Calendar Year 2021 Results

Benchmark Trend Report

State of Delaware
Department of Health and Social Services

Contents

1. Executive Summary

This is the third annual Benchmark Trend Report (Report) produced by the Department of Health and Social Services (DHSS). This Report summarizes the spending and quality data collected from all payers who participated in the benchmark data collection process. Unless otherwise noted, the data contained herein represents spending and quality data incurred (i.e., dates of service) in:

- Calendar year (CY) 2021 Estimate (spending)
- CY 2020 Final
- CY 2019 Final

It is important to remind users of this Report that the benchmark data collection process has its own unique reporting requirements and methodology. Therefore, direct comparisons of this data to any other external data source of Delaware health care spending or per capita values should not be done. All spending data is net of pharmacy rebates.

The DHSS considers this Report an important tool for raising awareness and spurring dialogue regarding the level of and type of health care spending occurring in Delaware along with what Delawareans are receiving in terms of quality outcome results. Please note, the spending data in this Report does not include federal or state COVID-19 relief/special payments. See page 11 for more information about COVID-19 relief/special payments.

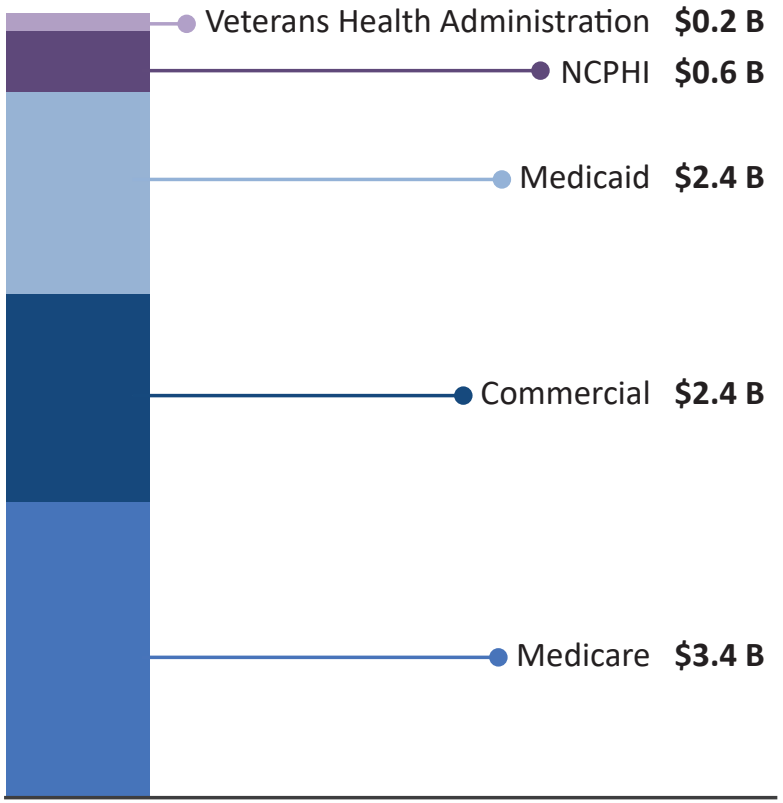
CY 2021 Per Capita Spending versus Spending Benchmark

Delaware's spending benchmark is the year-over-year percentage change in total health care expenditures (THCE) expressed on a per capita basis. For the CY 2021 performance period, the spending benchmark was set at a 3.25 percent growth rate. As shown in Figure 1-1, Delaware's total CY 2021 THCE was approximately $9.1 billion. The per capita amount was $9,088 which represents a 11.2 percent year-over-year increase. The 11.2 percent per capita increase is significant, but this figure reflects Delaware's health care market rebounding from the reduction in health care spending and utilization in CY 2020 caused by the COVID-19 pandemic. As shown in Figure 2-1, every state experienced a large increase in per capita health care spending in 2021.

11.2%

On a per capita basis, THCE increased 11.2% relative to the CY 2021 spending benchmark of 3.25%.

Figure 1-1: CY 2021 State Total Health Care Expenditures
Aggregate and Per Capita



Total Overall Spending $9.1 B

THCE per capita $9,088

CY 2021 Quality Results versus Quality Benchmarks

In addition to the State level per capita spending benchmark, Delaware established annual quality benchmarks for several different quality measures. For the respective quality measures, Delaware-specific benchmarks were set through CY 2021.

DHSS added the Use of Opioids at High Dosages as a new quality benchmark beginning with the CY 2020 performance period while discontinuing the Adult Tobacco Use and High School Students Who Were Physically Active quality benchmarks.

As noted in last year's Report, for CY 2020 the National Committee for Quality Assurance (NCQA) changed the methodology for reporting Emergency Department Utilization and thus no results were available. For CY 2021, results have been obtained, however, the CY 2021 benchmark was developed using the older methodology and hence caution should be exercised when interpreting the 2021 results.

As seen in the table below, relative to each respective quality benchmark, CY 2021 results across the six quality measures were mixed:

Quality Measures	CY 2021 Benchmark	CY 2021 Results	Notes
Adult Obesity	28.7%	33.9%	Lower result is better
Use of Opioids at High Dosages	11.6%	9.6%	Lower result is better
Opioid-related Overdose Deaths	14.7 deaths per 100,000	48.1 deaths per 100,000	Lower result is better
Emergency Department Utilization	178.0 visits per 1,000 Commercial only	163.0 visits per 1,000 Commercial only	Lower result is better
Persistence of Beta-Blocker Treatment After a Heart Attack	87.2% Commercial 81.3% Medicaid	88.5% Commercial 80.7% Medicaid	Higher result is better
Statin Therapy for Patients with Cardiovascular Disease	81.0% Commercial 63.7% Medicaid	81.8% Commercial 66.1% Medicaid	Higher result is better

Conclusion

The DHSS appreciates and thanks everyone, particularly our valued insurer partners, who participated in the benchmark process including consultants from Mercer Health & Benefits LLC that assisted in the production of this Report. We look forward to the ongoing collaboration with our stakeholders and data partners to make this Report meaningful and useful to the benefit of all Delawareans.

2. Introduction

This is the third annual Benchmark Trend Report (Report) produced by the Department of Health and Social Services (DHSS). This Report summarizes the spending and quality data collected from all payers who participated in the benchmark data collection process. Unless otherwise noted, the data contained herein represents spending and quality data incurred (i.e., dates of service) in:

- CY 2021 Estimate (spending)
- CY 2020 Final
- CY 2019 Final

It is important to remind users of this Report that the benchmark data collection process has its own unique reporting requirements and methodology. Therefore, direct comparisons of this data to any other external data source of Delaware health care spending or per capita values should not be done. Prior to this year's data collection cycle, data was voluntarily submitted by payers. However, HA 1 for HB 442, signed on August 19, 2022, by Governor Carney, mandated the provision of benchmark data. All spending data is net of pharmacy rebates.

The DHSS considers this Report an important tool for raising awareness and spurring dialogue regarding the level of and type of health care spending occurring in Delaware along with what Delawareans are receiving in terms of quality outcome results. Please note, the spending data in this Report does not include federal or state COVID-19 relief/special payments. See page 11 for more information about COVID-19 relief/special payments.

Refreshed CY 2020 Spending Data

For this benchmark data collection cycle, CY 2020 spending data was collected again. All Figures in this Report reflect the refreshed CY 2020 spending data.

Spending Data and Benchmark

The spending benchmark is measured as the annual change in Delaware's per capita total health care expenditures (THCE). The reported per capita change is then compared to the established spending benchmark target applicable to each CY. THCE sums total medical expense (TME) and the estimated net cost of private health insurance (NCPHI) at the State level and divides by Delaware's state population to arrive at a State level per capita figure for each CY. Please see the Glossary in Section 8 for more information about the terms used throughout this Report.

The spending benchmark for CY 2021 (i.e., the per capita change from CY 2020) was set at a 3.25 percent growth rate.

As shown in Figure 3-2, the CY 2021 change in Delaware's THCE per capita amount was 11.2 percent. The 11.2 percent increase is significant, but this figure reflects Delaware's health care market rebounding from the reduction in health care spending and utilization in CY 2020 caused by the COVID-19 pandemic. As indicated in Figure 2-1, every state experienced a large increase in per capita health care spending in 2021. Please note that the data in Figure 2-1 is not directly comparable to the benchmark data contained in this Report.

More information on the development of the benchmarks, the data collection process, and the implementation manual can be found on DHSS's website at https://dhss.delaware.gov/dhcc/global.html. In an addition to this Report, DHSS will post an Appendix 1 - Benchmark Data Tables CY 2021 that is an Excel-based document containing all the underlying data that were used to create this Report.

Quality and Spending Interactive Dashboard

The DHSS is pleased to announce that there will be a new, online and interactive quality and spending dashboard posted to the DHSS's website where the public can view and download benchmark data. The dashboard is expected to be updated annually to further support the data collection and summarization process and is expected to go live in Spring 2023.

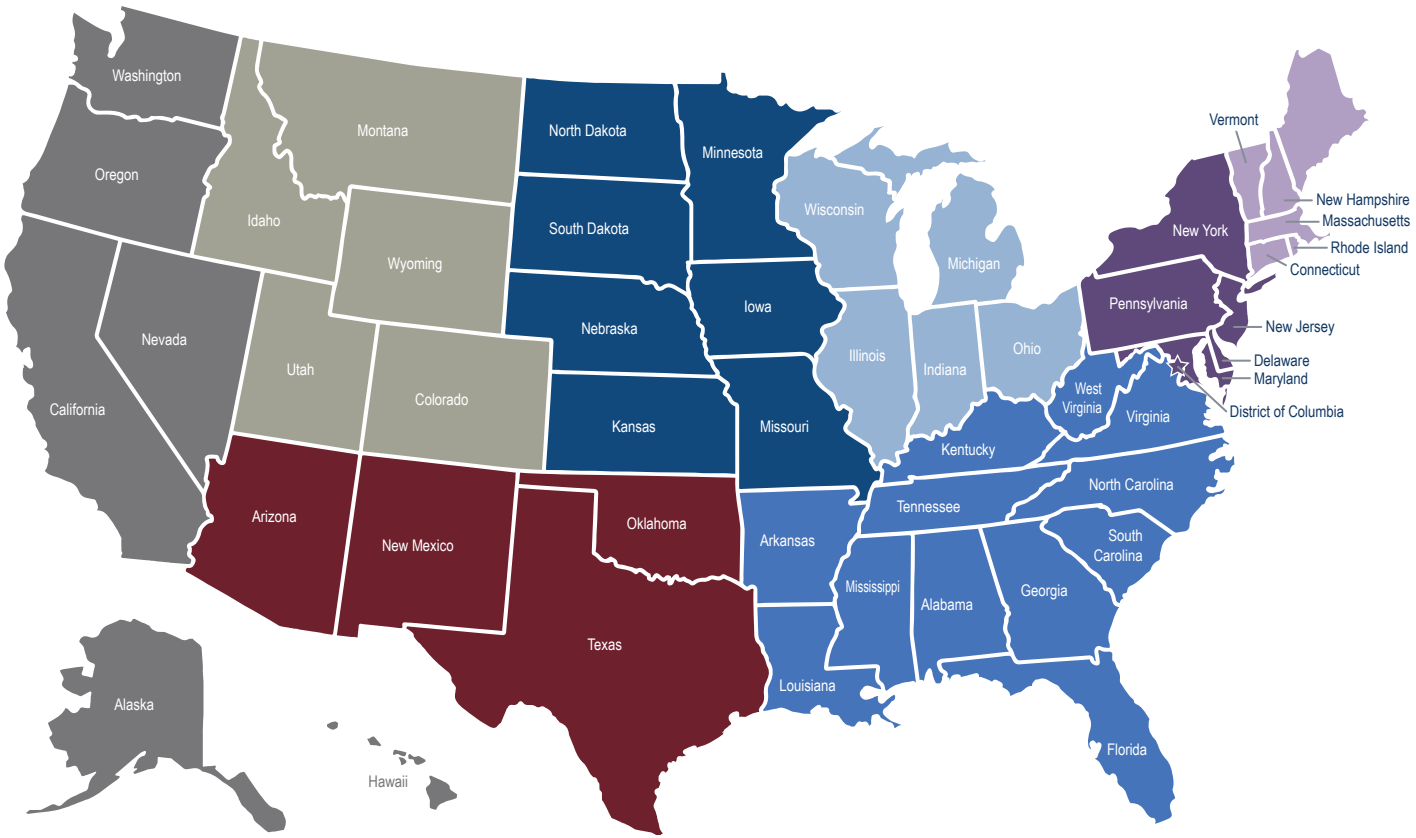
DHSS thanks every entity's participation in this process and we look forward to an ongoing collaboration in each annual cycle.

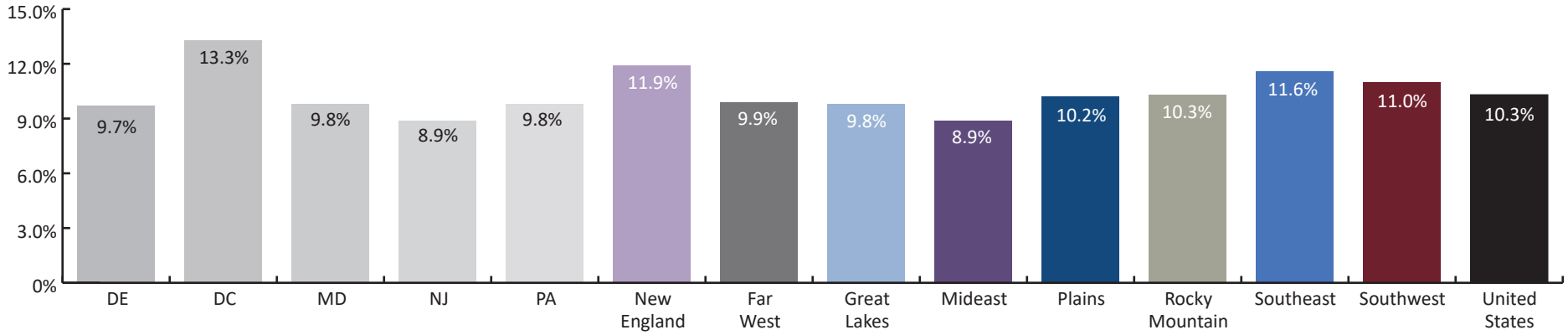
Table 2-1: Spending Data Sources

Spending Data	Data Source	Notes
Commercial Data	Carriers serving Delaware: • Aetna • Cigna • Highmark • United Healthcare (UHC)	Carriers with multiple lines of business were required to provide data on all lines. For example, Cigna provided spending data on their commercial operations as well as their Medicare Advantage operations (i.e., Cigna Bravo). United Healthcare did provide data on their Medicare Advantage program.
Medicaid Data[1]	• Delaware's Division of Medicaid and Medical Assistance (DMMA) • Amerihealth Caritas of Delaware (ACDE) and Highmark Health Options (Highmark)	DMMA was the source of Medicaid fee-for-service (FFS) spending data. The insurers provided data on the Medicaid managed care program.
Medicare Data	• Centers for Medicare and Medicaid Services (CMS) • Aetna • Cigna	CMS provided Medicare Part A and B spending on FFS beneficiaries only as well as total Part D[2] (pharmacy) spending for all Medicare FFS and managed care enrollees. The insurers provided spending data on Medicare Advantage (managed care).
VHA Data	• Veterans Health Administration public report	Detailed spending from the VHA is not available. Only aggregate member count and total health care spending on Delaware veterans is available. VHA data is reported on a federal fiscal year (FFY) basis which runs October-September. For purposes of this Report FFY 2021 = CY 2021.
NCPHI	• Insurer reported data	NCPHI was computed using insurer submitted revenue and expenditure data.

1 Unless otherwise noted, references to "Medicaid" in this Report includes data on both the Title XIX Medicaid program and the Title XXI CHIP program.
2 CMS did not provide any Part D pharmacy rebate data and hence the CMS pharmacy spending data is gross of rebates. The only pharmacy rebate information applicable to the Medicare program was provided by the insurers on their respective Medicare Advantage operations.

Figure 2-1: **Bureau of Economic Analysis - Per capita personal consumption expenditures: Health Care 2021 change from 2020**





U.S. Bureau of Economic Analysis, "SAPCE2 Per capita personal consumption expenditures (PCE) by major type of product 1/" (accessed Monday, February 27, 2023).

Quality Data and Benchmarks

Delaware also established annual benchmarks for select number of quality measures.

