DELAWARE HEALTH AND SOCIAL SERVICES

Delaware Health Care Spending and Quality Benchmarks

Implementation Manual
Version 6.0: Insurers

State of Delaware

Department of Health and Social Services

August 15, 2024

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. The Department of Health and Social Services (DHSS), along with the support of the State's health care systems and insurance providers, is continuing to navigate a new era of health care while continuing 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 — consumers, health care providers, 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 May 2024, DHSS released the State's fourth annual Health Care Spending and Quality Benchmarks Trend Report. This report summarized health care spending and quality data collected for calendar year (CY) 2022 and compared it to baseline data from 2020 and 2021. For CY 2022, the spending benchmark was set at a 3.0% target growth rate. Delaware's total CY 2022 Total Health Care Expenditures (THCE) was approximately $9.8 billion. The per capita amount was $9,657, which represents a 6.3% year-over-year increase relative to the CY 2022 spending benchmark of 3.0%.

As we now enter our fifth 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 crucial 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. Moreover, the recent passage of House Substitute 2 for House Bill 350 by the General Assembly in June 2024 creates the Diamond State Hospital Cost Review Board, which will be responsible for an annual review of hospital budgets and related financial information. This act supports the intent of the spending benchmark as a tool

to help lower the growth in health care costs while protecting health care quality and access. The act highlights the importance and usefulness of the spending benchmark as a means to evaluate hospital performance.

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 6.0 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

Contents

Section 1

Major Revisions in This Version

With the assistance of Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, the State of Delaware (Delaware or State) Department of Health and Social Services (DHSS), and Delaware Health Care Commission (DHCC), various wording changes and clarifications, label changes, formatting revisions, and other updates were made 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 6.0 Change	Rationale
Note to Stakeholders	• Message updated	• From Secretary Manning
Spending Data Collection Period	• Two years of spending data to submit: new calendar year (CY) 2023 and refreshed/final CY 2022	• Ensure accurate reporting
Spending Data Template	• Breakout of Medicare Managed Care Duals from Medicaid Managed Care Duals	• More accurately report Duals by Medicare and Medicaid in the trend report
Quality Data Sections	• Additional detail on measures and reporting	• Additional guidance for accurate reporting
Quality Data Template	• Formatting updates: additional race and ethnicity categories • Updates as needed for Electronic Clinical Data Systems (ECDS) reporting to screening measures	• Consistency and better use; more accurate reporting of race and ethnicity and screening data
Due Date for Spending and Quality Data	• September 13, 2024	• Allow for more complete and accurate data
Spending Data Service Categories	• Hospital Inpatient separated into Hospital Inpatient — Not Pharmacy and Hospital Inpatient — Pharmacy • Existing Pharmacy service category relabeled to Pharmacy — Prescription Drug Benefit. • New service category Pharmacy — Medical Benefit	• Obtain more information on the impact of pharmacy on benchmark spending • Respond to stakeholder inquiries

Section 2

Overview of Benchmarks

This implementation manual describes the data reporting requirements for insurers to submit their respective benchmark spending and quality data to the DHSS/DHCC. In addition to this narrative reference document, insurers are requested to use the DHCC's Excel-based benchmark data templates to submit data. Each insurer has been provided Excel templates to use for this purpose. More information about the benchmark process can be found on the 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	No specific dates
2Q of CY	• Delaware Economic and Financial Advisory Council (DEFAC) subcommittee meeting(s) on spending benchmark changes	By May 3, 2024 and June 30, 2024
	• DEFAC recommendation on spending benchmark	By June 30, 2024
	• Update/revise implementation manual and data templates	July 2024/August 2024
3Q of CY	• Finish/publish current implementation manual and data templates	August 2024
	• Conduct benchmark webinar for insurers/Division of Medicaid & Medical Assistance	August 2024
	• Send request to Centers for Medicare & Medicaid Services for Medicare data	August 2024
	• Respond to payer questions on benchmark process	As needed
	• Receive spending and quality data submissions	By September 13, 2024
	• Begin validation of data (request resubmissions, if needed)	After data is received

Time Period	Key Activity	Key Dates
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 1Q of following CY
	• Conduct public meetings/share results	As needed/schedules permit
1Q of following CY	• Release new benchmark trend report	No specific dates

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 CY basis.

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–CY 2023. Governor Carney's Executive Order (EO) 25 set the spending benchmarks for CY 2019–CY 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 3.10%)

On an annual basis, the spending benchmark is subject to review and change by the DEFAC subcommittee. For CY 2023, the spending benchmark was 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, in its June 9, 2023, report, DEFAC recommended that the Governor maintain the 3.0% spending benchmark for CY 2024 and retain the current PGSP formula for determining the spending benchmark.

For CY 2025, the DEFAC subcommittee met twice to review the methodology of the benchmark for updates and modifications. In its June 13, 2024, report DEFAC recommended that the Governor set the CY 2025 spending benchmark to 4.2%, reflecting the subcommittee's methodology change to include the average of 2023 and 2024 inflation as opposed to the long-term inflation five years to 10 years into the future using the PGSP formula.

In support of the spending benchmarks, insurers are asked to provide data on their respective spending consistent with the reporting requirements described in this implementation manual.

