Delaware Health Information Network
Health Care Claims Data Base

Data Submission Guide v4.1

DHIN HCCD Contact Information
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Version 4.1 Effective March 1, 2026, which is the due date for January 2026 HCCD file submissions, please reference DSG 4.1 and associated files

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1 Data Submission Requirements

1.1 Introduction and Contact Information

1.1.1 . The purpose of this document is to provide detailed information to Reporting Entities about how to prepare and submit Claims Data to the Delaware Health Care Claims Database (HCCD). Data submission requirements are detailed in the accompanying **DHIN DSG_File Layout Specifications_v4.1**, and include member eligibility, medical claims, pharmacy claims, and provider data.

The Delaware Health Information Network (DHIN) serves as the HCCD Administrator. For questions about the HCCD, its statutory regulations, and other issues, please use the contact information below:

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1.1.2 All definitions in this document shall be the same as those contained in the HCCD rule at DE ADC 1-100-103.2.0 which shall supersede the definitions in this document

1.1.3 This Submission Guide applies to both Mandatory Reporting Entities **and** to Voluntary Reporting Entities. This information is provided to facilitate accurate data submission and is not intended to expand authority conveyed in legislation or rule.

1.2 Annual Registration:

All Reporting Entities shall complete an initial mandatory Annual Registration Form at time of beginning participation as a data submitter. Thereafter, each Reporting Entity must complete an Annual Registration Form no later than December 31st of each year to ensure that the HCCD Administrator's records are kept current. The Annual Registration Form will include information on the total number of covered lives (as anticipated for the following calendar year), as well as two points of contact for each line of business required to submit files to the HCCD:

- Technical lead who is responsible for file production and submission
- Regulatory compliance officer

Upon receipt of each Annual Registration Form, the HCCD Administrator will provide each new Reporting Entity with their Reporting Entity Code and Reporting Entity Name which will be used within its HCCD submissions. The HCCD Administrator will also provide new Reporting Entities with SFTP credentials for the secure transmission of files to the HCCD. For Reporting Entities continuing participation, the HCCD Administrator will provide confirmation of Reporting Entity Code and Reporting Entity Name.

1.3 Data to be Submitted

1.3.1 Claims Data Generally

1.3.1.1 **"Claims" shall mean** any claims paid**,** modified, or adjusted partially or in whole during the reporting period. If a procedure is denied within a claim that was partially paid, the Reporting Entity must report all claim lines, including the denied lines. Reporting Entities are not required to submit data for wholly denied claims but may choose to do so voluntarily. The reporting entity must report subsequent adjustments and denials for any claim that was previously reported as paid.

1.3.1.2 **Header and Trailer:** Each submitted data file shall have a Header and Trailer record. The Header and Trailer data elements for each defined file (ME, MC, PC, MP) provide file transmission control data, such as Record Count HD006. (see the **DHIN DSG_File Layout Specifications_v4.1** for specific formats).

1.3.1.3 **Versioning:** Reporting Entities shall provide documentation that describes how an original claim may be linked to all subsequent actions associated with that claim. DHIN versions claims for ease of analytical use of the data. Claims versioning methodology is attested to by the Reporting Entity on the Annual Registration form. Claims data must pass versioning quality checks.

1.3.1.4 **Data Quality Requirements:** Please see Section 4 and the **DHIN DSG_File Layout Specifications_v4.1** for an outline of the data quality checks performed by DHIN on received data and the requirements for each file type. Reporting Entities shall adhere to the element definitions and requirements such as format, valid code sets and threshold expectations.

1.3.2 **Medical Claims**:

Reporting Entities shall report claims and encounters for all Members for all covered services provided in all care settings, including but not limited to inpatient, outpatient, professional, therapies, home health, rehabilitative and skilled nursing facility care, durable medical equipment, medical transportation, and medical devices.

1.3.3 **Pharmacy Claims**:

Reporting Entities shall report all pharmacy claims for prescriptions dispensed to Members.

1.3.4 **Member Eligibility Data**

Reporting Entities shall report information for all Members, as follows: "**Member**" means individuals, employees, and dependents for which the Reporting Entity has an obligation to adjudicate, pay or disburse claims payments. The term includes covered lives. For employer-sponsored coverage, Members include certificate holders and their dependents. This definition applies to members residing in the state of Delaware and, for

the State Group Health Insurance Program, applies to all members, regardless of state of residence.

