



AN INTEGRATED APPROACH TO IMPROVE ACCESS, QUALITY AND VALUE



FEBRUARY 15, 2021

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

Fellow Delawareans -



As Delaware's Insurance Commissioner, I understand that Delaware's healthcare landscape is facing real and quantifiable challenges. Whether as a patient needing care, a physician or health system providing care, or an insurance company reimbursing for care, Delaware's health care system is primed to catalyze new opportunities and emerging data assets to improve value for its citizens.

Insurance is an effective tool that helps consumers manage risk in many aspects of their lives, including managing their families' health and wellness. The Department is part of a state-based, national regulatory framework that is designed to protect policyholders and serve the greater public interest through effective insurance marketplace regulation. While our jurisdictional reach extends only to payers in the private commercial market, we hope that our work helps inform the work of stakeholders in the public and self-insured markets.

The Department's Office of Value Based Health Care Delivery is tasked with providing the infrastructure to establish affordability standards and collect and analyze data for the assessment of adequate levels of primary care spending in Delaware. The Office is also required to establish targets for carrier investment in primary care with recommendations to the Insurance Commissioner and the Primary Care Reform Collaborative regarding appropriate levels of reimbursement rates for primary care.

Sincerely yours,

TRINIDAD NAVARRO

Delaware Insurance Commissioner

I am proud of the early work of the Office, as presented in this report. As you read this report, you will see that the Office leveraged data collected from available databases, commercial health insurance carriers, national best practices and the work of the Primary Care Reform Collaborative. This effort had three ambitious goals, all of which I believe are met in this report: 1) present a clear eyed, data-driven review of Delaware's existing healthcare landscape, 2) develop and implement affordability standards for health insurance premiums, and 3) set targets for carrier investment in primary care that effectively address Delaware's current primary care shortage.

The ongoing work of the Office will be to measure and report on progress against these early goals and I look forward to those results. Additionally, the Office is conducting a related analysis of carriers' compliance with statutory mandates concerning primary care reimbursement under Senate Bill 227. Parallel efforts in other State agencies are also underway that will help shape future analyses. Last but not least, the effects of the COVID-19 pandemic are yet to be determined.

Accordingly, the Office is committed to integrating evolving data and observations into future analyses, targets and reports.

I believe the information in this report presents a meaningful opportunity towards shaping healthcare reimbursement systems in Delaware and I look forward to continuing to support the work of the Office.



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EXECUTIVE SUMMARY: DELAWARE'S HEALTHCARE MARKET AND PROVISIONAL AFFORDABILITY STANDARDS

The Delaware Healthcare Market

Through conversations with stakeholders and an extensive review of data on utilization, cost and access, the Delaware Department of Insurance's (DOI) Office of Value-Based Health Care Delivery (the Office) finds the Delaware healthcare market operates amid three challenging dominant market forces, all of which contribute to high health care costs, and as a result, higher insurance premiums.



Limited primary care investment and, in turn, primary care access



Health systems and health insurance carriers with strong market power



Older, sicker population than most states



Higher healthcare costs and insurance premiums

THE PROBLEM

Primary care spending in Delaware is [low](#) relative to the national average and about half of what is spent in leading states¹. This low investment in primary care services has likely contributed to [declining numbers](#) of primary care providers and poor access to primary care in Delaware². Health systems and health insurers with [strong market power](#)³, and in turn greater leverage in negotiations, have made it even more difficult for Delaware primary care providers to receive adequate reimbursement. Though many states face similar trends, the primary care access problem in Delaware is particularly acute. The state's population is among the [oldest in the nation](#) and its growing⁴.

A strong system of primary care undergirds a strong system of care delivery. Increased numbers of primary care providers have been associated with improvements in health and decreases in mortality⁵. Increased investment in primary care has also been associated with lower rates of emergency department visits and hospital admissions⁶.

However, necessary increases in primary care investment must not result in [unsustainable increases in total cost of care](#), especially in Delaware where health insurance premiums are among the highest in the nation⁷.

The average cost of care for Delaware residents with commercial health insurance grew to more than \$7,000 in 2019, rising 6.4% over the previous year or more than twice as fast as per capita income in the state^{8,9}. The average premium for health insurance coverage in the individual market was nearly \$8,600 in 2019, or 16% of Delaware per capita income¹⁰. Delaware premiums are now 4th highest in the nation for the fully insured small group market and 5th for the individual market¹¹. ***The strain on Delaware consumers and employers is real.***

¹ Office of Value Based Health Care Delivery Questionnaire (2020).

² Toth (2018).

³ American Hospital Directory (2018).

⁴ United Health Foundation (2020).

⁵ Basu, et al. (2019).

⁶ Primary Care Collaborative 2020.

⁷ Center for Consumer Information & Insurance Oversight (2020).

⁸ Office of Value Based Health Care Delivery Questionnaire (2020); DHIN (2020).

⁹ St. Louis Federal Reserve (2020).

¹⁰ Center for Consumer Information & Insurance Oversight (2020); St. Louis Federal Reserve (2020).

¹¹ Center for Consumer Information & Insurance Oversight (2020).

A RECOMMENDED SOLUTION

The data analyzed and the perspectives shared during more than two dozen stakeholder interviews support the need for a multi-pronged approach that would aim to increase primary care investment, decrease unit price growth for other services, and expand the use of alternative payment models without increasing growth in the total cost of care.

Specifically, the Office recommends implementing the following three Affordability Standards, each with its own achievement target.

THE THREE STANDARDS ARE

1

Increase Primary Care Investment

2

Decrease Unit Price Growth for Certain Services, as defined here

3

Expand Alternative Payment Model Adoption

By implementing these three Affordability Standards, the Office aims to create an environment that supports Delaware health insurance carriers in offering consumers more affordable, higher quality health insurance products and improved access to high value care.



THIS REPORT CONTAINS THE OFFICE'S FINDINGS AND:

- Provides an overview of the data and stakeholder input that informed development of the three Affordability Standards;
- Provides a Theory of Change that includes details on provisional Affordability Standard targets; and
- Discusses how the Affordability Standard targets will be integrated with the DOI rate review process.





DATA GATHERING AND ANALYSIS: SIX KEY FINDINGS

To better understand Delaware's health care market, the Office conducted an extensive review of:

- Data on healthcare costs and utilization from two principle sources: 1) a questionnaire specifically designed by the Office to generate the data needed to inform this work and completed by the Delaware health insurance carriers, and 2) data requests from the Delaware Health Information Network Health Care Claims Database (DHIN HCCD);
- Survey data from licensed physicians practicing in Delaware from the Delaware Department of Health and Social Services (DHSS);
- Data on hospital and health insurance carrier finances and market share from publicly available sources including the Internal Revenue Service (IRS), the Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO) and the Delaware Hospital Discharge Dataset;
- Information on health status and risk factors from national health policy foundations; and
- The experience of other states in controlling their health care costs.

In addition, the Office conducted extensive interviews with more than two dozen Delaware stakeholders. Six key findings emerged from this research.



Finding 1. Delaware commercial health insurance carriers' primary care investment will need to increase to support a robust system of primary care by 2025.

1a. Commercial carriers in Delaware spend less than half as much for primary care services as commercial carriers in leading states, as a percent of total cost of care and on a per member per month basis.

As shown in **Exhibit 1**, primary care spending across Delaware's payers was between 4.5% and 5.9% of total cost of care, excluding pharmacy spending, in 2019. Delaware commercial carriers spent approximately 4.5% of total cost of care on primary care services, which equates to \$22 per member per month¹². Models developed in other states and one published in a peer reviewed journal find investment of \$45 or more is necessary¹³ to support expanded care teams and other features typically included in leading models of comprehensive primary care delivery.

**EXHIBIT 1:
Primary Care
Spending as a
Percentage of
Total Cost of
Care*****

OVBHCD*	DHIN			
Commercial	Commercial	Medicaid	Medicaid Advantage	Medicaid FFS
2019	2019	2019	2019	2018**
4.5%	4.7%	5.9%	4.6%	5.3%

* OVBHCD data provided by DE carriers for individual, small group, large group and State Group Health Plan.

** 2019 Data was not available

*** No Rx in denominator

Of note, Delaware primary care providers received little reimbursement through care management fees or other types of flexible, supplemental payments to support primary care transformation. Reimbursement through these types of payments averaged \$1.70 per member per month across all payers, with 3 of 5 commercial health insurance carriers contributing nothing¹⁴. This is even less than provided under most Primary Care Medical Home programs, which have been determined to be too little to fund transformation. These payments are included in the \$22 referenced above.

Research by the Primary Care Collaborative (PCC), a national health policy organization focused on primary care investment and delivery, has shown a negative association between measures of primary care spending as a percent of total cost of care and measures of utilization, including emergency department visits and hospitalizations¹⁵.

In interviews, primary care providers described an urgent need to raise reimbursement quickly and in multiple ways. They noted a need to increase primary care investment as a percent of total cost of care, both through higher

¹² Office of Value Based Health Care Delivery (2020).

¹³ (Toth, 2018); Connecticut Office of Health Strategy (2019).

¹⁴ Office of Value Based Health Care Delivery (2020).

¹⁵ Primary Care Collaborative (2020).

unit prices paid for primary care services and through additional upfront, flexible payments to support investments in health information technology, integrated behavioral health, care management, care coordination and health promotion.

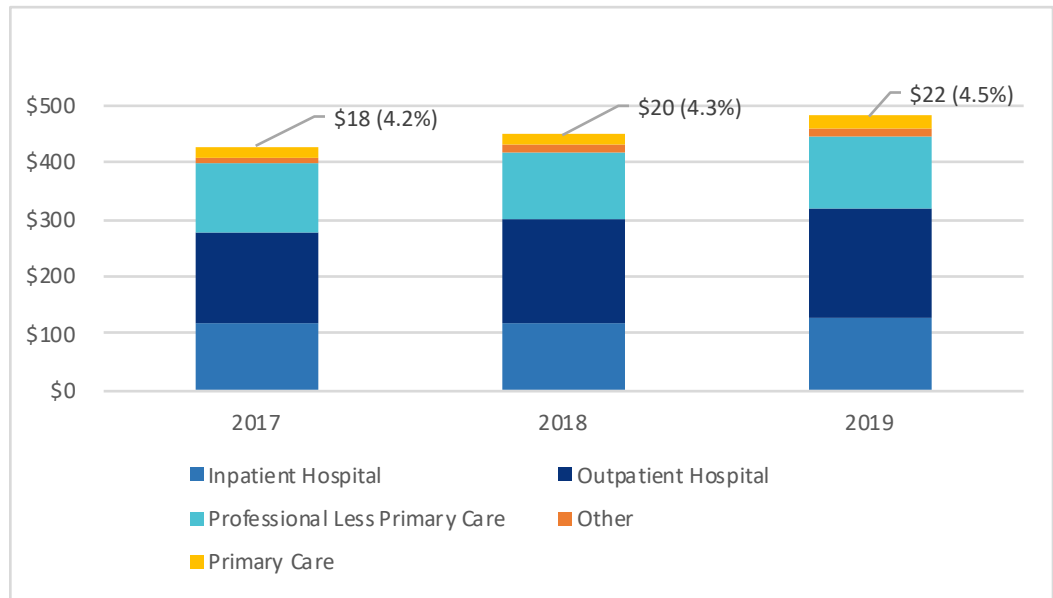
They also discussed the added difficulties brought by the pandemic including fewer patient visits and in turn, lower revenues, as well as higher costs including technology to support virtual care delivery and personal protective equipment to protect staff seeing patients in the office.

Primary care physicians nationally have reported how the financial challenges of the pandemic have compounded existing frustrations with low reimbursement rates. Nearly a fifth of primary care clinicians nationally surveyed in September by the PCC say someone in their practice plans to retire early or has already retired because of COVID-19, and 15% say someone has left or plans to leave the practice¹⁶.

1b. Although primary care investment increased more than 20% from 2017 to 2019, its portion of total cost of care remained approximately the same during the same period.

Commercial carriers in Delaware increased primary care spending 21% from 2017 to 2019, on a per member per month basis, but primary care spending as a percent of total cost of care only increased slightly from 4.2% and 4.5%¹⁷. This is shown in **Exhibit 2** below. The PCC reported primary care spending at 4.4% in Delaware in 2019, compared to an average of 4.8% nationally. For comparison, states that have prioritized investment in primary care devote twice as much spending to primary care. The PCC did not include non-claims spending in its calculation which likely skewed the national percentage downward. This type of flexible primary care investment was minimal in Delaware as explained on [page 7](#)¹⁸.

**EXHIBIT 2:
Per Member Per
Month Spending by
Service Category¹⁹:
Commercial Carriers**



¹⁶ Primary Care Collaborative (2020).
¹⁷ Office of Value Based Health Care Delivery (2020).
¹⁸ Primary Care Collaborative (2020).
¹⁹ Office of Value Based Health Care Delivery (2020).

