HEALTH WEALTH CAREER

DELAWARE HEALTH CARE SPENDING AND QUALITY BENCHMARKS

INSURER TOTAL MEDICAL EXPENSE REPORTING SPECIFICATION

VERSION 1.1

APRIL 16, 2019

State of Delaware

INSURER TME REPORTING SPECIFICATION

This insurer TME data specification provides technical details to assist insurers in reporting and filing data to enable the DHCC to calculate TME.

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

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

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

TME FILE SUBMISSION INSTRUCTIONS AND SCHEDULE

TME file layouts for insurers are included in this appendix. Further file submission instructions will be available on DHCC's website. Insurers will submit flat files of their TME data.[1] The fields are variable in length and relative to position; therefore, they need to be separated by an asterisk (*). Insurers will submit this information on an annual basis.

Insurers will submit TME data on the following schedule:

INSURERS' TME FILING SCHEDULE

Date	Files Due
August 1, 2019	CY 2018 final TME
August 1, 2020	CY 2019 final TME
August 1, 2021	CY 2020 final TME
August 1, 2022	CY 2021 final TME
August 1, 2023	CY 2022 final TME
August 1, 2024	CY 2023 final TME

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

TME DATA SUBMISSION

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

Insurers must include only information pertaining to:

- Members who are residents of Delaware
- For which the insurer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer)

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

1. Delaware members required to select a PCP by plan design (member months for members who were attributed to more than one PCP in a calendar year should be allocated based on the number of months associated with each PCP).

1. Members not included in (1) who were attributed during the measurement year to a PCP, pursuant to a contract between the insurer and provider for financial or quality performance

2. Members not included in (1) or (2), attributed to a PCP by the insurer's own attribution methodology

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

Insurers must report TME for each of the 10 largest providers within their network and for members who are not attributable to a PCP. DHCC will only publicly report data on large providers, which are any practitioner, physician group, ACO, independent practice association or contracting entity for which the insurer has a minimum number of member lives attributed during the reporting period as follows:

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

Insurers must report three categories of data:

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

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

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

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

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

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

Claims Run-Out Period Specifications

Insurers shall allow for a claims run-out period of at least 120 days after December 31 of the prior calendar year. Payers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

TME DATA FILE LAYOUTS AND FIELD DEFINITIONS

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

Header Record File

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

Insurer Org ID: The DHCC-assigned organization ID for the insurer submitting the file.[2]

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

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

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

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

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

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

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

Large Provider Record File

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

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

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

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

Insurance Category Code: A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for large providers for which the insurer is able to collect information on all direct medical claims and subcarrier claims should be reported in the "Full Claims" category. Commercial data that does not include all medical and subcarrier claims should be reported in the "Partial Claims", and an actuarial adjustment should be made to those claims to allow for them to be comparable to full claims. Such an adjustment must use actuarially sound principles and be reviewed with DHCC before the adjustment is made. The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve out vendors, such as PBMs or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. Insurers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold. For insurers reporting in the "Other" category, insurers should describe in the Comments field (HD006) what is included in the "Other" category.

INSURANCE CATEGORY CODE	DEFINITION
1	Medicare & Medicare Advantage
2	Medicaid & Medicaid Managed Care (MCO) including CHIP
3	Commercial — Full Claims
4	Commercial — Partial Claims, Adjusted
5	Omitted[3]
6	Medicare and Medicaid Dual Eligibles, ages 65 years and over
7	Medicare and Medicaid Dual Eligibles, ages 21 years–64 years
8	Other

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

Health Status Adjustment Score: A value that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must

[3] Omitted in Delaware in order to keep specification as similar to Massachusetts as possible for the benefit of national insurers.

disclose the health status adjustment tool and version number and calibration settings in the header record.

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

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

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

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

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

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

Claims: Professional Physician, Primary Care: All TME data to physicians or physician group practices generated from claims. Includes services provided by any care provider defined by the health plan as a PCP (including doctors of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physicians assistants or

others not explicitly listed here). The one exception is OB/GYNs may not be considered a PCP for this purpose.

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

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

Claims: Retail Pharmacy: All TME data from claims to health care providers for prescription drugs, biological products or vaccines as defined by the insurer's prescription drug benefit.

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

Claims: Other: All TME data from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the insurer is unable to classify the service. However, TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category.

Non-Claims: Incentive Programs: All payments made to providers for achievement in specific predefined goals for quality, cost reduction or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses and EMR/HIT adoption incentive payments.

