DEPARTMENT OF HEALTH AND SOCIAL SERVICES (DHSS)

Benchmark Data Submission Technical Webinar for Data Due September 16, 2026

Delaware Health Care Commission
August 18, 2026

TODAY'S PRESENTERS

- Department of Health and Social Services (DHSS)
  - Kaitlyn Arthur
- Bailit Health
  - Jessica Mar, Christopher Romero-Gutierrez, and Caitlin Otter
- Introductions/Roll Call of Payers Participating Today
  - Insurers: Aetna, AmeriHealth, Cigna, DE First Health, Highmark, Humana, and United
  - Division of Medicaid and Medical Assistance (DMMA)

COST GROWTH BENCHMARK

COST GROWTH BENCHMARK

- Delaware's cost growth benchmark is a target annual rate of growth for per-person healthcare spending.
- The benchmark values are based on forecasted per capita potential gross state product (PGSP), which accounts for growth in labor productivity, the civilian labor force, inflation, and state population.

Year	Benchmark
2025	3.0%

MEASURING HEALTH CARE EXPENDITURES

- Spending is primarily assessed as Total Health Care Expenditure (THCE) and Total Medical Expense (TME).

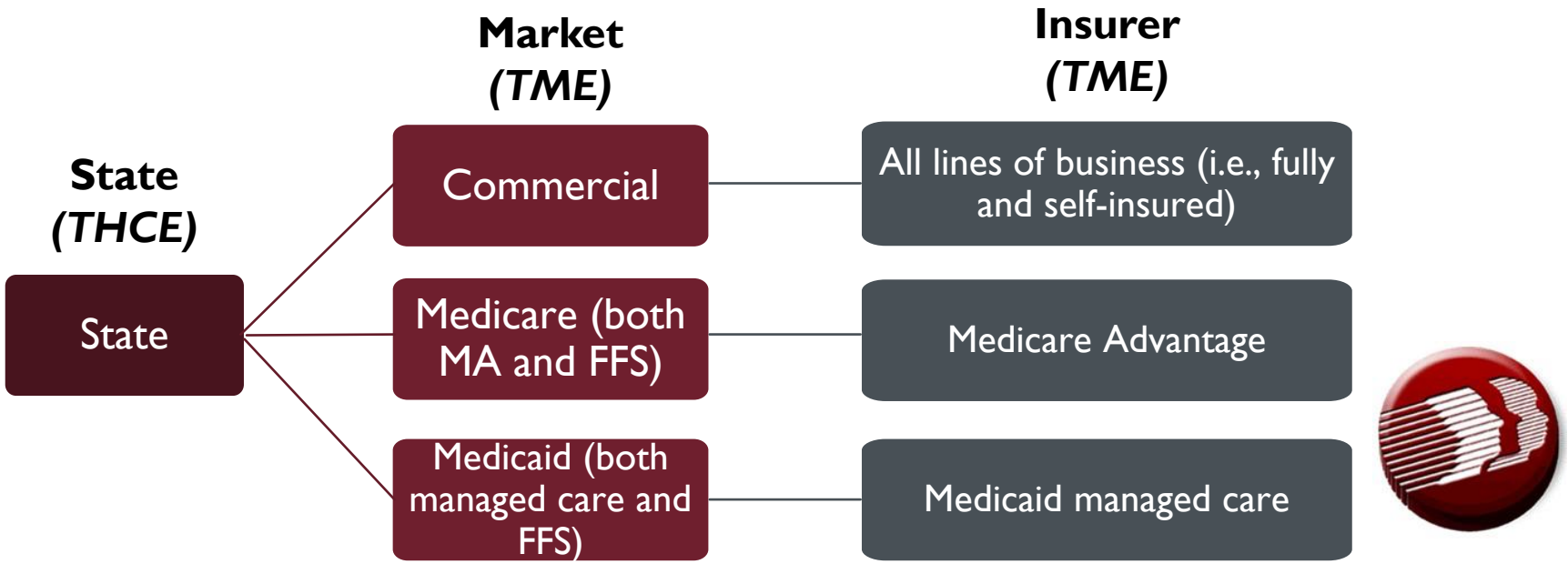
Total Medical Expense (TME) + **Net Cost of Private Health Insurance (NCPHI)** = **Total Health Care Expenditures (THCE)**

All incurred expenses for DE residents for all health care services, regardless of where the care was delivered and regardless of the situs of the member's plan.

