DELAWARE HEALTH AND SOCIAL SERVICES

Delaware Health Care Spending and Quality Benchmarks

Data Submission Guide Version 8.1: DHCC Complete

State of Delaware

Department of Health and Social Services

September 2, 2026

Delaware Health and Social Services

Office of the Secretary

A Note to Delaware's Health Care Stakeholders

As we launch this year's data collection cycle, the urgency of our mission has never been clearer: health care costs in Delaware remain among the highest in the nation, and Delaware families, businesses, and taxpayers are feeling that burden every day. The data provided through the Health Care Spending and Quality Benchmark Initiative is essential to holding our system accountable and accelerating our transition to value-based care that delivers better outcomes at a sustainable cost.

The spending and quality benchmarks program only works because of the accurate, timely data payers submit each year. This information drives the transparency needed to bend the cost curve while protecting access and quality of care for every Delawarean.

Enclosed is version 8.0 of the Benchmark's Data Submission Guide. Thank you for your continued partnership in this critical work.

Sincerely,

Christen Linke Young

Cabinet Secretary

Contents

Section 1

Major Revisions in This Version

The State of Delaware (Delaware or State) Department of Health and Social Services (DHSS) and Delaware Health Care Commission (DHCC) made various wording changes and clarifications, label changes, formatting revisions and other updates to make this document easier to read and use. The following table highlights major revisions incorporated into this version relative to the prior version of the data submission guide.

Table 1. Major Revisions in this Version of the Benchmark Data Submission Guide

Topic	Version 8.0 Change	Rationale
Note to Stakeholders	Message updated	From Secretary Young
Primary Care Services Definition	Coding logic has been updated (see Appendix F)	Maintain consistency with other Delaware initiatives[1]
Spending Data Collection Period	Two years of spending data to submit: new calendar year (CY) 2025 and refreshed/final CY 2024	Ensure accurate reporting
Spending Data Specifications	Removal of clinical risk adjustment	Lessen reporting burden on payers; clinical RA results in minimal changes in unadjusted spending
	Removal of Non-Claims: Recoveries, and addition of guidance to report claims net of recoveries	Payers inconsistently report spending in “Recoveries”
	Update of non-claims run-out period from eight months to 180 days	180 days of run-out is sufficient; eight months means health plans have only two weeks to submit
	Addition of Income from Fees of Uninsured Plans	MLRs do not include data on premiums earned for self-insured business
	Addition of Non-Claims: Capitation and Full Risk Payments	Collect data on global capitation arrangements

[1] DHSS employs the same definition of primary care used in the Delaware Department of Insurance Office of Value-Based Health Care Delivery’s measurement of primary care investment established under its Affordability Standards.

Topic	Version 8.0 Change	Rationale
Quality Data Sections	Additional detail on measures and reporting Addition of new CY 2025-2027 quality benchmark cycle measures	Additional guidance for accurate reporting New measures for reporting period
Quality Data Template	Formatting updates Updates as needed for Electronic Clinical Data Systems (ECDS) reporting to screening measures Updates to measure stratifications as needed Additional measures added	Consistency and better use New measures for reporting period
Due Date for Spending and Quality Data	September 16, 2026	Allow for more complete and accurate data
Net Cost of Private Health Insurance (NCPHI)	Remove legacy NCPHI reporting tabs in data template (collect submissions of Supplemental Health Care Exhibits (SHCE) and Medical Loss Ratio (MLR) only) (Delaware and Grand Total)	Calculate NCPHI based on SHCE/MLR reports
Age/Gender Data	Combine age/gender and TME data requests into one template	Consistency and better use One single spending data template
Enrollment for Spending Data	Remove census.gov enrollment data collection	Align denominator of per capita spend with other states' cost growth benchmark calculations

Section 2

Overview of Benchmarks

This data submission guide 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 with Excel templates to use for this purpose. More information about the benchmark process can be found on the DHCC's website.

On August 19, 2022, Governor Carney signed into legislation House Amendment 1 for House Bill 442 (HA1/HB442) 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 in 2022 and annually thereafter.

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	May and June 2026
	• DEFAC recommendation on spending benchmark	By June 30, 2026
3Q of CY	• Update data submission guide and data templates	July 2026/August 2026
	• Conduct benchmark webinar for insurers/Division of Medicaid & Medical Assistance (DMMA)	August 2026

Time Period	Key Activity	Key Dates
	• Send request to Centers for Medicare & Medicaid Services (CMS) for Medicare data	August 2026
	• Respond to payer questions on benchmark process	As needed
	• Receive spending and quality data submissions	By September 16, 2026
	• Begin validation of data (request resubmissions, if needed)	After data are received
4Q of CY	• Complete data validation process	As soon as practical
	• Compile results and develop 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

Overview of 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 (THCE), expressed as **the percentage change from the prior year's per capita spending**. The spending benchmark is set on a CY basis.