1.3.4.1 Reporting Entities must provide a data file that contains information on every Member who was enrolled at any time and for any duration during the reporting period, whether or not the Member utilized services (including pharmacy) during the reporting period. The file must include member identifiers, subscriber name and identifier, member relationship to subscriber, residence, date of birth, race, ethnicity and language, and other required fields to allow retrieval of related information from pharmacy and medical claims data sets.

1.3.4.2 As per the **DHIN DSG_File Layout Specifications_v4.1**, Reporting Entities must flag whether the coverage is primary or secondary using data element ME028 'Primary Insurance Indicator'.

1.3.5 Provider Data

1.3.5.1 Reporting Entities must provide a data file that contains information on every provider for whom claims were adjudicated during the targeted reporting period.

1.3.5.2 In the event the same provider delivered and was reimbursed for services rendered from two different physical locations, then the provider data file shall contain two separate records for that same provider reflecting each of those physical locations. One record shall be provided for each unique physical location for a provider.

1.3.6 **Coordination of Submissions**:

If the Reporting Entity subcontracts with a pharmacy benefits manager or any other organization that manages claims for its Members, the Reporting Entity shall be responsible for ensuring that complete and accurate files are submitted to the HCCD from its subcontractors. The Reporting Entity shall ensure that the Member information on the subcontractor's file(s) is consistent with the Member information on the Reporting Entity's eligibility, medical claims, and prescription drugs files. The Reporting Entity shall include utilization and cost information for all services provided to members under any financial arrangement, including sub-capitated, bundled, and global payment arrangements.

2 File Submission Methods

2.1. **SFTP Information:**

Upon receipt of the completed Annual Registration Form, the HCCD Administrator shall provide information to each Reporting Entity regarding a secure file submission methodology and access. This information will include the necessary SFTP credentials (i.e. login and

password) for secure data transmission as well as the Reporting Entity Name and Reporting Entity Code to be used in the submitted files. Apart from the SFTP instructions, there will be no additional encryption requirement (e.g. PGP encryption) for files submitted to the HCCD.

3 Submission Schedule

3.1 Initial Data Submissions

Reporting Entities shall follow the Submission Schedule set forth in the HCCD Regulations. The information in this Section is provided to assist in planning, especially for the first few data submissions to the HCCD. The submission schedule contained in the final HCCD Regulations, Attachment A, will be followed.

3.1.1 Test Files: For New Reporting Entities or Reporting Entities submitting New File Types

Reporting Entities shall submit one month of Required Claims Data files containing Member Eligibility, Medical Claims, Pharmacy Claims and Provider records, by the due date defined in collaborative data implementation meetings. The purpose of the Test file is to validate production quality of the data and compliance with this Data Submission Guide.

3.1.2 Historical Files: For Reporting Entities providing Historical Files

Reporting Entities may be required to submit Claims Data files for calendar years prior to their automated monthly reporting periods. Historical Files might be necessary if a Reporting Entity experiences an interruption of monthly submissions or, simply to provide a previous period's claims data that would not otherwise be available from monthly submissions.

3.1.3 Partial year submission: A Subset of Historical Files

As a method for providing partial year historical data, Reporting Entities may submit Claims Data files for claims adjudicated in the elapsed months of a calendar year. If historical and/or partial year submissions are required, DHIN will coordinate the submission schedule with the Reporting Entity.

3.2 Ongoing Data Submission

Reporting Entities shall submit monthly files containing claims activity (per Section 1.3.1.1) having occurred within the prior calendar month within 30 calendar days of the last day of the following month. The schedule for this submission is provided below and will continue in a similar format in subsequent years. Submission dates falling on a weekend or legal holiday are extended to the next following business day.

Submission Due to HCCD	Date of Claims and Eligibility Begin Date	Date of Claims and Eligibility End Date
By January 1	November 1	November 30
By February 1	December 1	December 31
By March 1	January 1	January 31
By April1	February 1	February 28/29

Submission Due to HCCD	Date of Claims and Eligibility Begin Date	Date of Claims and Eligibility End Date
By May 1	March 1	March 31
By June 1	April 1	April 30
By July 1	May 1	May 31
By August 1	June 1	June 30
By September 1	July 1	July 31
By October 1	August 1	August 31
By November 1	September 1	September 30
By December 1	October 1	October 31

4 Data Quality Requirements

4.1 Required Data Elements

The **DHIN DSG_File Layout Specifications_v4.1** document lists all data elements, including definitions, formats and expected fill rates (Thresholds). The thresholds and conditions listed dictate the reporting and completion expectations for each data element. A data element with an "R" in the "Req'd" column means that this data element is required to be populated with a valid value at the percentage displayed in the threshold column. Elements with no completion expectations have a blank entry in the threshold column. Data files that do not achieve the threshold percentage for each data element, and for which there is no Override or Exception (see 4.3 below), may be rejected.