In contrast, total spending on medical services in Delaware increased approximately 12% from 2017 to 2019, driven largely by increases in inpatient and outpatient hospital services, according to data provided by Delaware's health insurance carriers²⁰. A similar analysis of data from the DHIN, the state's all-payer claims database²¹, had analogous findings.

Further review found these increases in total cost of care were due to a combination of increases in price, as described in Finding 1c, and in utilization.

Utilization trends for hospital and professional services in Delaware were higher than observed in other states and may reflect a combination of factors including the state's aging population, limited access to primary care, and the predominance of a traditional fee-for-service payment model, with little utilization or network management.

1c. Prices for physician and other professional services, including primary care services, have increased an average 0.5% a year in recent years compared to an average of 3% to 4% a year for hospital services.

Exhibit 3 graphically depicts the two major drivers in health care spending in Delaware, price and utilization. As demonstrated in the price trend graph, increases in prices for hospital services during the period 2016-2019 have been a key contributor to rising healthcare costs for the commercially insured in Delaware. This was similar to national trends. In contrast, the health care professional price trend has remained relatively flat for that same period.

A review of other data on Delaware commercial prices supported these findings. An analysis by the RAND Corporation reported commercial health insurance carriers²² in Delaware paid only 110% of Medicare reimbursement rates for professional services. The RAND analysis of professional services included primary care services as well as services performed by specialists. An analysis by the Office focused exclusively on primary care services suggested commercial carrier reimbursement rates to professionals for primary care and chronic care management services to be even lower. The analysis, which used data from DHIN, is discussed [here](#)²³. Comparatively, RAND found the same commercial health insurance carriers paid Delaware hospitals and health systems, on average, 272% of Medicare reimbursement for inpatient services and 334% of Medicare for outpatient services. Analyses by Johns Hopkins University²⁴ and the North Dakota Department of Insurance²⁵ produced similar results.

²⁰ Office of Value Based Health Care Delivery (2020).

²¹ DHIN (2020).

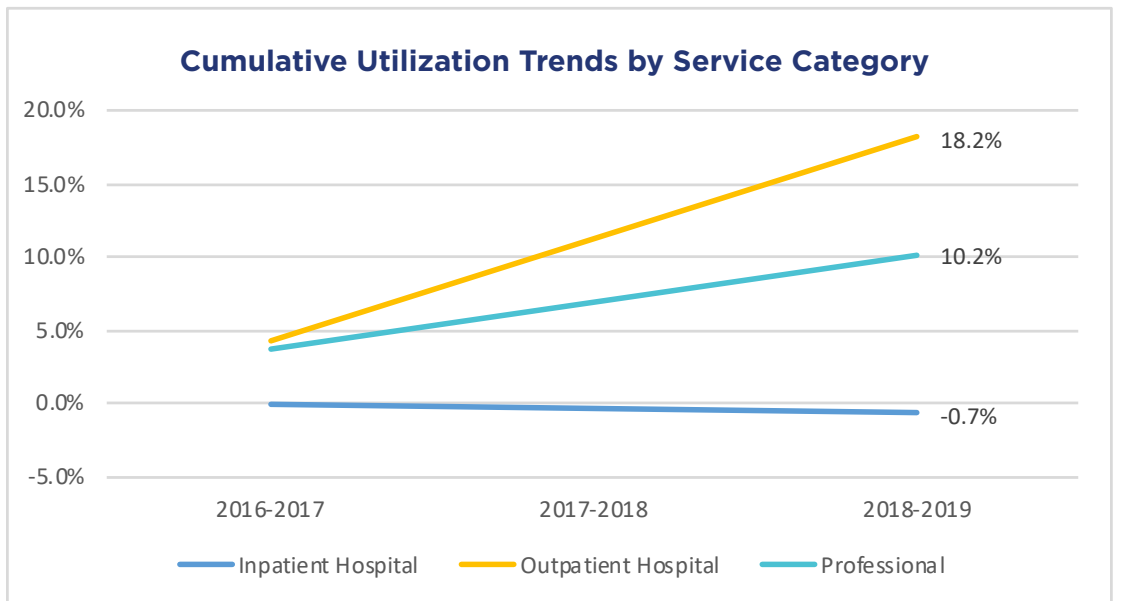
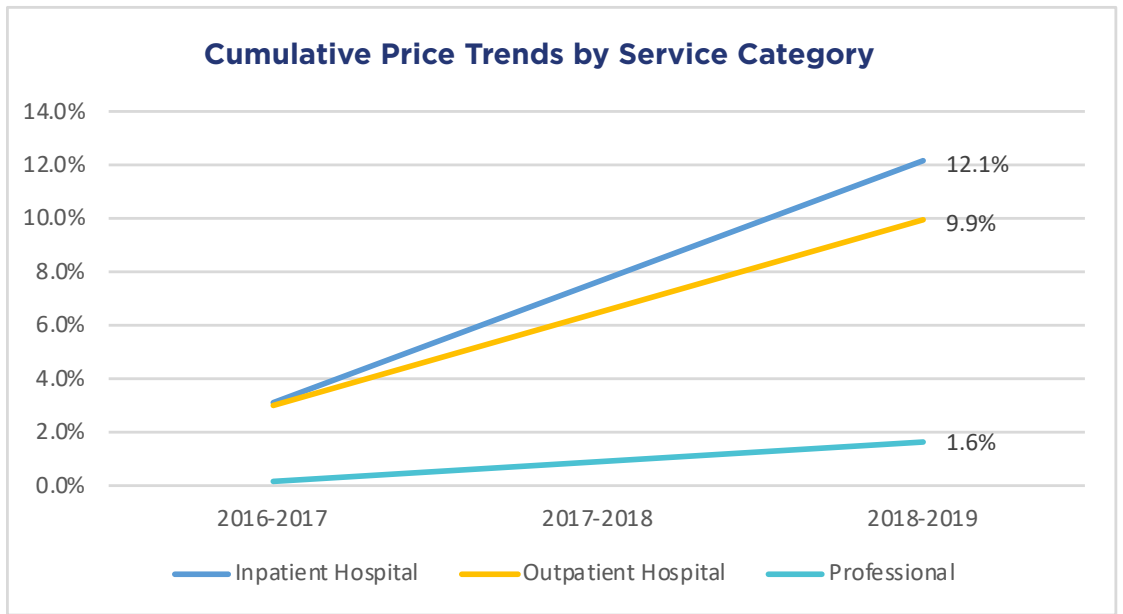
²² Whaley, Briscoe, Kerber, O'Neill, & Kofner (2020).

²³ DHIN (2020).

²⁴ Sen (2020)

²⁵ Horizon Government Affairs (2020).

**EXHIBIT 3:
Trends in Price and
Utilization²⁶**



²⁶ Office of Value Based Health Care Delivery (2020).

1d. Increasing primary care investment to levels sufficient to support robust primary care- without reducing projected price and utilization growth in other categories - would likely result in unacceptable and unsustainable annual increases in total healthcare spending and in health insurance premiums.

Conversations at the Delaware Primary Care Reform Collaborative (PCRC)²⁷, which was established to develop recommendations to strengthen Delaware's primary care system, suggested primary care spending in Delaware eventually should reach 10% to 12% of total cost of care, consistent with targets in other states²⁸. The Office modeled several scenarios using data supplied by Delaware's commercial health insurance carriers and DHIN²⁹. The modeling showed reaching this level of investment in primary care by 2025 without reducing carriers' projected price or utilization growth in other categories would result in annual increases in total healthcare spending of more than 9% and likely similar increases in health insurance premiums. This level of unsustainable growth would not be acceptable to the DOI, carriers, employers, or consumers.



PRIMARY DATA SOURCES SUPPORTING

FINDING 1: The Office developed a questionnaire to collect data from Delaware's commercial health insurance carriers on their fully insured individual, small group, and large group plans, all of which are required to file rates with the DOI. The carriers also completed the same questionnaire on behalf of the State Group Health Insurance Plan administered by the Statewide Benefits Office, which then provided those results to the Office for inclusion in its analysis. The questionnaire aligned definitions for primary care, capitation categories, and advanced payment model categories with those already used by the PCRC, the Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark³⁰ and the State Employee Benefits Committee (SEBC) (see [Appendix 1: Definition of Primary Care Investment](#) and [Appendix 3: APM Category Definitions](#) for more information). The questionnaire developed for this report is similar to the template carriers will submit via the rate review process beginning in 2021 to support the Office and DOI evaluation of their progress toward achieving the Affordability Standard targets. The Office also submitted two data requests to DHIN³¹. Information collected from both sources aligned with each other and with publicly available data.

²⁷ Townsend, Bentz, & Fan (2019); Townsend, Bentz, & Fan (2020).

²⁸ Townsend, Bentz, & Fan (2019).

²⁹ Office of Value Based Health Care Delivery (2020); DHIN (2020).

³⁰ Delaware Health and Human Services (2020).

³¹ Delaware Health Information Network, Trends in Cost and Utilization by Care Setting, (2020); Delaware Health Information Network, Primary Care and Chronic Care Payment Analysis (2020).



Finding 2. Access to primary care in Delaware is limited and will likely further erode without action.

In a 2018 survey³², licensed physicians practicing in Delaware reported that:

- Delaware primary care physician full-time equivalents declined about 6% from 2013 to 2018, despite a growing population.
- Two of Delaware's three counties qualify as a primary care shortage area per the US Health Resources and Services Administration³³.
- Just as Delaware's population is aging, so are its physicians. In the 2018 survey, only 60% of Kent County primary care physicians said they plan to be active in 5 years. The percentages were 70% in Sussex County and 78% in New Castle County.

PRIMARY DATA SOURCES SUPPORTING FINDING 2: In 2018, Delaware DHSS contracted with the University of Delaware Center for Applied Demography & Survey Research to conduct a survey of primary care physicians in the State. Survey questions focused on attributes of primary care providers that affect the availability of primary care services, including the age distribution and location of practitioners who are still regularly providing care to patients. The Delaware Division of Professional Regulation provided the licensure data that served as the basis for the survey. Physicians were first contacted with a pre-survey letter, followed up by the repeated mailings of the survey instrument and reminder cards. More than 950 of the 2,533 physicians contacted responded to the survey and provided usable data.

While some hospital systems are now starting primary care residency programs, physician group leaders said the lack of an in-state medical school, lower income potential and limited loan repayment programs make physician recruitment challenging³⁴.

³² Toth, (2018).

³³ Health Resources and Services Administration (2020).

³⁴ Delaware Health and Social Services (2020).





Finding 3. Delaware's health systems and health insurance carriers have strong market power.

A review of commonly accepted measures of market concentration finds Delaware is a highly concentrated market for health systems and health insurance carriers. Health systems' market power is even more pronounced within their primary service areas. As a result, health systems have strong leverage in negotiations with health insurance carriers, making it difficult for carriers to reject health systems' proposed price increases. Therefore, price increases for hospital services have been sharper than for professionals including primary care providers (see **Exhibit 3**).

HEALTH SYSTEM MARKET CONCENTRATION IN DELAWARE

The degree of market concentration is commonly measured using the Herfindahl-Hirschman Index (HHI). When calculated as a percent of discharges, Delaware's HHI of more than 3,220 exceeds the commonly accepted threshold (2,500) for a highly concentrated market³⁵. Delaware's health system market concentration can also be evaluated by examining percent of adult beds and percent of net revenues³⁶.

EXPLAINING THE HERFINDAHL-HIRSCHMAN INDEX

The Herfindahl-Hirschman Index is a commonly used measure of market share in healthcare and other industries. HHI is calculated by squaring the percent of discharges of each hospital competing in the market and then summing the resulting numbers. For example, for a market consisting of four hospitals with shares of 30%, 30%, 20%, and 20% percent of total discharges, the HHI is 2,600 ($30^2 + 30^2 + 20^2 + 20^2 = 2,600$). Based on discharges, Delaware's HHI is 3229 ($8.2^2 + 9.8^2 + 51.2^2 + 19.5^2 + 5.9^2 + 5.4^2$).

In addition to a statewide HHI that exceeds the commonly accepted threshold, Delaware is rare in that its hospitals and health systems appear to each dominate a particular sub-geography of the state. As shown in the bottom graph in **Exhibit 4**, an analysis of each health system's market share within its own service area as defined in its community benefit report shows that four of the six adult hospitals had at least 40% of the discharges for their service areas and two had market share percentages exceeding 80%³⁷.

