MERCER

Delaware Spending and Quality Benchmarks

Insurer Technical Briefing for the Upcoming 2020 Submission Year

State of Delaware

June 26, 2020

welcome to brighter

Today's Webinar

Today's webinar will be a technical briefing for insurers on how to submit data to the Delaware Health Care Commission (DHCC) 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

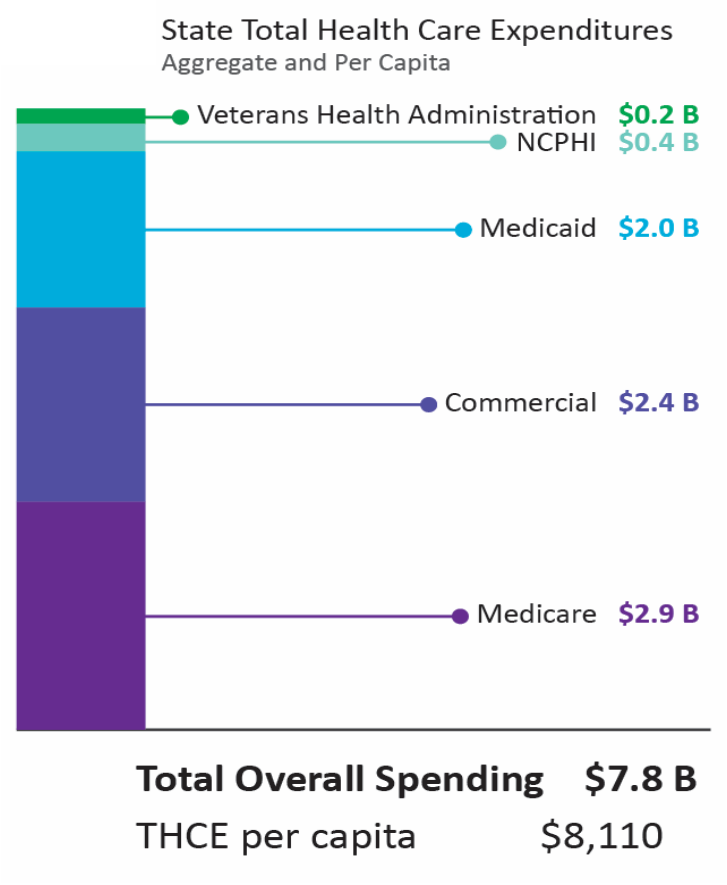
1. Health Care Spending and Quality Benchmarks Overview
2. Detailed Review of the Total Medical Expense Data Reporting Requirements
3. Detailed Review of the Quality Data Reporting Requirements
4. Questions

Overview: Health Care Spending Benchmark

- Governor Carney established health care spending and quality benchmarks in Executive Order (EO) 25 (November 2018).
- Delaware set targets for keeping year-over-year (i.e., calendar year CY) per capita health care spending growth at or below:
  - 3.8% (CY 2019)
  - 3.5% (CY 2020)
  - 3.25% (CY 2021)
  - 3.0% (CY 2022 and CY 2023)
- To measure the annual change in health care spending, the DHCC requested data from each insurer in 2019 and will do so again in 2020.
- This webinar will review the technical specifications of the 2020 submission year and corresponding data request and how it differs from the previous request.

Preliminary Results
CY 2018 Spending Data Collection

- Thank you for participating in the CY 2018 preliminary data collection process last year.
- The data collection process was a helpful learning exercise for both the insurers and DHCC.
- **Preliminary** data was released and reported at a recent DHCC meeting. The press release, presentation and preliminary results can be found here: https://dhss.delaware.gov/dhcc/global.html
- **Note**: Until CY 2019 data are collected, there is no appropriate comparator for these data.



Overview: Quality Benchmarks

- EO 25 established the CY 2019–2021 quality benchmarks and aspirational longer term goals.
- There are eight quality benchmarks. This year, insurers will need to submit data for the DHCC to calculate performance for at least three quality benchmarks.

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 per 100,000	16.2 deaths per 100,000
Tobacco Use	% of adults who currently smoke	17.1%

HEALTH CARE MEASURE	SPECIFICATION	CY 2019 BENCHMARK
Opioid-related measure	TBD	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

Spending Data Submission Instructions

Total Medical Expense Data
Detailed Reporting Requirements

- The DHCC is requesting CY 2018 and CY 2019 TME data.
  - CY 2018 data is being requested again to ensure both data years are produced using the same updated specifications.
- Data are due to the DHCC on, or before **September 1, 2020**.
  - The deadline this year has been extended one month in recognition of the challenges of operating during the pandemic.

