by Medicare. They decided to allow the discounted rate consistent with Medicare policy.

### Business Rule 2: Multiple services provided during the same visit

- **DOI Determination:** Allowed. This is a common practice across all payers, including Delaware commercial carriers and Medicare.

### Business Rule 3: Provider was paid below Medicare fee schedule for a specific code but, across all services, paid above the Medicare fee schedule

- **DOI Determination:** Not allowed. Carriers must reimburse for each CPT code at a rate greater than or equal to Medicare.

### Business Rule 4: Provider billed a rate less than the Medicare rate

- **DOI Determination:** Not allowed if the contract between the provider and payer has not been updated to reflect the Medicare parity requirement.

## *Requirement 2: Increase primary care investment to reach minimum, annual thresholds*

For 2023, carriers must increase primary care investment to a minimum of 8.5% of total medical expense. The Office calculates compliance based on primary care spending for fully-insured Delawareans who are “attributed to” or regularly visit Delaware primary care providers who participate in care transformation activities, such as those listed in Appendix 2. Participation can occur through a carrier program or by earning National Committee for Quality Assurance Patient-Centered Medical Home Recognition. The required level of investment increases by 1.5 percentage points annually until reaching 11.5% in 2025.

### Data Collected to Assess Compliance

The Office evaluates primary care investment using a definition informed by national best practices and input from the PCRC. The definition includes a code set for fee-for-service payments and other criteria for non-fee-for-service payments. More information on the definition numerator and denominator can be found in Appendix 1. Carriers provided results of the analysis in the ASDS. Data from the Delaware Health Information Network (DHIN), the state’s all-payer claims database, was used to help validate fee-for-service primary care spending.

### Compliance

All carriers project they will be in compliance for the 2023 plan year. Compliance does not require carriers increase payment equally across all providers. It also does not require carriers implement a specific care transformation program with defined terms or payment mechanisms.

For Delawareans attributed to Delaware primary care providers participating in care transformation activities, carriers project they will spend 10% of total medical expense or an estimated $67 per member, per month on primary care services in 2023. This is a projected 63% increase over the previous year. Carriers project primary care investment across their entire populations will equal 7% of total medical expense or $38 per member, per month, as shown in Exhibit 1. This level of investment is higher than most states nationally and a 31% increase over the previous year.

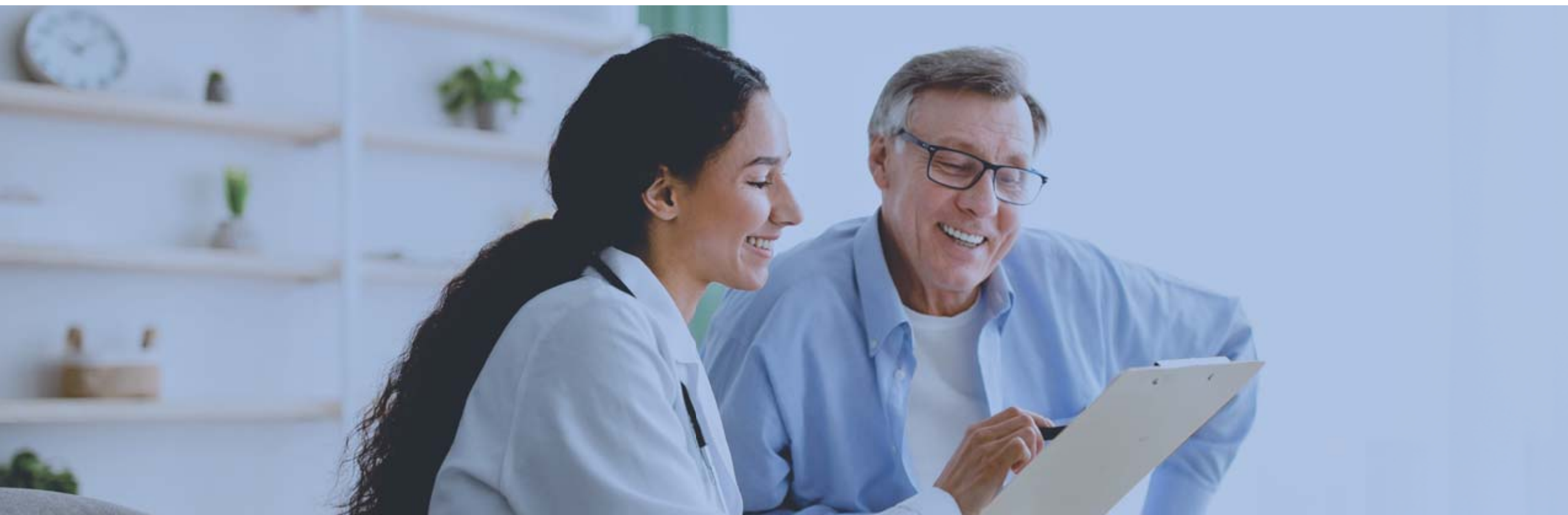
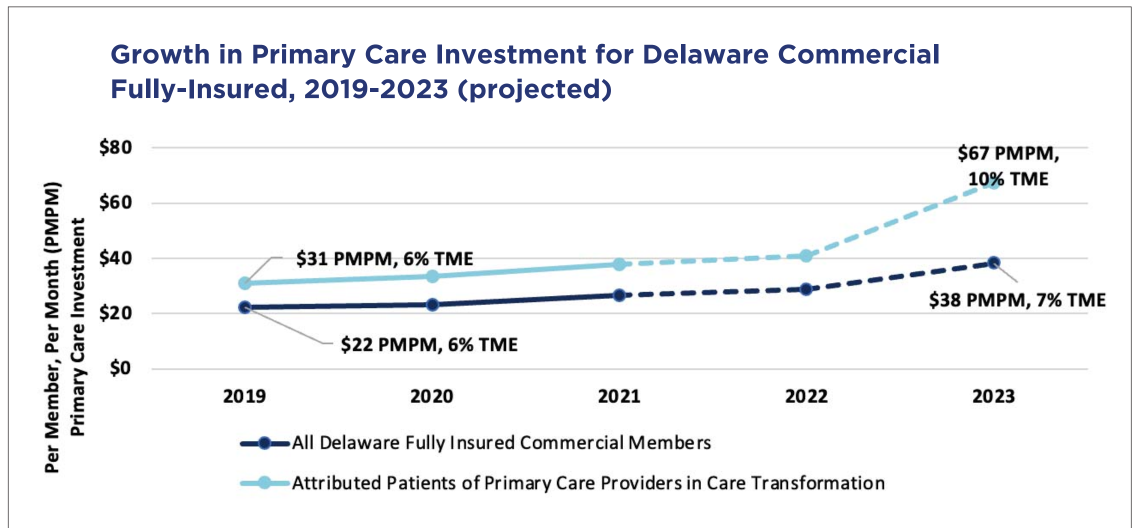


**EXHIBIT 1:**




Source: Carrier Affordability Standards Data Submissions to the Office. Data reflects commercial fully insured.

