Data Submission Manual

Plan Year 2026 Affordability Standards Data Submission

18 **Del.C.** §§ 311, 334, 2503, 3342B & 3556A; 29 **Del.C.** Ch. 101

Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance

March 6, 2025

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1. Introduction

18 **Del.C.** § 334 requires the Office of Value-Based Health Care Delivery to establish affordability standards, develop regulations on mandatory minimums for payment innovations, collect data and develop reports regarding carrier investments in health care and conduct other activities as necessary to support a robust system of primary care by January 1, 2026.

This data submission manual provides the format and contents of information needed to complete the Affordability Standards Data Submission template that will be used to assess compliance with requirements outlined in 18 **Del.C.** §§311, 2503, 3342B & 3556A regarding primary care spending as a percent of total cost of medical care, aggregate unit price growth for nonprofessional services and uptake and adoption of alternative payment models.

To meet this requirement, submitters shall provide a completed template, henceforth referred to as the "Affordability Standards Data Submission" or “Data Submission.” The Data Submission Template is available at the OVBHCD web page and shall be prepared in accordance with the instructions in this manual.

Please submit completed Affordability Standards Data Submissions to the Director of the Office of Value-Based Health Care Delivery at OVBHCD@delaware.gov no later than June 20, 2025 for Individual and Small Group market segments and no later than September 19, 2025 for the Large Group market segment. Please submit questions to OVBHCD@delaware.gov.

2. Required Submitters and Submission Instructions

Required Submitters: Per Title 18 of the Delaware Code, all commercial carriers that are required to file rates for health benefit plans as outlined in 18 **Del.C.** § 2503 shall also provide a completed Affordability Standards Data Submission Template.

Per 18 **Del.C.** § 2503, carriers with health benefit plans that cover more than 10,000 members across all fully insured products will be evaluated for compliance with the requirements outlined in Section 8.2 of Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance as reported on worksheet "5a. APMA HCP-LAN." Carriers with health benefit plans that cover fewer than 10,000 members across all fully insured products will not be evaluated for compliance but still must complete the worksheet.

Carriers with fewer than 250 Delaware-sitused, fully insured members in a market segment, "expat plans" and Student Health Plans, may request a waiver of the Data Submission completion requirement on the OVBHCD website by completing the Waiver Demographics File and emailing OVBHCD@delaware.gov.

Additional Documentation: Each carrier shall submit a copy (in PDF and Excel format) of its completed Centers for Medicare & Medicaid Services (CMS) 2024 Medical Loss Ratio (MLR) Annual Reporting Form in the 2025 MLR Reporting Year to the OVBHCD at OVBHCD@delaware.gov seven days after submissions to CMS.

3. Population Specification

Carriers should report a separate Excel template for each fully insured market segment: individual, small group, large group, and student health plan.

Worksheets 2, 2a, 3a, and 4: These worksheets represent the carrier's situs-based population for the specific fully insured market segment. These worksheets all should be based on the same population. Use the drop-down menu at the top of each worksheet to indicate the market segment.

Worksheet 3: This worksheet represents members that meet the following criteria:

- Enrolled in a fully insured, Delaware-situsedplan and market segment represented in Worksheets 2, 2a, 3a, and 4.
- Delaware resident
- Attributed to a contracted primary care provider, care team or organization participating in care transformation activities including:
    - A carrier primary care incentive program
    - The Delaware Primary Care Model
    - The National Committee for Quality Assurance Patient-Centered Medical Home certification program
    - Other standards as may be added by the Department and communicated annually to carriers by annual notice.

Use the drop-down menu at the top of the worksheet to indicate the market segment.

Worksheet 5a: This worksheet must represent a carrier's Delaware-situsedplans fully insured population across all commercial market segments. If Worksheet 5a data includes data for all market segments, please indicate this in Worksheet 7: Notes. If one or more market segments of the plan are exempt or waived from this year's submission, please include data for that market segment in this worksheet only.

Carriers also may choose to include their self-insured populations in this worksheet. This is optional. Use the drop-down menu at the top of the worksheet to select either the fully insured market or the fully insured and self-insured markets.

Please refer to the Data Submission Template Instructions below for detailed information on completion of the Data Submission.

4. Data Submission Template Instructions

The Plan Year 2026 Affordability Standards Data Submission Template contains the following worksheets:

1. Overview

This worksheet requires carriers to provide contact and market segment information. The market segment field is a drop-down menu and should be the same market segment reported in Worksheets 2, 2a, 3, 3a, and 4. This worksheet also includes dashboards that summarize information reported in other worksheets. Below is a description of each dashboard.