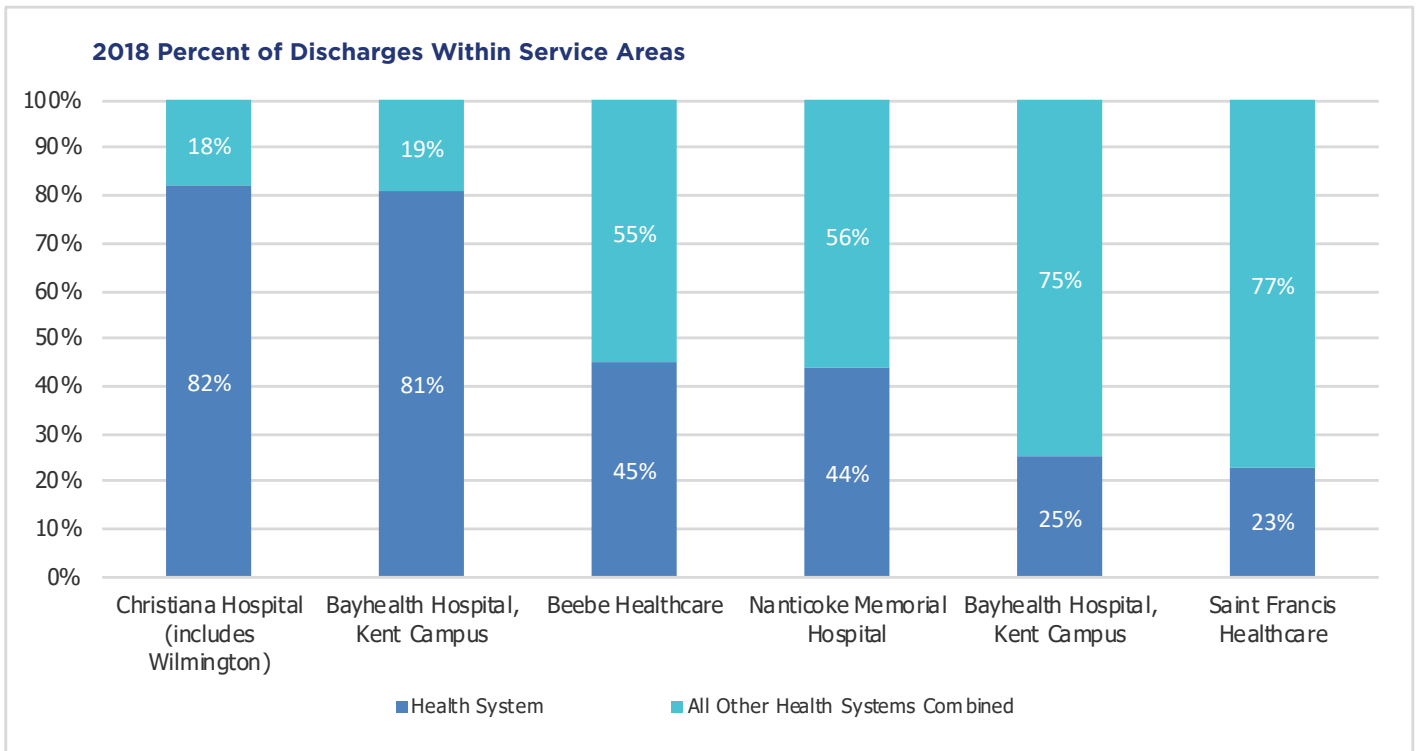
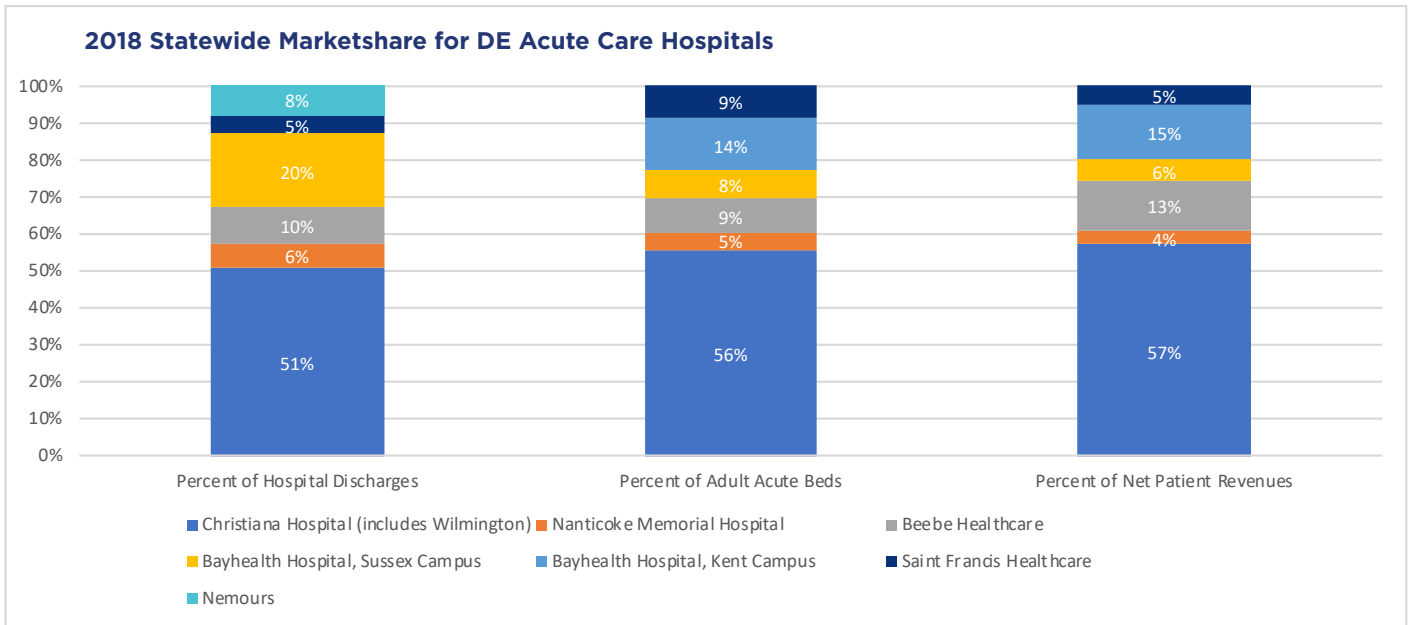
These findings suggest that Delaware's hospital market is highly concentrated statewide and is even more highly concentrated when considering the actual service areas of its hospitals. Provider concentration is a concern in nearly all parts of the country; the data demonstrate that Delaware has greater concentration than is typical in the US.

³⁵ The United States Department of Justice (2018)

³⁶ American Hospital Directory (2018).

³⁷ Delaware Department of Health and Human Services (2020); Delaware Healthcare Association (2020).

EXHIBIT 4: Hospital Market Share in Delaware



Note: In the top graphic, Bayhealth discharges are aggregated in the first column, which is consistent with how the data appear in the discharge dataset. In the second two columns, they are disaggregated which is consistent with how the data is shown by the American Hospital Directory. In the bottom graphic, Bayhealth data is disaggregated. It is possible some discharges attributed to one Bayhealth facility actually occurred at the other Bayhealth facility approximately 25 miles away. As a children's hospital created to care for a large portion of children across the state, Nemours was not included in any of the regional market share graphs.

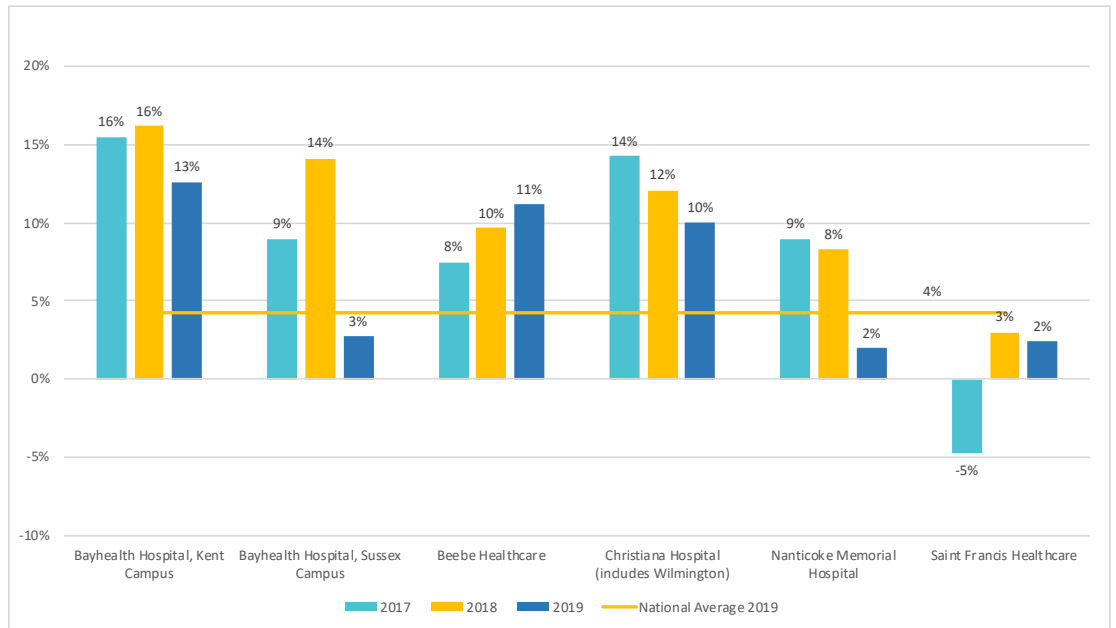
HEALTH INSURANCE MARKET CONCENTRATION IN DELAWARE

The Delaware commercial health insurance market is also highly concentrated, with Highmark controlling 87% of the small group market and 68% of large group market and serving as the only health plan (100% market share) on the state's individual marketplace³⁸.

HEALTH SYSTEM FINANCIAL INDICATORS IN DELAWARE

To further understand the financial health of Delaware's acute care hospitals, the Office looked at financial data reported by Delaware's adult hospitals and health systems to the IRS and CMS as aggregated by the American Hospital Directory. As shown in **Exhibit 5**, according to these data, three of Delaware's six adult hospitals' total margins, including income earned on investments, physician practice revenue, joint ventures, and non-core hospital services, exceeded national averages, often by a factor of two or more.

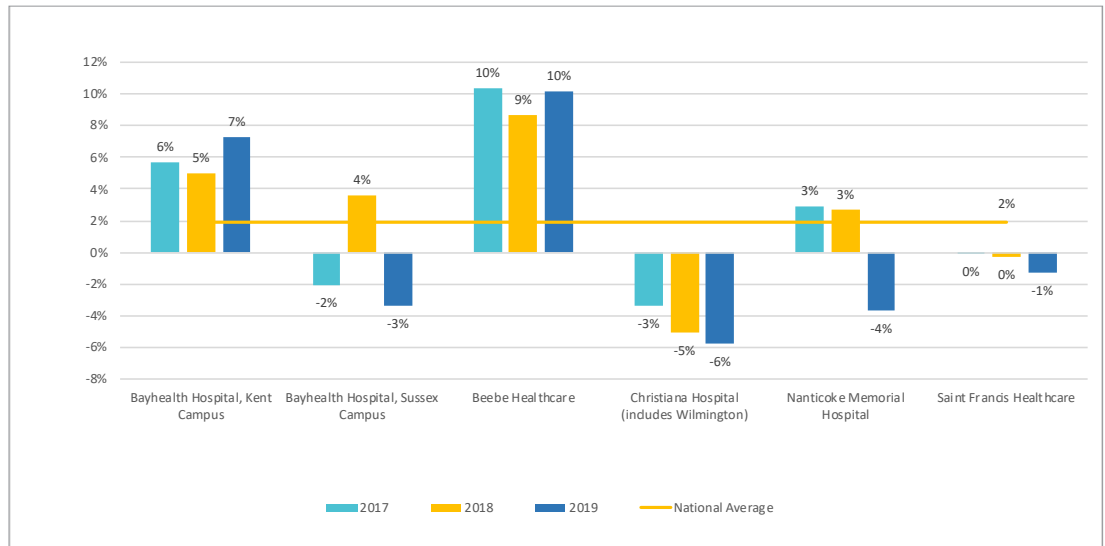
EXHIBIT 5: Total Margins of Delaware Acute Care Hospitals 2017-2019



³⁸ CCIIO (2020).

Hospital operating margins were lower than total margins, but still exceeded national averages in all three years at two of the state’s six adult hospitals, as shown in **Exhibit 6**³⁹. Further, hospitals in Delaware ranked 34th in patient financial assistance to insured and uninsured residents as a percent of net patient revenues, meaning that hospitals in only 16 states provided less financial assistance to patients as a percent of net patient revenues⁴⁰.

**EXHIBIT 6:
Operating Margins
of Delaware Acute
Care Hospitals
2017-2019**



PRIMARY DATA SOURCES TO SUPPORT FINDING 3:

Market Concentration in Delaware

Health systems: Information on the number of discharges by hospital was provided by the Delaware Hospital Discharge Data Set from the Delaware Health Statistics Center within DHSS⁴¹. Delaware hospital discharge data are based upon inpatient hospitalizations and do not include outpatient, clinic, or emergency room data.

Hospitals’ primary service areas were defined using the service areas the hospitals defined in their most recent Community Health Needs Assessment (CHNA). The Federal Affordable Care Act (ACA) requires all not-for-profit hospitals to complete the CHNA every three years and to make their CHNAs widely available to the public as a key component of maintaining their not-for-profit status under the Federal Internal Revenue Code⁴².

