Delaware Health Care Commission

Spending and Quality Benchmark Reporting

Frequently Asked questions

June 11, 2019

1. **Should insurers report the top ten providers by line of business?** Yes. Insurers should report the top 10 providers by line of business. Therefore for insurers with multiple lines of business (e.g., Medicare Advantage and commercial), each line of business will be reported for the top 10 providers, for all other providers with an attributed population, and all other spending for non-attributed members. A technical correction to the reporting template (Attachment 5) has been made and is now available on the DHCC website.

2. **How are stand-alone prescription drug plans (PDP) and Medicare Prescription Drug Plans (MAPD) to be reported in for Delaware?** At this time, data for stand-alone PDPs should be excluded from total medical expense (TME) reporting, however, will be included in the calculations performed for the net cost of private health insurance (NCPHI). For insurers with stand-alone PDP products, separate communication will be made regarding how to report NCPHI information.

   As of 2019, no Delaware insurer reporting data for the spending benchmark has a Medicare Advantage only plan (Part C with no prescription drug benefit). If in future years, insurers reporting for the spending benchmark have both Medicare Advantage and MAPD, then reporting TME for Medicare Advantage will need to be separated from MAPD.

3. **Member months for pharmacy rebate and member months for medical expenses may vary. Is this okay?** Yes, it is okay if total member months for pharmacy rebates and total member months for medical expenses vary as some insurers have medical only, or prescription drug only benefits.

4. **Can we use 90 day instead of 120 day claims run-out for total medical expense and quality data reporting?** No.

   TME: Total medical expense claims-run must be at least 120 days. This may differ from an insurer's customary practice, but will reduce the amount of estimation (from IBNR/IBNP) within the data.

   Quality: A claims run-out is not defined in the Quality Data Reporting Specification and is not customarily included in HEDIS specifications. DHCC requests using 120 days to be consistent with the TME requirement.

5. **Are Medicare Advantage members who are DE residents in scope for reporting?** Yes, Medicare Advantage members who are DE residents should be included in the spending reporting. There are no quality measures for the Medicare population, however, and should not be reported in the quality measure data.

6. **What is the date for when members should be attributed to primary care providers for the TME and quality measures?** The last day of the calendar year for which performance is being assessed. For example, an HMO population should be attributed to primary care providers as of 12/31/2018 for the 2018 performance period (baseline year). PPO members should be attributed to primary care providers using a look-back date as of 12/31/2018 for the 2018 performance period (baseline year).