Government Human Services Consulting

DELAWARE SPENDING AND QUALITY BENCHMARKS

INSURER TECHNICAL BRIEFING

State of Delaware

MAY 16, 2019

Presenter:
Megan Burns, Bailit Health

TODAY'S WEBINAR

Today's webinar will be a technical briefing for insurers on how to submit data to the Delaware Health Care Commission in support of the Health Care Spending and Quality Benchmarks.

The intended audience for this webinar is insurer staff who will be tasked with preparing the data files for submission.

Note: This webinar is being recorded.

TODAY'S WEBINAR

1. Health Care Spending and Quality Benchmarks Overview
2. Detailed Review of the Total Medical Expense Data Reporting Requirements
3. Detailed Review of the Quality Data Reporting Requirements
4. Questions

OVERVIEW: HEALTH CARE SPENDING BENCHMARK

- Governor Carney established Health Care Spending and Quality Benchmarks in Executive Order (EO) 25 (November 2018).
- Delaware has set a target of keeping annual per capita health care spending growth at or below:
  - 3.8% (2019)
  - 3.5% (2020)
  - 3.25% (2021)
  - 3.0% (2022 and 2023)
- To measure the change in health care spending year-over-year, the Delaware Health Care Commission has requested data of each Insurer. This webinar will review the technical specifications of that data request.

OVERVIEW: QUALITY BENCHMARKS

- EO 25 established the calendar year (CY) 2019–2021 quality benchmarks and aspirational longer term goals.
- There are eight quality benchmarks; annually starting in 2020, insurers will need to submit data for the state to calculate performance for four.

HEALTH STATUS MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Adult Obesity	% of adults with body mass index ≥30	30.0%
High School Students Physically Active	% of students with physical activity for ≥60 mins a day on five or more days	44.6%
Opioid-related Overdose Deaths	# of opioid-related deaths	16.2 deaths per 100,000
Tobacco Use	% of adults who currently smoke	17.1%

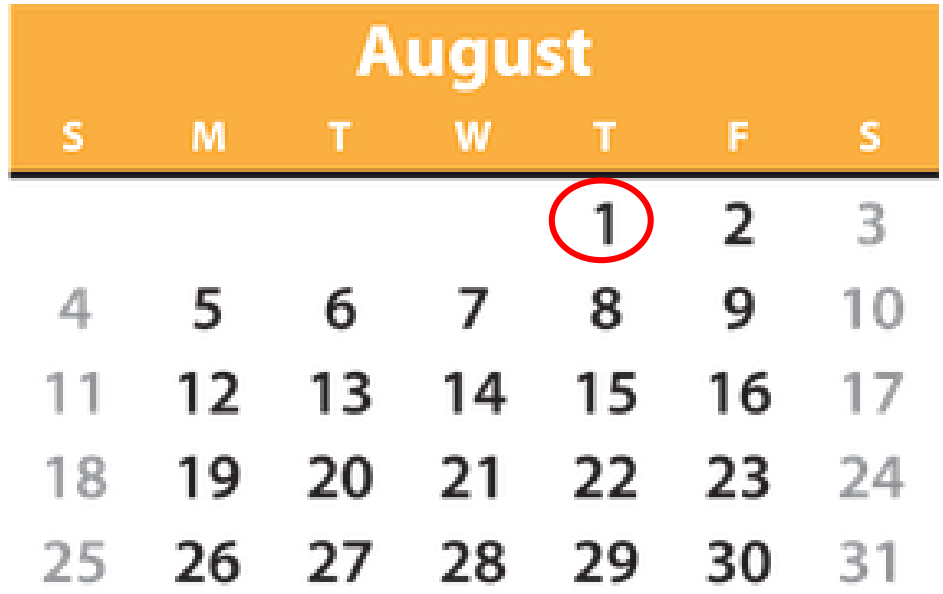
HEALTH CARE MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Concurrent Use of Opioids and Benzodiazepines	% of individuals age 18 and older with concurrent use of opioids and benzos	TBD
Emergency Department (ED) Utilization (Commercial Market only)	# of ED visits for individuals age 18 and older	190 visits per 1,000
Persistence of Beta Blocker Treatment After a Heart Attack	% of individuals age 18 and older who received beta-blockers for 6 months after discharge	82.5% Commercial 78.8% Medicaid
Statin Therapy Adherence for Patients with Cardiovascular Disease	% of at-risk individuals who adhered to medication for ≥ 80% of treatment period	79.9% Commercial 59.2% Medicaid

TOTAL MEDICAL EXPENSE DATA

SUBMISSION INSTRUCTIONS

TOTAL MEDICAL EXPENSE DATA – DETAILED REPORTING REQUIREMENTS

- Data are due to the Health Care Commission on, or before August 1, 2019.



