DELAWARE HEALTH AND SOCIAL SERVICES

Delaware Health Care Spending and Quality Benchmarks

Implementation Manual
Version 5.0: DMMA

State of Delaware

Department of Health and Social Services

August 29, 2023

Delaware Health and Social Services

Office of the Secretary

A Note to Delaware's Health Care Stakeholders

The State of Delaware is excited to begin another year of data collection for our health care spending and quality benchmark initiative. This initiative continues the State's efforts along the "Road to Value," which is deeply rooted in our dedication to improving access to affordable, quality health care for all Delawareans. As we continue to evaluate the impacts of the COVID-19 pandemic on health care-related costs, the Department of Health and Social Services (DHSS), along with the support of the State's health care systems and insurance providers, are navigating a new era of health care while advancing efforts on transforming health care delivery from volume-based care to meaningful, cost-effective, value-based care models.

Historically, Delaware has one of the highest per-capita health care spending rates in the nation. This spurred DHSS in 2019 to establish annual health care spending and quality benchmarks for Delaware as a strategy to help address the unsustainable growth in health care spending and to improve health outcomes. The health care spending and quality benchmarks program provides transparency and public awareness in a way that is beneficial for everyone in the system — health care providers, consumers, taxpayers, insurers, and businesses.

DHSS and the Delaware Economic and Financial Advisory Council (DEFAC) work closely to establish the spending and quality benchmarks and update them as needed. In April 2023, DHSS released the State's third annual Health Care Spending and Quality Benchmarks Trend Report. This report summarized health care spending and quality data collected for calendar year (CY) 2021 and compared it to baseline data from 2019 and 2020. For CY 2021, the spending benchmark was set at a 3.25% target growth rate. Delaware's total CY 2021 Total Health Care Expenditures (THCE) was approximately $9.1 billion. The per capita amount was $9,088, which represents a 11.2% year-over-year increase relative to the CY 2021 spending benchmark of 3.25%.

The 11.2% per capita increase is significant, but this figure reflects Delaware's health care market rebounding from the reduction in health care spending and utilization in CY 2020 caused by the COVID-19 pandemic.

As we begin our fourth data collection cycle, it has become apparent to DHSS and our health care systems that this initiative contributes invaluable data, which is key in our fight to improving the health and well-being of all Delawareans. To continue the support of this initiative, the Delaware General Assembly passed in 2022 House Amendment 1 for House Bill 442, an act that codifies the Benchmark program into law. This legislation establishes Delaware as a leader in health care innovation and transparency, ensuring that all payers submit timely, accurate quality and spending data reports for DHSS to evaluate against progressive benchmarks.

On behalf of all Delawareans, I extend my gratitude to all who support and contribute to the health care spending and quality benchmarks initiative. This initiative would not be possible without the participation of dedicated health care professionals, payers, and stakeholders like you.

Enclosed you will find version 5.0 of the Benchmark's Implementation Manual for your review. This manual was developed by the Department as a result of the previous data collection cycles, countless stakeholder meetings, and the publication of three data summary reports.

Our goal of ensuring that Delawareans can access and afford quality health care is only possible when agencies across the State work collectively to pursue answers and solutions. The benchmarks are a means to continue the conversation about how to improve the cost of care and its quality for the individuals we serve as patients and members of our communities. Thank you again for your dedication and participation in this important work.

Sincerely,

Josette D. Manning, Esq.
Cabinet Secretary

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Section 1

Major Revisions in This Version

With the assistance of Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, Department of Health and Social Services (DHSS), and Delaware Health Care Commission (DHCC) made various wording changes and clarifications, label changes, formatting revisions, and other updates to make this document easier to read and use. The following table highlights major revisions incorporated into this version relative to the prior version of the implementation manual.

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

Topic	Version 5.0 Change	Rationale
Note to Stakeholders	Message updated	From Secretary Manning
Spending Data Collection Period	One year of spending data to submit: calendar year (CY) 2022 only	Simplify process for timely and accurate reporting
Due Date for Spending Data	October 1, 2023	Allow for more complete and accurate data

Section 2

Overview of Benchmarks

This implementation manual describes the data reporting requirements for DMMA to submit its respective benchmark spending data to DHSS/DHCC). In addition to this narrative reference document, DMMA is requested to use DHSS/DHCC's Excel-based benchmark data templates to submit data. More information about the benchmark process can be found on DHCC's website.