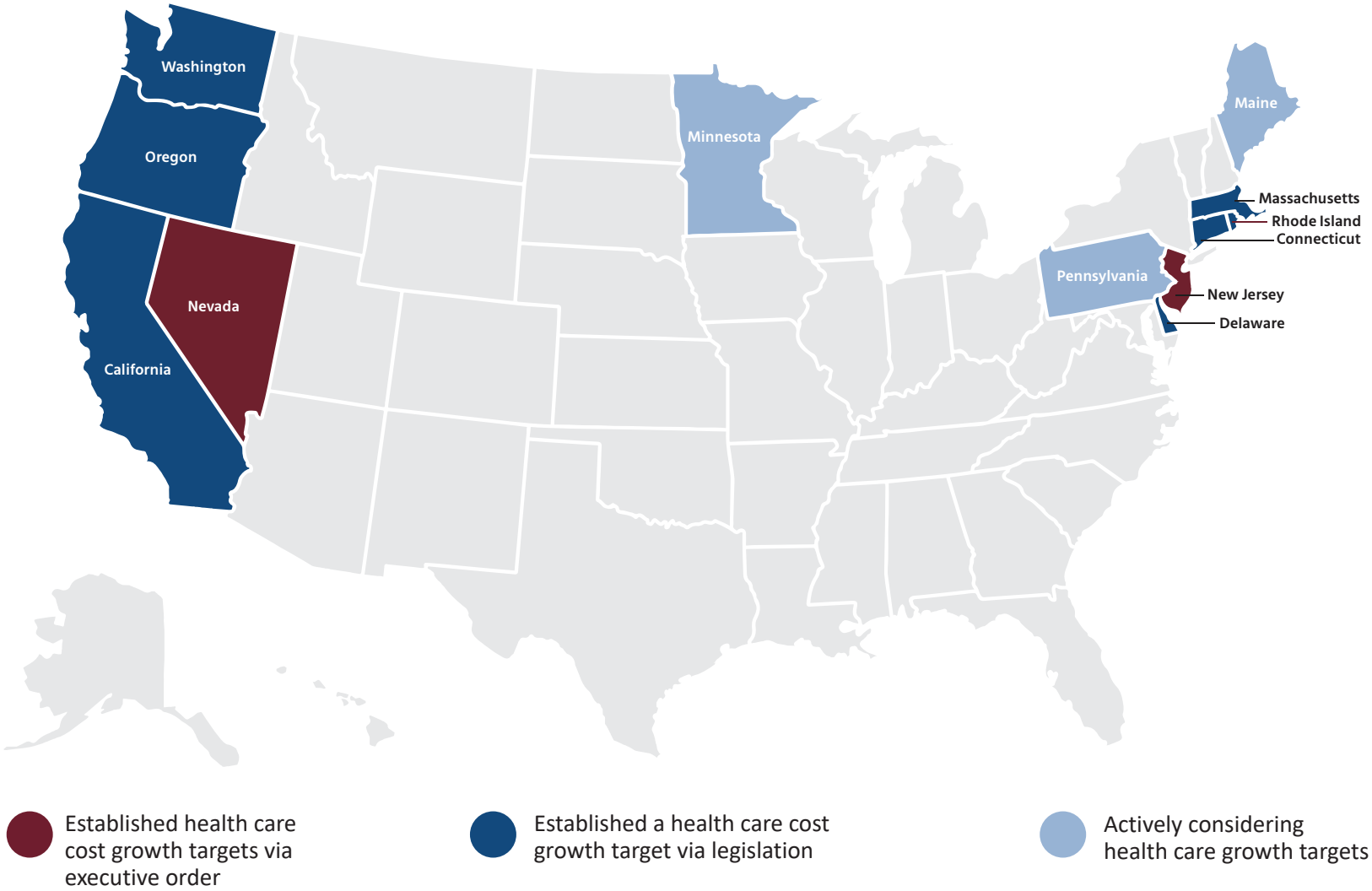
Beginning with the CY 2020 performance period, DHSS added the Use of Opioids at High Dosages as a new quality benchmark while discontinuing the Adult Tobacco Use and High School Students Who Were Physically Active quality benchmarks.

Prior to this year's data collection cycle, data was voluntarily submitted by payers. However, HA 1 for HB 442, signed on August 19, 2022, by Governor Carney, mandated the provision of benchmark data.

Table 2-2: Quality Measures, Population, Data Sources and CY 2021 Benchmark

Quality Measure	Population	Data Source	CY 2021 Benchmark
Adult Obesity	• Statewide (all populations)	• CDC public report	28.7 percent
Use of Opioids at High Dosages	• Statewide (all populations)	• Delaware Prescription Monitoring Program	11.6 percent
Opioid-related Overdose Deaths	• Statewide (all populations)	• CDC public report	14.7 deaths per 100,000
Emergency Department Utilization	• Commercial market	• Delaware insurers	178.0 visits per 1,000
Persistence of Beta-Blocker Treatment After a Heart Attack	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 87.2 percent (Commercial) • 81.3 percent (Medicaid)
Statin Therapy for Patients with Cardiovascular Disease	• Commercial market • Medicaid market (managed care only)	• Delaware insurers	• 81.0 percent (Commercial) • 63.7 percent (Medicaid)

Statewide Health Care Cost Growth Benchmark



Nine states have now established statewide health care cost growth targets, ranging from 2.9% to 3.4%, with many additional states considering similar proposals.

Source: https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/ and https://www.milbank.org/focus-areas/total-cost-of-care/peterson-milbank/

3. Spending Data: State Level

This Section includes several different views of Delaware's health care spending data at the State level.

Even though multiple views of the data have been provided, the value that is directly comparable to the spending benchmark is the State level change in per capita THCE which is shown in Figure 3-3. Other year-over-year comparisons are for informational purposes only.

COVID-19 Impact on CY 2021 Results

This Report focuses on the CY 2021 performance period, a period in which health care utilization, service delivery, and payer and provider finances were significantly impacted by the COVID-19 pandemic. This Report contains actual reported spending and quality results consistent with the benchmark data reporting requirements. Due to the impact of COVID-19, the results for CY 2021 should be viewed in the context of the unprecedented and extraordinary circumstances that occurred throughout CY 2021 and even subsequently into later years. CY 2021 results may not be indicative of the results associated with future years.

CY 2021 THCE increased 12.8% compared to CY 2020

CY 2021 THCE increased in all Delaware markets

Medicare continues to be the largest Market in Delaware

Hospital Inpatient continues to be the largest single service category of TME at the State level

Delaware's total State population increased 1.5%

On a per capita basis, THCE increased 11.2% in CY 2021

As of March 2023, Delaware had received $423 million in relief funds.

AMERICAN RESCUE PLAN
INVESTING *in* DELAWARE

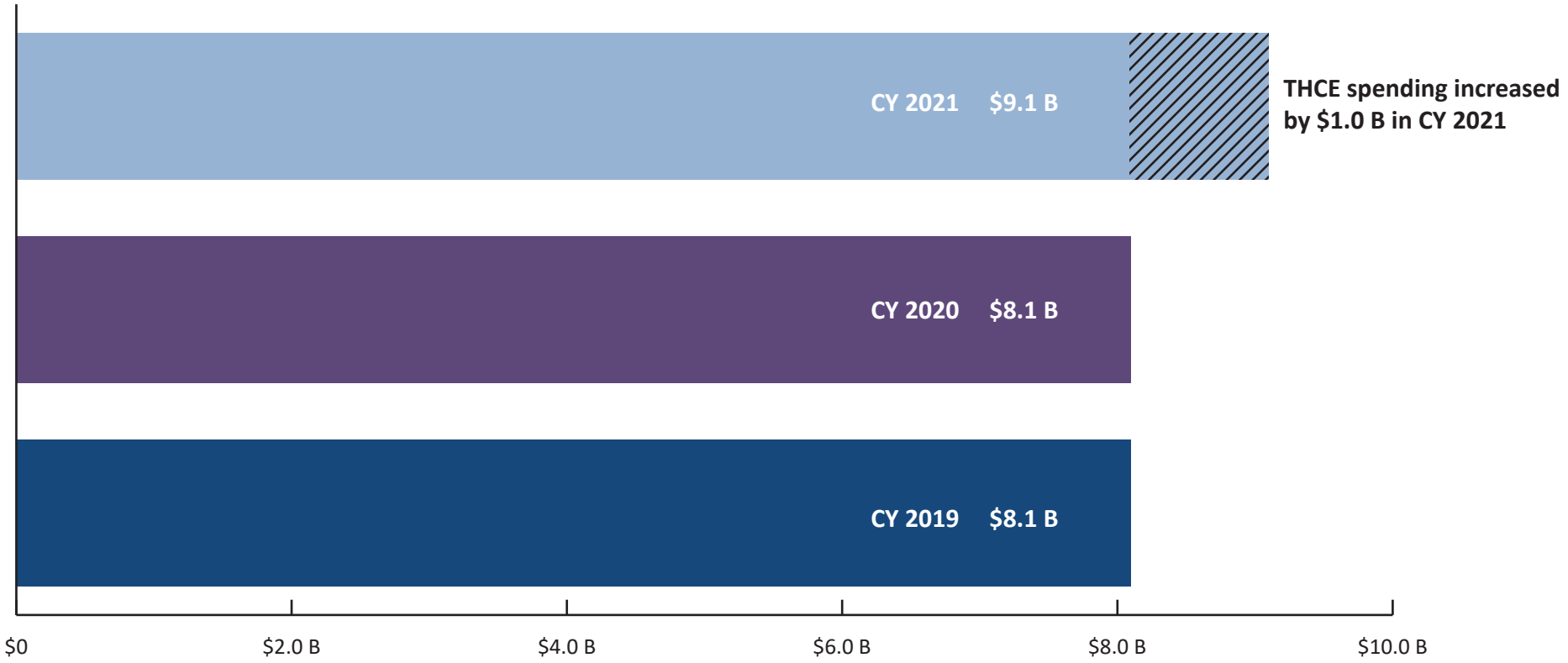
As of March 6, 2023, Delaware had distributed $183.7 million to hospitals, mental health services, and other local health care operations.

COVID-19 RELIEF & SUPPORT
Governor Carney Announces
Health Care Relief Fund

In 2020 and 2021, DHSS distributed $92 million in CARES Act funds to more than 359 health care entities.

The State and Federal COVID-19 relief payments supported Delaware's health care systems through the pandemic by providing financial assistance, medical equipment, and numerous other valuable resources to help keep Delaware residents as safe and healthy as possible.

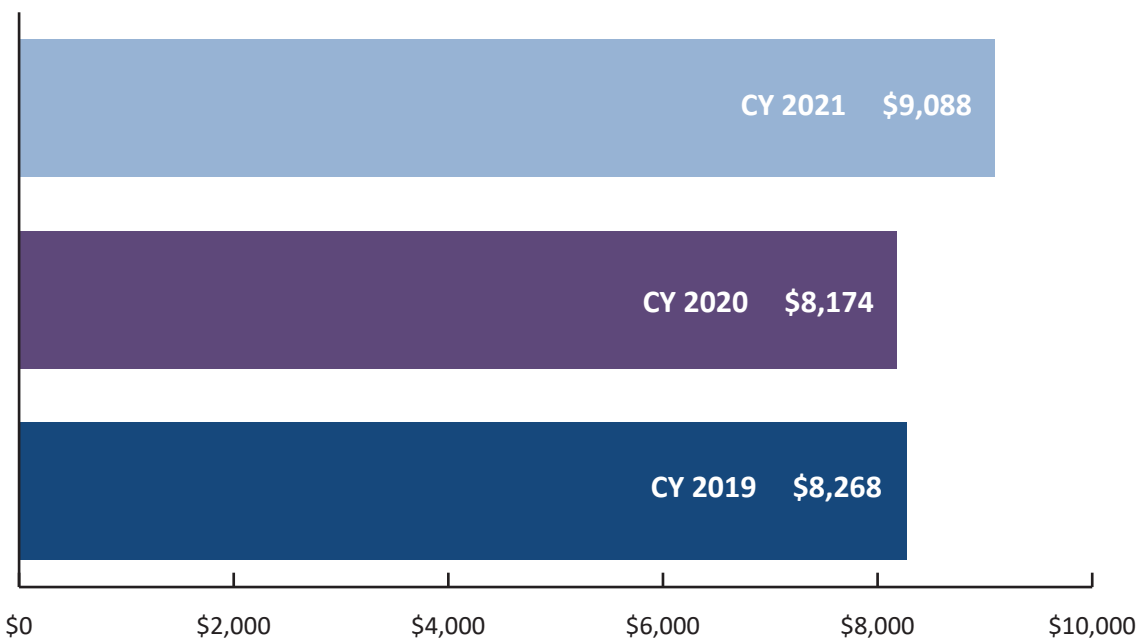
Figure 3-1: State Level Total Health Care Expenditures, Total Spending

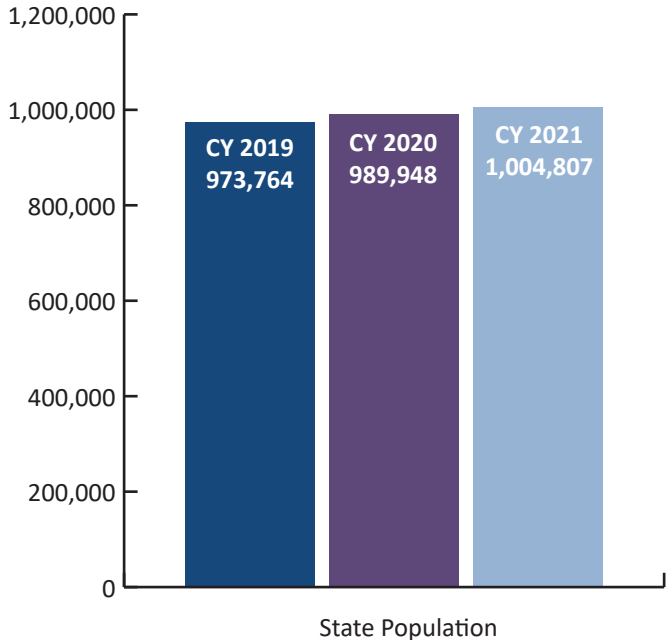


12.8%

THCE spending increased 12.8% or by $1.0 B.

Figure 3-2: State Level Total Health Care Expenditures, Per Capita

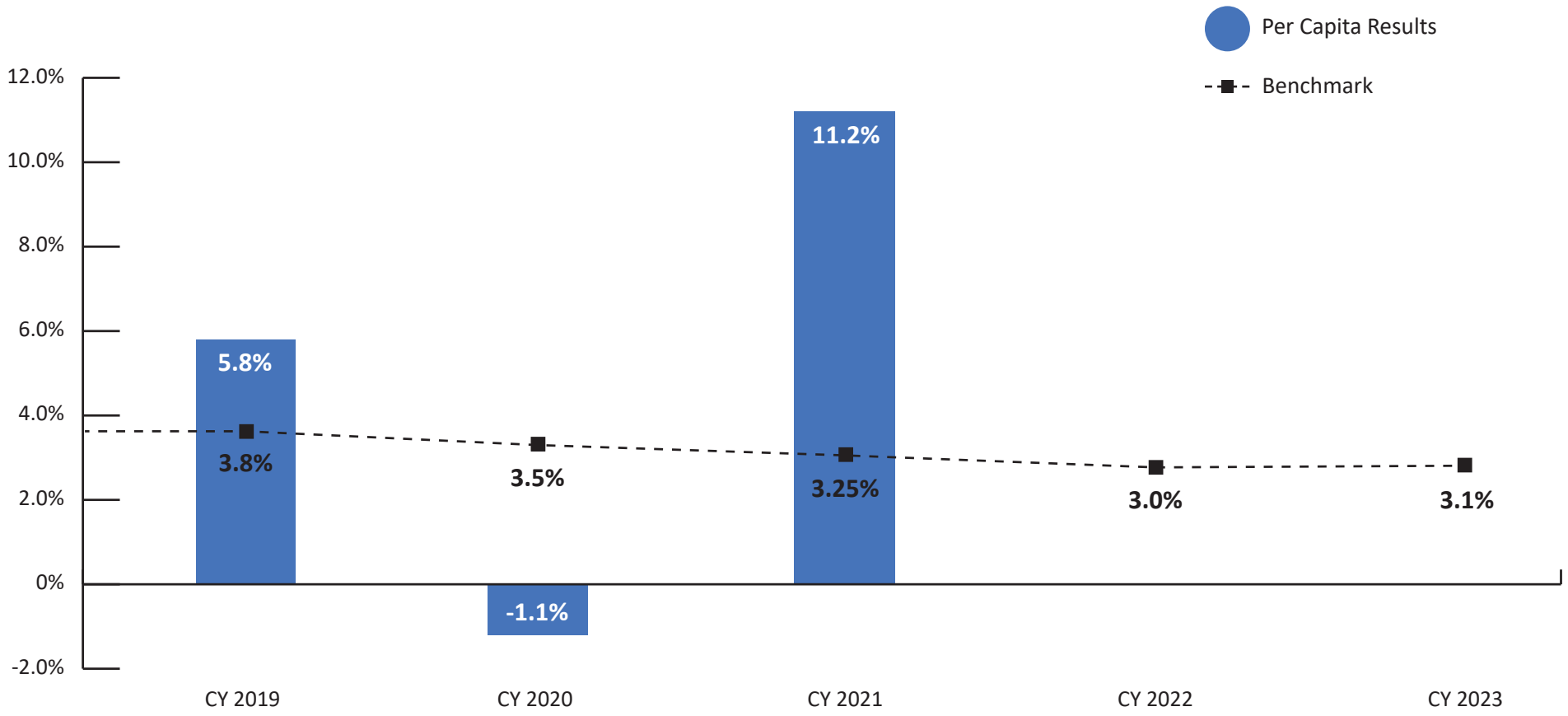




On a per capita basis, THCE spending increased by 11.2% in CY 2021.

Delaware's population increased by 1.5%.