Total Medical Expense Data
Detailed Reporting Requirements (Cont'd)

- Insurers should submit **separate Excel files** (each CY data is a separate Excel file) with the required spending data for CY 2018 and CY 2019, respectively, to the DHCC.
- The Excel file template is located here (see Attachment 3: Spending Benchmark Performance Submission Template): https://dhss.delaware.gov/dhcc/global.html
- 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 insurer total medical expense (TME) data specification instructions for more information on how to populate the Excel file.
- Each tab of the Excel file will be described in this webinar.

No Change in What is to be Reported

DHCC will continue to compute the following two measures on a per member per year (PMPY) basis:

1. **Total Medical Expense (TME)**: all incurred expenses for Delaware residents for all health care services, regardless of where the care was delivered and regardless of the situs of the member's plan.
2. **Net Cost of Private Health Insurance (NCPHI)**: the costs to Delaware residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as 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.

TME + NCPHI = Total Health Care Expenditures (THCE)

Member Attribution Process

- DHCC did not make any revisions to the process of attributing members to a PCP for insurer reporting.
- For additional information on the member attribution process or insurer reporting, please refer to the detailed instructions in the insurer TME data specification instructions.
- Should you have any further questions, email ayanna.harrison@delaware.gov and DHCC@delaware.gov.

Updated and New Insurance Category Codes

DHCC modified the insurance category codes from last year to include the new categorization for dually eligible members. Insurers should use the following insurance category codes for reporting TME spending and pharmacy rebates.

Insurance Category Code	Definition
1	Medicare and Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid and Medicaid Managed Care including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims, Adjusted
5*	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6*	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7*	Other

*New for the 2020 submission year.

Updated Process for Reporting Data
Medicare/Medicaid Dual Eligible Members

- DHCC revised the reporting requirements for Medicare and Medicaid dual eligible to the following:
  - If an insurer enrolls Medicare/Medicaid dual eligibles, the DHCC requires the insurer to report **Medicare-related expenditures under insurance category code 5** and **Medicaid-related expenditures under insurance category code 6**.
  - For example, if an insurer covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under insurance category code 6.
  - However, if an insurer is an integrated care entity providing both Medicare and Medicaid benefits to dual eligibles, the insurer should use both insurance category codes 5 and 6, respectively, to report applicable expenditures.
  - If direct assignment of the expenditure cannot be made to code 5 or 6, the insurer should use reasonable and appropriate methods to allocate expenditures to the respective insurance category code.

Are there any concerns about this new process?

TME Reporting: Details

- Insurers are to report TME data in the Large Provider Record File in the spending template.
- TME includes **claims** and **non-claims** payments for a single calendar year.
  - Non-claims payments are payments to providers not associated with a claim and include incentive payments, capitation payments, risk settlements, care management payments, etc.
- TME is to be reported based on all **allowed amounts** (i.e., the amount the insurer paid plus any member cost sharing) for:
  - Members who are **residents of Delaware**.
  - Members who, at a minimum, **have medical benefits**.*
  - For whom the **insurer is the primary on a claim**.

*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.

Updated Guidance
Claims and Non-Claims Reporting

- The **claims run-out period has been extended to 180 days after December 31 of the prior calendar year**.
  - DHCC prefers insurers to use as much claims run-out as possible to minimize the impact of IBNR/IBNP adjustment factors.
- DHCC also specified the **inclusion of a non-claims run-out period to reconcile non-claims payments, which is also 180 days after December 31 of the prior calendar year**.
  - Insurers should apply reasonable and appropriate estimates of non-claims liability to each provider reported (including payments expected to be made to organizations not separately identified for TME reporting purposes) expected to be reconciled after the 180 day "run-out" period.

Updated Guidance
"Commercial, Partial Claims – Adjusted" Reporting

- Commercial (fully and self-insured) data that does not include all medical and subcarrier claims should be reported in the "Partial Claims" category.
- An actuarial adjustment should be made by the insurer to those claims to allow for them to be comparable to full claims. Such an adjustment must use actuarially sound principles **and be reviewed with DHCCC before the adjustment is made**.
- **DHCC did not make any substantive changes to the process for reporting data for the "Partial Claims" category. However, it will now follow up with a confirmation accepting the adjustment process or request additional information from insurers as necessary**.
- The goal of the adjustment is to *estimate* what total spending might be for those members without having to collect claims data from carve-out vendors, such as PBMs or behavioral health vendors.

Updated Definitions
TME – Claims Categories

Similar to last year, there are eight claims categories for TME. The bolded categories have updated specifications for the 2020 submission year.

1. Hospital Inpatient
2. Hospital Outpatient
3. **Professional, Physician**
4. **Professional, Specialty**
5. **Professional, Other**
6. **Pharmacy**
7. **Long-Term Care**
8. **Other**

This webinar will focus on changes made to these eight claims categories and will not review the specifications of these categories in detail. Please refer to these slides at a later time or to the Insurer TME data specification instructions for additional information.

