MERCER

Delaware Health Care Spending and Quality Benchmarks

Implementation Manual Version 2.0

State of Delaware
June 25, 2020

welcome to brighter

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. While we are still addressing the health care, humanitarian and fiscal crisis created by COVID-19, our essential purpose in driving change to make health care better for all Delawareans through our "Road to Value" is still vitally important. We need to support our health care system to rebound from the global pandemic with value-based goals, so it can be stronger than ever. Now, more than ever, our vision to improve transparency and public awareness of spending and quality in our State through the adoption of spending and quality benchmarks will assist in these efforts.

In 2018, the Department of Health and Social Services, the Delaware Health Care Commission and the Delaware Economic and Financial Advisory Council worked together to establish the spending and quality benchmarks. I want to personally thank the insurers that reported initial calendar year 2018 baseline data during 2019, giving them and the Department experience in collecting and reporting data, which is essential to the benchmarks and improving the process moving forward.

The enclosed updated implementation manual (version 2.0) reflects the experience the Department gained as a result of collecting the preliminary calendar year 2018 baseline data. We thank the participating insurers for submitting data and working with the Department to improve the data collection and reporting process. 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.

Working together, we can support the goal of making sure Delawareans can access and afford quality health care. The benchmarks are a means to continue the conversation about how to improve cost and quality for the individuals we serve as patients and members in our communities.

Sincerely,

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 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:

Section 1: Overview

Section 2: Health Care Spending Benchmark Definition and Methodology

Section 3: Methodology for Assessing Performance Against the Spending Benchmark

Section 4: Health Care Quality Benchmarks

Appendix A. Insurer TME Data Specification and Request for Net Cost of Private Health Insurance (NCPHI)-Related Data

Appendix B. Delaware Division of Medicaid & Medical Assistance (DMMA) TME Data Specification

Appendix C. Medicare Fee for Service (FFS) TME Data Collection Process

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Attachment 1. Center for Health Information and Analysis – Performance of the Massachusetts Health Care System Annual Report (October 2019 version)

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Attachment 3. Spending Benchmark Performance Submission Template

Attachment 4. Quality Benchmark Performance Submission Template

Attachment 5. DMMA Spending Benchmark Performance Submission Template

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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 CY 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 CY 2022–2023.

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

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

The sources for each of the components of the PGSP formula are included below in Table 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 Congressional Budget Office's (CBO's) Projections of Real Potential Gross Domestic Product, which includes the potential labor force productivity projected average annual growth (e.g., page 13, Table 2 of the August 2018 report for the values from 2023–2028). The figure used to calculate PGSP should be the value 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, DHCC must calculate the average percentage change in civilian labor force growth for five and 10 years into the future (e.g., in 2018, the average annual growth was calculated by averaging the percentage growth for years 2023–2028 from the "Delaware-Summary" tab for the "Civilian" data row).
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 (e.g., page five, Table 1 of the August 2018 report for CY 2023–2028). 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 May 26, 2020, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1. The budget projections and economic forecast are generally issued each January and updated in August.

[2] Ibid

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, DHCC must average the forecasted percentage change in total population growth for years five to 10 into the future (e.g., in 2018, the average annual growth was calculated using the percentage growth for years 2023–2028 from the "Delaware-Summary" tab for the "Population" data row).

For the development of the initial spending benchmarks, the period of 2023–2028 was consistent with the desired future forecast period of five to 10 years into the future, which is a common future period used in economic modeling. If DEFAC chooses to update the spending benchmark, a commensurate future 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 (i.e., if the computed value of expected state population growth is 0.87%, the value used in the PGSP formula should be rounded to 0.9%).

Using the sources listed above, the value calculated in 2018 to establish the PGSP (excluding any transitional market adjustments) is presented in Table 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 PGSP	3.5%	D = A + B + C
Expected state population growth	0.5%	E
Potential per capita gross state product	3.0%	D - E

Process for Annual Review of Components of PGSP for CY 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 large

unanticipated economic changes have occurred in Delaware's economy, which warrant spending benchmark modification.

Starting in 2019, the DEFAC Subcommittee is to review all components of the PGSP methodology on an annual basis to determine whether the PGSP growth rate has changed in a material way, which 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[3] 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 CY 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 2028–2033 (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.

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

3 Methodology for Assessing Performance Against the Spending Benchmark

Executive Order 25 encourages the DHCC[4] 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.[5] This section 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.[6] This section is organized as follows:

1. Definitions of Key Terms.
2. Methodology for Measuring 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 THCE.

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

[5] To complete the work, it is estimated 2.5 FTEs will be needed for the two months following the annual data submissions and 0.25 FTE required the rest of the year. These FTEs could be State staff or vendor staff contracted by DHCC. For more information on what types of skills staff would need to complete the analysis, please see Appendix H.

[6] 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 one or more of the following, commercial insurance benefit administration for self-insured employers, Medicare managed care products and/or are Medicaid/Children's Health Insurance Program (CHIP) managed care organization (MCO) products.
- **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 managed care are collectively referred to as the "Medicare Market." Medicaid/CHIP 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 managed care and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels. NCPHI will not be reported at the provider level.
- **Payer:** A term used to refer collectively to both insurers and public programs submitting data to DHCC.
- **Payer Recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or through a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer TME reporting.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[7] The

[7] Fair market value bona fide service fees are 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 manufacturer, which the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service feeds, distribution service fees, patient care management programs, etc.).

computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[8]

- **Provider:** A term referring to an individual clinician, medical group, accountable care organization (ACO) or similar entities.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid/CHIP FFS, the Veterans Health Administration (VHA) and similar entities/programs.
- **Total Health Care Expenditures (THCE):** The TME incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC, plus the insurers' NCPHI.
- **Total Health Care Expenditures per Capita:** THCEs (as defined above) divided by Delaware's total state population. The annual change in THCE per capita is compared to the Spending Benchmark at the State, market and insurer levels. THCE will not be reported at the large provider level.[9]
- **Total Medical Expense (TME):** The sum of the allowed amount of total claims spending and total non-claims paid to providers incurred by Delaware residents for all health care services. TME is reported at multiple levels: state, market, payer and provider. TME is reported net of pharmacy rebates at the state, market and payer levels, only. Payers report TME by insurance category code (e.g., Medicare and Medicare Managed Care, Commercial — Full Claims, etc.) and at the provider level whenever possible. TME excludes Medigap members and claims. More detailed TME reporting specifications are contained in the Appendices of this manual.
- **Veterans Health Administration (VHA):** The federal agency responsible for provision of health care benefits to veterans.

Methodology for Measuring THCE

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.

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[8] 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.

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

THCE (in aggregate) =

Commercial TME + Medicare Managed Care TME + Medicare FFS TME + Medicaid/CHIP Managed Care TME + DMMA FFS TME + VHA TME + Insurer NCPHI

THCE (per capita) =

$$\frac{\text{Commercial TME + Medicare Managed Care TME + Medicare FFS TME + Medicaid/CHIP Managed Care TME + DMMA FFS TME + VHA TME + Insurer NCPHI}}{\text{Delaware Population}}$$

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

Example: If the CY 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).

- Vision and dental spending are generally excluded except in instances where vision and dental services are covered as a health insurance benefit or are a covered benefit under Medicaid and Medicare.

- It represents the total allowed amount, which is inclusive of both amounts covered by payers and out-of-pocket spending associated with insured medical expenditures (e.g., copays and deductibles). In order to avoid double counting expenditures, health care premium payments are not included. Also, due to the lack of available data, other out-of-pocket expenditures recorded by providers, but not by insurers, are not included (e.g., “charity care” or spending for medical care by residents of Delaware who cannot afford to pay providers, privately purchased health care services).