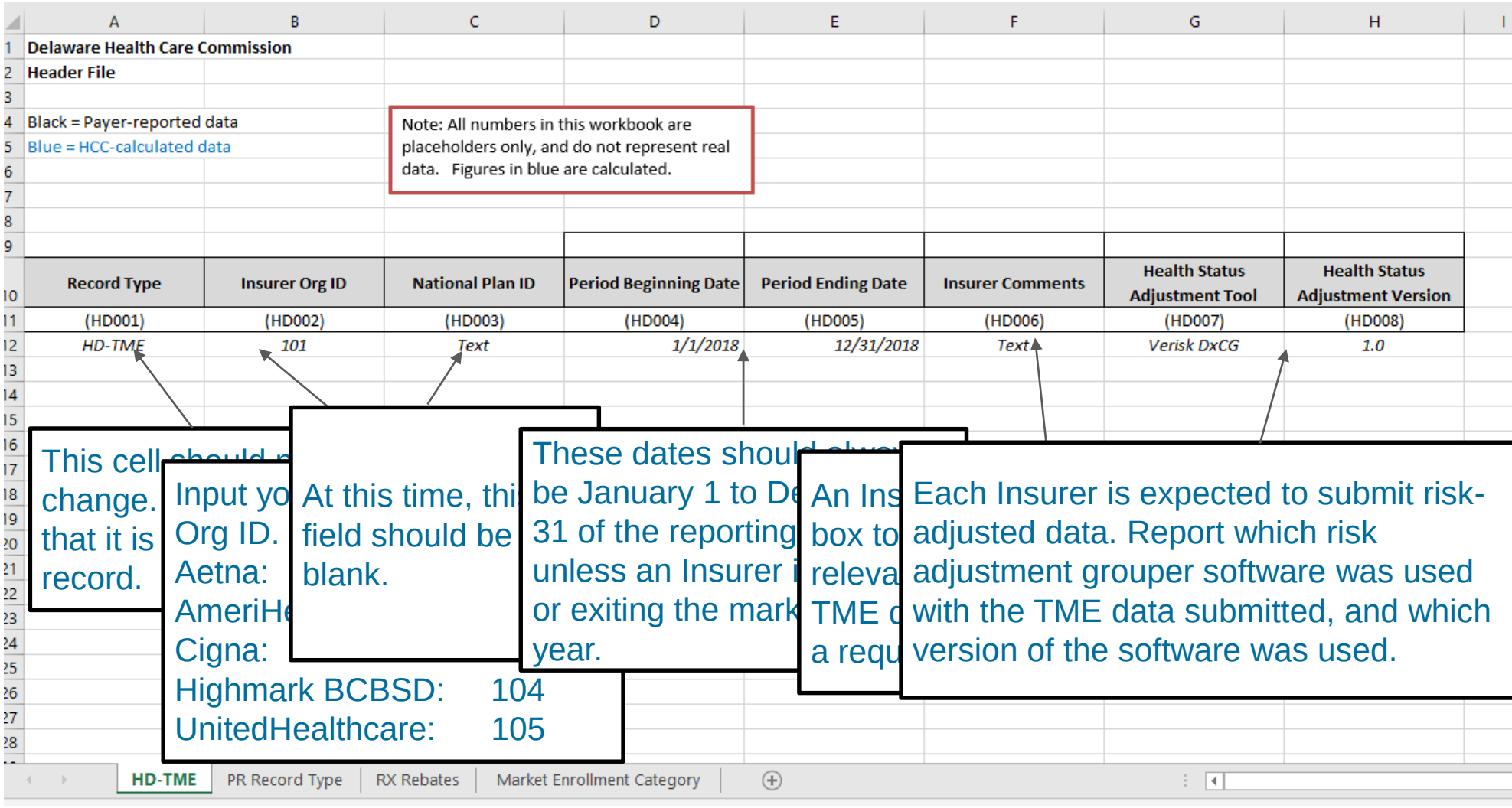
TOTAL MEDICAL EXPENSE DATA – DETAILED REPORTING REQUIREMENTS

- Insurers should submit an Excel file with the necessary information required for Delaware Health Care Commission (DHCC) to calculate performance against the Spending Benchmark.
- The Excel file template is located here: https://dhss.delaware.gov/dhss/files/benchmarkattachment5_021519.xlsx
- Insurers should input their data into the cells used as examples and not alter the file in any other way:
  - Cells with blue text will automatically calculate pre-populated formulas.
  - Data in cells with blue font should not be altered.
- Insurers may refer to this webinar and the Total Medical Expense (TME) Data Submission Instructions for more information on how to populate the Excel file.
- Each tab of the Excel file will be described in this webinar.

TOTAL MEDICAL EXPENSE – WHAT IS IT?

- TME is all allowed amounts (i.e., the amount the insurer paid plus any member cost sharing) for:
  - Members who are residents of Delaware.
  - For whom the insurer is primary on a claim (exclude any paid claims for which the insurer was the secondary or tertiary insurer).
- Insurers must include all allowed amounts for all TME data for members, regardless of whether services are provided by providers located inside or outside of Delaware, and regardless of the situs of the member's plan.
- If the Insurer operates in multiple states, the Insurer should only report for lines of business which are subject to Delaware laws and regulations.

TOTAL MEDICAL EXPENSE DATA – HEADER FILE



Delaware Health Care Commission
Header File

Black = Payer-reported data
Blue = HCC-calculated data

Note: All numbers in this workbook are placeholders only, and do not represent real data. Figures in blue are calculated.

Record Type	Insurer Org ID	National Plan ID	Period Beginning Date	Period Ending Date	Insurer Comments	Health Status Adjustment Tool	Health Status Adjustment Version
(HD001)	(HD002)	(HD003)	(HD004)	(HD005)	(HD006)	(HD007)	(HD008)
HD-TME	*101*	*Text*	*1/1/2018*	*12/31/2018*	*Text*	*Verisk DxCG*	*1.0*

This cell change. that it is record.

Input yo Org ID. Aetna: AmeriH Cigna: Highmark BCBSD: 104 UnitedHealthcare: 105

At this time, thi field should be blank.

These dates shoul be January 1 to De 31 of the reporting unless an Insurer i or exiting the mark year.

An Ins box to releva TME d a requ

Each Insurer is expected to submit risk-adjusted data. Report which risk adjustment grouper software was used with the TME data submitted, and which version of the software was used.

HD-TME | PR Record Type | RX Rebates | Market Enrollment Category

TOTAL MEDICAL EXPENSE – PROVIDER DATA

- EO 25 requires the DHCC to report performance against the benchmark at the provider level. In order to do so, Insurers will need to do the following:
- Insurers must attribute members to a primary care provider (PCP) so that all member spending can be attributed to one PCP. The following are hierarchal steps that an Insurer should take in order to attribute members to a PCP:
  - Delaware members required to select a PCP by plan design.
  - Members not required to select a PCP by plan design who were attributed during the measurement year to a PCP, pursuant to a contract between the Insurer and provider for financial or quality performance.
  - Members not attributed to a PCP in either of the two previous manners, should be attributed to a PCP using the Insurer's own attribution methodology.

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

TOTAL MEDICAL EXPENSE – PROVIDER DATA

- Data on TME spending must be reported in three ways:
  1. TME data applicable to the insurer's 10 largest providers based on the number of attributed members (using the previously mentioned methodology). Spending for members attributed to each of the 10 largest providers must be reported separately by provider. Should any of the 10 largest providers not meet the minimum attribution threshold for public reporting, DHCC will not publicly report its performance.
  2. TME data applicable to providers not counted as the insurer's 10 largest providers must be reported in aggregate.
  3. Member spending not attributable to a PCP must also be reported in aggregate.

