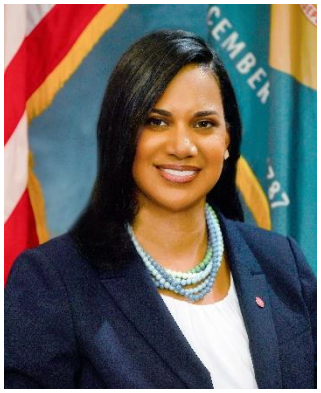
HEALTH WEALTH CAREER

DELAWARE HEALTH CARE SPENDING AND QUALITY BENCHMARKS

IMPLEMENTATION MANUAL VERSION 1.2

JUNE 6, 2019

State of Delaware



Delaware Health and Social Services

Office of the Secretary

A Note to Delaware's Health Care Stakeholders

The State of Delaware is continuing along our "Road to Value" for our entire health care system. In signing Executive Order 25 in November 2018, Governor John Carney laid out a vision for improving the transparency and public awareness of health care spending and quality in our State through the adoption of spending and quality benchmarks. The Department of Health and Social Services is excited to help champion the implementation of the benchmarks, along with our State partners at the Delaware Health Care Commission and the Delaware Economic and Financial Advisory Council. Additionally, this effort would not have been possible without the valued contribution of our state's health care leaders and other subject-matter experts.

Our collective progress on the "Road to Value" shows that we are still early in our efforts. However, implementing the health care cost and quality benchmarks is a necessary step forward in focusing on total cost of care. Unfortunately, on the current trajectory affordability is already threatened and will only worsen in the coming years. Additionally, the benchmarks allow us to focus on and measure the impacts of chronic disease. This constellation of health conditions becomes more prevalent each year based on the combination of an aging population, the effect of primary care access as it intersects the impact of poverty on the health of our most vulnerable residents, and the increasing prevalence of illnesses related to substance use disorder and obesity across many demographics of Delaware's population.

The enclosed implementation manual is a milestone achievement for our State. This manual lays out the technical steps to implement the benchmarks and provides a road map for the important activities that will be occurring in the future. The Department acknowledges that this manual will inevitably undergo changes as we gain more hands-on experience. We all are looking forward to learning what the benchmarks will tell us about the spending on health care in our state, and adding to our knowledge about health care quality.

While this manual represents a significant achievement, much work is yet to come to operationalize fully the benchmark data collection and public reporting processes. Working together, we can support the goal of making sure Delawareans can access and afford quality health care. The benchmarks are the start to a conversation about how to improve cost and quality for the individuals we serve as patients and members in our communities.

Sincerely,

Kara Odom Walker, MD, MPH, MSHS
Cabinet Secretary

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OVERVIEW

Governor Carney established health care spending and quality benchmarks in Executive Order 25 issued on November 20, 2018. This implementation manual contains the technical and operational steps that 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 Executive Order 25. This manual contains the methodologies for setting the health care spending and quality benchmarks, and the methodologies for calculating performance against the benchmarks. It also contains the technical specifications for data reporting and collection.

The document is outlined as follows:

Chapter 2: Health Care Spending Benchmark Definition and Methodology

Chapter 3: Methodology for Assessing Performance Against the Spending Benchmark

Chapter 4: Health Care Quality Benchmarks Definitions and Methodologies

Chapter 5: Methodologies for Assessing Performance against the Quality Benchmarks

Appendix A. Insurer TME Data Specification

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HEALTH CARE SPENDING BENCHMARK DEFINITION AND METHODOLOGY

Definition: The health care spending benchmark (Spending Benchmark) is the target annual per capita growth rate for Delaware's total health care spending, expressed as the percentage growth from the prior year's per capita spending. The Spending Benchmark is set on a calendar year (CY) basis.

Methodology: Executive Order 25 sets the Spending Benchmark 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%

As specified in Executive Order 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 CYs 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 1.

Table 1. Sources for PGSP Formula

COMPONENTS	SOURCE
Expected growth in national labor force productivity	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 CBO's Projections of Real Potential GDP* that includes the potential labor force productivity projected average annual growth. For example, see page 13, Table 2 of the August 2018 report for the values from 2023–2028. The figure used to calculate PGSP should be the value that is forecasted for five and 10 years into the future.
Expected growth in the state civilian labor force	The source is the most recently published *Population Projections by Single Year, Age, Race and Sex* from the **Delaware Population Consortium**. To calculate the expected growth in the state civilian labor force, one must calculate the average percentage change in civilian labor force growth for five and 10 years into the future. For example, in 2018, the average annual growth was calculated by averaging the percentage growth for years 2023 through 2028.
Expected national inflation	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. For example, see page 5, Table 1 of the August 2018 report for CYs 2023 to 2028. 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.

[1] As of January 22, 2019, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

[2] As of January 22, 2019, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

COMPONENTS	SOURCE
Expected state population growth	The source is the most recently published *Population Projections by Single Year, Age, Race and Sex* from the **Delaware Population Consortium**. To calculate the expected growth in the state population, one must average the forecasted percentage change in total population growth for years five to 10 into the future. For example, in 2018, the average annual growth was calculated using the percentage growth for years 2023 through 2028.

For purposes of this version of the manual and the development of the initial Spending Benchmarks, the time 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). In subsequent updates to the Spending Benchmark, a commensurate future time period will need to be used.

To determine the input values for the PGSP formula, each input value should be rounded to the nearest tenth decimal point. For example, 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 2.

Table 2. PGSP Calculation

COMPONENTS	VALUE FROM SOURCES LISTED IN TABLE 1	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 potential gross state product	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, Executive Order 25 provided information on the Spending Benchmark 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 that large unanticipated economic changes have occurred in Delaware's economy that warrant Spending Benchmark modification.

Therefore, annually, starting in 2019, the DEFAC Subcommittee is to review all components of the PGSP methodology to determine whether the PGSP growth rate has changed in a material way that it should be recalculated, therefore, changing 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 1 and compare them to the values calculated in 2018 and presented in Table 2. 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, Executive Order 25 requires DEFAC to report such changes to the Governor and DHCC no later than May 31 of the year preceding the restated Spending Benchmark. To maintain public awareness and support transparency, the new value of the Spending Benchmark should also be subsequently announced to the 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 CYs 2024 and Beyond: Per Executive Order 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 modify the methodology and/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, including but not limited to, Massachusetts and Rhode Island. If DEFAC decides to recalculate the PGSP, it will need to obtain new forecasts from the sources listed in Table 1, using data that forecast growth from 2028 through 2033 (or other years as it deems appropriate for future updates). Whether DEFAC decides on a new methodology and/or a recalculated PGSP, any changes should 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

Executive Order 25 encourages the DHCC[3] 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 large providers. To do so, DHCC staff and/or DHCC's contractor will need to perform a series of data collection activities and calculations.[4] This chapter contains the 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.[5] This chapter is organized as follows:

1. Definitions of Key Terms
2. Methodology for Measuring Total Health Care Expenditures (THCE)
3. Data Sources for THCE
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 Total Health Care Expenditures.

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

[4] To complete the work, it is estimated that 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. For more information on what types of skills staff would need to complete the analysis, please see Appendix H.

[5] These methodologies and reporting specifications are derived, in part, from materials published by the Massachusetts Center for Health Information and Analysis. Its published materials have been edited to reflect the Delaware model.

- **Insurer:** A private health insurance company that offers commercial insurance and may also administer benefits for self-insured employers, Medicare Advantage and/or are Medicaid/Children's Health Insurance Program (CHIP) managed care organization (MCO) products.
- **Large Provider:** A provider of sufficient size to yield statistically meaningful assessments of performance relative to the Spending or the Quality Benchmarks, as determined by the DHCC for public reporting purposes.
- **Market:** The highest level of categorization of the health insurance market. For example, Medicare and Medicare Advantage are collectively referred to as the "Medicare Market". Medicaid/CHIP fee-for-service (FFS) and Medicaid/CHIP 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 Advantage 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 that are 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 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 total medical expense (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]

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

The computation of THCE at the statewide, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[7]

- **Provider:** A term referring to a medical group, individual provider, accountable care organization (ACO) or similar entities for which TME data is collected from payers in support of the Spending Benchmarks.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid/CHIP FFS, the US Department of Veterans Affairs (VA) and similar entities/programs.
- **Total Health Care Expenditures:** The total medical expense incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC, plus the insurers' net cost of private health insurance.
- **Total Health Care Expenditures Per Capita:** Total health care expenditures (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, market and insurer levels. THCE will not be reported at the large provider level.[8]
- **Total Medical Expense:** The total medical expense incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC. TME is reported net of pharmacy rebates at the state, market and payer level, but not at the provider level. Payers report TME by line of business (e.g., Individual, Self- Insured, Large Group, Small Group, Medicare, Medicaid, etc.) and at the provider level whenever possible. More detailed TME reporting specifications are contained in the Appendices of this manual.
- **US Department of Veterans Affairs (VA):** The federal agency responsible for provision of health care benefits to veterans.

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[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.

[8] NCPHI, a component of THCE, is not reportable at the large provider level; therefore, THCE is not reported at the large provider level.

METHODOLOGY FOR MEASURING TOTAL HEALTH CARE EXPENDITURES

To assess changes in the amount of health care spending, the DHCC will need to calculate THCE annually. The 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 per capita basis will be used to assess performance against the Spending Benchmark (see Chapter 1).

THCE (in aggregate) =

Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid/CHIP MCO TME + DMMA[9] FFS TME + VA TME + Insurer NCPHI

THCE (per capita) =

$$\left(\frac{\text{Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid/CHIP MCO TME + DMMA}^{10}\text{ FFS TME + VA TME + Insurer NCPHI}}{\text{Delaware Population}} \right)$$

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 2019 (i.e., measurement year) THCE per capita amount is $9,500 and the CY 2018 (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 2019 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/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).

[9] Division of Medicaid and Medical Assistance.

[10] Ibid.

- 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 both of 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., spending for medical care by uninsured residents of Delaware, privately purchased health care services).
- It includes all insurance market segments, including public and private payers listed in this 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 that is not otherwise covered by Medicaid/CHIP.
- The administrative costs and underwriting gain/loss of insurers, referred to as the NCPHI, are included (see Section 3 of this chapter for more detail).
- TME data is only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting of a portion of the allowed amount by the primary payer.
- TME is adjusted to account for any pharmacy rebates received by the payer.