Worksheet 2 Issues and Worksheet 2a Underpaid Amounts: This dashboard summarizes how many CPT codes are out of compliance, i.e., allowed amounts less than the Medicare Fee. In addition, the amount underpaid is calculated.

Worksheet 3 Primary Care % of Medical: This dashboard summarizes primary care investment as a percent of total medical expense by year for members that meet the following criteria:

- Enrolled in a fully insured, Delaware-situsedplan and market segment represented in Worksheets 2, 2a, 3a, and 4
- Delaware resident
- Attributed to a contracted primary care provider, care team or organization participating in care transformation activities including:
    - A carrier primary care incentive program
    - The Delaware Primary Care Model
    - Practices recognized by the National Committee for Quality Assurance Patient-Centered Medical Home program
    - Other standards as may be added by the Department and communicated annually to carriers by annual notice.

In addition, this dashboard checks for compliance.

Worksheet 3a # of Errors: This dashboard summarizes the number of errors reported for each year. An error is reported when data reported in Worksheet 3a is less than what is reported in Worksheet 3 as it is expected that the population reported in Worksheet 3 is a subset of the population in Worksheet 3a. Carriers with questions should email the OVBHCD at OVBHCD@delaware.gov. An error will also appear when primary care professional dollars are greater than total professional dollars. If errors appear, the carrier must correct them prior to submission.

Worksheet 4 # of Errors: This dashboard summarizes the number of errors reported for each year. An error is reported when trend information reported in Worksheet 4 is inconsistent with trend information reported in Worksheet 3a. If errors appear, the carrier must correct them prior to submission.

History of Hospital IP, OP, Other Price Trends: This dashboard reports historical and projected price trends. This dashboard also checks for compliance.

Attestations: Carriers must complete the attestation for data accuracy and consistency with the federal URRT.

Carriers must also attest that either the contracted and allowed amount fees submitted in Worksheets 2 and 2a are correct **OR,** if they have previously submitted, that contracted and allowed amount fees for all CPT codes in worksheets 2 and 2a are paid above the Medicare fee for Delaware (non-facility). If attesting that previously submitted processes are in place and these processes include new codes added to worksheets 2 and 2a, carriers do not need to submit data.

NOTE: Cells shaded in blue are the input cells for the carrier. All other cells have been locked. Carriers are not able to change locked cells. If a carrier needs to change a cell shaded gray or black, it should email the OVBHCD at OVBHCD@delaware.gov.

2. Medicare Parity Fee-For-Service

Carriers who have previously submitted data for worksheet 2 and 2a for the market segment do not have to complete this worksheet. They must sign the appropriate attestation included in the Overview worksheet.

Carriers that have not previously submitted data for the market segment should complete the worksheet as follows. The population included in this worksheet should mirror the populations in Worksheets 2a, 3a, and 4. For CY 2024 and 2025, provide facility (if applicable) and non-facility payment information for each CPT code listed, when paid to a Delaware primary care provider and performed in a primary care place of service. This worksheet only includes codes with a corresponding Medicare fee. Therefore, this list of codes is a subset of codes shown in Worksheet 8: App A.

For each code listed, use the drop-down menu to indicate whether 2024 utilization was present in Column D for Facility and Column H for Non-Facility. In addition, provide the lowest allowed amount (Facility: 2024 Column E; Non-Facility: 2024 Column I) for each code. Columns F and J are checks. One of the following messages will automatically populate in each row.

- Valid
- Column has been reported as “No Utilization” however an Allowed Amount has been provided. Please check utilization.

- Please complete Worksheet 2a for this CPT code – May be out of compliance
- Please report if there was utilization in CY 2024
- Please provide the Lowest Allowed Amount

For 2025, for each code listed, provide the lowest contracted fee in Column M and P for Facility and Non-Facility respectively. Columns N and Q are checks. One of the following messages will automatically populate in each row.

- Valid - Contracted Fee is >= Medicare Fee
- May be out of compliance

2a. Medicare Parity Fee-For-Service Underpayment

Carriers who have previously submitted data for worksheet 2 and 2a for the market segment do not have to complete this worksheet. They must sign the appropriate attestation included in the Overview worksheet.

The population included in this worksheet should mirror the populations in Worksheets 2, 3a, and 4.