- It includes all insurance market segments, including public and private payers listed in this manual, fully and self-insured and student insurance with the following limited exceptions: the TRICARE

program and health spending by the Delaware Department of Corrections, which is not otherwise covered by Medicaid/CHIP.

- The administrative costs and underwriting gain/loss of insurers, referred to as the NCPHI, are included (see Section 3 for more detail).
- TME data is only collected from a payer when it is the primary payer for that specific claim. The primary payer will report on the allowed amount. If the secondary payer on that specific claim were to report, it would cause double counting of a portion of the allowed amount by the primary payer.
- TME is adjusted (i.e., net of rebates) to account for any pharmacy rebates received by the payer.

Data Sources for THCE

Data for THCE comes from several sources. Insurers need to report TME for all lines of business, and in some instances, insurers need to report data for the State to calculate the NCPHI. Other data sources include the Centers for Medicare & Medicaid Services (CMS), DMMA and VHA. 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 Part D.[10]	CMS	Appendix C

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

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
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
VHA summarized data	Veterans Health Administration	Appendix D
Net Cost of Private Health Insurance		
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 and in some limited amount by the insurers[11]	Appendix B
Population Statistics		
Population of Delaware	U.S. 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, DHCC will direct applicable insurers to submit TME data using the specifications outlined in **Appendix A** and the template provided as **Attachment 3**. Specifications for public programs to submit their TME data are included in **Appendices B–D** with the Medicare template provided as **Attachment 2** and the DMMA template provided as **Attachment 5**. The full list of payers reporting by

level, the insurer reported Part D pharmacy data could be used. See Appendix C for more information on reporting Medicare Part D spending data.

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

line of business is included in **Appendix I**. Table 4, below, lists that insurers should report for their commercial, Medicare managed care and Medicaid/CHIP managed care markets.[12]

Table 4. Insurers Requested to Report TME Data by Market

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

The TME data includes claims and non-claims payments[13] for a single CY. Payers should submit these data based on allowed amounts, which include paid claims as well as patient cost-sharing amounts, such as copayments, coinsurance and deductibles.

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

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

In some circumstances, insurers are only able to report claim payments for a subset of medical services due to benefit design, in which the contracting employer may “carve-out” some services, such as behavioral health or pharmacy services, and contract for their coverage separately from the main medical coverage. In these instances, insurers are unable to obtain the payment information and do not hold the insurance risk for the carved out services. Insurers will need to report this type of TME

[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.

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

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 include the full spending estimated amounts without having to collect data from carve-out vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per member per month (PMPM) for the same year, calculated on members who had pharmacy coverage, applied to all member months for which the carve-out applied. Before this adjustment is made, insurers should discuss appropriate methodologies with DHCC, recognizing there is no standardized approach to this estimate, but that actuarially sound principles should be used.

Appendix A includes instructions for insurers to submit pharmacy rebate data so DHCC can subtract pharmacy rebates from THCE and TME at the market and insurer levels. Payers will need to proportionally allocate total pharmacy rebates by line of business to Delaware resident members, unless rebates can be directly associated to a specific line of business.

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 including net additions to reserves, rate credits and dividends and profits and losses.

DHCC will need to calculate NCPHI for all Delaware residents whose insurers are submitting data to DHCC, using data obtained from insurers and other public sources. NCPHI should exclude out-of-state residents covered under Delaware-based insurance plans. The methodology 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 DHCC should undertake. The type of public reporting of performance relative to the spending benchmark will likely evolve over time, and thus, this manual will 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.

[14] It is not recommended VHA 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 VHA consists of spending by veterans within the VHA system and does not cover the spending those veterans receive from non-VHA health care facilities, possibly underestimating their per capita spending.

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
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 managed care and Medicaid managed care)	PMPY Compare PMPY rate of change against benchmark	Report TME and NCPHI components
Large provider (if statistically valid)	N/A	Report TME only, PMPY Compare PMPY rate of change against benchmark

Reporting should be done using both text and graphics, which 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 (October 2019 version).

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

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

Reporting TME by Service Category

The TME data specifications for payers requires data to be reported by major service category (e.g., hospital inpatient). 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 attributable to each service category.

A goal with the collection of TME data is to obtain summary level payer data segmented into a manageable number of distinct service categories all payers can consistently and accurately report. However, in reality, there may be limitations on some payers' ability to report data at the desired service category level. Therefore, the DHCC will 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. A standardized, hierarchical-based service category-coding matrix for all service categories may be included in a future version of this manual.

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 (Primary Care).
- Professional Physician (Specialty Care).
- Professional Other.
- Long-Term Care.
- Pharmacy.[18]
- Pharmacy Rebates.
- Other.

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

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

More information on what specific types of services are included in each of the respective service categories provided within the payer technical specification appendices. DHCC will acknowledge when analyzing and reporting these data publicly there may be some limitations in consistent interpretation across payers, for the duration these categories are not defined with specific codes.

Reporting TME by Large Provider and Members Unattributed to a Primary Care Provider (PCP)

DHCC will request insurers submit TME data at the provider level by applying an attribution methodology, which will assign members to a 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 CY should be allocated based on the number of months associated with each PCP).

2. Members not included in the first option above, 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 the first and second option above, 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. For DHCC to calculate market performance, insurers must report spending in aggregate for members not attributable to a PCP. The details of insurer attribution to a Large Provider is included in the TME specification in **Appendix A.**

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. However, DHCC will continue to collect data by provider level to monitor market changes, which may allow for provider-level attribution.

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.

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

Given the small size of many Delaware providers, prior to reporting CY 2019 data, 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 originally called for DHCC to publish THCE statistics in the fourth quarter of each CY following the respective reporting/data year. However, given the time required to collect and validate the data and to create the public reporting template, it is expected DHCC will be given permission to issue its report in the first quarter following the year the data is collected (e.g., CY 2019 report issued in Q1 2021).

Preliminary CY 2018 data was collected in 2019 to give insurers and DHCC an opportunity to test the data submission process. Based on lessons learned, CY 2018 data will be collected again as part of the CY 2019 data collection process to ensure better year-over-year comparisons of payer submitted data. DHCC intends to collect least two years of data in each annual cycle to ensure year-over-year comparisons are as “apples-to-apples” as practical.

Prior to data requests being submitted to insurers, DHCC 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.

Information related to the timeline for benchmark measuring and reporting can be found on DHCC’s benchmark website: https://dhss.delaware.gov/dhcc/global.html

4

Health Care Quality Benchmarks

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

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

Key Terms and Common Acronyms

Annual Quality Benchmark: A measure of frequency describing the annual performance target for a priority Delaware population-health or quality-of-care concern. Performance relative to an annual quality benchmark is assessed at the state level and depending upon the measure and its data source, the market,[20] insurer and provider levels.

Aspirational Quality Benchmark: A measure of frequency describing the five-year performance goal for a priority Delaware population-health or quality-of-care concern.

1. **Behavioral Risk Factor Surveillance System (BRFSS)**: A health-related telephonic survey, which collects state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions and use of preventive services.

[20] Excluding Medicare FFS and Medicare managed care.

2. **Centers for Disease Control and Prevention (CDC):** National health protection agency with responsibilities including detecting and responding to new and emerging health threats, and promoting healthy and safe behaviors, communities and environment.

3. **CDC Wonder — Multiple Cause of Death (MCD):** CDC Wonder is a system for disseminating public health data and information. The MCD data available on CDC WONDER are county-level national mortality and population data. Data are based on death certificates for U.S. residents. For the purposes of the benchmark, state level information is utilized.