DATA SOURCES FOR THCE

Data for THCE comes from several sources. **Attachment 2** is a sample template DHCC can use to input data from these sources. Please note that **Attachment 2** contains illustrative data that will need to be replaced with the actual data DHCC receives. Insurers will need to report TME for all lines of business and, in some instances, insurers will need to report data for the State to calculate the NCPHI. Other data sources include the Centers for Medicare and Medicaid Services (CMS), the Division of Medicaid and Medical Assistance (DMMA) and VA. Table 3 below outlines the data source by THCE category and the location of the detailed specification or collection process within this manual.

Table 3. Data Sources for THCE

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 Advantage only, for market level reporting only. Insurer-level reporting data source is within TME reported by insurers.[11]	CMS	Appendix C
Expenditures from Public Programs		
DMMA claim (Medicaid/CHIP FFS and other) calculated values	Delaware DMMA	Appendix B
Medicare FFS claim (Parts A, B and D) calculated values	CMS	Appendix C
Veterans Health Administration summarized data	US Department of Veterans Affairs	Appendix D
Net Cost of Private Health Insurance		

[11] CMS will provide DHCC with allowed amounts for Medicare FFS beneficiaries with a stand-alone prescription drug plans (PDP), for Medicare managed care beneficiaries with stand-alone PDP and Medicare Advantage Prescription Drug plans (MAPD) (in aggregate). CMS should be the source of pharmacy expenditure data for market-level spending as it will include all stand-alone PDP spending, even by insurers not reporting TME data to DHCC and insurers specifically excluding stand-alone PDP spending from TME. For reporting at the insurer-level, each individual insurer should be the source of spending. However, stand-alone PDP spending has been excluded from reporting at the insurer-level because doing so would compromise the integrity of the spending calculations.

THCE CATEGORY	DATA SOURCE	LOCATION OF DATA SPECIFICATION/ COLLECTION PROCESS IN MANUAL
Insurer NCPHI	Calculated from regulatory reports submitted by the insurers or obtained through public sources	Appendix E
Pharmacy Rebates		
Insurers	Pharmacy rebate data filing by insurers	Appendix A
Medicaid/CHIP program	Pharmacy rebate data filing by Delaware DMMA	Appendix B
Population Statistics		
Population of Delaware	United States Census Bureau	Appendix F

Insurer TME Data

TME represents all payments for medical expenses for the Delaware resident population and will be reported by payers for all members (including fully and self-insured members). TME is adjusted (reduced) to account for pharmacy rebates.

Annually, the DHCC will need to direct applicable insurers to submit TME data using the specifications outlined in **Appendix A** and the template provided as **Attachment 5**. Specifications for public programs to submit their TME data are included in **Appendices B–D,** with the Medicare template provided as **Attachment 3** and the DMMA template provided as **Attachment 7**. The full list of payers reporting by line of business is included in **Appendix J**. Table 4, below, lists which insurers should report for their commercial, Medicare Advantage and Medicaid/CHIP managed care markets[12].

Table 4. Insurers Requested to Report TME Data by Market

INSURER	COMMERCIAL FULLY AND SELF-INSURED	MEDICARE ADVANTAGE	MEDICAID/CHIP MANAGED CARE
Aetna	✓	✓	

[12] 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 Executive Order 25 is to capture data from all major insurers for all market segments in the state.

INSURER	COMMERCIAL FULLY AND SELF-INSURED	MEDICARE ADVANTAGE	MEDICAID/CHIP MANAGED CARE
AmeriHealth Caritas			✓
Cigna	✓	✓	
Highmark Blue Cross Blue Shield Delaware	✓		✓
UnitedHealthcare	✓	✓	

The TME data includes claims and non-claims payments[13] for a single calendar year. 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. TME spending is only reported by a payer 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.

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. Thus, insurers will need to report this type of TME data separately in the partial-claim category (see **Appendix A** for more information). 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 estimate the full spending amount 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, DHCC should discuss appropriate methodologies with the insurers, recognizing there is no standardized approach to this estimate, but that actuarially sound principles should be used.

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

Appendix A includes instructions for insurers to submit pharmacy rebate data so that 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.

NCPHI 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, 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 methodology that DHCC will need to 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 should report at the statewide level, with several “drill-down” analyses. The following specifications propose the minimal levels of public reporting that the DHCC should undertake. The type of public reporting of performance relative to the Spending Benchmark will likely evolve over time and, thus, this manual should be updated as the public reporting processes change.

Table 5 outlines the minimum level at which DHCC should publicly report performance.[14] When reporting TME, DHCC should report on a per-member per-year (PMPY) basis, which calculates the average amount of spending per member for a particular market segment.

Table 5. Levels at Which Public Reporting of Performance Against Spending Benchmark Should Occur

LEVEL	THCE	TME/NCPHI
State level	Aggregate and per capita Compare per capita rate of change against benchmark	Report TME and NCPHI components

[14] It is not recommended that VA data be reported separately because the TME data are not comparable in nature to the calculated data reported by insurers. The data supplied by the VA consists of spending by veterans within the VA system and does not cover the spending those veterans receive from non-VA health care facilities, possibly underestimating their per capita spending.

LEVEL	THCE	TME/NCPHI
Commercial market	Aggregate and PMPY Compare PMPY rate of change against benchmark	Report TME and NCPHI components
Medicare market[15]	Aggregate and PMPY Compare PMPY rate of change against benchmark	Report TME only (NCPHI not applicable)
Medicaid market[16]	Aggregate and PMPY Compare PMPY rate of change against benchmark	Report TME only (NCPHI not applicable)
Insurer level (e.g., Highmark, AmeriHealth), by line of business (including Medicare Advantage and Medicaid MCO)	PMPY Compare PMPY rate of change against benchmark	Report TME and NCPHI components
Large provider	N/A	Report TME only, PMPY Compare PMPY rate of change against benchmark

[15] This includes Medicare FFS and Medicare Advantage. Medicare Advantage will 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, 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 it 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.

[16] This includes Medicaid FFS and Medicaid MCO. Medicaid MCO will 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.

Reporting should be done using both text and graphics that are engaging to the reader and easy to understand. For an example of how reporting can be done, please see **Attachment 1** – Center for Health Information and Analysis' Performance of the Massachusetts Health Care System Annual Report.

Reporting TME by Service Category

The TME data specifications for payers will allow for data to be reported by major service category. By analyzing service category spending, DHCC is able to understand the scale of changes in individual service categories and the share of TME spending changes that are 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 that 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, for at least the first year of reporting, the DHCC should collect service category data at the highest level. Ideally, payers would utilize a standardized list of claims codes by service category, but to create a list requires a time-intensive effort on behalf of the State to define the categories or an agreement to use a pre-defined list, like one developed by the Health Care Cost Institute.[17] Payers would also have to undergo a resource-intensive effort to configure reports in the standardized format.

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

- Hospital Inpatient
- Hospital Outpatient
- Professional Physician (Primary Care)
- Professional Physician (Specialty Care)
- Professional Other
- Long-Term Care

[17] See: www.healthcostinstitute.org/images/pdfs/HCCI_2016_Methodology_v1.0_1.23.18.pdf

- Retail Pharmacy[18]
- Pharmacy Rebates
- Other

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. For the duration that these categories are not defined with specific codes, DHCC should acknowledge when analyzing and reporting these data publicly that there may be some limitations in consistent interpretation across payers. In future years, DHCC should consider facilitating a process whereby a pre-established claims code-level definition could be used consistently across payers. At that time, additional, more detailed categories of services could be added, such as lab and imaging, for example, to deepen DHCC analysis capabilities.

Reporting TME by Large Provider and Members Unattributed to a PCP

DHCC will request that insurers submit TME data at the provider level by applying an attribution methodology that will assign members to a primary care provider (PCP)[19] as follows:

1. Delaware members required to select a PCP by plan design (member months for members who were attributed to more than one PCP in a calendar year should be allocated based on the number of months associated with each PCP)
2. Members not included in (1) who were attributed during the measurement year to a PCP, pursuant to a contract between the insurer and provider for financial or quality performance
3. Members not included in (1) or (2), attributed to a PCP by the insurer's own attribution methodology
4. Members not attributable to a PCP (aggregate line)

The data reported for each PCP must be reported in aggregate at the Large Provider level, which is outlined in the TME specification in **Appendix A.** It must include all TME for all attributed members, even when care was provided by providers outside of or not affiliated with the respective PCP entity. Furthermore, for DHCC to calculate market performance, insurers must report spending in aggregate for members not attributable to a PCP and in aggregate for providers that fall below the

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[18] Insurers that have both Medicare Advantage 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.

[19] In this context, PCP could be an individual clinician, a physician/medical group or similar entity, designated by the insurer as a PCP.

minimum member threshold (see below). The details of insurer attribution to a Large Provider is included in the TME specification in **Appendix A.**

In order to publicly report on Delaware provider performance, DHCC will need to determine which Delaware providers will be subject to public reporting. Annually, DHCC should publicly report, by line of business, on the health-status adjusted TME for providers that meet the following criteria:

- A minimum of 60,000 attributed Medicare member months (5,000 lives) with an individual payer for one or more lines of business
- A minimum of 120,000 attributed Medicaid or commercial member months (10,000 lives) with an individual payer for one or more lines of business

Because many Delaware providers will have small member attribution counts, public reporting of TME data on all providers is not appropriate due to the effects of random variation in health care spending with small populations. In order to report on primary care providers, DHCC should ask each of the insurers to submit data to DHCC on the number of members attributed to each insurer's 10 largest contracts and create a list according to insurer reports of provider size. DHCC should then modify **Appendix A** TME Data Submission instructions to include this list.

DHCC will request insurers submit health status-adjusted and non-adjusted data. TME should be adjusted based on health status using insurer-reported health status (risk) adjustment tools. Because these tools will likely vary from insurer to insurer, it is not possible to compare or combine health status-adjusted TME data across insurers for public reporting purposes.

Given the small size of many Delaware providers, prior to reporting data in 2020, DHCC should consult with a statistician regarding how to report large provider data with proper statistical interpretation.

TIMELINE FOR MEASURING AND REPORTING THE HEALTH CARE SPENDING BENCHMARK

Executive Order 25 calls for DHCC to publish THCE statistics in the fourth quarter of each calendar year following the respective reporting/data year. For example, CY 2019 performance will be reported in the fourth quarter of CY 2020. To the extent practicable, DHCC should publish the THCE statistics close to the beginning of the fourth quarter. DHCC should anticipate that the first year of reporting may involve a longer timeline and higher start-up costs due to the time required to process questions, develop reporting templates, create data exhibits and resolve unanticipated issues.

