



DELAWARE HEALTH AND SOCIAL SERVICES

Delaware Health Care Spending and
Quality Benchmarks

Implementation Manual Version 3.0

State of Delaware
Delaware Health Care Commission

June 15, 2021



Delaware Health and Social Services

Office of the Secretary

A Note to Delaware's Health Care Stakeholders

The health care spending and quality benchmark initiative continues our movement along the State's "Road to Value" and is deeply rooted in our steadfast efforts to improve access to affordable, quality health care for all Delawareans. As Delaware continues to respond to the challenges created by the global pandemic, the Department of Health and Social Services (DHSS) is committed to doing the work to support our health care system and to transform the delivery of health care away from volume-based care to value-based care to be consistent with the overall economic growth of the State.

DHSS has accepted the challenge to drive change within health care, and as we position ourselves to rebound from the global pandemic, we acknowledge the increased importance of this work. The health care spending benchmarks provide transparency and public awareness of health care spending and quality that is beneficial for everyone in the system — health care providers, consumers, taxpayers, insurers, and businesses.

The Department of Health and Social Services, the Delaware Health Care Commission, and the Delaware Economic and Financial Advisory Council worked closely to establish the spending and quality benchmarks and to update them as needed. Earlier this year, DHSS released the State's first Benchmark Trend Report summarizing health care spending and quality data collected for calendar year 2019. The report found that per-capita spending in our State increased 7.8% for 2019 compared to the baseline data collected for 2018. That increase was more than twice as high as the 3.8% target spending benchmark for 2019. Our next steps include engaging health care providers, insurers, government agencies, and consumers to peel back the layers of spending and determine why health spending increased at a rate greater than our overall economic growth in Delaware.

I want to take a moment to extend my sincerest gratitude to the insurers, on behalf of all Delawareans, for their support and efforts. Their cooperation through the collection and submission of data has moved us closer to our goal of identifying and implementing strategies to mitigate the key drivers of health care costs. Their partnership and insight are essential and have assisted us with improving the process. This initiative would not be possible without their participation.

The enclosed updated implementation manual (version 3.0) reflects the lessons learned by the Department as a result of two data collection cycles, countless stakeholder meetings, and the development of the two data summary reports (Preliminary Calendar Year 2018 Baseline report and the Calendar Year 2018 Benchmark Trend report). We will continue to work with the participating insurers and various stakeholders to strengthen the data collection and reporting process. The knowledge obtained thus far has proven to be invaluable. We now have a better and consistent understanding of our health care quality and the spending on health care in our State.

Our goal to ensure Delawareans can access and afford quality health care will only be possible if agencies across the State work collectively to pursue answers and solutions. The benchmarks are a means to continue the conversation about how to improve cost and quality for the individuals we serve as patients and members in our communities.

Sincerely,

Molly K. Magarik, MS
Cabinet Secretary

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Major Revisions in This Version

With the assistance of Mercer Health & Benefits LLC, DHCC has made various minor wording changes and clarifications, label changes, formatting revisions, and other updates to make this document easier to read and follow. The following table highlights major revisions incorporated into this version relative to the prior version of the implementation manual:

Table 1. Major Revisions in this Version of the Benchmark Implementation Manual

Topic	Version 3.0 Change	Rationale
Note to Stakeholders	Message updated	From Secretary Magarik
Primary Care Services definition	Coding logic has been updated	Maintain consistency with other Delaware initiatives
HEDIS® specifications for applicable quality measures	HEDIS® specifications have been removed	Comply with National Committee for Quality Assurance requirements
Insurer Spending Data	Replace Large Provider Group with Insurance Line of Business	Simplify/standardize data reporting and obtain more useable data
Insurer Spending Data	Request two new columns: Premium Revenues and Net Paid	Support computing the Net Cost of Private Health Insurance
DMMA spending data submission	DHCC is asking DMMA to provide two calendar years (CYs) of spending data (i.e., CY 2020 and restate CY 2019)	Consistency with insurers' data and get two years of DMMA spending data with same data specifications
Insurer due data for spending data	September 1, 2021 (same as quality data)	Ongoing COVID challenges, work from home, etc. DHCC Intends to use an August 1 due date next year
Preview of CY 2022–2024 quality measures	Added information about quality measure set planned for next three year cycle	Provide additional advanced notice. Previously shared at April 1, 2021 DHCC Commissioners Meeting and posted to DHCC website.
Tobacco Use and High School Students Who Are Physically Active quality measures	Notification that these quality measures have been discontinued for the CY 2020 and CY 2021 reporting periods	Limited/unavailable data or focus on other priority measures
Massachusetts Report Example	Deleted Attachment 1 and renumbered	Delaware has now produced its own benchmark trend report.
Use of Opioids at High Dosage quality measure	Added documentation related this replacement measure	Add current documentation

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Overview of Benchmark Activities

Governor Carney established health care spending and quality benchmarks in [Executive Order \(EO\) 25](#), issued on November 20, 2018. This implementation manual contains the technical and operational steps the Delaware Health Care Commission (DHCC) and the Delaware Economic and Financial Advisory Council (DEFAC) Health Care Spending Benchmark Subcommittee (DEFAC Subcommittee) will need to take to implement EO 25.

Timeline of Key Activities

Delaware’s spending and quality benchmarks follow an annual cycle of activities with key dates for specific events as noted in the table below.

Table 2. Timeline of Key Activities

Time Period	Key Activity	Key Dates
1Q of CY	<ul style="list-style-type: none"> Release/wrap-up Benchmark Trend Report Respond to inquiries about Report Perform ad hoc analyses if needed 	<ul style="list-style-type: none"> None specific
2Q of CY	<ul style="list-style-type: none"> Update/Revise implementation manual and data templates DEFAC Subcommittee meetings Conduct benchmark webinar for insurers/DMMA Send request to CMS for Medicare data 	<ul style="list-style-type: none"> May/June 2021 By March 31, 2021 and May 31, 2021 June 22, 2021 (this year’s cycle webinar) By June 1, 2021
3Q of CY	<ul style="list-style-type: none"> Respond to payer questions on benchmark process Receive spending and quality data submissions Begin validation of data (request resubmissions if needed) 	<ul style="list-style-type: none"> As needed By September 1, 2021 (this year’s cycle data due date) After data is received
4Q of CY	<ul style="list-style-type: none"> Complete data validation process Compile results and produce final benchmark trend report Conduct public meetings/share results 	<ul style="list-style-type: none"> As soon as practical Goal is to release report in the 4Q As needed/schedules permit

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Health Care Spending Benchmark

The health care spending benchmark is defined as the target annual per capita growth rate for Delaware's statewide total health care spending, expressed as the **percentage growth from the prior year's per capita spending**. The spending benchmark is set on a CY basis. EO 25 set the spending benchmarks for CYs 2019–2023 as follows:

- CY 2019: 3.80%
- CY 2020: 3.50%
- CY 2021: 3.25%
- CY 2022: 3.00%
- CY 2023: 3.00%

Potential Gross State Product Methodology

As specified in EO 25, for CYs 2020–2023, the spending benchmark is the forecasted growth in Delaware's per capita potential gross state product (PGSP) plus the following transitional market adjustments (i.e., add-on factors): +0.5% for CY 2020, +0.25% for CY 2021 and +0% for CY 2022–2023.

The formula for the forecasted growth in per capita PGSP is as follows:

Expected growth in national labor force productivity
+ Expected growth in the state civilian labor force
+ Expected national inflation
– Expected state population growth

The sources for each of the components of the PGSP formula are included below in Table 3.

Table 3. Sources for Potential Gross State Product Formula

Components	Source
Expected growth in national labor force productivity	<p>The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.¹ Included within the report is a table of key inputs in the Congressional Budget Office’s (CBO’s) Projections of Real Potential Gross Domestic Product, which includes the potential labor force productivity projected average annual growth (e.g., page 13, Table 2 of the August 2018 report for the values from 2023–2028).</p> <p>The figure used to calculate PGSP should be the value forecasted for five and 10 years into the future.</p>
Expected growth in the state civilian labor force	<p>The source is the most recently published Population Projections by Single Year, Age, Race and Sex from the Delaware Population Consortium.</p> <p>To calculate the expected growth in the state civilian labor force, DHCC must calculate the average percentage change in civilian labor force growth for five and 10 years into the future (e.g., in 2018, the average annual growth was calculated by averaging the percentage growth for years 2023–2028 from the “Delaware-Summary” tab for the “Civilian” data row).</p>
Expected national inflation	<p>The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.² Included within the report is a table of CBO’s Economic Projections (e.g., page five, Table 1 of the August 2018 report for CY 2023–2028).</p> <p>The figure used to calculate PGSP should be the value of the Personal Consumption Expenditures price index annual average percentage change for five and 10 years into the future.</p>
Expected state population growth	<p>The source is the most recently published population projections by single year, age, race and sex from the Delaware Population Consortium.</p> <p>To calculate the expected growth in the state population, DHCC must average the forecasted percentage change in total population growth for years five to 10 into the future (e.g., in 2018, the average annual growth was calculated using the percentage growth for years 2023–2028 from the “Delaware-Summary” tab for the “Population” data row).</p>

For the development of the initial spending benchmarks, the period of 2023–2028 was consistent with the desired future forecast period of five to 10 years into the future, which is a common future period used in economic modeling. If DEFAC chooses to update the spending benchmark based on the PGSP formula, a commensurate future period will need to be used.

¹ As of May 26, 2020, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

² Ibid

To determine the input values for the PGSP formula, each input value should be rounded to the nearest tenth decimal point (i.e., if the computed value of expected state population growth is 0.87%, the value used in the PGSP formula should be rounded to 0.9%).

Using the sources listed above, the value calculated in 2018 to establish the PGSP (excluding any transitional market adjustments) is presented in Table 4.

Table 4. Potential Gross State Product Calculation (as calculated in 2018)

Components	Value from Sources Listed in Table 3	Formula
Expected growth in national labor force productivity	1.4%	A
Expected growth in the state civilian labor force	0.1%	B
Expected national inflation	2.0%	C
Nominal PGSP	3.5%	$D = A + B + C$
Expected state population growth	0.5%	E
Potential per capita gross state product	3.0%	$D - E$

Process for Annual Review of Components of PGSP for CYs 2020–2023

In order to provide advance notice to providers, insurers and the State on the value of the spending benchmark, EO 25 provided information on the spending benchmarks for five years. Because there is importance to providers, insurers and the State in having these values established in advance, modifications to those values is expected to occur only if DEFAC and its Subcommittee find large unanticipated economic changes have occurred, which warrant spending benchmark modification.

Starting in 2019, the DEFAC Subcommittee is to review all components of the PGSP methodology on an annual basis to determine whether the PGSP growth rate has changed in a material way and therefore requires a recommendation to change the value of the spending benchmark. To do so, the DEFAC Subcommittee should review the most recently published values for the source data listed in Table 3 and compare them to the values calculated for prior years to assess if the PGSP growth rate has materially changed.

Prior to making recommendations to DEFAC on whether to utilize a recalculated PGSP using updated forecast figures for the next year’s health care spending benchmark, the DEFAC Subcommittee is required to solicit and consider comments from the public and interested stakeholders. Should DEFAC approve use of a recalculated PGSP, and therefore, a new spending benchmark, EO 25 requires DEFAC to report such changes to the Governor and DHCC no later than May 31³ of the year preceding the restated spending benchmark (e.g., by May 31, 2021 for the CY 2022 spending benchmark). To maintain public awareness and support transparency, DHCC recommends that if a new value of the spending benchmark is to be adopted, this change should be announced to the

³ Due to the unforeseen challenges presented by the COVID-19 pandemic, DEFAC was given the option last year to complete its task in the fall of 2020.

public, state agencies, payers, and providers no later than July 1 of the year preceding the restated spending benchmark.

Process for Annual Review of Spending Benchmark Methodology for CY 2024 and Beyond

Per EO 25, no later than March 2023 and each March thereafter, the DEFAC Subcommittee is to review the full methodology for defining the spending benchmark. Prior to making recommendations to DEFAC on whether to change the methodology or recalculate PGSP, the DEFAC Subcommittee is to solicit and consider comments from the public and interested stakeholders. The DEFAC Subcommittee should also consider the methodologies and experiences of other states operating health care spending benchmarks, such as Massachusetts and Rhode Island.

If DEFAC decides to retain and update the PGSP formula, it will need to obtain new input values from the sources listed in Table 3, using data that forecast growth from an appropriate future period. Whether DEFAC decides to utilize a different methodology or a recalculated PGSP, DHCC recommends the new spending benchmark(s) be announced to the public, state agencies, payers and providers no later than July 1 of the year preceding its implementation.

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Methodology for Assessing Performance Against the Spending Benchmark

EO 25 encourages DHCC⁴ to report each year on the performance relative to the spending benchmark for the State as a whole, for each insurance market (e.g., Medicare, Medicaid, Commercial), for each individual payer and for each insurance line of business. To do so, DHCC staff and/or DHCC's contractor will need to perform a series of data collection activities and calculations.⁵ This section contains the recommended methodology for measuring the growth in health care spending at each level, including which data are necessary to collect and which calculations need to be performed. This section is organized as follows:

1. Definitions of Key Terms.
2. Methodology for Measuring Total Health Care Expenditures.
3. Data Sources for Total Health Care Expenditures.
4. Public Reporting of Spending Benchmark Performance.
5. Timeline for Measuring and Reporting the Health Care Spending Benchmark.

Definition of Key Terms

- **Allowed Amount:** The amount the payer paid plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of THCE.
- **Division of Medicaid and Medical Assistance (DMMA):** The single State agency responsible for Delaware's Medicaid and Children's Health Insurance Program (CHIP) program. Unless otherwise stated, references to "DMMA" or "Medicaid" includes the CHIP program.

⁴ Herein, references to DHCC refer to DHCC staff and/or its contracted vendor. They do not refer to the commissioners.

⁵ To complete the work, it is estimated 2.5 FTEs will be needed for the two months following the annual data submissions and 0.25 FTE required the rest of the year. These FTEs could be State staff or vendor staff contracted by DHCC.

- **Insurer:** A private health insurance company that offers one or more of the following, commercial insurance benefit administration for self-insured employers, Medicare managed care products and/or are Medicaid managed care organization (MCO) products.
- **Insurance Line of Business:** The standard level of reporting benchmark-spending data insurers will use. See Appendix A for more information.
- **Market:** The highest level of categorization of the health insurance market. For example, Medicare fee for service (FFS) and Medicare managed care are collectively referred to as the “Medicare Market.” Medicaid FFS and Medicaid managed care are collectively referred to as the “Medicaid Market.” Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the “Commercial Market.”
- **Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Delaware residents associated with the administration of private health insurance (including Medicare managed care and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers’ costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels. NCPHI will not be reported at the provider level.
- **Payer:** A term used to refer collectively to both insurers and public programs submitting data to DHCC.
- **Payer Recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or through a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer TME reporting.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.⁶ The computation of THCE at the State, market and payer level is net of pharmacy rebates (i.e., expenditures are reduced by the amount of the pharmacy rebates).⁷
- **Premium Revenues (for NCPHI):** A term used to refer to an insurer’s total premium revenues for a given Insurance Line of Business code for Delaware residents. To be used in the computation of

⁶ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer and PBM) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer, which the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service feeds, distribution service fees, and patient care management programs).

⁷ CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the State and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

Net Cost of Private Health Insurance. See Appendix A and Appendix E for a more detailed description.

- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid FFS, the Veterans Health Administration (VHA), and similar entities/programs.
- **Total Health Care Expenditures (THCE):** The TME incurred by Delaware residents for all health care benefits and services by all payers reporting to DHCC plus the insurers' NCPHI.
- **Total Health Care Expenditures per Capita:** THCEs (as defined above) divided by Delaware's total state population. The annual change in THCE per capita is compared to the spending benchmark at the State level.
- **Total Medical Expense (TME):** The sum of the allowed amount of total claims spending and total non-claims paid to providers incurred by Delaware residents for all health care services. TME is reported at multiple levels: state, market, payer and provider (if applicable). TME will be reported net of pharmacy rebates at the State, market and payer levels in DHCC's annual benchmark trend report. Payers report TME by insurance category code (e.g., Medicare and Medicare Managed Care and Commercial — Full Claims) and at the provider level whenever possible. TME excludes Medigap members and claims. More detailed TME reporting specifications are contained in the Appendices of this implementation manual.
- **Total Net Paid Expenditures (for NCPHI):** A term used to refer to an insurer's actual net paid expenditures for services and benefits for a given Insurance Line of Business code for Delaware residents. To be used in the computation of Net Cost of Private Health Insurance. See Appendix A and Appendix E for a more detailed description.
- **Veterans Health Administration (VHA):** The federal agency responsible for provision of health care benefits to veterans.

Methodology for Measuring Total Health Care Expenditures

To assess changes in the amount of health care spending, DHCC will need to calculate THCE annually based on the data submitted by payers. DHCC should measure THCE on an aggregate dollar and per capita basis. The aggregate dollar figure will be for informational purposes only. The change in THCE on a statewide per capita basis will be used to assess performance against the spending benchmark.

THCE (aggregate dollars) =

$$\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} \\ + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI}$$

THCE per capita =

$$\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} \\ + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI}$$

Delaware Population

The percentage change in THCE per capita between the measurement CY and the prior CY will be used to assess performance against the spending benchmark, applicable to the respective measurement CY.

Example: If the CY 2020 (i.e., measurement year) THCE per capita amount is \$9,500 and the CY 2019 (i.e., prior year) THCE per capita amount is \$9,200, the change in THCE per capita is $(\$9,500 - \$9,200) / \$9,200 = 3.3\%$. The 3.3% change will be compared to the CY 2020 spending benchmark as part of assessing performance and subsequent public reporting.

THCE is based on the following principles:

- It represents spending by or on behalf of Delaware residents. Spending associated with people who live out-of-state is excluded. However, spending by or for Delaware residents on health care that is provided out-of-state is included.
- It includes spending on health care services and benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are generally excluded except in instances where vision and dental services are covered as a health insurance benefit or are a covered benefit under Medicaid and Medicare.
- It represents the total allowed amount, which is inclusive of both amounts covered by payers and out-of-pocket spending associated with insured medical expenditures (e.g., copays and deductibles). In order to avoid double counting expenditures, health care premium payments are not included. Also, due to the lack of available data, other out-of-pocket expenditures recorded by providers, but not by insurers, are not included (e.g., “charity care” or spending for medical care by residents of Delaware who cannot afford to pay providers, privately purchased health care services).
- It includes all insurance market segments, including public and private payers listed in this implementation manual, fully and self-insured and student insurance with the following limited exceptions: the TRICARE program and health spending by the Delaware Department of Corrections, which is not otherwise covered by Medicaid.

- The administrative costs and underwriting gain/loss of insurers, referred to as NCPHI, are included (see Section 3 for more detail).
- TME data is only collected from a payer when that payer is the primary payer for that specific claim. The primary payer will report on the allowed amount; the secondary payer will not. If the secondary payer on that specific claim were to also report that claim’s allowed amount, it would cause double counting of that amount.
- TME is adjusted (i.e., net of rebates) to account for any pharmacy rebates reported by the payer(s).

Data Sources for Total Health Care Expenditures

Data for THCE comes from several sources. Insurers need to report TME for all lines of business, and in some instances, insurers need to report data for the State to calculate NCPHI. Other data sources include the Centers for Medicare & Medicaid Services (CMS), DMMA and VHA. Table 5 below outlines the data source by THCE category and the location of the detailed specification or collection process within this implementation manual.

Table 5. Data Sources for Total Health Care Expenditures

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures From Insurers		
Insurer full claim (comprehensive coverage with no carve-outs) calculated values	TME reported by insurers	Appendix A
Insurer partial claim (coverage with carve-outs, such as pharmacy or behavioral health) calculated values	TME reported by insurers, with actuarial estimates produced by insurers	Appendix A
Insurer non-claim payments calculated values	TME reported by insurers	Appendix A
Prescription drug spending for Medicare Part D. ⁸	Insurers (and CMS)	Appendix A and C

⁸ CMS will provide DHCC with allowed amounts for Medicare FFS beneficiaries with a stand-alone PDP, for Medicare managed care beneficiaries with stand-alone PDP and Medicare Advantage Prescription Drug plans (MAPD) (in aggregate). Stand-alone PDP spending will not be collected from insurers to avoid double-counting. Because CMS provided Part D expenditure data includes all forms of Medicare managed care, to avoid double counting, DHCC should only use CMS provided Part D Total Expenditures data to report Medicare **market** level pharmacy spending. When reporting at the **insurer** level, the insurer reported Part D pharmacy data could be used. See Appendix C for more information on reporting Medicare Part D spending data.

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures From Public Programs		
DMMA claim (Medicaid, FFS, and other) calculated values	Delaware DMMA	Appendix B
Medicare FFS claim (Parts A and B) and all Part D calculated values	CMS	Appendix C
VHA summarized data	Veterans Health Administration	Appendix D
Net Cost of Private Health Insurance		
Insurer NCPHI	Calculated data submitted by the insurers or obtained through public sources	Appendix E
Pharmacy Rebates		
Insurers	Pharmacy rebate data filing by insurers	Appendix A
Medicaid program	Pharmacy rebate data filing by Delaware DMMA and in some limited amount by the insurers ⁹	Appendix B
Population Statistics		
Population of Delaware	U.S. Census Bureau	Appendix F

Insurer Total Medical Expense Data

TME represents all allowed amounts for medical and service expenses for the Delaware resident population and will be reported by payers for all applicable members (including fully and self-insured members).

Annually, DHCC will ask applicable insurers to submit spending data using the specifications outlined in **Appendix A** and the template provided as **Attachment 2**. Specifications for public programs to submit their TME data are included in **Appendices B–D** with the Medicare template provided as **Attachment 1** and the DMMA template provided as **Attachment 4**. Table 6, below, lists that insurers should report for their commercial, Medicare managed care and Medicaid managed care markets.¹⁰

⁹ DMMA currently prohibits the Medicaid managed care plans from collecting pharmacy rebates on all drugs on the State's preferred drug list (PDL). Since the PDL is very comprehensive, the Medicaid managed care plans typically report little to no rebates of their own collection.

¹⁰ This table represents the largest insurers in the Delaware insurance market as of 2018. Because the market may change, this table may need to be updated over time. The intent of Governor Carney's EO 25, is to capture data from all major insurers for all market segments in the State.

Table 6. Insurers Requested to Report TME Data by Market

Insurer	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care
Aetna	✓	✓	
AmeriHealth Caritas			✓
Cigna	✓	✓	
Highmark Blue Cross Blue Shield Delaware	✓		✓
UnitedHealthcare	✓	✓	

The TME data includes claims and non-claims payments¹¹ for a specific CY (i.e., incurred in/dates of service). Payers should submit these data based on allowed amounts, which include paid claims as well as patient cost-sharing amounts, such as copayments, coinsurance and deductibles.

Payers are expected to adjust expenditure data for a reasonable and appropriate estimate of unpaid claims liability (i.e., incurred but not reported (IBNR) or incurred but not paid (IBNP)) using actuarially sound principles, when claims run-out alone is not sufficient.

A payer only reports TME spending **when it is the primary insurer on the claim**, as secondary coverage expenditures would generally double count a portion of the allowed amount by the primary insurer. Even though an individual enrolled with an insurer can have other forms of health insurance, the reporting of TME data are based on **whether the insurer was primary on the respective claim** not whether the member had other forms of insurance. For example, for members enrolled in Medicaid managed care who also have Medicare coverage (e.g., dual eligible), the insurer must report as part of its TME data submission the allowed amount for all claims for which it was the primary payer (e.g., a large portion of long-term care services incurred by those members).

In some circumstances, insurers are only able to report claim payments for a subset of medical services due to benefit design, in which the contracting employer may “carve-out” some services, such as behavioral health or pharmacy services, and contract for their coverage separately from the main medical coverage. In these instances, insurers are unable to obtain the payment information and do not hold the insurance risk for the carved out services. To estimate the full TME amount for partial claim population, the insurer will need to make actuarial adjustments based on the reported partial-claim TME data. An actuarial adjustment will allow DHCC to include the full spending estimated amounts without having to collect data from carve-out vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per member per month (PMPM) for the same year, calculated on members who had pharmacy coverage, applied to all member months for which the carve-out applied. Before this adjustment is made, insurers should discuss appropriate methodologies with

¹¹ Claims payments are payments to providers associated with a health care claim. Non-claims payments are payments to providers not associated with a claim, and include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc.

DHCC, recognizing there is no standardized approach to this estimate, but that actuarially sound principles should be used.

Appendix A includes instructions for insurers to separately submit pharmacy rebate data so DHCC can subtract pharmacy rebates from THCE and TME at the market and insurer levels. Payers will need to proportionally allocate total pharmacy rebates by line of business to Delaware resident members, unless rebates can be directly associated to a specific line of business. Pharmacy TME spending data on a service category basis is to be reported gross of rebates. Pharmacy rebates will be reported separately to enable DHCC to compute TME net of rebates.

Net Cost of Private Health Insurance Data

The final component of THCE is NCPHI. This element captures the costs to Delaware residents associated with the administration activities and underwriting gain/loss of insurers. It is the difference between health premiums earned and benefits incurred. It includes all categories of administrative expenditures including net additions to reserves, rate credits and dividends and profits and losses.

DHCC will need to calculate NCPHI for all Delaware residents whose insurers are submitting data to DHCC, using data obtained from insurers and other public sources. NCPHI should exclude out-of-state residents covered under Delaware-based insurance plans. The recommended methodology DHCC should follow in order to calculate NCPHI is included in **Appendix E**.

Public Reporting of Spending Benchmark Performance

To publicly report on performance against the spending benchmark, DHCC will report at the State level, with several “drill-down” analyses as the data permits. The following specifications propose the minimum level of public reporting DHCC should undertake. The specific type and content of public reporting of performance relative to the spending benchmark will likely evolve over time, and thus, this implementation manual will be updated as the public reporting processes change. DHCC’s annual benchmark trend report should include engaging and easy to understand text and graphics and provide meaningful views of the data.

The term “per capita” is generally reserved for when total spending data is reported at the State level using Delaware’s total population in the denominator of the per capita calculation. When reporting spending data at the market or insurer level, DHCC should report the data on a per member per year (PMPY) basis, which uses member counts applicable to the respective market or insurer in the PMPY calculation. As such, the change in PMPY values is not directly comparable to the spending benchmark, but comparisons of market and insurer level PMPY changes can be informative relative to the statewide spending benchmark.

Table 7. Recommended Levels for Public Reporting of Performance Against Spending Benchmark

Level	THCE	TME/NCPHI
State level	Aggregate and per capita Compare per capita rate of change against benchmark	Report TME and NCPHI components as applicable
Commercial market	Aggregate and PMPY Compare PMPY change relative to the benchmark	Report TME and NCPHI components as applicable
Medicare market ¹²	Aggregate and PMPY Compare PMPY change relative to the benchmark	Report TME only (NCPHI not applicable)
Medicaid market ¹³	Aggregate and PMPY Compare PMPY change relative to the benchmark	Report TME only (NCPHI not applicable)
VHA ¹⁴	Aggregate and PMPY Compare PMPY change relative to the benchmark	Report TME only (NCPHI not applicable)
Insurer level (e.g., Highmark and AmeriHealth), by line of business (e.g., Medicare managed care and Medicaid managed care)	PMPY Compare PMPY change relative to the benchmark	Report TME and NCPHI components as applicable
Insurance Line of Business	PMPY Compare PMPY change relative to the benchmark	Report TME only on PMPY basis if applicable

Collecting Total Medical Expense Data by Service Category

The TME data specifications for payers requires data to be reported by major service category (e.g., hospital inpatient, hospital outpatient, and pharmacy). By analyzing service category spending,

¹² This includes Medicare FFS and Medicare managed care, but does not include Medigap members or claims. Medicare managed care will also be reported separately in the Insurer Level category; however, Medicare FFS will not. Medicare FFS is not reported separately as the denominator to calculate the PMPY is not available. Medicare FFS will report data on individual lines of coverage (Part A, Part B, and Part D) and each line of coverage will have its own enrollment figures, which cannot be combined for risk of duplicating beneficiaries in the denominator. DHCC could conceivably report PMPY by line of coverage, but is not comparable to commercial insurance, which does not separate out hospital insurance, medical insurance, and pharmaceutical insurance, therefore making interpretation of the data confusing to the reader.

¹³ This includes Medicaid FFS and Medicaid managed care. Medicaid managed care will also be reported separately in the Insurer Level category; however, Medicaid FFS will not. Medicaid FFS data is not comparable in nature to the calculated data reported by insurers since the population in Medicaid FFS consists of small populations eligible for different sets of services, and not always a beneficiary's full spending.

¹⁴ The VHA data does include a Veteran Population count, which can be used to compute a PMPY value for informational purposes. However, the data available from the VHA consists of spending by veterans within the VHA system and does not cover the spending those veterans receive from non-VHA health care facilities, possibly underestimating their spending.

DHCC is able to understand the scale of changes in individual service categories and the share of TME spending changes attributable to each service category.

A goal with the collection of TME data is to obtain summary level payer data segmented into a manageable number of distinct service categories all payers can consistently and accurately report. However, in reality, there may be limitations on some payers' ability to report data at the desired service category level. Therefore, DHCC will collect service category data at the highest level. Ideally, all payers will utilize a standardized list of claims codes by service category to enable better comparisons across payers or markets. However, to create a standardized, hierarchical-based service category coding algorithm requires a time-intensive effort on behalf of DHCC to define the categories, or an agreement to use a pre-defined list, like one developed by the Health Care Cost Institute.¹⁵ Payers would also likely have to undergo a resource-intensive effort to configure their reporting to comply with DHCC's service category coding logic. Therefore, unless the implementation manual contains specific coding logic for a service category (e.g., primary care services), each payer will interpret the service category instructions in their own way. A standardized, hierarchical-based service category-coding matrix for all service categories may be included in a future version of this implementation manual.

The highest-level individual service categories for the submission and subsequent reporting of TME claims data from all payers consists of the following common service categories for claims data:

- Hospital Inpatient
- Hospital Outpatient.
- Professional, Primary Care
- Professional, Specialty Care
- Professional, Other
- Long-Term Care
- Pharmacy (gross of rebates)¹⁶
- Other
- Pharmacy Rebates (separately reported)

More information on what specific types of services are included in each of the respective service categories is provided within the payer technical specification appendices. DHCC will acknowledge when analyzing and reporting these data publicly there may be some limitations in consistent

¹⁵ See: www.healthcostinstitute.org/images/pdfs/HCCI_2016_Methodology_v1.0_1.23.18.pdf

¹⁶ Insurers with both Medicare managed care and stand-alone PDP lines of business must exclude their stand-alone PDP data from their TME submission. Stand-alone PDP expenditure data will be obtained from CMS.

interpretation across payers, for the duration these categories are not defined with a specific coding logic.

Reporting Spending Data by Insurance Line of Business

DHCC will request insurers submit spending data by their applicable Insurance Line of Business code. It is not expected all insurers will have data for all Insurance Line of Business codes. Data to be reported at the Insurance Line of Business code level are:

- Premium Revenues (for use in NCPHI calculations)
- Total Net Paid Expenditures (for use in NCPHI calculations)
- Member Months
- Pharmacy Rebate (must be a negative value)
- Health Status Risk-Adjustment Score
- Claims Spending Data
- Non-Claims Spending Data

The Insurance Line of Business codes are the same codes insurers have previously been asked to report their member months. This revision extends that same level of reporting to other data fields as noted previously. The Insurance Line of Business codes are shown in the following table. These line of business codes are **mutually exclusive** ensuring insurers do not duplicate any of their reported spending data.