4. **Health Care Effectiveness Data and Information Set (HEDIS):** Standardized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). These measures are designed to allow consumers and purchasers to compare plans against national or regional benchmarks.

5. **Health Status Measures:** These measures quantify certain population-level characteristics of Delaware residents.

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

7. **National Committee for Quality Assurance (NCQA**): Organization that works to improve health care quality through the administration of evidence-based standards, measures, programs and accreditation.

8. **Youth Risk Behavior Survey (YRBS):** Includes national, state, territorial, tribal and local school-based surveys to monitor health behaviors, which contribute to death, disability and social problems in youth. Typically conducted every two years.

Overview of Measures

Delaware has adopted eight quality benchmarks for measurement of CY 2019–2021. These measures are categorized as health status measures or health care measures, and are described in the table below:

Measure Name	Description	Market	Data Source/Technical Specifications[21]
Health Status Measures			
Adult obesity	The percentage of adults with a body mass index (BMI) greater than or equal to 30 weight (kg)/height (m2), as defined by the CDC.	All State	BRFSS, CDC https://www.cdc.gov/brfss/ 2016_BRFSS_Questionnaire_FINAL.pdf
High school students who were physically active	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.	All State	YRBS, CDC https://www.cdc.gov/healthyyouth/data/yrbs/index.htm 2017_yrbs_standard_hs_questionnaire.p
Opioid-related overdose deaths	Number of opioid-related overdose deaths per 100,000 persons, as defined by the CDC.[22]	All State	CDC — Wonder: MCD Data https://wonder.cdc.gov/wonder/help/mcd.html Multiple Cause of Death

[21] Note the surveys and the technical specifications included here are the originals used to calculate the baseline.

[22] Deaths were classified 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).

Measure Name	Description	Market	Data Source/Technical Specifications[21]
Tobacco use	The percentage of adults who report 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.		BRFSS, CDC https://www.cdc.gov/brfss/ 2016_BRFSS_Questionnaire_FINAL.pdf
Health Care Measures			
Opioid-related measure	TBD		
Emergency department utilization (EDU)	For members 18 years of age and older, a risk-standardized measure of the emergency department (ED) visits during the measurement year.	Commercial	Claims https://www.ncqa.org/hedis/measures/ (NCQA-HEDIS, modified[23]) Emergency Department Utilizati
Persistence of beta-blocker treatment after a heart attack	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.	Commercial and Medicaid	Claims NCQA-HEDIS https://www.ncqa.org/hedis/measures/ Persistence of Beta Blocker Treatment A

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

Measure Name	Description	Market	Data Source/Technical Specifications[21]
Statin therapy for patients with cardiovascular disease — statin adherence 80%	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.	Commercial and Medicaid	Claims NCQA-HEDIS https://www.ncqa.org/hedis/measures/ Statin Therapy for Patients with Cardio

CY 2019–2021 Quality Benchmarks

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

Measure	Aspirational Goal and Source	Baseline Rate	2019 Goal	2020 Goal	2021 Goal	Annual Percentage Point Change Goal
Health Status Measures						
Adult obesity	27.4% All State. Seventy-fifth percentile (all states, 2016 BRFSS, CDC)	30.7%	30%	29.4%	28.7%	0.7%
High school students who are physically active	48.7% All State. Seventy-fifth percentile (all states, 2017 YRBS, CDC)	43.5%	44.6%	NA[24]	46.8%	1.1%

[24] There is no benchmark for 2020 performance as the survey serving as the federal government every other year administers the data source.

Measure	Aspirational Goal and Source	Baseline Rate	2019 Goal	2020 Goal	2021 Goal	Annual Percentage Point Change Goal
Opioid-related overdose deaths	13.3 deaths per 100,000 (state population) Fiftieth percentile (all states, 2016, CDC)	16.9 deaths per 100,000	16.2 per 100,000	15.5 per 100,000	14.7 per 100,000	0.7 deaths per 100,000
Tobacco use	14.6% All State. Seventy-fifth percentile (all states, 2016 BRFSS, CDC)	17.7%	17.1%	16.4%	15.8%	0.6%
Health Care Measures						
Opioid-related Measure	TBD					
EDU	165.9 visits[25] per 1,000 risk standardized rate. Commercial. Seventy-fifth percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)	196 visits[26] per 1,000	190 per 1,000	183.9 per 1,000	177.9 per 1,000	6 visits per 1,000

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

[26] 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.

Measure	Aspirational Goal and Source	Baseline Rate	2019 Goal	2020 Goal	2021 Goal	Annual Percentage Point Change Goal
Persistence of beta blocker after a heart attack — Commercial	91.9% Commercial. Ninetieth percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)	80.2%[27]	82.5%	84.9%	87.2%	2.3%
Persistence of beta blocker after a heart attack — Medicaid	83.9% Medicaid. Seventy-fifth percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)	77.6%[28]	78.8%	80.1%	81.3%	1.3%
Statin therapy for patients with cardiovascular disease — Commercial	82.1% Ninetieth percentile (national, commercial all lines of business, 2017, NCQA 2018 Quality Compass)	79.4%[29]	79.9%	80.5%	81%	0.5%
Statin therapy for patients with cardiovascular disease — Medicaid	68.3% Seventy-fifth percentile (national, Medicaid HMO, 2017, NCQA 2018 Quality Compass)	56.9%[30]	59.2%	61.5%	63.7%	2.3%

[27] 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).

[28] 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).

[29] 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.

[30] 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.

Annual Review of Changes to Measure Specifications

DHCC staff should conduct an annual review of the specifications to determine if any changes have been made, which could have an impact on performance rates as compared to the benchmark year.

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

For health care measures, the technical specifications need to be reviewed and compared. HEDIS measures are typically updated on an annual basis and identify the changes to the methodology. DHCC should also review the modified HEDIS specifications for the EDU measure to determine if any revisions are required.

The review should be completed by August 1 following the measurement year for all measures except for Opioid-related overdose deaths, which should be completed by February 1 two years following the measurement year.

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

1. For Health Status Measures, DHCC should ask the Department of Health and Social Services (DHSS) Division of Public Health staff if the changes to the specifications are substantive.

    A. If DHSS Division of Public Health staff view these changes as potentially substantive, DHCC should obtain the national median performance for the measurement year in which the potentially substantive specification change occurred as well as the three most recent available performance periods prior to the potentially substantive change.[31] Steps to calculate the national performance are included in **Appendix J**.

    B. If changes are deemed not potentially substantive, no further steps need to be taken.

2. For health care measures,[32] review NCQA's Measure Trending Determinations (posted at https://www.ncqa.org/hedis/measures/ in March/April following the measurement period).

    A. If NCQA has recommended trending with caution or a break in trending, DHCC should obtain the national median performance for the measurement year in which the potentially substantive specification occurred as well as the three most recent available performance periods prior to the potentially substantive change. Steps to calculate the national performance are included in **Appendix J**.

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

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

B. If NCQA has not recommended trending with caution or a break in trending, no further steps need to be taken.

3. Look at performance change over time. For measures with separate commercial and Medicaid rates, this step should be performed individually for each line of business.

   A. Calculate the year-over-year trend for each of the prior performance years and compare that value to the measurement year trend absolute value.

      i. If the difference between the two absolute values is greater than three percentage points, the change should be considered substantive.

4. If the change is deemed substantive, DHCC staff have three options:

   A. Remove the measure's quality benchmark for the affected and future years (this should only be done if the revised measure's results indicate there is 1) no longer an opportunity for improvement in Delaware; or 2) the change to the measure is so dramatic any benchmark adjustment is deemed inappropriate to DHSS or DHCC).

   B. Reset the measure's benchmark for the year in which there was a substantive change as well as all future years for which there is a benchmark.