Since CY 2019 is the first year for which performance against the Spending Benchmark will be measured, the DHCC will need to collect CY 2018 THCE data to serve as the initial baseline comparison for CY 2019 results. Therefore, the DHCC will first need to collect CY 2018 THCE data in the third and fourth quarters of CY 2019. This step will enable the DHCC and payers to work

through and resolve issues with the data collection process, file formats and other technical or logistical issues in advance of the following year's process of reporting CY 2019 performance against the Spending Benchmark.

Prior to data requests being submitted to insurers, DHCC will need to complete some activities to finalize **Appendix A**, including identifying the final list of large providers for whom 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.

The annual timeline for measuring and reporting on the Spending Benchmark is included as **Attachment 4.**

4
HEALTH CARE QUALITY BENCHMARKS

Delaware has established 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 Chapter 4 is to describe the process for the DHCC to evaluate performance against the quality benchmarks. This chapter includes six sections:

- Quality Definitions
- Methodology for 2019–2021 Quality Benchmarks
- Data Sources for Evaluating Performance Against Quality Benchmarks
- Health Insurer Reporting Requirements
- Calculating Performance Against the Benchmark
- Quality Benchmark Implementation Training

QUALITY DEFINITIONS

Annual quality benchmark is 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 and its data source, the market[20], insurer and provider levels.

Aspirational quality benchmark is a measure of frequency describing the five-year performance goal for a priority Delaware population health or quality-of-care concern.

[20] Excluding Medicare FFS and Medicare Advantage

METHODOLOGY FOR 2019–2021 QUALITY BENCHMARKS

There are eight quality measures for which Delaware has adopted quality benchmarks for the years 2019 through 2021. These measures fall into two categories:

1. **Health status measures:** These measures quantify certain population-level characteristics of Delaware residents.

2. **Health care measures:** These measures quantify performance on health care processes or outcomes. Performance is assessed at the state, market, insurer and provider levels.

Although the annual quality benchmarks have been defined for three years at the outset, the corresponding aspirational values assume a longer time horizon (five years). 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.

MEASURE AND MEASURE STEWARD	ASPIRATIONAL QUALITY BENCHMARK	BENCHMARK SOURCE(S)
Health Status Measures		
Adult obesity (CDC)	27.4%	75th percentile (all states, 2016 Behavioral Risk Factor Surveillance System, CDC)
High school students who were physically active (CDC)	48.7%	75th percentile (all states, 2017 Youth Risk Behavior Survey, CDC)
Opioid-related overdose deaths (CDC)	13.3 per 100,000 (state population)	50th percentile (all states, 2016, CDC)
Tobacco use (CDC)	14.6%	75th percentile (all states, 2016 Behavioral Risk Factor Surveillance System, CDC)
Health Care Measures		
Concurrent use of opioids and benzodiazepines (PQA)	TBD[21] (commercial and Medicaid)	Analysis of insurer-generated baseline data for CY 2018
Emergency department utilization (EDU) (NCQA-HEDIS, modified[22])	165.9 per 1,000 risk-standardized rate (commercial)	75th percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)

[21] The State will gather baseline performance data from Delaware insurers during CY2019 in order to set annual and aspirational benchmarks for 2020 and 2021.

[22] 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.

MEASURE AND MEASURE STEWARD	ASPIRATIONAL QUALITY BENCHMARK	BENCHMARK SOURCE(S)
Persistence of beta-blocker treatment after a heart attack (NCQA-HEDIS)	91.9% (commercial) 83.9% (Medicaid)	90th percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass) 75th percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)
Statin therapy for patients with cardiovascular disease – statin adherence 80% (NCQA-HEDIS)	82.1% (commercial) 68.3% (Medicaid)	90th percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass) 75th percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)

Health Status Measures

Below are the specifications, methods used to establish the benchmarks and state-level benchmark values for Delaware's four health status measures.

1) Adult Obesity

Specification: The percentage of adults with a body mass index (BMI) greater than or equal to 30 weight (kg)/height (m2), as defined by the Centers for Disease Control and Prevention (CDC).[23]

Methods: Delaware used the 75th percentile value from the 2016 Behavioral Risk Factor Surveillance System (BRFSS) results.

[23] Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. BRFSS Prevalence & Trends Data. 2016. Available at www.cdc.gov/brfss/brfssprevalence/. Last accessed on January 22, 2019.

Benchmark Values:

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware	30.7	0.7	30.0	29.4	28.7	27.4

2) High School Students Who Were Physically Active

Specification: The percentage of high school students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some of the time for a total of at least 60 minutes a day on five or more days during the seven days before the survey, as defined by the CDC.

Methods: Delaware used the of 75th percentile value from the 2017 Youth Risk Behavior Survey.

Benchmark Values:

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware	43.5	1.1	44.6	N/A*	46.8	48.7

*There is no benchmark for 2020 because there will be no data available to measure performance. The survey serving as the data source is administered by the federal government every other year.

3) Opioid-Related Overdose Deaths

Specification: Number of opioid-related overdose deaths per 100,000 persons, as defined by the CDC. Opioid overdose deaths were identified using underlying cause-of-death codes X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide) or Y10–Y14 (undetermined intent). Among the deaths with drug overdose as the underlying cause, the type of opioid involved is indicated by the following ICD-10 multiple cause-of-death codes: opioids (T40.0, T40.1, T40.2, T40.3, T40.4 or T40.6); natural and semisynthetic opioids (T40.2); methadone (T40.3); synthetic opioids, other than methadone (T40.4); and heroin (T40.1). [24]

[24] Kaiser Family Foundation (KFF). Opioid Overdose Death Rates and All Drug Overdose Death Rates per 100,000 Population (Age-Adjusted). 2016. Available at www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Last accessed on January 22, 2019.

Methods: Delaware used the 50th percentile of state opioid-related overdose deaths, obtained from 2016 CDC data, as the aspirational benchmark.

Benchmark Values:

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware	16.9	0.7	16.2	15.5	14.7	13.3

4) Tobacco Use
Specification: The percentage of adults who report that they are current smokers. Current smokers are defined as persons who reported smoking at least 100 cigarettes during their lifetime and who, at the time they participated in a survey about this topic, reported smoking every day or some days as defined by the CDC.

Methods: Delaware used the 75th percentile value for the number of adults who are current smokers from the 2016 BRFSS results as its aspirational benchmark.

Benchmark Values:

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware	17.7	0.6	17.1	16.4	15.8	14.6

Health Care Measures

Below are the specifications, methods used to establish the benchmarks and state-level benchmark values for Delaware's four health care measures. These benchmark values shall also be applied at market, insurer and provider levels, all by line of business as indicated below.

1) Concurrent Use of Opioids and Benzodiazepines
Specification: The percentage of individuals 18 years and older with concurrent use of prescription opioids and benzodiazepines, as defined by the Pharmacy Quality Alliance. The denominator includes individuals 18 years and older by the first day of the measurement year, with two or more prescription claims for opioids filled on two or more separate days, for which the sum of the days' supply is 15 or more days during the measurement period. Patients in hospice care and those with a cancer diagnosis are excluded. The numerator includes individuals from the denominator with two or more prescription claims for benzodiazepines filled on two or more separate days, and concurrent use of opioids and benzodiazepines for 30 or more cumulative days.

The complete measure specification can be found here:

Concurrent Use of Opioids & Benzodia

Methods: Benchmark baseline data from Delaware plans will be needed to inform the development of an aspirational benchmark. The DHCC should request 2018 baseline data for this measure from Aetna, AmeriHealth Caritas, Cigna, Highmark and UnitedHealthcare for their Medicaid and commercial lines of business (as applicable) for reporting to the DHCC by August 1, 2019. Following acquisition of plan-specific baseline performance, the DHCC should consult with one or more persons with relevant clinical subject matter expertise to determine the aspirational benchmark value.

Benchmark Values: To be determined for 2020–2021 and for the aspirational benchmark after insurer data are obtained by the State during 2019.

2) Emergency Department Utilization

Specification: For members 18 years of age and older, a risk-standardized measure of the emergency department (ED) visits during the measurement year. The complete measure specification can be found here:

Emergency Department Utilizati

The specification used for the Delaware quality benchmark is adapted from NCQA's HEDIS 2018 EDU measure above, by using risk-standardized rates instead of the risk-adjusted ratio of observed-to-expected ED visits. Please see "Methods" below for additional details.

Methods: Delaware used the national 75th percentile, risk-standardized rate for commercial all-lines-of-business from NCQA's 2018 Quality Compass (calendar year 2017 data) as the aspirational benchmark. HEDIS benchmark data were not available for the Medicaid population for this measure.

There were three steps involved in calculating risk-standardized rates from the publicly available observed-to-expected EDU rates. The first step was calibration of the national data. The national EDU risk-standardized rate was calculated by multiplying the national average observed-to-expected ratio by the national average observed rate. The national average observed rate must be obtained through NCQA, as it is not available publicly. The second step was a calculation of risk-standardized baseline rates for Delaware plans. Delaware plan-specific risk-standardized rates are calculated dividing the plan's observed-to-expected ratio by the national risk-standardized rate. The third step was calculating the national 75th percentile risk standardized rate to use as the aspirational benchmark. The 75th percentile risk-standardized rate is calculated dividing the national 75th percentile observed-to-expected ratio by the national risk-standardized rate.

Benchmark Values:

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware*	196.0	6.0	190.0	183.9	177.9	165.9

* 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.

3) Persistence of Beta-Blocker Treatment After a Heart Attack

Specification: The percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged from July 1 of the year prior to the measurement year to June 30 of the measurement year, with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge, as defined by the HEDIS 2018. The complete measure specification can be found here:

Methods: Delaware used the national 90th percentile for commercial all-lines-of-business from NCQA's 2018 Quality Compass (CY 2017 data) as the aspirational benchmark. Delaware used the national 75th percentile for Medicaid HMO business from NCQA's 2018 Quality Compass (CY 2017 data) as the aspirational benchmark. Data were not available for the majority of Delaware health plans.

Benchmark Values:

Commercial

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware*	80.2	2.3	82.5	84.9	87.2	91.9

* 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).