Commercial health insurance carriers: The ACA requires health insurance carriers to submit data on the proportion of premium revenues spent on clinical services and quality

improvement, also known as the Medical Loss Ratio (MLR). This filing, which carriers submit to the Center for Consumer Information & Insurance Oversight (CCIIO)⁴³, also includes information on the carrier’s number of covered lives by market segment for the individual, small group and large group health insurance markets.

Health System Financial Indicators

In addition to the triennial CHNA report required by the IRS discussed above, not-for-profit hospitals annually report information on their financial status to the IRS through a Form 990, officially known as the “Return of Organization Exempt from Income Tax” form. This form includes information on revenues, expenses, assets, liabilities, compensation for executives and a high-level overview regarding the hospital’s operations. Hospitals also report detailed information on their operations and finances to CMS each year through the Medicare Cost Report. Several firms aggregate these publicly available data into digestible reports for a small fee. The Office purchased access to these reports for Delaware hospitals through the American Hospital Directory⁴⁴.

³⁹ American Hospital Directory (2018).

⁴⁰ Horizon Government Affairs (2020).

⁴¹ Delaware Department of Health and Human Services (2020).

⁴² IRS (2020).

⁴³ CMS (2020).

⁴⁴ American Hospital Directory (2018).



Finding 4. Delaware has an older, sicker population than most states.

Hospitals and health systems mentioned that Delaware has an older and sicker population. When compared to national data, Delaware residents tend to be older, more likely to be obese and less likely to regularly engage in physical activity. Delaware residents also are more likely to die of a drug overdose or use tobacco, particularly during pregnancy. These characteristics of the state population are an additional driver of total cost of care⁴⁵.

PRIMARY DATA SOURCES SUPPORTING FINDING 4

The Office reviewed data from several national health policy foundations to better understand the demographics of the Delaware patient population, their health risk factors and health status. The Commonwealth Fund Scorecard on State Health System Performance⁴⁶ and the United Health Foundation's America's Health Rankings were among the primary sources consulted.

⁴⁵ United Health Foundation (2020).

⁴⁶ The Commonwealth Fund (2020); United Health Foundation (2020).





Finding 5. Pairing increases in primary care investment with other reforms allows states to maximize improvements in care delivery and value.

Affordability Standards are emerging as an important tool for states (see Exhibit 7). Most states apply multiple Affordability Standards to achieve desired goals and protect against unintended consequences. Maryland, Rhode Island, and Oregon implemented primary care investment targets paired with regulation of provider price increases and alternative payment model adoption. Other states such as Massachusetts and Connecticut instituted total cost of care benchmarks and monitoring of market consolidation.

EXHIBIT 7: Affordability Standards in Other States

	Total cost of care benchmark	Primary care spend targets/redesign	Enhanced rate review and other payer reforms	Market consolidation monitoring	Public option	APM adoption targets	Provider price regulation
Connecticut	...	✓		✓			✓
Colorado		✓	✓
Maryland	★	✓				✓	●
Massachusetts	✓	...	✓	✓			✓
Rhode Island	✓	✓				✓	●
Oregon	...	★				★	✓
Vermont	★		✓			✓	✓
Washington					...	✓	✓

Developed
 In progress
 Special CMS Negotiation
 Medicaid focused
 Rate caps

The Office's enabling legislation requires it to increase the availability of high-quality, cost-efficient health insurance products; create more stable, predictable, and affordable health insurance rates; and guarantee primary care investment would support a robust system of primary care⁴⁷.

Based on a review of the experience of other states and studies conducted by national experts, the Office concludes that to meet its charge, it must recommend and implement multiple standards that aim to guide the market to higher value care. For example, in Rhode Island, the Office of the Health Insurance Commissioner (OHIC) instituted a combination of increased investment in primary care, an expansion of alternative payment models and limits on price increases for hospital services. A detailed review of other states' strategies is provided in [Appendix 4: State Profiles](#).

DATA SOURCES SUPPORTING

FINDING 5: The Office reviewed statutes, regulations, legislation and public reports from each of the states listed above and, in some cases, commentaries written by health policy researchers on a particular state's policies, to inform its assessment of the best path forward for Delaware. The Office's team of contracted experts also includes individuals who have supported relevant health policy work in all states listed in **Exhibit 7** except Washington State. Their firsthand knowledge and experience informed the recommendations for Delaware.



⁴⁷ State of Delaware, *Title 18* (2020).



Finding 6. Delaware stakeholders support a multi-pronged approach.

Collectively, the data and perspectives shared during the stakeholder interviews supported the need for a multi-pronged approach that would aim to increase primary care investment, moderate unit price growth for other services, and expand the use of alternative payment models, particularly those with significant opportunities for provider organizations to take more accountability for total cost of care.

Stakeholders expressed different preferences regarding the pace of implementation. Specifically, stakeholders varied on how quickly primary care spending should increase and to what extent the alternative payment model targets should require more uptake of advanced alternative payment models (i.e. those requiring large provider systems to take on some amount of risk if care for a population was more costly than expected).

SUMMARY OF INTERVIEWS TO SUPPORT FINDING 6:

Primary care providers described an urgent need to raise reimbursement quickly and in multiple ways. They said the decline in access due to primary care providers leaving practice was exacerbated by primary care providers moving to concierge care. They noted a need to increase primary care investment as a percent of total cost of care, both through higher unit prices paid for certain high use primary care services and through additional upfront, flexible payments to support investments in health information technology, integrated behavioral health, care management, care coordination and health promotion. Data from DHIN, DOI's carrier questionnaire, the SBO, and national data sources supported their observations.

Consumers and consumer advocates shared challenges related to affordability and access, particularly access to primary care services. A consumer mentioned she could not afford health insurance on the state's exchange and did not qualify for Medicaid. Therefore, she purchased some coverage through a "health sharing" plan. Meanwhile, her primary care physician had moved to concierge medicine and was requiring an \$1,800 upfront payment to continue to provide care. She paid this fee for one year, then no longer could afford it, and relied on a family member's connections as a nurse to find a new PCP.

The primary care provider shortage in Delaware increases stress on those who are practicing, and many stakeholders report that access has been further compromised by a growing number of primary care providers choosing to practice concierge medicine to try to regain a sense of joy of practice and work-life balance.

Policymakers, purchasers and payers frequently referred to the challenges they faced regarding payer and health system market power. Several referred to health systems "carving out" sub geographies of the state. Publicly available data from the Delaware hospital discharge data set, hospitals' community benefit reports and health plan filings with the federal government support these perceptions.

Two **health system stakeholders** expressed concern regarding the unit price growth target. One said increases in primary care spending should not be tied to efforts to moderate increases in total cost of care. The other agreed with the majority of stakeholders that current trends in cost growth were unsustainable but hoped movements to alternative payment models would be sufficient to moderate these trends. Generally, health system stakeholders expressed support for targets aimed at increasing spending on primary care services and expanding alternative payment model adoption.

THEORY OF CHANGE – THE FUTURE LANDSCAPE

Over the past three years, Delaware has acted to improve healthcare quality and bend the healthcare cost growth curve by:

- Implementing healthcare quality and spending benchmarks⁴⁸;
- Creating the PCRC to make recommendations on payment reform, value-based care, workforce and recruitment, and primary care investment and access⁴⁹;
- Implementing a state reinsurance program funded by a federal 1332 waiver program to stabilize the health insurance marketplace⁵⁰;
- Issuing regulations to increase the registration, oversight and transparency of pharmacy benefit managers and require corrective action as needed⁵¹; and
- Lifting payment and other barriers to ensure that providers could easily transition to providing telemedicine services including phone-based visits during the COVID-19 pandemic⁵².

To further help bend the healthcare cost curve, in 2019, Senate Bill 116 of the 150th Delaware General Assembly⁵³ directed the DOI to create the Office to “reduce health-care costs by increasing the availability of high quality, cost-efficient health insurance products with stable, predictable, and affordable rates.” SB 116 charged the Office with three tasks:

1

Establish Affordability Standards for health insurance premiums based on recommendations from the PCRC and annually monitor and evaluate these standards;

2

Establish targets for carrier investment in primary care to support a robust system of primary care by January 1, 2025; and

3

Collect data and develop annual reports regarding carrier investments in health care, including commercial reimbursement rates for primary and chronic care services.

⁴⁸ Health Care Commission, Health Care Spending and Quality Benchmarks (2020).

⁴⁹ Health Care Commission, Primary Care Reform Collaborative (2020).

⁵⁰ Health Care Commission (2020); Navarro, NO. 113 (2019).

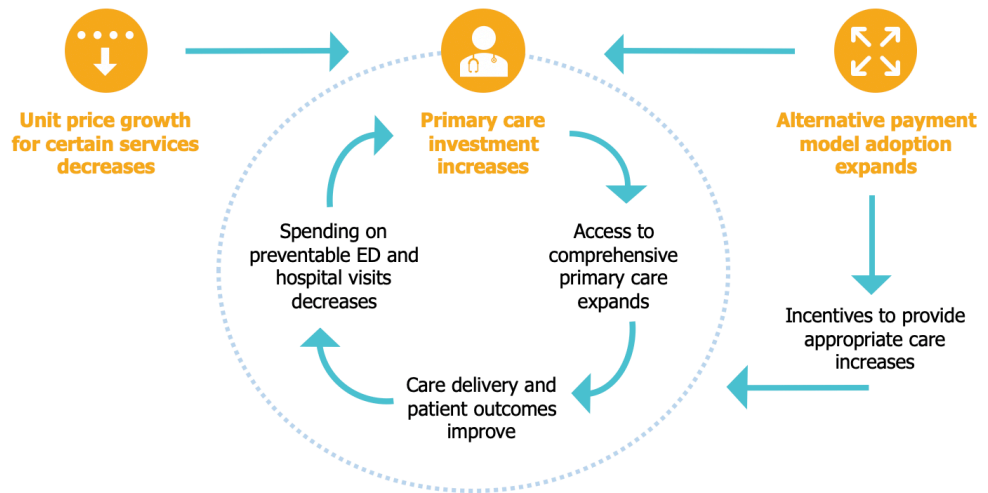
⁵¹ Delaware General Assembly (2020).

⁵² 150th General Assembly (2020); Navarro, No. 120 and No. 34 (2020).

⁵³ 150th General Assembly (2020).

To meet that directive, the Office recommends a Theory of Change as shown in **Exhibit 8**, that would consist of implementing three Affordability Standards, working together, to address Delaware’s dominant market forces discussed earlier in this report: 1) limited primary care investment and access 2) health systems and health insurance carriers with strong market power and 3) older, sicker population. It is important to note that the choice of these three Affordability Standards and the achievement targets developed for each standard were guided by data on the Delaware commercial health insurance market and may not be applicable to or appropriate for other payer types including Medicare and Medicaid.

**EXHIBIT 8:
Theory of Change**



THE THREE STANDARDS ARE

1

Increase Primary Care Investment

Increased primary care investment coupled with targets for expanded alternative payment model adoption will give primary care providers more flexible reimbursement options to support comprehensive care teams, provide care beyond the office walls and improve patients’ access to care management, care coordination and disease prevention services.

2

Decrease Unit Price Growth for Certain Services

While a target for actuarially justified unit price growth will not address the state’s market dominance issues directly, it will offer important regulatory guidance to support a better functioning market. It will also allow for additional investment in primary care services and will help reduce the impact of that increased investment on total cost of care.

3

Expand Alternative Payment Model Adoption

Increases in primary care investment have the potential to reduce costs over time, especially when coupled with provider accountability for total cost of care through shared savings or risk. These more effective approaches can help address patients’ medical, behavioral and social challenges sooner, reduce certain expensive hospital-based services and improve health outcomes.

WORKING TOGETHER

As depicted in the central circle in **Exhibit 8**, the organizing principle behind this theory of change is that with decreases in avoidable utilization and decreases in unit price growth for non-professional services, more dollars are freed up to invest in primary care and promote ongoing transformation and improvement without increasing the growth in total cost of care.

The Office also created a framework for accountability, which integrates the Affordability Standards into the DOI rate review process⁵⁴. Under this approach, the Office will provide spending targets and give providers and health insurance carriers flexibility to determine how they achieve those targets. Progress toward achieving the targets will be considered when DOI determines whether to approve health insurance carriers' proposed rates. The Affordability Standards integration into the rate review process is discussed in more detail [here](#).

⁵⁴ State of Delaware, *Title 18* (2020).