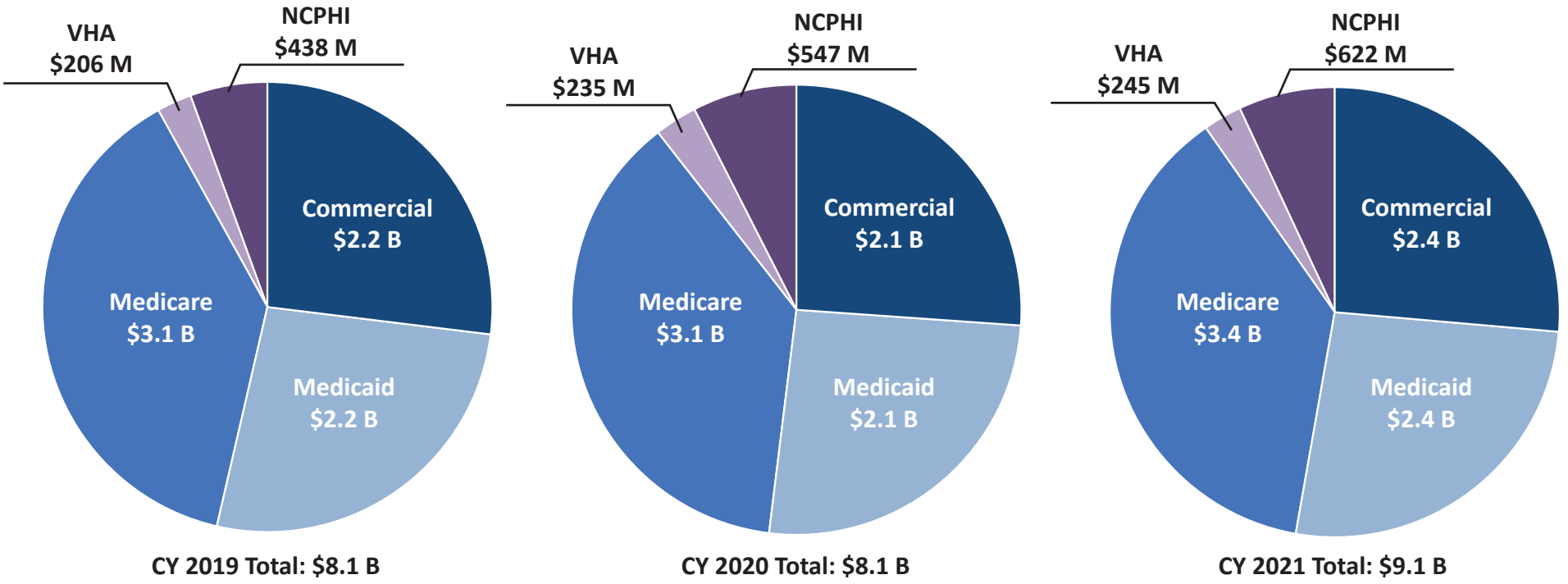
Figure 3-3: State Level Total Health Care Expenditures, Change in Per Capita versus Spending Benchmark



11.2%

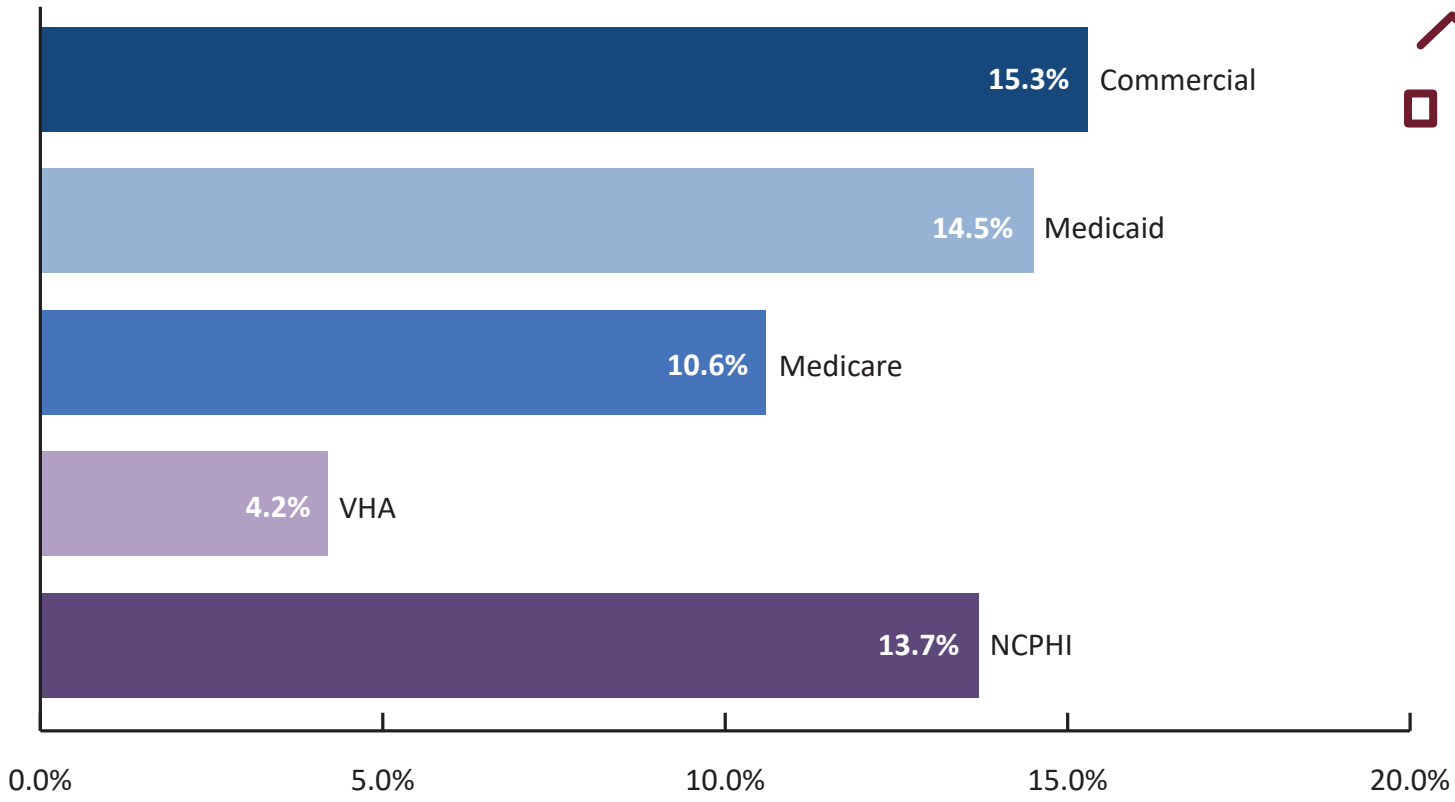
On a per capita basis, THCE increased 11.2% relative to the CY 2021 spending benchmark of 3.25%.

Figure 3-4: Total Health Care Expenditures, Statewide THCE by Component



The Medicare market (inclusive of FFS and managed care) was the largest component of all health care spending.

Figure 3-5: **Total Health Care Expenditures, Annual Change in Statewide THCE by Component**

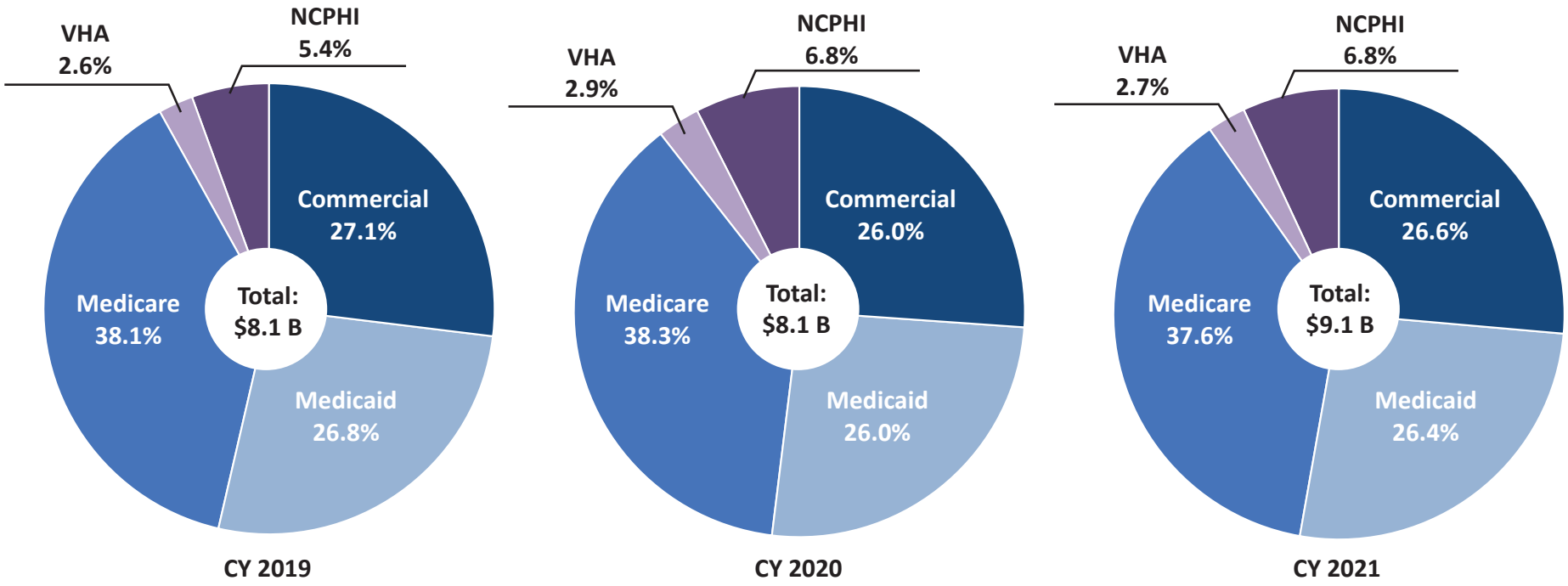


12.8% overall THCE spending growth in CY 2021

Commercial had the largest reported increase in THCE spending at 15.3% in CY 2021.

Variations in each Component share of THCE is expected as enrollment and spending patterns vary from year to year.

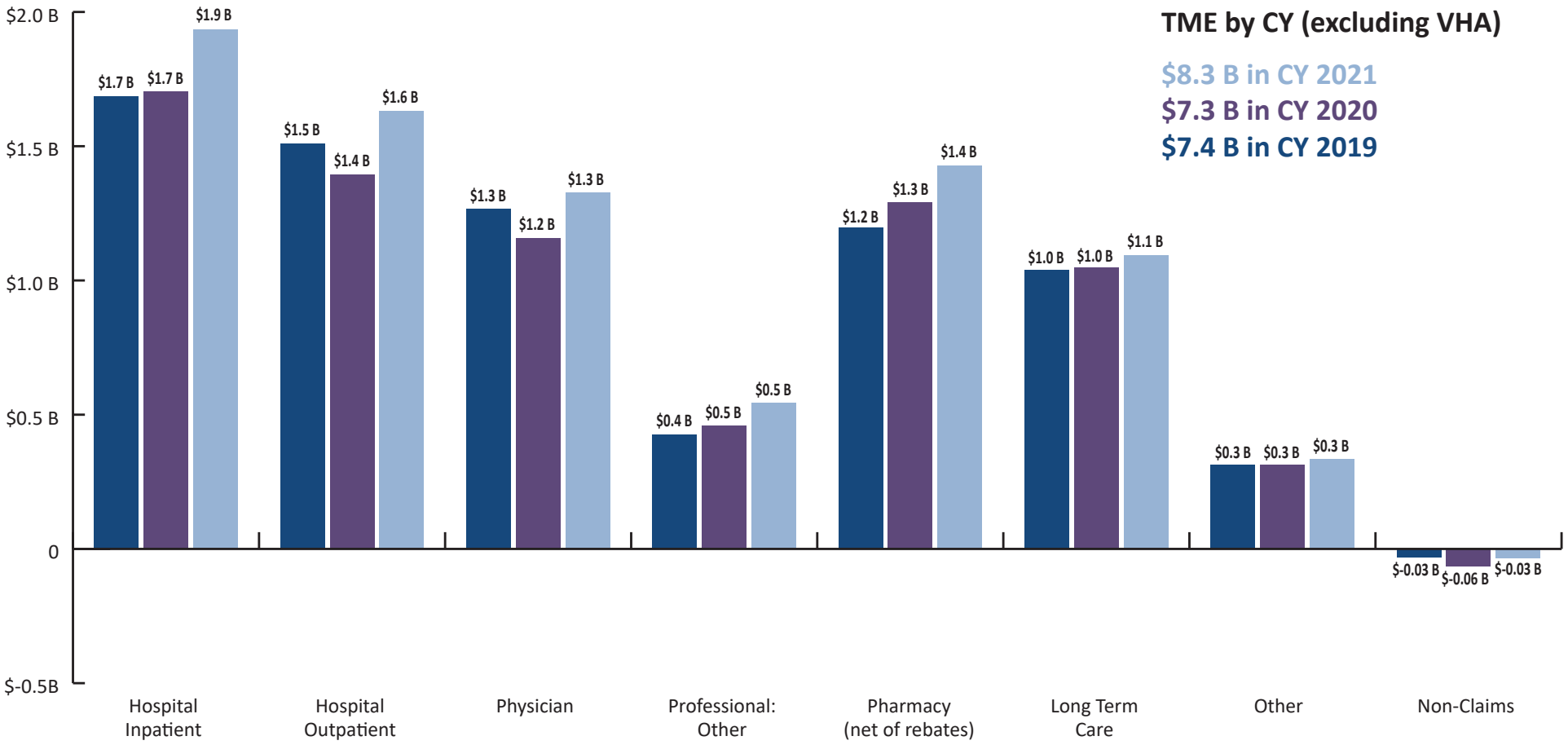
Figure 3-6: Total Health Care Expenditures, Proportion of State Level THCE by Component



By Component, the proportion of THCE remained relatively consistent between CY 2019 and CY 2021.

The VHA remained the smallest component of all health care spending, representing 2.7% of THCE in CY 2021.

Figure 3-7: State Level TME by Service Category (excluding VHA)

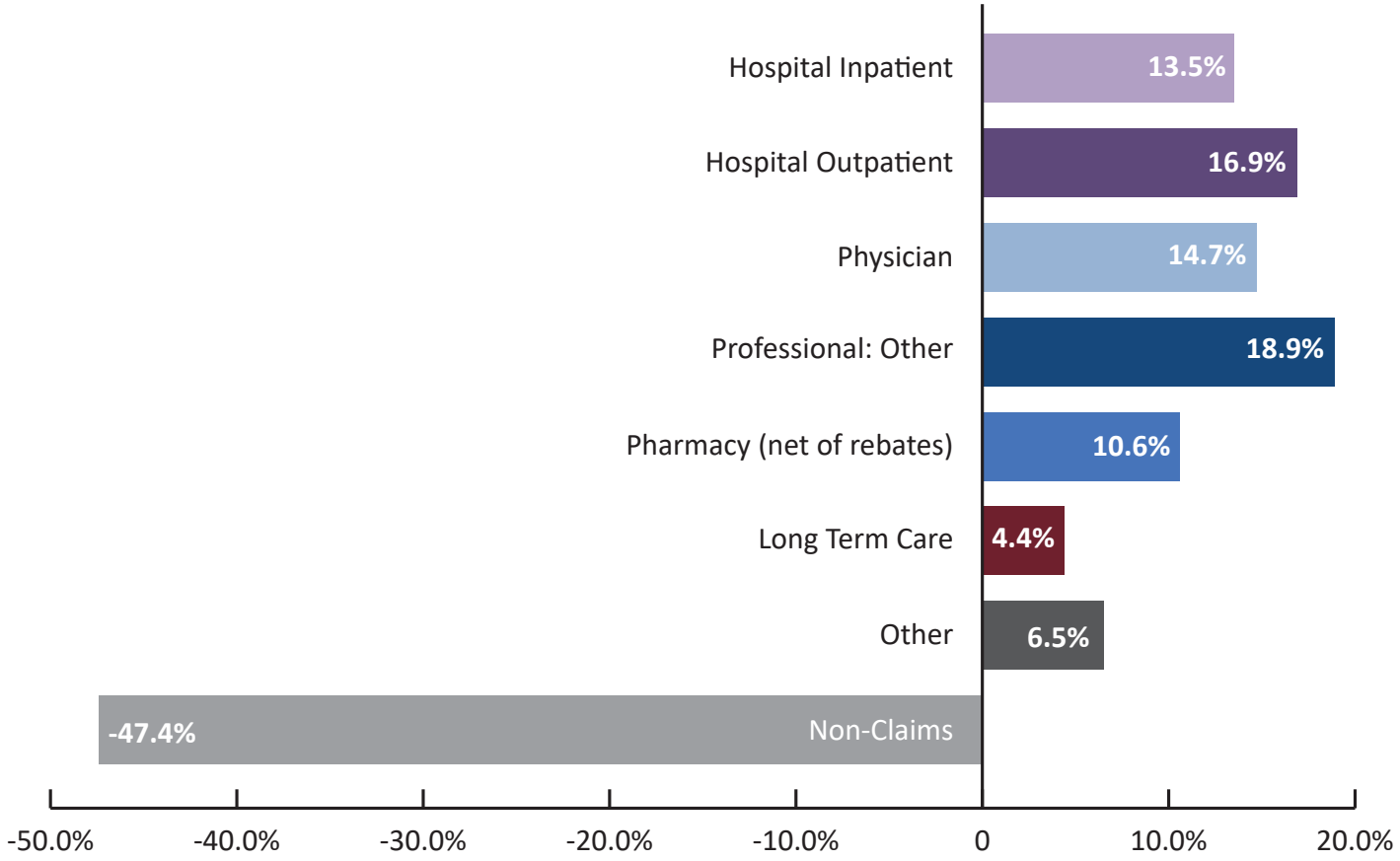


13.1%

TME increased 13.1% in total in CY 2021.

Hospital Inpatient continues to be the largest, single TME service category.

Figure 3-8: CY 2021 Change in State Level TME by Service Category (excluding VHA)



Non-Claims spending had the largest percentage change going from -$64 million in CY 2020 to -$34 million in CY 2021.

Professional Other increased the most in CY 2021 among the claims categories.

4. Spending Data: Market Level

For purposes of this section of the Report, DHSS is including summaries of the benchmark spending data on the four Markets for which data was collected:

- Commercial
- Medicaid (managed care and FFS)
- Medicare (managed care and FFS)
- VHA

In the Commercial market, the insurers offer different insurance products/coverages (e.g., fully insured, self-insured, preferred provider organizations, etc.). NCPHI is only applicable to insurers.

In the Medicaid market, the vast majority of individuals are mandatorily enrolled in managed care resulting in most spending being reported by the two insurers under contract with DMMA in CY 2021. However, DMMA did provide Medicaid FFS spending information on individuals not enrolled in managed care as well as FFS spending on services that are excluded from managed care (e.g., pediatric dental services). NCPHI is not applicable to the Medicaid FFS data.