Medicaid

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware*	77.6	1.3	78.8	80.1	81.3	83.9

* 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).

4) Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%
Specification: The percentage of males 21 years to 75 years of age and females 40 years to 75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease and who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period, as defined by HEDIS 2018 (CY 2017 data). The complete measure specification can be found here:


Statin Therapy for Patients with Cardio

Methods: Delaware used the national 90th percentile for commercial all-lines-of-business from NCQA's 2018 Quality Compass (CY 2017 data) as the aspirational benchmark. Delaware used the national 75th percentile for Medicaid HMO business from NCQA's 2018 Quality Compass (CY 2017 data) as the aspirational benchmark.

Benchmark Values:

Commercial

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware*	79.4	0.5	79.9	80.5	81.0	82.1

* 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.

Medicaid

ENTITY	BASELINE	ANNUAL CHANGE	2019 B'MARK	2020 B'MARK	2021 B'MARK	ASPIRATIONAL B'MARK
Delaware*	56.9	2.3	59.2	61.5	63.7	68.3

* 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.

DATA SOURCES FOR EVALUATING PERFORMANCE AGAINST QUALITY BENCHMARKS

Moving forward, the DHCC should annually evaluate performance against the quality benchmarks at the state level, and depending upon the measure and its data source, the market, insurer and provider levels.

To do so requires the collection of data both from insurer-reported and non-insurer-reported sources.

Insurer-Reported Data: Annually, the DHCC will need to direct insurers to submit performance data on select quality measures by August 1. See Insurer Reporting Requirements, below for additional information.

Non- Insurer-Reported Data: Annually, DHCC staff will need to collect relevant state and insurer-market segment data from the following sources: The National Committee for Quality Assurance and the Centers for Disease Control and Prevention.

SOURCE	TIMING
Insurers	By March 31, the DHCC should request quality performance measurement data from insurers with instructions on content and format. DHCC will request that insurers submit all requested data by August 1 each year.
NCQA – Data Request	The DHCC should make a request to NCQA, by March 31, for the national average EDU observed-to-expected ratio and for the national average EDU observed rate. Details on the data request of NCQA can be found below under *Calculating Performance Against the Benchmark*.
CDC – BRFSS	The DHCC should annually seek out the BRFSS performance, by July 31 in the year following the performance period.
CDC – YRBSS	The DHCC should annually seek out the YRBSS performance, by June 30 in the year following the performance period. Survey data are only collected at the state level during odd years.
CDC – Wonder: Multiple Cause of Death (MCD) Data	The DHCC should annually seek out CDC Wonder performance by December 15 of the year after the performance period.

INSURER REPORTING SPECIFICATIONS

Annually, DHCC should request the following data from insurers listed in Table 4 of Chapter 3.

MEASURE	REPORTING LEVEL
Health Care Measures	
Concurrent use of opioids and benzodiazepines	Insurer – by line of business Provider – by line of business
Emergency department utilization	Insurer – by line of business Provider – by line of business

MEASURE	REPORTING LEVEL
Persistence of beta-blocker treatment after a heart attack	Insurer – by line of business Provider – by line of business
Statin therapy for patients with cardiovascular disease – statin adherence 80%	Insurer – by line of business Provider – by line of business

Insurers will submit provider-level data by line of business for the top 10 largest providers (defined by attributed members, consistent with the methodology in Chapter 3 and Appendix A) and for those measures which meet the minimum size and denominator thresholds indicated within the detail of each measure, below.

Annually, by March 31 of the reporting year, the DHCC will need to direct insurers to submit performance data by August 1. When communicating to insurers, the DHCC should provide the following materials:

1. Insurer Reporting Manual. This document outlines the steps required for submission of health insurer-reported data to the DHCC and is included in this document as **Appendix G**.

2. Quality Benchmark Performance Submission Template. This document should be used by insurers to submit insurer-level and provider-level data to the DHCC and is included as **Attachment 6**.

3. Attestation of the Accuracy and Completeness of Reported Data. This document should be used by insurers to attest to the accuracy and completeness of both the Spending and Quality benchmarks performance data submissions and is included in this document as **Appendix H**.

CALCULATING PERFORMANCE AGAINST THE BENCHMARK

Annually, by September 30 of the reporting year, DHCC staff should 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 2019 performance are not available until December 2020). Therefore, performance against the quality benchmark for opioid-related overdose deaths for 2019 should be calculated by February 1, 2021. This delayed reporting timeline will repeat annually. Performance should be calculated at the state, market, insurer and/or provider level depending on the measure. The levels at which performance should be calculated are outlined below. Data sources are italicized.

MEASURE	STATE AND MARKET			INSURER		PROVIDER	
	Overall	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid
Health Status Measures							
Adult Obesity	X *CDC*						
High School Students Who Were Physically Active*	X *CDC*						
Tobacco Use	X *CDC*						
Opioid-Related Overdose Deaths	X *CDC*						
Health Care Measures							
Concurrent Use of Opioids and Benzodiazepines		X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*
Emergency Department Utilization		X *Insurer*		X *Insurer*		X *Insurer*	
Persistence of Beta-Blocker Treatment After a Heart Attack		X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*
Statin Therapy for Patients with Cardiovascular Disease – Statin Adherence 80%		X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*	X *Insurer*

* Performance can only be measured for performance periods in which a YRBSS survey has been performed.

Health Status Measures

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 "BRFSS Prevalence & Trends Data".

Under “Explore BRFSS Data By Topic” select:

A. Class: Overweight and Obesity (BMI)

B. Topic: BMI Categories

Once redirected, select the following options:

C. Selected Year: [Performance Period]

D. View By: Overall

E. Response: Obese (BMI 30.0-99.8)

F. Data Type: Crude Prevalence

Hover over “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 that the quality benchmark has been met. Performance above the annual quality benchmark indicates that the annual quality benchmark has not been met.

High School Students Who Were Physically Active
Performance Level: State

Performance Periods: Performance can only be measured for measurement years in which a YRBSS survey has been performed. As such, performance can only be measured for the 2019 and 2021 annual quality benchmarks.

State-Level Performance: Obtain Delaware’s measurement year rate from the CDC YRBSS webpage (www.cdc.gov/healthyyouth/data/yrbs/index.htm).

1. Select “Youth Online Data Analysis Tool,” then “View Data From” “High School YRBS.”

   Under “View one question for all locations” select “Physical Activity.”

   When re-directed, select:

   A. Question Direction: Less Risk

   B. Physical Activity: Were physically active at least 60 minutes per day on 5 or more days.

   Once redirected, select the following options:

C. Question: Physical activity >= 5 days

D. Locations: States

Search for Delaware to obtain the rate.

Interpreting Performance: Performance equal to or above the annual benchmark value indicates that the quality benchmark has been met. Performance below the annual quality benchmark indicates that 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 Multiple Cause of Death mortality files (http://wonder.cdc.gov/mcd-icd10.html).

1. Select the following filters:

   A. Organize table layout:

      i. Group Results by: State

   B. And by year

   C. Measures: Deaths, Population, Crude Rate and Age-Adjusted Rate

   Select location:

   D. Click a button to choose locations by State, Census Region or HHS Region: State

   E. Browse: Delaware

   Select demographics:

   F. Pick between: Ten-Year Age Groups, All Ages

   G. Gender: All Genders

   H. Race: All Races

   I. Hispanic Origin: All Origins

   Select year and month:

   J. Year/Month: [Measurement Year]

Select weekday, autopsy and place of death:

K. Weekday: All Weekdays

L. Autopsy: All Values

M. Place of Death: All Places

Select underlying cause of death:

N. Click a button to select ICD codes by Chapters or by Group: UCD – Drug/Alcohol Induced Causes

O. Browse: Drug-induced causes

Select multiple cause of death:

P. Click a button to select ICD codes by Chapters or by Groups: MCD-ICD-10 Codes

Q. Browse and click “Move Items Over” for: Opioids: T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6.

Other options:

R. Check “Show results”

S. Precision: select “1” decimal place

Click “Send”

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 that the quality benchmark has been met. Performance above the annual quality benchmark indicates that the annual quality benchmark has not been met.

Tobacco Use
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 “BRFSS Prevalence & Trends Data”.

Under “Explore BRFSS Data By Topic” select:

A. Class: Tobacco Use

B. Topic: Current Smoker Status

Once redirected, select the following options:

C. Selected Year: [Measurement Year]

D. View By: Overall

E. Response: Yes

F. Data Type: Crude Prevalence

Hover over “DE” to obtain the rate.

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

Health Care Measures

Concurrent Use of Opioids and Benzodiazepines

Performance Level: State, health insurer and provider for the commercial and Medicaid populations.

Benchmark Value: The DHCC should have calculated benchmark performance using payer-requested data by September 30, 2019. Values collected will be compared against this benchmark.

Provider-Level Performance:

1. Aggregate numerator and denominator values, by line of business, using the health insurer-reported data for each provider.

   Divide the aggregated numerator by the aggregated denominator by line of business to obtain provider-level rates.

Health Insurer-Level Performance: Divide the numerator by the denominator, by line of business, using health insurer-reported data for each payer.

State-Level Performance:

1. Aggregate numerator and denominator values, by line of business, using the health insurer-reported data for each health insurer.

   Divide the aggregated numerator by the aggregated denominator, by line of business, to obtain state-level rates.

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

Emergency Department Utilization
Performance Level: State, health insurer and provider for the commercial population

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

1. The national average EDU observed-to-expected ratio and the national average EDU observed rate will likely need to be purchased from NCQA through either an existing consultant contractor or directly from NCQA. To contact NCQA, email Karen Onstad (onstad@ncqa.org) and Chris Carrier (carrier@ncqa.org) and ask for the national average EDU observed-to-expected ratio by 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:

1. To calculate provider-specific risk-standardized rates, divide the provider’s emergency department 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 emergency department 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:

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

To calculate insurer-specific risk-standardized rates, divide the provider's emergency department 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 emergency department observed-to-expected ratio are input.

B. Minimum Size Threshold: Rates should only be calculated for insurers with a minimum of 150 enrolled members[25] 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 that the annual quality benchmark has been met. Performance above the annual quality benchmark indicates that the annual quality benchmark has not been met.

Persistence of Beta-Blocker Treatment After a Heart Attack
Performance Level: State, insurer and provider for commercial and Medicaid populations

[25] The threshold value of 150 was recommended to Delaware by NCQA.