THE PROVISIONAL AFFORDABILITY STANDARDS AND TARGETS

#1: Increase Primary Care Investment

Increasing primary care investment has a long history of support in Delaware. Stakeholders, particularly consumers and primary care providers, report that low reimbursement contributes heavily to limited primary care access, and as a result, patients do not receive necessary care. Further, Senate Bill 227, which requires Delaware individual, group, and State employee insurance plans to reimburse primary care physicians, certified nurse practitioners, physician assistants, and other front-line practitioners for chronic care management and primary care services at no less than the physician Medicare rate, only serves to strengthen this standard. Delaware's focus on ensuring primary care access is founded in evidence. Research⁵⁵ finds increasing access to primary care providers by increasing the number of available primary care providers may help improve life expectancy through reduced mortality associated with cardiovascular disease, cancer, and respiratory illnesses.

⁵⁵ Basu, et al. (2019).

STAKEHOLDERS TOLD US

“

Payment reform needs to happen now. Too many practices are going out of business!”



KEY FINDINGS TO SUPPORT TARGET DEVELOPMENT

- Low primary care investment as a percent of total cost of care compared to leading states⁵⁶
- Low commercial reimbursement for primary care and other professional services compared to providers nationally and compared to hospital services⁵⁷ in Delaware
- Shrinking and aging primary care workforce⁵⁸
- Limited investment, approximately \$1.70 per member per month, in flexible care management and incentive payments to primary care providers that could be used to support a move toward high-value, comprehensive primary care

PROVISIONAL TARGET

Commercial health insurance carriers will increase investments in primary care, as defined by the Office, by 1% to 1.5% of total cost of care each year until 2025.

This target:

- More than doubles primary care spending from 2022 to 2025, on a per member per month basis
- Increases primary care spending as a percent of total cost of care from approximately 5% in 2021 to between 9% to 11% by 2025, see **Exhibit 9**
- Grows primary care investment, on a per member per month basis, to levels consistent with leading models of comprehensive primary care delivery nationally

⁵⁶ Office of Value Based Health Care Delivery Questionnaire (2020).

⁵⁷ Whaley, Briscoe, Kerber, O'Neill, & Kofner (2020).

⁵⁸ Basu, et al. (2019).

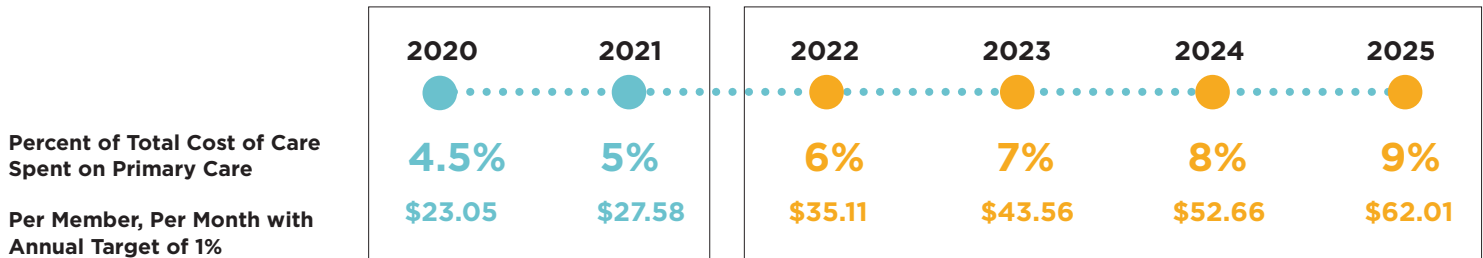
NOTES ON TARGET DEVELOPMENT

- As described in Finding 1 and repeated above, the Office recognizes that primary care spending in Delaware historically has been insufficient to support comprehensive primary care delivery.
- Primary care spending for 2021 is projected to be approximately 5% of total cost of care. This projection is based on data submitted by commercial health plans via DOI's carrier questionnaire and actuarial knowledge of the market. These projections reflect existing negotiated rates, established provider contracts, premium rate filings already approved by the DOI, and utilization projections. They also factor in [the requirement](#) in SB 227⁵⁹ that commercial carriers reimburse at least as much as Medicare for primary care and chronic care management services.
- Beyond enforcement of SB 227, the Office's first opportunity to increase primary care spending is in 2022. The Office appreciates other action may be necessary to increase primary care spending in 2021.
- If primary care spending in 2021 is higher than currently projected, the glidepath shown below would be adjusted upward to reflect this change. More information on carrier accountability for meeting the targets and the annual process the Office will use to update the targets can be found in the [Integration into the Rate Review Process](#) section.
- The Office modeled several possible primary care investment glidepaths. [Appendix 5: Primary Care Investment Glidepaths](#) shows glidepaths of 1% and 1.5% annual increases.

EXHIBIT 9: Projected Increased Primary Care Investment Ranges

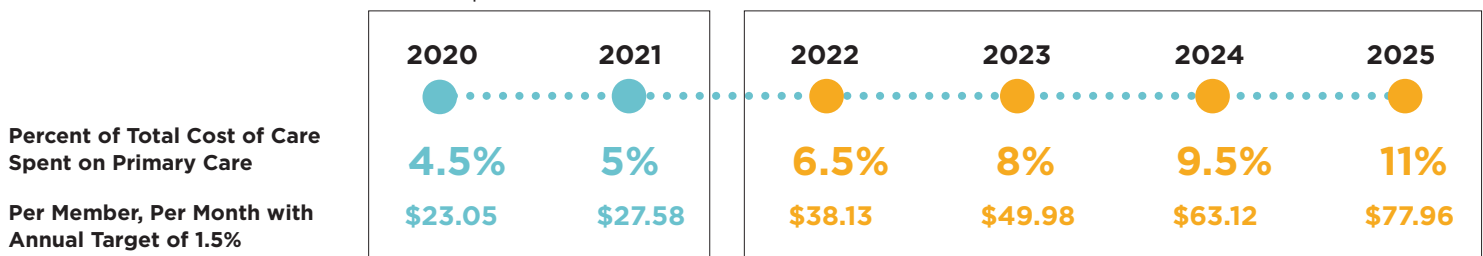
Based on existing provider contracts, approved premium rates and compliance with SB 227*

Projected Increase in Primary Care Spending Based on Annual Target of 1%



Based on existing provider contracts, approved premium rates and compliance with SB 227*

Projected Increase in Primary Care Spending Based on Annual Target of 1.5%



*More information on SB 227 [here](#).

⁵⁹ 149th Delaware General Assembly (2018).

Discussion

ROBUST SYSTEM OF PRIMARY CARE | The Office is charged with establishing targets for carrier investment in primary care to support a “robust system of primary care.” In developing this target, it is important to consider primary care as a percent of total cost of care and the actual dollars or budget primary care providers would need to support this type of care delivery.

PRIMARY CARE AS A PERCENT OF TOTAL COST OF CARE | With regard to the percent of total cost of care, several states now target primary care investment at 10% to 12%. However, these states also spend less per member per month on healthcare than Delaware. For example, in 2018, commercial carriers in Oregon invested \$44 per member per month on primary care, which included care for certain OB-GYN and behavioral health services that are not classified as primary care services in Delaware. In Oregon, the \$44 investment equaled 13%⁶⁰ of total cost of care not including spending on retail and mail order pharmacy, which Oregon excludes. In Delaware, in 2018, that same \$44 investment would have represented 10% of total cost of care. ***Since Delaware is a higher cost state, the same investment in primary care represents a smaller portion of total cost of care than in a lower cost state.***

⁶⁰ Oregon Health Authority (2020)



Exhibit 10: Oregon’s Patient-Centered Primary Care Home

The Oregon Health Authority recognizes 645 Patient-Centered Primary Care Homes, an enhanced version of the National Committee for Quality Assurance’s Patient Centered Medical Home model, as of 2020. These primary care practices provide enhanced primary care delivery to their patients. Key attributes of these practices are:

- **EXPANDED CARE TEAMS PROVIDING ACCESS TO:**
 - > Integrated behavioral health and substance use disorder treatment
 - > Convenient telephonic and electronic care
 - > Prescription drug adherence tracking and medication reconciliation and management
 - > Coordinated preventive and chronic care leveraging patient and clinical data and including coordination with patient support systems, specialty care, and ancillary providers and systems
 - > Social determinants of health assessment and referrals
 - > Oral health integration
 - > Culturally appropriate patient education
- **VALUE-BASED PAYMENT ARRANGEMENTS based on clinical quality measures with data sharing with providers**
- **COLLECTION AND UTILIZATION OF PATIENT SURVEYS and population health data for quality improvement and utilization management**

A BUDGET TO SUPPORT A ROBUST SYSTEM OF PRIMARY CARE

Changes in Care Delivery: In determining the dollars necessary to support “robust” primary care delivery it is important to estimate the cost of the standard components of this type of care delivery including:

- Expanded care teams with access to behavioral health support, care management, patient navigation and other services to address patients’ physical, behavioral and social needs
- Access to care beyond the office through phone, text, email, virtual visits, and community-based services
- Increased health information technology infrastructure and data analytical capabilities
- New opportunities to build leadership and teaming skills

Quantifying the Cost: Two recent efforts have quantified the cost of developing this type of comprehensive care delivery model and produced similar results.

A 2018 article published in the Journal of General Internal Medicine defined high-quality, comprehensive primary care and the functions needed to deliver it. It then translated those functions into full-time equivalent staffing requirements for a practice serving a panel of 10,000 adults and then revised the models to reflect the needs of practices serving older adults, patients with higher social needs, and a rural community. Finally, the research estimated the labor and overhead costs associated with each model. The index model, intended to serve an average adult population, estimated a reimbursement of \$45 per member per month in 2015 dollars, which would be approximately \$50 per member per month in 2020⁶¹.

The Connecticut State Innovation Model Primary Care Modernization Initiative measured the state’s primary care spend and worked with stakeholders to identify how primary care delivery should evolve. To achieve the primary care capabilities stakeholders’ desired, the initiative estimated most practices serving adult patients would need to be reimbursed approximately \$47-\$51 per member per month in 2019 dollars, which would be equal about \$48-\$52 in 2020⁶².

Sustainability Requires Accountability: Both of these models envision a very different system of primary care than typically offered in Delaware today. Of note, the Connecticut model required providers to achieve certain transformation milestones including improvements in quality, and reductions in avoidable utilization. Providers receiving the highest levels of reimbursement in the Connecticut model also were required to be affiliated with an accountable care organization or a clinically integrated network willing to take accountability for the total cost of care of its patients.

Increasing investment in primary care cannot occur in a vacuum. It will need to be accompanied by increasing levels of provider accountability for outcomes and cost, as outlined in **Affordability Standard 3, Expanding Alternative Payment Model Adoption**.

⁶¹ Meyers, et al., (2018).

⁶² Connecticut Office of Health Strategy (2019).

Sustainability Requires Funding: It is important to note carriers are required by Senate Bill 227 under the 149th Delaware General Assembly to reimburse at least as much as Medicare for primary and chronic care services. The Office is tasked with measuring whether carriers comply. An initial analysis based on information from DHIN suggests Delaware carriers reimbursed providers for primary care and chronic care management services at approximately 90% to 95% of Medicare. While this was an increase over previous years, it is insufficient to meet the statutory requirement, which is “no less than the physician Medicare rate.” Since the DHIN data is reported in aggregate across commercial carriers, the Office will now work with each carrier to determine individual compliance.

Meanwhile, CMS released a CY 2021 Medicare Physician Fee Schedule Final Rule that increases payment rates for office visits and other evaluation and management services, typically delivered by primary care providers. Under the proposed rule, payment rates for family practice physicians, for example, would increase by an estimated 13%⁶³. To keep pace and meet the statutory requirement, carriers will likely need to make similar adjustments to their own fee schedules. ***The Office envisions these increased fee-for-service payments would be one component of a multi-layered approach to achieving the primary care investment targets that would also include growth in non-fee-for-service payments.***

⁶³ Advisory Board (2020).).

STAKEHOLDERS TOLD US

“

Access is very important, especially in Delaware. We must ensure that we do not lose providers.”



#2: Decrease unit price growth for certain services

The charge of the Office is to “reduce health-care costs by increasing the availability of high quality, cost-efficient health insurance products with stable, predictable, and affordable rates.” Nationally, and in Delaware, price has been a key contributor to rising healthcare costs⁶⁴. Stakeholders reported and data supported that several of the state’s health systems dominate a particular sub-geography of the state making it difficult for commercial health insurance carriers, even those with dominant market power themselves, to effectively negotiate price.

In Rhode Island, OHIC instituted a combination of increased investment in primary care and limits on price increases for hospital services. Health care costs in Rhode Island decreased⁶⁵ 8.1% in the six years following enactment of the Rhode Island affordability standards, compared to a control population of residents in other states. The decrease in spending has been largely attributed to decreases in hospital price growth.

KEY FINDINGS TO SUPPORT TARGET DEVELOPMENT

- Prices for outpatient and inpatient hospital services in Delaware for the commercial fully insured and the state group health insurance plan increased an average of 3.2% to 3.9% a year, respectively, compared to 0.5% a year for professional services such as those provided by primary care providers⁶⁶ from 2017 to 2019.
- Commercial carriers paid Delaware hospitals and health systems, on average, 272% of Medicare reimbursement for inpatient services and 334% of Medicare reimbursement for outpatient services.
- Four of the six adult hospitals had at least 40% of the discharges for their service areas, and two had market share percentages exceeding 80%⁶⁷.