For any CPT code with an allowed amount less than the Medicare fee ("Please complete Worksheet 2a for this CPT code – May be out of compliance"), populate a row for each allowed amount lower than the Medicare fee (i.e., carriers shall add a row for each allowed amount for each CPT code). Provide the total utilization paid at that allowed amount.

NOTES: If there were multiple allowed amounts paid lower than the Medicare fee, there should be multiple rows for each CPT code. In columns G and L, provide an explanation as to why the fee is lower than the corresponding Medicare fee or leave blank. Please provide this data for facility and non-facility payments.

Consistent with Section 5.1.1 of Regulation 1322, the carrier's reimbursement rate must be greater than or equal to the non-facility Delaware Medicare Physician Fee Schedule.

CMS changes fees for certain codes throughout a calendar year. Carriers will have one reporting cycle to comply with changes to Medicare fees and additional codes.

2b. Medicare Parity Non-Fee-For-Service

Section 5.2 of Regulation 1322 requires carriers to offer primary care providers, care teams and organizations the opportunity to participate in primary care incentive programs, as defined in the regulation.

Use the drop-down menu to respond to each of the questions listed. Include additional information on relevant programs in Worksheet 7: Notes or as an attachment.

Guidance for Calculating Primary Care Spending

Worksheets 3 and 3a report on primary care spending as a percentage of total medical expense. Refer to the following guidance to complete these worksheets.

Primary Care (Total) is defined as the sum of the total of Primary Care (Professional, Claims), Primary Care (Facility, Claims) and Primary Care (Non-Claims).

The Primary Care (Professional, Claims) category is the sum of all fee-for-service, professional primary care expenditures. These services must be performed by a primary care provider at a primary care place of service to qualify as primary care investment. See Appendices A, B, and C (Worksheets 8, 9, and 10) in the Data Submission Template for relevant definitions. Appendix A identifies the CPT codes defined as primary care services. Appendix B identifies the provider taxonomy codes defined as primary care providers. Appendix C identifies place of service taxonomy codes defined as primary care places of service.

The Primary Care (Facility, Claims) category is the sum of all facility fees associated with professional claims identified as Primary Care (Professional, Claims). If the dollars cannot be unbundled, report the total in Primary Care (Professional). If facility fees associated with primary care cannot be quantified, state this on Worksheet 7: Notes. If the carrier does not reimburse facility fees for primary care services, please state this on Worksheet 7: Notes.

Example Scenarios: In its review of data from the Delaware Health Information Network, the Office found some carriers reimbursed facility fees for certain primary care services. The three most common scenarios below may assist submitters in identifying when facility fees have been reimbursed for primary care services:

- Scenario 1: Two separate claims for the same person on the same day. One claim line has type of bill = 131 and procedure code = G0463. The other claim line has a place of service = 19 or 22 and an office visit procedure code (99202, 99203, 99214, 99215).
- Scenario 2: Two separate claims for the same person on the same day. One claim line has type of bill = 131. The other claim line has a place of service = 19 or 22. Both claims have an office visit procedure code (99202, 99203, 99214, 99215).
- Scenario 3: One claim line which has type of bill = 131. Claims have an office visit procedure code (99202, 99203, 99214, 99215…) and revenue code = 510 or the claim has a procedure code = G0663.

Once identified, carriers shall report all payments associated with the facility fees paid for primary care services in Worksheets 3 and 3a for their respective populations.

The Primary Care (Non-Claims) category is the sum of five subcategories which have been automatically summed in the worksheet. Definitions for each category are provided in Section 5: Definitions.

- “Non-Claims: Primary Care Incentive Programs”
- “Non-Claims: Primary Care Capitation”
- “Non-Claims: Risk Settlements (Net) to Support Primary Care Services”
- “Non-Claims: Primary Care, Care Management”
- “Non-Claims: Primary Care, Other”

NOTES:

Primary Care Incentive Programs: All non-claims payments requiring primary care providers to achieve specific, predefined goals for quality, cost reduction or infrastructure development must be included in the "Primary Care Incentive Programs" category.

Primary Care, Care Management: Non-claims payments included in the “Primary Care, Care Management” category should be paid prospectively.

Risk Settlements: Risk Settlement payments include payments for shared savings and other total cost of care accountability programs. Risk settlement payments DO NOT include other types of non-fee-for-service payments. Risk settlement payments should be reported as net of provider shared savings and provider losses, if any occurred.