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.

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 that the quality benchmark has been met. Performance below the annual quality benchmark indicates that 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 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.

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 that the quality benchmark has been met. Performance below the annual quality benchmark indicates that the annual quality benchmark has not been met.

QUALITY BENCHMARK IMPLEMENTATION TIMELINE

TASK	DETAIL	TIMING
1. Establish quality benchmarks	Governor Carney's Executive Order establishes 2019–2021 quality benchmarks	November 20, 2018
2. Set concurrent use of opioids and benzodiazepines benchmark	Request data from health insurers to create benchmark	March 31, 2019
	Receive data from health insurers	August 1, 2019
	Establish benchmarks for 2020–2021	September 30, 2019
3. Measure and publish performance against the benchmarks	Request the national emergency department utilization observed rate from NCQA	Annually, March 31
	Request health insurers submit performance data	Annually, March 31
	Receive the national emergency department utilization observed rate from NCQA	Annually, August 1
	Receive data from health insurers	Annually, August 1
	Calculate performance for all measures except for opioid-related overdose deaths	Annually, September 30
	Publish performance data for all measures except for opioid-related overdose deaths	Annually, early November

TASK	DETAIL	TIMING
	Calculate performance for opioid-related overdose deaths for the performance period two calendar years prior	Annually, February 1
	Update published performance data to include opioid-related overdose deaths	Annually, February 28
4. Update benchmarks	Review the benchmark measures and methodology to define quality benchmarks for the year beginning 2022	Commence January 2021 and complete by September 30, 2021

Establish Quality Benchmarks: Quality benchmarks were established for calendar years 2019 through 2021 through Governor Carney's Executive Order #24, effective as of November 20, 2018.

Set Concurrent Use of Opioids and Benzodiazepines Benchmark: Insurer data are needed to determine commercial and Medicaid benchmarks for concurrent use of opioids and benzodiazepines. The DHCC should request necessary data of insurers by March 31, 2019. Insurers should submit data for this measure by August 1, 2019, and DHCC should establish a benchmark for this measure by September 30, 2019.

Measuring and Publishing Performance Against the Benchmarks:

- For DHCC requesting national EDU information from NCQA: The DHCC should annually request the national EDU observed rate from NCQA by March 31 of the reporting year for August 1.

- For DHCC requesting performance data from insurers: The DHCC should annually direct insurers, by March 31 of the reporting year, to submit performance data. When requesting data, staff should provide the "Insurer Reporting Manual," the "Quality Benchmark Performance Submission Template" and the "Insurer Attestation".

- For insurers reporting data to the DHCC: Insurers should, annually, by August 1 of the reporting year, report data to the DHCC using the "Quality Target Performance Submission Template" for the prior year's performance beginning for performance year 2019.

- For calculating the data and releasing performance data:

  – All measures except opioid-related overdose deaths: The DHCC should annually calculate performance by September 30 of the performance year on performance relative to the quality benchmark the prior year and publish the results with the health care spending benchmark results by early November.

  - Opioid-related overdose deaths: The DHCC should annually calculate performance for two calendar years prior on or near February 1 (e.g., performance for CY 2019 should be calculated on or near February 1, 2021). DHCC should then update the previously published quality results to include the performance on the opioid-related overdose deaths on or by February 28.

- Update benchmarks: The DHCC should review the quality benchmark methodology in 2021, and every three years thereafter, to determine whether changes should be made to the quality benchmark measures, the values used to establish the quality benchmarks to 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 the DHCC identify appropriate changes, the 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.

APPENDIX A

INSURER TME DATA SPECIFICATION

This insurer TME data specification provides technical details to assist insurers in reporting and filing data to enable the DHCC to calculate TME. This appendix can serve as a stand-alone document that DHCC can distribute as a guide for TME data reporting.

DHCC will annually request TME data file(s) with dates of service during the prior calendar year, and any other past years upon request. Files will contain different record types, including:

- Header, including summary data and payer comments
- TME by large providers

This insurers TME data specification appendix is directly based on the Massachusetts' TME data collection specification. The Massachusetts model has been simplified to meet the needs of Delaware. However, the file format is as close to identical as Massachusetts' as possible to aid insurers who may operate in both markets. The DHCC may periodically update and revise these data specifications in subsequent versions.

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 submit flat files of their TME data.[26] The fields are variable in length and relative to position; therefore, they need to be separated by an asterisk (*). Insurers will submit this information on an annual basis.

Insurers will submit TME data on the following schedule:

INSURERS' TME FILING SCHEDULE

Date	Files Due
August 1, 2019	CY 2018 final TME
August 1, 2020	CY 2019 final TME
August 1, 2021	CY 2020 final TME
August 1, 2022	CY 2021 final TME

[26] A flat file is a file without structure or formatting.

INSURERS' TME FILING SCHEDULE	
Date	**Files Due**
August 1, 2023	CY 2022 final TME
August 1, 2024	CY 2023 final TME

TME DATA SUBMISSION

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
- For which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer)

Insurers must attribute members to a PCP using the following hierarchal steps:

1. Delaware members required to select a PCP by plan design (member months for members who were attributed to more than one PCP in a calendar year should be allocated based on the number of months associated with each PCP).
2. Members not included in (1) who were attributed during the measurement year to a PCP, pursuant to a contract between the insurer and provider for financial or quality performance
3. Members not included in (1) or (2), attributed to a PCP by the insurer's own attribution methodology

Any members not attributable to a PCP shall be reported together in aggregate.

Insurers must report TME for a) each of the 10 largest providers within their network by Insurance Category Code (see page 46), b) in aggregate for all providers that fall below the 10 largest providers by Insurance Category Code and c) in aggregate for members who are not attributable to a PCP by Insurance Category Code. Size of the provider is determined by the number of attributed lives. DHCC will only publicly report data on large providers, which are any practitioner, physician group, ACO, independent practice association or contracting entity for which the insurer has a minimum number of member lives attributed during the reporting period as follows:

- A minimum of 60,000 attributed Medicare member months (5,000 lives) with an individual payer for one or more lines of business

- A minimum of 120,000 attributed Medicaid or commercial member months (10,000 lives) with an individual payer for one or more lines of business

Insurers must report three categories of data, by Insurance Category Code:

1. TME data applicable to the 10 largest providers based on the number of attributed members (using the aforementioned attribution methodologies). Each of the 10 largest providers will be reported separately, not in aggregate. Should any of the 10 largest providers not meet the minimum attribution threshold, DHCC will not publicly report its performance.

2. TME data applicable to providers with fewer numbers of attributed members than in the top 10, reported in aggregate.

3. Member spending not attributable to a PCP, reported in aggregate.

If an insurer holds multiple contracts with providers that are affiliated with the same health system or ACO, data for those providers should be reported in aggregate for the health system or ACO, regardless of whether the members attributed to the smaller entities by contract would be categorized into the 10 largest. For example, if an insurer is contracted with a health system-affiliated health center or provider group separately from other health system primary care physicians, and the contract with the affiliated health center or provider group does not fall into the top 10 largest providers, it should be combined with other health system providers for the reporting of the health system. If, after combining the data for multiple contracts, the provider group still falls below the top 10 largest, then the data should be reported in the category of spending by groups with fewer numbers of attributed members than in the top 10.

Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Delaware, and regardless of the situs of the member's plan.[27]

The data reported for each PCP must include all TME for all attributed members for each month a member was attributed, even when care was provided by providers outside of or not affiliated with the respective PCP entity.

Claims Run-Out Period Specifications

Insurers shall allow for a claims run-out period of at least 120 days after December 31 of the prior calendar year. Payers should apply reasonable and appropriate IBNR/IBNP completion factors to

[27] If the insurer pays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

each respective TME service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

TME DATA FILE LAYOUTS AND FIELD DEFINITIONS

Each item below represents a column in the TME Data File Layout that insurers will use to submit TME data to the DHCC using an Excel template provided by DHCC. There are two TME data files that insurers must submit: a header record file and a PCP group file. A pharmacy rebate data file will also be submitted. Each is described below in more detail:

Header Record File

Record Type: Must have "HD-TME" inputted to indicate that this is a header record.

Insurer Org ID: The DHCC-assigned organization ID for the insurer submitting the file.[28]

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

National Plan ID: National plan identification number. This element is not required at this time, but may be required for future filings.

Period Beginning and Ending Dates: The beginning period of time 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.

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.

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

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

Reserved: There are data elements labeled as “Reserved” in the header record file layout. These are fields that are reserved for possible future use.

Large Provider Record File

The large provider record file will be the source of the insurer’s expenditure data that will be used by DHCC to compute THCE. Insurers will report their permissible claims and non-claims payments in this file.

Record Type: Must have “PR” inputted to indicate that this is a PCP record.

Large Provider Org Name: The name of the provider that is being reported.

Insurance Category Code: A number that indicates the insurance category that is being reported. All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for large providers for which the insurer is able to collect information on all direct medical claims and subcarrier claims should be reported in the “Full Claims” category. Commercial data that does not include all medical and subcarrier claims should be reported in the “Partial Claims”, and an actuarial adjustment should be made to those claims to allow for 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. The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve out vendors, such as 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 per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. Insurers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold. For insurers reporting in the “Other” category, insurers should describe in the Comments field (HD006) what is included in the “Other” category.

INSURANCE CATEGORY CODE	DEFINITION
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid Managed Care (MCO) including CHIP
3	Commercial — Full Claims
4	Commercial — Partial Claims, Adjusted

INSURANCE CATEGORY CODE	DEFINITION
5	Omitted[29]
6	Medicare and Medicaid Dual Eligibles, ages 65 years and over
7	Medicare and Medicaid Dual Eligibles, ages 21 years–64 years
8	Other

Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.

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, DxCG, etc.) 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) and 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.

[29] Omitted in Delaware in order to keep specification as similar to Massachusetts as possible for the benefit of national 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. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that 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 that have been billed directly by a physician group practice or an individual physician.

Claims: Professional Physician, Primary Care: All TME data to physicians or physician group practices generated from claims. Includes services provided by any care provider defined by the health plan as a PCP (including doctors of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physician assistants or others not explicitly listed here). The one exception is OB/GYNs may not be considered a PCP for this purpose.

Claims: Professional Physician, 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 by the health plan as a PCP.

Claims: Professional Other: All TME data from claims to health care providers for services provided by a licensed practitioner other than a physician. 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, dieticians, dentists and chiropractors.