⁶⁴ Cooper, et al. (2019).

⁶⁵ Baum, et al. (2019).

⁶⁶ Office of Value Based Health Care Delivery Questionnaire (2020).

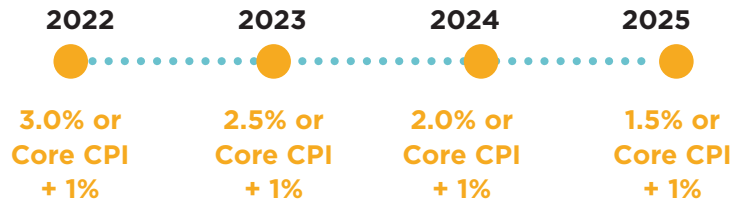
⁶⁷ Delaware Department of Health and Human Services (2020); Delaware Healthcare Association (2020).

PROVISIONAL TARGET

Through their contracts with healthcare providers, commercial health insurance carriers will limit aggregate unit price growth for non-professional services according to the schedule below. Non-professional services will be defined as those categorized as “Inpatient Hospital,” “Outpatient Hospital,” and “Other Medical Services” in the Unified Rate Review Template (URRT), see [Appendix 2: Benefit Categories in the Unified Rate Review Template](#). These categories do not include professional services.

The “Core CPI” is the Consumer Price Index for All Urban Consumers: All Items Less Food & Energy⁶⁸. Developed by the US Bureau of Labor Statistics, it is a widely used aggregate of prices paid by urban consumers for a typical basket of goods. It excludes food and energy because food and energy have very volatile prices.

EXHIBIT 11: Provisional Target Will Be the Greater of the Following



Discussion

TARGET TIED TO ECONOMIC GROWTH | Similar to Rhode Island, the Delaware unit price growth Affordability Standard is tied to Core CPI to reflect the critical need to tie healthcare unit price growth to measures of overall inflation. Rhode Island constructed its hospital price growth affordability standard as a cap. In Delaware, the Affordability Standard is constructed as a target. Payers will submit information on historical and prospective price increases to DOI and the Office annually via a template completed as part of the rate review process. Progress toward achieving the price growth target will inform but not determine DOI’s rate review decision.

⁶⁸ U.S. Bureau of Labor Statistics (2020).

MODELING | The Office modeled several scenarios including commercial carriers' current projected increases in hospital price and utilization. Pairing these projected increases with the necessary increases in primary care investment discussed in Affordability Standard #1 resulted in unsustainable annual increases in total cost of care of 9% or more. Consumers, employers and carriers would not find this level of cost growth to be an acceptable solution. The Office also modeled increases in unit price growth lower than displayed in the schedule. Though these assumptions allowed primary care investment to grow more quickly or projected lower increases in total cost of care, the Office felt they were less realistic.

FINDING COMPROMISE | The annual cost growth targets in the schedule represents a compromise that addressed competing needs to increase primary care investment, and in turn, patients' access to comprehensive, high quality primary care, limit growth in total cost of care, and maintain sufficient and appropriate access to necessary inpatient and outpatient services. Further, by embedding the Affordability Standards into the rate review process, DOI has the flexibility to evaluate commercial health insurance carriers' progress toward achieving the targets in the context of the COVID-19 pandemic and other current market conditions. The Office recognizes achieving the targets will require time, compromise and collaboration across hospitals, health systems and commercial health insurance carriers. DOI looks forward to supporting those discussions as needed.

STAKEHOLDERS TOLD US



Going to a hospital is like planning a wedding. Everything is 10x more expensive than it would be otherwise.”



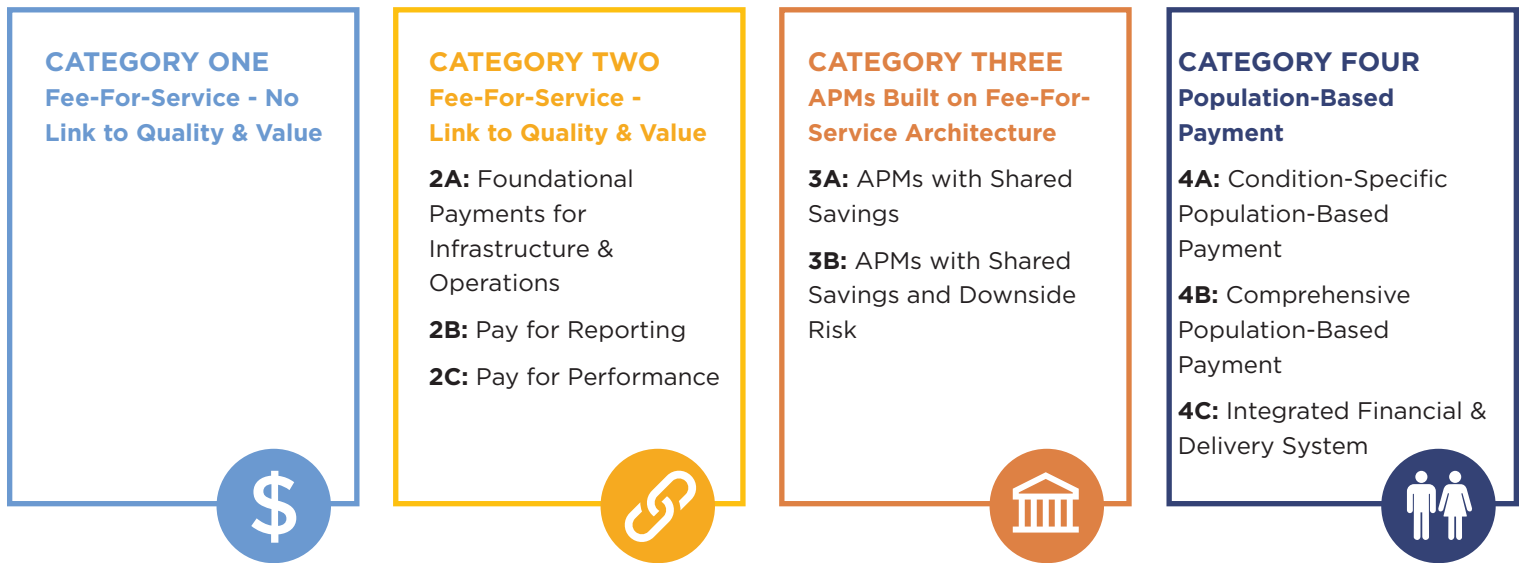
#3: Expand alternative payment model adoption

Nationally, and in Delaware, a growing number of accountable care organizations (ACOs) are improving the quality of care delivered to patients for comparable, or in some cases, reduced cost⁶⁹. In Delaware, nearly 105,000 Medicare beneficiaries are attributed to ACOs participating in the CMS Medicare Shared Savings Program (MSSP), one of the highest percentages nationally. Delaware ACOs outperformed ACOs nationally in 2019⁷⁰. With the success of Delaware MSSP ACOs, the Delaware Division of Medicaid and Medical Assistance (DMMA) recently authorized four Delaware ACOs to enter into agreements directly with the state's two Medicaid managed care organizations (MCOs)⁷¹. Medicaid aims to gradually move ACOs to take risk for the total cost and quality of care delivered to their patients.

PROGRESS AMONG COMMERCIAL PAYERS HAS BEEN SLOWER.

While some Delaware commercial health insurance carriers offer alternative payment model (APM) arrangements, most do not require providers to take on “downside risk” or pay back losses if the total cost of care for a patient population is higher than expected. Similarly, Delaware commercial health insurance carriers’ “shared savings” programs often offered less opportunity for providers to share in savings than MSSP. Shared savings programs are attributed to Category 3A of the Health Care Payment Learning & Action Network (HCP-LAN)⁷² APM categories in **Exhibit 12**, with further descriptions in [Appendix 3: APM Category Definitions](#).

EXHIBIT 12: HCP-LAN Alternative Payment Model Categories



Commercial health insurance carriers will need to keep pace with Medicare and Medicaid, or risk complicating providers’ efforts to transform and further misalign incentives. Providers, particularly health systems, trying to transform care delivery are best served by multi-payer approaches that support them in focusing their attention

⁶⁹ McWilliams, Hatfield, Landon, Hamed, & Chernew (2018); Song, Ji, Safran, & Chernew (2019); Verma (2020).

⁷⁰ Centers for Medicare and Medicaid Services (2020).

⁷¹ Delaware Health and Social Services, Delaware News (2020).

⁷² Health Care Payment Learning & Action Network (2017).

and revenues on opportunities to improve care value. Otherwise, they might have one patient walking through the door where the greatest opportunity to generate revenue is through a hospital admission and another patient walking through the door where the greatest opportunity for revenue is to avoid that admission. This bifurcation, often described as the “a foot in each canoe” problem, heavily constrains opportunities for true transformation.

Providers’ challenges in maintaining sustainable fee-for-service revenues during the pandemic has increased interest in expanding non-fee-for-service revenues. And, as discussed above, an expansion of APMs will be important to support the total cost of care accountability that will be needed to ensure the highest levels of primary care investment are sustainable long-term.

KEY FINDINGS TO SUPPORT TARGET DEVELOPMENT

• Other Current Targets

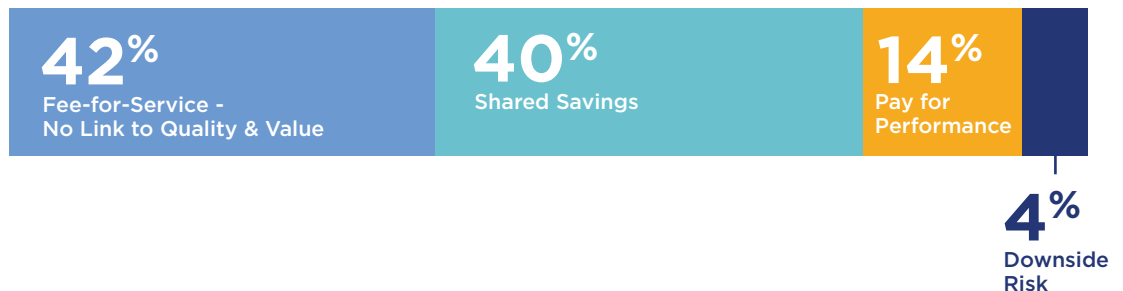
- > Delaware set a target to have at least 60% of Delawareans attributed to a “value-based model” by 2021⁷³. Data collection efforts differ on whether this specific benchmark was met. However, progress is occurring, particularly for the state’s Medicare and Medicaid beneficiaries.
- > The SEBC targets for 2023 aim for 40% of healthcare spending to be under a Category 3 model and 10% under a Category 4 model by 2023. SEBC recently released a request for information to gain more insights into provider and payer readiness to support achieving those targets.

- **State of APMs in Delaware Commercial Contracts:** As shown in Exhibit 13, carriers reported 44% of commercial total cost of care is subject to a total cost of care accountability contract, such as a shared savings arrangement. They reported an even smaller proportion of dollars, 4%, flow through contracts that require providers to pay back a portion of losses if a population’s medical expenses exceed expected costs.

- **Dollars at Stake:** It’s important to note the actual, shared savings dollars being earned by providers under these contracts appear to be minimal and will need to increase over time for providers to prioritize transformation.

- **Physician-Led ACOs Tend to Outperform Those Led by Health Systems:** In Delaware and nationally, MSSP ACOs led by physicians, known as “low-revenue” ACOs, have generally performed better than “high-revenue” ACOs, usually led by hospitals and health systems. Nationally, low-revenue ACOs had net per-beneficiary savings of \$201 in 2019 compared to \$80 per beneficiary for high-revenue ACOs. In Delaware, the state’s three low-revenue ACOs generated net savings of about \$253 per beneficiary after payments back to providers. Comparatively, high-revenue ACOs generated net savings of \$250 per beneficiary. Of note, none of the state’s high revenue ACOs generated sufficient savings to earn savings payments. Delaware low-revenue ACOs generated savings of more than \$556 per member, per year before shared savings payments were made⁷⁴.
- **The Move to Downside Risk:** In Delaware, most ACOs currently participating in MSSP will move to downside risk in the next few years. In 2020, 37% of ACOs in the program nationally were in downside-risk arrangements including Aledade in Delaware. Further, at least one Delaware ACO is planning a move to CMS’ Direct Contracting program and in doing so will take on full risk for the Medicare population it serves. CMS has offered some ACOs an extension of their current terms and other allowances as they managed the pandemic.

**EXHIBIT 13:
Percent of Total Cost
of Care in Contracts
Tied to APMs in
Delaware in 2019⁷⁵**



⁷³ State of Delaware, Title 16 (2020).

⁷⁴ Verma (2020).