For 2023, carriers may allocate up to 8.5% of their total risk settlement payments to “Risk Settlements (Net) to Support Primary Care Services” without supplying documentation from providers. For 2024, carriers may allocate up to 10% of their total risk settlement payments to “Risk Settlements (Net) to Support Primary Care Services” without supplying documentation from providers. For 2025 and 2026, carriers may allocate up to 11.5% of their total risk settlement payments to “Risk Settlements (Net) to Support Primary Care Services” without supplying documentation from providers. Carriers wishing to allocate more dollars to this category will need to supply attestations from all provider organizations receiving payments allocated to this category. The attestation should include confirmation that the dollars were used to support primary care activities and a description of how such dollars were used. As required, please submit attestations with the completed Data Submission.

Please email the OVBHCD at OVBHCD@delaware.gov with any questions.

3. Primary Care Percent Spend (Delaware Attributed Members)

In this worksheet, carriers shall provide data regarding primary care investment as a percent of total medical expense by year only for members that meet the following criteria:

- Enrolled in the fully insured, Delaware-sitused plan represented in Worksheets 2, 2a, 3a, and 4 Delaware resident
- Attributed to a contracted primary care provider, care team or organization participating in care transformation activities including:
    - A carrier primary care incentive program
    - The Delaware Primary Care Model
    - Practices recognized by the National Committee for Quality Assurance Patient-Centered Medical Home program; or
    - Other standards as may be added by the Department and communicated annually to carriers by annual notice

This worksheet requests historical incurred and paid claims data and allowed claims data by service category. Indicate the market segment for this worksheet in Cell C1.

All claims data should be adjusted for IBNR. The difference between incurred and paid claims, adjusted for IBNR, and allowed claims should be equal to member cost sharing. Consistent with the URRT, report allowed claims by service category not adjusted for reinsurance payments.

For the historical periods (i.e., CY 2022, CY 2023, and CY 2024) report total claims dollars and member months in the blue sections. The gray sections will automatically calculate per member, per month (PMPM), trends, and primary care investment as a percentage of total medical expense. For the projected periods (i.e., CY 2025 and CY 2026), report Allowed PMPM and projected member months in the blue sections. The gray sections will automatically calculate total allowed claims and trends.

Note: All member months should be rounded to the next integer, i.e. partial months should not be submitted. For example, 100.2 member months should be submitted at 101 member months.

In cells Z7, AB7, and AD7, report primary care utilization for this population. Utilization should include the number of primary care services performed by primary care providers in primary care places of service, using the code sets provided in Appendices A, B and C.

Cells highlighted in orange are automatic checks. In cells G31, L31, T31, F68, and K68, an error will appear if primary care dollars reported are greater than professional dollars. The carrier has the ability to widen the column to read the full error message. If errors appear, the carrier must correct them prior to submission.

Unless otherwise noted in "Section 5: Definitions" service category definitions should align with those reported to the CMS' Center for Consumer Information and Insurance Oversight (CCIIO) in the Unified Rate Review Template (Federal URRT) instructions which may be viewed at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/2021-URR-Instructions.pdf.

To be in compliance with Section 6 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance, the carrier's total primary care spending must be equal to 8.5% of total medical expense for these members in 2023, 10% of total medical expense in 2024, and 11.5% of total medical expense in 2025 and 2026. This metric is automatically calculated and labeled Primary Care % of Medical. These metrics are brought into Worksheet 1, Overview.

3a. Primary Care Percent Spend All Members

Carriers shall provide data for all members enrolled in the Delaware-sitused plan for the specific market segment, including those who live outside of Delaware and regardless of whether they are attributed to a provider. This population should mirror the population used to complete the Federal URRT. This population also should mirror the populations in Worksheets 2, 2a, and 4.

Report historical incurred and paid claims data and allowed claims data by service category. All claims data should be adjusted for IBNR. The difference between incurred and paid claims and allowed claims should be member cost sharing. Please indicate the market segment reported in cell C1.

The service categories should align with the categories reported within the Federal URRT. Consistent with the URRT, report allowed claims by service category not adjusted for reinsurance payments. The allowed claims dollars should match what is reported in the URRT. If they do not, please provide an explanation on Worksheet 7: Notes.

For the historical periods (i.e., CY 2022, CY 2023, and CY 2024) report total claims dollars and member months in the blue sections. The gray sections will automatically calculate PMPMs, trends, and primary care investment as a percentage of total medical expense. For the projected periods (i.e., CY 2025 and CY 2026), report Allowed PMPM and projected member months in the blue sections. The gray sections will automatically calculate total allowed claims and trends.