Potential Gross State Product Methodology

Since 2019 Delaware has set its annual spending benchmarks using Potential Gross State Product (PGSP) as the basis for the value. The formula for determining the PGSP is described below in Table 3.

Table 3. PGSP Methodology

PGSP Component	Methodology	Illustrative Example
Expected growth in national labor force productivity	A	1.4%
***Plus* expected growth in the State civilian labor force**	B	0.1%
***Plus* expected national inflation**	C	2.0%

PGSP Component	Methodology	Illustrative Example
***Less* expected State population growth**	D	0.5%
PGSP	A + B + C – D	3.0% = 1.4% + 0.1% + 2.0% - 0.5%

The data sources for each of the components of the PGSP methodology are presented below in Table 4.

Table 4. Data Sources for Calculating PGSP

Components	Source
Expected growth in national labor force productivity	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[2] Included within the report is a table of key inputs in the Congressional Budget Office's (CBO's) "Projections of Real Potential Gross Domestic Product" which includes the potential labor force productivity projected average annual growth.
Expected growth in the State civilian labor force	The source is the most recently published population projections by single year, age, race, and sex from the Annual Projection from the Delaware Population Consortium.
Expected national inflation	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[3] Included within the report is a table of CBO's economic projections.
Expected State population growth	The source is the most recently published population projections by single year, age, race, and sex from the Annual Projection from the Delaware Population Consortium.

Process for Annual Review of the Spending Benchmark Methodology

Per HA1/HB442, effective for the CY 2024 performance year and beyond, the DEFAC subcommittee shall review the methodology for setting the spending benchmark to determine whether any updates or modifications are recommended. Specifically, the DEFAC subcommittee can recommend a methodology different from the current PGSP to set future spending benchmarks. Recommendations are to be made to DEFAC no later than May 31 for the following year's spending benchmark (e.g., by May 31, 2026, for the CY 2027 spending benchmark). In the event a recommendation is made that the spending benchmark methodology and/or the growth rate should change, the DEFAC subcommittee is to provide the public and interested stakeholders with a reasonable opportunity to provide feedback on

[2] The Congressional Budget Office publishes its Budget and Economic Outlook Reports at: www.cbo.gov/about/products/major-recurring-reports#1.

[3] Ibid

the proposed changes and consider any recommendations provided as to the proposed changes.

For CY 2025, the Delaware Economic and Financial Advisory Council (DEFAC) DEFAC recommended that the Governor set the CY 2025 spending benchmark to 4.20%. This value reflected the subcommittee's recommended methodology change to include the average of 2023 and 2024 inflation as opposed to the projected long-term inflation five to ten years into the future, as prescribed by the PGSP formula.

Brief Review of the Quality Benchmarks

For CY 2025–CY 2027 performance periods, in addition to the spending benchmarks, DHSS/DHCC will assess performance relative to thirteen Quality Benchmark measures, as shown in Table 5 below. The DHSS/DHCC request insurers report CY 2025 performance for each of the measures designated with an asterisk, providing additional data stratifications for measures by race, ethnicity, sex, and age as described in Appendix A.

Table 5. Current Quality Measures

Quality Measure	Quality Measure Description	Benchmark Level
Adult Obesity	The percentage of adults with a body mass index (BMI) greater than or equal to 30 weight (kg)/height (m2), as defined by the CDC.	State
Emergency Department Utilization (EDU)*	For members 18 years of age and older, the risk-adjusted number of emergency department (ED) visits during the measurement year (MY) per 1,000. (Administrative Reporting Measure)	Commercial Market
Opioid-Related Overdose Deaths	Number of opioid related overdose deaths per 100,000 persons, as defined by the CDC.	State
Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)*	The percentage of persons 18 years of age and older during the MY who were hospitalized and discharged from July 1 of the year prior to June 30 of the MY with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge. (Administrative Reporting Measure)	Commercial and Medicaid Markets