Timeline of Key Activities

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

Table 2. Timeline of Key Activities

Time Period	Key Activity	Key Dates
1Q of CY	• Release/Wrap up Benchmark Trend Report • Respond to inquiries about report • Perform ad hoc analyses, if needed	• None specific
2Q of CY	• DEFAC subcommittee meetings	• By May 3, 2023 and June 30, 2023
	• Update/Revise implementation manual and data templates	• May/June 2023
3Q of CY	• Finish/Publish current implementation manual and data templates	• July 2023
	• Conduct benchmark webinar for insurers/DMMA	• August 2023
	• Send request to Centers for Medicare & Medicaid Services (CMS) for Medicare data	• By August 2023
	• Respond to payer questions on benchmark process	• As needed
	• Receive spending and quality data submissions	• By October 1, 2023
	• Begin validation of data (request resubmissions if needed)	• After data is received
4Q of CY	• Complete data validation process	• As soon as practical
	• Compile results and produce final benchmark trend report	• Goal is to release report in the 4Q
	• Conduct public meetings/share results	• As needed/schedules permit

Brief Review of the Spending Benchmark

The health care spending benchmark is defined as the target annual per capita growth rate for Delaware's statewide total health care expenditures, expressed as the **percentage change from the prior year's per capita spending.** The spending benchmark is set on a calendar year (CY) basis.

The spending benchmark is the forecasted growth in Delaware's per capita potential gross state product 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. Governor Carney's Executive Order (EO) 25 set the spending benchmarks for CYs 2019–2023 as follows:

- CY 2019: 3.80%
- CY 2020: 3.50%
- CY 2021: 3.25%
- CY 2022: 3.00%
- CY 2023: 3.00% (revised to 3.1%)

On an annual basis, the spending benchmark is subject to review and change by the Delaware Economic and Financial Advisory Council (DEFAC) subcommittee. For CY 2023, the spending benchmark will be changed to 3.10% per the DEFAC subcommittee's recommendation.

For CY 2024, the DEFAC subcommittee recommended no change to the 3.0% spending benchmark at its May 2023 meeting. Subsequently, DEFAC recommended to the Governor in its June 9, 2023, report to maintain the 3.0% spending benchmark for CY 2024 and retain the current potential gross state product (PGSP) formula for determining the spending benchmark.

In support of the spending benchmarks, DMMA is asked to provide data on its respective spending consistent with the reporting requirements described in this implementation manual.

Benchmark Data Submission Process and Recent Legislation

Historically, DMMA was asked to submit its applicable benchmark data consistent with the instructions and templates contained in this implementation manual. DHSS/DHCC appreciates the support of DMMA in reporting timely, complete, and accurate data to ensure the resulting benchmark trend report is useful and informative to all Delawareans.

On August 19, 2022, Governor Carney signed into legislation House Amendment 1 for House Bill 442 that codifies the key aspects of EO 25 and now serves as the replacement for EO 25. Additionally, Section 11 of the bill requires "….Payers, Insurers, and Public Programs shall report annually to the Commission…" benchmark spending and quality data. This legislation went into effect for the data due October 1, 2022 onward. DHSS/DHCC's goal is to not make the benchmark data submission process onerous or burdensome, but updates to the data submission requirements are expected from time to time and will be communicated

to stakeholders through future implementation manual updates and/or other communication strategies.

Section 3

TME Data Submission Instructions – DMMA

When submitting benchmark TME data to DHSS/DHCC, DMMA is to follow these instructions and use DHSS/DHCC's Excel submission template to expedite DHSS/DHCC's review and use of the data.

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).
- **Division of Medicaid and Medical Assistance (DMMA):** The single State agency responsible for Delaware's Medicaid and Children's Health Insurance Program (CHIP). Unless otherwise stated, references to "DMMA" or "Medicaid" includes CHIP.
- **Payer:** A term used to refer collectively to both insurers and public programs submitting data to DHSS/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 the spending data template.
- **Pharmacy Rebates:** Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[1] The computation of THCE at the State, market, and payer level is net of pharmacy rebates (i.e., expenditures are reduced by the amount of the pharmacy rebates).[2] DMMA will separately report pharmacy rebates.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare fee-for-service (FFS), Medicaid FFS, the Veterans Health Administration, and similar entities/programs.
- **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

[1] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (for example, insurer and pharmacy benefit manager) 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 (for example, data service feeds, distribution service fees, and patient care management programs).