This worksheet includes checks highlighted in orange. If the total dollars reported in this worksheet are less than those reported in worksheet 3a, an error will appear. In cells G31, O31, Y31, G68, and O68, an error will appear if primary care dollars reported are greater than professional dollars.

The carrier has the ability to widen the column to read the full error message. If errors appear, the carrier must correct prior to submission or email the OVBHCD at OVBHCD@delaware.gov with any questions.

In cells AG7, AI7, and AK7, the carrier is expected to report primary care utilization for this population. Utilization should include the number of primary care services performed by primary care providers in primary care places of service, using the code sets provided in Appendices A, B and C.

3b. Care Transformation

This worksheet will serve as the report referenced in Section 6.2.2.2 of Regulation 1322. Report data on CY 2024 and Q1 of CY 2025.

NOTES: "Participating in Care Transformation Activities" includes any of the following, per Section 6.2.2.3 of Regulation 1322:

- A carrier primary care incentive program;
- The Delaware Primary Care Model established by the Primary Care Reform Collaborative under the authority of 16 Del.C. §9903(a)(1);
- Practices recognized by the National Committee for Quality Assurance Patient-Centered Medical Home program; or
- Any other standards as may be added by the Department and communicated annually to carriers by annual notice.

Some provider contracting entities may have entries in Section B and Section C, if some of the organization's Delaware primary care providers are participating in care transformation activities and others are not.

In "Section A. Primary Care Provider Overview" provide the number of contracted Delaware primary care providers participating in care transformation activities and the number of Delaware contracted primary care providers not participating in these activities. The number of providers should be defined as the number of contracted National Provider Identifiers (NPIs) with a primary specialty listed in Appendix B. Column B will automatically sum Column C and Column E and should equal the total number of contracted NPIs with a primary specialty listed in Appendix B.

In Column D, provide the number of member months of Delaware residents enrolled in a situs-based plan within the market segment identified in the drop-down menu and attributed to the providers identified in Column C.

In Column F, provide the number of member months of Delaware residents enrolled in a situs-based plan within the market segment identified in the drop-down menu and not attributed to the providers identified in Column C.

Column G will automatically sum Column D and Column F. It should equal the total number of member months of Delaware residents enrolled in a situs-based plan within the market segment identified in the drop-down menu.

In "Section B. Delaware Primary Care Not Providers Participating in Care Transformation Activities," Column J should include the name of the Provider Contracting Entity i.e., the organization that contracted with the carrier on the providers' behalf. Column K should include the Tax Identification Number (TIN) of the organization identified in Column J. In

Column L, provide the number of Delaware primary care NPIs affiliated with the organization in Column J.

In Column M, use the drop-down menu to provide information on the programs the provider contracting entity is enrolled in. For all providers listed in Section B and enrolled in a program, use Column O to explain why the provider is not considered to be participating in care transformation activities.

In "Section C. Delaware Primary Care Providers Participating in Care Transformation Activities" Column R should include the name of the Provider Contracting Entity i.e., the organization that contracted with the carrier on the providers' behalf. Column S should include the Tax Identification Number (TIN) of the organization identified in Column R. In Column T, provide the number of Delaware primary care NPIs affiliated with the organization in Column R. Column U should include the number of member months for Delaware residents enrolled in a situs-based plan within the market segment identified in the drop-down menu and attributed to the primary care providers in Column T.

The total number of NPIs identified in Column T of Section C should be equal to the total number of NPIs identified in Column C of Section A. The total number of member months identified in Column U of Section C should equal the total number of member months identified in Column D of Section A.

Columns Z-AD requires information on non-claims payments paid to support primary care by provider contracting entity. The non-claims categories are consistent with those used in other worksheets within the ASDS template. Column AE will automatically populate based on the data included in Columns Z-AD.

In Columns AG-AL, use the drop-down menu to identify whether the provider is contractually obligated to provide the listed care transformation activity. An error will appear if any activity is left blank. Please resolve all errors before submission. In Column AM, use the drop-down menu to identify how the carrier is documenting compliance with the contractually required activities.

4. Measurement of Non-Professional Price Growth

This worksheet requires historical and projected price and utilization and mix trends by the same service categories as reported in Worksheets 3 and 3a for all members enrolled in Delaware-situsedplans. This population should mirror the populations in Worksheets 2, 2a, and 3a.

- The utilization trend should include service mix and provider mix.
- The price trend should reflect the actual price change of services.
- All trends reported should be on an allowed basis.