Quality Measure	Quality Measure Description	Benchmark Level
Statin Therapy for Patients with Cardiovascular Disease (SPC) – Statin Adherence 80%*	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 (ASCVD) and remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period. (Administrative Reporting Measure. Note that this measure transitions to ECDS for MY 2026.)	Commercial and Medicaid Markets
Use of Opioids at High Dosage	The percentage of the population ≥ 18 years of age who received a prescription for opioids at an average daily dose ≥ 90 morphine milligram equivalents for ≥ 15 total day supply during the CY.	State
Breast Cancer Screening (BCS-E)*	Women 40–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. (ECDS Reporting Measure)	Commercial and Medicaid Markets
Colorectal Cancer Screening (COL-E)*	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. (ECDS Reporting Measure)	Commercial and Medicaid Markets
Cervical Cancer Screening (CCS-E)*	The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening and who were screened for cervical cancer using specific criteria. (ECDS Reporting Measure)	Commercial and Medicaid Markets
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-E)*	**Initiation Phase:** Assesses members between six years and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing	Commercial and Medicaid Markets

Quality Measure	Quality Measure Description	Benchmark Level
	authority within 30 days of their first prescription of ADHD medication. **Continuation and Maintenance Phase:** Assesses members between six years and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days and had at least two follow-up visits (in addition to the visit in the Initiation Phase) with a practitioner in the nine months after the Initiation Phase. (ECDS Reporting Measure)	
Follow-Up After Emergency Department Visit for Substance Use (FUA)*	Assesses ED visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who had a follow-up visit for SUD within seven days and 30 days. (Administrative Reporting Measure)	Commercial and Medicaid Markets
Depression Screening and Follow-up for Adolescents and Adults (DSF-E)*	The percentage of members 12 years of age and older screened for clinical depression using a standardized instrument, and if screened positive, received follow-up care. (ECDS Reporting Measure)	Commercial and Medicaid Markets
Oral Evaluation, Dental Services (OEV CH)*	The percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the MY. (Administrative Reporting Measure)	Medicaid Market

CY 2025 through CY 2027 Quality Benchmarks

The annual benchmarks for CY 2025 through CY 2027 for each quality measure are shown in Table 6.

Table 6. CY 2025 through CY 2027 Quality Benchmarks

Quality Measure	CY 2025 Benchmark	CY 2026 Benchmark	CY 2027 Benchmark
Adult Obesity	35.0%	34.8%	34.6%
Emergency Department Utilization (EDU) — Commercial Market	165.0 visits per 1,000	163.0 visits per 1,000	161.0 visits per 1,000
Opioid-Related Overdose Deaths	45.5 deaths per 100,000	43.0 deaths per 100,000	40.5 deaths per 100,000
Persistence of Beta-Blocker after a Heart Attack — Commercial Market	86.8%	89.9%	91.7%
Persistence of Beta-Blocker after a Heart Attack — Medicaid Market	83.0%	84.9%	86.8%
Statin Therapy for Patients with Cardiovascular Disease — Commercial Market	85.2%	87.3%	89.1%
Statin Therapy for Patients with Cardiovascular Disease — Medicaid Market	73.1%	75.8%	78.5%
Use of Opioids at High Dosage	Maintain at or below 10.0%	Maintain at or below 10.0%	Maintain at or below 10.0%
Breast Cancer Screening — Commercial Market	79.5%	81.5%	83.5%
Breast Cancer Screening — Medicaid Market	58.4%	61.8%	65.2%
Colorectal Cancer Screening — Commercial Market	65.7%	68.1%	70.5%
Colorectal Cancer Screening — Medicaid Market	36.4%	38.4%	40.4%
Cervical Cancer Screening — Commercial Market	76.2%	78.5%	82.1%
Cervical Cancer Screening — Medicaid Market	55.1%	60.1%	65.5%
Follow-Up Care for Children Prescribed ADHD Medication — Commercial Market	Initiation Phase: 43.3% Continuation and Maintenance Phase: 48.5%	Initiation Phase: 45.3% Continuation and Maintenance Phase: 50.5%	Initiation Phase: 47.3% Continuation and Maintenance Phase: 52.5%