In the Medicare market, the majority of spending is through the traditional FFS program and hence provided by CMS. Medicare managed care (i.e., Medicare Advantage) spending data was also provided by some insurers. Since CMS did not provide any pharmacy rebate information, the rebates reported by insurers is used to at least partially account for some level of Medicare pharmacy rebates. NCPHI is not applicable to the Medicare FFS data.

The VHA market has limited data available and thus only aggregate health care spending is obtainable. NCPHI is not applicable to the VHA data.

Per member per year (PMPY) values were computed as total CY expenditures divided by estimated number of members in the respective CY.

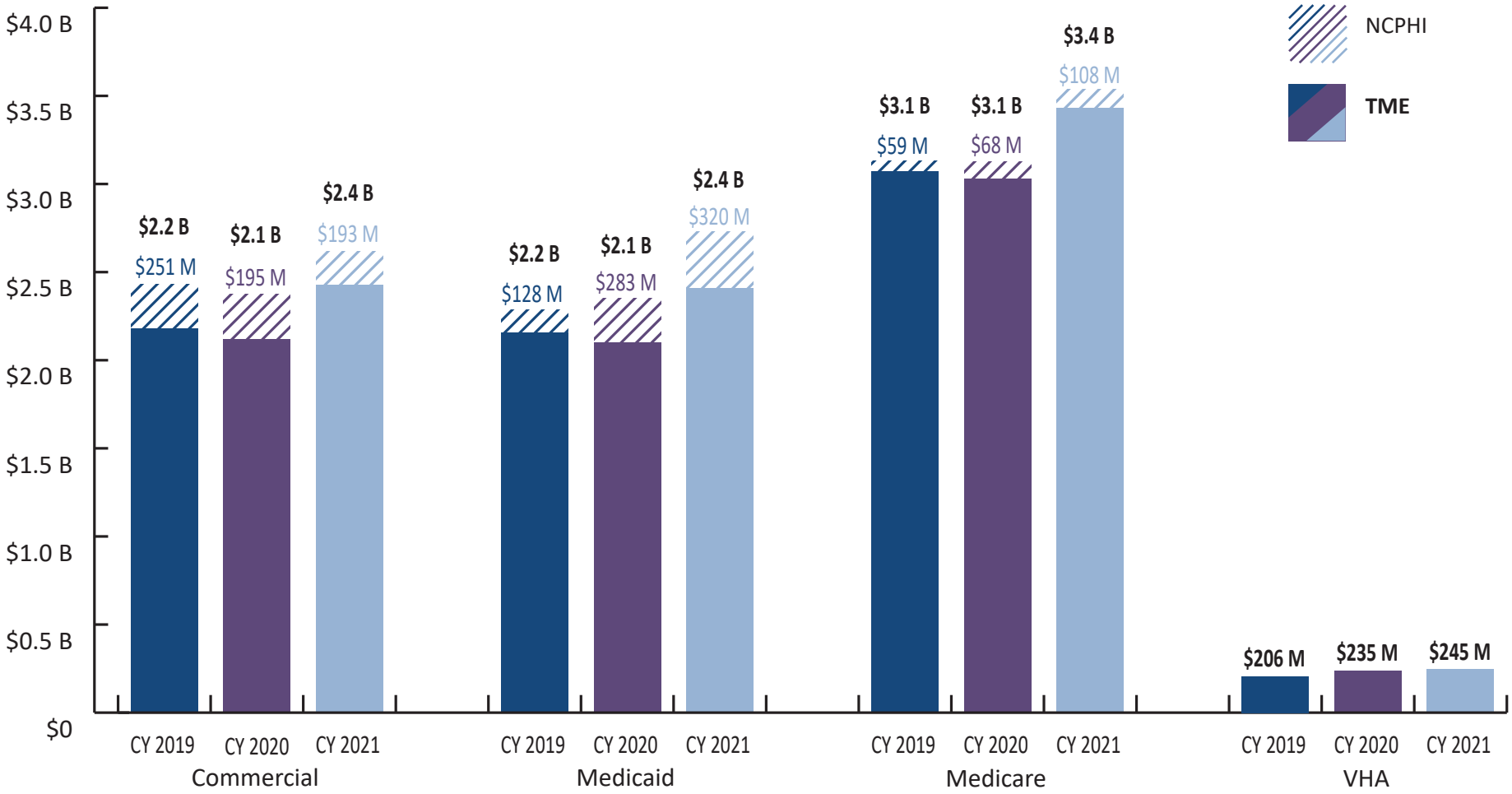
CY 2021 TME increased by $965 million

TME increased in all markets

NCPHI increased by $75 million

The Commercial Market had the largest per capita change in THCE with a 16.5% increase

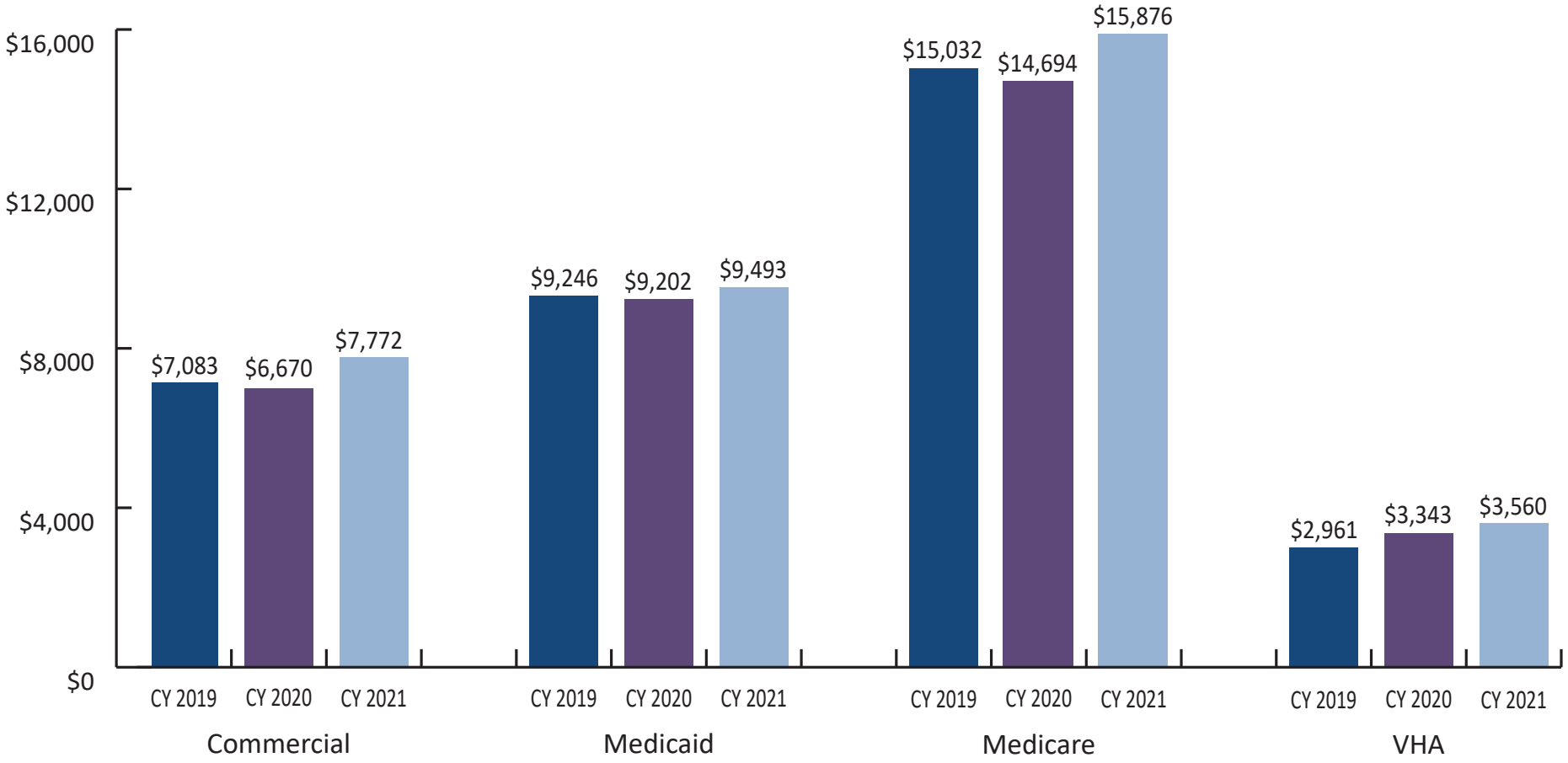
Figure 4-1: Total Health Care Expenditures, Total Spending by Market



TME increased in CY 2021 in all Markets.

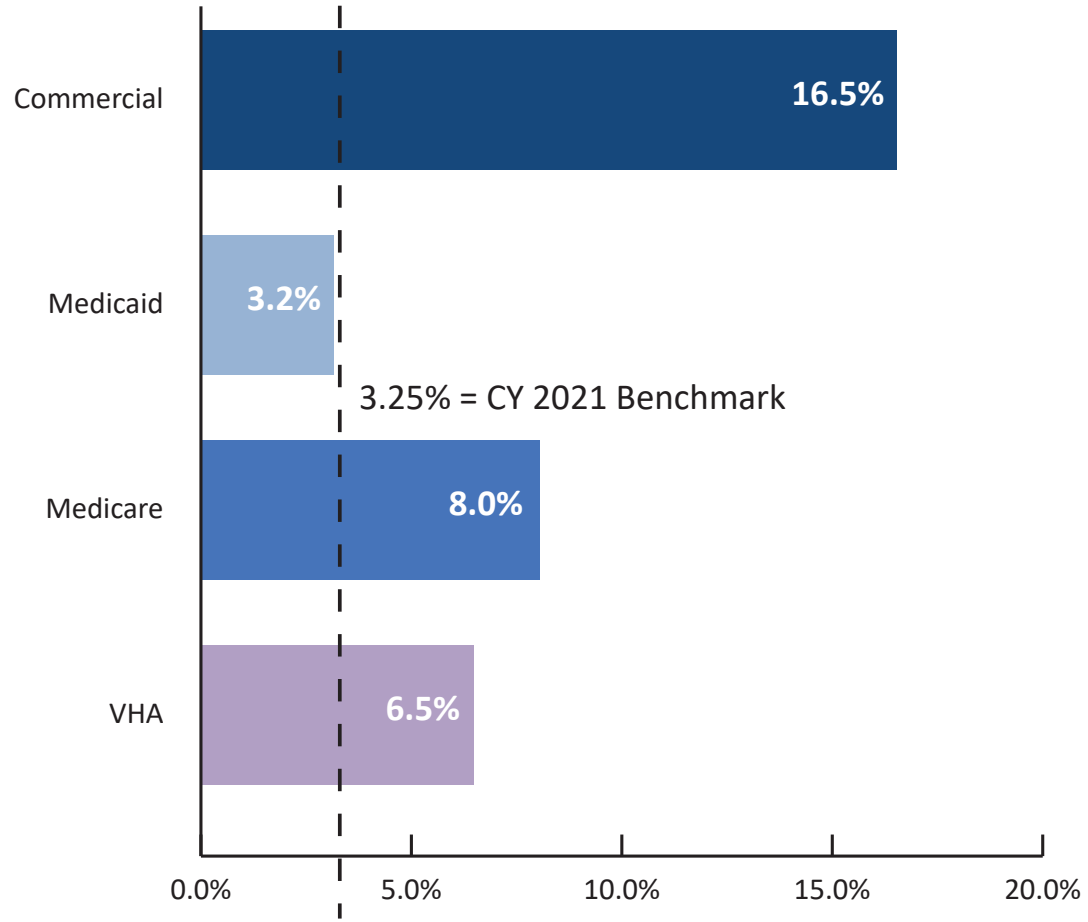
NCPHI for the Medicaid and Medicare Markets reflects the managed care plans only.

Figure 4-2: **Total Health Care Expenditures, THCE Per Member Per Year by Market**



Member counts were estimated for each Market to compute PMPY values. Since members may have coverage in more than one program (e.g., Medicare and Medicaid), member counts are not mutually exclusive.

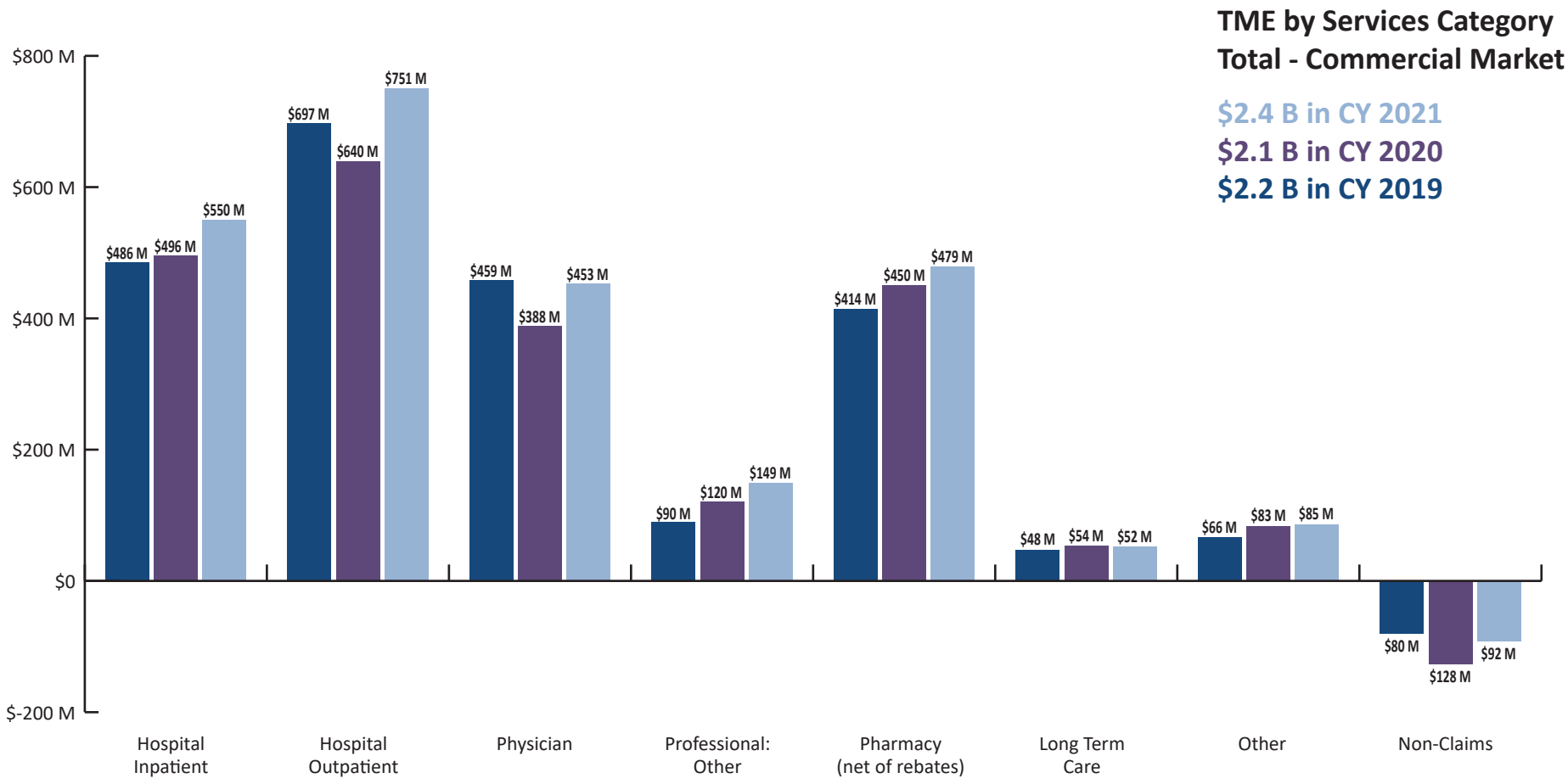
Figure 4-3: Total Health Care Expenditures, CY 2021 THCE Per Member Per Year Change by Market



The THCE spending benchmark is measured at the State level as shown in Figure 3-3.

The CY 2021 THCE per member per year change at the Market level is provided for informational purposes only.