Brief Review of the Quality Benchmarks

In addition to the spending benchmark, for use in the CY 2022–CY 2024 performance periods, the DHSS/DHCC established annual benchmarks for nine[1] quality measures:

- Adult Obesity (statewide)
- Opioid-Related Overdose Deaths (statewide)
- Use of Opioids at High Dosage (statewide)
- Emergency Department Utilization (EDU) (commercial market only)
- Persistence of Beta-Blocker Treatment after a Heart Attack (commercial and Medicaid markets)
- Statin Therapy for Patients with Cardiovascular Disease (commercial and Medicaid markets)
- Breast Cancer Screening (commercial and Medicaid markets)[2]
- Colorectal Cancer Screening (commercial and Medicaid markets)[1]
- Cervical Cancer Screening (commercial and Medicaid markets)[1]

In support of these quality benchmarks, insurers are asked to provide data consistent with the reporting requirements described in this implementation manual for the following six measures:

- EDU (commercial market only)
- Persistence of Beta-Blocker Treatment after a Heart Attack (commercial and Medicaid markets)
- Statin Therapy for Patients with Cardiovascular Disease (commercial and Medicaid markets)
- Breast Cancer Screening (commercial and Medicaid markets)
- Colorectal Cancer Screening (commercial and Medicaid markets)
- Cervical Cancer Screening (commercial and Medicaid markets)

The DHSS/DHCC obtains data on the other quality benchmarks through other sources.

[1] Percentage of Eligibles Who Received Preventive Dental Services measure previously included in v5.0 of this manual has been retired and is no longer included.

[2] New measure for the CY 2022–CY 2024 cycle.

Benchmark Data Submission Process and Recent Legislation

Historically, insurers were asked to submit their applicable benchmark data consistent with the instructions and templates contained in this implementation manual. The DHSS/DHCC appreciates the support of all insurers 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. The DHSS/DHCC's goal is not to 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

Total Medical Expense Data Submission Instructions — Insurers

When submitting benchmark Total Medical Expense (TME) data to the DHSS/DHCC, insurers are to follow these instructions and use the DHSS/DHCC's Excel submission template to ensure consistency among insurers, as well as to expedite the 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).
- **Insurer:** A private health insurance company that offers one or more of the following: commercial insurance benefit administration for self-insured employers, Medicare managed care products, and/or are Medicaid/Children's Health Insurance Program (CHIP) managed care organization (MCO) products. **Unless otherwise stated, references to "Medicaid" include CHIP.**
- **Insurance Line of Business (LOB)**: The standard level of reporting benchmark-spending data insurers will use. Mutually exclusive categorization of spending data in different insurance market segments, such as Individual, Large Group-Fully Insured, Small Group-Fully Insured, Self-Insured, and so on.
- **Market:** The highest level of categorization of the health insurance market. For example, Medicare fee-for-service (FFS) and Medicare managed care are collectively referred to as the "Medicare market". Medicaid FFS and Medicaid 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.
- **Payer:** A term used to refer collectively to both insurers and public programs submitting data to the 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 drugs or pharmacy products, excluding manufacturer-provided fair market value bona fide service fees.[3] The DHSS/DHCC publishes spending data net of rebates reported by payers.
- **Premium Revenues (for NCPHI):** A term used to refer to an insurer's total premium revenues for a given Insurance LOB code for Delaware residents. To be used in the computation of NCPHI only. This data element is akin to premium revenues insurers typically report on financial statement (e.g., income statements). Total premium revenue means all monies paid by a policyholder, subscriber, or third party as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan. Amounts should be reported on a direct basis, meaning gross of any private reinsurance arrangements and on a CY earned basis. Include advance payments of the premium tax credit, other types of federal subsidies (e.g., premium portion of low-income subsidy in Medicare Part D program), risk-sharing or risk mitigation arrangement payments/accruals, or retrospective premium adjustments (e.g., estimated or reported risk adjustment transfer payments or risk corridor transfers in the Affordable Care Act [ACA] or Medicare programs, where applicable), and any State-based premium subsidies. Include medical loss ratio (MLR) rebate payments or accruals and any experience-rated premium adjustments. For fully insured employer-sponsored coverage, include the total of employee and employer share of premium cost. For self-insured plans, include any income from administrative expenses and fees. Exclude investment income or revenues not directly related to the cost of providing the health plan coverage. Direct reimbursements for ACA Section 9010 Fees (i.e., Health Insurer Provider Fees) received from the State should not be included.
- **Public Program:** A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid FFS, the Veterans Health Administration and similar entities/programs.
- **THCE:** The TME incurred by Delaware residents for all health care benefits and services by all payers reporting to the DHSS/DHCC, plus the insurers' NCPHI.
- **THCEs per Capita:** THCEs (as defined above) divided by Delaware's total population. The annual change in THCE per capita is compared to the spending benchmark at the State level.
- **TME:** The sum of the allowed amount of total claims spending and total non-claims paid to providers incurred by Delaware residents for all health care services. TME is reported at multiple levels: State, market, payer, and provider. Payers report TME by insurance category code (e.g., Medicare and Medicare Managed Care and Commercial — Full Claims) and at the provider level whenever possible. TME excludes Medigap members and claims.

[3] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., 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 (e.g., data service feeds, distribution service fees, and patient care management programs).

- **Total Net Paid Expenditures (for NCPHI):** A term used to refer to an insurer's actual net paid expenditures for services and benefits for a given Insurance LOB code for Delaware residents. To be used in the computation of NCPHI only. This data element is akin to net expenditures insurers typically report on financial statement (e.g., income statements). This includes direct claims or indirect payments for incentives and bonuses, including under capitation contracts, paid to or received by physicians, and other non-physician providers whose services are covered by the policy for services or supplies covered by the policy. Amounts should reflect the insurer paid net of any provider contract discounts, member cost sharing, third-party liability, pharmacy rebates, and more. Amounts should be reported on a direct basis, meaning gross of any private reinsurance arrangements; however, amounts should be adjusted for any federal or State subsidy programs, such as State-based reinsurance program payments or accruals in the ACA market (e.g., 1332 waiver program). Amounts should be adjusted for the low-income cost sharing portion of subsidy payments or accruals in the Medicare Part D program. Report amounts on a CY incurred basis, including any remaining incurred but not reported (IBNR) or incurred but not paid (IBNP) claims reserves. Do not include any quality improvement, claims utilization, and claims processing expenses, premium taxes/assessments, and expenses paid to third-party vendors.