- The worksheet includes a check to ensure that the overall PMPM trends are within +/-0.1% of the PMPM trends reported in Worksheet 3a. If the reported trends do not meet the check, an error will appear in the shaded orange area. If errors appear, the carrier must correct them prior to submission. If the error is not appropriate, email OVBHCD at OVBHCD@delaware.gov.
- This worksheet also requests prospective trend assumptions which should align with the insurer's expectations and pricing trend assumptions. These prospective trends should align with what is reported in the URRT. The PMPM trends reported here should also be consistent with trends reported in Worksheet 3a. If they are not an error will appear in the shaded orange area. If errors appear, the carrier must correct them prior to submission. If the error is not appropriate, email OVBHCD at OVBHCD@delaware.gov.
- Price trend refers to the anticipated change in negotiated rates. All other components of trend should be included in the utilization and mix trends column. If the price trend is different from what is typically reported in the URRT's "Cost Trend" column, state this on Worksheet 7: Notes.
- Report the trend percentage, not the trend factor in this worksheet.

Compliance with Section 7 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance and HA 2 to SS 1 for SB 222 dictates that the carrier's price trend for each of the following categories – Inpatient Hospital, Outpatient Hospital and Other Medical – must not exceed 5.50% in CY 2023, 5.76% in CY 2024, 6.35% in CY 2025, and 5.50% in CY 2026.

5. Alternative Payment Model Adoption Fixed Payment Methodology

Complete the table to share information on your organization's progress towards meeting the requirements of Section 8.1 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance. Information should be provided across a carriers' market segments and may be updated during Large Group submissions. If needed, provide additional information to demonstrate compliance in a Microsoft Word document or PDF.

5a. Alternative Payment Model Adoption Health Care Payment Learning and Action Network (HCP-LAN)

This worksheet must represent a carrier's Delaware-sitused plans fully insured population, across all market segments. If a carrier submits multiple data submissions to reflect multiple market segments, it is expected that Worksheet 5a will report the same data in each of these submissions and the population will represent all the market segments combined. If one or more market segments of the plan are exempt or waived from this year's submission, please include data for that market segment in this worksheet only.

Carriers also may choose to include their self-insured populations in this worksheet. This is optional. Use the drop-down menu in Cell C1 to select either fully insured market or fully insured and self-insured markets.

Note: All carriers must complete all blue cells within this worksheet. Member months and total medical expense for all services should match data submitted in worksheet 3a. Primary Care Percent Spend All Members.

Carriers with health benefit plans that cover at least 10,000 Delaware residents across all fully insured products must ensure that the minimum percentage splits for savings and losses follow requirements outlined in Section 8.2 of 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.

Compliance with the requirement that 50% of total cost of care be tied to an alternative payment model contract that qualifies as a HCP-LAN Category 3 will be assessed by summing the percentages in HCP-LAN 3A and HCP-LAN 3B. Compliance with the requirement that 25% of total cost of care be tied to an alternative payment model contract that qualifies as a HCP-LAN Category 3B will be assessed using the percentage reported as 3B. Compliance only requires meeting these thresholds for Delaware residents. If a carrier meeting the 10,000 Delaware residents compliance threshold is not projected to achieve compliance using its entire population as the denominator, the carrier may create a duplicate Worksheet 5a for only Delaware residents. The carrier should include this duplicate Worksheet 5a as part of its ASDS submission.

For this Worksheet, carriers shall categorize medical expenses into the categories listed below using the definitions for each HCP-LAN Category included in “Section 5: Definitions”. Historical total allowed medical expenses, including IBNR, should be reported in the year incurred.

NOTES:

- For HCP-LAN Categories 2A through 4C, report the total dollars, including the underlying payment plus any incentive, such as fee-for-service with a bonus for performance (P4P), fee-for-service and savings that were shared with providers, etc.
- For APMs in which the provider is responsible for the total cost of a member’s health care, include the total costs incurred by the member or beneficiary covered under that plan.
- Not all carriers will report dollars under each subcategory. In most cases, carriers are experimenting with different payment methods that span across Categories 2 through 4.
- Carriers should report the alternative payment models in effect for the appropriate calendar year. ***Please report ALL medical expenses that are under the alternative***

payment arrangement, not just the risk settlement, bonus or savings or other non-claims payments.

In addition, carriers shall provide information on the shared savings and loss percentages and savings and losses caps in contracts categorized as HCP-LAN Category 3A and 3B, as defined in "Section 5: Definitions". Complete rows 42-47 for each shared savings contract in HCP-LAN Category 3A and 3B for each year.