## Additional Discussion

The Office estimates primary care investment will increase approximately $8 million more in 2023 with the passage of SB 120 than it would have without passage of the legislation.

The increase in primary care investment aims to help address primary care access issues across the state[5]. The Office will continue discussions with Carriers regarding their prospective payment programs to ensure projected amounts are realized into program design. This upfront investment is important for providers prior to their commitment to fully engage in value-based care delivery.

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5. Toth, Primary Care Physicians in Delaware 2021, 2022

A 2021 survey of Delaware primary care providers reported significant challenges with access, and some improvement, compared to a 2018 survey[6]. Both surveys were conducted by the University of Delaware on behalf of the Delaware Department of Health and Social Services. The most recent survey found slight increases in the number of primary care physicians practicing in two of Delaware's three counties as compared to a similar survey conducted in 2018. Respondents to the 2018 survey projected the number of Delaware primary care physicians practicing in Delaware would decline by 2023. This exodus does not appear to be occurring yet. However, a similar percentage of primary care physicians - more than 30% - said they were not planning to be in practice or were "unsure" if they would be in practice in five years. The survey also estimated the average wait time for a new patient appointment with a primary care provider to be nearly 26 days, the highest in the 20-year history of the survey with the exception of 32 days in 2013.

Whether carriers meet their 2023 primary care investment projections will depend, in part, on primary care providers' ability to implement care transformation activities targeted to transform care delivery. So far, carriers have had difficulty widely deploying programs that offer sufficient financial incentives, especially prospective payments, to gain providers' interest. Nationally, successful programs aimed at increasing primary care investment require primary care providers to offer additional access and advanced capabilities that include care management and care coordination.

6. Toth, Primary Care Physicians in Delaware 2018, 2018

## *Requirement 3: Target 75% of primary care providers in care transformation activities by 2026*

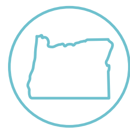
Carriers must target 75% of primary care providers in care transformation activities by 2026. Primary care providers qualify as participating in care transformation activities if they meet one of the following criteria:

- Enroll in a carrier program that provides additional payments to primary care providers working to achieve advanced primary care capabilities
- Achieve National Committee for Quality Assurance Patient-Centered Medical Home Recognition (PCMH)
- Participate in the Delaware Primary Care Model (in development by the PCRC)
- Any other standards as may be added by the DOI and communicated annually to carriers by annual notice

### Data Collected to Assess Compliance

Carriers provided information on the number of individual primary care providers and provider organizations contractually required to achieve each of the care transformation activities listed below. Carriers also reported the number of members attributed to those providers. The suggested activities below reflect goals for primary care in Delaware discussed at the PCRC in 2020 and 2021. More information on these activities can be found in Appendix 2: Care Transformation Program Capabilities.

#### Examples of Care Transformation Activities Tied to Additional Investment in Other States



Oregon's Patient-Centered Primary Care Home Program offers financial incentives to primary care providers able to meet a set of defined standards. Through this model, payers including the Public Employee's Benefit Board and Medicaid pay practices attaining PCMH recognition per member, per-month supplemental payments.

Rhode Island's Office of the Health Insurance Commissioner (OHIC) requires that insurers make supplemental payments to primary care practices recognized as Patient-Centered Medical Homes (PCMH) to help finance their transformation and operations. OHIC requires PCMH practices demonstrate participation in a formal care transformation initiative through National Committee for Quality Assurance (NCQA) recognition or another program meeting a defined set of criteria.

Washington Health Care Authority's (WHCA) Multi-Payer Primary Care Transformation Model plans to require providers meet a defined set of care transformation capabilities in exchange for increased, flexible investment and other support.

### Examples of Care Transformation Activities

- Team-Based Care & Care Management
- Planned Care at Every Visit
- Active Use of Data
- Integration of Primary Care & Behavioral Health
- Effective Management of Tests and Referrals
- Integration of Primary Care & Social Services

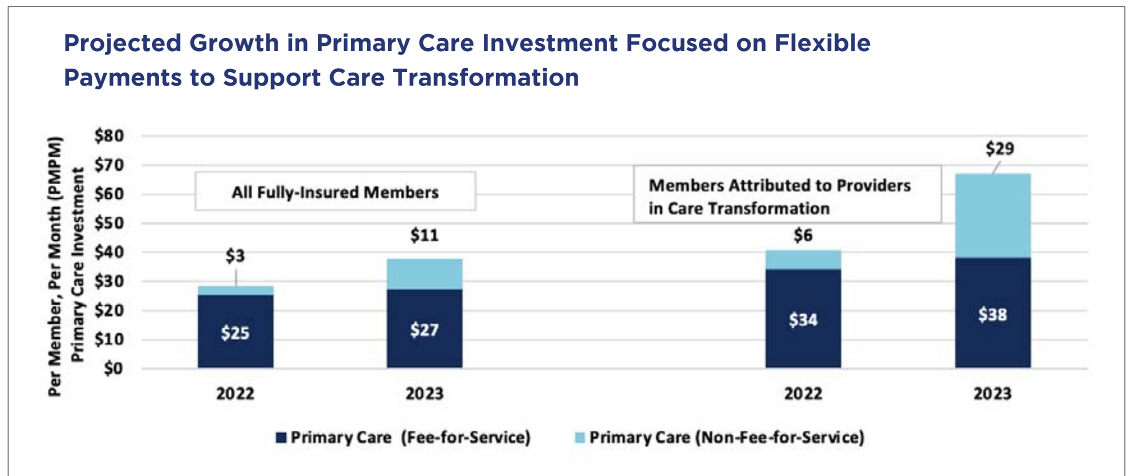
## Compliance

No compliance requirement for 2023.

Carriers project 35% of fully-insured members will be attributed to a primary care provider participating in care transformation activities in 2023. To achieve this projection, carriers are developing new programs that include substantial non-fee-for-service payments, averaging $29 per member, per month, as shown in Exhibit 2. These payments will support care management, integrated behavioral health, and other activities listed above.

## EXHIBIT 2:

Source: Carrier Affordability Standards Data Submissions to the Office. Data reflects commercial fully insured.