Quality Measure	CY 2025 Benchmark	CY 2026 Benchmark	CY 2027 Benchmark
Follow-Up Care for Children Prescribed ADHD Medication — Medicaid Market	Initiation Phase: 45.3% Continuation and Maintenance Phase: 52.1%	Initiation Phase: 47.3% Continuation and Maintenance Phase: 54.1%	Initiation Phase: 49.3% Continuation and Maintenance Phase: 56.1%
Follow-Up After Emergency Department Visit for Substance Use (FUA) — Commercial Market	7 Day: 21.6% 30 Day: 32.0%	7 Day: 23.6% 30 Day: 34.0%	7 Day: 25.6% 30 Day: 36.0%
Follow-Up After Emergency Department Visit for Substance Use (FUA) — Medicaid Market	7 Day: 24.1% 30 Day: 35.5%	7 Day: 26.1% 30 Day: 37.5%	7 Day: 28.1% 30 Day: 39.5%
Depression Screening and Follow-up for Adolescents and Adults (DSF-E) — Commercial Market	Screening: 4.1% Follow-up: 73.1%	Screening: 4.7% Follow-up: 73.7%	Screening: 5.3% Follow-up: 74.3%
Depression Screening and Follow-up for Adolescents and Adults (DSF-E) — Medicaid Market	Screening: 4.9% Follow-up: 68.0%	Screening: 5.5% Follow-up: 68.5%	Screening: 6.0% Follow-up: 69.0%
Oral Evaluation, Dental Services (OEV CH) — Medicaid Market	25.0%	31.0%	37.0%

DHCC's Annual Review of Changes to Quality Measure Specifications

The DHCC staff conduct an annual review of the specifications of each quality measure to determine whether any changes have been made that could have an impact on performance rates when compared to the respective benchmark. For the respective measure, this review may involve assessing the technical specifications, survey question and/or coding logic for changes that might impact comparisons to prior year results. For example, the National Committee for Quality Assurance (NCQA) periodically makes updates to the Healthcare Effectiveness Data and Information Set (HEDIS®) measure set and provides information on which measures were changed and how the methodology has changed. Any material changes to HEDIS® specifications will need to be reviewed and an assessment made on whether the existing benchmarks are still appropriate or need to be revised to align with the applicable new specifications.

The DHCC and the Prescription Monitoring Program (PMP) will need to review the methodology of the Use of Opioids at High Dosage measure to determine whether any methodological changes are needed, and/or DHCC may request the PMP sign an attestation that the methodology is still relevant and valid.

Three-Year Cycle of Quality Benchmarks

HA1/HB442 provides that the DHCC is responsible for reviewing the quality benchmarks on a three-year cycle. This review may result in a change in the quality measures and/or a change to the benchmarks for existing quality measures. Revisions to the quality benchmarks should reflect changes in new population health or health care priority opportunities for improvement and/or whether the quality benchmarks' values should be changed to reflect improved health care performance in the State.

Should the DHCC identify appropriate changes, the DHCC should make such changes to measures and/or to benchmark values used for the quality benchmarks only after providing the public and interested stakeholders an opportunity to provide feedback and after considering their recommendations. The DHCC finalized the quality benchmarks for the CY 2025–CY 2027 cycle after presenting the new measures at Stakeholder Meetings in August and September 2024. These measures will be reported based on the instructions listed herein.

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 THCE.

Quality Benchmark: A target for performance on a quality measure reflecting a priority Delaware population health or quality of care concern. Performance relative to an annual quality benchmark is assessed at the State level and, depending upon the measure, also its data source, market, insurer, and, potentially, provider levels.

Behavioral Risk Factor Surveillance System (BRFSS): A health-related telephonic survey that collects State data about US residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services.

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

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

Division of Medicaid and Medical Assistance (DMMA): The single State agency responsible for Delaware's Medicaid and Children's Health Insurance Program (CHIP). Unless otherwise stated, references to "DMMA" or "Medicaid" includes CHIP.

Early and Periodic Screening, Diagnostic and Treatment: Medicaid benefit that provides preventative and comprehensive health care services for children and adolescents who are under the age of 21 years. The benefit aims to ensure that children and adolescents under

the age of 21 years can receive appropriate preventative, dental, behavioral health, developmental, and specialty services.

Healthcare Effectiveness Data and Information Set (HEDIS®): Standardized performance measures developed and maintained by the NCQA. These measures are designed to allow consumers and purchasers to compare plans against national or regional benchmarks.

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/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 more.

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 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.”

MLR Report (Commercial): A federal commercial report submitted by the insurers in Excel format (where applicable) that complements the insurer-submitted spending data templates for the purposes of calculating the insurers’ NCPHI (defined below) for the Commercial lines of business in the benchmarks trend report.

MLR Report (Medicaid): A federal Medicaid report submitted by the insurers in Excel format (where applicable) that complements the insurer-submitted spending data templates for the purposes of calculating the insurers’ NCPHI (defined below) for the Medicaid line of business in the benchmarks trend report.

National Committee for Quality Assurance (NCQA): An organization that works to improve health care quality through the administration of evidence-based standards, performance measures, and practice and health plan accreditation. NCQA stewards the HEDIS® measures.

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 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. All claims categories should be net of recoveries.