TME Data Submission Schedule

Insurers are asked to submit TME data on the following schedule. Please note that for the CY 2022 data collection process, each insurer will submit **two years** of data for this benchmark data collection cycle: CY 2022 and CY 2023. The CY 2023 data will be submitted for the first time, but the CY 2022 will be final data that will replace the CY 2022 data submitted as part of last year's data collection process. The due date for all data is September 13, 2024.

Table 3. TME Data Submission Schedule

Due Date	Spending Data Submitted
September 13, 2024	CY 2023 New and CY 2022 Final

TME Data Submission Specifications

Insurers should **apply the same data extract specifications to the CY 2023 and CY 2022 data.** This will enable better year-over-year comparisons. The 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. The DHSS/DHCC's goal is to minimize these differences, but data specification changes are expected to occur from time to time.

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.**

- **Pertaining to members who, at a minimum, have medical benefits.**[4]
- For which **the insurer is primary on a claim** (exclude any paid claims for which the insurer was the secondary or tertiary insurer). Even though an individual enrolled with an insurer can have other forms of health insurance, the reporting of **TME data is based on whether the insurer was primary on the respective claim**, not whether the member had other forms of insurance. For example, for members enrolled in Medicaid managed care who also have Medicare coverage (e.g., dual eligible), the insurer must report as part of its TME data submission the allowed amount for all claims for which it was the primary payer (e.g., a large portion of long-term care services incurred by those members).

Data Run-Out Period Specifications

Since the due date for submission is September 13, insurers should allow for a claims and non-claims run-out period of approximately eight months of run-out: summarize CY 2023 and CY 2022 data, with run-out through approximately August 13, 2024.

Insurers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective claim category based on commonly accepted actuarial principles. If applicable, insurers should apply reasonable and appropriate estimations of non-claims liability, including payments expected to be made to organizations not separately identified for TME reporting purposes expected to be reconciled after the run-out period.

The DHSS/DHCC prefer insurers use as much run-out as possible to minimize the impact of IBNR/IBNP or other adjustment factors.

The principle of using as much run-out/known data as possible to minimize adjustments also applies to the submission of the NCPHI data elements.

When resubmitting CY 2022 data, insurers should pull this data at or around the same time the new CY 2023 data is summarized. As a result, the DHSS/DHCC expects the resubmitted CY 2022 data to have extensive run-out and; therefore, be complete and accurate.

Partial Claims Data Adjustment

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

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

[4] 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.

Such an adjustment must use actuarially sound principles and be reviewed with the DHSS/DHCC before the adjustment is made. Please email the DHSS/DHCC (send to: dionna.reddy@delaware.gov and DHCC@delaware.gov) with a description of how you propose to make actuarial adjustments to partial claims data to allow those claims 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 the DHSS/DHCC's response time. Upon reviewing submissions, the DHSS/DHCC staff will follow up with a confirmation accepting the adjustment process or request additional information as necessary. Therefore, reasonable and appropriate time should be given to the DHSS/DHCC to review and respond to any partial claims adjustment methodology prior to submission of the final TME data.

TME Data File Layouts and Field Definitions

The DHSS/DHCC will provide each insurer an Excel-based template to use in submitting TME data. The format/layout of the TME data template will be the same across insurers, but the DHSS/DHCC will now be including data comparison/validation tabs to aid each insurer in reviewing its data for accuracy and completeness. Therefore, each insurer's Excel spending data template will be unique.

Each Excel TME data submission template contains the following tabs:

- Contents
- Mandatory Questions
- Header Record File (HD-TME)
- CY 2022 TME Data
- CY 2023 TME Data
- CY 2022 NCPHI
- CY 2023 NCPHI Data
- 2022 to 2023 TME Comp
- 2022 NCPHI Comp
- 2022 to 2023 NCPHI Comp
- Definitions
- Version Updates
- Appendix A Primary Care Logic
- Appendix B Insurer Attestation Form

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

Insurers can use the drop-down box to select their insurer name and input the email address of the contact person if the DHSS/DHCC has questions regarding the data submission.

Insurers are 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 the insurer complete the TME data submission template correctly, expedite the DHSS/DHCC's review of the data, and minimize or avoid the need for data resubmissions.

Header Record File (HD-TME)

This tab provides high-level information about the entity submitting the data.

Insurer Org ID: the DHSS/DHCC-assigned organization ID for the insurer submitting the file.[5] This information will be pre-populated within the Excel template.

Table 4. Insurer to DHSS/DHCC Organizational IDs

Insurer	DHSS/DHCC Organizational ID
Aetna	101
AmeriHealth Caritas	102
Cigna	103
Highmark Blue Cross Blue Shield Delaware	104
UnitedHealthcare	105
Humana[6]	106
Delaware First Health	107

Period Beginning and Ending Dates: The beginning period represented by the reported data. The beginning and ending 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 spending data is based on date of service.

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

Health-Status Adjustment Tool: The health-status adjustment tool, software, or product used to calculate the health-status adjustment score. The health-status risk adjustment score is used to normalize the insurer's TME to enable better year-over-year comparisons.

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

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

[6] Humana was added for the CY 2022 data collection process.

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

CY 2022 TME Data and CY 2023 TME Data

This tab will be the source of the insurer's TME data used by the DHSS/DHCC to compute THCE. Insurers will report their applicable CY 2022 and CY 2023 claims and non-claims payments in the respective tab. Both tabs have the same layout.

Insurance LOB Code and Description: A number that indicates the insurance LOB being reported. All data reported by Insurance LOB **must be mutually exclusive**.