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

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

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

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

Pharmacy Rebate Record File

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

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

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

Pharmacy Rebates: The estimated value of rebates attributed to Delaware resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the period beginning date through end date from the Large Provider Record file, excluding manufacturer-provided fair market value bona fide service fees.[4] This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.). Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done. If insurers are unable to report rebates specifically for Delaware residents, insurers should report estimated rebates attributed to Delaware resident members in a proportion equal to the proportion of Delaware resident members compared to total members, by line of business. For example, if Delaware resident commercial members represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported.

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

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

Market Enrollment File

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

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

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

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

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

Data File Layout Table

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

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

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	2	PR002	Large Provider Org Name	1/1/2019	Text	Text	25	Yes	Large Provider Org Name of top 10 For aggregation of all other sites that fall below the top 10, use “all other”. For aggregation of all members unattributed to a PCP, use “unattributed”.
PR	3	PR003	Insurance Category Code	1/1/2019	Integer	#	1	Yes	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCOs 3 = Commercial: Full-Claim 4 = Commercial: Partial-Adjusted 6 = Medicare and Medicaid

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

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									No negative values. Number must be between '0.2' and '10'.
PR	6	PR006	Claims: Hospital Inpatient	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for hospital inpatient medical expenses. No negative values.
PR	7	PR007	Claims: Hospital Outpatient	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for hospital outpatient medical expenses. No negative values.
PR	8	PR008	Claims: Professional Physician, Primary Care	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for professional physician medical expenses. No negative values.
PR	9	PR009	Claims: Professional Physician, Specialty	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for professional physician medical expenses. No negative values.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	10	PR010	Claims: Professiona l Other	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for other professional services medical expenses. No negative values.
PR	11	PR011	Claims: Retail Pharmacy	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for pharmacy medical expenses. No negative values.
PR	12	PR012	Claims: Long-Term Care	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for all long term care expenses. No negative values.
PR	13	PR013	Claims: Other	1/1/2019	Money	#######.##	12	Yes	Total allowed claims for all other medical expenses. No negative values.
PR	14	PR014	Non-Claims: Incentive Programs	1/1/2019	Money	#######.##	12	Yes	
PR	15	PR015	Non-Claims: Capitation and Risk Settlements	1/1/2019	Money	#######.##	12	Yes	

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
PR	16	PR016	Non-Claims: Care Management	1/1/2019	Money	#######.##	12	Yes	
PR	17	PR017	Non-Claims: Recovery	1/1/2019	Money	#######.##	12	Yes	Report as a negative number.
PR	18	PR018	Non-Claims: Other	1/1/2019	Money	#######.##	12	Yes	
RX	1	RX001	RX Record Type ID	1/1/2019	Text	Text	2	Yes	This must have RX reported here. Indicates the beginning of the Pharmacy Rebate file.
RX	2	RX002	Insurance Category Code	1/1/2019	Integer	#	1	Yes	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid & Medicaid MCOs 3 = Commercial: Full-Claim 4 = Commercial: Partial-Adjusted

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
									6 = Medicare and Medicaid Dual-Eligibles, 65 and over 7 = Medicare and Medicaid Dual-Eligibles, 21–64 8 = Other Value must be an integer between '1' and '4' or '6' and '8'.
RX	3	RX0003	Pharmacy Rebates	1/1/2019	Money	#####.##	15	Yes	Total pharmacy rebates estimated for Delaware members.
RX	4	RX0004	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in a plan over a specified period of time expressed in months of membership.
ME	1	ME001	ME Record Type ID	1/1/2019	Text	Text	2	Yes	This must have ME reported here. Indicates the beginning of the Market Enrollment file.

RECORD TYPE	COLUMN	ELEMENT	DATA ELEMENT NAME	DATE ACTIVE (VERSION)	TYPE	FORMAT	LENGTH	CONTENT REQUIRED	ELEMENT SUBMISSION GUIDELINE
ME	2	ME002	Market Enrollment Category Code	1/1/2019	Integer	#	1	Yes	1 = individual 2 = large group 3 = small group 4 = self-insured 5 = student market
ME	3	ME003	Member Months	1/1/2019	Integer	#########	9	Yes	The number of members participating in market over a specified period of time expressed in months of membership.

File Record Legend:

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

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

Insurer Name_TME_YYYY_Version.xls

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

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

TME_2018_01.xlsx or TME_2018_1.xlsx or TME_2018.xlsx

Submitting Files to the DHCC

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

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