Carriers project non-fee-for-service payments will include care management, capitation, incentive and shared savings payments. Average payment amounts by category, in aggregate across payers, are shown in Exhibit 3.

## EXHIBIT 3:

Source: Carrier Affordability Standards Data Submissions to the Office. Data reflects commercial fully insured.

**Projected Non-Fee-For-Service Primary Care Investment (PMPM) for Members Attributed to Providers in Care Transformation, 2023**

## Additional Discussion

The Office has met frequently with carriers to provide technical assistance. Its guidance has focused on the following six principles:

1. Though not required, extend programs and related investments to self-insured members. This approach offers primary care providers the greatest opportunity to transform care across patients and limit the risk of fully-insured members subsidizing the provision of care management and other services delivered to self-insured members.
2. Align its program goals with the Office's list of care transformation activities so providers can focus on an aligned set of activities and pool resources across carriers.
3. Identify and promote opportunities for smaller practices to "buy in" to shared services (e.g., care management, integrated behavioral health) offered by other provider organizations.
4. Expand programs to layer multiple types of payments to balance provider need for guaranteed revenue and carrier need for accountability. Examples may include:
    - Increased fee-for-service rates
    - Per member, per month, prospective payments to support care transformation activities
    - Incentive payments to recognize quality and value
5. Recognize that achieving new capabilities requires upfront investment. Primary care providers may be hesitant to join programs where new investments are delayed or uncertain.
6. Enact accountability mechanisms including requiring providers attest to a defined set of care transformation activities and milestones. Over time, outcomes reporting may be necessary to ensure employers and members receive access and value in exchange for these increased investments.

As implementation continues, the Office will continue collaborating with carriers, providers, and policymakers. The Office is requiring each carrier provide quarterly email updates and participate in quarterly calls to track progress, address challenges, and receive technical assistance.

## *Requirement 4: Limit price growth for hospital and other non-professional services to better align with growth in the overall economy*

For 2023, carriers must limit price increases to 5.5% for each of the three categories of non-professional medical services – inpatient hospital, outpatient hospital, and other medical services, as defined by the Unified Rate Review Template (URRT). ***See Glossary for definitions***. In future years, carriers must limit price growth for each of these service categories to the regional Core Consumer Price Index (CPI) plus 1%. To smooth fluctuations in inflation, the Core CPI is averaged over the previous two years. More information on how the Core CPI is calculated is provided in the box below.

### Data Collected to Assess Compliance

Carriers provided information on aggregate price, utilization, and total cost of care trends across providers for 2019, 2020 and 2021. Carriers projected the same information for 2022 and 2023. Data was provided by URRT service category for each market segment.

### Compliance

All carriers project compliance across all market segments for each of the three required service categories – inpatient hospital, outpatient hospital, and other medical.

**Key Findings:** The Office estimates these limits saved Delawareans $2 million to $12 million in 2023, depending on the price increases hospitals would have otherwise negotiated.

**HOW IS THE CORE CPI CALCULATED?**

The Core Consumer Price Index (CPI) is an inflation rate developed by the United States Bureau of Labor Statistics. It measures inflation across industries except food and energy, which tend to be more volatile. SB 222 defines how the Core CPI is used to determine Delaware's limits on non-professional price growth. For this purpose, Core CPI is calculated as the average of the 12 preceding, bimonthly indices. The methodology looks at the year-over-year changes in these indices and is based on the results for the Philadelphia-Camden-Wilmington area.

**WHAT IS THE UNIFIED RATE REVIEW TEMPLATE (URRT)?**

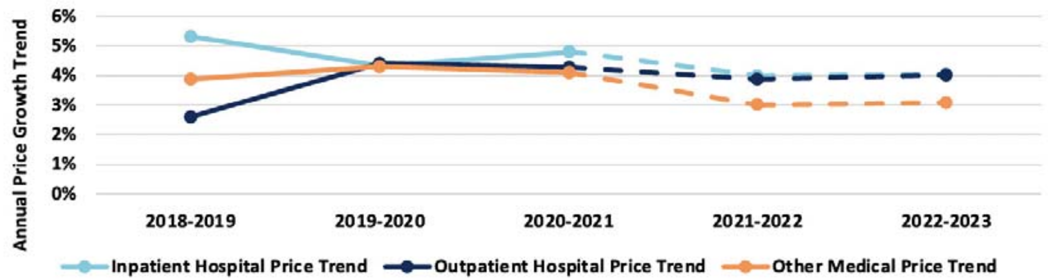
Carriers offering health insurance coverage for small group and individual plans are required to submit information on rate increases to the federal government. The URRT is the format used for these filings.

Carriers expect commercial fully-insured prices for inpatient and outpatient hospital and other non-professional services will continue to increase 3% to 5% per year, on average, until 2023, as shown in Exhibit 4. This rate of growth is consistent with previous trends. The limits on price growth for non-professional services help Delaware avoid the steep commercial hospital price growth being reported in some states for 2022 and 2023.

## EXHIBIT 4:

Source: Carrier Affordability Standards Data Submissions to the Office. Data reflects commercial fully insured.

**Annual Price Growth by Service Category for Delaware Commercial Fully-Insured, 2018-2023 (projected)**

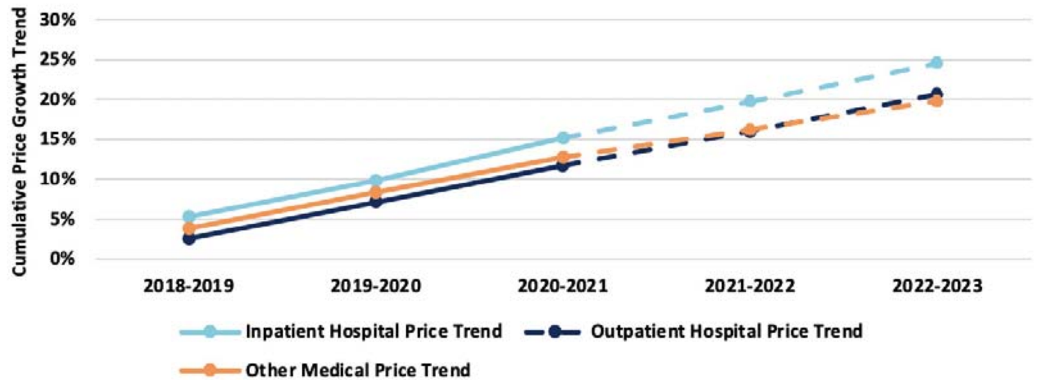



Though annual price growth trends have begun to moderate, the compounded impact of price growth over the years continues to put pressure on efforts to lower total costs. Price growth for hospital and other non-professional services are projected to increase 20% to 25% from 2018 to 2023 depending on the service category as shown in Exhibit 5.