Table 5. LOB Category Code to Description

LOB Category Code	LOB Category Code Description
901	Individual
902	Large Group, Fully Insured
903	Small Group, Fully Insured
904	Self-insured
905	Student Market
906	Medicare Managed Care (excluding Medicare/Medicaid Duals)
907	Medicaid/CHIP Managed Care (excluding Medicare/Medicaid Duals)
908a	Medicare Duals[7]
908b	Medicaid Duals[8]
909	Other

As a change to this year's data collection process, if an insurer enrolls Medicare/Medicaid dual eligibles, **the DHSS/DHCC is requesting insurers report all relevant data applicable to Medicare dual eligibles in code 908a and all relevant data applicable to Medicaid dual eligibles in 908b.** This will ensure data reported in all the Insurance LOB codes is mutually exclusive.

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. Member months reported will be the same for TME and NCPHI.

For insurers who have data for dually eligible members in both 908a and 908b, please provide the **total count of unique member months**.

Pharmacy Rebates: The estimated value of rebates attributed to Delaware resident members provided by pharmaceutical manufacturers for drugs with specified dates of fill, corresponding to the respective reporting period (e.g., CY 2023), excluding

[7] Medicare-related spending on members who are dually enrolled in both Medicare and Medicaid.
[8] Medicaid-related spending on members who are dually enrolled in both Medicare and Medicaid.

manufacturer-provided fair market value bona fide service fees.[9] Include rebates associated with drugs provided under the insurer's prescription drug benefit, and if applicable, the insurer's medical benefit. This amount shall include PBM rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments or on a claims-by-claim basis). Payers should apply IBNR factors to preliminary 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 LOB. 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**.

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.

Insurers can use a health-status adjustment tool and software of their own choosing, but must disclose the tool (e.g., ACG and DxCG) and the version in the HD-TME tab.

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.

The DHSS/DHCC acknowledges that insurers may change health-risk adjustment tools over time, which may cause differences between current and historical data collection periods.

Insurers are to provide health-status risk adjustment scores that 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). The Excel template performs this computation automatically after the requisite data is input. Insurers are encouraged to review the Health-Status Risk-Adjusted TME PMPM for reasonableness.

The DHSS/DHCC intends to only use health status risk-adjusted spending data when insurer-level data is publicly reported. At the State and market levels, unadjusted spending data will be reported.

TME Claims and Non-Claims Categories

Insurers are to report TME data using the following claims and non-claims categories. **To avoid double-counting, all categories must be mutually exclusive.** The DHSS/DHCC

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

may request additional information regarding how insurers mapped their data into these categories to improve consistency in reporting across all insurers:

- **Claims: Hospital Inpatient — Not Pharmacy:** 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 nonhospital facilities. Exclude TME data specific to hospital inpatient pharmacy services using methods deemed reasonable and appropriate by the insurer.
- **Claims: Hospital Inpatient — Pharmacy**: All TME data to hospitals for pharmacy services applicable to hospital inpatient. This includes pharmacy associated with room and board and ancillary payments. Includes all hospital types. Includes pharmacy-related payments for ED services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. This does not include pharmacy payments made for observation services, pharmacy payments made for physician services provided during an inpatient stay billed directly by a physician group practice or an individual physician, or inpatient services at non-hospital facilities.
- **Claims: Hospital Outpatient:** All TME data to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in a hospital admission. This includes observation services. Does not include payments made for physician services provided on an outpatient basis 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 — Prescription Drug Benefit (gross of rebates):** All TME data from claims to health care providers for 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 standalone prescription drug plans (PDPs) are asked to exclude standalone PDP data from their TME.** Pharmacy data in this category is to be reported gross of applicable rebates. Rebates will be reported separately.

  - 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, the insurer would report $100 in the Pharmacy claims column and −$5 in the separate Pharmacy Rebates column. Pharmacy rebates are reported as a negative value.

- **Claims: Pharmacy — Medical Benefit (gross of rebates):** All TME data from claims to health care providers for drugs, biological products, or vaccines **as defined by the insurer's medical benefit**. This category should not include claims paid for drugs and products under the insurer's PDP. Medicare managed care insurers that offer standalone PDPs are asked to exclude standalone PDP data from their TME. Pharmacy data in this category is to be reported gross of applicable rebates (see prior description). Rebates, if applicable, will be reported separately.
- **Claims: Long-Term Care:** All TME data from claims to health care providers such as skilled or custodial nursing facility services, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living, personal care services (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 the DHSS/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 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 emergency medical record (EMR)/health information technology (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 (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 recoveries, 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 Coronavirus Disease 2019 public health emergency. **Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.**

The remaining fields in these tabs automatically compute totals, PMPMs, and health-status risk-adjusted values based on the data input by the insurer. Each insurer is encouraged to review these fields for reasonableness before submitting a completed Excel workbook to the DHSS/DHCC.

CY 2022 NCPHI and CY 2023 NCPHI

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

NCPHI is computed using separate data elements that are different than the TME data elements previously described. Whereas the TME data is based on allowed amounts in which the insurer is the primary payer of the claim, NCPHI uses more “traditional” premium

revenues and total net paid expenditures commonly reported on audited financial statements (e.g., income/expense statements). Therefore, the DHSS/DHCC anticipates the NCPHI data elements to be easier for insurers to report, although some allocations may be required to reflect Delaware residents. **If an insurer needs to estimate what the Delaware resident portion of premiums revenues is, please share the proposed methodology for the DHSS/DHCC's review.**

- **Premium Revenues (for NCPHI):** For the applicable LOB code, total premium revenue means all monies paid by a policyholder, subscriber, or third party as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan for Delaware residents. Amounts should be reported on a direct basis, meaning gross of any private reinsurance arrangements and on a CY earned basis. Include advance payments of the premium tax credit, other type of federal subsidies (e.g., premium portion of low-income subsidy in Medicare Part D program), risk-sharing or risk-mitigation arrangement payments/accruals, or retrospective premium adjustments (e.g., estimated or reported risk adjustment transfer payments or risk corridor transfers in the ACA or Medicare programs where applicable), and any State-based premium subsidies. Include MLR rebate payments or accruals and any experience-rated premium adjustments. For fully insured employer-sponsored coverage, include the total of employee and employer share of premium cost. For self-insured plans, include any income from administrative expenses and fees. Exclude investment income or revenues not directly related to the cost of providing the health plan coverage. Direct reimbursements for ACA Section 9010 Fees (i.e., Health Insurer Provider Fees) received from the State of Delaware should not be included.