Table 8. Insurance Line of Business Codes

Line of Business Category Code	Line of Business Category Code Description
901	Individual
902	Large Group, Fully Insured
903	Small Group, Fully Insured
904	Self-insured
905	Student Market
906	Medicare Managed Care (excluding Medicare/Medicaid Duals)
907	Medicaid/CHIP Managed Care (excluding Medicare/Medicaid Duals)
908	Medicare/Medicaid Duals
909	Other

Timeline for Measuring and Reporting the Health Care Spending Benchmark

EO 25 originally called for DHCC to publish its annual benchmark trend report in the fourth quarter of each CY following the respective reporting/data year. However, depending on the data collection and validation process, the release of the annual benchmark trend report may need occur in the first quarter following the year the data is collected (e.g., CY 2020 report issued in Q1 2022). The goal remains to release the report in the fourth quarter of the CY in which the data is received.

Last year, CY 2018 and CY 2019 spending data was collected. Based on lessons learned, CY 2019 data will be collected again along with CY 2020 data for the first time as part of this year's data collection process to ensure better year-over-year comparisons of payer submitted data. DHCC intends to collect at least two years of data in each annual cycle to ensure year-over-year comparisons are as "apples-to-apples" as practical.

Prior to data requests being submitted to insurers, DHCC may need to complete some activities to finalize **Appendix A**, including identifying the final list of insurance line of business codes for which insurers will report data, and update a website where insurers can access file submission instructions and other key details related to the spending (and quality) benchmarks.

More information regarding the benchmarks process can be found DHCC's website:
<https://dhss.delaware.gov/dhcc/global.html>

5

Health Care Quality Benchmarks

Delaware has established eight health care quality benchmark values intended to foster accountability at multiple levels for improved health status and health care quality in the State. The purpose of this section is to describe the process for DHCC to facilitate data collection and evaluate performance against the quality benchmarks. This section includes five parts:

- Key Terms and Common Acronyms.
- Overview of CY 2019–2021 Measures.
- CY 2019–2021 Quality Benchmarks.
- Annual Review of Changes to Measure Specifications.
- Preview of the CY 2022–2024 Quality Benchmarks.
- Data Collection.
 - Request for Information.
 - Calculating Delaware Performance Against the Benchmark.

Key Terms and Common Acronyms

- **Annual Improvement Goal:** The defined percentage point or other calculation the measure is required to increase or decrease in order to meet the applicable benchmark.
- **Annual Quality Benchmark:** A measure of frequency describing the annual performance target for a priority Delaware population-health or quality-of-care concern. Performance relative to an annual quality benchmark is assessed at the State level and depending upon the measure, its data source, market,¹⁷ insurer, and potentially provider levels.
- **Aspirational Quality Benchmark:** A measure of frequency describing the five-year performance goal for a priority Delaware population-health or quality-of-care concern. To be discontinued in consideration of the three-year cycle for quality benchmark evaluation.
- **Behavioral Risk Factor Surveillance System (BRFSS):** A health-related telephonic survey, which collects state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions and use of preventive services.




¹⁷ Excluding Medicare FFS and Medicare managed care.

- **Centers for Disease Control and Prevention (CDC):** National health protection agency with responsibilities including detecting and responding to new and emerging health threats, and promoting healthy and safe behaviors, communities and environment.
- **CDC Wonder — Multiple Cause of Death (MCD):** CDC Wonder is a system for disseminating public health data and information. The MCD data available on CDC WONDER are county-level national mortality and population data. Data are based on death certificates for U.S. residents. For the purposes of the benchmark, state level information is utilized.
- **Health Care Effectiveness Data and Information Set (HEDIS®):** Standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). These measures are designed to allow consumers and purchasers to compare plans against national or regional benchmarks.
- **Health Status Measures:** These measures quantify certain population-level characteristics of Delaware residents.
- **Health Care Measures:** These measures quantify performance on health care processes or outcomes associated with Delaware residents. Performance is assessed at the state, market, insurer, and provider levels.
- **National Committee for Quality Assurance (NCQA):** Organization that works to improve health care quality through the administration of evidence-based standards, measures, programs and accreditation.
- **Prescription Monitoring Program (PMP):** State program/entity with goal to reduce misuse of controlled substances in Delaware and to promote improved professional practice and patient care. PMP will be the source of data for the Use of Opioids at High Dosage quality measure.
- **Youth Risk Behavior Survey (YRBS):** Includes national, state, territorial, tribal and local school-based surveys to monitor health behaviors, which contribute to death, disability and social problems in youth. Typically conducted every two years.

Overview of CY 2019–2021 Quality Measures

For the CY 2020 reporting period (and expected for CY 2021), Delaware originally established eight quality benchmarks, but has since discontinued two measures for the CY 2020–2021 performance period. The two discontinued benchmarks are Tobacco Use in Adults and High School Students Who Were Physically Active. The measures were discontinued due to lack of available data and/or a shift in Delaware’s focus to other priorities. Use of Opioids at High Dosage was selected as the new opioid-related health care measure. Consistent with the spending benchmark, the quality measures apply to Delaware residents only. The active and discontinued measures are described in the table below:

Table 9. Quality Measures

Measure Name	Description	Market	Data Source/Technical Specifications ¹⁸
Health Status Measures			
Adult obesity	The percentage of adults with a body mass index (BMI) greater than or equal to 30 weight (kg)/height (m ²), as defined by the CDC.	All State	BRFSS, CDC https://www.cdc.gov/brfss/  2016_BRFSS_Questionnaire_FINAL.pdf
High school students who were physically active	Discontinued for the CY 2020–2021 performance period		
Opioid-related overdose deaths	Number of opioid-related overdose deaths per 100,000 persons, as defined by the CDC.	All State	CDC — Wonder: MCD Data https://wonder.cdc.gov/wonder/help/mcd.html  Multiple Cause of Death
Tobacco use	Discontinued for the CY 2020–2021 performance period		
Health Care Measures			
Use of opioids at high dosage	The percentage of the population ≥ 18 years of age who received a prescription for opioids at an average daily dose ≥ 90 morphine milligram equivalents (MME) for ≥ 15 total day supply during the CY.	All State	Delaware Prescription Monitoring Program  Delaware Opioid Quality Benchmark Me
Emergency department utilization (EDU)	For members 18 years of age and older, a risk-standardized measure of the emergency department (ED) visits	Commercial	Claims https://www.ncqa.org/hedis/measures/ (NCQA-HEDIS®, modified ¹⁹)

¹⁸ Note the surveys and the technical specifications included here are the original sources used to calculate the baseline.

¹⁹ Rather than use the HEDIS® observed-to-expected ratio, NCQA recommended, and Delaware has adopted, use of a risk-standardized rate for the quality benchmark. The specification used for the Delaware quality benchmark is adapted from NCQA’s HEDIS® 2018 EDU measure, by using risk-standardized rates instead of the risk-adjusted ratio of observed-to-expected ED visits

Measure Name	Description	Market	Data Source/Technical Specifications ¹⁸
	during the measurement year.		
Persistence of beta-blocker treatment after a heart attack (PBH)	The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge.	Commercial and Medicaid	Claims NCQA-HEDIS® https://www.ncqa.org/hedis/measures/
Statin therapy for patients with cardiovascular disease (SPC)	The percentage of males 21 years to 75 years of age and females 40 years to 75 years of age who have clinical atherosclerotic cardiovascular disease and who received and adhered to statin therapy.	Commercial and Medicaid	Claims NCQA-HEDIS® https://www.ncqa.org/hedis/measures/

CY 2019–2021 Quality Benchmarks

Baseline data were reported for each measure using the specified methodology. Aspirational benchmarks were determined for each measure, with a five-year goal for the measure. Annual quality benchmark values were determined by comparing baseline data to the aspirational value and dividing by five, with the annual quality benchmark value being adjusted annually by the quotient. Resulting values were rounded to one decimal point.

Table 10. Quality Benchmarks

Measure	Aspirational Goal and Source	Baseline Rate	2019 Goal	2020 Goal	2021 Goal	Annual Improvement Goal
Health Status Measures						
Adult obesity	27.4% All State. Seventy-fifth percentile (all states, 2016 BRFSS, CDC)	30.7%	30.0%	29.4%	28.7%	0.7 percentage points
Opioid-related overdose deaths	13.3 deaths per 100,000 (state population) Fiftieth percentile (all states, 2016, CDC)	16.9 deaths per 100,000	16.2 per 100,000	15.5 per 100,000	14.7 per 100,000	0.7 deaths per 100,000
Health Care Measures						
Use of opioids at high dosage	10% Based on historical trend of data prior to baseline	13.2%	N/A	12.4%	11.6%	0.8 percentage points
EDU	165.9 visits ²⁰ per 1,000 risk standardized rate. Commercial. Seventy-fifth percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)	196 visits ²¹ per 1,000	190.0 per 1,000	183.9 per 1,000 ²²	177.9 per 1,000 ²⁸	6 visits per 1,000 ²⁸

²⁰ The national EDU risk-standardized rate was calculated by multiplying the national average observed-to-expected ratio by the national average observed rate. Delaware plan-specific risk-standardized rates are calculated dividing the plan's observed-to-expected ratio by the national risk-standardized rate.

²¹ Delaware's baseline was derived from the weighted average performance of Aetna, Cigna, Highmark and UnitedHealthcare. Aetna Health Inc. (Pennsylvania) — Delaware and Aetna Life Insurance Company (Delaware) rates have been combined based on Delaware enrollment rates to create the "Aetna" rate. Weights were HEDIS® 2018 (CY 2017 data) enrollment by plan.

²² Due to substantive change in EDU measure specification, NCQA recommends a break in trending for all product lines. Benchmarks may need to be reset once the CY 2020 national median rate result is available.

Measure	Aspirational Goal and Source	Baseline Rate	2019 Goal	2020 Goal	2021 Goal	Annual Improvement Goal
Persistence of beta blocker after a heart attack — Commercial	91.9% Commercial. Ninetieth percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)	80.2% ²³	82.5%	84.9%	87.2%	2.3 percentage points
Persistence of beta blocker after a heart attack — Medicaid	83.9% Medicaid. Seventy-fifth percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)	77.6% ²⁴	78.8%	80.1%	81.3%	1.3 percentage points
Statin therapy for patients with cardiovascular disease — Commercial	82.1% Ninetieth percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)	79.4% ²⁵	79.9%	80.5%	81.0%	0.5 percentage points
Statin therapy for patients with cardiovascular disease — Medicaid	68.3% Seventy-fifth percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)	56.9% ²⁶	59.2%	61.5%	63.7%	2.3 percentage points

²³ Delaware's baseline is Highmark's baseline rate, as Highmark was the only plan with commercial data available in NCQA's Quality Compass for HEDIS® 2018 (CY 2017 data).

²⁴ Delaware's baseline is Highmark's baseline rate, as Highmark was the only plan with Medicaid data available in NCQA's Quality Compass for HEDIS® 2018 (CY 2017 data).

²⁵ Delaware's baseline was derived from the weighted average performance of Aetna, Cigna, Highmark and UnitedHealthcare. Aetna data are from Aetna Life Insurance Company (Delaware), as no data were available for Aetna Health Inc. (Pennsylvania) — Delaware. Weights were HEDIS® 2018 (CY 2017 data) enrollment by plan.

²⁶ Delaware's baseline is Highmark's baseline rate, as Highmark was the only plan with Medicaid data available in NCQA's Quality Compass for HEDIS® 2018.

DHCC's Annual Review of Changes to Quality Measure Specifications

DHCC staff will conduct an annual review of the specifications to determine if any changes have been made that could have an impact on performance rates when compared to the benchmark year.

For the respective measure, the BRFSS and YRBS surveys will be evaluated to determine if there are changes to the survey questions, the method of distribution or with the population receiving the survey or any other difference, which might affect the comparison. The Wonder MCD will also be reviewed to identify any changes in coding or reporting. This information is available on the CDC website.

For other quality measures, the technical specifications will be reviewed and compared. NCQA makes updates to the HEDIS[®] measure set on an annual basis, and provides information on which measures were changed and how the methodology has changed. Any material changes to HEDIS[®] specifications will need to be reviewed and an assessment made on whether the existing benchmarks are still appropriate or need to be revised to align with the applicable new specifications. Alternatively, DHCC may ask the payers to submit data using the previous specifications if that is determined to be the preferred solution. DHCC and the Prescription Monitoring Program will review the methodology of the Use of Opioids at High Dosage measure to determine if any methodological changes are needed and/or DHCC may request that PMP sign an attestation the methodology is still relevant and valid.

Once the review is completed, DHCC will take the following steps:

1. For Health Status Measures, DHCC should ask the Department of Health and Social Services (DHSS) Division of Public Health staff if the changes to the specifications are substantive.
 - A. If DHSS Division of Public Health staff view these changes as potentially substantive, DHCC should obtain the national median performance for the measurement year in which the potentially substantive specification change occurred as well as the three most recent available performance periods prior to the potentially substantive change.²⁷ Steps to calculate the national performance are included in **Appendix I**.
 - B. If changes are deemed not substantive, no further steps need to be taken.
2. For health care measures,²⁸ DHCC will review NCQA's Measure Trending Determinations (posted at <https://www.ncqa.org/hedis/measures/> in March/April following the measurement period).
 - A. If NCQA has recommended trending with caution or a break in trending, DHCC should obtain the national median performance for the measurement year in which the potentially substantive specification occurred once available, as well as the three most recent available performance periods prior to the potentially substantive change. Steps to calculate the national performance are included in **Appendix I**.
 - B. If NCQA has not recommended trending with caution or a break in trending, no further steps need to be taken.

²⁷ The YRBS survey is administered every other odd year, so a lookback for "high school students who were physically active" will span six years for prior performance.

²⁸ It will be necessary to develop an alternative approach if the opioid related measure is not an NCQA HEDIS[®] measure.



3. For measures that have a recommended trending with caution, evaluate the performance change over time to assess the measure's benchmark. For measures with separate Commercial and Medicaid rates, this step should be performed individually for each line of business. DHCC may elect to perform this step with measures that have a recommended break in trending or they may eliminate this step and proceed to number 4.
 - A. Calculate the year-over-year trend for each of the prior performance years and compare that value to the measurement year trend absolute value.
 - i. If the difference between the two absolute values is greater than three percentage points, the change should be considered substantive.
4. If NCQA has recommended a break in trending and/or the change is deemed substantive, DHCC staff have three options:
 - A. Remove the measure's quality benchmark for the affected and future years. This should only be done if the revised measure's results indicate there is:
 - i. No longer an opportunity for improvement in Delaware; or
 - ii. The change to the measure is so dramatic any benchmark adjustment is deemed inappropriate to DHSS or DHCC).
 - B. Reset the measure's benchmark for the year in which there was a substantive change as well as all future years for which there is a benchmark.
 - C. Maintain the original benchmark and re-evaluate after the next measurement period.
5. If DHCC staff choose to reset the benchmark, the following steps will be taken:
 - A. DHCC will adjust both the aspirational benchmark and the prior year's performance rate by the trend difference as calculated in step 3.
 - B. DHCC will next subtract the prior year's benchmark rate from the aspirational benchmark value and divide the result by the number of years remaining until the aspirational benchmark year (2023).
 - C. Finally, DHCC will adjust the annual benchmarks by the quotient of step 5b with resulting values rounded to one decimal point.

Data Sources for Review of 2020 Quality Data Year Specifications

The table below includes the following information for each quality measure:

- The specification used to calculate the original benchmarks.
- The location for obtaining updated specifications each year.
- The 2020 specifications, as well as a determination of whether there were substantive changes in 2020.