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

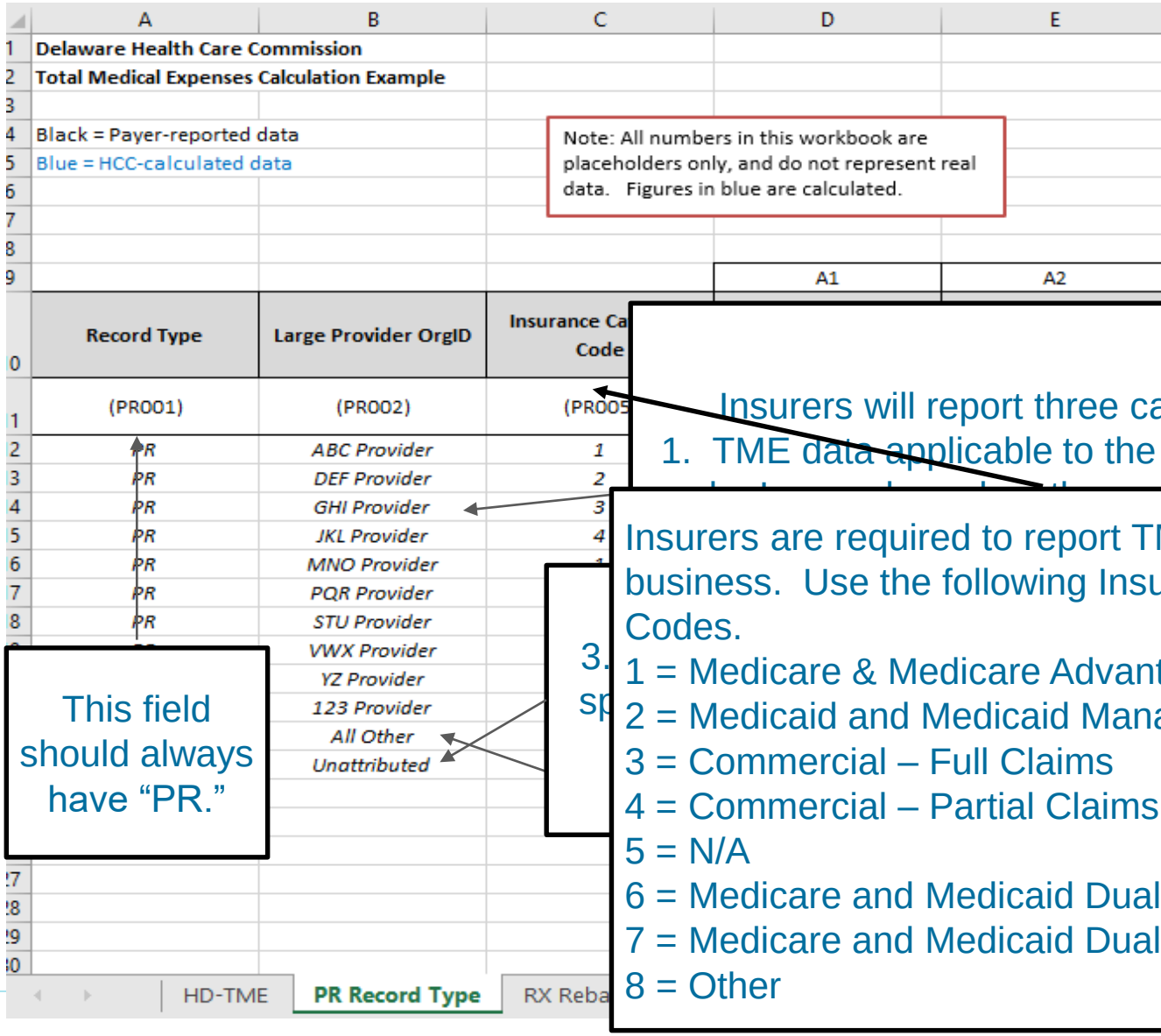
TOTAL MEDICAL EXPENSE – PROVIDER DATA

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

TOTAL MEDICAL EXPENSE – PROVIDER DATA

- There should be a claims run-out period of at least 120 days after December 31 of the prior calendar year.
- Insurers should apply reasonable and appropriate incurred but not reported/incurred but not paid (IBNR/IBNP) completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

TOTAL MEDICAL EXPENSE – PROVIDER DATA



	A	B	C	D	E
1	Delaware Health Care Commission				
2	Total Medical Expenses Calculation Example				
3					
4	Black = Payer-reported data				
5	Blue = HCC-calculated data				
6					
7					
8					
9				A1	A2
10	Record Type	Large Provider OrgID	Insurance Ca… Code		
11	(PR001)	(PR002)	(PR005		
12	PR	ABC Provider	1		
13	PR	DEF Provider	2		
14	PR	GHI Provider	3		
15	PR	JKL Provider	4		
16	PR	MNO Provider			
17	PR	PQR Provider			
18	PR	STU Provider			
		VWX Provider			
		YZ Provider			
		123 Provider			
		All Other			
		Unattributed			
27					
28					
29					
30					

HD-TME | PR Record Type | RX Reba…

Note: All numbers in this workbook are placeholders only, and do not represent real data. Figures in blue are calculated.

This field should always have "PR."