   C. Maintain the original benchmark and re-evaluate after the next measurement period.

5. If DHCC staff would like to reset the benchmark, the following steps should be taken:

   A. DHCC should adjust both the aspirational benchmark and the prior year's performance rate by the trend difference as calculated in step 3.

   B. DHCC should next subtract the prior year's benchmark rate from the aspirational benchmark value and divide the result by the number of years remaining until the aspirational benchmark year (2023).

   C. Finally, DHCC should adjust the annual benchmarks by the quotient of step 5b with resulting values rounded to one decimal point.

The table below includes the following information for each quality measure: 1) the specification used to calculate the aspirational benchmarks, 2) the location for obtaining updated specifications each year and 3) the 2019 specifications, as well as a determination of whether there were substantive changes in 2019.

Measure	Benchmark Specification[33]	Specification Location	2019 Determination of Substantive Changes And Specification
Health Status Measures			
Adult obesity	2016 BRFSS	https://www.cdc.gov/brfss/questionnaires/index.htm	No substantive changes 2019-BRFSS-Questionnaire-508.pdf
High school students who were physically active	2017 CDC YBRS	https://www.cdc.gov/healthyyouth/data/yrbs/questionnaires.htm	No substantive changes 2019_YRBS-Standard-HS-Questionnaire
Opioid-related overdose deaths	1999–2016 CDC WONDER	https://wonder.cdc.gov/wonder/help/mcd.html	2019 specification not available as of 4/16/2020 but no substantive changes in 2018 Multiple Cause of Death 1999-2018.pd
Tobacco use	2016 BRFSS	https://www.cdc.gov/brfss/questionnaires/index.htm	No substantive changes 2019-BRFSS-Questionnaire-508.pdf
Health Care Measures			
Opioid-related measure — TBD			
EDU	HEDIS 2018, modified to use risk-standardized rate	https://www.ncqa.org/hedis/measures/	No substantive changes Emergency Department Utilizati

Measure	Benchmark Specification[33]	Specification Location	2019 Determination of Substantive Changes And Specification
Persistence of beta-blocker treatment after a heart attack	HEDIS 2018	https://www.ncqa.org/hedis/measures/	No substantive changes Persistence of Beta Blocker Treatment.p
Statin therapy for patients with cardiovascular disease — statin adherence 80%	HEDIS 2018	https://www.ncqa.org/hedis/measures/	NCQA updated the HEDIS 2020 specification to change the method for identifying medications. Different dosages of a medication are now considered different medications. Previous specifications, including HEDIS 2018, considered different doses the same medication. This impacts the calculation of days covered for multiple prescriptions and could impact the statin adherence 80% rate. Statin Therapy for Patients with Cardio

Data Collection

The DHCC should annually collect data sources relevant to each measure using the following steps.

Request for Information

The measures are evaluated using various data sources. For the 2020 submission due date, DHCC will direct insurers to submit provider-level data by line of business by September 1 (or next applicable business day) for the top 10 largest providers (defined by attributed members, consistent with the methodology in Section 3 and **Appendix A**) and for those measures which meet the minimum size and denominator thresholds indicated within the detail of each measure. When communicating to insurers, the DHCC should provide the following materials:

1. Insurer Quality Data 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 4**.

3. Attestation of the Accuracy and Completeness of Reported Data. Insurers to attest to the accuracy and completeness of both the spending should use this document and quality benchmarks performance data submissions, and is included in this document as **Appendix H**.

4. DHCC will obtain additional data from NCQA and CDC using the data sources and timelines outlined in the table.

Data Source	Measures	Timing
Insurers. 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 Section 3 and Appendix A) and for those measures which meet the minimum size and denominator thresholds indicated within the detail of each measure.	EDU. Persistence of a beta blocker treatment after a heart attack Statin therapy for patients with cardiovascular disease — statin adherence 80%. Opioid Measure.	By June 1, the DHCC should request quality performance measurement data from insurers with instructions on content and format. DHCC will request insurers submit all requested data by September 1 each year.
NCQA — Data Request	EDU.	The DHCC should make a request to NCQA, by June 1, for the relevant data. Details on the data request of NCQA can be found below under Calculating Delaware Performance Against the Benchmark.
CDC — BRFSS	Adult Obesity Tobacco Use.	The DHCC should annually seek out the BRFSS performance via the website, by July 31 in the year following the performance period.
CDC — YRBS	High school students who were physically active.	The DHCC should annually seek out the YRBS performance via the website, by June 30 in the year following the performance period. Survey data are only collected at the state level during odd years.

Data Source	Measures	Timing
CDC — Wonder: MCD Data	Opioid related overdose deaths.	The DHCC should annually seek out CDC Wonder performance via the website by December 15 of the year after the performance period.

Calculating Delaware Performance Against the Benchmark

Annually, by approximately October 31 of the reporting year (or other date as determined necessary), 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). 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[34]	X CDC						
Tobacco use	X CDC						
Opioid-related overdose deaths	X CDC						
Health Care Measures							
Opioid-related measure — TBD							

[34] Performance can only be measured for performance periods in which a YRBS survey has been performed.

Measure	State and Market			Insurer		Provider	
	Overall	Commercial	Medicaid	Commercial	Medicaid	Commercial	Medicaid
EDU		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

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

Click on "DE" to obtain the rate.

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

High School Students Who Were Physically Active

Performance Level: State.

Performance Periods: Performance can only be measured for measurement years in which a YRBS 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 YRBS webpage (www.cdc.gov/healthyyouth/data/yrbs/index.htm).

1. Select "Youth Online Data Analysis Tool," then "View Data From" "High School YRBS."
    A. Under "View one question for all locations" select "Physical Activity."
    B. When re-directed, select:
        i. Question Direction: Less Risk.
        ii. Physical Activity: Were physically active at least 60 minutes per day on five or more days.
    C. Once redirected, select the following options:
        i. Question: Physical activity >= 5 days.
        ii. Location: Delaware.
        iii. Year: [Measurement Year].
    D. Look below to obtain the rate.

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

Opioid-Related Overdose Deaths

Performance Level: State.

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

1. Click "I Agree" under the data use restriction and sanctions for violating rules language.

2. Select the following filters:
   A. Organize table layout:
      i. Group Results by: State.
      ii. And by year.
   C. Measures: Deaths, Population, Crude Rate and Age-Adjusted Rate.
   D. Select location:
      i. Click a button to choose locations by State, Census Region or Health and Human Services (HHS) Region: State.
      ii. Browse: Delaware.
   E. Select demographics:
      i. Pick between: Ten-Year Age Groups, All Ages.
      ii. Gender: All Genders.
      iii. Race: All Races.
      iv. Hispanic Origin: All Origins.
   F. Select year and month:
      i. Year/Month: [Measurement Year].
   G. Select weekday, autopsy and place of death:
      i. Weekday: All Weekdays.
      ii. Autopsy: All Values.
      iii. Place of Death: All Places.
   H. Select underlying cause of death (UCD):
      i. Click a button to select International Classification of Disease (ICD) codes by Chapters or by Group: UCD — Drug/Alcohol Induced Causes.
      ii. Browse: Drug-induced causes.
   I. Select multiple cause of death:

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

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

J. Other options:

i. Check “Show results.”

ii. Precision: select “1” decimal place.

K. Click “Send.”

L. Click the “Results” tab and use the “Age-Adjusted Performance Rate per 100,000” value for Delaware’s performance.

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

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 “Prevalence & Trends Data.”