[2] 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.

services. DMMA reports TME by service category (for example, claims and non-claims categories).

TME Data Submission Schedule

DMMA is required to submit TME data (and managed care organization [MCO] financial report information) on the following schedule.[3] Please note that DMMA will submit **one year** of data for this benchmark data collection cycle: CY 2022. The CY 2022 data will be submitted for the first time, and there is no longer a data refresh for previously-submitted CY 2021 data. The due date for all data is October 1, 2023. The later due date of October 1 is intended to allow for more complete and accurate data (for example, more claims payment run-out).

Table 3. TME Data Submission Schedule

Due Date	Data Submitted
October 1, 2023	CY 2022 Final

TME Data Submission Specifications

DHSS/DHCC acknowledges that over time as more benchmark data is collected, there may be instances when the oldest data differs from the newer data due to data specification changes. DHSS/DHCC's goal is to minimize these differences, but data specification changes are expected to occur from time to time.

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 (received or expected) by DMMA for pharmacy claims incurred in the reporting period.

DMMA must include only information:

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

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

- **FFS claims expenditures for enrollees in Medicaid managed care, such as:**

[3] DMMA should provide copies of the relevant Medicaid MCO financial statements to support a reasonable/validation review of the insurers' benchmark TME data contributions.

  - Wraparound dental services for children, behavioral health services in excess of managed care coverage limits, etc.

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

- **FFS claims expenditures for individuals not eligible for or not-yet-enrolled in Medicaid managed care, such as:**
  - FFS TME data on Medicaid populations excluded from managed care enrollment (for example, breast and cervical cancer population).
  - FFS TME data for Medicaid managed care eligible individuals during their "FFS window" prior to enrollment in managed care.

  This should be accomplished based on aid category code and/or other eligibility fields.

- **Other DMMA FFS claims expenditures not included in any of the aforementioned categories, such as:**
  - FFS expenditures on non-Medicaid populations or programs paid with State-only general funds (for example, 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):**
  - Including 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 for FFS and/or managed care:**
  - DMMA's total pharmacy rebate collections are reported separately. See below for more details.

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

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

MCO Financial Data Needed From DMMA

To support DHSS/DHCC's review of the Medicaid managed care plans' benchmark data submissions, DHSS/DHCC will need copies of select financial report schedules from the

Medicaid managed care plans' CY-end audited financial reports. At a minimum, the managed care financial reports DMMA will be requested to provide include:

- Income Statement (for example, Schedule B in the DMMA managed care financial reporting template)
- Health Care Quality Indicators (HCQI) and Administrative Expenses Statement (for example, Schedule B.1 in the DMMA managed care financial reporting template)
- Footnotes Disclosures Statement (for example, Schedule C in the DMMA managed care financial reporting template)

DMMA is asked to include copies of the applicable managed care financial reports when DMMA provides its TME data.

Data Run-Out Period Specifications

DMMA should allow for claims payment run-out and non-claims processing in the TME data prior to submitting the data files to DHSS/DHCC. DMMA should not apply completion factors for incurred but not reported/incurred but not paid 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 DHSS/DHCC data request.

Since DMMA's TME data submission is not due until October 1, DHSS/DHCC anticipates DMMA can use a minimum of approximately eight months of run-out: summarize CY data, with run-out through approximately August 31, 2023.

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

TME Data File Layouts and Field Definitions

DHSS/DHCC will provide DMMA with an Excel-based template to use in submitting TME data. The format/layout of the TME data template will be similar to prior submission cycles, including data comparison tabs to aid DMMA in reviewing its data for accuracy and completeness.

DMMA's Excel TME data submission template contains the following tabs:

- Contents
- Mandatory Questions
- Header Record File (HD-TIME)
- CY 2022 TME Data
- CY 2022 Pharmacy Rebates
- 2021 to 2022 TME Comp
- 2021 to 2022 Rx Rebates Comp
- Definitions

- Appendix A Primary Care Logic
- Version Updates

Each of these tabs and the data elements/fields therein are described in more detail below.