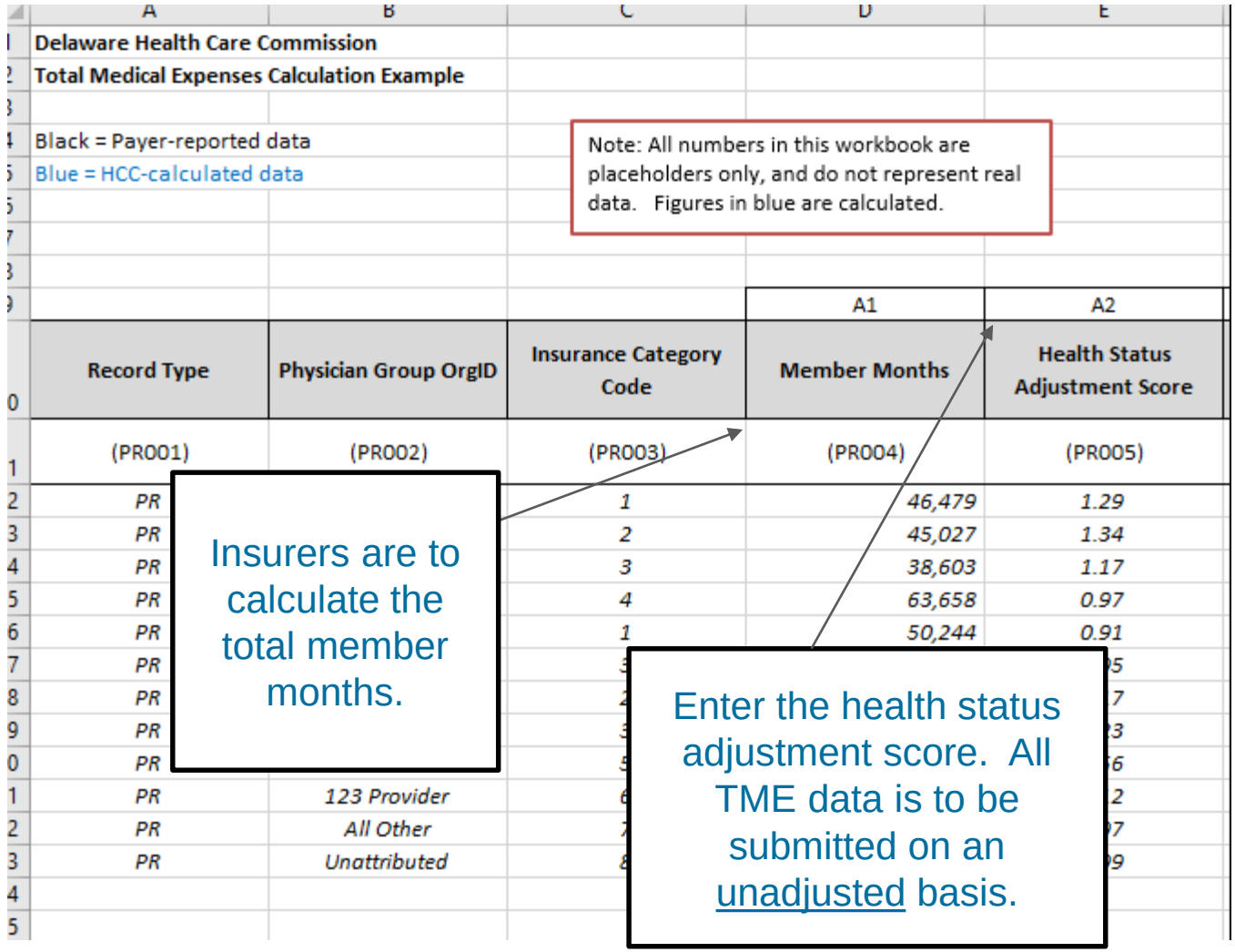
Insurers will report three categories of data:

1. TME data applicable to the 10 largest providers

Insurers are required to report TME by line of business. Use the following Insurance Category Codes.

1 = Medicare & Medicare Advantage
2 = Medicaid and Medicaid Managed Care
3 = Commercial – Full Claims
4 = Commercial – Partial Claims, Adjusted
5 = N/A
6 = Medicare and Medicaid Dual eligibles 65+
7 = Medicare and Medicaid Dual eligibles 21-64
8 = Other

TOTAL MEDICAL EXPENSE – PROVIDER DATA



Delaware Health Care Commission

Total Medical Expenses Calculation Example

Black = Payer-reported data

Blue = HCC-calculated data

Note: All numbers in this workbook are placeholders only, and do not represent real data. Figures in blue are calculated.

				A1	A2
	Record Type	**Physician Group OrgID**	**Insurance Category Code**	**Member Months**	**Health Status Adjustment Score**
	(PR001)	(PR002)	(PR003)	(PR004)	(PR005)
	PR		*1*	*46,479*	*1.29*
	PR		*2*	*45,027*	*1.34*
	PR		*3*	*38,603*	*1.17*
	PR		*4*	*63,658*	*0.97*
	PR		*1*	*50,244*	*0.91*
	PR				
	PR				
	PR				
	PR				
	PR	*123 Provider*			
	PR	*All Other*			
	PR	*Unattributed*			

Insurers are to calculate the total member months.

Enter the health status adjustment score. All TME data is to be submitted on an unadjusted basis.

TOTAL MEDICAL EXPENSE – PROVIDER DATA CLAIMS

- There are eight categories of claims data to be submitted, all with specific definitions:

1. Hospital inpatient
2. Hospital outpatient
3. Professional physician, primary care
4. Professional physician, specialty
5. Professional other
6. Retail pharmacy
7. Long-term care
8. Other

TOTAL MEDICAL EXPENSE – PROVIDER DATA CLAIMS

A3	A4	A5	A6	A7	A8	A9
Claims: Hospital Inpatient	Claims: Hospital Outpatient	Claims: Professional Physician (Primary Care)	Claims: Professional Physician (Specialty Care)	Claims: Professional Other	Claims: Rx	Claims: Long Term Care
(PR006)	(PR007)	(PR008)	(PR009)	(PR010)	(PR011)	(PR012)
$8,258,932	$1,293,760	$3,783,312	$3,783,312	$85,876	$136,722	$65,322
$5,364,945	$3,940,079	$3,863,444	$3,863,444	$98,327	$51,339	$94,394
$5,065,497	$3,890,368	$736,836	$736,836	$80,895	$140,256	$89,040
$3,210,161	$6,964,459	$1,829,054	$1,829,054	$82,524	$91,235	$102,974
$8,177,123	$2,774,083	$2,897,230	$2,897,230	$96,760	$57,085	$122,560
$8,736,267	$3,029,577	$1,213,413	$1,213,413	$106,207	$117,469	$66,130
$8,228,056	$5,004,948	$3,779,168	$3,779,168	$100,927	$70,482	$86,455
$6,054,856	$6,765,734	$1,556,997	$1,556,997	$115,162	$82,812	$81,867
$5,534,263	$6,709,044	$1,567,106	$3,046,336	$85,694	$60,442	$54,305
$7,675,213	$2,995,912	$928,459	$2,262,329	$117,815	$112,546	$95,258
$6,690,024	$4,300,764	$2,916,973	$3,071,553	$58,811	$78,248	$121,887
$5,052,858	$2,474,067	$2,168,375	$1,203,196	$55,365	$89,762	$103,623

TOTAL MEDICAL EXPENSE – PROVIDER DATA CLAIMS

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

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

TOTAL MEDICAL EXPENSE – PROVIDER DATA CLAIMS

3. **Professional physician, primary care:** The TME data from claims to physicians or physician group practices generated from claims. Includes services provided by any care provider defined by the health plan as a PCP (including doctors of medicine or osteopathy in family medicine, internal medicine, general medicine or pediatric medicine, nurse practitioners, physicians assistants or others not explicitly listed here). The one exception is OB/GYNs may not be considered a PCP for this purpose.