A. Under “Explore BRFSS Data By Topic” select:

i. Class: Tobacco Use.

ii. Topic: Current Smoker Status

B. Once redirected, select the following options:

i. Selected Year: [Measurement Year].

ii. View By: Overall.

iii. Response: Yes.

iv. Data Type: Crude Prevalence.

C. Click on “DE” to obtain the rate.

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

Health Care Measures

Opioid-Related Measure — TBD

Performance Level:

Benchmark Value:

Provider-Level Performance:

Health Insurer-Level Performance: State-Level Performance:

Interpreting Performance:

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

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

   EDU Risk
   Standardized Rate Ca

   Provider-Level Performance:

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

   A. The “EDU Risk Standardized Rate Calculator” performs this calculation in row 12 in the embedded tool above if the national average observed-to-expected ratio, national average observed rate and the provider’s ED observed-to-expected ratio are input.

B. Minimum Size Threshold: Rates should only be calculated for providers with a minimum of 150 attributed patients for a given performance period. Minimum size thresholds should be determined by taking the data from column K of the payer-submitted "Quality Benchmark Performance Submission Templates" and dividing the value by 12.

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

Insurer-Level Performance:

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

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

   A. The "EDU Risk Standardized Rate Calculator" performs this calculation in row 12 if the national average observed-to-expected ratio, national average observed rate and the insurer's ED observed-to-expected ratio are input.

   B. Minimum Size Threshold: Rates should only be calculated for insurers with a minimum of 150 enrolled members[35] in a given performance period. Minimum size thresholds should be determined by taking the data from column K of the payer-submitted "Quality Benchmark Performance Submission Templates" and dividing the value by 12. Rates should only be calculated for providers with a minimum of 150 attributed members in a given performance period.

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

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

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

Persistence of Beta-Blocker Treatment After a Heart Attack

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

Provider-Level Performance:

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

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

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

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

Provider-Level Performance:

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

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

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

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

State-Level Performance:

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

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

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

Periodic Review of Quality Benchmark Methodology

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 and Request for NCPHI-Related Data

This insurer total medical expense (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, which the Delaware Health Care Commission (DHCC) can distribute as a guide for TME data reporting.

Definition of Key Terms

- **Allowed Amount:** The amount the payer paid plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Health Care Expenditures (THCE).

- **Insurer:** A private health insurance company that offers one or more of the following, commercial insurance benefit administration for self-insured employers, Medicare managed care products and/or are Medicaid/Children's Health Insurance Program (CHIP) managed care organization (MCO) products.

- **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 managed care 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 managed care and Medicaid managed care). It is defined as the difference between health premiums earned and benefits incurred, and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of THCE at the state, market and insurer levels. NCPHI will not be reported at the provider level.

- **Payer:** A term used to refer collectively to both insurers and public programs submitting data to DHCC.
- **Payer Recoveries:** Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or through a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in insurer TME reporting.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[36] The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[37]
- **Provider:** A term referring to an individual clinician, medical group, accountable care organization (ACO) or similar entities.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid/CHIP FFS, the Veterans Health Administration (VHA) and similar entities/programs.
- **Total Health Care Expenditures (THCE):** The TME incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHCC, plus the insurers' NCPHI.
- **Total Health Care Expenditures per Capita:** THCEs (as defined above) divided by Delaware's total state population. The annual change in THCE per capita is compared to the Spending Benchmark at the state, market and insurer levels. THCE will not be reported at the large provider level.[38]
- **Total Medical Expense (TME):** The sum of the allowed amount of total claims spending and total non-claims paid to providers incurred by Delaware residents for all health care services. TME is reported at multiple levels: State, market, payer and provider. TME is reported net of pharmacy rebates at the state, market and payer levels, only. Payers report TME by insurance category code (e.g., Medicare and Medicare Managed Care, Commercial — Full Claims, etc.) and at the provider level whenever possible. TME excludes Medigap members and claims.

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[36] Fair market value bona fide service fees are 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 manufacturer, which the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service feeds, distribution service fees, patient care management programs, etc.).

[37] 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.

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

DHCC will annually request TME data file(s) with dates of service during the prior CY, 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 TME data on the following schedule:

Insurers' TME Filing Schedule	
Date	Files Due
September 1, 2020	CY 2018 Final and CY 2019 Estimated TME
August 2, 2021	CY 2019 Final and CY 2020 Estimated TME
August 1, 2022	CY 2020 Final and CY 2021 Estimated TME
August 1, 2023	CY 2021 Final and CY 2022 Estimated TME
August 1, 2024	CY 2022 Final and CY 2023 Estimated 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.

- Members who, at a minimum, have medical benefits.[39]
- For which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer). Even though an individual enrolled with an insurer can have other forms of health insurance, the reporting of TME data is based on whether the insurer was primary on the respective claim not whether the member had other forms of insurance. For example, for members enrolled in Medicaid managed care who also have Medicare coverage (e.g., dual eligible), the insurer must report as part of its TME data submission the allowed amount for all claims for which it was the primary payer (e.g., a large portion of long-term care services incurred by those members).

Insurers must attribute members to a primary care provider (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 CY should be allocated based on the number of months associated with each PCP).
2. Members not included in the first option above, 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 the first and second option above, attributed to a PCP by the insurer's own attribution methodology.
4. Members not attributable to a PCP (aggregate line).

Insurers must report TME for 1) each of the 10 largest providers within their network by Insurance Category Code (see page 46), 2) in aggregate for all providers that fall below the 10 largest providers by Insurance Category Code and 3) in aggregate for members who are not attributable to a PCP by Insurance Category Code. The number of attributed lives determines size of the provider. DHCC will only publicly report data on large providers, when statistically valid to do so.

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.

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

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 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 as part of a business arrangement

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. Insurers may choose whether residency is established as of the first of the month, last of the month or another day of the month, consistent with their monthly attribution methodology.

Claims Run-Out Period Specifications

Insurers shall allow for a claims run-out period of at least 180 days after December 31 of the prior CY. Insurers should apply reasonable and appropriate incurred but not reported/incurred but not paid (IBNR/IBNP) completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest they are reasonable and appropriate. DHCC prefers insurers use as much claims run-out as possible to minimize the impact of IBNR/IBNP adjustment factors.

Non-Claims Payment Run-Out Period Specifications

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

TME Data File Layouts and Field Definitions

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

Header Record File

Insurer Org ID: The DHCC-assigned organization ID for the insurer submitting the file.[40]

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

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

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

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

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

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

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.

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

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

Insurance Category Code: A number that indicates the insurance category 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 them to be comparable to full claims. Such an adjustment must use actuarially sound principles and be reviewed with DHCC before the adjustment is made. Please email the DHCC (send to: ayanna.harrison@delaware.gov and DHCC@delaware.gov) with a description of how you propose to make actuarial adjustments to "partial claims" data to allow them to be comparable to full claims. The description should be detailed and include any underlying assumptions. A thorough and easy to understand description of the adjustment methodology will streamline DHCC's response time. Upon reviewing submissions, DHCC staff will follow up with a confirmation accepting the adjustment process or request additional information as necessary. The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve-out vendors, such as pharmacy benefit managers (PBMs) or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending PMPM for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve-out applied.

Insurers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold.

If an insurer enrolls Medicare/Medicaid dual eligibles, the DHCC requires the insurer to report Medicare-related expenditures under insurance category code 5 and Medicaid-related expenditures under insurance category code 6. For example, if an insurer covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under insurance category code 6. However, if an insurer is an integrated care entity providing both Medicare and Medicaid benefits to dual eligibles, the insurer should use both insurance category codes 5 and 6, respectively, to report applicable expenditures. If direct assignment of the expenditure cannot be made to code 5 or 6, the insurer should use reasonable and appropriate methods to allocate expenditures to the respective insurance category code. This will allow the DHCC to include the Medicare- or Medicaid-related expenditure for dual eligibles in the respective market for reporting purposes.