The **costs to DE residents associated with the administration of private health insurance.**

LEVELS OF PUBLIC REPORTING

- Data collected will be reported at the state level, as well as the market and insurer level.



SUMMARY OF METHODOLOGICAL UPDATES FOR 2024-2025 TME DATA

- DHSS will now rely on the SHCE/MLR reports to calculate NCPHI. The NCPHI-related tabs have now been removed from the data submission template.
  - *DHSS asks that health plans submit their SHCE and MLR reports by September 16, 2026. If this version differs from what insurers report to CCIIO,* ***insurers must let DHSS know ASAP****.*
- Non-claims categories have been updated to more closely reflect those used by other states.
- There is now **one** universal template for insurers to fill out. This replaces the insurer-specific data templates.
  - Insurers are expected to conduct a validation check with their historical data before submitting their data to DHSS.
- Templates no longer have cross-data submission comparisons for the baseline year but include internal data validation checks for member months and spending.
- Age/gender data requests are now part of the data submission template.

HEALTH PLAN TME REPORTING TEMPLATE

Contents	• Descriptions for individual tabs.
Mandatory Questions	• Contact information and questions to complete.
HD-TME	• Insurer Data Entry for Header Record.
CY 2024 & 2025 TME Data	• Insurer Data Entry for 2024 and 2025 TME.
CY 2024 & 2025 Age-Gender	• Insurer Data Entry for 2024 and 2025 TME by Age/Gender Bracket.
Data Validation	• Data validation checks for TME, membership, and truncation across tabs.
Definitions	• Definitions for payers to reference when completing templates.
Appendix A Primary Care Logic	• Primary Care Taxonomies, Place of Service, and Procedure Codes.
Appendix B Insurer Attestation	• Attestation to Accuracy and Completeness.
Version Updates	• Notes updates to individual tabs.

CONTENTS TAB

- The contents tab includes a list of all the tabs in the template. It indicates which tabs require data to be inputted.

This workbook contains the following tabs:

Tab Name	Contents
Mandatory Questions	Contact information and questions to complete
HD-TME	Insurer Data Entry for Header Record
CY 2024 TME Data	Insurer Data Entry for 2024 TME
CY 2025 TME Data	Insurer Data Entry for 2025 TME
2025 to 2024 TME Comp	Tables comparing new 2025 and new 2024 TME data
Definitions	Definitions for payers to reference when completing templates
Data Validation Tab	Checks for internal consistency of member months and spending data reported in template
CY 2024 Age-Gender	Insurer Data Entry for 2024 Age-Gender data
CY 2025 Age-Gender	Insurer Data Entry for 2025 Age-Gender data
Appendix A	Primary care coding logic
Appendix B	Insurer attestation
Version Updates	Changes made to the template for 2024 and 2025 data collection

MANDATORY QUESTIONS TAB

- Please complete the questions on the "Mandatory Questions" prior to providing your submission.
- Questions have been consolidated since the previous cycle. Please review all questions carefully.
  - Only one column is provided for responses for both 2024 and 2025, as the methodology should be the same for both years.

HD-TME TAB

- Carriers should still provide the following information:
  - Reporting period start and end dates
  - Listing of "d/b/a"
- Data for both 2024 and 2025 should be provided on this tab.

CY 2024 & 2025 TME DATA

- On this tab, please report all enrollment and spending by service categories.
  - Truncation is not reported on this tab. Truncation is only performed on the age/gender reporting tabs.
- Please also enter Income from Fees of Uninsured Plans for each year in cell C22.

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

CY 2024 & 2025 TME DATA

- All the claims and non-claims service category for the 2024-2025 submission cycle can be found below.

Claims Categories	Non-Claims Categories
• Hospital Inpatient — Excluding Pharmacy • Hospital Inpatient — Pharmacy • Hospital Outpatient • Professional, Primary Care • Professional, Specialty • Professional, Other • Pharmacy — Prescription Drug Benefit (gross of rebates) • Pharmacy — Medical Benefit (gross of rebates) • Long-Term Care • Other	• Primary Care Incentive Programs • Incentive Programs, for Services Other than Primary Care • Primary Care Capitation • Capitation, for Services Other than Primary Care • **Capitation and Full Risk Payments** • Risk Settlements • Primary Care, Care Management • Care Management, Other than for Primary Care • Other

2025 TO 2024 TME COMP

- This tab allows for direct comparison for 2024 and 2025 TME data within the submission.
  - It allows for review of enrollment values by line of business both as a % change and a # change.
  - It allows for review of aggregate spending values by service category by line of business both as a % change and a # change.
  - It allows for review of total spending values by service category by line of business as a % change and a # change.