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. DHCC publishes spending data net of rebates reported by payers.

Prescription Monitoring Program (PMP): A State program/entity with the goal to reduce misuse of controlled substances in Delaware, and to promote improved professional practice and patient care. PMP is the source of data for the Use of Opioids at High Dosage quality measure.

Public Program: A term used to refer to payers that are not insurers. This includes Medicare FFS, Medicaid FFS, the Veterans Health Administration (VHA), and similar entities/programs.

Supplemental Health Care Exhibit (SHCE): An exhibit reported by the insurers in Excel format (where applicable) that complements the insurer-submitted spending data templates for the purposes of calculating the insurers' NCPHI (defined above) for the Self-Insured and Medicare Advantage lines of business in the benchmarks trend report.

Total Health Care Expenditures (THCE): The total medical expense (TME) incurred by Delaware residents for all health care benefits and services by all payers reporting to DHCC, plus the insurers' NCPHI.

THCE per Capita: THCEs (as defined above) divided by Delaware's covered population based on cost growth data reporting. The annual change in THCE per capita is compared to the spending benchmark at the State level.

Total Medical Expense (TME): The sum of the allowed amount of total claims spending and total non-claims paid to providers, incurred by Delaware residents for all health care services. TME is reported at multiple levels: State, market, and payer; DHSS will consider reporting TME at the provider level in future years. Payers report TME by insurance market (e.g., Medicare and Medicare Managed Care and Commercial). TME excludes Medigap members and claims.

Veterans' Health Administration (VHA): The federal agency responsible for provision of health care benefits to veterans.

Youth Risk Behavior Surveillance Survey: Includes national, State, territorial, tribal, and local school-based surveys to monitor health behaviors that contribute to death, disability, and social problems in youth. Typically, conducted every two years.

Spending Data Submission Instructions

Insurers are asked to submit TME data on the following schedule. Please note that for the CY 2025 data collection process, each insurer should submit **two years** of data for this benchmark data collection cycle: CY 2025 and CY 2024. The CY 2025 data will be submitted for the first time, but the CY 2024 will be final data that will replace the CY 2024 data submitted as part of last year's data collection process. The due date for all data is September 16, 2026.

Table 12. Spending Data Submission Schedule

Due Date	Spending Data Submitted
September 16, 2026	CY 2025 New and CY 2024 Final

TME Data Submission Specifications

Insurers should apply the same data extract specifications to the CY 2025 and CY 2024 data. This will enable accurate year-over-year comparisons.

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., are dually 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.

Data Run-Out Period Specifications

Insurers should allow for a claims and non-claims run-out period of 180 days: summarize CY 2025 and CY 2024 data with run-out through at least June 30, 2026.

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.

When resubmitting CY 2024 data, the insurers should pull these data at or around the same time the new CY 2025 data are summarized. As a result, the DHCC expects the resubmitted CY 2024 data to have extensive run-out, and thus, adjustments for IBNR/IBNP or other issues should be immaterial or not applicable.

[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.

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 do 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 PMPM for the same year, calculated on members who had pharmacy coverage, and applied to all MMs for which the carve-out applied.

Such an adjustment must use actuarially sound principles and be reviewed with DHSS/DHCC before the adjustment is made. Please email the DHSS/DHCC (send to: kaitlyn.arthur@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.

CY 2024 NCPHI and CY 2025 NCPHI

DHSS/DHCC is planning on utilizing SHCE/MLR reports for the calculation of NCPHI in the CY 2025 Benchmarks Trend Report. Insurers are asked to submit their SHCE and federal commercial MLR reports in Excel format (where applicable) by September 16, 2026. In an instance in which the MLR report submitted to DHSS/DHCC by September 16, 2026 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. This year, NCPHI will not be requested from the insurers in the TME reporting template.

TME Data File Layouts and Field Definitions

The DHSS/DHCC will provide each insurer with 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 now includes 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 2024 TME Data
- CY 2025 TME Data
- 2024 to 2025 TME Comp
- Data Validation Tab
- CY 2024 Age-Gender
- CY 2025 Age-Gender
- 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 describes the contents of each tab in the workbook.

Mandatory Questions

Insurers can input the email address to which DHSS/DHCC should direct any questions about the data submission.

Insurers are to review and respond to all of the mandatory questions. Responses can be a simple “Yes” if applicable; 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 regarding the entity submitting the data.