## EXHIBIT 5:

Source: Carrier Affordability Standards Data Submissions to the Office. Data reflects commercial fully insured.

**Cumulative Price Growth by Service Category for Delaware Commercial Fully-Insured for 2018-2023 (projected)**



## Additional Discussion

Carriers reported that before statutory requirements, they lacked the negotiating power necessary to secure competitive pricing for their members. Carriers now recommend strengthening the existing statute to include additional requirements for hospitals and other providers to meet the price growth limits. Similar requirements are in place in Rhode Island and under consideration in Massachusetts.

Delaware hospitals opposed cost containment efforts throughout the 2021 legislative process. Some moved to support the effort, only after a January 2027 sunset provision was included. The sunset provision was intended to show the General Assembly that such codified oversight was unnecessary and could be self-imposed by the parties.

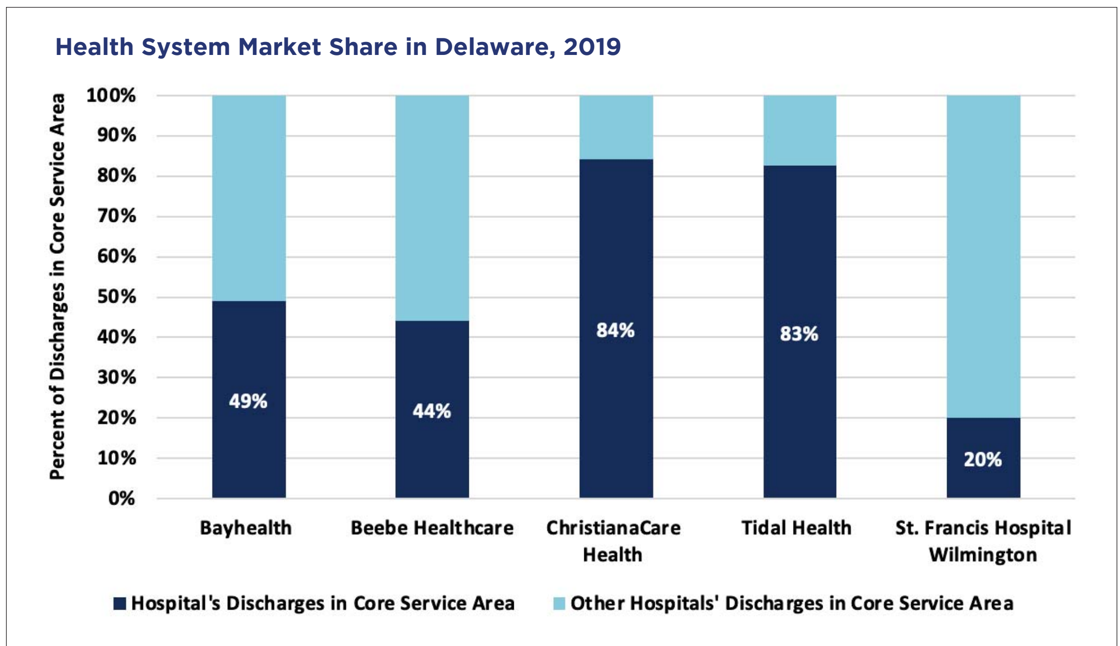
In 2022, Delaware hospitals pushed back on the price growth limits, citing unusually high inflation and staffing costs. The General Assembly passed a compromise, SB 222, hours before carriers were required to submit rate filings demonstrating compliance. The compromise included a one-time adjustment to increase the 2023 price growth limits to 5.5% from 3.7%. It also revised the methodology for calculating the price growth limits in future years. Previously, the limits were based on three years of national economic data. They now are based on two years of regional economic data.

Though carriers expect to be in compliance with the 2023 price growth limits, they continue to share frustrations with some health systems' reluctance to make necessary contract adjustments to further cost containment.

Delaware has a highly concentrated health system market, as shown in Exhibit 6. There are six major health systems in the state including Nemours Children's Health, which is not shown below. ChristianaCare and Nanticoke Health Systems receive more than 80% of patient discharges in their core service areas. Carriers report this level of market concentration and lack of competition within each hospital's service area make it challenging to exclude any hospital from their networks.

### EXHIBIT 6:

Source: Delaware Health Statistics Center- Hospital Discharge Data, 2019. Core service area information sourced from hospital community benefit reports and community health needs assessments from Bayhealth, Beebe Healthcare, ChristianaCare Health, Nanticoke Health Services, and St. Francis Hospital Wilmington. Nanticoke merged with Peninsula Regional Medical Group in 2020 and is now named TidalHealth. The core service area reported for TidalHealth contains fewer zip codes, with more concentrated market share than in previous years.

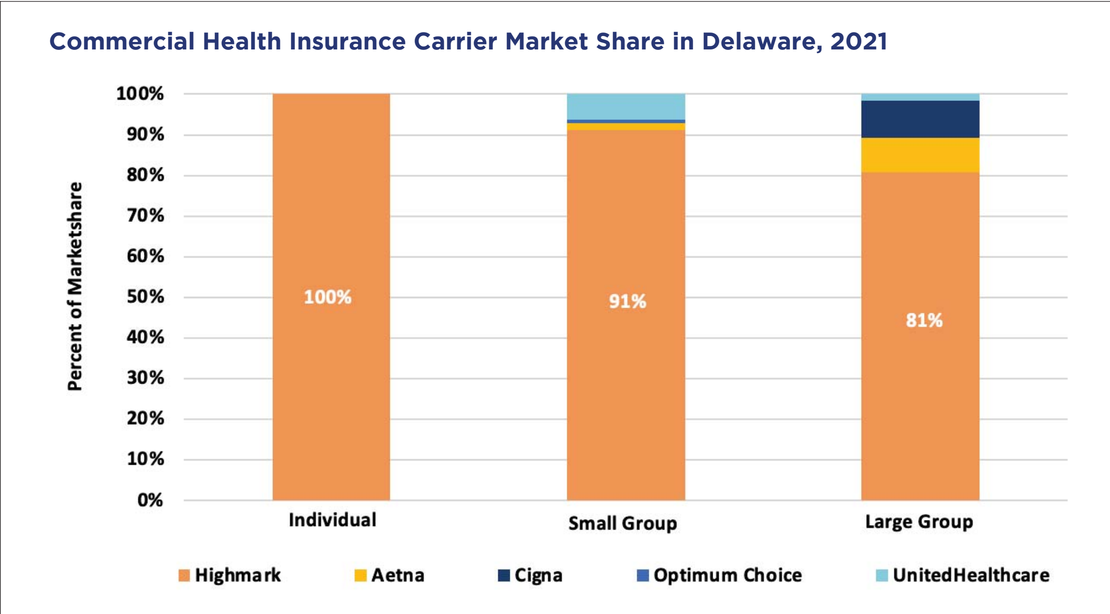


Strong market power has helped Delaware hospitals garner higher prices than many of their peers nationally. Commercial hospital prices in Delaware are among the highest in the nation, at 281% of Medicare rates for inpatient facility services and 369% of Medicare rates for outpatient facility services, according to the RAND Corporation[7]. This ranks Delaware 11th in the nation for inpatient facility prices and 9th in the nation for outpatient facility prices. Comparatively, Delaware physician prices averaged 115% of Medicare, ranking it the lowest of any state in the nation, according to RAND.