Figure 4-4: TME by Service Category - Commercial Market

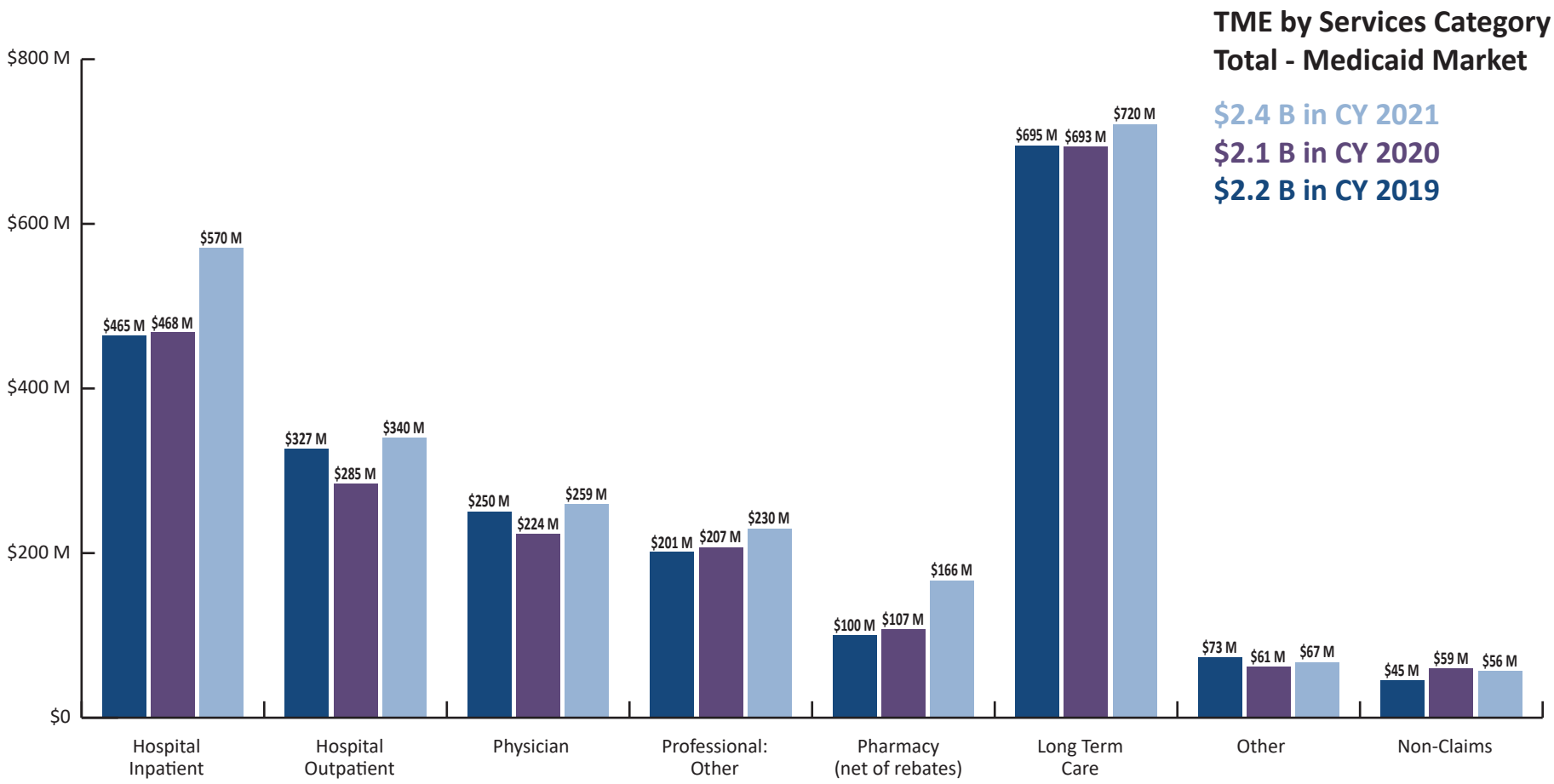


Commercial Market

15.3% TME increased 15.3% in CY 2021.

$2.4 B in CY 2021 TME spend versus $2.1 B in CY 2020.

Figure 4-5: TME by Service Category - Medicaid Market

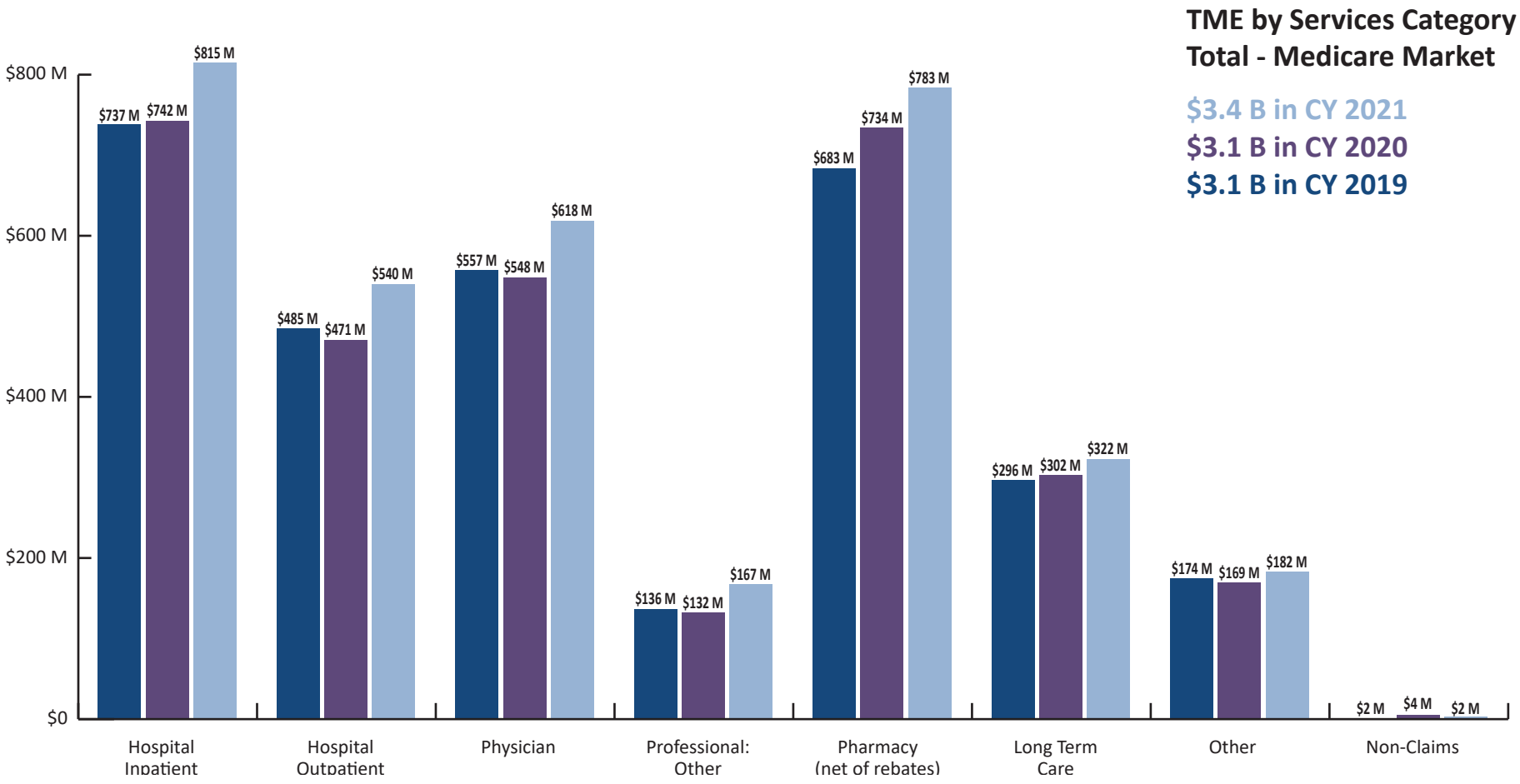


Medicaid Market

14.5% TME increased 14.5% in CY 2021.

$2.4B in CY 2021 TME spend versus $2.1B in CY 2020.

Figure 4-6: TME by Service Category - Medicare Market



Medicare Market

10.6% TME increased 10.6% in total in CY 2021.

$3.4 B in CY 2021 TME spend versus $3.1 B in CY 2020.

5. Spending Data: Insurer Level

The five major health insurers in Delaware all voluntarily provided benchmark spending data as requested by the DHSS. This data included both fully-insured and self-insured programs. Each insurer attested to the accuracy and completeness of their data and each were given an opportunity to review their data for inclusion in this public report.

At an insurer level, changes in the health risk of the respective insurer's member population can change from year-to-year impacting spending levels. A higher risk population is expected to incur higher costs than a lower risk population all else being equal. Therefore, the spending data contained in this section of the Report has been adjusted based on the estimated health risk of each insurer's member population. Since different insurers used different risk adjustment models, results are not directly comparable across insurers. The reader should focus on comparisons of the same insurer for the data provided in this Section of the Report.

Aggregate spending by insurer is a function of the size of the insurer's membership. Insurers with more members are likely to have more spending relative to smaller insurers. On a per member basis, the relative size of each insurer is normalized to a degree.

CY 2021 TME increased by $965 million in total for all insurers

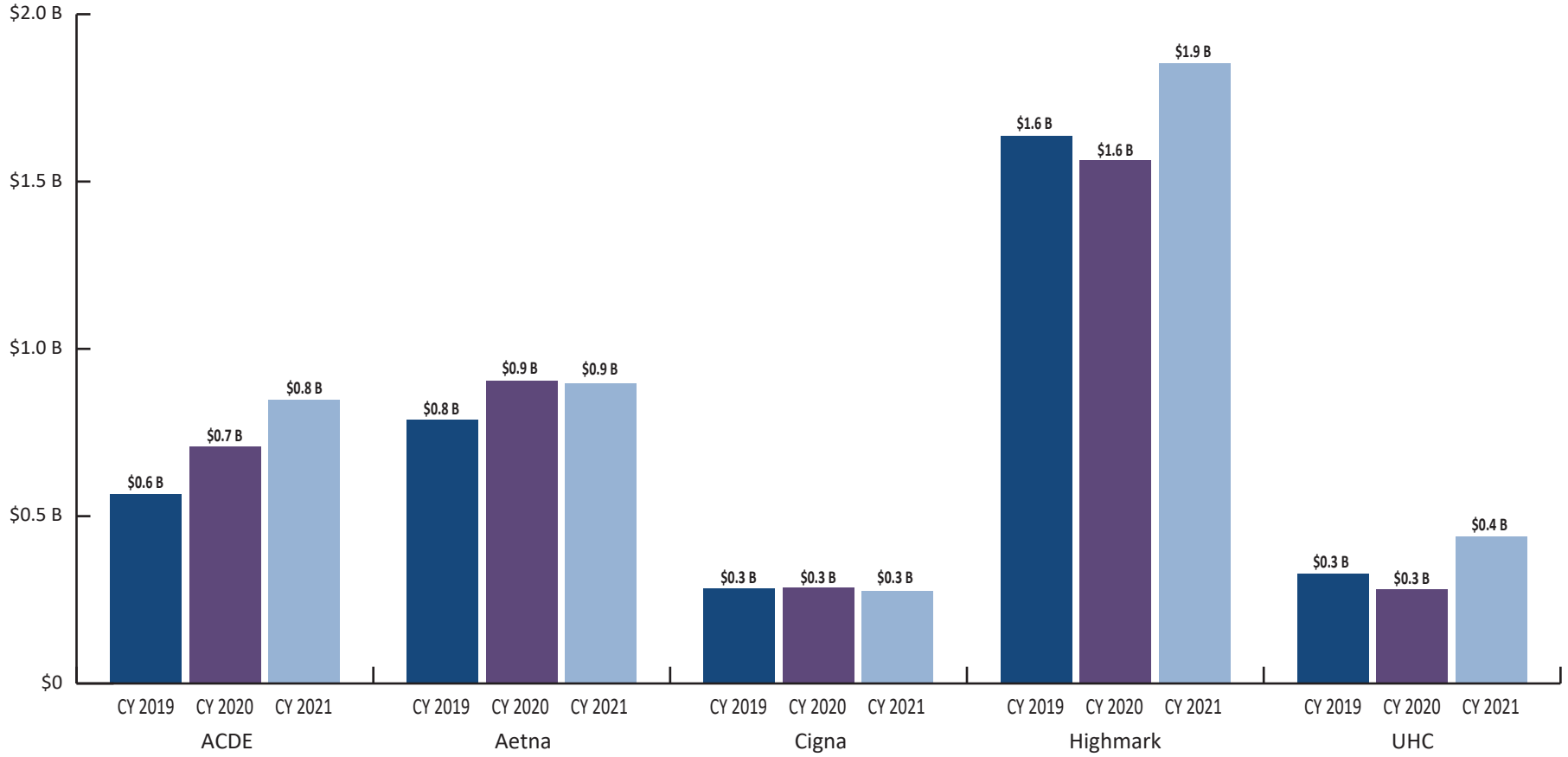
CY 2021 NCPHI increased by $75 million in total for all insurers

Highmark continues to be the largest single Delaware insurer

ACDE and Cigna reported a decrease in their respective CY 2021 THCE PMPYs

Aetna, Highmark, and UHC all reported an increase in their respective CY 2021 THCE PMPYs

Figure 5-1: **Total Health Care Expenditures, Health Risk Adjusted THCE by Insurer**

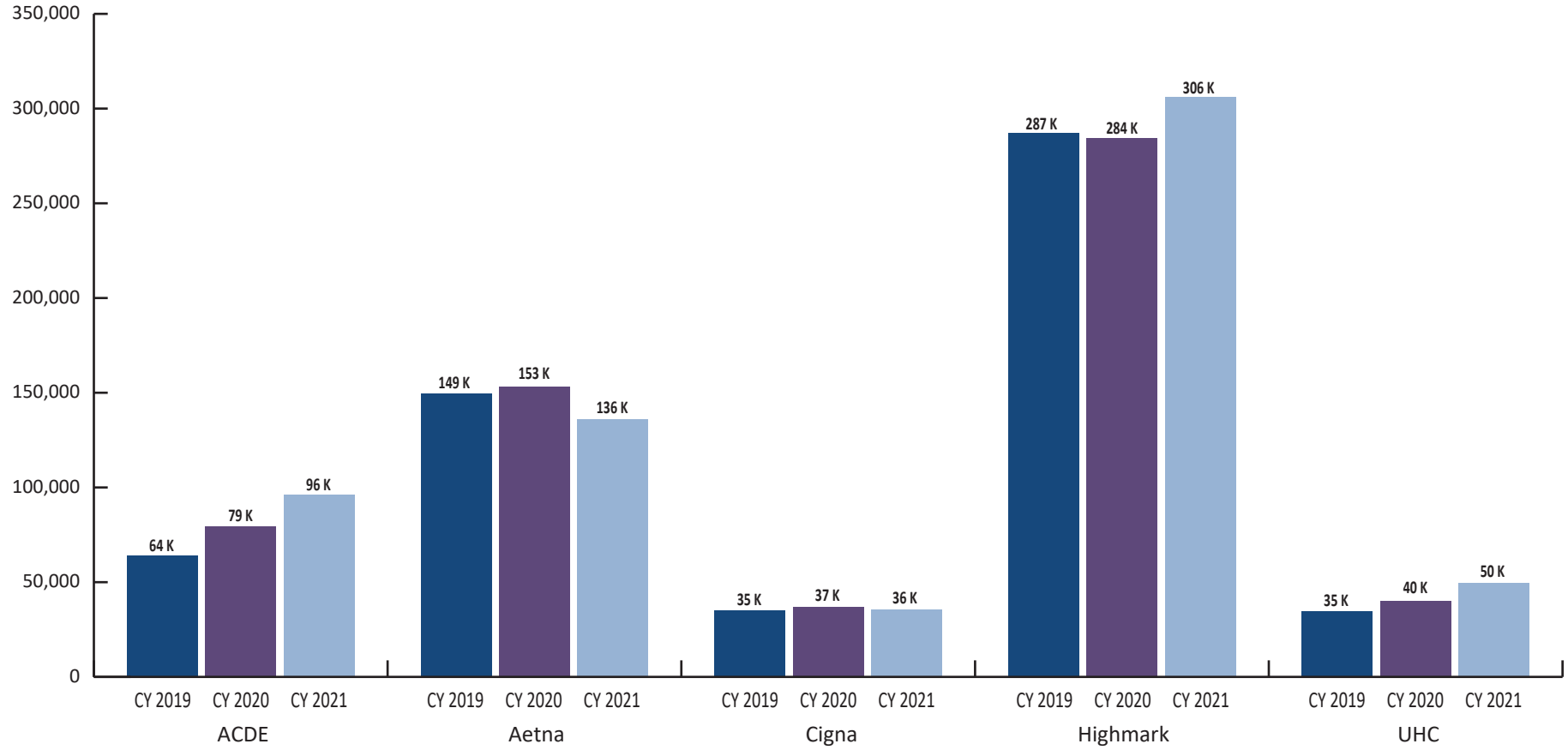


56.5%

UHC has the largest increase in HRA THCE at 56.5%, driven in large part by membership growth.

Highmark was the largest insurer in Delaware in terms of HRA THCE in all CYs.

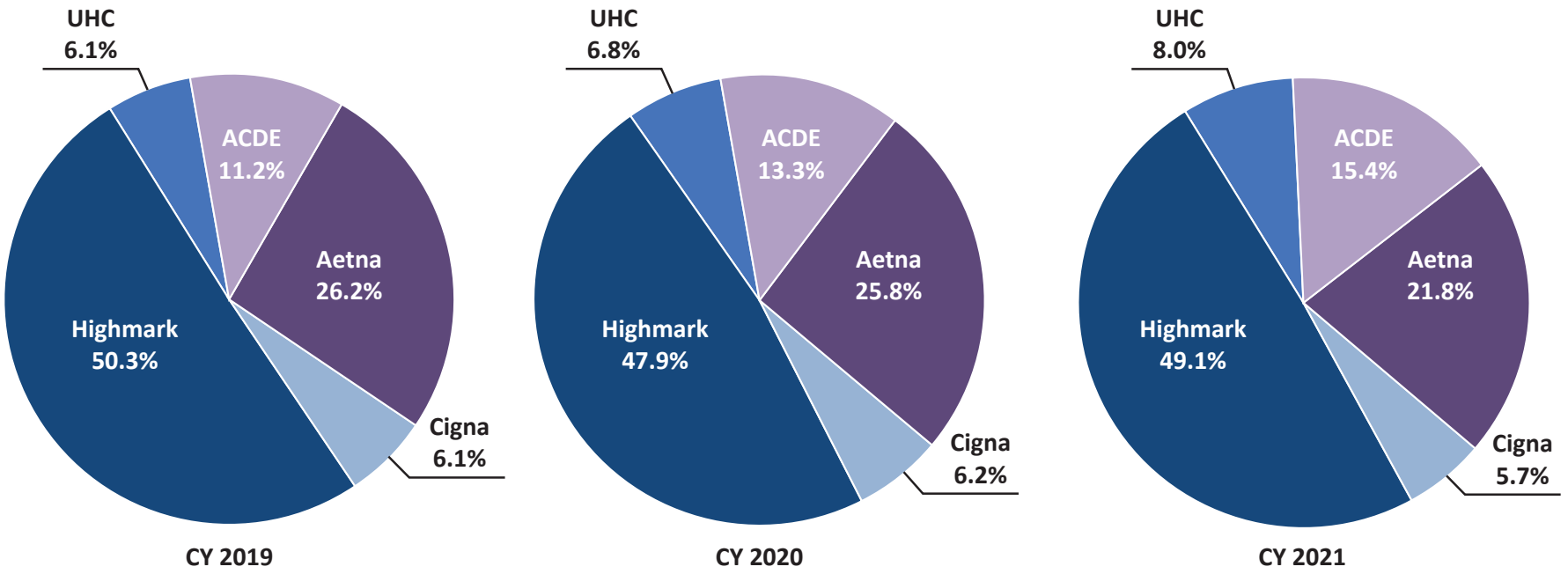
Figure 5-2: Estimated Membership by Insurer



21.2% Estimated membership in ACDE, a Medicaid managed care only insurer, increased 21.2% in CY 2021.