Claims: Retail 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. Medicare Advantage insurers that offer stand-alone PDPs should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.

Claims: Long-Term Care: All TME data from claims to health care providers for skilled or custodial nursing facility services, home health care services, home- and community-based services, 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. However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category.

Non-Claims: Incentive Programs: All payments made to providers 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: Capitation and Risk Settlements: All payments made to providers as a reconciliation of payments made (risk settlements) and payments made not on the basis of claims (capitated amount). Amounts reported as capitation and risk settlement should not include any incentive or performance bonuses.

Non-Claims: Care Management: All payments made to providers for providing care management, utilization review and discharge planning.

Non-Claims: Recovery: All payments received from a provider, member/beneficiary or other payer that 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 that is 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 that were not made on the basis of a claim for health care benefits/services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Pharmacy Rebate Record File

The pharmacy rebate file will be the source of the insurer's pharmacy rebate and will be used by DHCC to compute THCE and TME. Insurers will report their rebate data in this file.

Record Type: Must have "Rx" inputted to indicate that this is a pharmacy rebate record.

Insurance Category Code: A number that indicates the insurance category that pharmacy rebates are being reported on. Use the applicable Insurance Category Code as defined previously in the Large Provider Record File (not all Insurance Category Codes may be applicable to pharmacy rebates).

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 period beginning date through end date from the Large Provider Record file, excluding manufacturer-provided fair market value bona fide service fees.[30] 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, on a claims-by-claim basis, etc.). Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year 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.

Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.

Market Enrollment File

The market enrollment file will be the source of the insurer's member months by market in that it will be used by DHCC to compute NCPHI. Insurers will report their member months by market in this file.

Record Type: Must have "ME" inputted to indicate that this is the market enrollment file.

Market Enrollment: The number of members participating in a plan categorized by the insurer as individual, large group, small group, self-insured and student markets. Insurers should report member months (see definition below) by market enrollment category listed below.

MARKET ENROLLMENT CATEGORY CODE	DEFINITION
1	Individual
2	Large group
3	Small group
4	Self-insured
5	Student market

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

Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.

Data File Layout Table

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
HD-TME	1	HD001	Record type	1/1/2019	Text	HD	2	Yes	This must have HD reported here. Indicates the beginning of the Header Record.
HD-TME	2	HD002	Insurer	1/1/2019	Integer	########	8	Yes	This is the Insurer OrgID.
HD-TME	3	HD003	National Plan ID	1/1/2019	Text		30	No	Unique identifier as outlined by CMS for Plans.
HD-TME	4	HD004	Period beginning date	1/1/2019	Date period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the start date period of the reported period in the submission file (based on date of service).
HD-TME	5	HD005	Period ending date	1/1/2019	Date period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the end date period of the reported period in the submission file (based on date of service); if the period reported is a single month of the same year, then period begin date and

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									period end date will be the same date.
HD-TME	6	HD006	Comments	1/1/2019	Text	Free Text Comments	255	No	Insurer's comments on TME data.
HD-TME	7	HD007	Health Status Adjustment Tool	1/1/2019	Text	Text	80	Yes	The health status adjustment tool, software or product used to calculate the health status adjustment score required in the TME file.
HD-TME	8	HD008	Health Status Adjustment Version	1/1/2019	Text	Text	20	Yes	The version number of the health status adjustment tool used to calculate the health status adjustment score required in the TME file.
PR	1	PR001	TME Record Type ID	1/1/2019	Text	Text	2	Yes	This must have PR reported here. Indicates the beginning of the Provider based TME record.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	2	PR002	Large Provider Org Name	1/1/2019	Text	Text	25	Yes	Large Provider Org Name of top 10 For aggregation of all other sites that fall below the top 10, use “all other”. For aggregation of all members unattributed to a PCP, use “unattributed”.
PR	3	PR003	Insurance Category Code	1/1/2019	Integer	#	1	Yes	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCOs 3 = Commercial: Full-Claim 4 = Commercial: Partial-Adjusted

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									6 = Medicare and Medicaid Dual-Eligibles, 65 and over 7 = Medicare and Medicaid Dual-Eligibles, 21–64 8 = Other Value must be an integer between ‘1’ and ‘4’ or ‘6’ and ‘8’.
PR	4	PR004	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in a plan over a specified period of time expressed in months of membership.
PR	5	PR005	Health Status Adjustment Score	1/1/2019	Number	##.##	6	Yes	A value that measures a patient’s illness burden and predicted resource use based on differences in

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									patient characteristics or other risk factors. No negative values. Number must be between '0.2' and '10'.
PR	6	PR006	Claims: Hospital Inpatient	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for hospital inpatient medical expenses. No negative values.
PR	7	PR007	Claims: Hospital Outpatient	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for hospital outpatient medical expenses. No negative values.
PR	8	PR008	Claims: Professional Physician, Primary Care	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for professional physician medical expenses. No negative values.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	9	PR009	Claims: Professional Physician, Specialty	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for professional physician medical expenses. No negative values.
PR	10	PR010	Claims: Professional Other	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for other professional services medical expenses. No negative values.
PR	11	PR011	Claims: Retail Pharmacy	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for pharmacy medical expenses. No negative values.
PR	12	PR012	Claims: Long-Term Care	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for all long term care expenses. No negative values.
PR	13	PR013	Claims: Other	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for all other medical expenses.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									No negative values.
PR	14	PR014	Non-Claims: Incentive Programs	1/1/2019	Money	#######.##	12	Yes	
PR	15	PR015	Non-Claims: Capitation and Risk Settlements	1/1/2019	Money	#######.##	12	Yes	
PR	16	PR016	Non-Claims: Care Management	1/1/2019	Money	#######.##	12	Yes	
PR	17	PR017	Non-Claims: Recovery	1/1/2019	Money	#######.##	12	Yes	Report as a negative number.
PR	18	PR018	Non-Claims: Other	1/1/2019	Money	#######.##	12	Yes	
RX	1	RX001	RX Record Type ID	1/1/2019	Text	Text	2	Yes	This must have RX reported here. Indicates the beginning of the Pharmacy Rebate file.
RX	2	RX002	Insurance Category Code	1/1/2019	Integer	#	1	Yes	Indicates the insurance category that is being reported:

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCOs 3 = Commercial: Full-Claim 4 = Commercial: Partial-Adjusted 6 = Medicare and Medicaid Dual-Eligibles, 65 and over 7 = Medicare and Medicaid Dual-Eligibles, 21–64 8 = Other Value must be an integer between ‘1’ and ‘4’ or ‘6’ and ‘8’.
RX	3	RX0003	Pharmacy Rebates	1/1/2019	Money	#####.##	15	Yes	Total pharmacy rebates estimated for Delaware members.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
RX	4	RX0004	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in a plan over a specified period of time expressed in months of membership.
ME	1	ME001	ME Record Type ID	1/1/2019	Text	Text	2	Yes	This must have ME reported here. Indicates the beginning of the Market Enrollment file.
ME	2	ME002	Market Enrollment Category Code	1/1/2019	Integer	#	1	Yes	1 = individual 2 = large group 3 = small group 4 = self-insured 5 = student market
ME	3	ME003	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in market over a specified period of time

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									expressed in months of membership.

File Record Legend:

FILE FIELD	DESCRIPTION
HD-TME	TME header record
PR	Large provider TME record
RX	Pharmacy rebate record
ME	Market enrollment member months

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

TME_2018_01.xlsx or TME_2018_1.xlsx or TME_2018.xlsx

Submitting Files to the DHCC

The files should be submitted to Elisabeth.Scheneman@Delaware.gov and DHCC@Delaware.gov

APPENDIX B

DELAWARE DMMA TME DATA SPECIFICATION

$$THCE = \frac{\text{Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid/CHIP MCO TME + DMMA TME + VA TME + Insurer NCPHI}}{\text{Delaware Population}}$$

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.
- **Insurer:** A private health insurance company that offers commercial insurance and may also administer benefits for self-insured employers. Medicare Advantage and/or are Medicaid/CHIP MCO.
- **Provider:** A term referring to a medical group, individual provider, ACO or similar entities for which TME data is collected from payers in support of the Spending Benchmarks.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[31] The computation of the THCE at the statewide, 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 would include federal and state supplemental rebates on both MCO and FFS drug claims.
- **Total Medical Expense:** The total medical expense incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC.

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

TME DATA OVERVIEW

This DMMA TME data specification provides technical details to assist DMMA in reporting and filing its data to enable the DHCC to calculate TME. This appendix can serve as a stand-alone document that 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 calendar year 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 submission is to include TME data on the following:

- **FFS claims expenditures for enrollees in the Medicaid/CHIP MCOs, such as:**

  Wrap-around dental services for children, behavioral health services in excess of MCO coverage limits, etc.

  This should be accomplished based on aid category code, MCO enrollment indicators and/or other data fields.

- **FFS claims expenditures for individuals not eligible for or not-yet-enrolled in the Medicaid/CHIP MCOs, such as:**

  FFS TME data on Medicaid/CHIP populations excluded from MCO enrollment (e.g., breast and cervical cancer population, DDDS waiver, partial Medicare/Medicaid duals)

  FFS TME data for Medicaid/CHIP MCO-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/non-CHIP populations or programs that are 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-emergency 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 that are 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/CHIP insurers/MCOs (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 the DHCC to calculate NCPHI, DHCC will need copies of select financial report schedules from the Medicaid/CHIP MCOs' calendar year-end audited financial reports. At a minimum, the MCO financial reports that DMMA will be requested to provide include:

- Income Statement (e.g., Schedule B in the CY 2019 DMMA MCO financial reporting template
- HCQI & 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 may request that DMMA include copies of the applicable MCO financial reports when DMMA provides its TME data by September 1 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 flat files of its TME data.[32] The fields are variable in length and relative to position; therefore, they need to be separated by an asterisk (*). DMMA will submit this information on an annual basis. DMMA will have an opportunity to review the final calculation before it is publicly reported by DHCC.

DMMA will submit TME data on the following schedule[33]:

DMMA's TME Filing Schedule

DATE	FILES DUE
September 1, 2019	CY 2018 Final TME
September 1, 2020	CY 2019 Final TME
September 1, 2021	CY 2020 Final TME
September 1, 2022	CY 2021 Final TME
September 1, 2023	CY 2022 Final TME
September 1, 2024	CY 2023 Final TME

TME DATA SUBMISSION

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)

[32] A flat file is a file without structure or formatting.