When a contractual arrangement begins during the reporting year, the carrier is expected to report the expenditures in the appropriate HCP-LAN Category. For example, if the carrier enters into a shared savings contract effective August 1, 2022, (and the reporting period is CY 2019) the carrier should report the total dollars (includes FFS payments and bonus/savings incentives) paid to that provider under the shared savings arrangement from August 1, 2022 – December 31, 2022, whereas it would report dollars paid to the provider between January 1, 2022, and July 30, 2022, under HCP-LAN Category 1.

Given the timing of the data request and the need to project future years, some carriers may not have access to complete or final data. If complete or final information for the calendar year is not complete, provide an estimate and state the basis for the estimate on Worksheet 7: Notes. Similarly, if the bonus or savings amounts are not reconciled by the time of data collection, estimate the bonus or savings payment amount (if any) and state the basis for this estimate on Worksheet 7: Notes.

If the carrier does not directly manage members and dollars in an APM, neither the lives nor dollars should be counted. The carrier that manages those lives should count those members and dollars if it is participating in the data collection effort.

6. Demographic Table

This worksheet must represent a carrier's enrollment data from March 31st, 2024 to March 31st, 2025.

In Section A, provide the number of member months for all members fitting the row's age band and gender criteria who are enrolled in fully insured Delaware-sitused plans within the market segment identified in the drop-down menu at the top.

In Section B, provide the number of member months for all Delaware resident members fitting the row's age band and gender criteria who are enrolled in fully insured Delaware-sitused plans within the market segment identified in the drop-down menu at the top.

The total for each column will automatically sum the rows above it. The total for Section A should equal all members enrolled in fully insured Delaware-sitused plans within the market segment identified in the drop-down menu at the top. The total for Section B should equal all Delaware residents enrolled in fully insured Delaware-sitused plans within the market segment identified in the drop-down menu at the top.

7. Notes

Provide notes to the questions asked in this worksheet and indicated in prior worksheets. In addition, please provide any additional information that may be necessary to determine compliance with Regulation 1322 Requirements for Mandatory Minimum Payment Innovations in Health Insurance.

8. **Appendix A – Primary Care CPT Codes**

This worksheet includes the list of CPT codes defining primary care. Please use this list of codes to determine primary care investment. Note new codes in green.

9. **Appendix B – Primary Care Provider Taxonomies**

This worksheet includes the list of primary care provider taxonomy codes associated with the delivery of primary care services. Please only report primary care spending for services provided by these provider taxonomies.

10. **Appendix C – Primary Care Place of Service**

This worksheet includes the list of place of service codes where primary care services are provided. Please only report primary care spending for services provided by provider taxonomies at these places of service. Note a new code in green.

11. Definitions

1. **"Allowed Amount" –** The total payment made for a service to the provider by the health insurance carrier and the member cost share, including the deductible, copayment or coinsurance.
2. **"Contracted Fee"** – The fee for a service as outlined in contracts between a health insurance carrier and healthcare provider.
3. **"Facility"** means a place where healthcare is delivered, including by way of example only, a hospital, outpatient clinic or nursing home.
4. **"Health benefit plan"** has the meaning set forth in 18 **Del.C.** §§ 3342A(a)(3)a. and 3559(a)(3)a.
5. **"Inpatient hospital services"** means non-capitated facility services for medical, surgical, maternity, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility and categorized as such as part of development of the URRT, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.
6. **"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.
7. **"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.
8. **"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.
9. **"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.
10. **"LAN Category 3A - APMs Built on Fee-For-Service Architecture**" - APMs with Shared Savings: In 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.

11. **"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.
12. **"LAN Category 4A - Population-Based Payment"** - Condition-Specific Population-Based Payment: Category 4A includes bundled payments for the comprehensive treatment of specific conditions.
13. **"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.
14. **"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.
15. **"Nonprofessional services**" means services categorized as part of development of the URRT as inpatient hospital, outpatient hospital, and other medical services.
16. **"Non-Claims: Primary Care Incentive Programs"** - All payments made to a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay for performance payments, performance bonuses and EMR/HIT adoption incentive payment. All non-claims payments requiring primary care providers to achieve specific, predefined goals for quality, cost reduction or infrastructure development must be included in this category.