A data element marked as "C" in the Req'd column means that it is "Conditionally Required". The Threshold percentage is applied to select records of the data element based on a certain condition, such as all Inpatient claims must have an Admit Date. A data element marked as "O" in the Req'd column is an optional data element that should be provided when available. Percentages in the Threshold column for data elements categorized as Optional, are based on expected frequency for that data element. Deviation from the frequency threshold will not cause the file to be rejected but may still require follow up using the Override Exception process.

4.2 Data Validation

Data Validation is a critical step in the process of loading the HCCD data into the database. There are four steps in this data validation process: file structure, Level 1, versioning and Level 2 checks. Each validation step is dependent on the success of the prior validation step. Some validation failures will cause a file to be rejected, while others require formal explanation. All unacceptable validation results will be shared with the Reporting Entity. Each Reporting Entity will work interactively with the HCCD Administrator when receiving feedback based on the data validation checks.

4.2.1 File Load Validation

This is the first validation check. Files may be rejected for missing column headings, if claim line/record count totals do not match, or if they have other structural errors. Files are also reviewed for consistency in counts month over month. A spike in member eligibility counts would cause the HCCD Administrator to contact the Reporting Entity for an explanation. Should the file be rejected, the Reporting Entity shall resubmit corrected files. After accepting the data for loading, DHIN will continue to perform a series of data validation checks.

4.2.2 Level 1 Data Validation

Upon successful loading of received files, Level 1 Data Validations are performed. Data elements will be validated against the requirements in the **DHIN DSG_File Layout Specifications_v4.1** such as definitions, code set values, data types, data formats and threshold ranges. Each Reporting Entity will need to work interactively with the HCCD Administrator to achieve conformance with the **DHIN DSG_File Layout Specifications_v4.1**.

4.2.3 Claims Versioning

The claims versioning step applies the versioning methodology provided by each Reporting Entity to the medical claims and the pharmacy claims files. The versioning methodology is defined by the Reporting Entity on the annual registration form.

4.2.4 Level 2 Data Validations

Level 2 Data Validations are largely "reasonableness" tests. Baselines for these tests began as national norms found in other multi-payer claims databases. As insurance plans and processes change in Delaware these reasonableness norms will also shift correspondingly. A full list of Level 2 Data Validations can be made available to Reporting Entities upon request.

4.3 Overrides and Exceptions

The HCCD Administrator may grant overrides and exceptions to threshold requirements at its discretion. To request an override or exception, the Reporting Entity must complete an Override and Exception Form detailing the reason why the mandated threshold or requirement cannot be achieved and when the Reporting Entity anticipates being able to comply with the requirement. To request an Override or Exception Form, please contact the HCCD Administrator using the contact information found in Section 1.1.1.

Completed Override and Exception Forms must be returned to the HCCD Administrator for review and consideration. The HCCD Administrator will notify the Reporting Entity of the status of their request within 10 business days of the application's submission. All approved requests will have an expiration date, requiring Reporting Entities to reapply and justify any continuing override or exception on an annual basis or sooner as determined by the expiration date of the exception.

5 File Format

5.1 Format Guidelines

All files submitted to the HCCD will be formatted as standard text files. Text files must comply with the following standards:

5.1.1 One line item per row. No single line item of data may contain carriage return or line feed characters.

5.1.2 All rows must be delimited by the carriage return + line feed character combination.

5.1.3 All fields are variable field length with some maximum length restrictions. Delimit fields using the pipe character (ASCII=124). It is imperative that no pipes ('|') appear in the data itself. If your data contains pipes, either remove them or discuss using an alternate delimiter character.

5.1.4 Text fields are *never* demarcated or enclosed in single or double quotes. Any quotes detected are regarded as a part of the actual data.

5.1.5 The first row of the files *always* contains the names of data columns. This includes the column names for the header and trailer portions as well as the data file column names.

5.1.6 Unless otherwise specified, numbers (e.g. ID numbers, account numbers, etc.) do not contain spaces, hyphens or other punctuation marks.