Table 11. Quality Measures' Data Sources

Measure	Benchmark Specification	Specification Location	2020 Determination of Substantive Changes And Specification
Health Status Measures			
Adult obesity	2016 BRFSS	https://www.cdc.gov/brfss/questionnaires/index.htm	No substantive changes  2019-BRFSS-Questionnaire-508.pdf
Opioid-related overdose deaths	1999–2019 CDC WONDER	https://wonder.cdc.gov/wonder/help/mcd.html	2020 specification not available as of 5/07/2021, but no substantive changes in 2019  Multiple Cause of Death 1999-2019.pdf
Health Care Measures			
Use of opioids at high dosage	2019 Delaware PMP Data	Implementation manual	No substantive changes
EDU	HEDIS® 2018, modified to use risk-standardized rate	https://www.ncqa.org/hedis/measures/	Measurement year 2020 contains substantive changes and NCQA recommends a break in trending. The specifications were updated to remove visits that convert to observation stays and remove high frequency utilizers from the risk-adjusted performance rates. A new outlier rate was added to report high-frequency utilizers.
Persistence of beta-blocker treatment after a heart attack	HEDIS® 2018	https://www.ncqa.org/hedis/measures/	No substantive changes
Statin therapy for patients with cardiovascular disease — statin adherence 80%	HEDIS® 2018	https://www.ncqa.org/hedis/measures/	No substantive changes

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Methodology for Assessing Performance Against the Quality Benchmarks

On an annual basis, DHCC will collect quality data from various data sources as described below.

Quality Data from Insurers

By June 30 of each year, DHCC will ask insurers to submit their quality data by line of business by September 1 (or next applicable business day) consistent with the methodology in Section 3 and **Appendix G** and for those measures which meet the minimum size and denominator thresholds indicated within the detail of each measure.

When communicating to insurers, DHCC should provide the following materials:

1. Insurer Quality Data Reporting: This document outlines the steps required for insurers to submit their quality data to DHCC and is included herein as **Appendix G**.
2. Quality Benchmark Data Submission Template: This document should be used by insurers to submit insurer-level and provider-level quality data to DHCC, and is included as **Attachment 3**.
3. Attestation of the Accuracy and Completeness of Reported Data: Insurers will attest to the accuracy and completeness of their data submissions by completing and submitting the attestation form, found in **Appendix H**, along with their data submission to DHCC.

Other Quality Data Sources

Separately, DHCC will obtain additional quality data from NCQA and CDC using the data sources and timelines outlined in the following table:

Table 12. Other Quality Data Sources

Data Source	Measures	Timing
NCQA — Data Request	EDU	DHCC will make a request to NCQA, by June 30 for the relevant data. Details on the data request of NCQA can be found below under Calculating Delaware Performance Against the Benchmark.
CDC — BRFSS	Adult obesity	DHCC will annually seek out BRFSS performance via the website, by July 31 in the year following the performance period.
CDC — Wonder: MCD Data	Opioid related overdose deaths	DHCC will annually seek out CDC Wonder performance via the website by December 15 of the year after the performance period.
PMP	Use of opioids at high dosage	DHCC will make a request to PMP for the data by June 30. DHCC will request the PMP submit the data by September 1.

Calculating Delaware Performance Against the Benchmarks

Annually, during the fourth quarter of the CY, DHCC staff will complete calculation of performance against the quality benchmarks for the measurement year for all measures except opioid-related overdose deaths. Data for opioid-related overdose deaths are on a delayed schedule because CDC Wonder does not publish annual performance data on opioid-related overdose deaths until 12 months after the performance year has ended (e.g., data for 2020 performance are typically not available until December 2021). Performance against the quality benchmark for opioid-related overdose deaths for 2020 may be delayed. This delayed reporting timeline will likely repeat annually. Performance should be calculated at the state, market, insurer, and/or provider level depending on the measure.

The suggested levels at which performance should be calculated are outlined below. Data sources are italicized.

Table 13. Suggested Public Reporting of Quality Benchmark Results

Measure	State	Market		Insurer		Provider	
	Overall	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid
Health Status Measures							
Adult obesity	X <i>CDC</i>						
Opioid-related overdose deaths	X <i>CDC</i>						
Health Care Measures							
Use of opioids at high dosage	X <i>PMP</i>						
EDU		X <i>Insurer</i>		X <i>Insurer</i>		X <i>10 largest providers who meet size and denominator thresholds</i>	
Persistence of beta-blocker treatment after a heart attack		X <i>Insurer</i>	X <i>Insurer</i>	X <i>Insurer</i>	X <i>Insurer</i>	X <i>10 largest providers who meet size and denominator thresholds</i>	X <i>10 largest providers who meet size and denominator thresholds</i>
Statin therapy for patients with cardiovascular disease — statin adherence 80%		X <i>Insurer</i>	X <i>Insurer</i>	X <i>Insurer</i>	X <i>Insurer</i>	X <i>10 largest providers who meet size and denominator thresholds</i>	X <i>10 largest providers who meet size and denominator thresholds</i>

For each quality measure, the steps to compute performance results are described below:

Adult Obesity

Performance Level: State.

State-Level Performance: Obtain Delaware’s measurement year rate from the CDC BRFSS webpage (www.cdc.gov/brfss/index.html).

1. Select “Prevalence Data and Analysis Tools,” then “Prevalence & Trends Data.”

- A. Under “Explore BRFSS Data By Topic” select:
 - i. Class: Overweight and Obesity (BMI).
 - ii. Topic: BMI Categories.
- B. Once redirected, select the following options:
 - i. Selected Year: [Measurement Year].
 - ii. View By: Overall.
 - iii. Response: Obese (BMI 30.0-99.8).
 - iv. Data Type: Crude Prevalence.

Click on “DE” to obtain the rate.

Interpreting Performance: Compare Delaware’s measurement year rate obtained from the BRFSS results to the annual quality benchmark. Performance equal to or below the annual benchmark value indicates the quality benchmark has been met. Performance above the annual quality benchmark indicates the annual quality benchmark has not been met.

Opioid-Related Overdose Deaths

Performance Level: State.

State-Level Performance: Obtain Delaware’s measurement year rate from the CDC Wonder’s MCD mortality files (<http://wonder.cdc.gov/mcd-icd10.html>).

1. Click “I Agree” under the data use restriction and sanctions for violating rules language.
2. Select the following filters:
 - A. Organize table layout:
 - i. Group Results by: State.
 - ii. And by year.
 - C. Measures: Deaths, Population, Crude Rate and Age-Adjusted Rate.
 - D. Select location:
 - i. Click a button to choose locations by State, Census Region or Health and Human Services (HHS) Region: State.
 - ii. Browse: Delaware.
 - E. Select demographics:

- i. Pick Between: Ten-Year Age Groups, All Ages.
 - ii. Gender: All Genders.
 - iii. Race: All Races.
 - iv. Hispanic Origin: All Origins.
- F. Select year and month:
- i. Year/Month: [Measurement Year].
- G. Select weekday, autopsy and place of death:
- i. Weekday: All Weekdays.
 - ii. Autopsy: All Values.
 - iii. Place of Death: All Places.
- H. Select underlying cause of death (UCD):
- i. Click a button to select International Classification of Disease (ICD) codes by Chapters or by Group: UCD — Drug/Alcohol Induced Causes.
 - ii. Browse: Drug-induced causes.
- I. Select multiple cause of death:
- i. Click a button to select ICD codes by Chapters or by Groups: MCD-ICD-10 Codes.
 - ii. Browse and click “Move Items Over” for Opioids: T40.0, T40.1, T40.2, T40.3, T40.4 or T40.6.
- J. Other options:
- i. Check “Show results.”
 - ii. Precision: select “1” decimal place.
- K. Click “Send.”
- L. Click the “Results” tab and use the “Age-Adjusted Performance Rate per 100,000” value for Delaware’s performance.

Interpreting Performance: Performance equal to or below the annual benchmark value indicates the quality benchmark has been met. Performance above the annual quality benchmark indicates the annual quality benchmark has not been met.

Use of Opioids at High Dosage

Performance Level: State.

State-Level Performance:

1. Calculate the number of unique individuals filling at least two opioid prescriptions during the CY on two separate days and with ≥ 15 days covered by opioids (denominator)
2. Calculate the number of individuals in the denominator with average MME/Day ≥ 90 (numerator)
3. Divide the numerator by the denominator

Interpreting Performance: Performance equal to or below the annual benchmark value indicates the annual quality benchmark has been met. Performance above the annual benchmark value indicates the quality benchmark has not been met.

EDU

Performance Level: State, health insurer and provider (if applicable) for the Commercial market only.

Calibration: Prior to performing any performance calculations, DHCC must calibrate the national data:

1. The national average EDU observed-to-expected ratio and the national average EDU observed rate would likely need to be purchased from NCQA either through an existing consultant contractor or directly from NCQA. To contact NCQA, email Chris Carrier (carrier@ncqa.org) and Samantha Firetti (firetti@ncqa.org), and ask for the national average EDU observed-to-expected ratio and the national average EDU observed rate for the performance period.

The national EDU risk-standardized rate is calculated by multiplying the national average observed-to-expected ratio by the national average observed rate. The “EDU Risk Standardized Rate Calculator” performs this calculation in row 11 in the embedded tool below if the national average observed-to-expected ratio and the national average observed rate are input.



EDU Risk
Standardized Rate Ca

Provider-Level Performance:

2. To calculate provider-specific risk-standardized rates, divide the provider’s ED observed-to-expected ratio from payer-reported data by the national risk-standardized rate.
 - A. The “EDU Risk Standardized Rate Calculator” performs this calculation in row 12 in the embedded tool above if the national average observed-to-expected ratio, national average observed rate and the provider’s ED observed-to-expected ratio are input.
 - B. Minimum Size Threshold: Rates should only be calculated for providers with a minimum of 150 attributed patients for a given performance period. Minimum size thresholds should be

determined by taking the data from column K of the payer-submitted “Quality Benchmark Performance Submission Templates” and dividing the value by 12.

Calculate provider-level aggregate commercial risk-standardized rate by taking the weighted average performance by provider-attributed lives for providers meeting the minimum size threshold.

Insurer-Level Performance:

3. Insurer-specific rates are obtained from the insurer-reported data.

To calculate insurer-specific risk-standardized rates, divide the provider’s ED observed-to-expected ratio from payer-reported data by the national risk-standardized rate.

- A. The “EDU Risk Standardized Rate Calculator” performs this calculation in row 12 if the national average observed-to-expected ratio, national average observed rate and the insurer’s ED observed-to-expected ratio are input.
- B. Minimum Size Threshold: Rates should only be calculated for insurers with a minimum of 150 enrolled members²⁹ in a given performance period. Minimum size thresholds should be determined by taking the data from column K of the payer-submitted “Quality Benchmark Performance Submission Templates” and dividing the value by 12. Rates should only be calculated for providers with a minimum of 150 attributed members in a given performance period.

Calculate insurer-level aggregate commercial risk-standardized rate by taking the weighted average performance by provider-attributed lives meeting the minimum size threshold.

State-Level Performance: Calculate Delaware’s commercial risk-standardized weight by taking the weighted average performance of all reporting health insurers, weighted by plan enrollment.

Interpreting Performance: Performance equal to or below the annual benchmark value indicates the annual quality benchmark has been met. Performance above the annual quality benchmark indicates the annual quality benchmark has not been met.

Persistence of Beta-Blocker Treatment After a Heart Attack

Performance Level: State, insurer, and provider (if applicable) for Commercial and Medicaid markets.

Provider-Level Performance:

1. Aggregate numerator and denominator values by line of business using the payer-reported rate for each provider.
2. Divide the aggregated numerator by the aggregated denominator by line of business to obtain provider-level rates.

²⁹ The threshold value of 150 was recommended to Delaware by NCQA.

3. **Minimum Denominator Threshold:** Rates should only be calculated with denominator values of 30 or more. Organizations with denominators less than 30 do not meet the HEDIS small denominator threshold.

Health Insurer-Level Performance: Divide the numerator by the denominator from the health insurer-reported data by line of business to obtain health insurer-level rates.

State-Level Performance:

1. Aggregate numerator and denominator values by line of business using the health insurer-reported data for each health insurer.
2. Divide the aggregated numerator by the aggregated denominator by line of business to obtain state-level rates.

Interpreting Performance: Performance equal to or above the annual benchmark value indicates the quality benchmark has been met. Performance below the annual quality benchmark indicates the annual quality benchmark has not been met.

Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80%

Performance Level: State, health insurer and provider (if applicable) for Commercial and Medicaid populations.

Provider-Level Performance:

1. Aggregate numerator and denominator values by line of business using the health insurer-reported data for each provider.
2. Divide the aggregated numerator by the aggregated denominator by line of business to obtain provider-level rates.
3. **Minimum Denominator Threshold:** Rates should only be calculated with denominator values of 30 or more. Organizations with denominators less than 30 do not meet the HEDIS small denominator threshold.

Insurer-Level Performance: Divide the numerator by the denominator from the insurer-reported data by line of business to obtain insurer-level rates.

State-Level Performance:

1. Aggregate numerator and denominator values by line of business using the insurer-reported data for each insurer.
2. Divide the aggregated numerator by the aggregated denominator by line of business to obtain state-level rates.

Interpreting Performance: Performance equal to or above the annual benchmark value indicates the quality benchmark has been met. Performance below the annual quality benchmark indicates the annual quality benchmark has not been met.

7

Three-Year Cycle of Quality Benchmarks

Per EO 25, DHCC is responsible to review the quality benchmarks on a three-year cycle. This review may result in a change in the quality measures and/or a change to the benchmarks for existing quality measures. Revisions to the quality benchmarks should reflect changes in new population health or health care priority opportunities for improvement, and/or whether the quality benchmarks values should be changed to reflect improved health care performance in the State.

Should DHCC identify appropriate changes, DHCC should make such changes to measures and/or to benchmark values used for the quality benchmarks only after providing the public and interested stakeholders an opportunity to provide feedback and after considering their recommendations.

Preview of CY 2022–2024 Quality Measures and Benchmarks

Consistent with the guidance in EO 25, DHCC is making updates to the quality measures and benchmarks for the next three-year cycle beginning with the CY 2022 performance period. DHCC publicly shared the proposed changes at the April 1, 2021, DHCC public meeting as well as posted materials on the proposed changes on its website. The public was given an opportunity to provide feedback. Minimal feedback was received and DHCC is moving forward with implementing the proposed changes as follows.

CY 2022–2024 Quality Measures

For the next three-year cycle, DHCC is proposing to retain the following six quality measures and the level in which performance is expected to be measured for Delaware residents:

- Adult obesity: State level.
- Opioid-related overdose deaths: State level.
- Use of opioids at high dosage: State level.
- EDU: Commercial market.
- Persistence of beta-blocker treatment after a heart attack: Commercial and Medicaid markets.
- Statin therapy for patients with cardiovascular disease: Commercial and Medicaid markets.

For these quality measures, new annual benchmarks will be developed for the CY 2022–2024 performance years. DHCC anticipates the process of developing new annual benchmarks will be similar to how the benchmarks were set for the CY 2019–2021 performance years, but this work still

needs to be completed. DHCC anticipates releasing the new annual benchmarks in the fall of 2021. Given the benchmarks are calculated on a three-year cycle, the aspirational goals will be discontinued.

In addition to six existing quality measures, DHCC will be adopting four new quality measures for Delaware residents as listed below along with the level in which performance is expected to be measured:

- Breast cancer screening: Commercial and Medicaid markets (excluding the Medicaid FFS program).
- Colorectal cancer screening: Commercial market.
- Cervical cancer screening: Commercial and Medicaid markets (excluding the Medicaid FFS program).
- Preventive dental services (ages 1–20): Medicaid market (**applies to Title XIX only**, including Medicaid FFS as applicable).

The three cancer screening measures align with the respective NCQA's HEDIS® specifications. Preventative dental services measure align with CMS' Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement. For these new quality measures, annual benchmarks will be developed for the CY 2022–2024 performance years. DHCC anticipates the process of developing these annual benchmarks will be similar to how the benchmarks have been developed for the other quality measures, but this work still needs to be completed. DHCC anticipates releasing the new annual benchmarks in the fall of 2021.

DHCC will provide payers information regarding any applicable data submission processes related to the next cycle of quality measures in future iterations of this implementation manual.

DHCC looks forward to an ongoing collaboration in obtaining complete and accurate data on the quality of care and health outcomes of Delawareans as part of this important benchmark initiative.