Updated definitions
TME – Claims Categories (Cont'd)

- **Hospital Inpatient**: No change
- **Hospital Outpatient**: No change
- **Professional, Primary Care**: Please use the following code level definition to identify primary care spending:
  - Taxonomy = 207Q00000X, 207QA0505X, 207QG0300X, 208D00000X, 207R00000X, 207RG0300X, 208000000X, 363L00000X, 363LA2200X, 363LP0200X, 363A00000X, 363AM0700X, 363LF0000X, 363LG0600X or 363LP2300X **AND**
  - Place of Service = 11, 71, 50, 17, 20, 02 or 12 **AND**
  - Procedure Code = 90460-90461, 90471-90474, 98966, 98967, 98968, 98969, 99201 99205, 99211-99215, 99241-99245, 99339-99340, 99324-99328, 99334-99337, 99341-99345, 99347- 99350, 99354-99355, 99358, 99359, 99381-99385, 99386-99387, 99391-99395, 99396- 99397, 99401-99404, 99406-99409, 99411-99412, 99420, 99429, 99441, 99442, 99443, G2010, 99444, 99495-99496, G0008, G0009, G0402, G0438-G0439, G0444, G0463, G0502-G0507, S9117, T1015, 99492-99494, 99483, 99487, 99489, 99490, G0506, G0511, G0467, G0468 or G0010.
  - *Updated to include a revised, code-level definition of primary care and to rename the spending category to recognize more than just physicians provide primary care.*

Updated Definitions
TME – Claims Categories (Cont'd)

- **Professional, Specialty**: All TME data 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 as primary care in the definition above.
  - *Updated to include reference to primary care provider types and services and to rename the spending category to recognize more than just physicians provide specialty care.*
- **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.
  - *Updated to include reference to primary care provider types and services.*

Updated Definitions
TME – Claims Categories (Cont'd)

- **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. This category should not include claims paid for pharmaceuticals under the insurer's medical benefit. Medicare managed care insurers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data is to be reported gross of applicable rebates.
  - *Updated to rename spending category to clarify what is to be reported.*
- **Long-Term Care**: All TME data from claims to health care providers for skilled or custodial nursing facility services, intermediate care facilities for individuals with intellectual disability, home health care services, home- and community-based services, assisted living, personal care (e.g., services in support of activities of daily living), adult day care, respite care, hospice, and private duty/shift nursing services.
  - *Updated to include intermediate care facilities for individuals with intellectual disability, assisted living, personal care (e.g., services in support of activities of daily living), adult day care and respite care.*

Updated Definitions
TME – Claims Categories (Cont'd)

- **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 DHCC about 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.
  - *Updated to specify that insurers should consult with DHCC about the appropriate placement of the service prior to categorizing it as "Claims: Other."*

Updated Definitions
TME – Non-Claims Categories

There are now nine non-claims categories for TME. Several previous categories have been divided into two separate categories to capture primary care and non-primary care spending. The bolded categories are new and/or have updated specifications for the 2020 submission year.

1. **Primary Care Incentive Programs**
2. **Incentive Programs, for Services Other Than Primary Care**
3. **Primary Care Capitation**
4. **Capitation, for Services Other Than Primary Care**
5. **Risk Settlements**
6. **Primary Care, Care Management**
7. **Care Management, Other Than for Primary Care**
8. Recovery
9. **Other**

This webinar will focus on changes made to these nine non-claims categories and will not review the specifications of these categories in detail. Please refer to these slides at a later time or to the Insurer TME Data Specification instructions for additional information.

Updated Definitions
TME – Non-Claims Categories (Cont'd)

- **Primary Care Incentive Programs**: All payments made to 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.
  - *Updated the previous spending category to separate reporting of primary care and non-primary care incentive program spending.*
- **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.
  - *Updated the previous spending category to separate reporting of primary care and non-primary care incentive program spending.*

Updated Definitions
TME – Non-Claims Categories (Cont'd)

- **Primary Care Capitation**: All payments made to PCPs (use the Claims: Professional, Primary Care definition for "primary care") made not on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.
  - *Updated the previous spending category to separate reporting of capitation and risk settlement spending and to separate reporting of primary care and non-primary care capitation spending.*
- **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 on the basis of claims (i.e., capitated amount). Amounts reported as capitation should not include any incentive or performance bonuses paid separately, and can be separately reported as Non-Claims: Incentive Program.
  - *Updated the previous spending category to separate reporting of capitation and risk settlement spending and to separate reporting of primary care and non-primary care capitation spending.*

Updated Definitions
TME – Non-Claims Categories (Cont'd)

- **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, and can be separately reported as Non-Claims: Incentive Program.
  - *Updated the previous spending category to separate reporting of capitation and risk settlement spending.*
- **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.
  - *Updated the previous spending category to separate reporting or primary care and non-primary care care management spending.*
- **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.
  - *Updated the previous spending category to separate reporting or primary care and non-primary care management spending.*