- **Total Net Paid Expenditures (for NCPHI):** For the applicable LOB code, net paid expenditures for services and benefits for Delaware residents. This includes direct claims or indirect payments for incentives and bonuses, including under capitation contracts, paid to or received by physicians, and other non-physician providers whose services are covered by the policy for services or supplies covered by the policy. **Amounts should reflect what the insurer paid, net of any provider contract discounts, member cost sharing, third-party liability, pharmacy rebates, and so on.** Amounts should be reported on a direct basis, meaning gross of any private reinsurance arrangements; however, amounts should be adjusted for any federal or State subsidy programs, such as State-based reinsurance program payments or accruals in the ACA market (e.g., 1332 waiver program). Amounts should be adjusted for the low-income cost sharing portion of subsidy payments or accruals in the Medicare Part D program. Risk-sharing transfer payments, positive or negative, incurred to providers for Delaware residents are to be included. Report amounts on CY incurred basis, including any remaining IBNR or IBNP claims reserves using actuarially sound methodologies.

  — The DHSS/DHCC expects insurers to report $0 for the self-insured LOB code 904, since insurers are not the payer of services/benefits for self-insured products.

  Do not include any health plan administrative, overhead, corporate allocations, quality improvement, claims utilization/processing expenses, premium taxes/assessments, or expenses paid to third-party vendors.

- **Member Months:** For the applicable LOB code, the field will auto-fill with the member months from the respective TME data tab.

The remaining fields in these tabs automatically compute NCPHI, NCPHI PMPM, and NCPHI as a percentage of Premium Revenues based on the data input by the insurer. Each insurer is encouraged to review these fields for reasonableness before submitting a completed Excel workbook to the DHSS/DHCC.

In support of NCPHI calculations**, insurers are asked to still submit their federal commercial MLR reports by October 1** (or the first business day thereafter). In an instance in which the MLR report submitted to the DHSS/DHCC by October 1 differs from the final submission an insurer makes to the federal Center for Consumer Information and Insurance Oversight, the insurer must notify the DHSS/DHCC in writing as soon as possible and submit an updated MLR.

Data Comparison/Validation Tabs

As noted previously, this benchmark data collection cycle includes only two CYs of data. Accordingly, the DHSS/DHCC included a feature in the TME data template that automatically creates data comparison/validation tables (if data was submitted last year). The goal is to help each insurer 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 the DHSS/DHCC. This is intended to expedite the DHSS/DHCC's review of the data and minimize/avoid the need for insurers to resubmit data. The comparison/validation tabs will either be prepopulated with data or compute comparative results automatically based on data input by each insurer. A summary of these comparison/validation tabs is provided below:

2022 TME Comp

These tabs compare new CY 2022 TME data submitted in this cycle to the old CY 2022 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 to help each insurer identify and resolve unexpected or unusual changes **in the same year of data** prior to submission. Some changes are expected due to additional run-out and instruction manual updates (e.g., changes in the definition of primary care), but unusual or unexpected changes should be addressed before submission to the DHSS/DHCC. A description of each table follows:

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

- Material anomalies and unusual or unexpected changes can be researched and resolved by the insurer prior to submitting the completed Excel spending data template to the DHSS/DHCC.

2023 to 2022 TME Comp

This tab compares the new CY 2023 TME data to the new CY 2022 TME data submitted this cycle for the applicable insurer. This tab contains four tables that will either auto-fill or be prepopulated with data. The purpose of this comparison is to help each insurer 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 the insurer's new CY 2023 TME data input by each insurer on the "CY 2022 TME Data" tab (i.e., New CY 2023 Submission).
- **Table 2:** This table will auto-fill with the insurer's new CY 2022 TME data input by each insurer on the "CY 2022 TME Data" tab (i.e., New CY 2022 Submission).
- **Table 3**: This table will automatically compute the change or difference in each TME data element between the new CY 2023 and new CY 2022 TME data.
  - Material anomalies and unusual or unexpected changes can be researched and resolved by the insurer prior to submitting the completed Excel spending data template to the DHSS/DHCC.
- **Table 4**: This table will automatically compute the percentage change in each TME data element between the new CY 2023 and new CY 2022 TME data.
  - Material anomalies and unusual or unexpected changes can be researched and resolved by the insurer prior to submitting the completed Excel spending data template to the DHSS/DHCC.

