LAWS OF DELAWARE
VOLUME 81
CHAPTER 392
149th GENERAL ASSEMBLY
FORMERLY
SENATE BILL NO. 227
AS AMENDED BY
SENATE AMENDMENT NO. 1
AND
HOUSE AMENDMENT NO. 1 AS AMENDED BY HOUSE
AMENDMENT NO. 1 TO HOUSE AMENDMENT NO. 1

AN ACT TO AMEND TITLE 16, TITLE 18, AND TITLE 29 OF THE DELAWARE CODE RELATING TO PRIMARY CARE SERVICES.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend § 9903, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 9903. Duties and authority of the Commission.

(f) The Commission must collaborate with the Primary Care Reform Collaborative to develop annual recommendations that will strengthen the primary care system in Delaware. The scope of the recommendations must include all of the following:

(1) Payment reform.

(2) Value-based care.

(3) Workforce and recruitment.

(4) Directing resources to support and expand primary care access.

(5) Increasing integrated care, including for women's and behavioral health.

(6) Evaluation of system-wide investments into primary care, using claims data obtained from the Delaware Health Care Claims Database.

Section 2. Amend Chapter 99, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 9905. Primary Care Reform Collaborative.

(a) The Commission shall convene a Primary Care Reform Collaborative ("Collaborative") to assist with the development of recommendations to strengthen the primary care system in this State. The Collaborative may collect and accept advice and input from stakeholders, including the Delaware healthcare and patient community.

(b) The Collaborative is comprised of the following members, or a designee appointed by the member:

(1) The Commission Chairperson.

(2) The Chair of the Senate Health, Children & Social Services Committee.

(3) The Chair of the House Health & Human Development Committee.

(c) The Commission may also require the submission of written reports by any health insurer, as defined in § 4004 of Title 18, to the extent permitted under federal law, and any hospital or acute health care facility licensed under § 1001 of Title 16, regarding all of the following matters:

(1) The hospital's, acute health care facility's, or health insurer's progress in adopting and implementing value-based payment models during the fiscal year immediately preceding the annual reporting deadline and the overall progress of the reporting entity on having at least 60% of Delawareans attributed to meaningful value-based payment models by 2021.

(2) The hospital's, acute health care facility's, or health insurer's efforts to support primary care access and primary care practitioners in the State of Delaware, including financial, operational, and other support, in conjunction with the adoption of meaningful value-based payment models.

Section 3. Amend § 10312, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 10312. Definitions.

For purposes of this chapter, unless amended, supplemented, or otherwise modified by regulations adopted under this chapter:

(4) "Mandatory reporting entity" means all of the following entities, ~~except as prohibited~~ to the extent permitted under federal law:

e. Any health insurer providing health-care coverage to a resident of this State.

Section 4. Amend § 10314, Title 16 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 10314 External and public reporting of claims data.

(a) The DHIN shall provide Delaware health-care payers, providers, and purchasers with access to the Delaware Health Care Claims Database for the purpose of facilitating the design and evaluation of alternative delivery and payment models, including population health research and provider risk-sharing arrangements.

(1) Claims data provided to the Delaware Health Care Claims Database shall only be provided to a requesting party when a majority of the DHIN Board of Directors, or of a subcommittee established under the DHIN's bylaws for purposes of administering the Health Care Claims Database, determines that the claims data should be provided to the requesting party to facilitate the purposes of this subchapter or to the Delaware Health Care Commission.

Section 5. Amend Chapter 33, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3342A. Primary care coverage.

(a) For purposes of this section:

(1)a. "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

b. "Carrier" does not mean a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. § 1395 et seq., § 1396 et seq. and § 1397aa. et seq.], known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

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

(3) "Medicare" means the federal Medicare Program (U.S. Public Law 89-87, as amended) [42 U.S.C. § 1395 et seq.].

(4) "Primary care" means health care provided by a physician or an 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.

(b)(1) A carrier shall provide coverage for chronic care management and primary care at a reimbursement rate that is not less than the Medicare reimbursement for comparable services.