[33] As noted previously, DMMA should provide copies of the relevant Medicaid MCO financial statements to support the NCPHI calculation following this same schedule.

Claims Run-Out Period Specifications

DMMA shall allow for as much 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 the DHCC data request.

TME DATA FILE LAYOUTS AND FIELD DEFINITIONS

Each item below represents a column in the TME Data File Layout that DMMA will use to submit TME data to the DHCC using an Excel template provided by DHCC.
There are two TME data files that 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

Record Type: Must have "HD-TME" inputted to indicate that this is a header record.

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 of time 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 that accompanies its TME data submission.

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

Provider Expenditure Record File

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

Record Type: Must have "PR" inputted to indicate that this is a provider expenditures record.

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 that is being reported.

PROGRAM CODE	DEFINITION
20	DMMA FFS TME data for Medicaid/CHIP individuals enrolled in the MCOs
21	DMMA FFS TME data for Medicaid/CHIP individuals not eligible or eligible-but-not-yet-enrolled in the MCOs
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[34]

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

- For Program Code 20, this would be the total number of member months associated with Medicaid/CHIP MCO enrollment in the reporting period.
- For Program Code 21, this would be the total number of member months associated with the Medicaid/CHIP individuals not eligible for or eligible-but-not-yet-enrolled in the MCOs (i.e., individuals in the Medicaid/CHIP 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/CHIP MCOs.
- For Program Code 29, this would be the total number of unique member months for all populations DMMA is reporting on (including any populations that were not already included in any previous program code). This will also include any non-Medicaid/CHIP populations that DMMA can readily report data on. In this total, individuals can only be counted once for

[34] DMMA should use Program Code 29 to report TME data for expenditures that are not otherwise easily allocated to a specific Program Code (e.g., DSH payments). DMMA should use its best judgment as to what category to report the applicable expenditure under (e.g., Non-Claims: Other, 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.

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: 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 that 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 that have been billed directly by a physician group practice or an individual physician.

Claims: Professional Physician, Primary Care: All TME data to physicians or physician group practices generated from claims. Includes, but is not limited to, services provided by a doctor of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physician assistants or others not explicitly listed here if defined by DMMA as PCP.

Claims: Professional Physician, 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, if not defined by DMMA as a PCP.

Claims: Professional Other: All TME data from claims to health care providers for services provided by a licensed practitioner other than a physician. 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, dieticians, dentists and chiropractors.

Claims: Retail 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:

- Pharmacy data must be reported in this file **gross** of pharmacy rebates.

- DMMA will report pharmacy rebates in a separate file to enable attribution of rebates to each Medicaid/CHIP MCO versus FFS.

- Medicare Part D claw back payments are not to be reported in any category.

Claims: Long-Term Care: All TME data from claims to health care providers for skilled or custodial nursing facility services, home health care services, home- and community-based services, 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.

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: Incentive Programs: Net payment to providers (**excluding** insurers/MCOs, PACE organizations and NEMT vendors) for achievement or non-achievement in specific predefined goals for quality, outcomes or cost reduction. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments. Report net amount, taking into consideration all provider incentives/bonuses and financial performance penalties for the applicable reporting line. Amount should be reported for each respective program code as applicable.

Non-Claims: Capitation and Risk Settlements: Net payment to providers (**excluding** insurers/MCOs, PACE organizations and NEMT vendors) for capitation, risk sharing, risk corridors, risk settlements or other risk mitigation programs. Report net amount taking into consideration all of DMMA's arrangements for applicable reporting line. Amount should be reported for each respective program code, as applicable.

Non-Claims: Care Management: All payments made to providers for providing care management, utilization review, discharge planning and other care management programs.

Non-Claims: Recovery: All payments received from a provider, member/beneficiary or other payer that 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 is this column that is not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recover amount in this column).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider that were not made on the basis of a claim for health care benefits/services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Reserved: There are data elements "Reserved" in the file layout. These are fields that are 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/CHIP FFS. Medicaid/CHIP MCOs and any other program or population for which DMMA obtains pharmacy rebates.

Record Type: Must have "Rx" inputted to indicate that this is a pharmacy rebate record.

Rebate Program Code: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed to:[35]

PROGRAM CODE	DEFINITION
50	AmeriHealth Caritas Medicaid/CHIP Claims (if practical)
51	Highmark Health Options Medicaid/CHIP Claims (if practical)
55	Total Medicaid/CHIP MCO Claims
56	Other Medicaid/CHIP Managed Care Claims (e.g., PACE) — use only if applicable
57	FFS Medicaid/CHIP Claims (i.e., not any form of managed care)
59	Total DMMA rebates for all programs/populations (inclusive of all expenditures reported in other Rebate Program Codes plus any other DMMA rebates that 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

[35] If, in the future, DMMA contracts with different MCOs, these codes will need to be revised.

respective calendar year, excluding manufacturer-provided fair market value bona fide service fees.[36] 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, on a claims-by-claim basis, etc.). DMMA has indicated the ability to report rebates applicable to each Rebate Program Code (e.g., AmeriHealth, Highmark, FFS, other). However, if DMMA is unable to report rebates specifically for Delaware residents by these Rebate Program Codes, DMMA should proportionally report estimated rebates attributed to each Rebate Program Code.

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

Member Months (Annual): The number of members participating in a Rebate Program Code over the specified period of time expressed in months of membership.

Data File Layout Table

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
HD-TME	1	HD001	Record Type	1/1/2019	Text	HD-TME	6	Yes	This must have HD-TME reported here. Indicates the beginning of the Header Record.
HD-TME	2	HD002	DMMA Org ID	1/1/2019	Text	DMMA	4	Yes	This is to identify this as DMMA's data submission

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

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
HD-TME	3	HD003	Period Beginning Date	1/1/2019	Date period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the start date period of the reported period in the submission file (based on date of service). Example: 01/01/2018
HD-TME	4	HD004	Period Ending Date	1/1/2019	Date period	MMDDYYYY Or MM/DD/YYYY	10	Yes	This is the end date period of the reported period in the submission file (based on date of service). Example: 12/31/2018
HD-TME	5	HD005	Data Pull Date	1/1/2019	Date	MMDDYYYY Or MM/DD/YYYY	10	Yes	Date that DMMA extracted/pulled data to complete the TME data submission.
HD-TME	6	HD006	Comments	1/1/2019	Text	Free Text Comments	255	No	DMMA's comments on TME submission.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	1	PR001	Record Type	1/1/2019	Text	PR	2	Yes	This must have PR reported here. Indicates the beginning of DMMA's provider expenditure TME record.
PR	2	PR002	DMMA Org ID	1/1/2019	Text	DMMA	4	Yes	This is to identify this as DMMA's data submission.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	3	PR003	Program Code	1/1/2019	Integer	####	4	Yes	Indicates the program or nature of DMMA TME data that is being reported: 20 = FFS data for Medicaid/CHIP MCO enrollees 21 = FFS data for Medicaid/CHIP individuals not eligible for or not yet enrolled in the MCOs 22 = DMMA's PACE program 23 = DMMA's NEMT vendor program 29 = Total of all of DMMA's programs and populations being reported on

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	4	PR004	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in a Program Code over a specified period of time expressed in months of membership.
PR	5	PR005	Claims: Hospital Inpatient	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for hospital inpatient medical expenses. No negative values.
PR	6	PR006	Claims: Hospital Outpatient	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for hospital outpatient medical expenses. No negative values.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	7	PR007	Claims: Professional Physician, Primary Care	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for professional physician primary care medical expenses. No negative values.
PR	8	PR008	Claims: Professional Physician, Specialty	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for professional physician specialty medical expenses. No negative values.
PR	9	PR009	Claims: Professional Other	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for other professional medical expenses. No negative values.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	10	PR010	Claims: Retail Pharmacy	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for pharmacy medical expenses. No negative values.
PR	11	PR011	Claims: Long-Term Care	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for long term care expenses. No negative values.
PR	12	PR012	Claims: Other	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for all other medical/benefit expenses. No negative values.
PR	13	PR013	Non-Claims: PACE	1/1/2019	Money	#######.##	12	Yes	DMMA's payments to PACE organization(s).
PR	14	PR014	Non-Claims: NEMT Vendor(s)	1/1/2019	Money	#######.##	12	Yes	DMMA's payments to the NEMT vendor(s).

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	15	PR015	Non-Claims: Incentive Programs	1/1/2019	Money	#######.##	12	Yes	
PR	16	PR016	Non-Claims: Capitation and Risk Settlements	1/1/2019	Money	#######.##	12	Yes	
PR	17	PR017	Non-Claims: Care Management	1/1/2019	Money	#######.##	12	Yes	
PR	18	PR018	Non-Claims: Recovery	1/1/2019	Money	#######.##	12	Yes	Report as a negative number.
PR	19	PR019	Non-Claims: Other	1/1/2019	Money	#######.##	12	Yes	
RX	1	RX001	RX Rebate Record Type ID	1/1/2019	Text	Rx	2	Yes	This must have “RX” reported here. Indicates the beginning of DMMA’s Pharmacy Rebate file.
Rx	2	RX002	DMMA Org ID	1/1/2019	Text	DMMA	4	Yes	This is to identify this as DMMA’s pharmacy rebate submission.

RX	3	RX003	Rebate Program Code	1/1/2019	Integer	####	4	Yes	Indicates the program/source of claims the rebate dollars are attributed to: 50 = AmeriHealth Caritas claims 51 = Highmark Health Options claims 55 = Total Medicaid/CHIP MCO claims 56 = Other Medicaid/CHIP managed care claims (e.g., PACE), if applicable 57 = FFS Medicaid/CHIP claims 59 = Total of all rebates for all claims including any other programs not reported in other Rebate Program codes
RX	4	RX004	Pharmacy Rebates	1/1/2019	Money	#####.##	15	Yes	Total pharmacy rebates for

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									Delaware members.
RX	5	RX005	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in the respective Rebate Program Code over a specified period of time expressed in months of membership.

FILE SUBMISSION NAMING CONVENTIONS

Data submissions should follow the following naming conventions:

DMMA_TME_YYYY_Version.xls

YYYY is the four-digit year of **submission** (which will generally be one year later than the year of the data reflected in the report).

Version is **optional** and indicates the submission number.