CY 2024 & 2025 AGE-GENDER

- The measurement of Insurer performance against the Benchmark will be demographically-adjusted by age and gender.
- One tab is provided for each reporting year.
- Carriers will need to provide TME data by age/gender bands.
  - Reporting is required **both before and after** truncation is applied.

Age Bands
0 to 1 year old
2 to 18 years old
19 to 39 years old
40 to 54 years old
55 to 64 years old
65 to 74 years old
75 to 84 years old
85 + years old

Gender Bands
Male
Female
Other

CY 2024 & 2025 AGE-GENDER

- On the age-gender reporting tabs, apply the truncation points below to the respective markets being reported. For members with estimated spending for carveouts, apply truncation after adding estimates for carveout spending.

Insurance Category Code	Truncation Points
901	$150,000
902	$150,000
903	$150,000
904	$150,000
905	$150,000
906	$150,000
907	$250,000
908a	$150,000
908b	$250,000
909	$150,000

DATA VALIDATION TAB

- In addition to the 2024 and 2025 comparison tab, the data validation tab shows consistency checks across tabs. Specifically, it checks enrollment and spending in the TME tabs and compares it directly against the age-gender tabs.
  - Because the TME tab does not collect truncated spending values, values across the TME and age/gender tab can only be compared before truncation is applied.

Table 1. Consistency of Member Months Across TME and Age-Gender for 2024

Line of Business Category Code	Line of Business Category Code Description	TME	Age-Gender	Consistent? If not, what is the variation between the TME and Age-Gender tabs?
901	Individual	0	0	Yes
902	Large Group, Fully Insured	0	0	Yes
903	Small Group, Fully Insured	0	0	Yes
904	Self-insured	0	0	Yes
905	Student Market	0	0	Yes
906	Medicare Managed Care (excluding Medicare/Medicaid Duals)	0	0	Yes
907	Medicaid/CHIP Managed Care (excluding Medicare/Medicaid Duals)	0	0	Yes
908a	Medicare Duals	0	0	Yes
908b	Medicaid Duals	0	0	Yes
909	Other	0	0	Yes

APPENDIX A PRIMARY CARE LOGIC

- This tab contains the primary care taxonomies, place of service codes, and procedure codes. Please ensure that claims that are classified as primary care match each of the criteria set in this tab.

Rendering or Servicing Provider Taxonomy **AND** **Place of Service** **AND** **Procedure Code**

APPENDIX B INSURER ATTESTATION

- **Insurers will need to attest** to the accuracy of the data reported and confirm that data are reported in a manner consistent with the requirements in the Data Submission Guide.
  - Please sign this tab prior to providing your submission.

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.

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

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

Insurer:

FINAL GENERAL REPORTING REMINDERS

- Reporting is based on allowed amount and limited to Delaware residents.
- Reporting is limited to claims where the payer is the primary payer on that claim.
- Reporting should occur by line of business.
- Provide as much run-out as possible for accuracy and completeness.
- The primary care services coding logic has been updated as of March 2026.

BRIEF TEMPLATE DEMONSTRATION

- We will now briefly review the new data submission template.

A	B	C	D	E
Delaware Health Care Commission				
Spending Data Record File				
Data Year: CY 2024				
Insurer:				
Blue = Payer-reported data				
Black = HCC-calculated data				
A1	A2	A3	A4	A5
Line of Business Category Code	**Line of Business Category Code Description**	**Member Months**	**Pharmacy Rebates: Prescription Drug Benefit**	**Pharmacy Rebates: Medical Benefi**
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			
908b	Medicaid Duals			
909	Other			
All Lines of Business Total			**$ -**	**$ -**
	Income from Fees of Uninsured Plans			

TIMELINE AND REMINDERS

- ***NEW*** DHSS requests that health plans provide their carve-out adjustment methodology; actuarially sound principles should be used.
  - This pertains to those instances where insurers are only able to report claim payments for a subset of medical services due to benefit design in which the contracting employer may "carve-out" some services, such as behavioral health or pharmacy services, and contract their coverage separately from the main medical coverage. For more information, see Insurer TME and NCPHI Data section of DSG.
- Spending and quality data will be due **September 16, 2026**.
  - CY 2025 (new) and CY 2024 (restated) based on incurred date of service.
  - The completed excel template and signed attestation should be sent to: Kaitlyn Arthur (Kaitlyn.Arthur@delaware.gov) and the DHCC (DHCC@delaware.gov).
- The Data Submission Guide has been updated.
- HA1/HB442 makes submission of benchmark data mandatory.
  - DHSS expects all payers to submit complete and accurate data for all respective lines of business applicable to Delaware.