Appendix A

Insurer TME Data Submission Instructions

$$THCE \text{ per capita} = \frac{\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI}}{\text{Delaware Population}}$$

This insurer total medical expense (TME) data specification provides technical details to assist insurers in reporting and filing data to enable the Delaware Health Care Commission (DHCC) to calculate TME. This Appendix can serve as a stand-alone document, which DHCC can distribute as a guide for TME data reporting.

Definition of Key Terms

- **Allowed Amount:** The amount the payer paid plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Health Care Expenditures (THCE).
- **Insurer:** A private health insurance company that offers one or more of the following, commercial insurance benefit administration for self-insured employers, Medicare managed care products and/or are Medicaid/Children’s Health Insurance Program (CHIP) managed care organization (MCO) products. **Unless otherwise stated, references to “Medicaid” include the CHIP program.**
- **Insurance Line of Business:** The standard level of reporting benchmark-spending data insurers will use. Mutually exclusive categorization of spending data in different insurance market segments such as Individual, Large Group-Fully Insured, Small Group-Fully Insured, Self-Insured, etc.
- **Market:** The highest level of categorization of the health insurance market. For example, Medicare FFS and Medicare managed care are collectively referred to as the “Medicare Market.” Medicaid FFS and Medicaid MCO managed care are collectively referred to as the “Medicaid Market.” Individual, self-insured, small and large group markets and student health insurance are collectively referred to as the “Commercial Market.”
- **Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Delaware residents associated with the administration of private health insurance (including Medicare managed care and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers’ costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels.

- **Payer:** A term used to refer collectively to both insurers and public programs submitting data to DHCC.
- **Payer Recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or through a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer TME reporting.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.³⁰ The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).³¹
- **Premium Revenues (for NCPHI):** A term used to refer to an insurer's total premium revenues for a given Insurance Line of Business code for Delaware residents. To be used in the computation of Net Cost of Private Health Insurance. Total premium revenue means all monies paid by a policyholder, subscriber, or third party as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan. Amounts should be reported on a direct basis, so gross of any private reinsurance arrangements and on CY earned basis. Include advance payments of the premium tax credit, other type of federal subsidies (e.g., premium portion of low income subsidy in Medicare Part D program), risk sharing or risk mitigation arrangement payments/accruals or retrospective premium adjustments (e.g., estimated or reported risk adjustment transfer payments or risk corridor transfers in the ACA or Medicare programs where applicable) and any state based premium subsidies. Include MLR rebate payments or accruals and any experience rated premium adjustments. For fully insured employer sponsored coverage, include the total of employee and employer share of premium cost. For self-insured plans, include any income from administrative expenses and fees. Exclude investment income or revenues not directly related to the cost of providing the health plan coverage. Direct reimbursements for ACA Section 9010 Fees (i.e., Health Insurer Provider Fees) received from the State of Delaware should not be included.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid FFS, the Veterans Health Administration (VHA) and similar entities/programs.
- **Total Health Care Expenditures (THCE):** The TME incurred by Delaware residents for all health care benefits and services by all payers reporting to DHCC, plus the insurers' NCPHI.

³⁰ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer and PBM) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer, which the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service feeds, distribution service fees, and patient care management programs).

³¹ CMS is unable to report pharmacy rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the State and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates. However, insurers will be asked to report their pharmacy rebates associated with their Medicare line of business. This rebate information can be used in the development of the Medicare market-spending reports so that at least some level of Medicare-related rebates are accounted for.

- **Total Health Care Expenditures per Capita:** THCEs (as defined above) divided by Delaware’s total state population. The annual change in THCE per capita is compared to the spending benchmark at the State level.
- **Total Medical Expense (TME):** The sum of the allowed amount of total claims spending and total non-claims paid to providers incurred by Delaware residents for all health care services. TME is reported at multiple levels: State, market, payer and provider. Payers report TME by insurance category code (e.g., Medicare and Medicare Managed Care and Commercial — Full Claims) and at the provider level whenever possible. TME excludes Medigap members and claims.
- **Total Net Paid Expenditures (for NCPHI):** A term used to refer to an insurer’s actual net paid expenditures for services and benefits for a given Insurance Line of Business code for Delaware residents. To be used in the computation of NCPHI. This includes direct claims or indirect payments for incentives and bonuses, including under capitation contracts, paid to or received by physicians, and other non-physician providers whose services are covered by the policy for services or supplies covered by the policy. Amounts should reflect the insurer paid net of any provider contract discounts, member cost sharing, third party liability, pharmacy rebates, etc. Amounts should be reported on a direct basis, so gross of any private reinsurance arrangements; however, amounts should be adjusted for any federal or state subsidy programs such as state-based reinsurance program payments or accruals in the ACA market (e.g., 1332 waiver program). Amounts should be adjusted for the low-income cost-sharing portion of subsidy payments or accruals in the Medicare Part D program. Report amounts on CY incurred basis, including any remaining incurred but not reported or paid claims reserves. Do not include any quality improvement, claims utilization, and claims processing expenses, premium taxes/assessments, and expenses paid to third-party vendors.

DHCC will annually request TME data file(s) with dates of service during the prior CY, and any other past years upon request.

TME File Submission Instructions and Schedule

TME file layouts for insurers are included in this Appendix. Further file submission instructions will be available on DHCC’s website.

Insurers will be asked to submit TME data on the following schedule:

Insurers’ TME Filing Schedule	
Date	Files Due
September 1, 2021	CY 2019 Final and CY 2020 Initial TME
August 1, 2022	CY 2020 Final and CY 2021 Initial TME
August 1, 2023	CY 2021 Final and CY 2022 Initial TME
August 1, 2024	CY 2022 Final and CY 2023 Initial TME

Insurers are asked to apply the same data extract specifications to the new year of data (e.g., CY 2020) as well as when resubmitting any previous year’s data again (e.g., CY 2019). This will enable better year-over-year comparisons. DHCC acknowledges over time as more benchmark data is collected, there may be instances when the oldest data differs from the newer data due to data

specification changes. DHCC’s goal is to minimize these differences, but data specification changes are expected to occur from time to time. As a result, DHCC may ask insurers to submit more than two years of benchmark data in a future data submission process.

TME Data Submission Specifications

Insurers must report TME data **based on allowed amounts** (i.e., the amount the insurer paid plus any member cost sharing).

Insurers must include only information pertaining to:

- **Members who are residents of Delaware.**
- **Members who, at a minimum, have medical benefits.**³²
- For which **the insurer is primary on a claim** (exclude any paid claims for which the insurer was the secondary or tertiary insurer). Even though an individual enrolled with an insurer can have other forms of health insurance, the reporting of TME data is based on whether the insurer was primary on the respective claim not whether the member had other forms of insurance. For example, for members enrolled in Medicaid managed care who also have Medicare coverage (e.g., dual eligible), the insurer must report as part of its TME data submission the allowed amount for all claims for which it was the primary payer (e.g., a large portion of long-term care services incurred by those members).

Insurance Line of Business Codes

All spending data is to be reported on a consistent basis using the following mutually exclusive Insurance Line of Business codes. Not all insurers are expected to have data reported in all codes.

Line of Business Category Code	Line of Business Category Code Description
901	Individual
902	Large Group, Fully Insured
903	Small Group, Fully Insured
904	Self-insured
905	Student Market
906	Medicare Managed Care (excluding Medicare/Medicaid Duals)
907	Medicaid/CHIP Managed Care (excluding Medicare/Medicaid Duals)
908	Medicare/Medicaid Duals
909	Other

³² Members who only have a non-medical benefit should be excluded as insurers who hold the medical benefit for those members will be making estimates of TME for those non-medical benefits.

Claims Run-Out Period Specifications

Insurers shall allow for a claims run-out period of at least 180 days after December 31 of the prior CY. In other words, CY 2020 spending data should reflect paid claims run-out through at least June 30, 2021. Insurers should apply reasonable and appropriate incurred but not reported/incurred but not paid (IBNR/IBNP) completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest they are reasonable and appropriate.

DHCC prefers insurers use as much claims run-out as possible to minimize the impact of IBNR/IBNP adjustment factors.

When resubmitting CY 2019 data, the insurers should pull this data at or around the same time the new CY 2020 data is summarized. As a result, DHCC expects the resubmitted CY 2019 data to have extensive run-out and thus adjustments for IBNR/IBNP should be immaterial or not applicable.

Non-Claims Payment Run-Out Period Specifications

Similar to claims run-out, insurers shall allow for a non-claims run-out period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation and risk-settlements or other non-claims based payments. Insurers should apply reasonable and appropriate estimations of non-claims liability to each provider reported (including payments expected to be made to organizations not separately identified for TME reporting purposes) expected to be reconciled after the 180 day run-out period.

When resubmitting CY 2019 data, the insurers should pull this data at or around the same time the new CY 2020 data is summarized. As a result, DHCC expects the resubmitted CY 2019 data to have extensive run-out and thus non-claims data should be very complete and accurate.

Partial Claims Data Adjustment

In some cases, an insurer may have Commercial claims data representing full or partial claims. Commercial self-insured or fully insured data for which the insurer is able to collect information on all direct medical claims and subcarrier claims are considered full claims. Commercial data that does not include all medical and subcarrier claims are considered partial claims, and an actuarial adjustment should be made to those claims to allow them to be comparable to full claims. Such an adjustment must use actuarially sound principles and be reviewed with DHCC before the adjustment is made.

Please email DHCC (send to: ayanna.harrison@delaware.gov and DHCC@delaware.gov) with a description of how you propose to make actuarial adjustments to partial claims data to allow them to be comparable to full claims. The description should be detailed and include any underlying assumptions. A thorough and easy to understand description of the adjustment methodology will streamline DHCC's response time. Upon reviewing submissions, DHCC staff will follow up with a confirmation accepting the adjustment process or request additional information as necessary.

The goal of the partial claims data adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve-out vendors, such as pharmacy benefit managers (PBMs) or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending PMPM for the same year, calculated on members who had pharmacy coverage and applied to all member months for which the carve-out applied.

TME Data File Layouts and Field Definitions

Each item below represents a column in the TME Data File Layout insurers will use to submit TME data to DHCC using an excel template provided by DHCC. There are two TME data files insurers must submit: a header record file and a PCP group file. A pharmacy rebate data record will also be submitted. At present, a “record” refers to a tab in DHCC’s excel template. In the future, DHCC may use other methods to collect insurer data such as a web-based platform. Each record element is described below in more detail:

Header Record File (HD-TME)

Insurer Org ID: DHCC-assigned organization ID for the insurer submitting the file.³³

Insurer	DHCC Organizational ID
Aetna	101
AmeriHealth Caritas	102
Cigna	103
Highmark Blue Cross Blue Shield Delaware	104
UnitedHealthcare	105

Period Beginning and Ending Dates: The beginning period represented by the reported data. These dates should always be January 1 and December 31, respectively, unless an insurer newly enters or exits the market during other parts of the year. All reporting is based on the date of service related to the TME data.

Comments: Insurers may use this field to provide any additional information or describe any data caveats for the TME submission.

Health Status Adjustment Tool: The health-status adjustment tool, software or product used to calculate the health-status adjustment score required in the TME file.

Health Status Adjustment Version: The version number of the health-status adjustment tool used to calculate the health-status adjustment score required in the TME file.

“Doing Business As:” Medicare MCOs must submit all names for which it is “doing business as” in the State of Delaware.

Spending Data File

The spending data record file will be the source of the insurer’s expenditure data that will be used by DHCC to compute THCE as well as be used to help compute NCPHI. Insurers will report their permissible claims and non-claims payments in this file. Descriptions of each data-reporting element are provided below.

³³ As noted previously, because the Delaware market may change, this table may need to be updated over time.

Insurance Line of Business Code and Description: A number that indicates the insurance line of business being reported. All data reported by Insurance Line of Business **must be mutually exclusive**.

- If an insurer enrolls Medicare/Medicaid dual eligibles, DHCC is requesting insurers report all relevant data applicable to Medicare/Medicaid dual eligibles in code 908. This will ensure data reported in all the Insurance Line of Business codes is mutually exclusive

Premium Revenues (for NCPHI): Insurer's reported premium revenues for the respective Insurance Line of Business taking into consideration all applicable revenue sources, risk mitigation arrangements, and/or revenue adjustments applicable to Delaware residents. See definition earlier in this Appendix. DHCC will use this field in support of NCPHI, not for purposes of reporting spending data versus the benchmark. This definition is specific to the benchmark process and while similar to other financial reporting requirements, the insurers are reminded the purpose of this field is to facilitate the computation of NCPHI.

Total Net Paid Expenditures (for NCPHI): Insurer's reported total net paid expenditures for all services and benefits for the respective Insurance Line of Business for Delaware residents taking into consideration provider contract discounts, coinsurance, third party liability sources, recoveries, etc. See definition earlier in this Appendix. DHCC will use this field in support of NCPHI not for purposes of reporting spending data versus the benchmark. This definition is specific to the benchmark process, and while similar to other financial reporting requirements, the insurers are reminded the purpose of this field is to facilitate the computation of NCPHI.

Member Months (Annual): The number of unique members participating in a plan each month with at least a medical benefit. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy.

Pharmacy Rebates: The estimated value of rebates attributed to Delaware resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the respective reporting period (e.g., CY 2020 and CY 2019), excluding manufacturer-provided fair market value bona fide service fees.³⁴ This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments or on a claims-by-claim basis). Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the CY for which reporting will be done. If insurers are unable to report rebates specifically for Delaware residents, insurers should report estimated rebates attributed to Delaware resident members in a proportion equal to the proportion of Delaware resident members compared to total members, by line of business. For example, if Delaware resident commercial members represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported. This field should be reported as **a negative number**.

³⁴ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers and PBMs), which represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer, which the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, and patient care management programs).

Health Status Adjustment Score: A value that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must disclose the health-status adjustment tool and version number and calibration settings in the header record.

Insurers are permitted to use a health-status adjustment tool and software of their own choosing, but must disclose the tool (e.g., ACG and DxCG) and the version in the comment fields of the TME data files.

Where possible, payers must apply the following parameters in completing the health-status adjustment:

- The health-status adjustment tool used should correspond to the insurance category reported (i.e., Medicare, Medicaid, commercial).
- Insurers must use concurrent modeling.
- The health-status adjustment tool must be all-encounter diagnosis-based (no cost inputs), output total medical, and pharmacy costs with no truncation.

If an insurer changes its health-status adjustment method and software (including version updates), it must re-report at least one prior year of TME data using the modified health-status adjustment method in order to ensure comparability between years.

Insurers are to provide health status risk adjustment scores, which can be applied in a divisional manner in computing the health status adjusted PMPMs (i.e., Unadjusted TME PMPM/Health Status Risk Adjustment Score = Health Status Risk Adjusted TME PMPM). DHCC intends to only use health risk adjusted spending data when insurer-level data is reported. At the State and market levels, unadjusted spending data will be used.

Claims and Non-Claims Categories

Insurers are to report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive. DHCC may request additional information regarding how insurers mapped their data into these categories to improve consistency in reporting across all insurers:

- **Claims: Hospital Inpatient:** All TME data to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. This does not include payments made for observation services, payments made for physician services provided during an inpatient stay billed directly by a physician group practice or an individual physician or inpatient services at non-hospital facilities.
- **Claims: Hospital Outpatient:** All TME data to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in a hospital admission. This includes observation services. Does not include payments made for physician services provided on an outpatient basis, which have been billed directly by a physician group practice or an individual physician.

- **Claims: Professional, Primary Care:** Please use the following code-level definition to identify primary care spending:
 - Rendering or Servicing Provider Taxonomy = 207Q00000X, 207QA0505X, 207QG0300X, 208D00000X, 207R00000X, 207RG0300X, 208000000X, 261QF0400X, 261QR1300X, 261QP2300X, 363L00000X, 363LA2200X, 363LP0200X, 363A00000X, 363AM0700X, 363LF0000X, 363LG0600X, or 363LP2300X. **Note:** services rendered by specialists with an internal medicine — general subspecialty and an additional internal medicine subspecialty (e.g., cardiology and endocrinology) are not to be included in this service category.