(2) This subsection applies to an individual health insurance policy, plan, or contract that is delivered, issued for delivery, or renewed by a carrier on or after [the effective date of this Act].

(c) Coverage for chronic care management must not be subject to patient deductibles, copayments, or fees.

(d) If a comparable Medicare reimbursement rate is not available, a carrier shall reimburse for services at the rates generally available under Medicare for services such as office visits and prolonged preventive services, which may be further delineated by regulation.

(e)(1) The Department shall arbitrate disagreements regarding rates under this section. The parties must pay the cost of the arbitration.

(2) The Department shall adopt regulations to implement the requirements of this subsection no later than [90 days after the effective date of this Act].

(f) The provisions of this section may not be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is void.

Section 6. Amend Chapter 35, Title 18 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 3556A. Primary care coverage.

(a) For purposes of this section:

(1)a. "Carrier" means any entity that provides health insurance in this State. "Carrier" includes an insurance company, health service corporation, health maintenance organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with health benefit plans.

b. “Carrier” does not mean a plan of health insurance or health benefits designed for issuance to persons eligible for coverage under Titles XVIII, XIX, and XXI of the Social Security Act [42 U.S.C. § 1395 et seq., § 1396 et seq. and § 1397aa. et seq.], known as Medicare, Medicaid, or any other similar coverage under state or federal governmental plans.

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

(3) "Medicare" means the federal Medicare Program (U.S. Public Law 89-87, as amended) [42 U.S.C. § 1395 et seq.].

(4) “Primary care” means health care provided by a physician or an 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.

(b)(1) A carrier shall provide coverage for chronic care management and primary care at a reimbursement rate that is not less than the Medicare reimbursement for comparable services.

(2) This subsection applies to a group health insurance policy, plan, or contract that is delivered, issued for delivery, or renewed by a carrier on or after [the effective date of this Act].

(c) If a comparable Medicare reimbursement rate is not available, a carrier shall reimburse for services at the rates generally available under Medicare for services such as office visits and prolonged preventive services, which may be further delineated by regulation.

(d)(1) The Department shall arbitrate disagreements regarding rates under this section. The parties must pay the cost of the arbitration.

(2) The Department shall adopt regulations to implement the requirements of this subsection no later than [90 days after the effective date of this Act].

(e) The provisions of this section may not be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is void.

Section 7. Amend § 5201, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows and by redesignating Delaware Code subsections and internal references accordingly:

§ 5201. Definitions.

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

( ) "Medicare" means the federal Medicare Program (U.S. Public Law 89-87, as amended) [42 U.S.C. § 1395 et seq.].

( ) "Primary care" means health care provided by a physician or an 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.

Section 8. Amend § 5203, Title 29 of the Delaware Code by making deletions as shown by strike through and insertions as shown by underline as follows:

§ 5203. Specifications of the coverage.

(c)(1)The basic plan must provide coverage for chronic care management and primary care and coverage at a reimbursement rate that is not less than the Medicare reimbursement for comparable physician services.

(2) Coverage for chronic care management must not be subject to patient deductibles, copayments, or fees.

(3) If a comparable Medicare reimbursement rate is not available, a plan shall reimburse for services at the rates generally available under Medicare for services such as office visits and prolonged preventive services, which may be further delineated by regulation.

Section 9. Sections 5 through 8 of this Act take effect on January 1, 2019.

Section 10. Sections 5 through 8 of this Act expire 3 years after enactment into law unless otherwise provided by a subsequent Act of the General Assembly.

Section 11. The Primary Care Collaborative shall convene on or before September 17, 2018, and shall issue written recommendations on or before January 8, 2019, regarding appropriate levels of system-wide primary care investment, including an evaluation of whether 12% of health care spending should be directed to primary care, and how primary care supports the State's efforts regarding a cost spending benchmark.

Section 12. The applicability of the Medicare coverage rate under Section 5 and Section 6 of this Act must be narrowly construed to apply only to reimbursement rates for primary care practice and nothing in this Act extends to incorporating other federal coverage rate structures or other distinctions between licensees.

Approved August 29, 2018