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

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

TOTAL MEDICAL EXPENSE – PROVIDER DATA CLAIMS

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

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

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

TOTAL MEDICAL EXPENSE – PROVIDER DATA NON-CLAIMS

- There are five categories of non-claims data to be submitted, all with specific definitions:

1. Incentive programs
2. Capitation and risk settlements
3. Care management
4. Recovery
5. Other

TOTAL MEDICAL EXPENSE – PROVIDER DATA NON-CLAIMS

A11	A12	A13	A14	A15
Non-Claims: Incentive Programs	Non-Claims: Risk Settlements	Non-Claims: Care Mgmt.	Non-Claims: Recovery	Non-Claims: Other
(PRO14)	(PRO15)	(PRO16)	(PRO17)	(PRO18)
$14,688	*$19,275*	*$7,478*	*-$597*	*$2,814*
$11,156	*$17,510*	*$8,069*	*-$8,945*	*$12,923*
$0	*$0*	*$0*	*-$5,978*	*$0*
$10,464	*$17,437*	*$7,768*	*-$59,412*	*$18,592*
$0	*$0*	*$0*	*-$96,872*	*$0*
$10,682	*$6,777*	*$8,853*	*-$5,974*	*$2,321*
$9,024	*$2,946*	*$5,969*	*-$15,647*	*$19,688*
$6,704	*$15,335*	*$9,732*	*-$45,687*	*$18,077*
$10,636	*$2,299*	*$8,154*	*-$45,497*	*$9,729*
$10,523	*$8,450*	*$5,358*	*-$6,534*	*$14,667*
$8,880	*$5,617*	*$10,813*	*-$1,247*	*$13,555*
$6,272	*$14,955*	*$10,320*	*-$7,594*	*$971*

TOTAL MEDICAL EXPENSE – PROVIDER DATA NON-CLAIMS

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

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

3. **Care management:** All payments made to providers for providing care management, utilization review, and discharge planning.

TOTAL MEDICAL EXPENSE – PROVIDER DATA NON-CLAIMS

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

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

TOTAL MEDICAL EXPENSE – PHARMACY REBATE

- The Total Health Care Expenditures and TME will be publicly reported net of pharmacy rebate. Insurers should enter data in the RX Rebate tab of the Spending Benchmark Submission Template.
- **Pharmacy Rebates:** The estimated value of rebates attributed to Delaware resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the period beginning date through end date from the Large Provider Record file, excluding manufacturer-provided fair market value bona fide service fees.
- This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.).

TOTAL MEDICAL EXPENSE – PHARMACY REBATE

- Payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done.
- If insurers are unable to report rebates specifically for Delaware residents, insurers should report estimated rebates attributed to Delaware resident members in a proportion equal to the proportion of Delaware resident members compared to total members, by line of business. For example, if Delaware resident commercial members represent 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported.

TOTAL MEDICAL EXPENSE – PHARMACY REBATE

A	B	C	D	E	F	G
Delaware Health Care Commission						
Pharmacy Rebate Example						
Black = Payer-reported data						
Blue = HCC-calculated data						
		A1	A2			
Record Type	**Insurance Category Code**	**Pharmacy Rebates**	**Member Months**	**Pharmacy Rebates PMPM**		
(RX001)	(RX002)	(RX003)	(RX004)	A1/A2		
RX	*1*	*$ 464,790*	*73,407*	$ 6.33		
RX	*2*	*$ 450,270*	*62,405*	$ 7.22		
RX	*3*	*$ 386,030*	*58,646*	$ 6.58		
RX	*8*	*$ 636,580*	*54,684*	$ 11.64		

Note: All numbers in this workbook are placeholders only, and do not represent real data. Figures in blue are calculated.

TOTAL MEDICAL EXPENSE – MARKET ENROLLMENT

- The market enrollment file will be the source of the insurer's member months by market. It will be used by DHCC to compute the net cost of private health insurance.
- Insurers will report their member months by market in this file.

TOTAL MEDICAL EXPENSE – MARKET ENROLLMENT

	A	B	C
1	**Delaware Health Care Commission**		
2	**Market Enrollment File Example**		
3			
4	Black = Payer-reported data		
5	Blue = HCC-calculated data		
6			A1
7	**Record Type**	**Market Enrollment Category Code**	**Member Months**
8	ME (001)	(ME002)	(ME003)
9	*ME*	*1*	*73,407*
10	*ME*	*2*	*62,405*
11	*ME*	*3*	*58,646*
12	*ME*	*4*	*54,684*
13	*ME*	5	*2,564*
14			
15			
16			
17			
18			
19			
20			
21			
22			

Note: All numbers in this workbook are placeholders only, and do not represent real data. Figures in blue are calculated.

Each market enrollment category should have data.
Categories:

1. Individual
2. Large Group
3. Small Group
4. Self-Insured
5. Student market

FILE SUBMISSION

- On or before August 1 (but not before 120 days of claims runout) insurers should submit an Excel file to: Elisabeth.Scheneman@Delaware.gov and DHCC@Delaware.gov with the data described in the TME instructions and through this webinar.
- The file must be in .XLSX or .XLS format.

NET COST OF PRIVATE HEALTH INSURANCE

- The Net Cost of Private Health Insurance captures the costs to Delaware residents associated with the administration of private health insurance. It is the difference between health premiums earned and benefits incurred. It consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses.
- All insurers will need to submit their federal commercial medical loss ratio (MLR) reports along with their TME and Quality Data files on or before August 1.
- In the event the MLR report submitted to DHCC on or before August 1 differs from the final submission an insurer makes to the federal Center for Consumer Information and Insurance Oversight (CCIIO), the insurer must notify DHCC in writing as soon as possible. Notification should be directed to: Elisabeth.Scheneman@Delaware.gov and DHCC@Delaware.gov.

QUESTIONS?

- Before we move onto the Quality Data Submission instructions, are there any questions about what TME data are being requested or how to submit TME data to DHCC?