AND
 - Place of Service = 02, 11, 12, 17, 19, 20, 22, 50, and 71.

AND
 - Procedure Code = 90460, 90461, 90471, 90472, 90473, 90474, 96160, 96161, 98966, 98967, 98968, 98969, 99078, 99173, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99339, 99340, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99358, 99359, 99366, 99367, 99368, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99452, 99491, 99495, 99496, 99497, 99498, G0008, G0009, G0101, G0102, G0396, G0397, G0402, G0436, G0437, G0438, G0439, G0442, G0443, G0444, G0463, G0502 - G0507, G2010, S9117, T1015, 99492, 99493, 99494, 99483, 99487, 99489, 99490, G0506, G0511, G0466, G0467, G0468, or G0010.
- **Claims: Professional, Specialty:** All TME data to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the definition above.
- **Claims: Professional, Other:** All TME data from claims to health care providers for services provided by a licensed practitioner other than a physician, but is not identified as primary care in the definition above. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dietitians, dentists and chiropractors.
- **Claims: Pharmacy:** All TME data from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the insurer's medical benefit. **Medicare managed care insurers that offer stand-alone prescription drug plans (PDPs) are asked to exclude stand-alone PDP data from their TME.** Pharmacy data in this category is to be reported gross of applicable rebates. Rebates will be reported separately.
- **Claims: Long-Term Care:** All TME data from claims to health care providers such as skilled or custodial nursing facility services, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living,

personal care (e.g., services in support of activities of daily living), adult day care, respite care, hospice, and private duty/shift nursing services.

- **Claims: Other:** All TME data from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in “Claims: Other” if the insurer is unable to classify the service. If this is the case, the insurer should consult with DHCC about the appropriate placement of the service prior to categorizing it as “Claims: Other.” However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts, whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.
- **Non-Claims: Primary Care Incentive Programs:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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 payments.
- **Non-Claims: Incentive Programs, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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 payments.
- **Non-Claims: Primary Care Capitation:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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.
- **Non-Claims Capitation, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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.
- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made (i.e., risk settlements). Amounts reported as risk settlement should not include any incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.
- **Non-Claims: Primary Care, Care Management:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for “primary care”) for providing care management, utilization review and discharge planning.

- **Non-Claims: Care Management, Other Than for Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for “primary care”) for providing care management, utilization review and discharge planning.
- **Non-Claims: Recovery:** All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as **a negative number**. Only report data in this column not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).
- **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. 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.

Net Cost of Private Health Insurance Related Data Submission

As described further in **Appendix E**, this element captures the costs to Delaware residents associated with the administration of private health insurance. It is defined as the difference between health premiums earned and benefits incurred and consists of insurers’ costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses. **NCPHI is reported as a component of THCE at the state, market, and insurer levels.** As a reminder, NCPHI is described as follows:

- **Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Delaware residents associated with the administration of private health insurance (including Medicare managed care and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers’ costs of paying bills, advertising, sales commissions, and other administrative costs, premium taxes, and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market, and insurer levels.

To support NCPHI, insurers are asked to include in their spending data submission two new data fields:

- Premium Revenues
- Net Paid Expenditures

These two fields may be used by DHCC to compute NCPHI by subtracting Net Paid Expenditures from Premiums Revenues. Descriptions of these fields have been provided previously in this Appendix. DHCC recommends each insurer allow for at least 180 days of run-out before compiling these two data elements so the data is as complete and accurate as practical.

In support of NCPHI calculations, **insurers are asked to still submit their federal commercial medical loss ratio (MLR) reports by September 1** (or the first business day thereafter). Although these reports become publicly available in the fall, insurers will need to submit them September 1 in order to meet the spending benchmark reporting timeline. In an instance in which the MLR report

submitted to DHCC on September 1 differs from the final submission an insurer makes to the federal Center for Consumer Information and Insurance Oversight (CCIIO), the insurer must notify DHCC in writing as soon as possible and submit an updated MLR.

Total Medical Expense File Submission Naming Conventions

TME data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xlsx

YYYY is the data year being reported (e.g., 2020 and 2019). Version indicates the submission number (e.g., 1 = first submission, 2 = second submission).

The file extension must be .xls or .xlsx. DHCC prefers .xlsx.

Below are examples of valid file names:

- DE Health Plan_TME_2019_1.xlsx
- DE Health Plan_TME_2020_2.xlsx

Submitting Files to DHCC

The files should be submitted to ayanna.harrison@delaware.gov and DHCC@delaware.gov.

Appendix B

Division of Medicaid & Medical Assistance TME Data Submission Instructions

$$THCE \text{ per capita} = \frac{\left(\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI} \right)}{\text{Delaware Population}}$$

Definitions of Relevant Key Terms

- **Allowed Amount:** The amount the payer paid plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Health Care Expenditures (THCE).
- **Insurer:** A private health insurance company that offers one or more of the following: commercial insurance benefit administration for self-insured employers, Medicare managed care products and/or are Medicaid/Children’s Health Insurance Program (CHIP) managed care organization (MCO) products. **Unless otherwise stated, references to “the Division of Medicaid & Medical Assistance (DMMA)” or “Medicaid” include CHIP.**
- **Provider:** A term referring to an individual clinician, medical group, accountable care organization (ACO) or similar entities.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.³⁵ The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates). For DMMA, this

³⁵ Fair market value bona fide service fees paid by a manufacturer to a third party (e.g., insurer and pharmacy benefit manager (PBM)), which represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturers the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service feeds, distribution service feeds, and patient care management programs).

would include federal and state supplemental rebates on both managed care and FFS drug claims. This field should be reported as a **negative number**.

- **Total Medical Expense (TME):** The sum of the allowed amount of total claims spending and total non-claims paid to providers incurred by Delaware residents for all health care services. TME is reported at multiple levels: State, market, payer and provider if applicable. Payers report TME by insurance category code (e.g., Medicare and Medicare Managed Care, Commercial — Full Claims) and at the provider level whenever possible. TME excludes Medigap members and claims.

Total Medical Expense Data Overview

This TME data specification provides technical details to assist DMMA in reporting and filing its data to enable the Delaware Health Care Commission (DHCC) to calculate TME. This Appendix can serve as a stand-alone document, which DHCC can distribute as a guide for TME data reporting.

DHCC will annually request TME data file(s) from DMMA of FFS data with dates of service during the prior CY and any other past years upon request. Files will contain two different record types:

- Header, including summary data and DMMA comments.
- TME by program/delivery system.

DMMA's Data Submission

DMMA's TME data submission will include expenditures related to the following:

- **FFS claims expenditures for enrollees in Medicaid managed care, such as:**
 - Wrap-around dental services for children, behavioral health services in excess of managed care coverage limits, etc.
 - This should be accomplished based on aid category code, managed care enrollment indicators and/or other data fields.
- **FFS claims expenditures for individuals not eligible for or not-yet-enrolled in Medicaid managed care, such as:**
 - FFS TME data on Medicaid populations excluded from managed care enrollment (e.g., breast and cervical cancer population).
 - FFS TME data for Medicaid managed care-eligible individuals during their "FFS window" prior to enrollment in managed care.
 - This should be accomplished based on aid category code and/or other eligibility fields.
- **Other DMMA FFS claims expenditures not included in any of the aforementioned categories, such as:**

- FFS expenditures on non-Medicaid populations or programs paid with state-only general funds (e.g., Vaccines for Children program).
- **DMMA's payments to Delaware's Program for All-Inclusive Care for the Elderly (PACE) organization(s) and non-emergent medical transportation (NEMT) vendor(s):**
 - This includes capitation or lump sum payments made to PACE organization(s) or NEMT vendor(s) for Medicaid/CHIP members.
 - PACE and NEMT payments are being reported as non-claims expenses to separate these payments from payments to providers based on claims data.
- **DMMA's other non-claims expenditures:**
 - May be immaterial, but would include any other provider payment not otherwise reported elsewhere.
- **Federal and state supplemental pharmacy rebate collections:**
 - There is a separate file to report DMMA's pharmacy rebate activity. See below for more details.

Any net expenditure from/to DMMA to/from the Medicaid managed care plans (e.g., monthly capitation, maternity supplemental payments, net risk mitigation payments, net incentives/penalties) are **not** to be included in this TME submission in any category.

DHCC may periodically update and revise these data specifications in subsequent versions of this implementation manual.

MCO Financial Data Needed From DMMA to Support NCPHI Calculation

In order for DHCC to calculate NCPHI for Medicaid managed care, DHCC will need copies of select financial report schedules from the Medicaid managed care plans' CY-end audited financial reports. At a minimum, the managed care financial reports DMMA will be requested to provide include:

- Income Statement (e.g., Schedule B in the CY 2019 DMMA managed care financial reporting template).
- HCQI and Administrative Expenses Statement (e.g., Schedule B.1 in the CY 2019 DMMA managed care financial reporting template).
- Footnotes Disclosures Statement (e.g., Schedule C in the CY 2019 DMMA managed care financial reporting template).

DMMA is asked to include copies of the applicable managed care financial reports when DMMA provides its TME data by September 1 (or the next business day) of each year.

TME File Submission Instructions and Schedule

TME file layouts for DMMA are included in this Appendix. Further file submission instructions will be available on DHCC’s website. DMMA will submit this information on an annual basis.

DMMA will submit TME data (and MCO financial report information) on the following schedule³⁶:

DMMA TME Filing Schedule	
Date	Files Due
September 1, 2021	CY 2019 Final and CY 2020 Initial TME
September 1, 2022	CY 2020 Final and CY 2021 Initial TME
September 1, 2023	CY 2021 Final and CY 2022 Initial TME
September 2, 2024	CY 2022 Final and CY 2023 Initial TME

DMMA is asked to apply the same data extract specifications to the new year of data (e.g., CY 2020) as well as when resubmitting the previous year’s data again (e.g., CY 2019). This will enable better year-over-year comparisons. DHCC acknowledges that over time as more benchmark data is collected, there may be instances when the oldest data differs from the newer data due to data specification changes. DHCC’s goal is to minimize these differences, but data specification changes are expected to occur from time to time. As a result, DHCC may ask DMMA to submit more than two years of benchmark data in a future data submission process.

DMMA’s TME Data Submission Specifications

DMMA must report applicable TME data based on **allowed amounts** (i.e., the amount DMMA paid plus any member cost sharing). Pharmacy rebate amounts are the amounts obtained (i.e., received or expected) by DMMA for pharmacy claims incurred in the reporting period.

DMMA must include only information pertaining to:

- Members who are **residents of Delaware**.
- For which **DMMA is the primary insurer on the claim** (exclude any paid claims for which it was the secondary or tertiary insurer). Even though an individual enrolled with DMMA can have other forms of health insurance, the reporting of **TME data is based on whether DMMA was the primary on the respective claim** not whether the member had other forms of insurance. For example, for members enrolled in DMMA FFS who also have other commercial coverage, DMMA must report as part of its TME data submission the allowed amount for all claims for which DMMA was the primary payer on that claim.

³⁶ DMMA should provide copies of the relevant Medicaid MCO financial statements to support NCPHI calculation following this same schedule.

Claims Run-Out Period Specifications

DMMA shall allow for claims payment run-out in the TME data prior to submitting the data files to DHCC. DMMA should not apply completion factors for IBNR/IBNP to its submission. DMMA's TME data files will have a "Data Pull Date" that will document the date as to when DMMA extracted/pulled the data for purposes of completing DHCC data request.

Since DMMA's TME data submission is not due until September 1, DHCC anticipates DMMA can use a minimum of 180 days of run-out (i.e., summarize CY 2020 data with run-out through at least June 30, 2021).

DHCC prefers DMMA use as much claims run-out as possible in order for the data to be as complete and accurate as practical.

When resubmitting CY 2019 data, DMMA should pull this data at or around the same time the new CY 2020 data is summarized. As a result, DHCC expects the resubmitted CY 2019 data to have extensive run-out and thus be complete and accurate.

Non-Claims Payment Run-Out Period Specifications

Similar to claims run-out, DMMA should allow for a non-claims run-out period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation, and risk-settlements or other non-claims based payments. DMMA should apply reasonable and appropriate estimations of non-claims liability to each provider reported (including payments expected to be made to organizations not separately identified for TME reporting purposes) expected to be reconciled after the 180 day run-out period.

When resubmitting CY 2019 data, DMMA should pull this data at or around the same time the new CY 2020 data is summarized. As a result, DHCC expects the resubmitted CY 2019 data to have extensive run-out and thus non-claims data should be complete and accurate.

TME Data File Layouts and Field Definitions

Each item below represents a column in the TME Data File Layout, which DMMA will use to submit TME data to DHCC using an excel template provided by DHCC.

There are two TME data files insurers must submit: a header record file and a provider expenditure record file. A pharmacy rebate data file will also be submitted. Each is described below in more detail:

Header Record File (HD-TME)

DMMA Org ID: For this submission, DMMA is to input "DMMA" as the value for this field.

Period Beginning and Ending Dates: The beginning period represented by the reported data. These dates should always be January 1 and December 31, respectively. All reporting is based on the date of service related to the TME data.

Comments: DMMA may use this field to provide any additional information or describe any data caveats for the TME submission. Additional information/context may be provided by DMMA in supporting documentation, which accompanies its TME data submission.

Data Pull Date: The date data was pulled/extracted by DMMA.

Expenditure Record File

The expenditure record file will be the source of DMMA’s expenditure data used by DHCC to compute THCE. DMMA will report its applicable claims and non-claims payments in this file.

DMMA Org ID: For this submission, DMMA is to input “DMMA” as the value for this field.

Program Code: A code that indicates the program or nature of DMMA TME data being reported.

Program Code	Definition
20	DMMA FFS TME data for Medicaid individuals enrolled in managed care
21	DMMA FFS TME data for Medicaid individuals not eligible or eligible-but-not-yet-enrolled in managed care
22	DMMA TME data on PACE provider(s)
23	DMMA TME data on NEMT vendor(s)
29	Total DMMA TME data for all programs/populations ³⁷

Total Member Months (Annual): The number of members for which DMMA is reporting TME data on over the specified period expressed in member months:

- For Program Code 20, this would be the total number of member months associated with Medicaid managed care enrollment in the reporting period.
- For Program Code 21, this would be the total number of member months associated with the Medicaid individuals not eligible for or eligible-but-not-yet-enrolled in managed care (i.e., individuals in the Medicaid FFS program).
- For Program Code 22, this would be the total number of member months associated with the PACE program.
- For Program Code 23, this would be the total number of member months associated with the NEMT vendor program. Note: This will duplicate other counts as currently most NEMT vendor enrollees are also enrolled in the Medicaid managed care.
- For Program Code 29, this would be the total number of unique member months for all populations DMMA is reporting on (including any populations not already included in any previous program

³⁷ DMMA should use Program Code 29 to report TME data for expenditures not otherwise easily allocated to a specific Program Code. DMMA should use its best judgment as to what category to report the applicable expenditure under (e.g., Non-Claims: Other and Non-Claims: Incentive Programs). DMMA may be asked to provide supplemental information regarding TME data reported. Consistency in reporting these types of expenditures in the same category will be beneficial in evaluating year-to-year changes.

code). This will also include any non-Medicaid/CHIP populations DMMA can readily report data on. In this total, individuals can only be counted once for purposes of computing annual member months. **Therefore, this figure cannot be a simple sum of the member months in the other Program Codes, as this would double count some individuals.**

- Member months reported in Program Code 20, 21 and 22 should be mutually exclusive.