⁷⁵ Office of Value Based Health Care Delivery (2020).

PROVISIONAL TARGET

A minimum of 50% of total cost of care will be tied to an APM contract that meets the HCP-LAN Category 3 definition by 2023, with a minimum of 25% of total cost of care covered by an APM contract that meets the definition of Category 3B. Total cost of care accountability may not be the right fit for all primary care providers. Delaware carriers will provide more opportunities for independent providers to participate in pay for performance programs to increase investment in high value services. Commercial health insurance carriers will also explore new ways to pilot and implement capitated payments for primary care and other services and report to the Office on the successes and lessons learned of those programs.

Discussion

Experience from MSSP and commercial total cost of care accountability programs offer lessons learned.

- **Transformation takes time.** ACOs typically need two to three years to achieve savings in excess of the additional investment necessary to transform care. Savings tend to grow over time as processes improve and patients have more time to benefit from improved care delivery.
- **A dual focus on price and utilization is needed.** Over the long-term, savings in commercial total cost of care accountability programs are generated from reductions in price and unnecessary utilization. In the Massachusetts Alternative Quality Contract, for example, most savings in the earlier years were generated through referrals to lower priced providers whereas in later years savings were more likely to come through lower utilization.
- **Physician-led ACOs tend to be more successful.** It is often easier for them to reduce spending on acute inpatient care, post-acute care, home health care initiated on an outpatient basis, and outpatient care in hospital-owned settings, all of which contribute to reductions in total spending. For hospital-led ACOs, the conflicting incentives can be challenging. They provide a range of care for patients who are not covered by their ACO contracts and can lose substantial fee-for-service revenue if they are unable to focus reductions in utilization on ACO-covered patients. Physician-led ACOs have stronger incentives to limit utilization because they do not lose revenue when they reduce unnecessary hospitalizations or outpatient hospital procedures and imaging for any patient, regardless of whether that patient is covered by an ACO contract.

Determining whether it's necessary for providers to be at risk for losses is tricky. Without incentive to provide hospital-based services, physician led ACOs are less likely to need the stick of downside risk to be successful, and they may be reluctant to take on downside risk without ready capital and experience⁷⁶.

⁷⁶ McWilliams, Landon, Rathi, Chernew (2019)

INTEGRATION INTO THE RATE REVIEW PROCESS

Beginning in 2021, plans will submit information to DOI and the Office each year on the progress in their individual, small and large group plans in achieving the targets in the Affordability Standards. Information will be submitted via an additional template as part of the rate review submission⁷⁷. Progress toward achieving the target would inform but not determine whether the rate filing was approved.



While DOI continues to view rate review as a collaborative process, it will utilize all aspects of the rate review and enforcement process including market conduct reports, audits and hearings to ensure data reported to the Office is accurate, progress toward achieving the Affordability Standards is sufficient, and proposed rate increases are actuarially justified.

The Office will also publish an annual report showing, in aggregate, payers' progress toward achieving each of the Affordability Standards. This annual Affordability Standards report will seek data from other sources including DHIN to add context to the information provided by the payers. It will also seek feedback from other stakeholders. Informed by each annual data collection, targets may be refined based on changing market conditions.

⁷⁷ Delaware Department of Insurance (2020).

In developing the targets, the Office considered the current ACO environment in Delaware, targets put forward by the SEBC, the PCRC and the shared state objective of reducing total cost of care growth. Some states begin with a process to define principles for care delivery transformation. In Delaware, stakeholders said targets would help focus current efforts to re-imagine care delivery and hasten movement toward meaningful alternative payment models.

Above all, the Office focused on developing aspirational yet achievable goals that would position the state's carriers and a wide range of providers for success. The Office also considered constraints shared by stakeholders including carriers' preference for nationally developed programs and providers' hesitation to accept certain terms. Deeper collaboration and more flexibility will be necessary. The Office expects stakeholders, guided by the PCRC and other multi-stakeholder bodies, to develop the vision for care delivery and a corresponding payment model to support that vision. These targets aim to motivate meaningful conversations between carriers, providers, purchasers and as needed, DOI.



FACTORS THAT MAY AFFECT FUTURE SPENDING TRENDS

THE IMPACT OF THE COVID-19 PANDEMIC

The impact of the COVID-19 pandemic on care delivery and health system finances cannot be fully understood at this time. For many, the pandemic has solidified a desire to move away from fee-for-service reimbursement. For others, it has raised further concerns about the risks of consolidation and accompanying price increases.

- **Changes in Utilization:** Healthcare utilization fell sharply during the early stages of the pandemic, with hospital discharges nationally down an average of 26% to 32% in March⁷⁸, depending on the size of the hospital. As a result, 2020 medical costs decreased an estimated 4% nationally⁷⁹. By Summer 2020, utilization had recovered to approximately 90% of pre-pandemic levels, due in part to increases in telehealth⁸⁰. Delaware utilization and cost estimates for 2020 are not yet available. However, the state's high infection rates in the Spring and its swift action to expand access to telehealth suggest its experience will be similar to national trends.
- **CARES Act Funding:** To make up for some of the revenue shortfall, Delaware hospitals received \$171,256,075 in 2020⁸¹ as part of the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act. This funding was equivalent to about 5% of their combined net patient revenue in 2019, the most recent year available.

⁷⁸ Cox, Kamal, & McDermott (2020).

⁷⁹ Segal Consulting (2019); Heist, Schwartz, & Butler (2020).

⁸⁰ IQVIA (2020).

⁸¹ Assistant Secretary for Public Affairs (2020).



- **State strategies to combat COVID-19, including resurgence preparation:** Through Executive Order 39, Delaware's Governor formed the Pandemic Resurgence Advisory Committee (PRAC) to devise a strategy that would inform Delaware's Governor's response to the anticipated resurgence of the SARS-CoV-2 virus (COVID-19). The PRAC was tasked with (1) developing a healthcare system and public health strategy that is ready in case of a resurgence of COVID-19; (2) identifying tactics and resources to manage a resurgence of COVID-19 including, but not limited to, testing capabilities, personal protective equipment (PPE), social distancing, economic development and recovery, and health facility readiness; and (3) assessing methods to protect vulnerable populations and consider disproportionate effects on minority-owned businesses in the event of a resurgence of COVID-19. A copy of their recommendations can be found in their Final Report⁸².
- **Unknowns Ahead:** Despite CARES Act and other support, actuaries predict⁸³ healthcare providers may try to increase prices to make up for revenues lost and additional infrastructure investments made during the first and second quarters of 2020 to respond to the pandemic. They expect growth in healthcare prices coupled with increased use of physician services for postponed services may lead to higher healthcare cost growth in 2021. They also caution there are many unknowns, including costs associated with COVID-19 testing, treatment and immunization.

1332 WAIVER

Delaware has received approval from CMS for a 1332 State Innovation Waiver to create a reinsurance program in an effort to reduce premiums by up to 20% in Delaware's individual health insurance market⁸⁴. Under Delaware's reinsurance program, which began this year, a portion of high-cost health care claims will be reimbursed through an estimated \$27 million fund. The fund will use a mix of federal funding and assessments collected by DOI from health insurance carriers. The assessments are collected from Delaware's health insurance carriers and the Delaware Health Care Commission (DHCC) administers the program. A March 2019 analysis by health care consultant Avalere⁸⁵ found state-run reinsurance programs reduce premiums by almost 20% on average in their first year.

FLEXIBILITY FOR UNCERTAIN TIMES

With regard to implementing the Affordability Standards, stakeholders largely agreed that the pandemic heightened the need to move forward quickly given how the pandemic has influenced the overall economy and noted the importance of a flexible system of accountability that could easily adapt to changing market conditions and external factors unknown today. Integrating the Affordability Standards into the DOI rate review process provides this flexibility. In addition, all three targets will be reevaluated annually and adjusted as needed to support a high quality, sustainable healthcare system.

⁸² Delaware Pandemic Resurgence Advisory Committee (2020).

⁸³ Segal Consulting (2019).

⁸⁴ Health Care Commission (2020); Navarro (2019).

⁸⁵ Sloan, Rosacker, & Carpenter (2019).

CONCLUSION

This report sets forth an integrated approach to improve access, quality and value in Delaware's healthcare landscape. The data and findings point to an overarching, shared goal on the part of Delaware's healthcare stakeholders to make healthcare more affordable by focusing on sustainability and accountability. The concurrent implementation of the three Affordability Standards and associated achievement targets presented in this report through the DOI's rate review process aims to create an environment that supports achieving that shared goal. Annual data collection, transparent reporting of aggregate trends, continued conversations with stakeholders, and accountability through the rate review process will track progress and measure success.



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Appendix 1: Definition of Primary Care Investment

PRIMARY CARE INVESTMENT

The Primary Care Investment definition was developed by the PCRC in 2019 and refined with guidance from the Primary Care Reform Collaborative Technical Subcommittee (PCRC TS).

A complete definition including the current procedural codes defining primary care services, the taxonomy codes defining who is a primary care provider, and the place of service codes defining primary care places of service can be found below. All three conditions must be met – service, provider, and place of service – for the expenditure to be classified as primary care investment. The definition also includes three categories of non-FFS payments made to support primary care: Primary Care Incentive Programs, Primary Care Capitation, and Primary Care, Care Management. The Office uses the specifications developed by the state's benchmarking process.

The PCRC TS agreed care provided at urgent care facilities should not be included as primary care. It did not reach consensus on whether to include retail clinics as a primary care setting. Some participants said the setting lacked sufficient comprehensiveness and continuity to be considered primary care. Others noted retail clinics provide convenient access to many consumers. After speaking with additional consumers and employers, the Office included retail clinics in the definition.

FACILITY FEES AND RISK SETTLEMENTS

At this time, the Primary Care Investment definition excludes indirect spending on primary care such as facility fees for primary care visits and primary care providers' portion of risk settlements.

- 1) Health systems report and an analysis of DHIN data found minimal use of facility fees for primary care. Therefore, the Office did not want to incent health systems to charge these fees.
- 2) Few dollars currently flow through risk settlements. Therefore, the Office will re-evaluate whether to include a portion of this spending after these programs are implemented and more can be understood regarding their goals and constructs.

EXCLUSION OF PHARMACY COSTS IN THE TOTAL COST OF CARE DENOMINATOR

While the Office will continue to monitor increases in total spending on medical and pharmacy services, it excluded pharmacy spending in the total cost of care denominator of the primary care spending calculation. Spending on prescription drugs, particularly high cost specialty drugs, is increasing rapidly and shows no signs of slowing. By including these costs, primary care spending risks being artificially inflated by high cost specialty medications. The exclusion of pharmacy spending in the total cost of care denominator is consistent with primary care spending calculations in Oregon, Colorado, and Connecticut.

CODE LEVEL PRIMARY CARE DEFINITION

— Taxonomy = 207Q00000X, 207QA0505X, 207QG0300X, 208D00000X, 207R00000X, 207RG0300X, 208000000X, 363L00000X, 363LA2200X, 363LP0200X, 363A00000X, 363AM0700X, 363LF0000X, 363LG0600X or 363LP2300X.

AND

— Place of Service = 11, 71, 50, 17, 20, 02 or 12.

AND

— Procedure Code = 90460 - 90461, 90471 - 90474, 98966, 98967, 98968, 98969, 99201 - 99205, 99211 - 99215, 99241 - 99245, 99339 - 99340, 99324 - 99328, 99334 - 99337, 99341 - 99345, 99347 - 99350, 99354 - 99355, 99358, 99359, 99381 - 99385, 99386 - 99387, 99391 - 99395, 99396 - 99397, 99401 - 99404, 99406 - 99409, 99411 - 99412, 99420, 99429, 99441, 99442, 99443, G2010, 99444, 99495 - 99496, G0008, G0009, G0402, G0438 - G0439, G0444, G0463, G0502 - G0507, S9117, T1015, 99492 - 99494, 99483, 99487, 99489, 99490, G0506, G0511, G0467, G0468 or G0010.

Appendix 2: Benefit Categories in the Unified Rate Review Template

INPATIENT HOSPITAL

Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse disorder, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.

OUTPATIENT HOSPITAL

Includes 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.

PROFESSIONAL

Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital based professionals whose payments are included in facility fees.

OTHER MEDICAL

Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services, and other services.

CAPITATION

Includes all services provided under one or more capitated arrangements.

PRESCRIPTION DRUG

Includes drugs dispensed by a pharmacy. This amount should be net of rebates received from drug manufacturers.

Appendix 3: APM Category Definitions

LAN CATEGORY 1 - FEE-FOR-SERVICE

Payment models classified in Category 1 utilize traditional FFS 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 - FEE-FOR-SERVICE LINKED TO QUALITY & VALUE - 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 - FEE-FOR-SERVICE LINKED TO QUALITY & VALUE - 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 - FEE-FOR-SERVICE LINKED TO QUALITY & VALUE - 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 BUILT ON FEE-FOR-SERVICE ARCHITECTURE - APMS WITH SHARED SAVINGS

Category 3A, 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. 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 BUILT ON FEE-FOR-SERVICE ARCHITECTURE - 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 - POPULATION-BASED PAYMENT - CONDITION-SPECIFIC POPULATION-BASED PAYMENT

Category 4A includes bundled payments for the comprehensive treatment of specific conditions.