2022 NCPHI Comp

This tab compares CY 2022 NCPHI data submitted in this cycle to the CY 2022 NCPHI 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 each insurer identify and resolve unexpected or unusual changes **in the same year of data** prior to submission. Some changes are expected due to additional run-out, but unusual or unexpected changes should be addressed before submission to the DHSS/DHCC. A description of each table follows:

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

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

2023 to 2022 NCPHI Comp

This tab compares the new CY 2023 NCPHI data to the new CY 2022 NCPHI data submitted in this cycle for the applicable insurer. This tab contains four tables that will either auto-fill or be prepopulated with data. The purpose of this comparison is to help each insurer 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 the insurer's new CY 2023 NCPHI data input by each insurer on the "CY 2023 NCPHI" tab (i.e., New CY 2023 Submission).
- **Table 2:** This table will auto-fill with the insurer's new CY 2022 NCPHI data input by each insurer on the "CY 2022 NCPHI" tab (i.e., New CY 2022 Submission).
- **Table 3**: This table will automatically compute the change or difference in each NCPHI data element between the new CY 2023 and new CY 2022 NCPHI data.
  - Material anomalies and unusual or unexpected changes can be researched and resolved by the insurer prior to submitting the completed Excel spending data template to the DHSS/DHCC.
- **Table 4**: This table will automatically compute the percentage change in each NCPHI data element between the new CY 2023 and new CY 2022 NCPHI data.
  - Material anomalies and unusual or unexpected changes can be researched and resolved by the insurer prior to submitting the completed Excel spending data template to the DHSS/DHCC.

Definitions

This tab provides insurers a quick reference guide of the spending data submission requirements.

Appendix A Primary Care Logic

This tab provides insurers a quick reference guide of the primary care logic.

Appendix B Insurer Attestation (Signed by Insurer's Actuary)

This tab provides insurers the Attestation form that must be signed by the insurer's actuary. Insurers can choose to submit a signed pdf version of the Attestation form.

Version Updates

This tab provides insurers a summary of key changes made to this cycle's benchmark spending data template.

Submitting TME Data to the DHSS/DHCC

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

Section 4

Quality Data Submission Instructions — Insurers

When submitting benchmark quality data to DHSS/DHCC, insurers are to follow these instructions and use the DHSS/DHCC's Excel submission template to ensure consistency among insurers, as well as to expedite the DHSS/DHCC's review and use of the data.

Definition of Key Terms

- **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 Medicaid/CHIP MCO products. **Unless otherwise stated, references to "Medicaid" include CHIP.**
- **Market:** The highest level of categorization of the health insurance market. For example, Medicare FFS and Medicare managed care are collectively referred to as the "Medicare market". Medicaid FFS and Medicaid MCO managed care are collectively referred to as the "Medicaid market". Individual, self-insured, small and large group markets, and student health insurance are collectively referred to as the "Commercial market".
- **Health Care Effectiveness Data and Information Set (HEDIS®):** Standardized performance measures developed and maintained by the National Committee for Quality Assurance. These measures are designed to allow consumers and purchasers to compare plans against national or regional benchmarks.
- **Health-Status Measures:** These measures quantify certain population-level characteristics of Delaware residents.
- **Health Care Measures:** These measures quantify performance on health care processes or outcomes associated with Delaware residents. Performance is assessed at the State, market, insurer, and provider levels.
- **National Committee for Quality Assurance**: An organization that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation.

Quality Data Submission Schedule

Insurers are asked to submit their respective quality data on the following schedule. Unlike the spending data, the DHSS/DHCC collects only one year of quality data, which is considered the final quality results for that particular year.

Table 6. Quality Data Submission Schedule

Due Date	Quality Data Submitted
September 13, 2024	CY 2023 Final

Quality Data Submission Specifications

Insurers are asked to provide quality data for the following measures by applicable market for Delaware residents.

Insurers are encouraged to review the data for reasonability. For example:

- Ensure the current reporting year data appears comparable to the previous year's data.
- Consider whether there are significant changes in the results and provide an explanation for the changes.
- Review the numerators and denominators relative to the membership for the reporting year.

For the CY 2023 reporting period, insurers need to submit data for the current quality measures (see table below). Some measures request insurers to provide additional data stratifications for race, ethnicity, gender, and age. Although data for the additional stratifications may not be available, the DHSS/DHCC encourages insurers to submit these data to support the DHSS/DHCC's effort to identify disparities and address care gaps.

Table 7. CY 2023 Quality Measures

Quality Measures	Description	Specification	Market	Reporting Unit
EDU	For members 18 years of age and older, the risk-adjusted ratio of observed-to-expected (O/E) emergency department (ED) visits during the measurement year.	HEDIS, version corresponding to performance period	• Commercial	Insurer
Persistence of Beta-Blocker Treatment After a Heart Attack[10]	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. (Administrative Reporting Measure)	HEDIS, version corresponding to performance period	• Commercial • Medicaid	Insurer

[10] Measure includes request for data to be stratified by race, ethnicity, gender, and age.

Quality Measures	Description	Specification	Market	Reporting Unit
Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80%[11]	The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year who were identified as having clinical atherosclerotic cardiovascular disease and met the following criteria. The following rate is reported: Statin Adherence 80%: members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period. (Administrative Reporting Measure)	HEDIS, version corresponding to performance period	• Commercial • Medicaid	Insurer
Breast Cancer Screening	Women 50–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. (ECDS Reporting Measure)	HEDIS, version corresponding to performance period	• Commercial • Medicaid	Insurer
Colorectal Cancer Screening	Assesses adults 50–75 years who had appropriate screening for colorectal cancer with any of the following tests: annual fecal occult blood test, flexible sigmoidoscopy every five years, colonoscopy every 10 years, computed tomography colonography every five years, stool DNA test every three years. (Administrative, Hybrid, or ECDS Reporting Measure; will transition to ECDS-only in 2024)	HEDIS, version corresponding to performance period	• Commercial • Medicaid	Insurer
Cervical Cancer Screening	The percentage of women 21–64 years of age who were screened for cervical	HEDIS, version corresponding to	• Commercial • Medicaid	Insurer

[11] Ibid

Quality Measures	Description	Specification	Market	Reporting Unit
	cancer using any of the following criteria: • Women 21–64 years of age who had cervical cytology performed within the last three years. • Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last five years. • Women 30–64 years of age who had cervical cytology/hrHPV co-testing within the last five years. (Administrative, Hybrid, or ECDS Reporting Measure; may transition to ECDS-only in 2025)	performance period		

The DHSS/DHCC will also obtain data from other data sources for the other quality measures included in the quality benchmarks.