Contents

This tab is akin to a table of contents and describes each tab in the workbook. It is self-explanatory.

Mandatory Questions

DMMA is to input the name and email address of DMMA's contact person if DHSS/DHCC has questions regarding the data submission.

DMMA is to review and respond to all of the mandatory questions. Responses can be a simple "Yes" if applicable, or otherwise respond as needed. These questions are intended to help DMMA complete the spending data submission template correctly, expedite DHSS/DHCC's review of the data, and minimize or avoid the need for data resubmissions.

Header Record File (HD-TME)

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

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

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

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

CY 2022 TME Data

This tab will be the source of DMMA's TME data used by DHSS/DHCC to compute THCE. DMMA will report its applicable CY 2022 claims and non-claims payments.

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

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

Table 4. Program Code Definitions

Program Code	Definition
20	DMMA FFS TME data for Medicaid individuals enrolled in managed care
21	DMMA FFS TME data for Medicaid individuals not eligible, or eligible but not yet enrolled in managed care
22	DMMA TME data on PACE provider(s)

Program Code	Definition
23	DMMA TME data on NEMT vendor(s)
29	Total DMMA TME data for all programs/populations[4]

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

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

TME Claims and Non-Claims Categories

DMMA is to report TME data using the following claims and non-claims categories. To avoid double-counting, all categories must be mutually exclusive. DHSS/DHCC may request additional information regarding how DMMA mapped its 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 that have been billed directly by a physician

[4] 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 (for example, 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.

group practice or an individual physician. Does not include inpatient services at nonhospital facilities.

- **Claims: Hospital Outpatient:** All TME data to hospitals for outpatient services generated from claims. Includes all hospital types, and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
- **Claims: Professional, Primary Care:** The coding logic for defining primary care is included in **Appendix A**.
- **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 (Gross of Rebates):** All TME data from claims to health care providers for prescription drugs, biological products, or vaccines as defined by DMMA's prescription drug benefit. This category should not include claims paid for pharmaceuticals under DMMA's medical benefit.
  - **Pharmacy data in this claims category must be reported gross of pharmacy rebates.** Gross of rebates means that the pharmacy spend amount is the amount prior to any rebates. For example, if the allowed amount was $100, and rebates were $5, DMMA would report $100 in the Pharmacy claims column and -$5 in the separate Pharmacy Rebates tab. Pharmacy Rebates are reported as a negative value.
  - DMMA will report pharmacy rebates **separately** to enable attribution of rebates to each Medicaid MCO versus FFS (if practical).
  - Medicare Part D claw-back payments are not to be reported in any category.
  - Delaware Prescription Assistance Program payments are not to be reported in any category.
- **Claims: Long-Term Care:** All TME data from claims to health care providers such as skilled or custodial nursing facility services, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living, personal care (for example, 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 primary care physicians (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 (e.g., 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 (e.g., 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 (for example, 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 that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. 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.

The remaining fields in these tabs automatically compute totals and per member per months values based on the data inputted by DMMA. DMMA is encouraged to review these fields for reasonableness before submitting a completed Excel workbook to DHSS/DHCC.

CY 2022 Pharmacy Rebates

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

Rebate Program Code and Description: A code that indicates the source of the pharmacy claims data for which the pharmacy rebates are attributed to:[5]

Table 5. Rebate Program Code Definitions

Program Code	Definition
50	AmeriHealth Caritas Medicaid Claims (if practical)
51	Highmark Health Options Medicaid Claims (if practical)
55[6]	Total Medicaid Managed Care Claims
56	Other Medicaid Managed Care Claims (e.g., PACE) — use only if applicable
57	FFS Medicaid Claims (i.e., not any form of managed care)
59	Total DMMA rebates for all programs/populations (inclusive of all rebates reported in other Rebate Program Codes plus any other DMMA rebates DMMA is able to report on)

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

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

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.[7] 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 (for example, through regular aggregate payments and on a claims-by-claim basis). DMMA has indicated the potential ability to report rebates applicable to each rebate program code (for example, AmeriHealth, Highmark, FFS, and other). However, if DMMA is unable to report rebates specifically for Delaware residents by these rebate program codes, DMMA can report all rebates obtained under the total code 59. This field should be reported as **a negative number.**