The Delaware fully-insured commercial health insurance market is also concentrated, with Highmark holding 80% to 90% of the small group and large group insurance business, as shown in Exhibit 7. The individual market is changing with two new entrants for the 2023 plan year, Aetna and AmeriHealth Caritas. Previously, only Highmark sold coverage in the Delaware individual market.

## EXHIBIT 7:

Source: CMS Center for Consumer Information and Insurance Oversight Medical Loss Ratio Reports. AmeriHealth Caritas and Aetna will begin offering individual plans for the 2023 plan year.




7. Whaley, et al. 2022

## *Requirement 5: Expand meaningful alternative payment model adoption by making healthcare providers more accountable for spending and value*

The alternative payment model adoption requirement includes two components 1) Movement to Fixed, Episode-Based and Population-Based Payment Methodologies and 2) Increased, Shared Accountability for Total Cost of Care. More information on carriers' progress toward meeting these requirements is discussed below.

### Fixed, Episode-Based and Population-Based Payment Methodologies

Carriers must transition a portion of inpatient and outpatient hospital facility services in Delaware to fee schedules and reimbursement structures that are based on fixed payment (e.g., case rate such as Medicare's Diagnosis-Related Group), episode-based or population-based payment methodologies (e.g., not a percent of charges).

### Data Collected to Assess Compliance

Carriers were asked to provide an update on activities including contracting changes and financial modeling to meet this requirement for plan year 2024. In these updates, Carriers reported that they have reached out to hospitals to begin adjusting contracts as necessary to meet the requirements.

### Compliance

No compliance requirement for 2023 plan year.

**WHAT IS THE HEALTH CARE PAYMENT – LEARNING AND ACTION NETWORK?**

The HCP-LAN is a group of public and private health care leaders who work together to develop frameworks and policies to accelerate adoption of alternative payment models (APMs).

Since 2015, the HCP-LAN has developed a common framework for classifying APMs, published an interactive tool for designing APMs, measured the annual progress of adoption, and hosted annual summits to connect stakeholders.

## Additional Discussion

DOI's Domestic and Foreign Insurers Bulletin 130 provided additional guidance on implementation of this requirement[8]. Language in Regulation 1322 had been misinterpreted by some as prohibiting or banning all other types of fee schedules or reimbursement structures, including fee-for-service or percent-of-charge payment methodologies. Bulletin 130 clarified that as carriers move towards adopting more fixed payment, episode-based or population-based payment methodologies, there are services that are not amenable to these types of payments. Additional guidance on implementation will be provided prior to the next rate filing cycle.

## Increased Shared Accountability for Total Cost of Care

Carriers with more than 10,000 Delaware residents enrolled across all fully-insured products are required to tie at least 50% of total medical expense to an alternative payment model contract that qualifies as Health Care Payment Learning and Action Network (HCP-LAN) Category 3 shared savings or shared savings with downside risk. Qualifying carriers must tie a minimum of 25% of total medical expense to a contract that qualifies as HCP-LAN Category 3B or those with downside risk. These requirements are not effective until the 2023 rate filing for the 2024 plan year.

In addition to meeting the criteria to qualify as HCP-LAN Category 3, carriers must share at least 30% of savings with providers in 2023 and 2024. In 2025, carriers must share at least 40% of savings with providers. For a program to qualify as HCP-LAN Category 3B in 2023 and 2024, providers must be responsible for at least 30% of losses, or 15% of losses if the provider organization would be considered low revenue by CMS. Providers must be responsible for 40% of losses in 2025 or 20% for low-revenue provider organizations.

## Data Collected to Assess Compliance

Carriers provided information on the percent of total medical expense tied to various HCP-LAN payment categories in their ASDS.

## Compliance

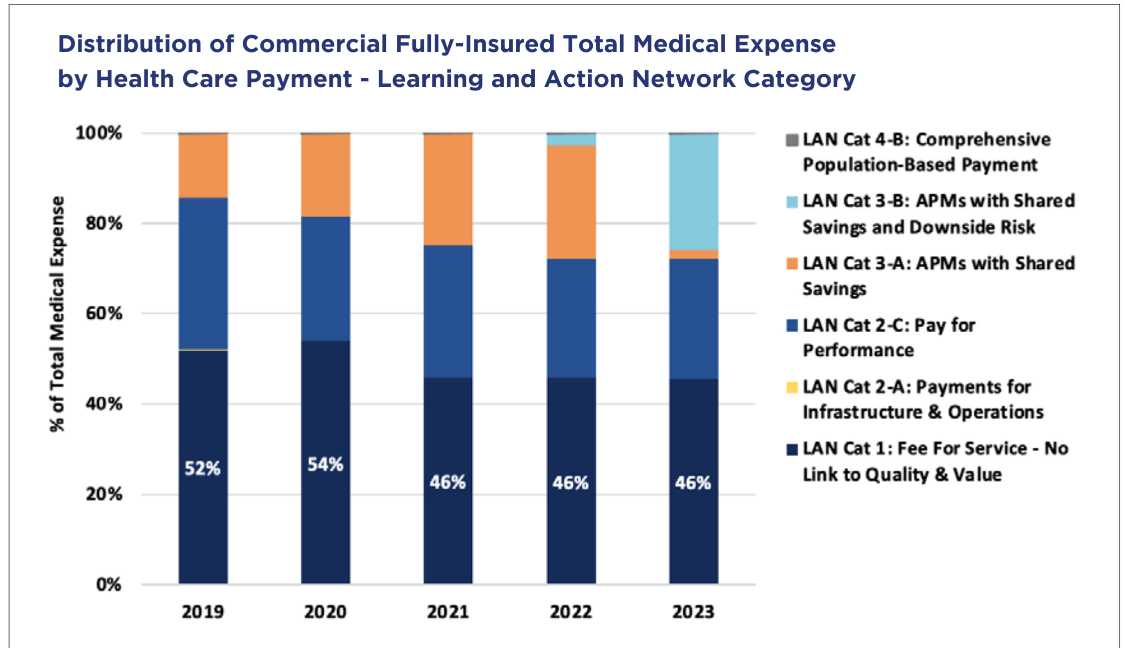
No compliance requirement for 2023 plan year.