5.1.7 Data Element values are never padded with leading or trailing spaces or tabs.

5.1.8 Numeric = numeric values only, no alpha characters. Some numeric fields have an assumed decimal, some are whole numbers. If an element has an assumed decimal, the decimal will be applied prior to performing data validation checks. It is the Payer's responsibility to provide the accuracy of the numeric value to the intended data element. Common errors have been with cost and payment data, or pharmaceutical quantity dispensed (PC033).

5.1.9 If a value is not available for a data element, or is not applicable, include the column and leave it blank. 'Blank' means do not supply any value at all between pipes (including quotes or other characters).

5.2 File Naming Convention

All files submitted to the HCCD shall have a naming convention developed to facilitate file management without requiring access to the contents.

All file names will follow the template:

TESTorPROD_Reporting EntityID_PeriodEndingDateFileTypePartNumberVersionNumber.txt

a. Examples
    i. TEST_XXX_201606MEv01.txt
    ii. PROD_XXX_201606MEv02.txt

Or, if using Part Number

    i. PROD_XXX_201606MC01v01.txt

- TEST or PROD – TEST for test files; PROD for production files.
- Reporting Entity Code – This is the code or acronym assigned by the HCCD Administrator to each Reporting Entity, for HCCD reporting purposes.
- Period ending date expressed as CCYYMM (four-digit calendar year and two-digit month; for example, 201403 indicates a March 2014 end date).
- **File Type:** Member Eligibility (ME), Medical Claims (MC), Pharmacy Claims (PC), Provider (MP),
- **Part Number:** This is optional and should only be used if necessary. This is used to identify a file that will be an addition to a file previously submitted of the same period, type and version. File Parts are cumulative to existing data. It is used if a single Reporting Entity supplies two data files of the same File Type for the same period and both datasets are valid for submission. The HCCD Administrator and Reporting Entity will agree on Part Number before use.
- **Version number**: This is used to differentiate multiple submissions of the same file. This will be important if a file needs to be resubmitted to resolve an issue such as a validation failure. The letter v should be used, followed by two digits, e.g. v02. You must include the leading zero. Original submissions of all files should be labeled v01. The HCCD will not accept files that have the same name as an existing file. A file name of the same name with the advancement of the version number will be used to Replace previously submitted data of the same file name and an earlier version number.
- **File extension:** (.txt)

5.3 Definitions for Data Element Types

- **date** – date data type for dates from 01/01/0001 through 12/31/9999
- **int** – integer (whole number)
- **decimal/numeric** – fixed precision and scale numeric data
- **char** – fixed length non-unicode data with a max of 8,000 characters unless length is otherwise specified
- **varchar** – variable length non-unicode data with a maximum of 8,000 characters unless length is otherwise specified
- **text** – variable length non-unicode data with a maximum of 2^31 -1 character

6 Data Element Overview

6.1 Member Eligibility:

The Reporting Entity's Member Number, ME009, must be unique to an individual. This unique identifier in the eligibility file must be consistent with the unique identifier in the medical claims/pharmacy file, MC010 and PC010 respectively. This provides linkage between medical and pharmacy claims during established coverage periods and is critical for the implementation of Episode of Care reporting.

For Historic Data Submissions, report eligibility for all Members during each reporting month. If historical address data is not available, report historical months' eligibility data based on the Member's last known or current address.

To reconcile the total number of Members in the historical data submissions, each Reporting Entity shall submit a summary report that totals the number of Members for each month for Historic Data.

Member Eligibility files must be formatted to provide one record per member per month.

6.2 Medical Claims Data:

Medical Claims file submissions shall include claims activity (as per Section 1.3.1.1.) for covered services under capitated, global, bundled, episode or other payment arrangement.

6.3 Pharmacy Claims Data:

Pharmacy Claims data file submissions shall include all claims activity (as per Section 1.3.1.1) for covered pharmaceutical services provided to Members.

6.4 Provider Data:

Frequency: Monthly Upload via FTP or Web Portal

Additional formatting requirements:

Reporting Entities submit data in a single, consistent format for each data type.

A provider means a health care facility, health care practitioner, health product manufacturer, health product vendor or pharmacy.

A billing provider means a provider or other entity that submits claims to health care claims processors for health care services directly or provided to a subscriber or member by a service provider.

A service provider means the provider who directly performed or provided a health care service to a subscriber of member.

One record submitted for each unique location where services are rendered.