For insurers reporting in the "Other" category (i.e., insurance category code 7), insurers should describe in the Comments field what is included in the "Other" category.

Insurance Category Code	Definition
1	Medicare and Medicare Managed Care (excluding Medicare/Medicaid dual eligibles)
2	Medicaid and Medicaid Managed Care including CHIP (excluding Medicare/Medicaid dual eligibles)

Insurance Category Code	Definition
3	Commercial — Full Claims
4	Commercial — Partial Claims, Adjusted
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

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

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), output total medical, and pharmacy costs with no truncation.

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

Insurers are to provide health status risk adjustment scores, which can be applied in a divisional manner in computing the health status adjusted PMPMs (i.e., Unadjusted TME PMPM / Health Status Risk Adjustment Score = Health Status Risk Adjusted TME PMPM).

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

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

- **Claims: Hospital Outpatient:** All TME data to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis, which have been billed directly by a physician group practice or an individual physician.

- **Claims: Professional, Primary Care:** Please use the following code-level definition to identify primary care spending:

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

    AND

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

    AND

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

- **Claims: Professional, Specialty:** All TME data to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the definition above.

- **Claims: Professional, Other:** All TME data from claims to health care providers for services provided by a licensed practitioner other than a physician, but is not identified as primary care in the definition above. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists and chiropractors.

- **Claims: Pharmacy:** All TME data from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the insurer's medical benefit. Medicare managed care insurers that offer stand-alone prescription drug plans (PDPs) 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, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living, personal care (e.g., services in support of activities of daily living), adult day care, respite care, hospice, and private duty/shift nursing services.

- **Claims: Other:** All TME data from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. If this is the case, the insurer should consult with DHCC about the appropriate placement of the service prior to categorizing it as "Claims: Other." However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts, whether given to the provider or given in the form of a capitated payment to an organization that assists the insurer with enrolling members in gyms is not a valid payment to include.

- **Non-Claims: Primary Care Incentive Programs:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

- **Non-Claims: Incentive Programs, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for "primary care") for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

- **Non-Claims: Primary Care Capitation:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.

- **Non-Claims Capitation, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for "primary care") made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any

incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.

- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made (i.e., risk settlements). Amounts reported as risk settlement should not include any incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.

- **Non-Claims: Primary Care, Care Management:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") for providing care management, utilization review and discharge planning.

- **Non-Claims: Care Management, Other Than for Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for "primary care") for providing care management, utilization review and discharge planning.

- **Non-Claims: Recovery:** All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as **a negative number**. Only report data in this column not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

- **Non-Claims: Other:** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

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.

Insurance Category Code: A number that indicates the insurance category, which 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.[41] This amount shall include

[41] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurers, PBMs, etc.), which represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer the

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 CY for which reporting will be done. If insurers are unable to report rebates specifically for Delaware residents, insurers should report estimated rebates attributed to Delaware resident members in a proportion equal to the proportion of Delaware resident members compared to total members, by line of business. For example, if Delaware resident commercial members represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported. This field should be reported as **a negative number**.

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.

Market Enrollment: The number of members participating in a plan categorized by the insurer as individual, large group — fully insured, small group — fully insured, self-insured, student market, Medicare managed care and Medicaid/CHIP managed care. Insurers should not include Medigap members or claims. Insurers should report member months (see definition below) by market enrollment category listed below.

Market Enrollment Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self-insured
905	Student market
906	Medicare managed care
907	Medicaid/CHIP managed care
908	Medicare/Medicaid duals

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

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.).

Net Cost of Private Health Insurance

As described further in **Appendix E**, this element captures the costs to Delaware residents associated with the administration of private health insurance. It is defined as the difference between health premiums earned and benefits incurred and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses. **NCPHI is reported as a component of THCE at the state, market and insurer levels. 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: (901) Individual; (902) Large group, fully insured; (903) Small group, fully insured; (904) Self-insured; (905) Student market; (906) Medicare managed care; (907) Medicaid/CHIP managed care; (908) Medicare/Medicaid duals. 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. In order to do so, insurers must submit federal commercial medical loss ratio (MLR) reports as part of their TME data submission due annually on September 1 (or the first business day thereafter). Although these reports become publicly available in the fall, insurers will need to submit them September 1 in order to meet the spending benchmark reporting timeline. In an instance in which the MLR report submitted to DHCC on September 1 differs from the final submission an insurer makes to the federal Center for Consumer Information and Insurance Oversight (CCIIO), the insurer must notify DHCC in writing as soon as possible and submit an updated MLR.

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 the respective 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
- TME_2019_01.xlsx or TME_2019_1.xlsx or TME_2019.xlsx

Submitting Files to the DHCC

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

Appendix B

Delaware Division of Medicaid & Medical Assistance (DMMA) TME Data Specification

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

Definitions of Relevant Key Terms

- **Allowed Amount:** The amount the payer paid plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Health Care Expenditures (THCE).

- **Insurer:** A private health insurance company that offers one or more of the following: commercial insurance benefit administration for self-insured employers, Medicare managed care products and/or are Medicaid/Children's Health Insurance Program (CHIP) managed care organization (MCO) products.

- **Provider:** A term referring to an individual clinician, medical group, accountable care organization (ACO) or similar entities.

- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[42] The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates). For DMMA, this

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

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

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

TME Data Overview

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

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

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

DMMA's submission is to include TME data on the following:

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

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

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

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

MCO Financial Data Needed From DMMA to Support NCPHI Calculation

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

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

- Footnotes Disclosures Statement (e.g., Schedule C in the CY 2019 DMMA managed care financial reporting template).

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

TME File Submission Instructions and Schedule

TME file layouts for DMMA are included in this appendix. Further file submission instructions will be available on DHCC's website. DMMA will submit this information on an annual basis. DMMA will have an opportunity to review the final calculation before it is publicly reported by DHCC.

DMMA will submit TME data on the following schedule[43]:

DMMA's TME Filing Schedule

Date	Files Due
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 2, 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). Even though an individual enrolled with DMMA can have other forms of health insurance, the reporting of TME data is based on whether DMMA was the primary on the respective claim not whether the member had other forms of insurance. For example, for members

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

enrolled in DMMA FFS who also have other commercial coverage, DMMA must report as part of its TME data submission the allowed amount for all claims for which DMMA was the primary payer.

Claims Run-Out Period Specifications

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

TME Data File Layouts and Field Definitions

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

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

Header Record File

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

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

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

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

Expenditure Record File

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

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

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

Program Code	Definition
20	DMMA FFS TME data for Medicaid/CHIP individuals enrolled in managed care
21	DMMA FFS TME data for Medicaid/CHIP individuals not eligible or eligible-but-not-yet-enrolled in managed care

Program Code	Definition
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[44]

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 managed care 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 managed care (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 managed care.
- For Program Code 29, this would be the total number of unique member months for all populations DMMA is reporting on (including any populations not already included in any previous program code). This will also include any non-Medicaid/CHIP populations DMMA can readily report data on. In this total, individuals can only be counted once for purposes of computing annual member months. **Therefore, this figure cannot be a simple sum of the member months in the other Program Codes, as this would double count some individuals.**
- Member months reported in Program Code 20, 21 and 22 should be mutually exclusive.

DMMA is to report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive. DHCC may request additional

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

information regarding how DMMA mapped their data into these categories to improve consistency in reporting across all payers:

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

- **Claims: Hospital Outpatient:** All TME data to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis, which have been billed directly by a physician group practice or an individual physician.