8. Navarro 2022

Carriers continue to make progress in moving total medical expense into value-based contracting arrangements. Carriers projected 46% of total medical expense will be tied to fee-for-service only contracts in 2023, as compared to 52% in 2019, as shown in Exhibit 8 below.

**EXHIBIT 8:**

Source: Carrier Affordability Standards Data Submissions to the Office. Data reflects commercial fully insured.



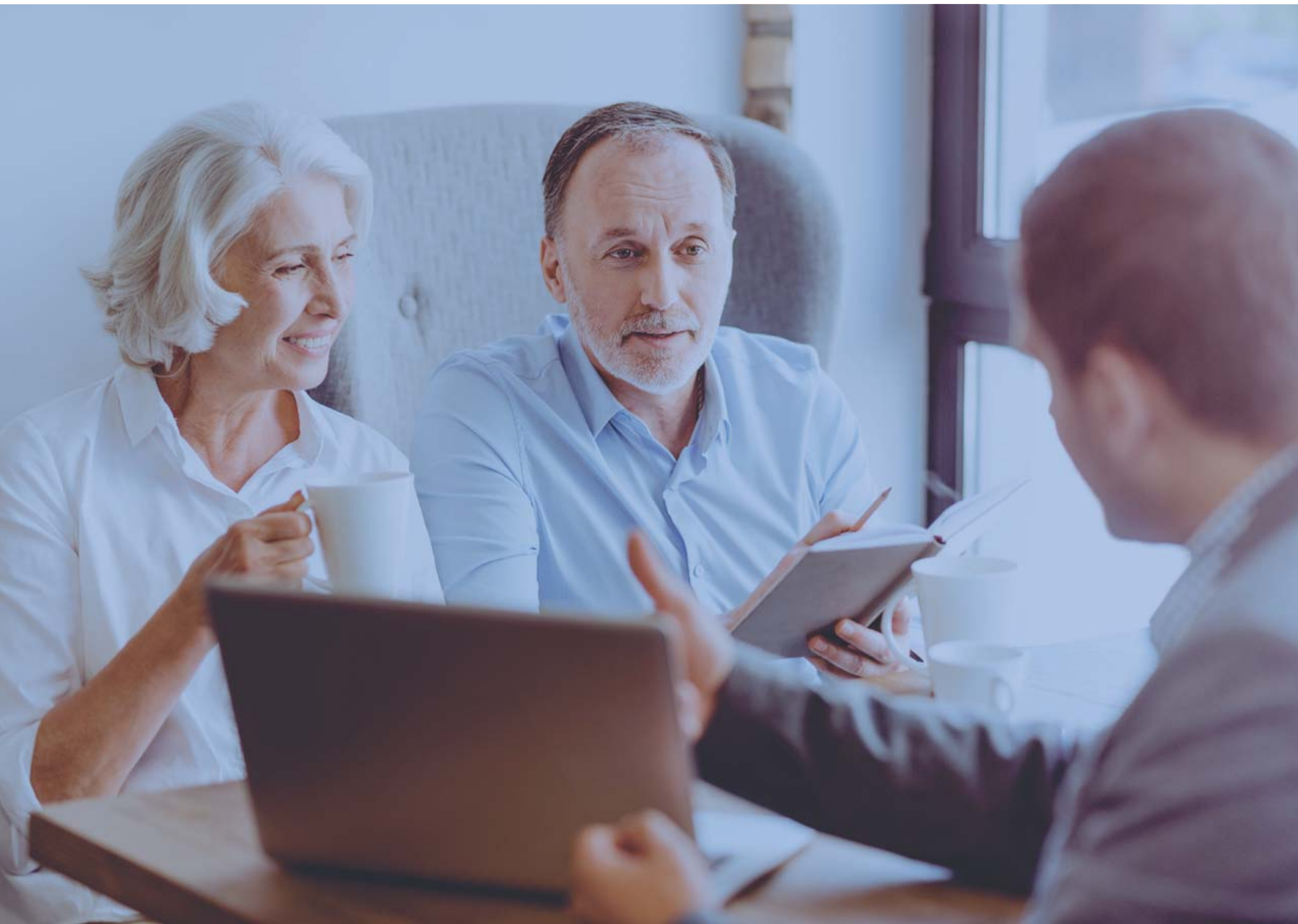

## Additional Discussion

The Office sees this progress in moving away from fee-for-service only contracts as key to developing a health care system with shared accountability across payers and providers. Carriers report multi-pronged approaches to move payments away from fee-for-service including modifying existing programs and developing new payment models. Program modifications to move providers into models with shared savings and downside risk are projected to occur in 2023. Carriers report that providers who have previously been in shared savings programs are those most likely to move to shared savings with downside risk arrangements. Carriers will need to continue to move contracts into shared savings arrangements to meet compliance requirements for plan year 2024.

# CONCLUSION

The Office appreciates the extensive efforts of carriers and providers to implement SB 120 and its related regulations and statutes. For plan year 2023, carriers expect to be in compliance with all requirements. Each year of implementation will bring new requirements, challenges and opportunities. The Office looks forward to continuing to work collaboratively with carriers and other stakeholders to achieve our shared goal of improving healthcare access and affordability in Delaware.

The Office will publish updated guidance via Bulletin and an updated 2024 ASDS template and instruction manual in March.



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# APPENDIX 1: PRIMARY CARE INVESTMENT DEFINITION

The Office uses the criteria described below to define primary care investment and total medical expense.

## *Fee-for-Service Primary Care Services*

Fee-for-service primary care services are defined as primary care services performed by primary care providers in primary care places of service. All three criteria must be met.

“Primary Care Place of Service” means a care delivery location where primary care services are frequently provided. For 2023, the following place of service codes were considered primary care.

| Place of Service Code Description | Place of Service Code |
| --- | --- |
| Telehealth Provided Other than in Patient’s Home | 02 |
| School | 03 |
| Telehealth Provided in Patient’s Home | 10 |
| Office | 11 |
| Home | 12 |
| Walk-In Retail Clinic | 17 |
| Place of Employment – Worksite | 18 |
| Urgent Care Facility | 20 |
| Federally Qualified Health Center | 50 |
| Public Health Clinic | 71 |
| Rural Health Clinic | 72 |

"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. For 2023, the definition included provider types defined by the following taxonomy codes.