Quality Data File Layouts and Field Definitions

The DHSS/DHCC will provide each insurer an Excel-based quality data template that will contain the following tabs:

- Instructions
- Measures Overview
- #1 — Insurer Information
- #2 — EDU
- #3 — Beta-Blocker
- #4 — Statin Therapy
- #5 — Breast Cancer
- #6 — Colorectal Cancer
- #7 — Cervical Cancer
- Attestation Form

Cells are color-coded, and all red, green, and blue columns are required to be completed. The lavender columns include additional stratification of the data that insurers are encouraged to populate. Each of these tabs and the data elements/fields therein are described in more detail below.

Instructions

This tab outlines the steps for completing the worksheet and some data review considerations for the insurer.

Measures Overview

This tab contains a brief description of each of the measures.

#1 — Insurer Information

- This tab requests the performance year, the contact information at the insurer, the LOB, and the average monthly membership.
- **Cell C2** notes the CY for which the data are being submitted.
- **Cells C3** and **E3** request the CY dates for the performance period being submitted.
- **Column B–Column E** request the submitter's contact information.
- **Column F** requests the name of the entity for which the performance is being reported in a given row.
- **Column G** requests the payer select the LOB 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 H** asks for membership information for the LOB being reported. Please submit health insurer enrollment using the average monthly membership.

#2 — EDU

- This tab requests the data for the EDU measures.
- **Cells C2, C3, E2, and F3** will auto-populate with the performance year, start, and end date, and specification type (Administrative, Hybrid, or ECDS), if applicable.
- **Column B and Column C** request the insurer name and LOB.
- **Column E**, EDU O/E Ratio, requests input of the O/E ratio.
- **Column G–Column N** request data for age and sex stratifications for a single insurer:
  - **Column I,** Observed ED Visits, requests the number of observed ED visits within each age and sex type and a total.
  - **Column J,** Observed ED Visits/1,000 Members, requests the number of observed ED visits divided by the number of non-outlier members in the eligible population,

multiplied by 1,000 within each age and sex type and a total. Calculated by Interactive Data Submission System (IDSS).

- **Column K,** Expected ED Visits, requests the number of expected ED visits within each age and sex type and a total.
- **Column L,** Expected ED Visits/1,000 Members, the number of expected ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 within each age and sex type and a total. Calculated by IDSS.
- **Column M**, Variance, requests the variance (from Risk Adjustment Weighting and Calculation of Expected Events, Predicted Unconditional Count of Visits [PUCV], and step 6) within each age and sex type and a total.
- **Column N**, O/E Ratio, requests the O/E ratio for each age and sex type and a total.

- **Column P–Column W** request data for race and ethnicity stratifications.
  - **Column R,** Observed ED Visits, requests the number of observed ED visits within each race or ethnicity type, and a total.
  - **Column S,** Observed ED Visits/1,000 Members, requests the number of observed ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 within each race or ethnicity type, and a total.
  - **Column T,** Expected ED Visits, requests the number of expected ED visits within each race or ethnicity type, and a total.
  - **Column U,** Expected ED Visits/1,000 Members, the number of expected ED visits divided by the number of non-outlier members in the eligible population, multiplied by 1,000 within each race or ethnicity type, and a total.
  - **Column V**, Variance, requests the variance (from Risk Adjustment Weighting and Calculation of Expected Events, PUCV, step 6) within each race or ethnicity type, and a total.
  - **Column W,** O/E Ratio, requests the O/E ratio for each race or ethnicity type, and a total.
- **Column Y–Column AT** provide an area to input all the above EDU data for a second insurer. If more than two insurers need to be submitted, please copy and paste these columns and enter in the additional insurers' information.

#3 — Beta-Blocker

- This tab requests the data for Persistence of Beta-Blocker Treatment After a Heart Attack.
- **Cells C2, C3, G2, and G3** will auto-populate with the performance year, start, and end date, and specification type (Administrative, Hybrid, or ECDS), if applicable.
- **Column B and Column C** request the insurer name and LOB. This information will auto-populate with the insurer names and LOBs as entered in Tab #1.

- **Column E–Column G**, Measure Rate, request the measure rate numerator and denominator. The rate will automatically populate in Column H.
- **Column I–Column AH** request data for race and ethnicity.
  - **Column I–Column U** request the number of members within the measure rate numerator within each race or ethnicity type.
  - **Column V–Column AH** request the number of members within the measure rate denominator within each race or ethnicity type.
- **Column AJ–Column AO** request data for sex.
  - **Column AJ–Column AL** request the number of members within the measure rate numerator of each sex type.
  - **Column AM–Column AO** request the number of members within the measure rate denominator of each sex type.
- **Column AQ–Column AX** request data for age.
  - **Column AQ–Column AT** request the number of members within the measure rate numerator within each age category.
- **Column AU–Column AX** request the number of members within the measure rate denominator within each age category.

#4 — Statin Therapy

- This tab requests the data for Statin Therapy for Patients with Cardiovascular Disease — Statin Adherence 80%, this measure also calculates two age/gender stratifications — Males ages 21 years–75 years and Females 40 years–75 years.
- **Cells C2, C3, G2, and G3** will auto-populate with the performance year, start, and end date, and specification type (Administrative, Hybrid, or ECDS), if applicable.
- **Columns B and C** request the insurer name and LOB. This information will auto-populate with the insurer names and lines of business as entered in Tab #1.
- **Column E–Column G,** Measure Rate, request the measure rate numerator and denominator. The rate will automatically populate in Column H.
- **Column I–Column L** request age and sex information for defined categories.
  - **Column I and Column J** request the number of members within the measure rate numerator who are male and within the ages of 21 years–75 years.
  - **Column K and Column L** request the number of members within the measure rate numerator who are female and within the ages of 40 years–75 years.
- **Column N and Column AM** request data for race and ethnicity.
  - **Column N–Column Z** request the number of members within the measure rate numerator within each race or ethnicity type.