17. **"Non-Claims: Incentive Programs, for Services Other Than Primary Care"** - All payments made for achievement in specific predefined goals for quality, cost reduction or infrastructure development that are not accounted for in **Non-Claims: Primary Care Incentive Programs"**. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.
18. **"Non-Claims: Primary Care Capitation"** - All payments made to a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately and can be separately reported as **"Non-Claims: Incentive Program"**. These payments are typically made monthly for the care of assigned beneficiaries.
19. **"Non-Claims Capitation, for services other than primary care"** - All payments made not on the basis of claims (i.e., capitated amount) not accounted for in **"Non-Claims: Primary Care Capitation"**. Amounts reported as capitation should not include any incentive or performance bonuses paid separately and can be separately reported as Non-Claims: Incentive Program.
20. **"Non-Claims: Risk Settlements to Support Primary Care Services"** - All payments made to a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services as a reconciliation of shared savings and/or loss payments used to implement total cost of care accountability programs. Amounts reported as "risk settlement" should not include any incentive or performance bonuses paid separately, that could be separately reported as "**Non-Claims: Primary Care Incentive Program".**
21. **"Non-Claims: Risk Settlements to Services Other than Primary Care" -** All payments made to providers as a reconciliation of shared savings and/or loss payments used to implement total cost of care accountability programs and not accounted for in **"Non-Claims: Risk Settlements to Support Primary Care Services".** Amounts reported as "risk settlement" should not include any incentive or performance bonuses paid separately, that could be separately reported as "**Non-Claims: Incentive Program".**
22. **"Non-Claims: Primary Care, Care Management"** - All payments made to a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services for providing care management, utilization review and discharge planning. These payments should be made in advance, known as prospective payments.
23. **"Non-Claims: Care Management other than for primary care"** - All payments made to

for providing care management, utilization review and discharge planning that are not accounted for in **"Non-Claims: Primary Care, Care Management".**

24. **"Non-Claims: Primary Care, Other" -** All other capitation and non-claims payments to support primary care that do not fit in the above categories, such as, including by way of example only, community health teams, integrated behavioral health, and coordination of social services and health care services. For CY 2020, this may also include supportive funds made to a contracted primary care provider, the provider's care team, and organizations for primary care and chronic care management services to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; grants and other insurer administrative expenditures (including corporate allocations) should not be included unless the carrier has received explicit approval from the OVBHCD. Insurer administrative expenditures approved by the OVBHCD will be considered indirect primary care spending and shall not exceed 1% of total medical expense excluding pharmacy spending.
25. **"Non-Claims: Other" -** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere including under **"Non-Claims: Primary Care, Other".** This may include governmental payer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.
26. **"Outpatient Hospital"** means non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility and categorized as such as part of development of the URRT, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.
27. **"Other medical services"** means non-capitated ambulance, home health care, durable medical equipment, prosthetics, supplies, and the facility component of vision exams, dental services, and other services when billed separately from professional services and categorized as such as part of development of the URRT, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.
28. "**Outpatient hospital services**" means non-capitated facility services for surgery, emergency services, lab, radiology, therapy, observation, and other services provided in an outpatient facility setting and billed by the facility and categorized as such as part of

development of the URRT, excluding services to treat individuals with a primary diagnosis of a behavioral health condition including mental health conditions and substance use disorder conditions.

29. **"Population-based payment"** means an arrangement in which a provider entity accepts responsibility for delivering covered services to a group of patients for a predetermined payment amount.
30. **"Prescription Drug"** means drugs dispensed by a pharmacy and categorized as such as part of development of the URRT. This amount should be net of rebates received from drug manufacturers.
31. **"Primary Care First" or "PCF"** means the CMS five-year alternative payment model program established under the authority of Section 1115A of the Social Security Act that aims to reward value and quality by offering an innovative payment structure to support delivery of advanced primary care.
32. **"Professional services"** includes services categorized as such as part of development of the URRT including primary care, dental, specialist, therapy, the professional component of laboratory and radiology, and similar services, other than the facility fee component of hospital-based services.
33. **"Total cost of medical care"** means the sum of all payments by carriers, including fee-for-service and non-fee-for-service payments, for medical services paid to healthcare providers on behalf of patients and excludes spending on pharmaceutical products categorized as "pharmacy" as part of development of the URRT.
34. **"Unified Rate Review Template**" means a form that summarizes the data used to determine rate increases for the entire single risk pool. The form and instructions to support its completion are released each year by CMS' Center for Consumer Information and Insurance Oversight (CCIIO). It is abbreviated URRT.
35. **"Year"** means the calendar year in which rates are filed with the Department and applicable to the following plan year.