Claims and Non-Claims Categories

DMMA is to report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive. DHCC may request additional information regarding how DMMA mapped their data into these categories to improve consistency in reporting across all payers:

- **Claims: Hospital Inpatient:** All TME data to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay, which have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.
- **Claims: Hospital Outpatient:** All TME data to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis, which have been billed directly by a physician group practice or an individual physician.
- **Claims: Professional, Primary Care:** Please use the following code-level definition to identify primary care spending:
 - Rendering or Servicing Provider Taxonomy = 207Q00000X, 207QA0505X, 207QG0300X, 208D00000X, 207R00000X, 207RG0300X, 208000000X, 261QF0400X, 261QR1300X, 261QP2300X, 363L00000X, 363LA2200X, 363LP0200X, 363A00000X, 363AM0700X, 363LF0000X, 363LG0600X, or 363LP2300X. **Note:** services rendered by specialists with an internal medicine — general subspecialty and an additional internal medicine subspecialty (e.g., cardiology, endocrinology) are not to be included in this service category.

AND

- Place of Service = 02, 11, 12, 17, 19, 20, 22, 50, 71.

AND

- Procedure Code = 90460, 90461, 90471, 90472, 90473, 90474, 96160, 96161, 98966, 98967, 98968, 98969, 99078, 99173, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99339, 99340, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99354, 99355, 99358, 99359, 99366, 99367, 99368, 99381, 99382,

99383, 99384, 99385, 99386, 99387, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99452, 99491, 99495, 99496, 99497, 99498, G0008, G0009, G0101, G0102, G0396, G0397, G0402, G0436, G0437, G0438, G0439, G0442, G0443, G0444, G0463, G0502 - G0507, G2010, S9117, T1015, 99492, 99493, 99494, 99483, 99487, 99489, 99490, G0506, G0511, G0466, G0467, G0468, or G0010.

- **Claims: Professional, Specialty:** All TME data to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, **not** defined as primary care in the definition above.
- **Claims: Professional, Other:** All TME data from claims to health care providers for services provided by a licensed practitioner other than a physician, but is **not** identified as primary care in the definition above. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dietitians, dentists and chiropractors.
- **Claims: Pharmacy:** All TME data from claims to health care providers for prescription drugs, biological products or vaccines as defined by DMMA's prescription drug benefit. This category should not include claims paid for pharmaceuticals under DMMA's medical benefit.
 - **Pharmacy data in this Claims category must be reported gross of pharmacy rebates.**
 - DMMA will report pharmacy rebates **separately** to enable attribution of rebates to each Medicaid MCO versus FFS (if practical).
 - Medicare Part D claw back payments are not to be reported in any category.
 - Delaware Prescription Assistance Program payments are not to be reported in any category.
- **Claims: Long-Term Care:** All TME data from claims to health care providers such as skilled or custodial nursing facility services, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living, personal care (e.g., services in support of activities of daily living), adult day care, respite care, hospice, and private duty/shift nursing services.
- **Claims: Other:** All TME data from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if DMMA is unable to classify the service. However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts, whether given to the provider or given in the form of a capitated payment to an organization that assists DMMA with enrolling members in gyms is not a valid payment to include.
- **Non-Claims: PACE:** Medicaid payments made to PACE organizations. The total amount is to be reported for Program Code 22 only.

- **Non-Claims: NEMT:** Medicaid payments made to the NEMT vendor(s). The total amount is to be reported for Program Code 23 only.
- **Non-Claims: Primary Care Incentive Programs:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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 payments.
- **Non-Claims: Incentive Programs, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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 payments.
- **Non-Claims: Primary Care Capitation:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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.
- **Non-Claims Capitation, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for “primary care”) 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.
- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made (i.e., risk settlements). Amounts reported as risk settlement should not include any incentive or performance bonuses paid separately and can be separately reported as Non-Claims: Incentive Program.
- **Non-Claims: Primary Care, Care Management:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for “primary care”) for providing care management, utilization review and discharge planning.
- **Non-Claims: Care Management, Other Than for Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for “primary care”) for providing care management, utilization review and discharge planning.
- **Non-Claims: Recovery:** All payments received from a provider, member/beneficiary or other payer distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as **a negative number**. Only report data in this column not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).
- **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, which cannot be properly classified elsewhere. 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; however, it should not include funds made to insurers as a pass-through payment. Payments to qualifying hospitals of Delaware’s supplemental Disproportionate Share Hospital allotment monies applicable to the reporting period are to be included in this category.

- **Reserved:** There are data elements “Reserved” in the file layout. These are fields reserved for possible future use.

Pharmacy Rebate Record File

The pharmacy rebate record file will be the source of the DMMA’s pharmacy rebate data for Medicaid FFS, Medicaid MCOs, and any other program or population for which DMMA obtains pharmacy rebates. DMMA is to collectively report both federal and state supplemental rebates.

Rebate Program Code: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed to:³⁸

Program Code	Definition
50	AmeriHealth Caritas Medicaid Claims (if practical)
51	Highmark Health Options Medicaid Claims (if practical)
55 ³⁹	Total Medicaid Managed Care Claims
56	Other Medicaid Managed Care Claims (e.g., PACE) — use only if applicable
57	FFS Medicaid Claims (i.e., not any form of managed care)
59	Total DMMA rebates for all programs/populations (inclusive of all rebates reported in other Rebate Program Codes plus any other DMMA rebates DMMA is able to report on)

Pharmacy Rebates: The estimated or actual value of total federal and state supplemental rebates attributed to Delaware resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding to the period beginning date through end date of the respective CY, excluding manufacturer-provided fair market value bona fide service fees.⁴⁰ This amount shall include rebate guarantee amounts and any additional rebate amounts. Total rebates should be reported without regard to how they are paid to DMMA (e.g., through regular aggregate payments and on a claims-by-claim basis). DMMA has indicated the potential ability to report rebates applicable to each Rebate Program Code (e.g., AmeriHealth, Highmark, FFS, and other). However, if DMMA is unable to report rebates specifically for Delaware residents by these Rebate Program

³⁸ If, in the future, DMMA contracts with different managed care plans, these codes will need to be revised.

³⁹ If DMMA is not able to allocate or report pharmacy rebates attributable to the individual managed care plans’ claims (i.e., using codes 50 and 51), then report all rebates associated with managed care claims in code 55. If DMMA is unable to separately report rebates applicable to managed care versus FFS, then report all rebates in code 59.

⁴⁰ Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers and PBMs) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer, which the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, and patient care management programs).

Codes, DMMA can report all rebates obtained under the total code 59. This field should be reported as **a negative number**.

The source of pharmacy rebates may be DMMA's "rebate system." DMMA will determine the most appropriate data source to use.

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

DMMA_TME_YYYY_Version.xlsx

YYYY is the data year being reported (e.g., 2020, 2019). Version indicates the submission number (e.g., 1 = first submission, 2 = second submission).

The file extension must be .xls or .xlsx. DHCC prefers .xlsx.

Below are examples of valid file names:

- DMMA_TME_2019_1.xlsx
- DMMA_TME_2020_2.xlsx

Submitting Files to DHCC

The files should be submitted to ayanna.harrison@delaware.gov and DHCC@delaware.gov.

Appendix C

Medicare FFS TME Data Collection Process

$$THCE \text{ per capita} = \frac{\left(\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} \right. \\ \left. + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI} \right)}{\text{Delaware Population}}$$

DHCC will be able to receive TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2020 data should be available by September 1, 2021). CMS believes data will be at least 90% complete by September 1.

Specifically, CMS will share total program payments and cost sharing for the following services:

- Hospital Inpatient
- Hospital Outpatient
- Non-hospital Outpatient
- Home Health Agency
- Hospice
- Skilled Nursing Facility
- Physician⁴¹
- Other Professionals
- Durable Medical Equipment
- Other Suppliers

⁴¹ CMS traditionally has not separated physician expenditures into Primary Care and Specialty; therefore, only one category is being listed. This will make comparison to other markets difficult.

- Part D⁴²

To enable better comparisons to other payers or markets, CMS services are mapped to the TME reporting categories as follows:

Medicare Service Categories	TME Service Mapping
Hospital Inpatient	Hospital Inpatient
Hospital Outpatient	Hospital Outpatient
Non-Hospital Outpatient	Other
Home Health Agency	Long-Term Care
Hospice	Long-Term Care
Skilled Nursing Facility	Long-Term Care
Physician	Professional Primary Care and Professional Specialty Care
Other Professionals	Professional Other
Durable Medical Equipment	Other
Other Suppliers	Other
Part D	Pharmacy

CMS will also share enrollment figures for Medicare Parts A, B and D broken out between managed care and FFS. Please note that CMS reports beneficiaries based on the resident location as of the end of the CY.

Medicare Part D Pharmacy Data

Because the CMS-provided Medicare spending data on Part D includes expenditures for FFS beneficiaries, beneficiaries enrolled in Medicare Advantage (MA) managed care (MA-only or MAPD plans) and beneficiaries in stand-alone Part D prescription drug plans (PDPs), DHCC must take the following steps to report Medicare pharmacy spend data correctly:

⁴² As part of the TME data received from CMS, CMS will be providing Delaware Part D data for individuals enrolled in FFS stand-alone PDPs as well as Medicare managed care enrollees in MAPD or MA-only plans.

- When reporting Medicare prescription drug spending at the State or Medicare **market** level, only use the CMS reported Part D Total Expenditures data to avoid double counting what insurers might also report in their respective TME submissions.
 - For Part D, the “Total Expenditures” line will be greater than the sum of the “Program Payments” and “Cost Sharing” because the “Total Expenditures” line includes spending by other entities on behalf of the beneficiary, which CMS recognizes as a valid Part D expense. While it is possible some of this other spending is being reported to DHCC by other payers, we believe the impact of this is minimal and hence it is more accurate to use the “Total Expenditures” line to better capture as much of the Part D-related spending as practical.
- When reporting Medicare prescription drug spending at the **insurer** level, use the prescription drug spending reported by the respective Medicare insurer.
- Medicare FFS pharmacy rebate data is not available (i.e., the CMS Medicare pharmacy spend data will be gross of rebates and no rebate dollars provided).
- CMS also does not provide Medicare managed care pharmacy rebate data.
- Therefore, the only source of any Medicare-related pharmacy rebates is the rebate data reported by the insurers for their Medicare managed care business. At the State and market level, Medicare rebates will be under-reported due to CMS not providing rebates for Medicare FFS, but using the insurers’ self-reported Medicare rebates will at least provide some consideration of rebates. At the insurer level reporting, use the insurers’ rebate information.

DHCC Steps to Request Medicare Data

To receive Medicare FFS TME data from CMS, DHSS needs to make a formal request to CMS by emailing the CMS template (see Attachment 1) to Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copying: CMSProgramStatistics@cms.hhs.gov.

CMS has specifically requested Delaware staff (not a contractor) make the official request. CMS is willing to share the data with DHCC by September 1 if the data request is made by June 1.

Appendix D

VHA TME Data Collection Process

$$THCE \text{ per capita} = \frac{\left(\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} \right. \\ \left. + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI} \right)}{\text{Delaware Population}}$$

Statistics on Delaware veteran health care spending is published in the summer by the Veterans Health Administration (VHA) National Center for Analysis and Statistics. DHCC can access the information here: www.va.gov/vetdata/Expenditures.asp and download the relevant year's expenditure tables. The figure "Medical Care" is what should be reported as "VHA TME" for purposes of the benchmark.

Per the notes on the VHA expenditure report, "Medical Care" includes expenditures for medical services, medical administration, facility maintenance, educational support, research support and other overhead items. Medical care expenditures do not include dollars for construction or other non-medical support.

It is important to note that VHA expenditure report data is reported on a federal fiscal year basis (October–September) and not on a CY basis. Therefore, DHCC should utilize the federal fiscal year that contains nine months of the reporting CY (e.g., federal fiscal year ending 2020 data should be used as the proxy for CY 2020 data). This is not consistent with the reporting from other payers who will report on a CY basis and should be footnoted as such, but it is not expected to make a large impact.

More detailed TME data on veterans has not been identified yet. If other sources of veterans' data are identified in the future, this implementation manual will need to be updated.

VHA TME is only reported at the State level. Service category detail has not been available in the VHA expenditure report only the total for all "Medical Care." Therefore, when reporting data at the service category level, VHA data will have to be excluded.

Appendix E

NCPHI Data Specification

$$THCE \text{ per capita} = \frac{\left(\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI} \right)}{\text{Delaware Population}}$$

Net Cost of Private Health Insurance

This element captures the costs to Delaware residents associated with the administration of private health insurance. The description of NCPHI is as follows:

- Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Delaware residents associated with the administration of private health insurance (including Medicare managed care and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels.

NCPHI is reported as a component of THCE at the State, market and insurer levels. NCPHI will not be reported at the provider level.

Because of substantial differences among segments of the Delaware health insurance market, NCPHI will be calculated on a PMPM basis separately for the following insurance line of business codes as applicable to Delaware insurers (i.e., not all lines of business will be applicable to each insurer):

Insurance Line of Business Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self insured
905	Student market
906	Medicare managed care (excluding Medicare/Medicaid Dual Eligibles)
907	Medicaid managed care (excluding Medicare/Medicaid Dual Eligibles)
908	Medicare/Medicaid Dual Eligibles
909	Other

The revised benchmark spending Excel template will ask insurers to submit their Premium Revenues and Net Paid Expenditures for use in computing NCPHI. Each insurer will also submit member months.

- **Premium Revenues (for NCPHI):** A term used to refer to an insurer's total premium revenues for a given Insurance Line of Business code for Delaware residents. To be used in the computation of Net Cost of Private Health Insurance. Total premium revenue means all monies paid by a policyholder, subscriber, or third party as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan. Amounts should be reported on a direct basis, so gross of any private reinsurance arrangements and on CY earned basis. Include advance payments of the premium tax credit, other type of federal subsidies (e.g., premium portion of low income subsidy in Medicare Part D program), risk sharing or risk mitigation arrangement payments/accruals or retrospective premium adjustments (e.g., estimated or reported risk adjustment transfer payments or risk corridor transfers in the ACA or Medicare programs where applicable) and any state-based premium subsidies. Include MLR rebate payments or accruals and any experience rated premium adjustments. For fully insured employer sponsored coverage, include the total of employee and employer share of premium cost. For self-insured plans, include any income from administrative expenses and fees. Exclude investment income or revenues not directly related to the cost of providing the health plan coverage. Direct reimbursements for ACA Section 9010 Fees (i.e., Health Insurer Provider Fees) received from the State of Delaware should not be included.
- **Total Net Paid Expenditures (for NCPHI):** A term used to refer to an insurer's actual net paid expenditures for services and benefits for a given Insurance Line of Business code for Delaware residents. To be used in the computation of NCPHI. Include direct claims or indirect payments for incentives and bonuses, including under capitation contracts, paid to or received by physicians, and other non-physician providers whose services are covered by the policy for services or supplies covered by the policy. Amounts should reflect the insurer paid net of any provider contract discounts, member cost sharing, third party liability, pharmacy rebates, etc. Amounts should be reported on a direct basis, so gross of any private reinsurance arrangements; however, amounts should be adjusted for any federal or state subsidy programs such state-based reinsurance program payments or accruals in the ACA market (e.g., 1332 waiver program). Amounts should be adjusted for low-income cost sharing portion of subsidy payments or accruals in the Medicare Part D program. Report amounts on CY incurred basis including any remaining incurred but not reported or paid claims reserves. Do not include any quality improvement, claims utilization and claims processing expenses, premium taxes/assessments, and expenses paid to third-party vendors.