Updated Definitions
TME – Non-Claims Categories (Cont'd)

- **Recovery**: No change.
- **Other**: All other payments made pursuant to the insurer's contract with a provider not made on the basis of 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. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.
  - *Updated to include future reporting of any COVID-19 related financial support make to providers.*

Pharmacy Rebate Record File

- **Pharmacy Rebates**: Specifications are unchanged, with the exception that member months are now eliminated from the reporting requirement.
  - *The template was updated so that pharmacy rebates may only be input as negative values.*

Market Enrollment File

- The Market Enrollment file caused some confusion during the past reporting period.
- This file captures the number of members participating in a plan categorized by the insurer according to its benefit arrangement. There are new codes for each market enrollment category.

Market Enrollment 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
907	Medicaid/CHIP managed care
908**	Medicare/Medicaid duals

*New category code numbers.
**New category for the 2020 submission year.

File Submission

- Insurers are asked to submit separate Excel files with their CY 2018 data and CY 2019 data, respectively, on or before September 1, 2020 (but not before the 180 days of claims runout) to: ayanna.harrison@delaware.gov and dhcc@delaware.gov.
- Insurers should re-submit data for CY 2018 and newly submit data for CY 2019. Insurers are asked to resubmit new CY 2018 data using the updated specifications in the Implementation Manual Version 2.0.
- Data submitted in formats other than the template provided will be rejected.
- Along with the updated specifications, there are also updated Excel spending templates to use. Insurers should submit their completed files using the following format:
  - Insurer Name_TME_YYYY_Version.xls.
- The file must be in .XLSX or .XLS format.

Excel Spending Template Orientation

- The Excel spending template has undergone significant changes from last year. It now includes:
  - A “Contents” tab that outlines all tabs in the workbook.
  - A set of “Mandatory Questions” for insurers to indicate the reporting year and verify alignment of reported data with the Implementation Manual.
  - A “Definitions” and “Reference Tables” tab for insurers to reference for additional support when completing the template.
  - Hover-over text for columns in the “HD-TME”, “Large Provider Record”, “Rx Rebates” and “Market Enrollment” tabs to provide quick information about the data category to be reported.
  - Conditional formatting to help insurers align with the reporting format outlined in the Implementation Manual and streamline DHCC analysis after reporting.
- We will now do a live walk through of the Excel spending template.

Net Cost of Private Health Insurance

- The Net Cost of Private Health Insurance (NCPHI) 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.
- The Implementation Manual now:
  - Requires insurers to submit all names for which it is "doing business as" in the State of Delaware in the Header Record File to assist DHCC in calculating the Medicare Managed Care market NCPHI.
  - Specifies the member months reported in the Market Enrollment File will be utilized to calculate NCPHI.
  - Includes instructions for how DHCC should aggregate NCPHI, specifically for adjusting commercial data to use in situ information.

Net Cost of Private Health Insurance (Cont'd)

- This year, 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 September 1.
- In the event the MLR report submitted to DHCC on or before September 1, 2020 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: ayanna.harrison@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 Data Submission Instructions

Quality Benchmarks Data
Detailed Reporting Requirements

- Insurers should submit an Excel file with their performance data for the required health care quality measures for CY 2019 performance year by insurer and/or provider for the DHCC to calculate performance against the quality benchmarks.
- The Excel file template is located here (see Attachment 4: Quality Benchmark Performance Submission Template): https://dhss.delaware.gov/dhcc/global.html
- Insurers should input their data into the cells used as examples, and not alter the file in any other way.
- Insurers may refer to this webinar and the insurer quality data reporting manual for more information on how to populate the Excel file.
- The components of the Excel file will be described in this webinar.

Quality Benchmarks Data
Detailed Reporting Requirements (Cont'd)

- Insurers are required to submit performance for the following three health care measures.
  - Insurers are no longer required to submit data for "Concurrent Use of Opioids and Benzodiazepines.' The health care opioid-related measure is TBD.

Measure	Specification	Line of Business	Reporting Unit
Opioid-related measure	TBD	TBD	TBD
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

Quality Benchmarks Data
Detailed Reporting Requirements (Cont'd)

- One Attachment 4 template should be submitted per insurer. Similar to the spending benchmark, **the completed file should contain all required health insurer and provider-level information with *at least* 180 days of claims runout**.
- Insurers should submit an Excel file with the data described in the insurer quality data reporting manual and through this webinar on or before September 1, 2020 (but not before the 180 days of claims runout) to: ayanna.harrison@delaware.gov and dhcc@delaware.gov.
- We will now do a live walk through of the Excel quality template.

Questions?

Services provided by Mercer Health & Benefits LLC.