LAN CATEGORY 4B - POPULATION-BASED PAYMENT - 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 - POPULATION-BASED PAYMENT - 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.

Appendix 4: State Profiles

CONNECTICUT

Background

- Office of Health Strategy leads, largely building on SIM efforts
- Efforts to finance primary care transformation via custom CMS deal stalled

Key Policies

- Benchmark coupled with 10% primary care spend target, performance improvement plans, public reporting of cost trends recently launched
- CMIR, quality benchmarks and “monitoring” of ACOs used to regulate market dynamics, quality and access
- Self-Sufficiency Standard defines the income necessary to meet basic needs, likely to be incorporated into benchmark work

Lessons Learned/Impact

- CMS less interested in custom arrangements than under previous administrations
- Communication and alignment across state agencies is key
- Overcoming stakeholder conflict requires strong state leadership

COLORADO

Background

- Passed legislation that set targets for investment in primary care and established a primary care payment reform collaborative in the division of insurance
- Draft regulations were under consideration when the COVID-19 pandemic hit

Key Policies

- Carriers to move at least 50% of applicable medical expense to APMs by 2023 or face DOI performance improvement plan
- Carriers to increase primary care spend as a percent of total cost of care 1 percentage point per year in 2021, 2022 and report how investments support advanced primary care
- State considering Public Option for individual market. Carriers would administer. It sets reimbursement for hospitals at 155% Medicare.
- New reinsurance program aims to reduce costs for the individual market

Lessons Learned/Impact

- Obtaining data to operationalize policy goals is an important and sometimes frustrating process
- Progress takes time. The state’s primary care collaborative has spent about 18 months working to develop the draft regulation.

MARYLAND

Background

- Total Cost of Care (TCOC) Model, the first CMS/state “full risk” agreement, sets a per capita limit on Medicare TCOC, with aims to save \$1 billion by 2023
- Builds on 40yrs of fixed payments to hospitals including the 2014 All-Payer Model
- Hospital cost growth per capita for all payers must not exceed 3.58% per year

Key Policies

- Hospital Payment Program: Each hospital receives a population-based

payment amount to cover all hospital services for a year

- Care Redesign Program: Hospitals incent non-hospital partners to improve quality of care. Total costs, including incentives, cannot exceed fixed global budget
- Maryland Primary Care Program: Incent advanced primary care through CPC Plus “like” program

Lessons Learned/Impact

- The All Payer Model (2014-2018) held the cost of hospital care to a cumulative 11.16 percent increase (less than half of the model’s target)
- Stakeholders felt that the All Payer Model made it difficult to engage other aspects of care delivery; the new model aims to give hospitals the ability to incent other providers

MASSACHUSETTS

Background

- An early adopter of a wide range of “affordability standards,” Massachusetts has reforms to measure and constrain total cost of care and improve affordability for consumers; extensive supplemental data collection and provider consolidation oversight. Significant provider price variation remains with some providers paid 2x to 3x others.
- Proposed legislation would require primary care and behavioral health spending to increase 30% over the next three years

Key Policies

- Total cost of care benchmark currently sits at 3.1%. It is reinforced by annual public cost trends hearings and reports, as well as performance improvement plans for providers.

- Additional state-based consumer subsidies, beyond Affordable Care Act minimums
- Carriers face limits on administrative charges, rate increases, and how much profit can be contributed to reserve. Individual and small group must post a higher medical loss ratio than required by ACA and offer a tiered network plan priced lower than a non-tiered plan.

Lessons Learned/Impact

- In many ways, MA is the national leader in developing policies aimed at improving affordability
- Data reported for the benchmark does not align with premium increases in the market creating confusion and more than 40% of MA consumers still report healthcare affordability challenges

RHODE ISLAND

Background

- Rhode Island 2010 Affordability Standards included increased primary care spending and limiting rate increases for hospital services and population-based contracts, regulated by Office of Health Insurances under the umbrella of rate review

Key Policies

- Health Care Cost Growth Target is 3.2% through 2022
- Examples of 2019 Affordability Standard Updates
 - > More flexibility for primary care investments (now required to hit 11% TME);
 - > 50% of insured medical payments to APMs, risk-based contracting targets and minimum downside risk standards that increase over time will be released
 - > Prospective payment for primary care required by January 2021

- > Carriers must reimburse for BH services at primary care and eliminate second copay for same day PCP/BH services
- > Limits on reimbursement rate increases remain with a one-time adjustment

Lessons Learned/Impact

- A study found overall spending declined 8.1% from 2010 to 2016 while primary care spend increased. Decline was largely attributed to hospital price constraints.
- RI said the 2019 revisions would be necessary to continue to see progress.

OREGON

Background

- Oregon has been working to increase primary care spend for several years and Medicaid and private health insurance carriers operate with a 12% primary care spend target.
- Medicaid has been held to a 3.4% growth rate since 2012, public employee health plans have been held to the same rate since 2014.

Key Policies

- In 2019, Oregon became the fourth state to adopt a benchmarking program. It aims to align providers and payers around a common set of cost control strategies.
- At least 70% of Medicaid payments to providers are supposed to be in the form of a value-based payment by 2024
- Primary care efforts focus on a multi-payer primary care payment model to standardize payment methodologies, increase investment in primary care

Lessons Learned/Impact

- Global budgets for Medicaid have led to increased primary care spending, and savings of about 7%. Savings were primarily attributed to lower inpatient spending.
- Significant variation in primary care spending across payer types

WASHINGTON

Background

- Green Mountain Care Board oversees health care payment and delivery system reform, provider rate-setting, health IT, workforce plan approval, hospital and ACO budget approval, insurer rate approval, CON, and the APCD.
- Single regulatory home for the state's affordability policies, which focus on the state's ACO and consumer affordability measures

Key Policies

- Vermont All-Payer ACO Model offers investment to help providers transition to value-based care. Limits major payers growth to 3.5%, with CMS enforcement beginning at 4.3% growth.
- In Vermont, if a household's premium is more than 9.69% of income or the deductible is greater than 5% of income, a plan is unaffordable and subsidies and other supports kick in.

Lessons Learned/Impact

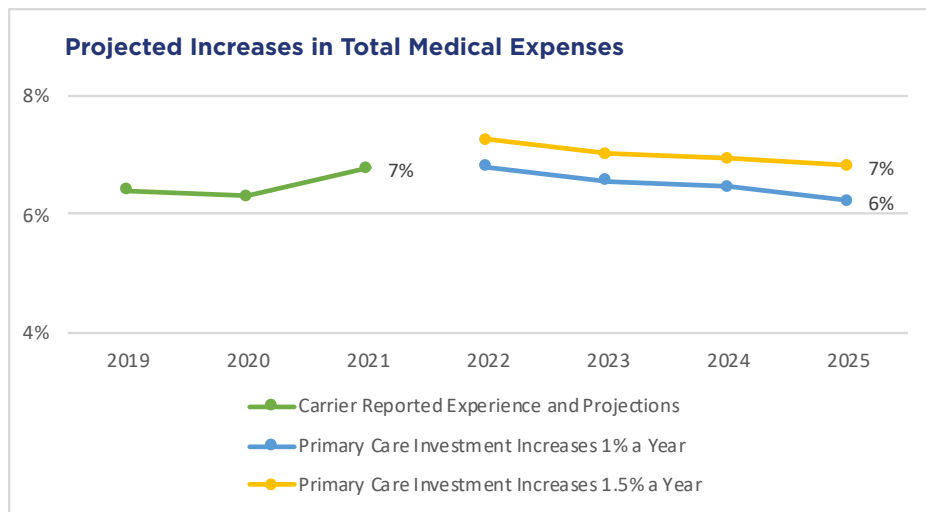
- Vermont TCOC per member per month (per member per month) increased 4.1% across all payer types in 2018, narrowly avoiding CMS enforcement action, thanks in large part to Medicare Advantage, a small part of the market that experienced dramatic reductions in cost
- Lower than expected attribution to all-payer ACO

Appendix 5: Primary Care Investment Glidepaths

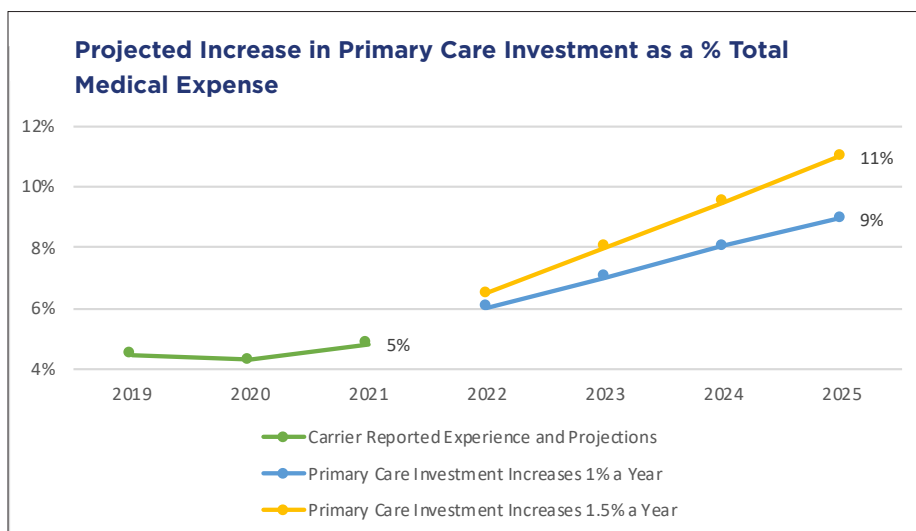


Affordability Standard 1 targets an increase in primary care investment of 1% to 1.5% a year. Each year’s specific target will be determined based on previous investment, current market conditions and other factors. In early years, it is likely the annual target will be closer to 1.5% to reflect compliance with SB 227 and create an environment that aims to stabilize primary care access.

The following graph displays the impact of projected primary care investment increases on total medical expense, if primary care is increased approximately 1% a year and 1.5% a year.



The following graph displays the impact of projected primary care investment increases on total medical expense, if primary care is increased approximately 1% a year and 1.5% a year.



Appendix 6: 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 health care providers, who come together voluntarily to with the dual aims of providing coordinated high-quality care and reducing growth in total cost of care.

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.

CAPITATION: A payment arrangement for health care services that pays a set amount for each enrolled person assigned to the provider, per period of time, whether or not that patient seeks care. The amount of payment is based on the average expected health care utilization of that patient, with payment for patients generally varying by age and health status.

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 MANAGEMENT: A set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminate duplication, and helping patients and caregivers more effectively manage health conditions.

CARE MANAGEMENT FEES: Additional reimbursement typically paid to primary care providers to support services not typically reimbursed in a fee-for-service model including care management and care coordination. The most common method of payment is a fixed amount per member per month.

CONCIERGE MEDICINE: A relationship between a patient and a primary care physician in which the patient pays an annual fee or retainer. This may or may not be in addition to other charges. In exchange for the retainer, doctors agree to certain enhanced services as well as adequate and timely access.

DOWNSIDE RISK: Under downside risk models, providers must refund a payer some portion of losses if the actual care costs exceed financial benchmarks. In contrast, under upside risk models providers can share in healthcare savings if their services make care delivery more efficient but are not required to compensate the payer for losses.

FEE-FOR-SERVICE PAYMENT MODEL: Services are unbundled and paid for separately. In health care, there are concerns this type of payment model gives providers an incentive to provide more treatments because payment is dependent on the quantity of care, rather than quality of care.

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

LARGE GROUP HEALTH INSURANCE: 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.

PAYERS: Any insurer or health maintenance organization licensed in this state that pays medical benefits pursuant to a policy, certificate or contract of health; any state and federal government payers of such benefits; or any third-party administrator that administers a self-funded health insurance plan.

FULL-TIME EQUIVALENTS: A metric that measures the total number of full-time employees based on hours worked rather than the exact number of employees. Each part-time employee counts as a fraction of one FTE based on how many hours they work on average..

PRIMARY CARE PROVIDERS: In Delaware, a primary care provider is a physician or another individual licensed under Title 24 to provide health care, with whom the patient has initial contact and by whom the patient may be referred to a specialist and includes family practice, pediatrics, internal medicine, and geriatrics.

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.

UNIT PRICE GROWTH: Increases in the cost of a specific service. For this project, the Office asked carriers to isolate and report on changes in unit prices, which was defined as changes in negotiated rates for a particular service.

UTILIZATION: The number of services used. The price of services multiplied by the number of services used equals the total cost of care.



This report's public comment period ended on January 25, 2021. Please see the [Office of Value Based Health Care Delivery webpage](#) for comments and responses.