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

Primary care services included the following list of categories of Current Procedure Terminology (CPT) codes in 2023. A complete list of each CPT included in the definition can be found within the ASDS Excel template on the Office's website.

- 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

## *Non-Fee-for-Service Primary Care Services*

Categories of non-fee-for-service payments that qualify as "primary care" are aligned with categories developed for Delaware's Health Care Spending and Quality Benchmarks. Additional subcategories were created to differentiate non-fee-for-service spending to support primary care versus non-fee-for-service spending to support other types of care delivery. The following categories of non-fee-for-service payments are 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.

**Risk Settlements (Net) to Support Primary Care Services:** The portion of shared savings dedicated to primary care providers and their health care teams.

**Primary Care, Other:** 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.

**Total Medical Expense Denominator:** Calculating primary care investment as a percentage of total spending requires defining total medical expense. The Offices define the total medical expense denominator as the sum of all payments from carriers, including fee-for-service and non-fee-for-service payments. It does include pharmaceutical spending.

# APPENDIX 2: CARE TRANSFORMATION CAPABILITIES

The Care Transformation Capabilities listed on the next page reflect goals established by the Delaware Primary Care Reform Collaborative (PCRC). The examples of activities that would move such goals forward are listed across the rows and separated by years. This table is for illustrative purposes to show practices how the achievement of activities should progress each year. Nationally, successful programs tend to offer care management, infrastructure, and other types of non-fee-for-service revenue opportunities to support providers achieving similar goals. Providers tend to be most willing to engage in these activities when the prospective payments require compliance for achieving the "Capability" and offer some level of "guaranteed" reimbursement in exchange (i.e., not subject to quality performance).

## Examples of Capabilities

| | Year 1 | Year 2 | Year 3 |
|---|---|---|---|
| **TEAM-BASED CARE AND CARE MANAGEMENT** | • Care is organized by teams responsible for specific patient panels and with defined roles and responsibilities<br>• Identify Nurse Care Manager and primary responsibilities and workflows | • Nurse Care Manager develops care plan for high-risk patients<br>• Nurse Care Manager provides disease-specific self-management support tools to patients | • Approximately 1% - 3% of patients are enrolled in care management<br>• Assess need for medication management program operated by pharmacist |
| **PLANNED CARE AT EVERY VISIT** | • Confirm a mechanism (via EMR) to receive patient discharge information (ED & IP)<br>• Develop Huddle checklist<br>• Begin transition of care calls for priority discharged patients (ED & IP) | • Care team routinely engages in patient huddles to identify high-need and high-risk patients to prepare for patient visits<br>• Identify pre-visit planning process and pilot program | • Huddles occur at least weekly<br>• Engaged in pre-visit planning<br>• Majority of discharged patients (ED & IP) receive a transition of care call |
| **ACTIVE USE OF DATA** | • Develop a method for identifying gaps in care, and high-risk patients<br>• Create a quality improvement team to track gaps in care and other data<br>• Identifies quality, satisfaction and utilization measures which are readily available | • Automate risk stratification process and conduct at least annually<br>• Quality improvement team reports on quality metrics monthly<br>• Practice identifies improved workflow to drive quality metric results | • Practices apply data-driven quality improvement processes |
| **EFFECTIVE MANAGEMENT OF TEST AND SPECIALISTS REFERRALS** | • Identify specialists that practice refers to most (eye exams, diabetes, blood work, mammography, etc.)<br>• Identify laboratories and specialists that practice is not receiving results or consultative notes from and collaborate to make improvements | • Practice demonstrates basic ability to track referrals to consulting specialty providers and labs<br>• Practice establishes workflows to receive referral results and update patient record | |
| **INTEGRATION OF PRIMARY CARE WITH BEHAVIORAL HEALTH** | • Practice evaluates current process of administering and documenting PHQ-2, PHQ-9, and anxiety assessments<br>• Practices retains a report that identifies number of patients with a positive depression screening and/or anxiety assessment | • Practice establishes workflows to ensure patients receive depression screenings and anxiety assessments at least<br>• Practices evaluates referral resources and assesses ability for embedded behavioral health services or other centralized options | • Practice implements a behavioral health program (in office or centralized) |
| **INTEGRATION OF PRIMARY CARE WITH SOCIAL SERVICES** | • Practice evaluates and identifies resources for patients and families<br>• Practice trains care team to use resource list when patient needs are identified (food, shelter, unable to access prescription medication, transportation, etc.) | • Providers screen for social drivers<br>• Practice identifies how patient record can support screening questions and documentation<br>• Practice has documented process for connecting patients/ families with resources once patient is screened, including protocols for follow-up | • Report generated to assess gaps in support system<br>• Practice introduces a social worker or centralized function to support patients with high needs |

# APPENDIX 3: GLOSSARY

***As used in this report, the following terms and phrases have the following, commonly accepted meanings:***

**ACCOUNTABLE CARE ORGANIZATION (ACO):** Groups of doctors, hospitals, and other healthcare providers, who come together voluntarily with the dual aims of providing coordinated, high-quality care and reducing growth in the total cost of care for Medicare patients.

**AFFORDABILITY STANDARDS:** Any one of a wide range of policies used, often by states, to improve the affordability of healthcare services and/or health insurance coverage. Delaware's 18 DE Code § 334 (2019) enables the Office to develop and annually evaluate affordability standards through an open and transparent process, in collaboration with the Primary Care Reform Collaborative.

**ALTERNATIVE PAYMENT MODEL (APM):** A payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

**ALL-PAYER CLAIMS DATABASES (APCDS):** Large state databases that include medical claims, pharmacy claims, dental claims, and eligibility and provider files collected from private and public payers.

**BUSINESS RULES:** Policies, requirements, and conditional statements that are used to determine the actions that take place in applications and systems.

**CARE COORDINATION:** In the primary care practice, care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. Care coordination also includes the coordination of a patient's care across different settings, generally termed care transitions.

**CARE MANAGEMENT:** A set of activities intended to improve patient care and reduce the need for traditional, office-based, medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage medical and behavioral health conditions through self-management and enhanced education.