QUALITY MEASURE DATA

SUBMISSION INSTRUCTIONS

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS

MEASURE	SPECIFICATION	LINES OF BUSINESS	REPORTING UNIT
Concurrent use of opioids and benzodiazepines	PQA	Commercial Medicaid	Insurer Provider
Emergency department utilization	HEDIS, version corresponding to performance period	Commercial	Insurer
Statin therapy for patients with cardiovascular disease - statin adherence 80%		Commercial Medicaid	Insurer Provider
Persistence of beta-blocker treatment after a heart attack		Commercial Medicaid	Insurer Provider

There is a live link to the PQA specification in the Quality Data Submission Instructions

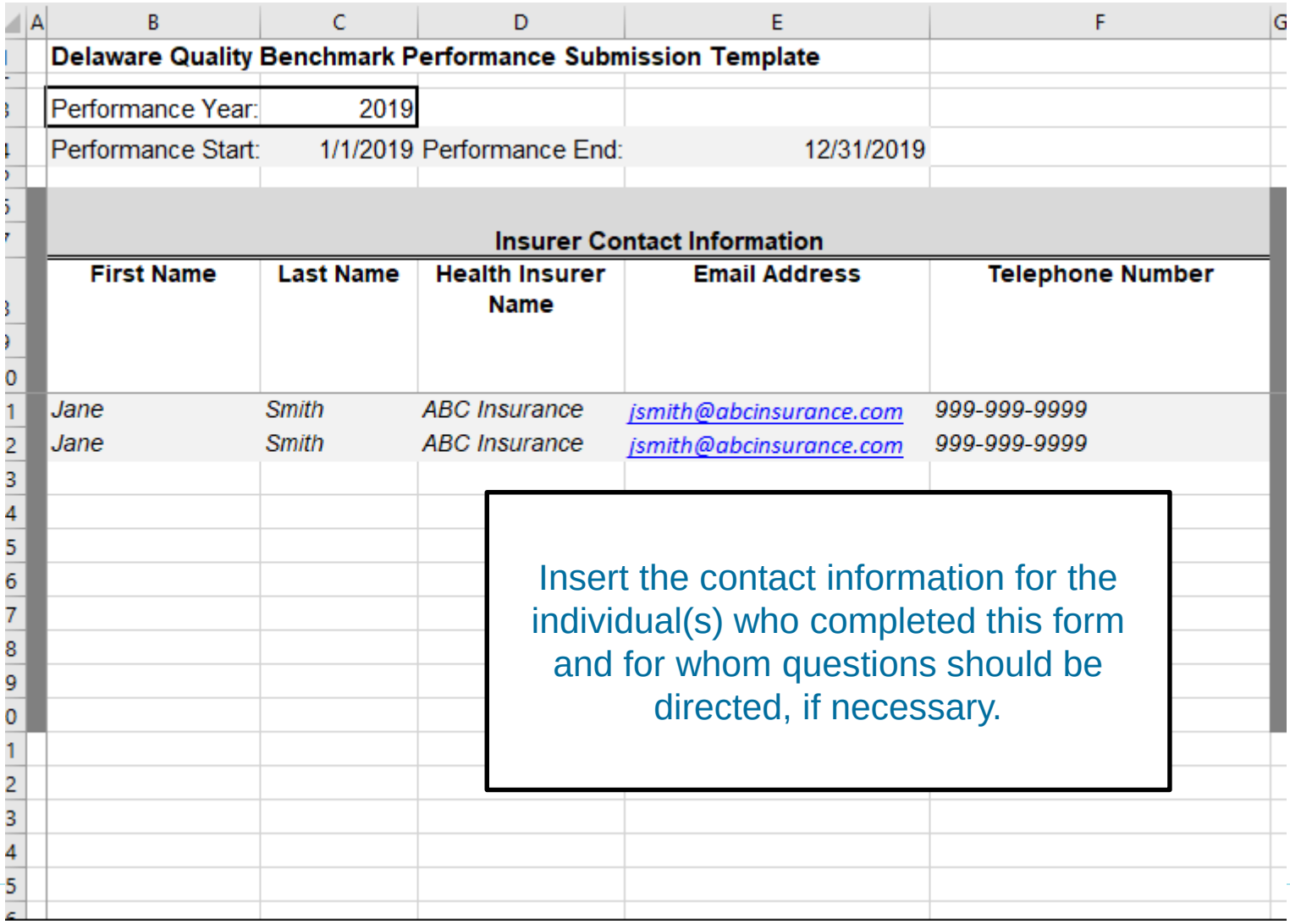
These are the quality measures for which insurers will need to report data. Other quality measures, identified at the outset of this webinar, will be calculated by the State.

When Reporting Unit is "Provider," data submitted will be for the same 10 providers for which TME data is reported

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS

- One Quality Benchmark Performance Submission Template should be submitted per Insurer. The completed file should contain all required health insurer and provider-level information with at least 120 days of claims runout.
- All data must be submitted to DHCC annually on, or before August 1.
- **NOTE:** No quality baseline data will be collected. Data for only one measure will be collected in 2019 and that is to create its benchmark for 2020 and 2021. The following slides will review both 2019 data submission, as well as the process for data submissions in 2020 and beyond.