Insurer Org ID: the DHSS/DHCC-assigned organization identification (ID) for the insurer submitting the file.[5]

Table 13. Insurer to DHSS/DHCC Organizational IDs

Insurer	DHCC Organizational ID
Aetna	101
AmeriHealth Caritas	102
Cigna	103
Highmark Blue Cross Blue Shield Delaware	104
UnitedHealthcare	105
Humana	106
Delaware First Health	107
Health Care Service Corporation	108

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

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

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

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

CY 2024 TME Data and CY 2025 TME Data

These tabs will be the source of the insurer's TME data used by the DHSS/DHCC to compute THCE. Insurers will report their applicable CY 2024 and CY 2025 claims and non-claims payments in the respective tab. Both tabs have the same layout.

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

Table 14. 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[6]
908b	Medicaid Duals[7]
909	Other

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 code 908b. This will ensure data reported in all the Insurance LOB codes are mutually exclusive.

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

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

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

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

Pharmacy Rebates (two categories): 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 2025), excluding manufacturer provided fair market value bona fide service fees.[8] Include rebates associated with drugs provided under the insurer's prescription drug benefit, and if applicable, the insurer's medical benefit, based on the associated rebate category within the template. Pharmacy Rebates have been broken out by the respective Pharmacy spending categories for Pharmacy — Prescription Drug Benefit and Pharmacy — Medical Benefit rather than in one consolidated Pharmacy Rebate column. This is to allocate rebates more appropriately based on their actual allocation, rather than a proxy allocation in the Trend Report. The rebate 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 claim-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.

Income from Fees of Uninsured Plans: DHSS requests that insurance carriers report aggregate information on the premiums earned from their self-insured accounts (e.g., "fees from uninsured plans"). Health plans should follow the instructions for Part 1, Line 12 on the NAIC SHCE for their Delaware-situs self-insured account. DHSS requests this information in the data submission template because it is not typically reported in the SHCE filed with the Delaware Department of Insurance.

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**. All claims categories must be reported net of recoveries. The DHCC may request additional information regarding how insurers mapped their data into these categories to improve consistency in reporting across all insurers:

Claims: Hospital Inpatient — 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 ED 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

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

physician, or inpatient services at non-hospital 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 ED 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 new coding logic for defining primary care is included in Appendix A of the Excel reporting template.

Claims: Professional, Specialty: All TME data to physicians or physician group practices, including hospital-employed physicians, generated from claims. Includes services provided by a Doctor of Medicine or Doctor of 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 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 (HCBS), 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 DHSS/DHCC regarding 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 electronic medical records/health information technology (EMRs/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 based on claims (e.g., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately, which 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 based on claims (e.g., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately, which can be separately reported as Non-Claims: Incentive Program.

Non-Claims: Capitation and Full Risk Payments: All payments made to providers made not based on claims (e.g., capitated amount), with the provider assuming full risk for all

services. All non-claims-based payments for services delivered under the following payment arrangements: a) prospective episode-based payments that include full risk, b) capitation, c) prospective global budget payment with full risk, and d) full risk payments to integrated finance and delivery systems.

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, which 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: Other: All other payments made pursuant to the insurer’s contract with a provider not made based on a claim for health care benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments.. 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 risk-adjusted values based on the data input by the insurer. Each insurer must to review these fields for reasonableness before submitting a completed Excel workbook to DHSS/DHCC.

Age/Gender Reporting Tabs

Age-Gender 2024 and Age-Gender 2025

These tabs will be the source of the insurer’s TME data used by the DHSS/DHCC to compute age/gender data summaries and for age/gender risk adjustment. Insurers will report their applicable CY 2024 and CY 2025 MMs and medical expenditures by age, gender, and LOB category code description. Both tabs have the same layout.

Insurers will input their data into Tables 5 (for member months), 6 (expenditures before truncation is applied), and 7 (expenditures after truncation is applied). The "Before Truncation" expenditures and MMs should be tied back to the CY 2024-2025 TME spending tabs. Tables 1-3 will sum up total member months and expenditures across all age and gender bands.

“Truncation” means that for a given member in a given year, the dollars above the truncation point are excluded from analysis. Truncation should be performed on a member-level basis based on total annual expenditures, inclusive of all medical and pharmacy spending. For the calculation of the "After Truncation" expenditures, please use the following truncation thresholds for each LOB:

Table 15. Truncation Thresholds

LOB Category Code	LOB Category Code Description	Per Member Truncation Point
901	Individual	$150,000
902	Large Group, Fully Insured	$150,000
903	Small Group, Fully Insured	$150,000
904	Self-Insured	$150,000
905	Student Market	$150,000
906	Medicare Managed Care (excluding Medicare/Medicaid Duals)	$150,000
907	Medicaid/CHIP Managed Care (excluding Medicare/Medicaid Duals)	$250,000
908a	Medicare Duals[9]	$150,000
908b	Medicaid Duals[10]	$250,000
909	Other	$150,000

Should your reported MMs and expenditures not tie to the aggregated MMs and expenditures, please explain in the "Comments" section of each tab.