To the extent that these data fields provide the necessary data, NCPHI can be computed by subtracting the Net Paid Expenditures from the Premium Revenues for each insurance line of business code as shown in the formula below:

$$\text{NCPHI PMPM} = (\text{Premium Revenues} - \text{Total Net Paid Expenditures}) / \text{Member Months}$$

However, for validation purposes and as an alternative means to compute NCPHI, the following methodology and data sources can still be used:

Individual, Small Group, Fully Insured, Large Group, Fully Insured, and Student Markets (Collectively “Commercial Fully Insured Market”)

The federal commercial medical loss ratio (MLR) reports will be used to calculate NCPHI for the commercial fully insured market and need to be requested from the insurers as part of their TME data submission, or obtained from CMS Center for Consumer Information and Insurance Oversight (CCIIO).⁴³ These reports become publicly available in the fall, but should be requested from insurers when they submit their TME data in order to meet the spending benchmark reporting timeline. In an instance in which the MLR report submitted to DHCC on the TME deadline differs from the final submission an insurer makes to CCIIO, the insurer must notify DHCC in writing as soon as possible. The data elements that will be used in the calculation are detailed below:

NCPHI Dollar Value = Premium as of March 31 (Part 1 Line 1.1) — [Total Incurred Claims as of March 31 (Part 1, Line 2.1) - Advance Payments of Cost Sharing Reductions (Part 2, Line 2.18)] - MLR Rebates Current Year (Part 3, Line 6.4)

NCPHI PMPM = NCPHI Dollar Value / Member Months (as reported in the insurer’s TME data⁴⁴)

Medicare Managed Care Market (i.e., Medicare Advantage Plans)

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners will be used to derive NCPHI of the Medicare Advantage market. The Medicare Advantage reporting combines stand-alone prescription drug plans (PDPs) and the Medicare Advantage plans with Part D inclusion (MAPDs). Therefore, insurers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims and member months for PDP and MAPD. Insurers must also submit names for which they are doing business as for Medicare and Medicare Advantage on an annual basis.

The data elements that will be used in the calculation are detailed below:

NCPHI Dollar Value = Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)

NCPHI PMPM = NCPHI Dollar Value / Member Months (as reported in the insurer’s TME data)

Medicaid Managed Care Market

This market includes government programs such as Medicaid Title XIX, CHIP Title XXI risk contracts and other federal or state government-sponsored coverage. Medicaid managed care plans participating in this market complete a financial reporting template on a quarterly basis, which reports financial experience. DMMA is responsible for the development of these required financial reporting templates. To support NCPHI calculation, DHCC will need to request from DMMA the applicable

⁴³ Available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html> Last accessed April 15, 2020.

⁴⁴ DHCC should not use the member months reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the spending benchmark is intended to capture Delaware residents. By using member months reported by market segment within the TME data, DHCC will be assuming the experience of the insurer across all of its Delaware business (regardless of whether it insurers a member from another state) is the same experience as Delaware residents.

financial report(s), which contain(s) the necessary information. At a minimum, the Medicaid MCO financial reports, which DHCC will need to obtain from DMMA are:⁴⁵

- Income Statement (e.g., Schedule B in the CY 2019 DMMA MCO financial reporting template).
- HCQI and Administrative Expenses Statement (e.g., Schedule B.1 in the CY 2019 DMMA MCO financial reporting template).
- Footnotes Disclosures Statement (e.g., Schedule C in the CY 2019 DMMA MCO financial reporting template).

DHCC can request DMMA include the financial report data when DMMA provides their TME data by September 1 of each year.

The data contained in the Medicaid MCO's financial statements will be used to derive NCPHI for the Medicaid MCO market. Specifically, DHCC can use the MCOs' year-end audited income statement to derive NCPHI as follows:

NCPHI Dollar Value = [TOTAL REVENUE (line 9) – Investment Income (line 7)] – [Total Medical Expenses & HCQI Expenses (line 70) – Total Healthcare Quality Improvement (line 69)]
NCPHI PMPM = NCPHI Dollar Value / Member Months (from line 1 of the MCO's Income Statement)

Since DMMA will occasionally revise the Medicaid MCO financial reporting templates, DHCC will need to confirm with DMMA the appropriate line number and statement name used to obtain the data necessary for NCPHI calculation. DHCC should contact Josh Aidala, josh.aidala@delaware.gov, or the current Health Care Cost Containment Specialist at DMMA.

Footnote 18 on the "C-Footnotes" tab should be reviewed. If a premium deficiency reserve is implicitly included in the values in the income statement, which is rare, adjustments may be needed after consulting with an individual with expertise in MCO financial statements.

Self-Insured Market

The SHCE will be used to derive NCPHI of the self-insured market. The formula will be:

NCPHI Dollar Value = Income from fees of uninsured plans (Part 1, Line 12)

NCPHI PMPM = NCPHI Dollar Value / Member Months (as reported in the insurer's TME data)

The table below provides the columns associated with each line of business/market in the SHCE and the MLR reports.

⁴⁵ DMMA will occasionally revise the Medicaid managed care financial reports, which may alter the schedule sequencing and Line item references. DHCC will need to confirm the current schedule labels each year with DMMA.

Line of Business/Market	SHCE Column	MLR Column (Parts 1 and 2)	MLR Column (Part 3)
Individual	N/A	2	4
Small Group, Fully Insured	N/A	7	8
Large Group, Fully Insured	N/A	12	12
Student	N/A	36	36
Medicare Managed Care	12	N/A	N/A
Medicaid Managed Care	10	N/A	N/A
Self-Insured	14	N/A	N/A

Aggregate NCPHI

Upon calculating each market segment NCPHI, DHCC will need to calculate the aggregate NCPHI. To do so, first commercial data need to be adjusted to use in situ information. Do so by calculating the average NCPHI PMPM by market segment, adding the total NCPHI by insurer within the segment and then dividing it by the total member months as reported in the MLR report. Next, take the newly calculated average NCPHI PMPM and multiply it by each insurer's market segment member months as reported within the TME submission to get NCPHI for each insurer within each market segment.

Now that data are comparable, each segment's PMPM amount should be multiplied by the Delaware resident market enrollment member months, in each segment, as reported within the TME submission.

Appendix F

Delaware Total Population Count

$$THCE \text{ per capita} = \frac{\left(\text{Commercial TME} + \text{Medicare Managed Care TME} + \text{Medicaid Managed Care TME} \right. \\ \left. + \text{DMMA TME} + \text{Medicare FFS TME} + \text{VHA TME} + \text{Insurer NCPHI} \right)}{\text{Delaware Population}}$$

The denominator of the THCE per capita calculation is the Delaware State population count for the respective reporting period. The source of the Delaware population value is the U.S. Census Bureau estimates.

There are links to these estimates on the websites of the [Office of State Planning Coordination](#) and the [Delaware Census Data Center](#). The most recently available census figures, which will be a snapshot in time figures (not full year estimates) for the measurement year, should be used as the “Delaware Population” figure in the THCE per capita formula listed below.

Appendix G

Insurer Quality Data Submission Instructions

Delaware has established health care quality benchmark values that foster accountability for improved health care quality in the State. The purpose of this Appendix is to provide instructions for insurer submission of their quality measure data. For additional information on the quality measures, please refer to section 5 and 6 of the implementation manual.

Insurers are asked to provide quality data for the following measures at both the health insurer level and provider level, by line of business for Delaware residents. Data for other quality measures will be obtained from other data sources.

Measure	Specification	Lines of Business	Reporting Unit
EDU	HEDIS®, version corresponding to performance period	• Commercial	• Insurer • Provider
Statin therapy for patients with cardiovascular disease — statin adherence 80%		• Commercial • Medicaid	• Insurer • Provider
Persistence of beta-blocker treatment after a heart attack		• Commercial • Medicaid	• Insurer • Provider

Quality Benchmark Data Submission Template

One “Quality Benchmark Data Submission Template” should be submitted per health insurer. The template should contain all health insurer and provider-level information requested of the health insurer **with at least 180 days of claims runout**. Include data on Delaware residents only.

The “Quality Benchmark Data Submission Template”, refer to **Attachment 3**, contains one tab payers should complete: “Quality Performance.” Illustrative examples are provided in rows 11 and 12 of the accompanying spreadsheet.

- **Cell C3** requests the CY for which performance is being submitted.
- **Columns B–F** ask for the submitter’s contact information.
- **Column H** asks for the name of the entity for which the performance is being reported in a given row.

- **Column I** requests the payer select the reporting level for which it is reporting data in the associated row: “Health Insurer” or “Provider.” The template is set up so that only one option may be selected per row.
- **Column J** requests the payer select the line of business for which it is reporting data in the associated row: “Commercial” or “Medicaid.” The template is set up so only one option may be selected per row.
- **Column K** asks for membership information for the line of business being reported. If "Health Insurer" is selected in column I, please submit health insurer enrollment in member months. If "Provider" is selected in column I, please submit provider-attributed lives in member months.
- **Columns L–T** ask for the measure performance data by measure:
 - **Column L**, EDU Observed-to-Expected Ratio requests input of the observed-to-expected ratio.
 - **Columns N-P** Persistence of Beta-Blocker Treatment after a heart attack request numerator and denominator information.
 - **Columns R-T** Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80% request numerator and denominator information.

Quality Data File Submission Schedule

Insurers are asked to submit their quality data on the following schedule:

Insurers’ Quality Data Filing Schedule	
Date	File Due
September 1, 2021	CY 2020 quality data
September 1, 2022	CY 2021 quality data
September 1, 2023	CY 2022 quality data
September 2, 2024	CY 2023 quality data

File Submission Naming Conventions

Quality data submissions should follow the following naming conventions:

Insurer Name_QM_YYYY_Version.xlsx

YYYY is the data year being reported (e.g., 2021, 2020). Version indicates the submission number (e.g., 1 = first submission, 2 = second submission).

The file extension must be .xls or .xlsx. DHCC prefers .xlsx.

Below are examples of valid file names:

- DE Health Plan_QM_2020_1.xlsx
- DE Health Plan_QM_2020_2.xlsx

Submitting Files to DHCC

The files should be submitted to ayanna.harrison@delaware.gov and DHCC@delaware.gov.

Appendix H

Insurer Attestation

Attestation of the Accuracy and Completeness of Reported Data

Instructions: Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation. Insurers should submit one “Attestation of the Accuracy and Completeness of Reported Data” per performance period covering both the spending and quality data. Scanned copies of the signed attestation(s) can be emailed to ayanna.harrison@delaware.gov and DHCC@delaware.gov. If an insurer resubmits their spending and/or quality data, a new, signed attestation form will need to accompany the resubmitted data.

Insurer: _____

Performance Period Being Reported: _____

Check Box(es) to which Attestation Applies: Spending Data Quality Data

Pursuant to Delaware’s establishment, monitoring and implementation of annual Health Care Spending and Quality Benchmarks under Governor Carney’s Executive Order 25 and State-defined reporting guidelines, certain health insurers operating in the State of Delaware must annually submit certain data requested to calculate insurer and provider performance relative to Delaware’s health care spending and quality benchmarks.

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under any applicable state laws. Failure to sign this Attestation of the Accuracy and Completeness of Reported Data will result in DHCC non-acceptance of the attached reports.

Signature

Date

Printed Name

Title

Appendix I

Calculating National Performance Benchmarks

If there is a substantive change to a methodology DHCC should calculate the national performance benchmarks for each measure using the guidelines below:

Measure	Steps to Obtain National Performance
Health Status Measures	
Adult obesity	<p>Obtain national rates from the CDC BRFSS webpage (www.cdc.gov/brfss/index.html).</p> <ul style="list-style-type: none"> • Select “Prevalence Data and Analysis Tools,” then “Prevalence & Trends Data.” <ul style="list-style-type: none"> – Under “Explore BRFSS Data By Location” select: <ul style="list-style-type: none"> – States and Territories: All States and DC. – Once redirected, select the following options: <ul style="list-style-type: none"> – States and Territories: All States, DC and Territories. – Class: Overweight and Obesity (BMI). – Topic: BMI Categories. – Selected Year: [Prior Year/Measurement Year]. <p>Once redirected, hover over the “Obese (30.0-99.8)” bar in the bar chart to see the national rate.</p>
Opioid-related overdose deaths	<p>Obtain national rates from the CDC Wonder’s Multiple Cause of Death (MCD) mortality files (http://wonder.cdc.gov/mcd-icd10.html).</p> <ul style="list-style-type: none"> • Click “I Agree” under the data use restriction and sanctions for violating rules language. • Select the following filters: <ul style="list-style-type: none"> – Organize table layout: <ul style="list-style-type: none"> – Group Results by: State. – And by year. – Measures: Deaths, Population, Crude Rate and Age-Adjusted Rate. <ul style="list-style-type: none"> – Select location: – Click a button to choose locations by State, Census Region or HHS Region: State. – Browse: All (The U.S.). <ul style="list-style-type: none"> – Select demographics: – Pick Between: Ten-Year Age Groups, All Ages. – Gender: All Genders.

Measure	Steps to Obtain National Performance
	<ul style="list-style-type: none"> – Race: All Races. – Hispanic Origin: All Origins. <ul style="list-style-type: none"> – Select year and month: – Year/Month: [Prior Year/Measurement Year]. – Select weekday, autopsy and place of death: – Weekday: All Weekdays. – Autopsy: All Values. – Place of Death: All Places. <ul style="list-style-type: none"> – Select underlying cause of death: – Click a button to select ICD codes by Chapters or by Group: UCD — Drug/Alcohol Induced Causes. – Browse: Drug-induced causes. <ul style="list-style-type: none"> – Select multiple cause of death: – Click a button to select ICD codes by Chapters or by Groups: MCD-ICD-10 Codes. – Browse and click “Move Items Over” for: Opioids: T40.0, T40.1, T40.2, T40.3, T40.4 or T40.6. <ul style="list-style-type: none"> – Other options: – Check “Show results.” – Precision: select “1” decimal place. <ul style="list-style-type: none"> – Click “Send.” – Click the “Results” tab and scroll to the “Total” row at the bottom and use the “Age-Adjusted Performance Rate per 100,000” for national performance.
Health Care Measures	
EDU	<p>To obtain the national commercial rate for this measure, DHCC staff need to contact NCQA.</p> <ul style="list-style-type: none"> • The national average EDU observed-to-expected ratio and the national average EDU observed rate could be purchased from NCQA either through an existing consultant contractor or directly from NCQA. To contact NCQA, email Chris Carrier (carrier@ncqa.org) and Samantha Firetti (firetti@ncqa.org) and ask for the national average EDU observed rate for the Prior Years and Measurement Year of interest. The national average observed rate must be obtained through NCQA, as it is not available publicly. • Calculate the national fiftieth percentile risk standardized rate for a given prior year or measurement year by dividing the national fiftieth percentile observed-to-expected ratio by the national risk-standardized rate.

Measure	Steps to Obtain National Performance
Persistence of beta-blocker treatment after a heart attack	<p>Obtain the national rate from Quality Compass (https://www.qualitycompass.org/QcsExternal/Login.aspx). The Quality Compass tool requires purchase of a license for use for each line of business. Please note, these steps will have to be done twice, once for commercial and once for Medicaid.</p> <ul style="list-style-type: none"> • Log in, “Accept” the license agreement and select the commercial/Medicaid license applicable for the Prior Year/Measurement Year of interest. <ul style="list-style-type: none"> – The licenses use HEDIS years, so subtract one from the year to find the appropriate Prior Year/Measurement Year equivalent (for example, if you would like to look at 2019 commercial rate, select the “2019 Commercial” license). – Select “Exporter/Standard Downloads” then select “National Benchmarks” to download a zip file. – Open the zip file and select the “National Benchmarks” excel comma separated values files. – Filter column B “MeasureName” by “Persistence of Beta-Blocker Treatment After a Heart Attack.” – Filter column G “AverageName” by “National — All LOBs: Average” for commercial or by “National — HMO: Average” for Medicaid. <ul style="list-style-type: none"> – Use the fiftieth percentile rate in column N as the national rate.
Statin therapy for patients with cardiovascular disease — statin adherence 80%	<p>Follow the steps above, but instead in step D, Filter column B “MeasureName” by “Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80% — Total.”</p>

Appendix J

List of Attachments

In addition to this information and instructions contained in this implementation manual, DHCC is also providing payers Excel templates for payers to use to submit their benchmark data, respectively. These templates are referred to as **Attachments** to the implementation manual and are available on DHCC's website: <https://dhss.delaware.gov/dhcc/global.html>

The current Attachments are as follows:

- Attachment 1: This is the data template for obtaining Medicare spending and enrollment data from CMS.
- Attachment 2: This is the data template for insurers to use/complete for submitting their spending data.
- Attachment 3: This is the data template for insurers to use/complete for submitting their quality data.
- Attachment 4: This is the data template for DMMA to use/complete for submitting their spending data.

Changes to these Attachments and/or new Attachments may be incorporated into future versions of this implementation manual.