QUALITY BENCHMARKS

QUALITY BENCHMARKS OVERVIEW

- The Quality Benchmarks were initially established in 2018 via Executive Order 25. In 2022, HA1/HB422 codified the Quality Benchmarks and mandated payer submission of benchmark data.
- The Quality Benchmarks are set in three-year cycles. Measurement year 2025 represents the first year of the 2025-2027 cycle; this cycle includes **thirteen** Quality Benchmark measures, **ten of which require submission of data by payers.**
- The previous cycle included nine measures, six of which required submission of data by payers. All nine measures will continue to be assessed for 2025-2027, as well as four new measures:
  - *Follow-Up Care for Children Prescribed ADHD Medication*
  - *Follow-Up After Emergency Department Visit for Substance Use*
  - *Depression Screening and Follow-Up for Adolescents and Adults*
  - *Oral Evaluation, Dental Services* (Medicaid only)

2025 QUALITY BENCHMARKS (1 OF 2)

Quality Benchmark Measure	Market(s) & 2025 Values
*Emergency Department Utilization**	Commercial (165.0)
Persistence of Beta-Blocker Treatment After a Heart Attack	Commercial (86.8%) and Medicaid (83.0%)
Statin Therapy for Patients with Cardiovascular Disease	Commercial (85.2%) and Medicaid (73.1%)
Breast Cancer Screening	Commercial (79.5%) and Medicaid (58.4%)
Colorectal Cancer Screening	Commercial (65.7%) and Medicaid (36.4%)
Cervical Cancer Screening	Commercial (76.2%) and Medicaid (55.1%)
Follow-Up Care for Children Prescribed ADHD Medication	Commercial (43.3% - Initiation 48.5% - Continuation) and Medicaid (45.3% - Initiation, 52.1% - Continuation)
Follow-Up After ED Visit for Substance Use	Commercial (21.6% - 7 day 32.0% - 30 day) and Medicaid (24.1% - 7 day 35.5% - 30 day)
Depression Screening and Follow-Up for Adolescents and Adults	Commercial (4.1% - Screening 73.1% - Follow up) and Medicaid (4.9% - Screening 68.0% - Follow Up)
Oral Evaluation, Dental Services	Medicaid (25.0%)

*A lower rate is better for this measure.

2025 QUALITY BENCHMARKS (2 OF 2)

- The table below shows the three 2025 Quality Benchmark measures that are reported only at the State-level and therefore do no require submission of data by insurers. For all three measures, a lower rate is better.

Quality Benchmark Measure	2025 Values
Adult Obesity	35.0%
Opioid-Related Overdose Deaths	45.5 per 100,000
Use of Opioids at High Dosage	10.0%

QUALITY BENCHMARKS EXCEL TEMPLATE

- DHSS sends payers an excel reporting template, along with a Data Submission Guide, for use in reporting Quality Benchmark data. These materials can also be accessed through the DHSS/DHCC website.

- The Quality Benchmarks excel template requires insurers to report numerators and denominators for each measure and each market, as applicable. This includes numerators and denominators for calculating overall performance and, for some measures, numerators and denominators for specific stratifications outlined by the measure steward.

- DHSS also asks payers to use the Quality Benchmarks excel template to report additional stratifications by race, ethnicity, age, and sex for each measure, as applicable.

- The Mandatory Questions tab of the excel template prompts payers to verify their submission is complete and accurate and provide any other necessary info.

QUALITY BENCHMARKS COLLECTION & REPORTING

- Payers must submit 2025 Quality Benchmark data **by September 16, 2026**.
  - Data should be limited to Delaware residents.
  - Payers should submit data for the commercial and/or Medicaid/CHIP markets, as applicable.

- The completed excel template and signed attestation should be sent to: Kaitlyn Arthur (Kaitlyn.Arthur@delaware.gov) and the DHCC (DHCC@delaware.gov).

- DHSS will publicly report performance at the state, market, and insurer levels.