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

Ensure the current reporting year's data appears comparable to the previous year's data.

Consider if there are significant changes in the results and provide an explanation for the changes.

CY 2024 and CY 2025 MMs and expenditures should be tied to the TME data tabs.

Data Comparison/Validation Tabs

As noted previously, this benchmark data collection cycle includes two CYs of data. Accordingly, the DHSS/DHCC included a feature in the TME data template that automatically creates data comparison/validation tables. The goal is to help each insurer identify anomalies 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:

2025 to 2024 TME Comp

This tab compares the new CY 2025 TME data to the new CY 2024 TME data submitted this cycle. This tab contains eight tables that will either auto-fill or be prepopulated with data. The

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

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

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 2025 aggregate TME data input by each insurer on the "CY 2025 TME Data" tab (i.e., New CY 2025 Submission).
- **Table 2:** This table will auto-fill with the insurer's new CY 2024 aggregate TME data input by each insurer on the "CY 2024 TME Data" tab (i.e., New CY 2024 Submission).
- **Table 3**: This table will automatically compute the change or difference in each TME data element between the new CY 2025 and new CY 2024 aggregate 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 2025 and new CY 2024 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 5**: This table will automatically compute the PMPM spending for each service category using data submitted by the insurer on the "CY 2025 TME Data" tab (i.e., New CY 2025 Submission).
- **Table 6**: This table will automatically compute the PMPM spending for each service category using data submitted by the insurer on the "CY 2024 TME Data" tab (i.e., New CY 2024 Submission).
- **Table 7**: This table will automatically compute the change or difference in each TME data element between the new CY 2025 and new CY 2024 TME PMPM 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 8**: This table will automatically compute the percentage change in each TME data element between the new CY 2025 and new CY 2024 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. To help with this, DHSS has added conditional formatting to this table to automatically identify instances when the differences in spending exceed +/-10%.

Data Validation Tab

This tab evaluates whether the member months and spending data the insurer submitted in the TME and Age-Gender tabs align. Insurers do not need to input any data in this tab, but must review it prior to submitting and either correct or explain any areas of misalignment in the data.

Definitions

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

Primary Care Logic (Appendix A of the Excel reporting template)

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

Insurer Attestation (Appendix B of the Excel reporting template)

This tab provides insurers with 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 with 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 Elisabeth.Massa@delaware.gov and Kaitlyn.Arthur@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 (NCQA)**: 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 CY.

Table 16. Quality Data Submission Schedule

Due Date	Quality Data Submitted
September 16, 2026	CY 2025 Final

Quality Data Submission Specifications

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

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

- Ensure the current reporting year's data appear 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 and assess comparability with prior years.

For the CY 2025 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, sex, and age.

Table 17. CY 2025 Quality Measures Reported by Insurers

Quality Measure	Description	Specification	Market
EDU	For members 18 years of age and older, the risk-adjusted number of emergency department (ED) visits during the measurement year (MY) per 1,000. (Administrative Reporting Measure)	Based on HEDIS®, version corresponding to the performance period	• Commercial
PBH	The percentage of members 18 years of age and older during the MY who were hospitalized and discharged from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of AMI and who received persistent beta-blocker treatment for six months after discharge. (Administrative Reporting Measure)	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid

Quality Measure	Description	Specification	Market
SPC — Statin Adherence 80%	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 (ASCVD) and 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 the performance period	• Commercial • Medicaid
BCS-E	Women 40–74 years of age who had at least one mammogram to screen for breast cancer in the past two years. The rate is reported by age stratifications 40–49 and 50–74, along with a total rate. (ECDS Reporting Measure)	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid
COL-E	The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer. (ECDS Reporting Measure)	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid
CCS-E	The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using specific criteria. (ECDS Reporting Measure)	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid
ADD-E	**Initiation Phase:** Assesses members between six years and 12 years of age who were diagnosed with ADHD and had one follow-up visit with a practitioner with prescribing authority within 30 days of their first prescription of ADHD medication. **Continuation and Maintenance Phase:** Assesses members between six years and 12 years of age who had a prescription for ADHD medication and remained on the medication for at least 210 days and had at least two	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid

Quality Measure	Description	Specification	Market
	follow-up visits (in addition to the visit in the Initiation Phase) with a practitioner in the nine months after the Initiation Phase. (ECDS Reporting Measure)		
FUA	Assesses ED visits for members 13 years of age and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, who had a follow-up visit for SUD within seven days and 30 days. (Administrative Reporting Measure)	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid
DSF-E	The percentage of members 12 years of age and older screened for clinical depression using a standardized instrument, and if screened positive, received follow-up care. (ECDS Reporting Measure)	HEDIS®, version corresponding to the performance period	• Commercial • Medicaid
OEV CH	The percentage of enrolled children under age 21 years who received a comprehensive or periodic oral evaluation within the MY. (Administrative Reporting Measure)	Dental Quality Association (required CMS Child Core Set Measure), version corresponding to the performance period	• Medicaid

Quality Data File Layouts and Field Definitions

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

Contents

Instructions

Measure Descriptions

#1 — Insurer Information

#2 — EDU

#3 — PBH

#4 — SPC

#5 — BSC-E

#6 — COL-E

#7 — CCS-E

#8 — ADD-E

#9 — FUA

#10 — DSF-E

#11 — OEV-CH

#12 — Mandatory Questions

#13 — Insurer Attestation

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

Contents

This tab outlines the contents of the template.

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

For the quality benchmark data submission contact, please enter first and last name, email address, and telephone number.

Enter insurer, line of business (Commercial or Medicaid), and average monthly membership.

#2 — EDU

The insurer name will auto-populate based on entry in Tab #1. Select commercial for the Line of Business. This measure is commercial only. Please report data for the specified performance dates and specification type.

For the total rate, enter the observed number of emergency department visits and the expected number of visits. The observed-to-expected ratio will auto-calculate.

For the age/sex and race and ethnicity/sex stratifications, enter the observed number of visits, the observed number of visits per 1,000 members, the expected number of visits, and the expected number of visits per 1,000 members.

Please also enter the variance for each stratification. See the NCQA HEDIS measure specification for Emergency Department Utilization for more information about how to calculate variance. Variance is calculated from the member-level Predicted Probability of a Visit (PPV), Predicted Unconditional Count of Visits (PUCV), and their covariance.

The observed-to-expected ratio for each stratification will auto-calculate.

#3 — PBH

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: race and ethnicity, sex, and age.

#4 — SPC

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: age/sex (required by NCQA), race and ethnicity, sex, and age. The NCQA-required stratified performance rates will auto-calculate.

#5 — BSC-E

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: age (required by NCQA), race and ethnicity, sex, and expanded age ranges. The NCQA-required stratified performance rates will auto-calculate.

#6 — COL-E

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: age (required by NCQA), race and ethnicity, sex, and expanded age ranges. The NCQA-required stratified performance rates will auto-calculate.

#7 — CCS-E

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: race and ethnicity, sex, and age.

#8 — ADD-E

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

For each of the two rates:

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: race and ethnicity, and sex.

#9 — FUA

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

For each of the two rates:

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: age (required by NCQA), race and ethnicity, and sex. The NCQA-required stratified performance rates will auto-calculate.

#10 — DSF-E

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

For each of the two rates:

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: age (required by NCQA), race and ethnicity, and sex. The NCQA-required stratified performance rates will auto-calculate.

#11 — OEV-CH

The insurer name and line of business will auto-populate based on entry in Tab #1. Please report data for the specified performance dates and specification type.

Enter the numerator and denominator for the total rate. The performance rate will auto-calculate by dividing the numerator by the denominator.

Enter the numerators and denominators for the following stratifications: age (required by NCQA), race and ethnicity, and sex. The NCQA-required stratified performance rates will auto-calculate.

#12 — Mandatory Questions

Please enter contact information and answer all mandatory questions.

#13 — Insurer Attestation

Complete the attestation form.

Submitting Spending and Quality Data to the DHSS/DHCC

The completed Excel workbook should be submitted to kaitlyn.arthur@delaware.gov and DHCC@delaware.gov.

Appendix A

Primary Care Services Coding Logic

For the purposes of submitting new CY 2025 and new CY 2024 TME data, please use the following coding logic to define primary care. This coding logic for primary care was reviewed and updated by the Delaware Department of Insurance, Office of Value-Based Health Care Delivery in March 2026.

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 CQO or Quality Lead signs the attestation.

Scanned copies of the signed attestation(s) can be emailed to: kaitlyn.arthur@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 Spening 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 DHSS/DHCC non-acceptance of the attached reports.

Signature	Date
Print Name	Title