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS



Delaware Quality Benchmark Performance Submission Template

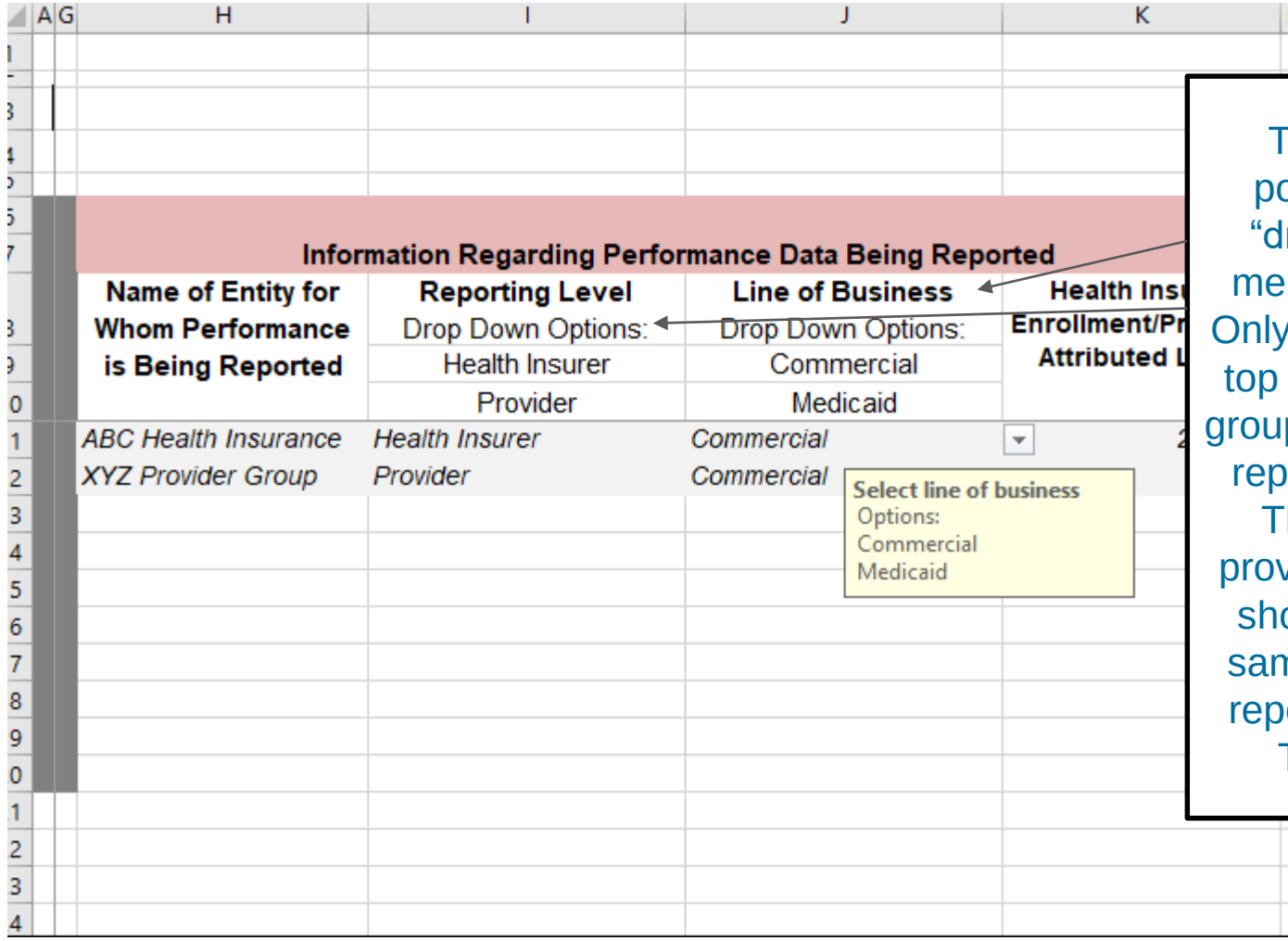
Performance Year:	2019		
Performance Start:	1/1/2019	Performance End:	12/31/2019

Insurer Contact Information

First Name	Last Name	Health Insurer Name	Email Address	Telephone Number
Jane	*Smith*	*ABC Insurance*	*jsmith@abcinsurance.com*	*999-999-9999*
Jane	*Smith*	*ABC Insurance*	*jsmith@abcinsurance.com*	*999-999-9999*

Insert the contact information for the individual(s) who completed this form and for whom questions should be directed, if necessary.

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS



Information Regarding Performance Data Being Reported			
Name of Entity for Whom Performance is Being Reported	**Reporting Level**	**Line of Business**	**Health Ins… Enrollment/Pr… Attributed L…**
	Drop Down Options:	Drop Down Options:	
	Health Insurer	Commercial	
	Provider	Medicaid	
ABC Health Insurance	*Health Insurer*	*Commercial*	
XYZ Provider Group	*Provider*	*Commercial*	

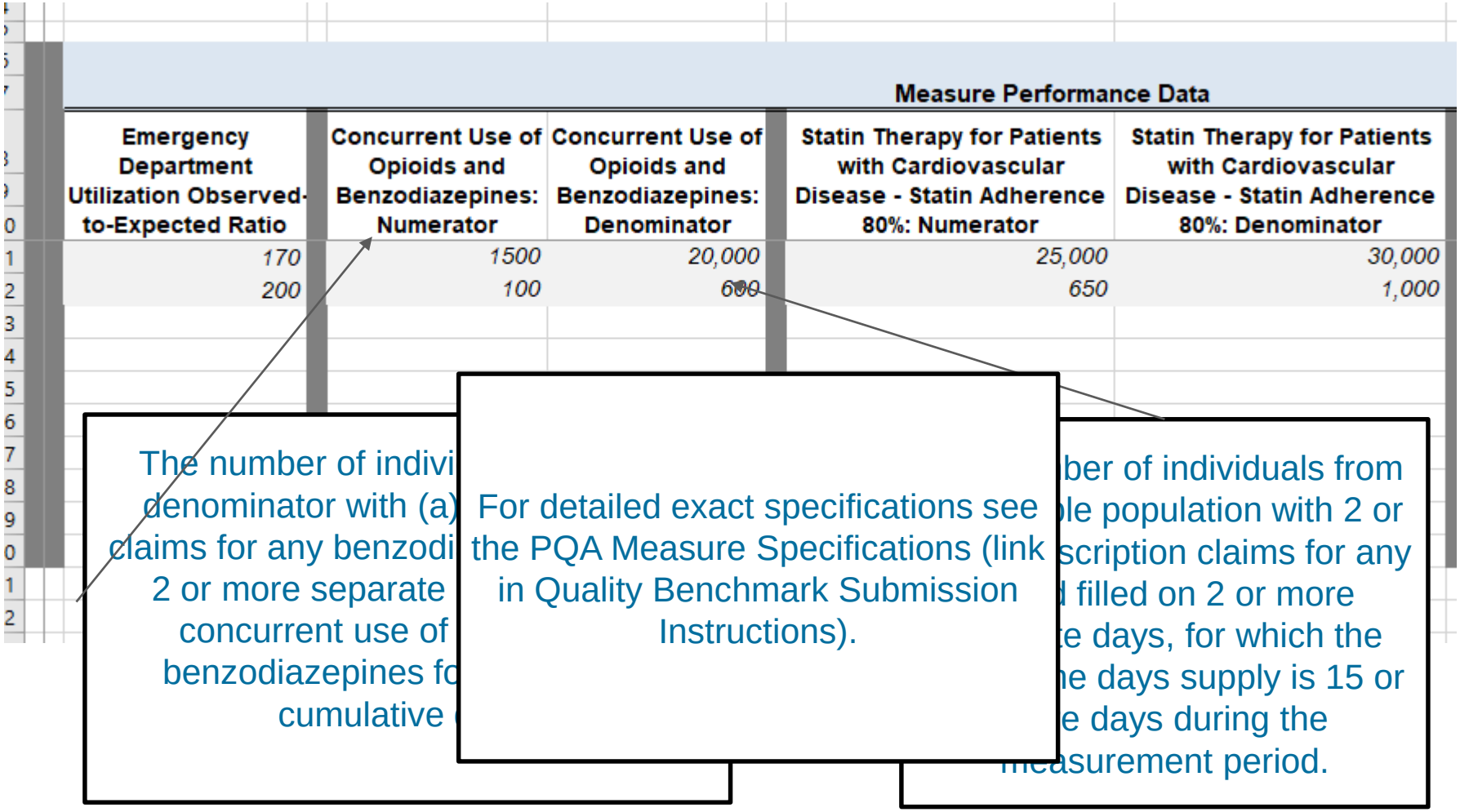
Select line of business
Options:
Commercial
Medicaid

These will populate as "drop-down" menu options. Only data on the top 10 provider groups should be reported here. The top 10 provider groups should be the same as those reported in the TME file.