- **Claims: Professional, Primary Care:** Please use the following code-level definition to identify primary care spending:

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

    AND

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

    AND

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

- **Claims: Professional, Specialty:** All TME data to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the definition above.

- **Claims: Professional, Other:** All TME data from claims to health care providers for services provided by a licensed practitioner other than a physician, but is not identified as primary care in the definition above. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners,

physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists and chiropractors.

- **Claims: Pharmacy:** All TME data from claims to health care providers for prescription drugs, biological products or vaccines as defined by DMMA's prescription drug benefit. This category should not include claims paid for pharmaceuticals under DMMA's medical benefit.
  - Pharmacy data 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.
  - Delaware Prescription Assistance Program payments are not to be reported in any category.
- **Claims: Long-Term Care:** All TME data from claims to health care providers for skilled or custodial nursing facility services, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living, personal care (e.g., services in support of activities of daily living), adult day care, respite care, hospice, and private duty/shift nursing services.
- **Claims: Other:** All TME data from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if DMMA is unable to classify the service. However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts, whether given to the provider or given in the form of a capitated payment to an organization that assists DMMA with enrolling members in gyms is not a valid payment to include.
- **Non-Claims: PACE:** Medicaid payments made to PACE organizations. The total amount is to be reported for Program Code 22 only.
- **Non-Claims: NEMT:** Medicaid payments made to the NEMT vendor(s). The total amount is to be reported for Program Code 23 only.
- **Non-Claims: Primary Care Incentive Programs:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.
- **Non-Claims: Incentive Programs, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for "primary care") for achievement in specific predefined goals for quality, cost reduction or infrastructure development.

Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

- **Non-Claims: Primary Care Capitation:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately and can be separately reported as Non-Claims: Incentive Program.

- **Non-Claims Capitation, for Services Other Than Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for "primary care") made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately and can be separately reported as Non-Claims: Incentive Program.

- **Non-Claims: Risk Settlements:** All payments made to providers as a reconciliation of payments made (i.e., risk settlements). Amounts reported as risk settlement should not include any incentive or performance bonuses paid separately and can be separately reported as Non-Claims: Incentive Program.

- **Non-Claims: Primary Care, Care Management:** All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") for providing care management, utilization review and discharge planning.

- **Non-Claims: Care Management, Other Than for Primary Care:** All payments made to non-PCPs (use the Claims: Professional, Primary Care definition for "primary care") for providing care management, utilization review and discharge planning.

- **Non-Claims: Recovery:** All payments received from a provider, member/beneficiary or other payer distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as **a negative number**. Only report data in this column not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

- **Non-Claims: Other:** All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services, which cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic; however, it should not include funds made to insurers as a pass-through payment. Payments to qualifying hospitals of Delaware's supplemental Disproportionate Share Hospital allotment monies applicable to the reporting period are to be included in this category.

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

Pharmacy Rebate Record File

The pharmacy rebate record file will be the source of the DMMA's pharmacy rebate data for Medicaid/CHIP FFS. Medicaid/CHIP MCOs and any other program or population for which DMMA obtains pharmacy rebates.

Rebate Program Code: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed to:[45]

Program Code	Definition
50	AmeriHealth Caritas Medicaid/CHIP Claims (if practical)
51	Highmark Health Options Medicaid/CHIP Claims (if practical)
55[46]	Total Medicaid/CHIP Managed Care 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 DMMA is able to report on)

Pharmacy Rebates: The estimated or actual value of total federal and state supplemental rebates attributed to Delaware resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding to the period beginning date through end date of the respective CY, excluding manufacturer-provided fair market value bona fide service fees.[47] 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. This field should be reported as **a negative number**.

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

[46] If DMMA is not able to allocate or report pharmacy rebates attributable to the individual managed care plans' claims (i.e., using codes 50 and 51), then report all rebates associated with managed care claims in code 55.

[47] 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, which 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.).

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

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

DMMA_TME_YYYY_Version.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
- TME_2019_01.xlsx or TME_2019_1.xlsx or TME_2019.xlsx

Submitting Files to the DHCC

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

Appendix C

Medicare FFS TME Data Collection Process

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

The DHCC will be able to receive TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2019 data is available September 1, 2020). CMS believes data will be at least 90% complete by September 1.

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

- Hospital Inpatient.
- Hospital Outpatient.
- Non-hospital Outpatient.
- Home Health Agency.
- Hospice.
- Skilled Nursing Facility.
- Physician.[48]
- Other Professionals.
- Durable Medical Equipment.
- Other Suppliers.

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

- Part D.[49]

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

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

Medicare Part D Data

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

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

- When reporting Medicare prescription drug spending at the Medicare **market** level, only use the CMS reported Part D Total Expenditures data to avoid double counting what insurers might also report in their respective TME submission.[50]
- When reporting Medicare prescription drug spending at the **insurer** level, use the prescription drug spending reported by the respective Medicare insurer.
- Medicare FFS pharmacy rebate data is not available. Since CMS also does not provide Medicare managed care pharmacy rebate data, the rebates reported by the insurers for their Medicare managed care or dual business must be deducted from the total Part D for market-level reporting OR the respective insurer spend for insurer-level reporting.

Requesting Medicare Data

To receive Medicare FFS TME data from CMS, DHSS needs to make a formal request to CMS by emailing the attached excel file **(Attachment 2)** to Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copying: CMSProgramStatistics@cms.hhs.gov. **Please note, CMS has specifically requested Delaware staff (not a contractor) make the official request.**

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

[50] For Part D, the "Total Expenditures" line will be greater than the sum of the "Program Payments" and "Cost Sharing" because the "Total Expenditures" line includes spending by other entities on behalf of the beneficiary, which CMS recognizes as a valid Part D expense. While it is possible some of this other spending is being reported to the DHCC by other benchmark data contributors, we believe the impact of this is minimal and hence it is more accurate to use the "Total Expenditures" line to better capture as much of the Part D-related spending as practical.

Appendix D

VHA TME Data Collection Process

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

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

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

It is important to note that VHA expenditure report data is reported on a federal fiscal year basis (October–September) and not on a CY basis. Therefore, DHCC should utilize the fiscal year that contains nine months of the reporting CY (e.g., fiscal year 2018 data should be used in lieu of CY 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.

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

Appendix E

NCPHI Data Specification

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

Net Cost of Private Health Insurance

This element captures the costs to Delaware residents associated with the administration of private health insurance. 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:
(901) Individual; (902) Large group, fully insured; (903) Small group, fully insured; (904) Self-insured; (905) Student market; (906) Medicare managed care; (907) Medicaid/CHIP managed care; (908) Medicare/Medicaid duals. 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 and need to be requested from the insurers as part of their TME data submission, or obtained from CMS Center for Consumer Information and Insurance Oversight (CCIIO).[51] These reports become publicly available in the fall, but should be requested from insurers when they submit their TME data in order to meet the spending benchmark reporting timeline. In an instance in which the MLR report submitted to DHCC on the TME deadline differs from the final submission an insurer makes to CCIIO, the insurer must notify DHCC in writing as soon as possible. The data elements that will be used in the calculation are detailed below:

[51] Available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html Last accessed April 15, 2020.

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)

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months (as reported in the market enrollment tab of TME data)}}$$ [52]

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

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

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

NCPHI =

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

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months (as reported in the market enrollment tab of TME data)}}$$

Medicaid Managed Care Market

This market includes government programs such as Medicaid Title XIX, CHIP Title XXI risk contracts and other federal or state government-sponsored coverage. Medicaid managed care plans participating in this market complete a financial reporting template on a quarterly basis, which reports financial experience. DMMA is responsible for the development of these required financial reporting templates. To support the NCPHI calculation, DHCC will need to request from DMMA the applicable financial report(s), which contain(s) the necessary information. At a minimum, the Medicaid MCO financial reports, which DHCC will need to obtain from DMMA are:[53]

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

[53] DMMA will occasionally revise the Medicaid managed care financial reports, which may alter the schedule sequencing. DHCC will need to confirm the current schedule labels each year with DMMA.