**COMMERCIAL HEALTH INSURANCE CARRIERS:** As defined by 18 *Del. C. §§* 3342A(a)(1), any entity that provides health insurance in the State of Delaware. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans. Carriers included in this report are inclusive of entities that file rates, as required in Section 1322 *Requirements for Mandatory Minimum Payment Innovations in Health Insurance.*

**CHRONIC CARE MANAGEMENT SERVICES:** 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.

**CORE CONSUMER PRICE INDEX (CPI):** An inflation rate developed by the United States Bureau of Labor Statistics. It measures inflation across industries except for food and energy, which tend to be more volatile. SB 222 defines how the Core CPI determines Delaware's limits on non-professional price growth. For this purpose, Core CPI is calculated as the average of the 12 preceding bimonthly indices. The methodology looks at the year-over-year changes in these indices and is based on the results for the Philadelphia-Camden-Wilmington area.

**"DIAGNOSIS RELATED GROUPS" OR "DRGS":** The patient classification scheme set forth in 42 CFR 412.60 that is used to categorize hospitalization costs and determine how much to pay for a patient's hospital stay. Rather than pay the hospital for each specific service it provides, Medicare or private insurers pay a predetermined amount for a set of services included in the DRG.

**EPISODE-BASED PAYMENTS:** A pre-determined price for a defined set of services related to a specific treatment, condition or procedure against which actual payments are retrospectively reconciled. It is typically for services within a discrete timeframe and initiated by combinations of diagnoses, procedures, and drugs furnished to a patient.

**HEALTH BENEFIT PLAN:** As defined by 18 *Del. C.* §§ 3342A(a)(3)a, any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract.

**HEALTH CARE PAYMENT LEARNING AND ACTION NETWORK (HCP-LAN) CATEGORY:** A framework for understanding APM models based on increasing clinical and financial risk. The framework categorizes these payment models across categories and subcategories as described below.

> **LAN Category 1 - Fee for Service (FFS):** These payments utilize traditional payments (i.e., payments made for units of service) that are adjusted to account for neither infrastructure investments, nor provider reporting of quality data, nor provider performance on cost and quality metrics. Additionally, it is important to note that diagnosis related groups (DRGs) that are not linked to quality and value are classified in Category 1.
>
> **LAN Category 2A: Foundational Payments for Infrastructure & Operations:** Payments placed into Category 2A involve payments for infrastructure investments that can improve the quality of patient care, even though payment rates are not adjusted in accordance with performance on quality metrics.

**LAN Category 2B - Pay for Reporting:** Payments placed into Category 2B provide positive or negative incentives to report quality data to the health plan and/or to the public.

**LAN Category 2C - Pay for Performance:** Payments are placed into Category 2C if they reward providers that perform well on quality metrics and/or penalize providers that do not perform well, thus providing a significant linkage between payment and quality. Note that a contract with pay-for performance that affects the future fee-for-service base payment would be categorized in Category 2C.

**LAN Category 3A - APMs with Shared Savings:** In Category 3A, providers have the opportunity to share in a portion of the 14 savings they generate against a cost target or by meeting utilization targets, if quality targets are met. However, providers do not need to compensate payers for a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included.

**LAN Category 3B - APMs with Shared Savings and Downside Risk:** In Category 3B, providers have the opportunity to share in a portion of the savings they generate against a cost target or by meeting utilization targets, if quality targets are met. Additionally, payers recoup from providers a portion of the losses that result when cost or utilization targets are not met. If a plan operates an APM where a physician group, primary care physician, or other physician is held responsible for ALL of the attributed member's health care spending, including outpatient, inpatient, specialists, pharmacy, out-of- network, etc., all of the dollars associated with the attributed members can be included.

**LAN Category 4A - Condition-Specific Population-Based Payment:** Category 4A includes bundled payments for the comprehensive treatment of specific conditions.

**LAN Category 4B - Comprehensive Population-Based Payment:** Payments in Category 4B are prospective and population-based, and they cover all an individual's health care needs. Category 4B encompasses a broad range of financing and delivery system arrangements, in which payers and providers are organizationally distinct.

**LAN Category 4C - Integrated Finance & Delivery System:** Payments in Category 4C also cover comprehensive care, but unlike Category 4B payments, they move from the financing arm to the delivery arm of the same, highly integrated finance and delivery organization.

**INDIVIDUAL HEALTH INSURANCE:** Health insurance coverage that is purchased on an individual or family basis, as opposed to being offered by an employer.

**INPATIENT HOSPITAL SERVICES:** 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.

**LARGE GROUP HEALTH INSURANCE:** Coverage that is purchased by an employer for companies with more than 99 employees. These plans are fully insured which means the risk is borne by the health insurance company, not the employer.

**MEDICARE PARITY:** A rule that requires any carrier that offers a program shall ensure that the total reimbursement made to a participating primary care provider, the provider's care teams, and organizations are 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.

**NON-PROFESSIONAL SERVICES:** Services categorized as part of development of the Unified Rate Review Template as inpatient hospital, outpatient hospital, and other medical services.

**OTHER MEDICAL SERVICES:** 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:** 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:** An arrangement in which a provider entity accepts responsibility for delivering covered services to a group of patients for a pre-determined payment amount.

**PRIMARY CARE:** 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 FIRST" OR "PCF":** The Centers for Medicare and Medicaid Services 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:** A care delivery location where primary care services are frequently provided. A list of primary care place of service codes used by the Office to define primary care is included in Appendix 1.

**PRIMARY CARE PROVIDER:** 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. A list of primary care taxonomy codes the Office used to define primary care is included in Appendix 1.

**PRIMARY CARE SERVICES:** Services typically provided by primary care providers in primary care places of service including office visits, preventive visits and minor procedures. A list of the primary care Current Procedure Terminology (CPT) codes the Office used to define primary care is included in Appendix 1. Primary care services also may be reimbursed via non-fee-for-service payments. The Office used the categories below to categorize non-fee-for-service payments defined 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. All payments that require achievement of specific, predefined goals for quality, cost reduction or infrastructure development should be included in this category.
>
> **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.
>
> **Care Management Fees:** All payments made to primary care providers for providing care management, utilization review and discharge planning. These payments should be made prospectively.

**Shared Savings Payments to Support Primary Care Services:** A portion of shared shavings dedicated to primary care providers and their health care teams.

**Other Primary Care Investments:** 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:** 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.

**SMALL GROUP HEALTH INSURANCE:** Health insurance coverage that is purchased by an employer for companies with 2 to 99 employees. These plans are fully insured which means the risk is borne by the health insurance company, not the employer.

**TOTAL COST OF MEDICAL CARE:** 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:** 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).

**FOR MORE INFORMATION PLEASE VISIT THE OFFICE OF VALUE BASED HEALTH CARE DELIVERY WEBSITE**