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS

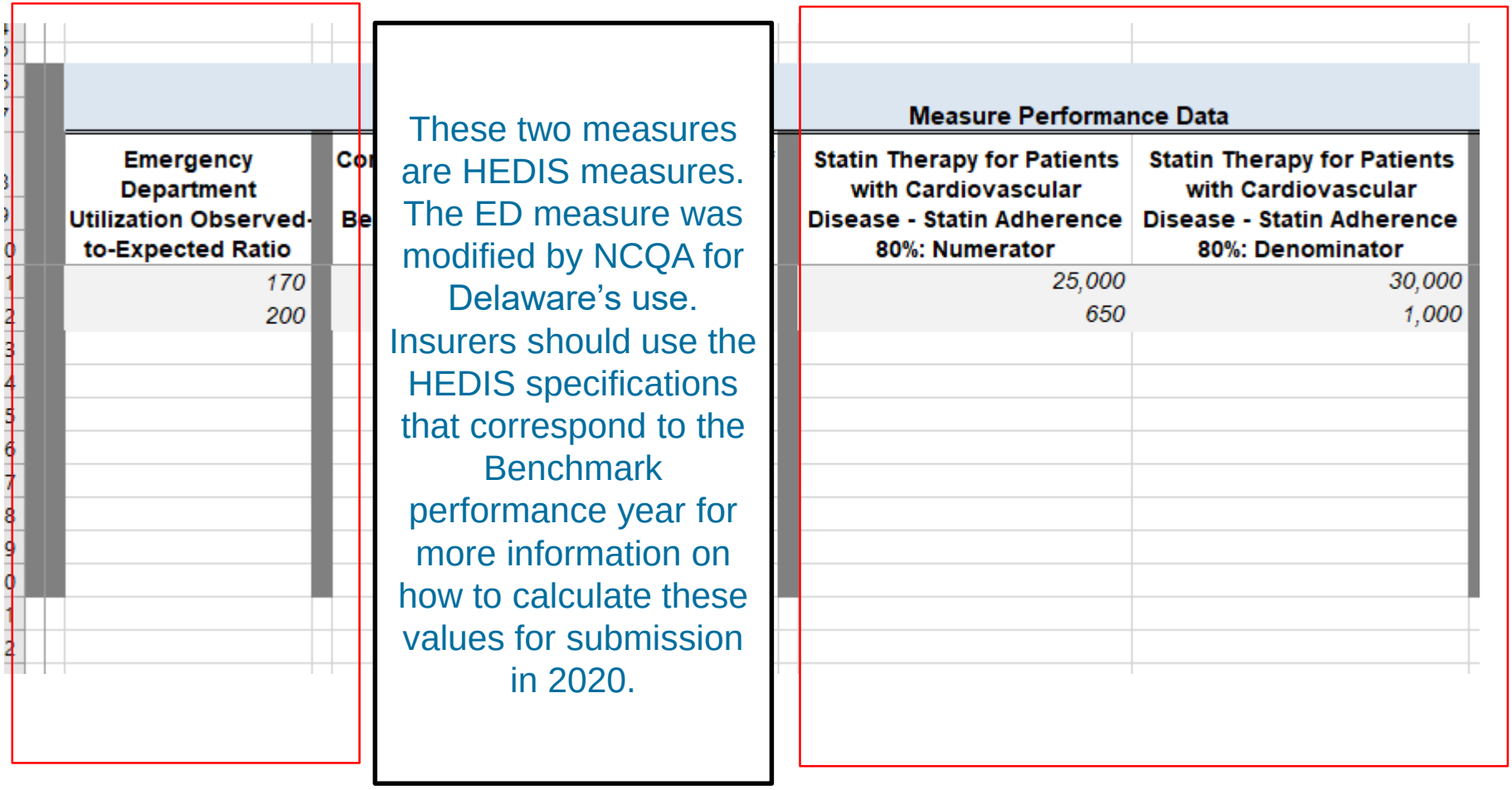
- EO 25 did not establish a benchmark for “concurrent use of opioids and benzodiazepines” as data were unavailable at the time to determine appropriate benchmarks:
  - Therefore, there is no CY 2019 quality benchmark for “concurrent use opioids and benzodiazepines.”
- To inform the establishment of future year quality benchmarks for “concurrent use opioids and benzodiazepines”, Delaware Insurers will need to submit data to DHCC:
  - Insurers must provide data to DHCC by August 1, 2019 (Commercial and Medicaid/CHIP, as applicable).
- Using the baseline data, DHCC will confer with subject matter experts to establish benchmarks for CYs 2020 and 2021, along with aspirational goals:
  - Benchmarks for this measure will be published in late 2019.

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS



Measure Performance Data				
Emergency Department Utilization Observed-to-Expected Ratio	Concurrent Use of Opioids and Benzodiazepines: Numerator	Concurrent Use of Opioids and Benzodiazepines: Denominator	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%: Numerator	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%: Denominator
170	1500	20,000	25,000	30,000
200	100	600	650	1,000

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS



Measure Performance Data			
Emergency Department Utilization Observed-to-Expected Ratio	Co... Be...	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%: Numerator	Statin Therapy for Patients with Cardiovascular Disease - Statin Adherence 80%: Denominator
170		*25,000*	*30,000*
200		*650*	*1,000*

These two measures are HEDIS measures. The ED measure was modified by NCQA for Delaware's use. Insurers should use the HEDIS specifications that correspond to the Benchmark performance year for more information on how to calculate these values for submission in 2020.

QUALITY BENCHMARKS DATA REPORTING REQUIREMENTS

This is also a HEDIS measure. Insurers should use the HEDIS specifications that correspond to the Benchmark performance year for more information on how to calculate these values for submission in 2020.

Persistence of Beta-Blocker Treatment After a Heart Attack: Numerator	Persistence of Beta-Blocker Treatment After a Heart Attack: Denominator
25,000	30,000
650	1,000

QUESTIONS?

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