  - **Column AA–Column AM** request the number of members within the measure rate denominator within each race or ethnicity type.

- **Column AO–Column AT** request data for sex.
  - **Column AO–Column AQ** request the number of members within the measure rate numerator of each sex type.
  - **Column AR–Column AT** request the number of members within the measure rate denominator of each sex type.
- **Column AV–Column BA** request data for age.
  - **Column AV–Column AX** request the number of members within the measure rate numerator within each age category.
  - **Column AY–Column BA** request the number of members within the measure rate denominator within each age category.

#5 — Breast Cancer

- This tab requests the data for Breast Cancer Screening.
- **Cells C2, C3, G2, and G3** will auto-populate with the performance year, start, and end date, and specification type (Administrative, Hybrid, or ECDS), if applicable.
- **Column B and Column C** request the insurer name and LOB. This information will auto-populate with the insurer names and LOBs as entered in Tab #1.
- **Column E–Column G**, Measure Rate, request the measure rate numerator and denominator. The rate will automatically populate in Column H.
- **Column I–Column AH** request data for race and ethnicity.
  - **Column I–Column U** request the number of members within the measure rate numerator within each race or ethnicity type.
  - **Column V–Column AH** request the number of members within the measure rate denominator within each race or ethnicity type.
- **Column AJ–Column AQ** request data for age. Age includes expanded age range. For example, if data are not available for members 40–49 years of age, please leave blank.
  - **Column AJ–Column AM** request the number of members within the measure rate numerator within each age category.
  - **Column AN–Column AQ** request the number of members within the measure rate denominator within each age category.

#6 — Colorectal Cancer

- This tab requests the data for Colorectal Cancer Screening.
- **Cells C2, C3, G2, and H3** will auto-populate with the performance year, start, and end date, and specification type (Administrative, Hybrid, or ECDS), if applicable.

- **Column B and Column C** request the insurer name and LOB. This information will auto-populate with the insurer names and LOBs as entered in Tab #1.
- **Column D** requests the specification type. Drop down options include Administrative or Hybrid.
- **Column F–Column H**, Measure Rate, request the measure rate numerator and denominator. The rate will automatically populate in Column H.
- **Column J–Column AI** request data for race and ethnicity.
  - **Column J–Column V** request the number of members within the measure rate numerator within each race or ethnicity type.
  - **Column W–Column AI** request the number of members within the measure rate denominator within each race or ethnicity type.
- **Column AK–Column AP** request data for sex.
  - **Column AK–Column AM** request the number of members within the measure rate numerator of each sex type.
  - **Column AN–Column AP** request the number of members within the measure rate denominator of each sex type.
- **Column AR–Column BA** request data for age.
  - **Column AR–Column AV** request the number of members within the measure rate numerator within each age category.
  - **Column AW–Column BA** request the number of members within the measure rate denominator within each age category.

#7 — Cervical Cancer

- This tab requests the data for Cervical Cancer Screening.
- **Cells C2, C3, G2, and H3** will auto-populate with the performance year, start, and end date, and specification type (Administrative, Hybrid, or ECDS), if applicable.
- **Column B and Column C** request the insurer name and LOB. This information will auto-populate with the insurer names and LOBs as entered in Tab #1.
- **Column D** requests the specification type. Drop down options include Administrative or Hybrid.
- **Column F–Column H**, Measure Rate, request the measure rate numerator and denominator. The rate will automatically populate in Column H.
- **Column J–Column AI** request data for race and ethnicity.
  - **Column J–Column V** request the number of members within the measure rate numerator within each race or ethnicity type.
  - **Column W–Column AI** request the number of members within the measure rate denominator within each race or ethnicity type.

- **Column AK–Column AP** request data for sex.
  - **Column AK–Column AM** request the number of members within the measure rate numerator of each sex type.
  - **Column AN–Column AP** request the number of members within the measure rate denominator of each sex type.
- **Column AR–Column AY** request data for age.
  - **Column AR–Column AU** request the number of members within the measure rate numerator within each age category.
  - **Column AV–Column AY** request the number of members within the measure rate denominator within each age category.

Attestation Form (Signed by the Insurer's Chief Quality Officer or Quality Lead)

This tab provides insurers the Attestation form that must be signed by the insurer's Chief Quality Officer (CQO) or Quality Lead. Insurers can choose to submit a signed, PDF version of the Attestation form.

Submitting Quality Data to the DHSS/DHCC

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

Appendix A

Primary Care Services Coding Logic

For the purposes of submitting new CY 2023 and 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 2024.

Appendix B
Insurer Attestation

Attestation of the Accuracy and Completeness of Benchmark Data

This attestation form is also included in the Excel-based benchmark spending and quality data submission templates.

Instructions: Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation.

The DHSS/DHCC requires that for TME data, the insurer's actuary signs the attestation. For quality data, the DHSS/DHCC requires that either the Chief Quality Officer (CQO) or Quality Lead signs the attestation.

Scanned copies of the signed attestation(s) can be emailed to: dionna.reddy@delaware.gov and DHCC@delaware.gov. If an insurer resubmits its spending and/or quality data, a new signed attestation form will need to accompany the resubmitted data.

Insurer: _____

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

Pursuant to Delaware's establishment, monitoring, and implementation of annual Health care Spending and Quality Benchmarks and State-defined reporting guidelines, certain health insurers operating in the State of Delaware are asked to 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 the DHSS/DHCC non-acceptance of the attached reports.

_____	_____
Signature	Date
_____	_____
Print Name	Title