7.7% Membership in Highmark, a multi-line insurer, increased by 7.7% in CY 2021.

Figure 5-3: Estimated Membership Distribution by Insurer

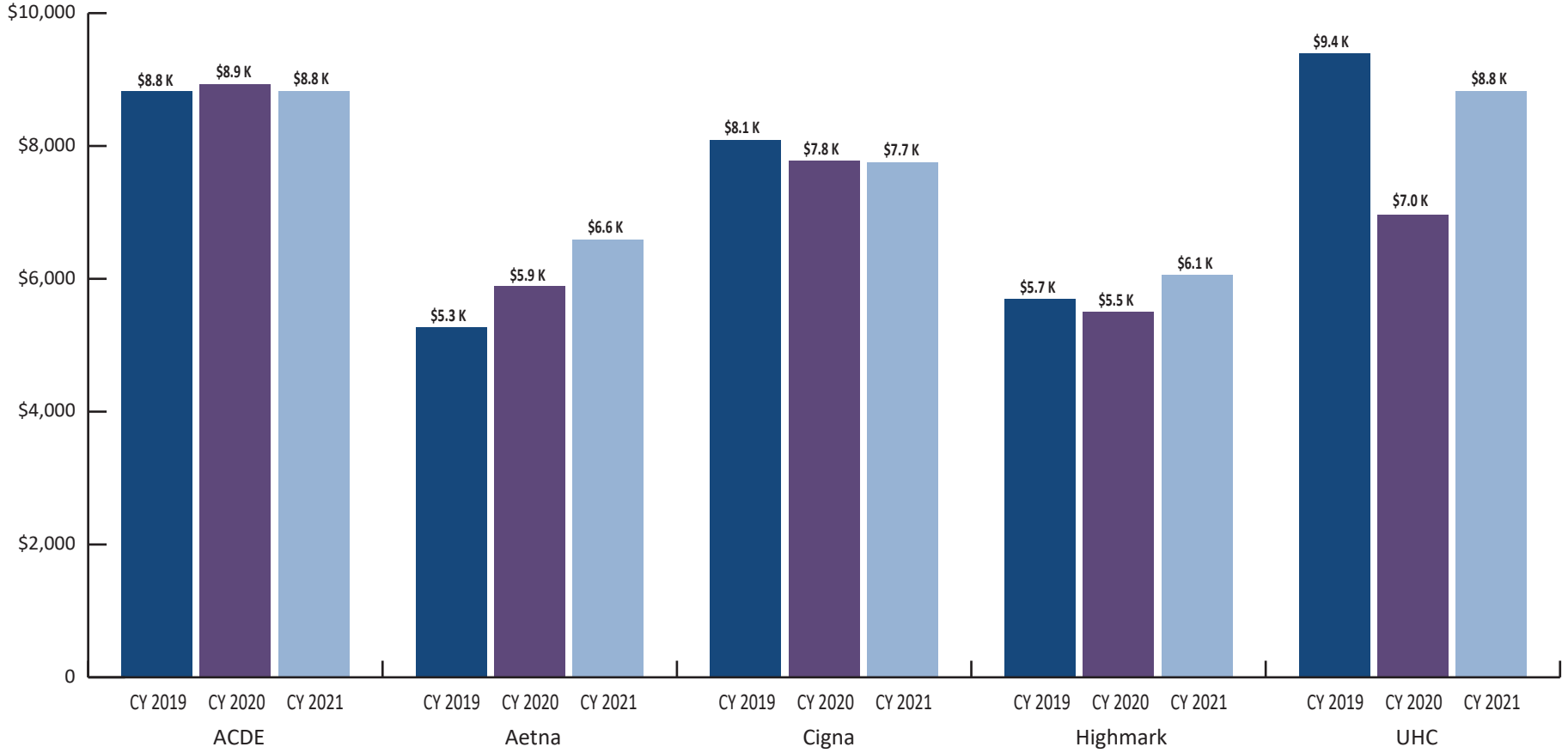


4.9%

Total Insurer membership increased by 29,000 or 4.9% in CY 2021 across all lines of business.

Highmark continues to be Delaware's largest insurer with nearly half of all members.

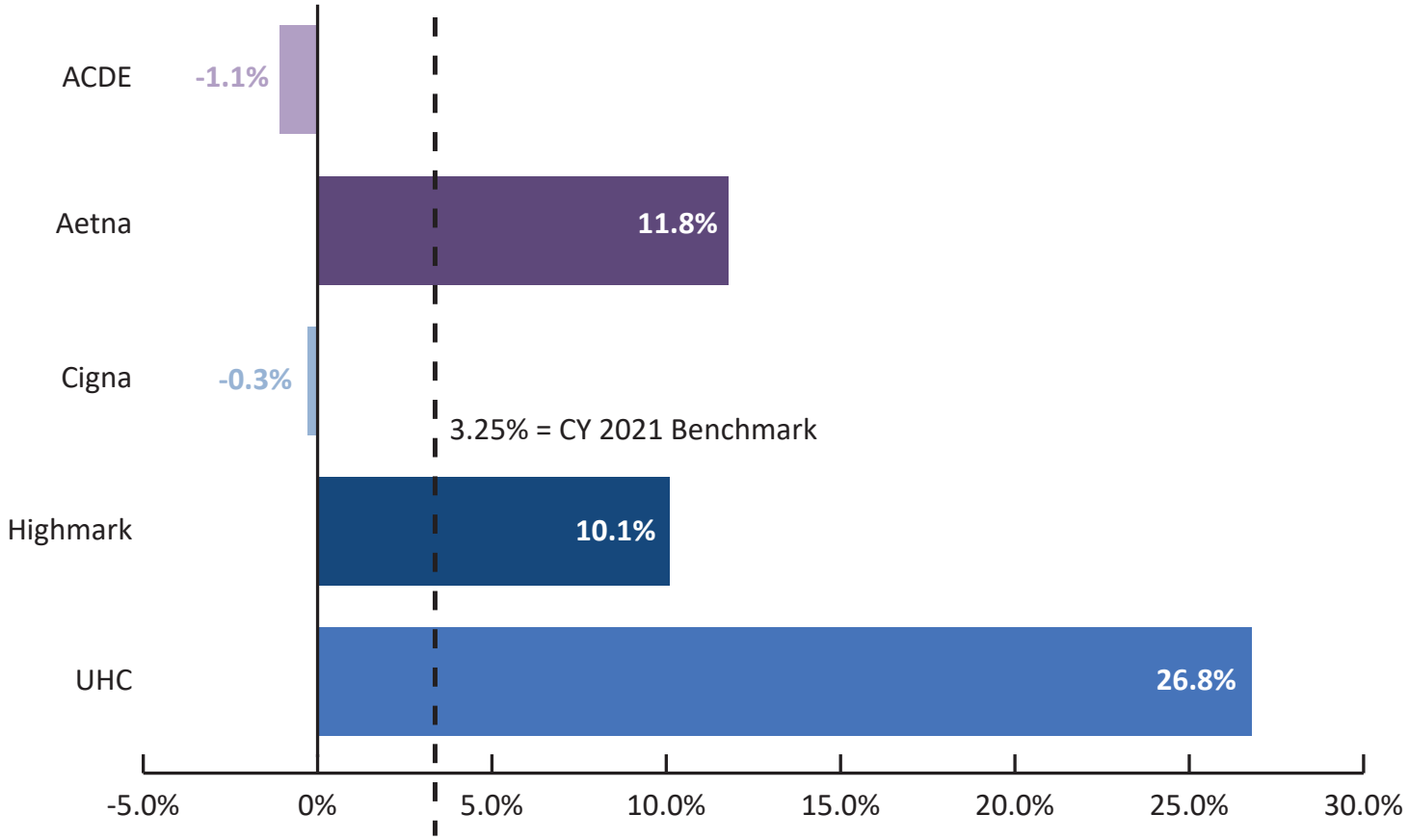
Figure 5-4: Total Health Care Expenditures, Health Risk Adjusted THCE PMPY by Insurer



Data reflects all lines of business reported by each insurer. Insurers do not have all the same lines of business (e.g., ACDE is a Medicaid-only insurer).

As a result of HA 1 for HB442, UHC's data for CY 2021 and CY 2020 includes their Medicare Advantage line of business. UHC did not provide Medicare Advantage data in prior years.

Figure 5-5: Total Health Care Expenditures, CY 2021 Change in Health Risk Adjusted THCE PMPY by Insurer



The THCE per capita change relative to the benchmark is measured at the State level and was 3.25% in CY 2021 as shown in Figure 3-3.

The CY 2021 HRA THCE PMPY change at the insurer level is provided for informational purposes only.

6. Net Cost of Private Health Insurance (NCPHI)

NCPHI measures the costs to Delaware residents associated with the administration of private health insurance.

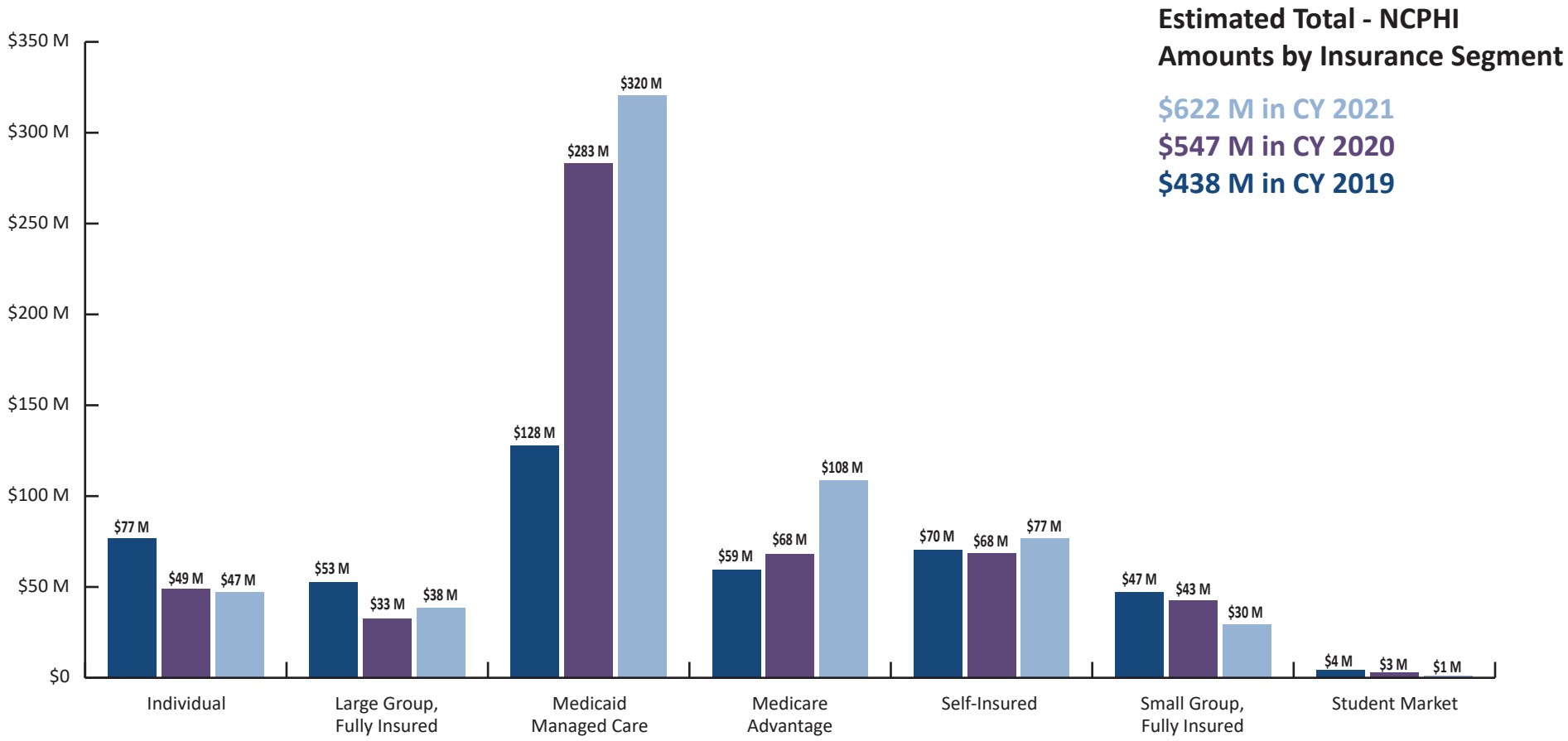
NCPHI is broadly defined as the estimated difference between health premiums earned and benefits incurred and consists of insurers' costs of processing claims, advertising/marketing, staff salaries, commissions, other administrative costs, premium taxes and any applicable profits or losses.

NCPHI is only applicable to insurers. NCPHI is not reported by CMS for the Medicare market nor DMMA for the Delaware Medicaid FFS program. If an insurer participates in Medicare Advantage and/or Delaware's Medicaid managed care program, the NCPHI applicable to those lines of business are included herein.

For insurers that have multiple lines of business, NCPHI is computed for each line of business and then aggregated across all insurers in that respective line of business.

As part of the CY 2020 benchmark data collection cycle, DHSS revised the process for collecting data to compute NCPHI. Each insurer was asked to provide by line of business their respective Premium Revenues and Total NetPaid Expenditures for purposes of computing NCPHI. The purpose of this change was to standardize and simplify the methodology for computing NCPHI and rely on data submitted by each insurer. Accordingly, now that this is the third annual Report, the CY 2019-21 NCPHI figures are comparable and calculated on the same basis.

Figure 6-1: Estimated NCPHI Amounts by Insurance Segment



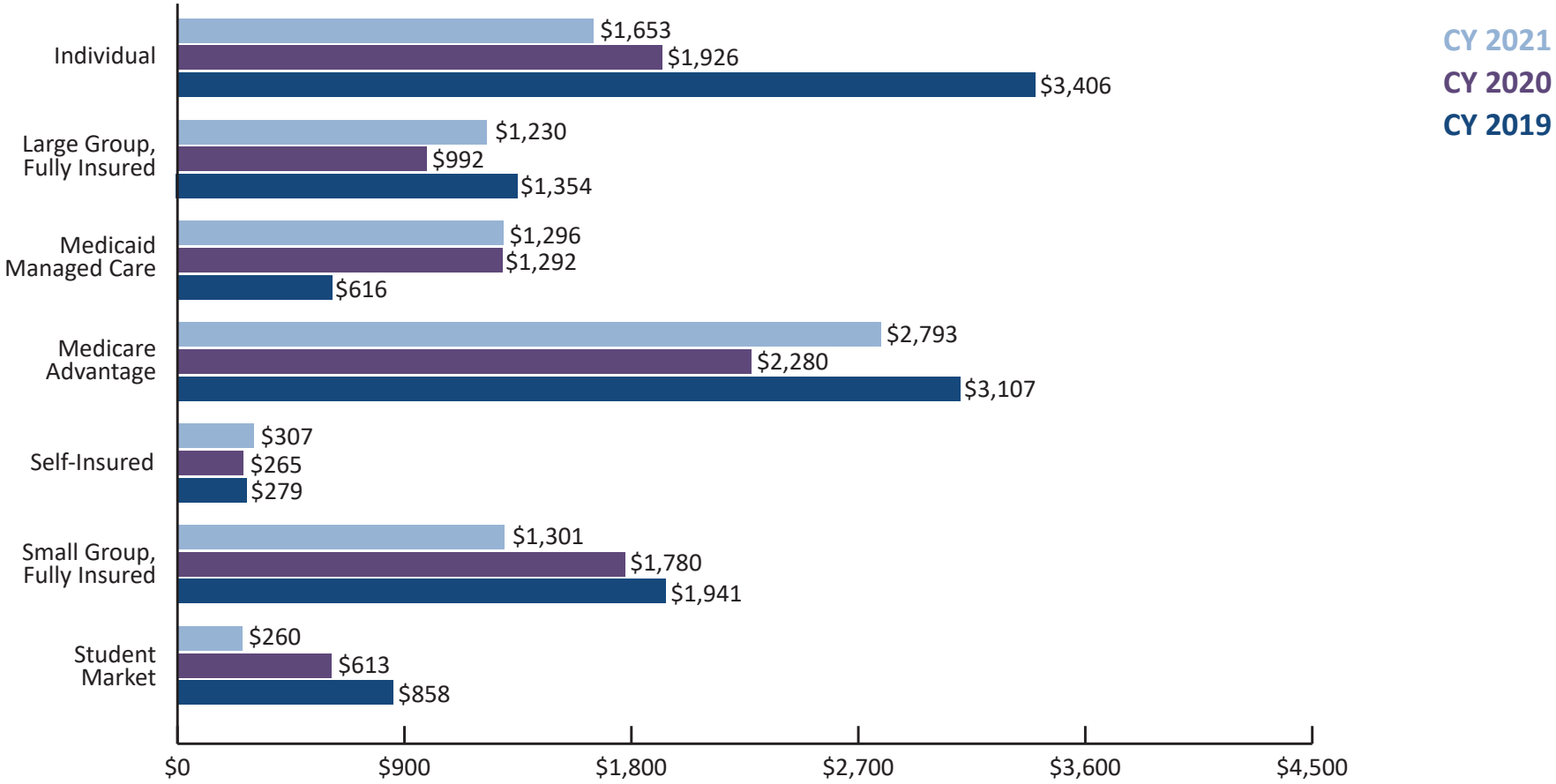
Estimated Total - NCPHI Amounts by Insurance Segment

$622 M in CY 2021
$547 M in CY 2020
$438 M in CY 2019

13.7%

Estimated NCPHI increased by $75 million or 13.7% in CY 2021, totaling $622 million.