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

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

The data contained in the Medicaid MCO's financial statements will be used to derive NCPHI for the Medicaid MCO market, specifically 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)] — [TME & HCQI EXPENSES (Line 70) — Total Health Care Quality Improvement (Line 69)]

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

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 Amanda Sipple, amanda.sipple@delaware.gov, or the current Health Care Cost Containment Specialist at DMMA.

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

$$\text{NCPHI PMPM} = \frac{\text{NCPHI}}{\text{Member Months (as reported in the market enrollment tab of TME data)}}$$

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
Medicare Managed Care	12	N/A	N/A
Medicaid Managed Care	10	N/A	N/A
Self-Insured	14	N/A	N/A

Aggregate NCPHI

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

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

Appendix F

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

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

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 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
Opioid-related measure — TBD			
EDU		Commercial	Insurer
Statin therapy for patients with cardiovascular disease — statin adherence 80%	HEDIS, version corresponding to performance period	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 180 days of claims runout.

The “Quality Benchmark Performance Submission Template”, refer to **Attachment 4,** contains one tab payers should complete: “Quality Performance.” Illustrative examples are provided in rows 11 and 12 of the accompanying spreadsheet.

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

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

Timeline

Materials must be electronically submitted annually by September 1 (or the next business day thereafter) of the year immediately following the performance period, to ayanna.harrison@delaware.gov and DHCC@delaware.gov.

Appendix H

Insurer Attestation

Attestation of the Accuracy and Completeness of Reported Data

Instructions: Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation. Insurers should submit one "Attestation of the Accuracy and Completeness of Reported Data" per performance period. Scanned copies of the signed attestations should be emailed to ayanna.harrison@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

List of Payers DHCC Requests Data From for Spending and Quality Benchmarks and Organizational ID

Payer	Commercial Fully and Self-Insured	Medicare Managed Care	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 (CMS)					107
Veterans Health Administration (VHA)					108

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

Appendix J

Calculating National Performance Benchmarks

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

Measure	Steps to Obtain National Performance
Health Status Measures	
Adult obesity	Obtain national rates from the CDC BRFSS webpage (www.cdc.gov/brfss/index.html). • Select "Prevalence Data and Analysis Tools," then "Prevalence & Trends Data." — Under "Explore BRFSS Data By Location" select: − States and Territories: All States and DC. — Once redirected, select the following options: − States and Territories: All States, DC and Territories. − Class: Overweight and Obesity (BMI). − Topic: BMI Categories. − Selected Year: [Prior Year/Measurement Year]. Once redirected, hover over the "Obese (30.0-99.8)" bar in the bar chart to see the national rate.
High school students who were physically active	Obtain national rates from the CDC YRBS webpage (www.cdc.gov/healthyyouth/data/yrbs/index.htm). • 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: − Question Direction: Less Risk. − Physical Activity: Were physically active at least 60 minutes per day on five or more days. — Once redirected, select the following options: − Question: Physical activity >= 5 days. − Location: All locations. − Year: [Prior Year/Measurement Year].

Measure	Steps to Obtain National Performance
	— Look below to obtain the U.S. rate.
Opioid-related overdose deaths	Obtain national rates from the CDC Wonder's Multiple Cause of Death (MCD) mortality files (http://wonder.cdc.gov/mcd-icd10.html). • Click "I Agree" under the data use restriction and sanctions for violating rules language. • Select the following filters: — Organize table layout: − Group Results by: State. − And by year. — Measures: Deaths, Population, Crude Rate and Age-Adjusted Rate. − Select location: — Click a button to choose locations by State, Census Region or HHS Region: State. — Browse: All (The U.S.). − Select demographics: — Pick between: Ten-Year Age Groups, All Ages. — Gender: All Genders. — Race: All Races. — Hispanic Origin: All Origins. − Select year and month: — Year/Month: [Prior Year/Measurement Year]. — Select weekday, autopsy and place of death: — Weekday: All Weekdays. — Autopsy: All Values. — Place of Death: All Places. − Select underlying cause of death: — Click a button to select ICD codes by Chapters or by Group: UCD — Drug/Alcohol Induced Causes. — Browse: Drug-induced causes. − Select multiple cause of death: — Click a button to select ICD codes by Chapters or by Groups: MCD-ICD-10 Codes. — Browse and click "Move Items Over" for: Opioids: T40.0, T40.1, T40.2, T40.3, T40.4 or T40.6. − Other options: — Check "Show results." — Precision: select "1" decimal place. − Click "Send."

Measure	Steps to Obtain National Performance
	– Click the "Results" tab and scroll to the "Total" row at the bottom and use the "Age-Adjusted Performance Rate per 100,000" for national performance.
Tobacco use	Obtain national rates from the CDC BRFSS webpage (www.cdc.gov/brfss/index.html). • Select "Prevalence Data and Analysis Tools," then "Prevalence & Trends Data." — Under "Explore BRFSS Data By Location" select: – States and Territories: All States, DC and Territories. — Once redirected, select the following options: – States and Territories: All States, DC and Territories. – Class: Tobacco Use. – Topic: Current Smoker Status. – Selected Year: [Prior Year/Measurement Year]. Once redirected, hover over the "Yes" bar in the bar chart to see the national rate.
Health Care Measures	
Opioid-Related Measure — TBD	
EDU	To obtain the national commercial rate for this measure, DHCC staff need to contact NCQA. • The national average EDU observed-to-expected ratio and the national average EDU observed rate could be purchased from NCQA either through an existing consultant contractor or directly from NCQA. To contact NCQA, email Chris Carrier (carrier@ncqa.org) and Samantha Firetti (firetti@ncqa.org) and ask for the national average EDU observed rate for the Prior Years and Measurement Year of interest. The national average observed rate must be obtained through NCQA, as it is not available publicly. • Calculate the national fiftieth percentile risk standardized rate for a given prior year or measurement year by dividing the national fiftieth percentile observed-to-expected ratio by the national risk-standardized rate.
Persistence of beta-blocker treatment after a heart attack	Obtain the national rate from Quality Compass (https://www.qualitycompass.org/QcsExternal/Login.aspx). The Quality Compass tool requires purchase of a license for use for each line of business. Please note, these steps will have to be done twice, once for commercial and once for Medicaid. • Log in, "Accept" the license agreement and select the commercial/Medicaid license applicable for the Prior Year/Measurement Year of interest. — The licenses use HEDIS years, so subtract one from the year to find the appropriate Prior Year/Measurement Year equivalent (for example, if you

Measure	Steps to Obtain National Performance
	would like to look at 2019 commercial rate, select the “2019 Commercial” license). – Select “Exporter/Standard Downloads” then select “National Benchmarks” to download a zip file. – Open the zip file and select the “National Benchmarks” excel comma separated values files. – Filter column B “MeasureName” by “Persistence of Beta-Blocker Treatment After a Heart Attack.” – Filter column G “AverageName” by “National — All LOBs: Average” for commercial or by “National — HMO: Average” for Medicaid. – Use the fiftieth percentile rate in column N as the national rate.
Statin therapy for patients with cardiovascular disease — statin adherence 80%	Follow the steps above, but instead in step D, Filter column B “MeasureName” by “Statin Therapy for Patients With Cardiovascular Disease Statin Adherence 80% — Total.”

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