The file extension must be .xls or xlsx

Below are examples of valid file names:

DMMA_TME_2018_01.xls or DMMA_TME_2018_1.xlsx or DMMA_TME_2018.xlsx

SUBMITTING FILES TO THE DHCC

The files should be submitted to Elisabeth.Scheneman@Delaware.gov and DHCC@Delaware.gov

APPENDIX C

MEDICARE FFS TME DATA COLLECTION PROCESS

$$THCE = \frac{\left(\begin{array}{l}Commercial\ TME + Medicare\ Advantage\ TME + Medicare\ FFS\ TME + \\ Medicaid/CHIP\ MCO\ TME + DMMA\ TME + VA\ TME + Insurer\ NCPHI\end{array}\right)}{Delaware\ Population}$$

DHSS 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., 2018 data is available September 1, 2019). CMS believes that 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
- Physician (primary care)
- Physician (specialty)
- Other professionals
- Durable medical equipment
- Other suppliers

- Part D[37]

These 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	Other
Hospice	Long-Term Care
Skilled Nursing Facility	Long-Term Care
Physician (Primary Care)	Professional Physician (Primary Care)
Physician (Specialty Care)	Professional Physician (Specialty Care)
Other Professionals	Other
Durable Medical Equipment	Other
Other Suppliers	Other
Part D	Retail Pharmacy

CMS will also share enrollment figures for Medicare Parts A, B and D broken out between managed care and FFS.

To receive Medicare FFS TME data from CMS, DHSS needs to make a formal request to CMS by emailing the attached Excel file **(Attachment 3)** to Stephanie Bartee, Acting 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. **Please note,**

[37] 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.

CMS has specifically requested that Delaware staff (not a contractor) make the official request.

CMS is willing to share the data with DHSS by September 1 if the data request is made by June 1.

APPENDIX D

VA TME DATA COLLECTION PROCESS

Statistics on Delaware veteran health care spending is published in the summer by the US Department of Veterans Affairs 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 "VA TME" in the formula below:

$$THCE = \frac{\left(\begin{array}{l} Commercial\ TME + Medicare\ Advantage\ TME + Medicare\ FFS\ TME + \\ Medicaid/CHIP\ MCO\ TME + DMMA\ TME + VA\ TME + Insurer\ NCPHI \end{array}\right)}{Delaware\ Population}$$

Per the notes on the VA 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 the VA expenditure report data is reported on a federal fiscal year basis (October–September) and not on a calendar year basis. Therefore, DHCC should utilize the fiscal year that contains nine months of the reporting calendar year (e.g., fiscal year 2018 data should be used in lieu of calendar year 2018 data). This is not consistent with the reporting from other payers 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 manual will need to be updated.

VA TME is only reported at the State level.

APPENDIX E

NCPHI DATA SPECIFICATION

$$THCE = \frac{\text{Commercial TME + Medicare Advantage TME + Medicare FFS TME + Medicaid/CHIP MCO TME + DMMA TME + VA TME + Insurer NCPHI}}{\text{Delaware Population}}$$

NET COST OF PRIVATE HEALTH INSURANCE

This element captures the costs to Delaware residents associated with the administration of private health insurance. 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. 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 seven different market segments: (1) Individual Market; (2) Small Group, Fully Insured; (3) Large Group, Fully Insured; (4) Student; (5) Medicare Advantage; (6) Medicaid MCOs; and (7) Self-Insured. To derive the aggregate NCPHI, each segment's PMPM amount will then be multiplied by the Delaware resident market enrollment, in each segment, in member months as reported within the TME submission. The methodology and data sources for the calculation of NCPHI for each market segment are described below.

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.[38] MLR reports need to be requested from insurers as part of their TME data submission due annually on August 1. Although these reports become publicly available in the fall, insurers will need to submit them August 1 in order to meet the Spending Benchmark reporting timeline. In an instance in which the MLR report submitted to DHCC on August 1 differs from the final submission an insurer makes to the federal Center for Consumer Information and Insurance Oversight, the insurer must notify DHCC in writing as soon as possible. The data elements that will be used in the calculation are detailed below:

[38] Available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html

NCPHI =

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)

$$\textit{NCPHI PMPM} = \frac{\textit{NCPHI}}{\textit{Member Months}}$$

Medicare Advantage

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 (PDP) 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. The data elements that will be used in the calculation are detailed below:

NCPHI =

Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)

$$\textit{NCPHI PMPM} = \frac{\textit{NCPHI}}{\text{Member Months}}$$

Medicaid MCO Market

The Medicaid MCO includes government programs such as Medicaid Title XIX and CHIP Title XXI risk contracts and other federal or State government-sponsored coverage. Medicaid MCOs participating in this market complete a financial reporting template on a quarterly basis that reports financial experience. DMMA is responsible for the development of these required financial reporting templates. To support the NCPHI calculation, DHCC will need to request from DMMA the applicable financial report(s) that contain(s) the necessary information. At a minimum, the Medicaid MCO financial reports that DHCC will need to obtain from DMMA are:

- Income Statement (e.g., Schedule B in the CY 2019 DMMA MCO financial reporting template)
- HCQI & 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 that 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 page "B-Income Statement QTRLY," column G showing year-to-date (YTD) results for period ending December 31. The formula will be:

NCPHI = [TOTAL REVENUES (Line 9) – Investment Income (Line 7)] – [TOTAL MEDICAL EXPENSES & HCQI EXPENSES (Line 70) – Total Healthcare Quality Improvement (Line 69)]

$$\textit{NCPHI PMPM} = \frac{\textit{NCPHI}}{\text{Member Months (Line 1)}}$$

Since DMMA will occasionally revise the Medicaid MCO financial reporting templates, DHCC will need to confirm with DMMA the appropriate Line # and Statement name used to obtain the data necessary for the NCPHI calculation. DHCC should contact Josh Aidala or the current Health Care Cost Containment Specialist at DMMA.

Footnote 18 on page "C-Footnotes" 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 financial statements.

Self-Insured Market

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

NCPHI =

Income from fees of uninsured plans (Part 1, Line 12)

$$\textit{NCPHI PMPM} = \frac{\textit{NCPHI}}{\textit{Member Months}}$$

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

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

LINE OF BUSINESS/MARKET	SHCE COLUMN	MLR COLUMN (PARTS 1 AND 2)	MLR COLUMN (PART 3)
Medicare Advantage and PDP	12	N/A	N/A
Medicaid MCO	N/A	N/A	N/A
Self-Insured	14	N/A	N/A

APPENDIX F

DELAWARE TOTAL POPULATION STATISTICS

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 US 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.

$$THCE = \frac{\left(\begin{array}{l}Commercial\ TME + Medicare\ Advantage\ TME + Medicare\ FFS\ TME + \\ Medicaid/CHIP\ MCO\ TME + DMMA\ TME + VA\ TME + Insurer\ NCPHI\end{array}\right)}{Delaware\ Population}$$

APPENDIX G

INSURER QUALITY DATA REPORTING MANUAL

Delaware has established health care quality benchmark values that foster accountability for improved health care quality in the state. The purpose of this document is to provide instructions for insurer submission of data.

Health insurers subject to reporting must annually provide performance data to the Delaware Health Care Commission (DHCC) for the following measures at both the health insurer level and provider level, by line of business.

MEASURE	SPECIFICATION	LINES OF BUSINESS	REPORTING UNIT
Concurrent use of opioids and benzodiazepines	PQA	Commercial Medicaid	Insurer Provider
Emergency department utilization	HEDIS, version corresponding to performance period	Commercial	Insurer
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 Performance Submission Template

One “Quality Benchmark Performance 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 120 days of claims runout.

The “Quality Benchmark Performance Submission Template”, refer to **Attachment 6,** contains one tab that payers should complete: “Quality Performance”. Illustrative examples are provided in rows 11 and 12 of the accompanying spreadsheet.

- **Cell C3** requests the calendar year 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 that 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 M–V** ask for the measure performance data by measure:
  - **Column M**, Emergency Department Utilization Observed-to-Expected Ratio requests input of the observed-to-expected ratio.
  - **Columns O–V**, Concurrent Use of Opioids and Benzodiazepines (columns O & P), Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80% (columns R & S), and Persistence of Beta-Blocker Treatment After a Heart Attack request numerator and denominator information (columns U & V).

Timeline

Materials must be electronically submitted annually by August 1 of the year immediately following the performance period, to Elisabeth.Scheneman@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. Scanned copies of the signed attestations should be emailed to Elisabeth.Scheneman@Delaware.gov and DHCC@Delaware.gov.

Insurer: _____

Performance Period Being Reported: _____

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

STAFF/CONTRACTOR REQUIREMENTS

To assess performance against the Spending and Quality Benchmarks, DHCC will need to acquire staff support to conduct the analysis. This may come in the form of State staff or contracted vendor staff. The following skills are necessary to complete the analysis.

- Strong analytical skills, including the ability to identify anomalies in data submissions or resulting analysis and to update the Benchmarks methodology as necessary
- Strong communication skills, particularly around communicating and understanding written and verbal communication about data and associated calculations and analyses. Experience communicating with a variety of health care stakeholders, including data professionals and business professionals
- Expertise in working with health care data, including understanding the strengths and limitations of claims and quality data
- Aptitude to develop expertise in the source data
- Expertise in Excel, including combining data across multiple data books, data manipulations, error checking and statistical analysis
- Strong organizational skills and ability to manage a complex project under time pressure

In addition to State or contracted vendor staff who will conduct the analysis, DHCC will also need access to staff who have expertise in communications so that performance against the benchmark can be published in materials that are easy to read. The following skills are necessary to publish the results of the analysis.

- Expertise in communications, preferably around health care data
- Expertise in displaying complex data in an easy to read format using multiple methods, including website design, electronic and print publications

APPENDIX J

LIST OF PAYERS DHCC REQUESTS DATA FROM FOR SPENDING AND QUALITY BENCHMARKS AND ORGANIZATIONAL ID

PAYER	COMMERCIAL FULLY AND SELF-INSURED	MEDICARE ADVANTAGE	MEDICAID/CHIP MANAGED CARE	GOVERNMENT	ID
Aetna	✓	✓			101
AmeriHealth Caritas			✓		102
Cigna	✓	✓			103
Highmark Blue Cross Blue Shield Delaware	✓		✓		104
UnitedHealthcare	✓	✓			105
DMMA				✓	106
Medicare				✓	107
Veterans Health Administration				✓	108

This table should be updated annually to account for any changes in the Delaware insurer market.

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