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

Data Comparison/Validation Tabs

As noted previously, this benchmark data collection cycle includes two CYs of data. Accordingly, DHSS/DHCC included a feature in this year's TME data template that automatically creates data comparison/validation tables. The goal is to help DMMA identify anomalies or unexpected changes in the data that can be proactively researched and resolved prior to submitting a complete and accurate Excel workbook to DHSS/DHCC. This is intended to expedite DHSS/DHCC's review of the data and minimize/avoid the need for DMMA to resubmit data. The comparison/validation tabs will either be prepopulated with data or compute comparative results automatically based on data inputted by DMMA. A summary of these comparison/validation tabs is provided below:

2022 to 2021 TME Comp

This tab compares DMMA's new CY 2022 TME data to the final CY 2021 TME data submitted in last year's cycle. This tab contains four tables that will either auto-fill or be prepopulated with data. The purpose of this comparison is to help DMMA identify and resolve unexpected or unusual *year-over-year changes in the new data*. A description of each table follows:

- **Table 1:** This table will auto-fill with DMMA's new CY 2022 TME data inputted by DMMA on the "CY 2022 TME Data" tab (i.e., New CY 2022 Submission).
- **Table 2:** This table will be prepopulated with DMMA's final CY 2021 TME data submitted by DMMA as part of last year's benchmark data collection cycle (i.e., Old CY 2021 Submission).

[7] Fair market-value bona fide service fees are fees paid by a manufacturer to a third party (for example, insurers and pharmacy benefit managers) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (for example, data service fees, distribution service fees, and patient care management programs).

- **Table 3:** This table will automatically compute the change or difference in each TME data element between DMMA's new CY 2022 and final CY 2021 TME data.
  - Material anomalies, unusual or unexpected changes can be researched and resolved by DMMA prior to submitting the completed Excel spending data template to DHSS/DHCC.
- **Table 4:** This table will automatically compute the percentage change in each data element between DMMA's new CY 2022 and final CY 2021 TME data.
  - Material anomalies, unusual or unexpected changes can be researched and resolved by DMMA prior to submitting the completed Excel spending data template to DHSS/DHCC.

2022 to 2021 Rx Rebates Comp

This tab is similar to the 2022 to 2021 TME Comp tab but is limited to comparing new CY 2022 and final CY 2021 pharmacy rebate data. The purpose of this comparison is to help DMMA identify and resolve unexpected or unusual *year-over-year changes in the new data*. This tab also has four tables:

- **Table 1:** This table will auto-fill with DMMA's new CY 2022 pharmacy rebate data inputted by DMMA on the "CY 2022 Pharmacy Rebates" tab (i.e., New CY 2022 Submission).
- **Table 2:** This table will be prepopulated with DMMA's final CY 2021 pharmacy rebate data submitted by DMMA in last year's benchmark data collection cycle (i.e., Old CY 2021 Submission).
- **Table 3:** This table will automatically compute the change or difference in each pharmacy rebate data element between DMMA's new CY 2022 and final CY 2021 data.
  - Material anomalies, unusual or unexpected changes can be researched and resolved by DMMA prior to submitting the completed Excel spending data template to DHSS/DHCC.
- **Table 4:** This table will automatically compute the percentage change in each pharmacy rebate data element between DMMA's new CY 2022 and final CY 2021 data.
  - Material anomalies, unusual or unexpected changes can be researched and resolved by DMMA prior to submitting the completed Excel spending data template to DHSS/DHCC.

Definitions

This tab provides DMMA with a quick-reference guide of the spending data submission requirements.

Appendix A Primary Care Logic

This tab provides DMMA with a quick-reference guide of the primary care logic.

Version Updates

This tab provides DMMA with a summary of key changes made to this cycle's benchmark TME data template.

Submitting TME Data to DHSS/DHCC

The completed Excel workbook should be submitted to dionna.reddy@delaware.gov and DHCC@delaware.gov.

Appendix A

Coding Logic for Defining Primary Care

For the purposes of submitting new CY 2022 TME data, please use the following coding logic to define primary care. This coding logic for primary care was reviewed by the Delaware Department of Insurance, Office of Value-Based Health Care Delivery in August 2023.