Figure 6-2: Estimated PMPY NCPHI by Insurance Segment



For CY 2021, based on the available data, the Medicare Advantage market segment had the highest estimated NCPHI while the student market had the lowest.

7. Quality Data

Delaware also established annual benchmarks for a select number of quality measures.

The six quality benchmarks applicable to CY 2021 and the population for which results will be evaluated relative to the respective benchmark are listed below.

Adult Obesity

Statewide population

Use of Opioids at High Dosages

Statewide population

Opioid-related Overdose Deaths per 100,000

Statewide population

Emergency Department Utilization

Commercial population only

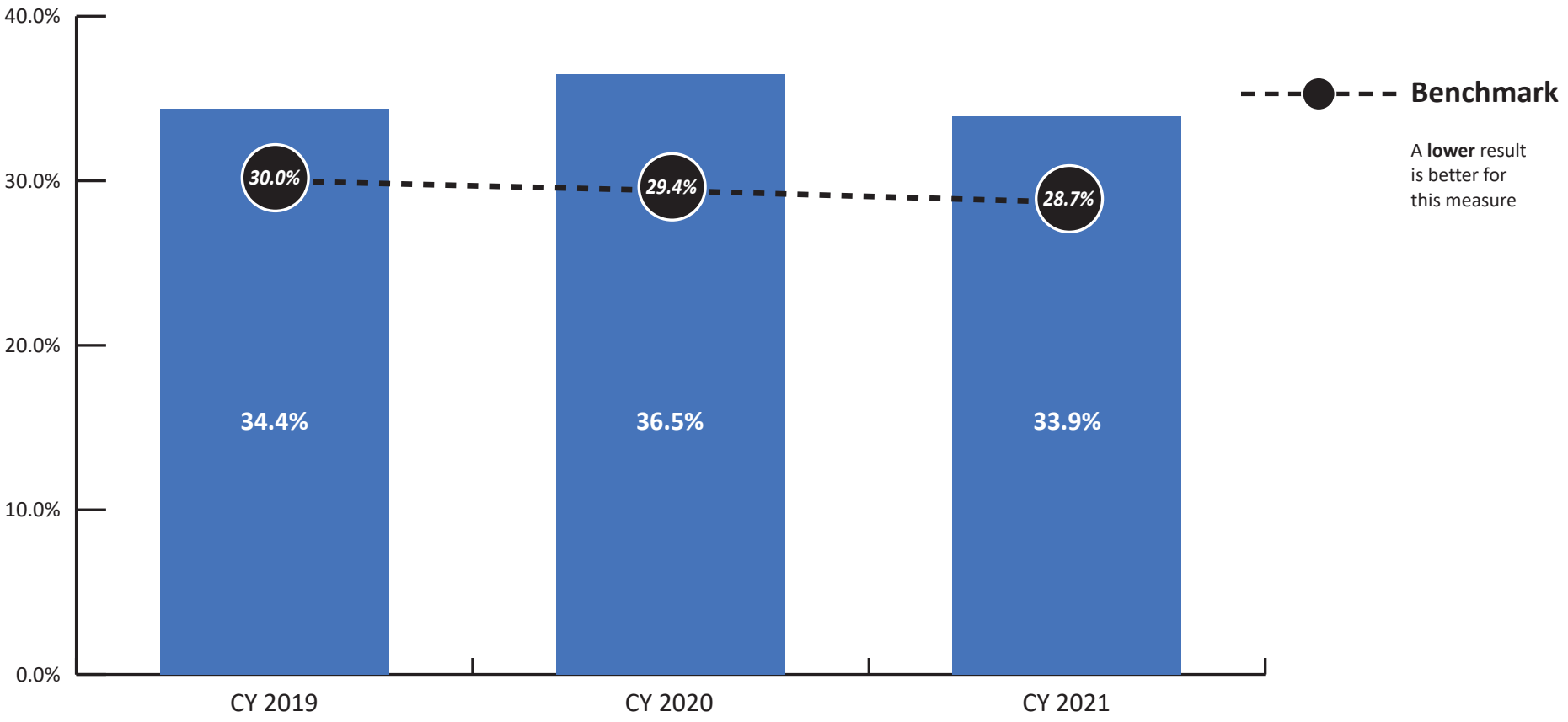
Persistence of Beta-Blocker Treatment After a Heart Attack

Commercial and Medicaid Managed Care populations, respectively

Statin Therapy for Patients with Cardiovascular Disease

Commercial and Medicaid Managed Care populations, respectively

Figure 7-1: Adult Obesity - Actual Results versus Benchmark

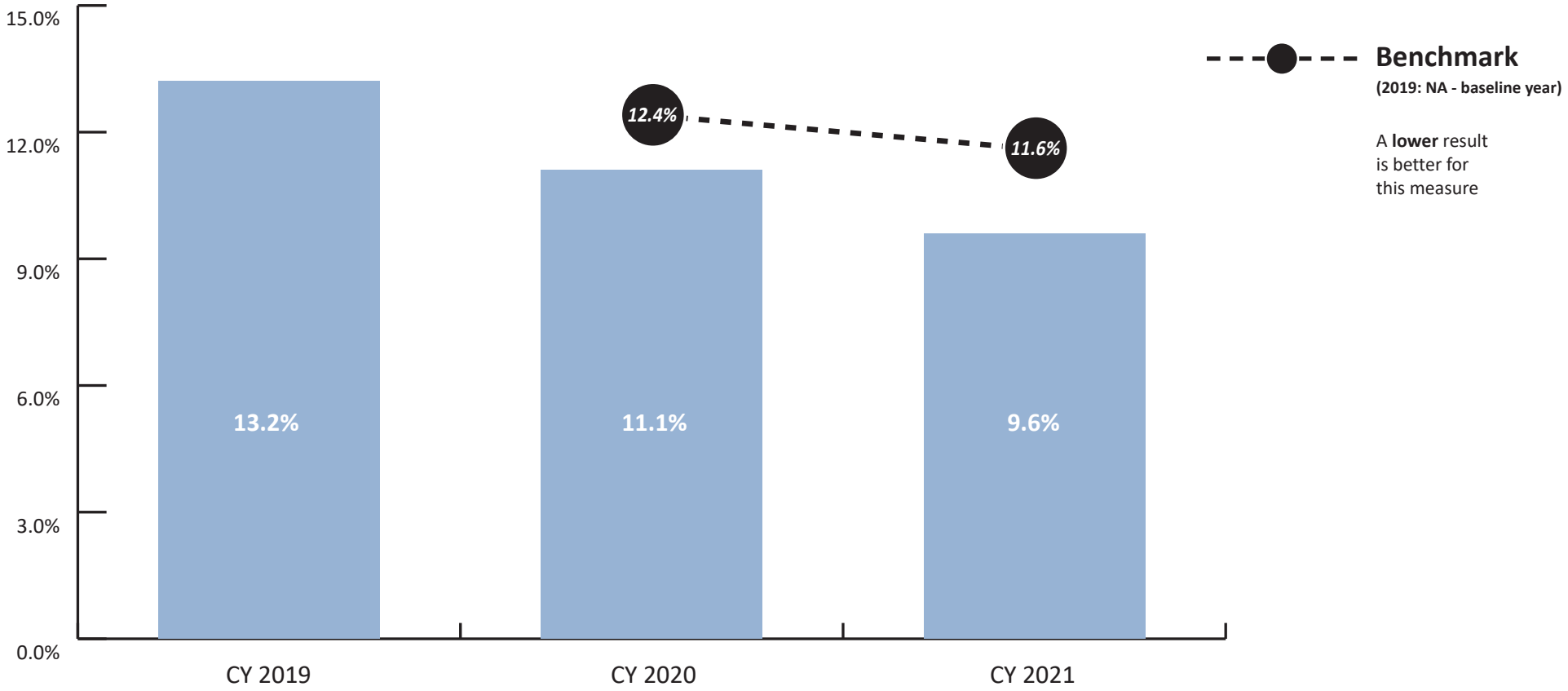


Adult Obesity

5.2% Points
above the benchmark

Results improved by 2.6 percentage points, but were still 5.2 percentage points higher (worse) than the CY 2021 benchmark.

Figure 7-2: Use of Opioids at High Dosages - Actual Results versus Benchmark

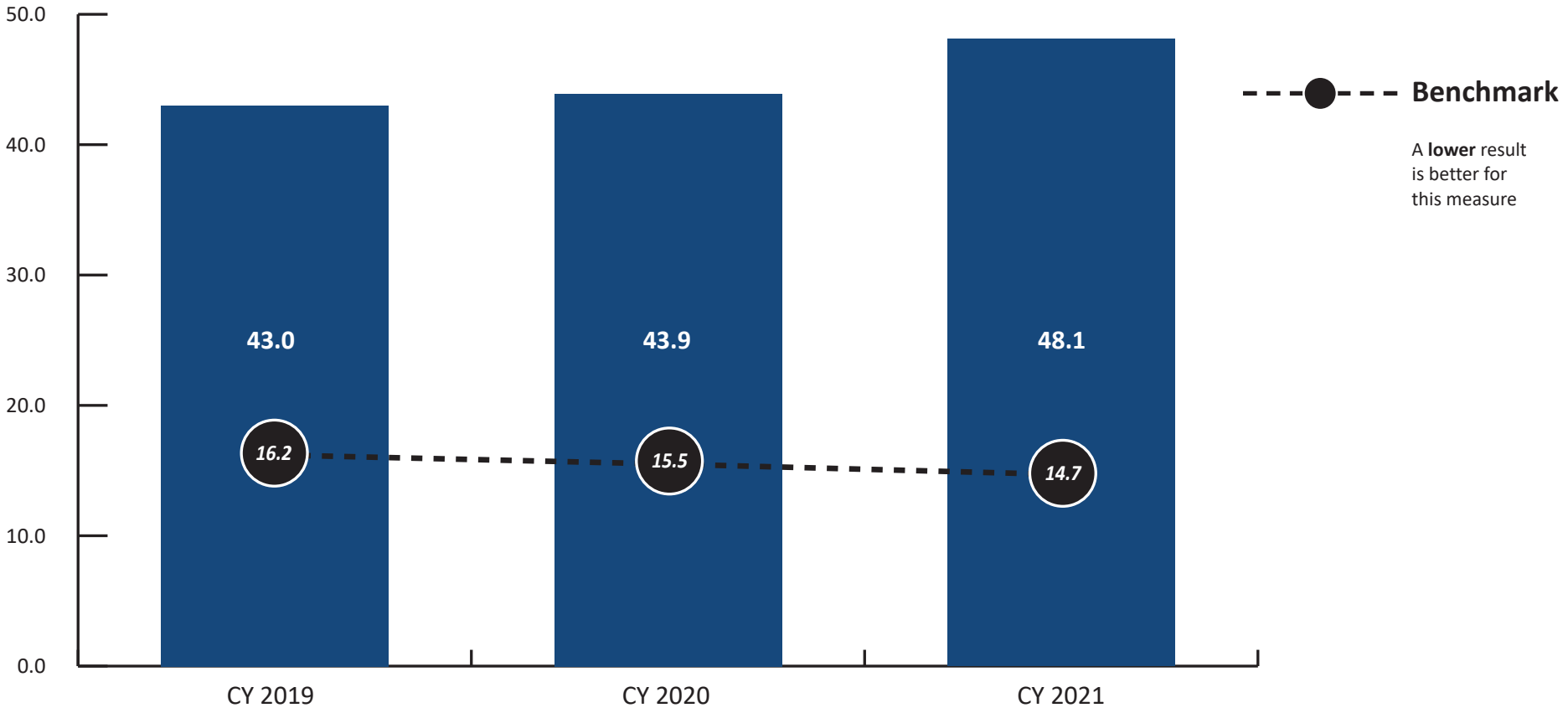


Use of Opioids at High Dosages

2.0% Points
below the benchmark

Results continued to improve and were 2.0 percentage points lower (better) than the CY 2021 benchmark.

Figure 7-3: Opioid-related Overdose Deaths per 100,000 Quality Measure - Actual Results versus Benchmark

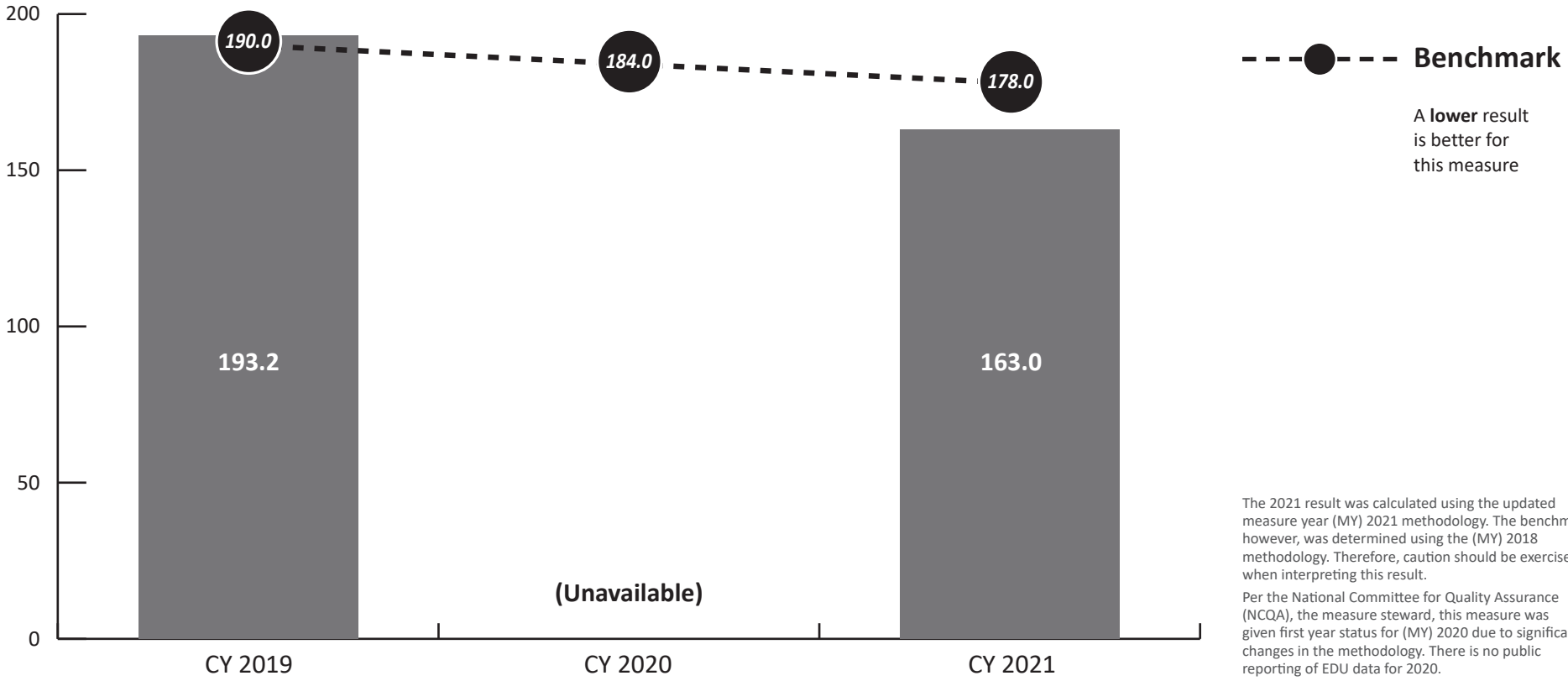


Opioid-related Overdose Deaths per 100,000

33.4 Deaths
above the benchmark

Results were 33.4 deaths per 100,000 higher (worse) than the benchmark CY 2021.

Figure 7-4: **Emergency Department Utilization Quality Measure - Actual Results versus Benchmark: Commercial**



The 2021 result was calculated using the updated measure year (MY) 2021 methodology. The benchmark, however, was determined using the (MY) 2018 methodology. Therefore, caution should be exercised when interpreting this result.

Per the National Committee for Quality Assurance (NCQA), the measure steward, this measure was given first year status for (MY) 2020 due to significant changes in the methodology. There is no public reporting of EDU data for 2020.

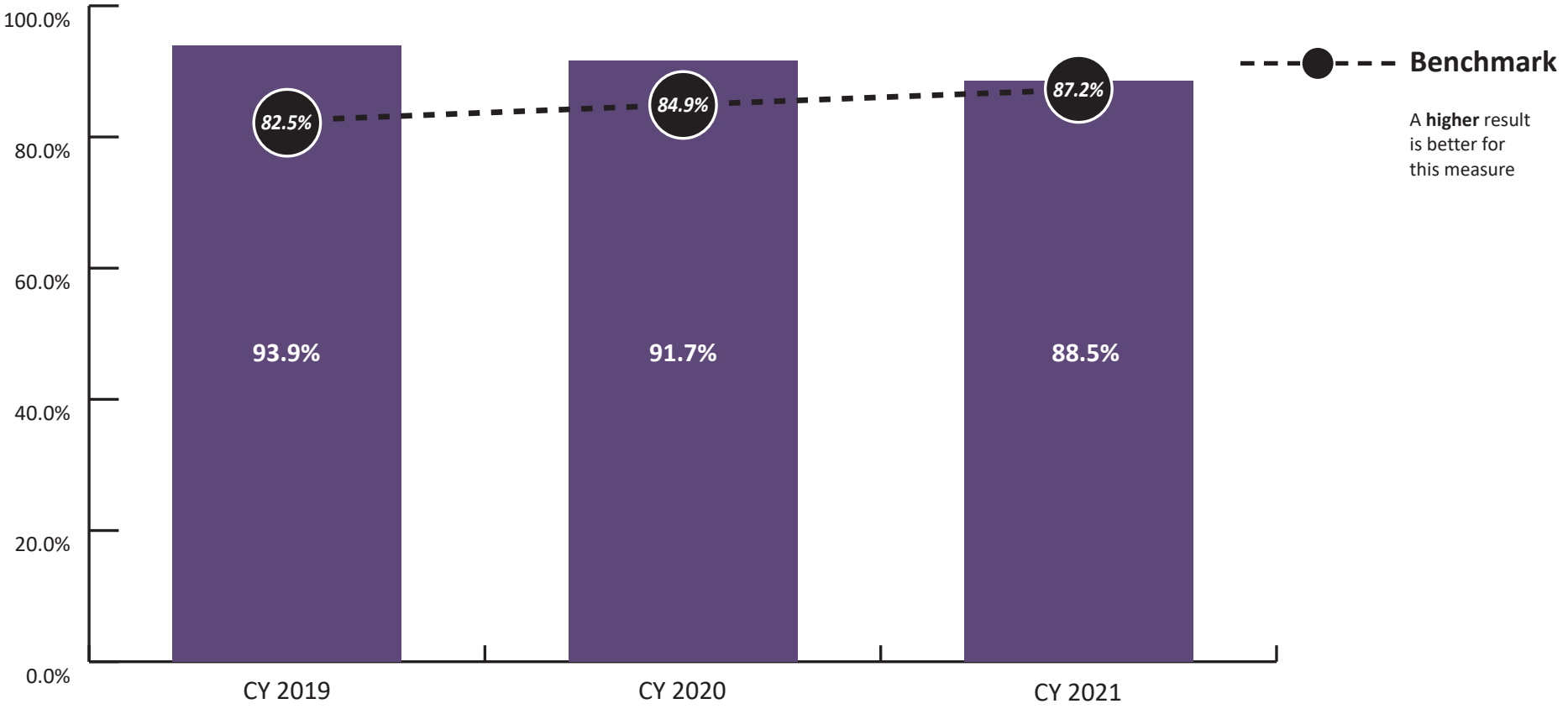
Emergency Department Utilization

15.0 Visits
below the benchmark

Results were 15.0 visits per 1,000 lower (better) than the CY 2021 benchmark.

2021 results reflect the updated methodology, but the benchmark was originally set based on the prior methodology.

Figure 7-5 A: **Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark: Commercial**



Persistence of Beta-Blocker Treatment After a Heart Attack

The Commercial market was 1.3 percentage points higher (better) than the CY 2021 benchmark.

Figure 7-5 B: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark: Medicaid

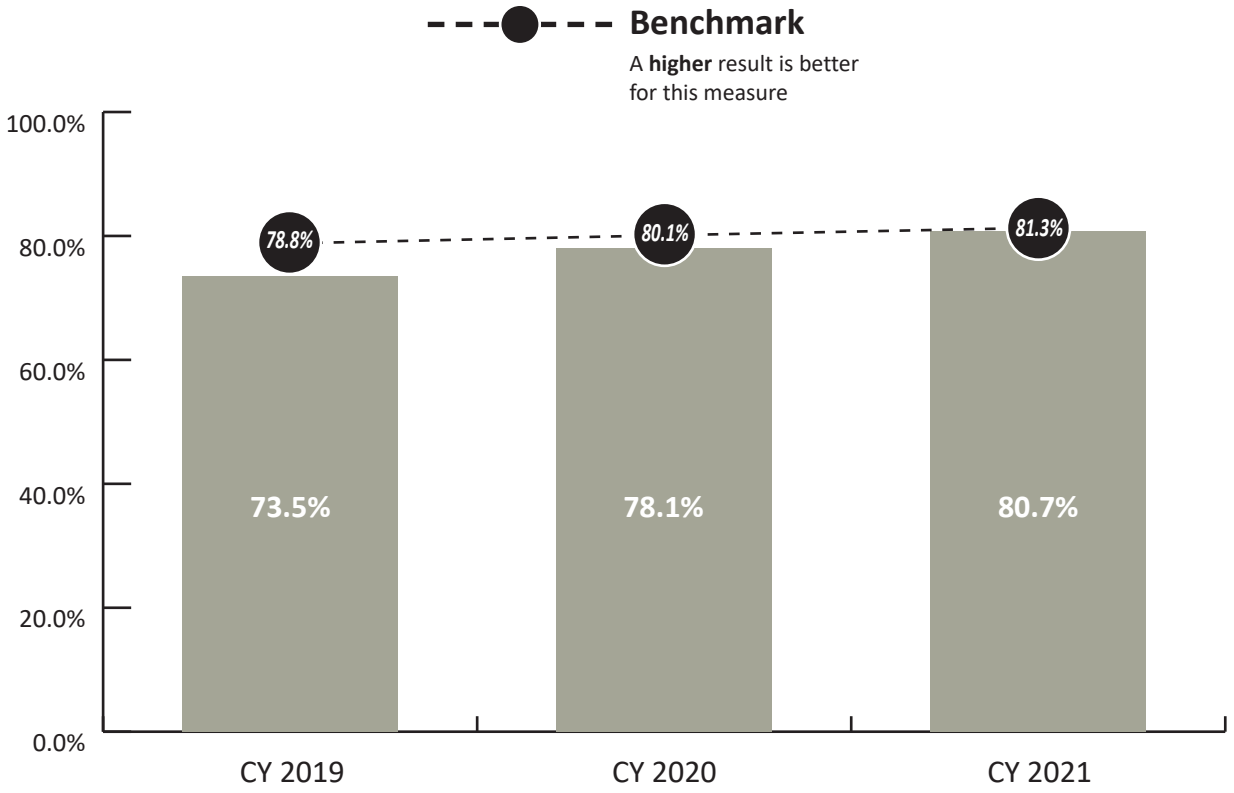
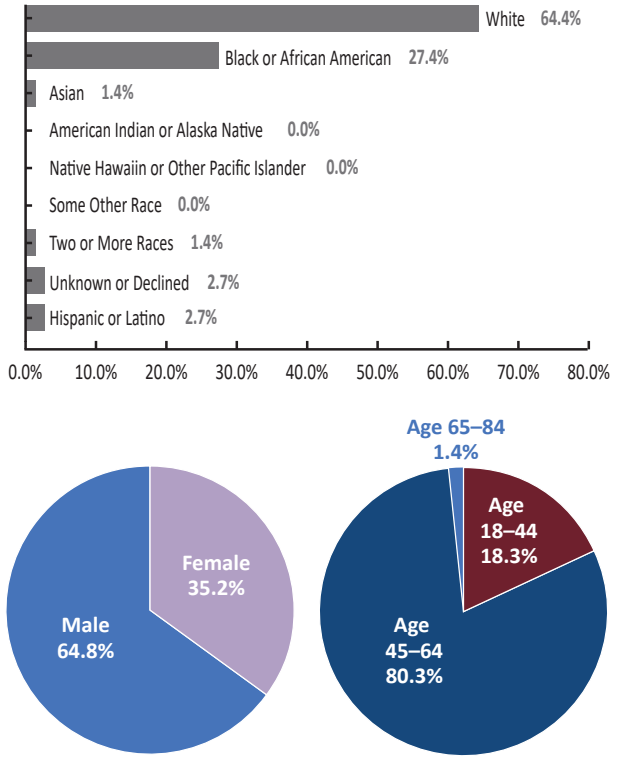


Figure 7-5 B1:

Individuals within the Medicaid Population who Received Persistent Beta-Blocker Treatment After a Heart Attack - Race, Ethnicity, Gender, and Age*



Persistence of Beta-Blocker Treatment After a Heart Attack

The Medicaid market continues to improve, but was 0.6 percentage points lower (worse) than the CY 2021 benchmark.

*Results reflect data submitted by Highmark and ACDE. Demographic data may be underreported and not truly representative of the total population.

Figure 7-6 A: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark: Commercial

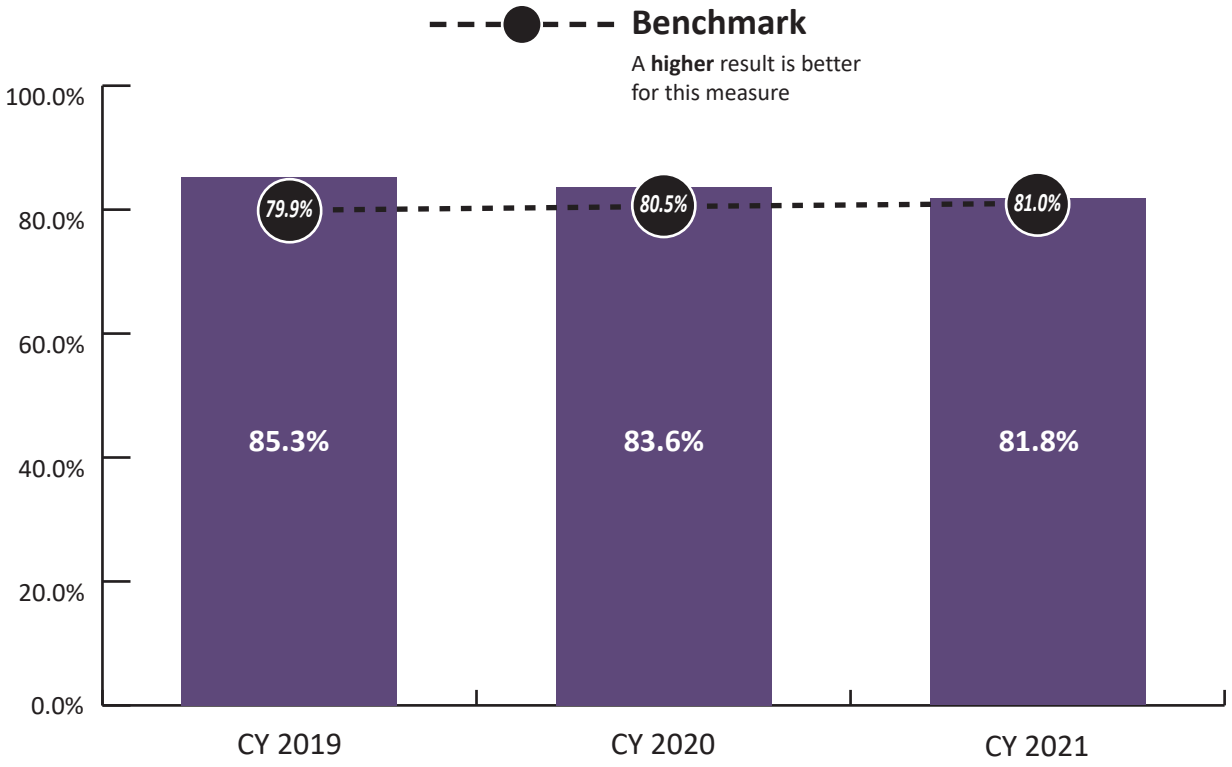
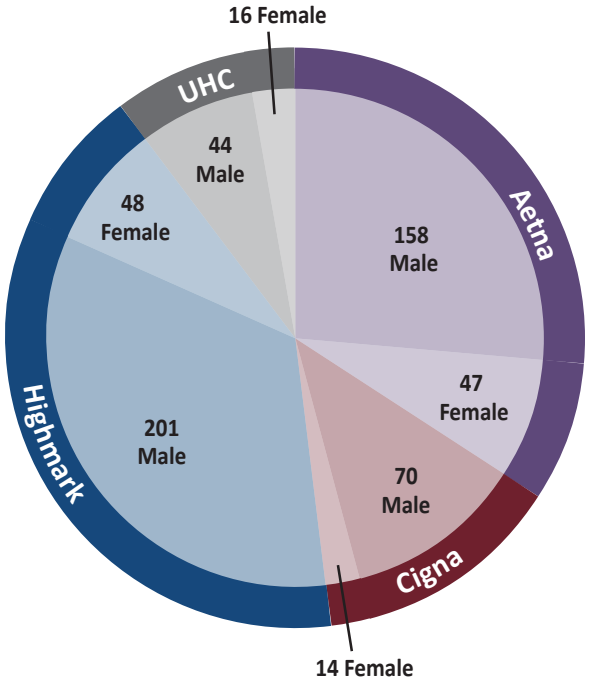


Figure 7-6 A1:

Individuals within the Commercial Population with Cardiovascular Disease who Received Statin Therapy - Gender and Age*



Males 21–75: 79.1% **Females 40–75: 20.9%**

Statin Therapy

Although results are declining, the Commercial market has consistently been better than the respective benchmark.

*Results reflect data submitted by Aetna, Cigna, Highmark, and UHC. Demographic data may be underreported and not truly representative of the total population.

Figure 7-6 B: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark: Medicaid

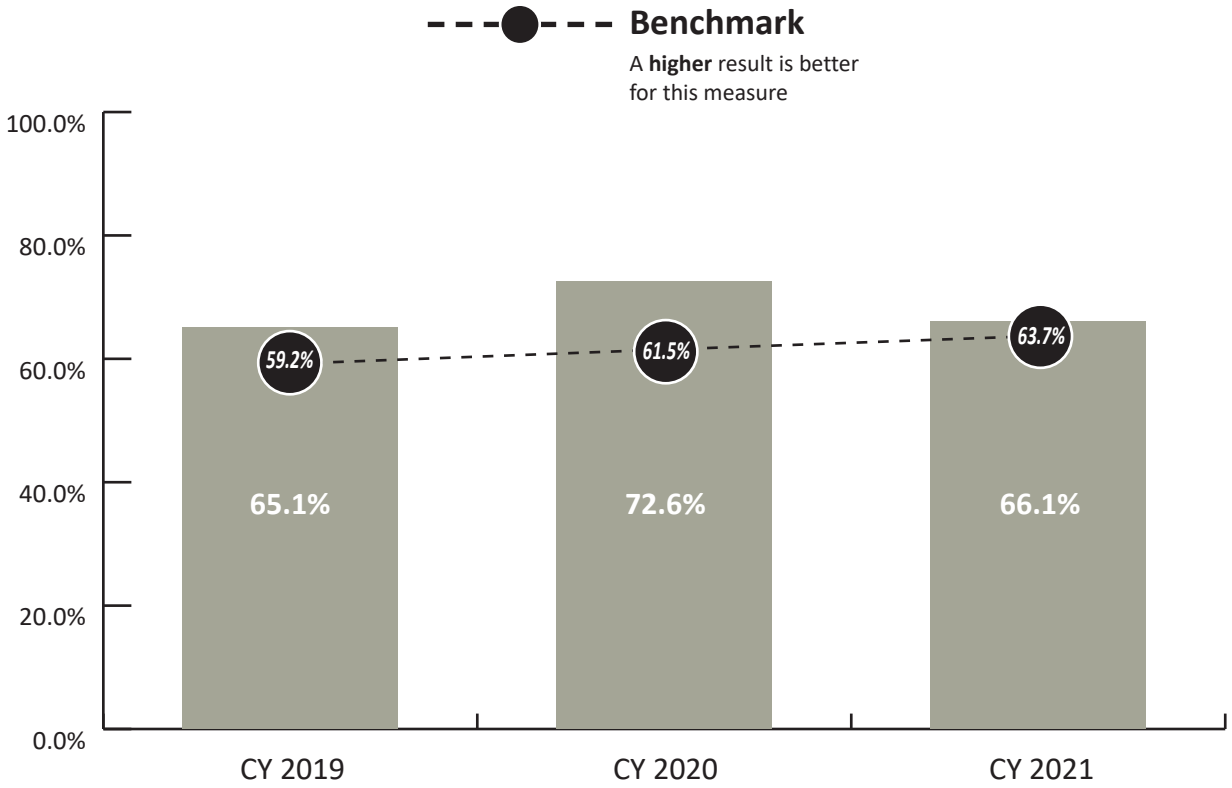
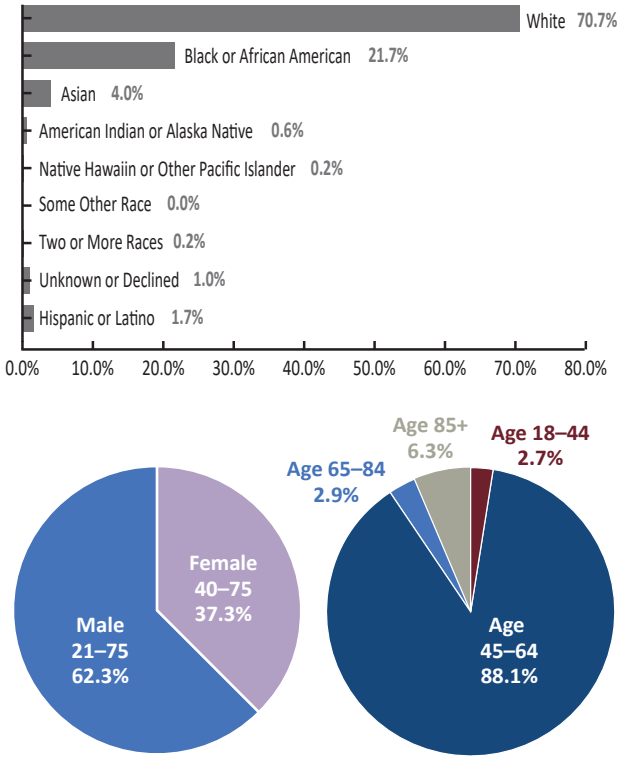


Figure 7-6 B1:

Individuals within the Medicaid Population with Cardiovascular Disease who Received Statin Therapy - Race, Ethnicity, Gender, and Age*



Statin Therapy

The Medicaid market was 2.4 percentage points higher (better) than the CY 2021 benchmark.

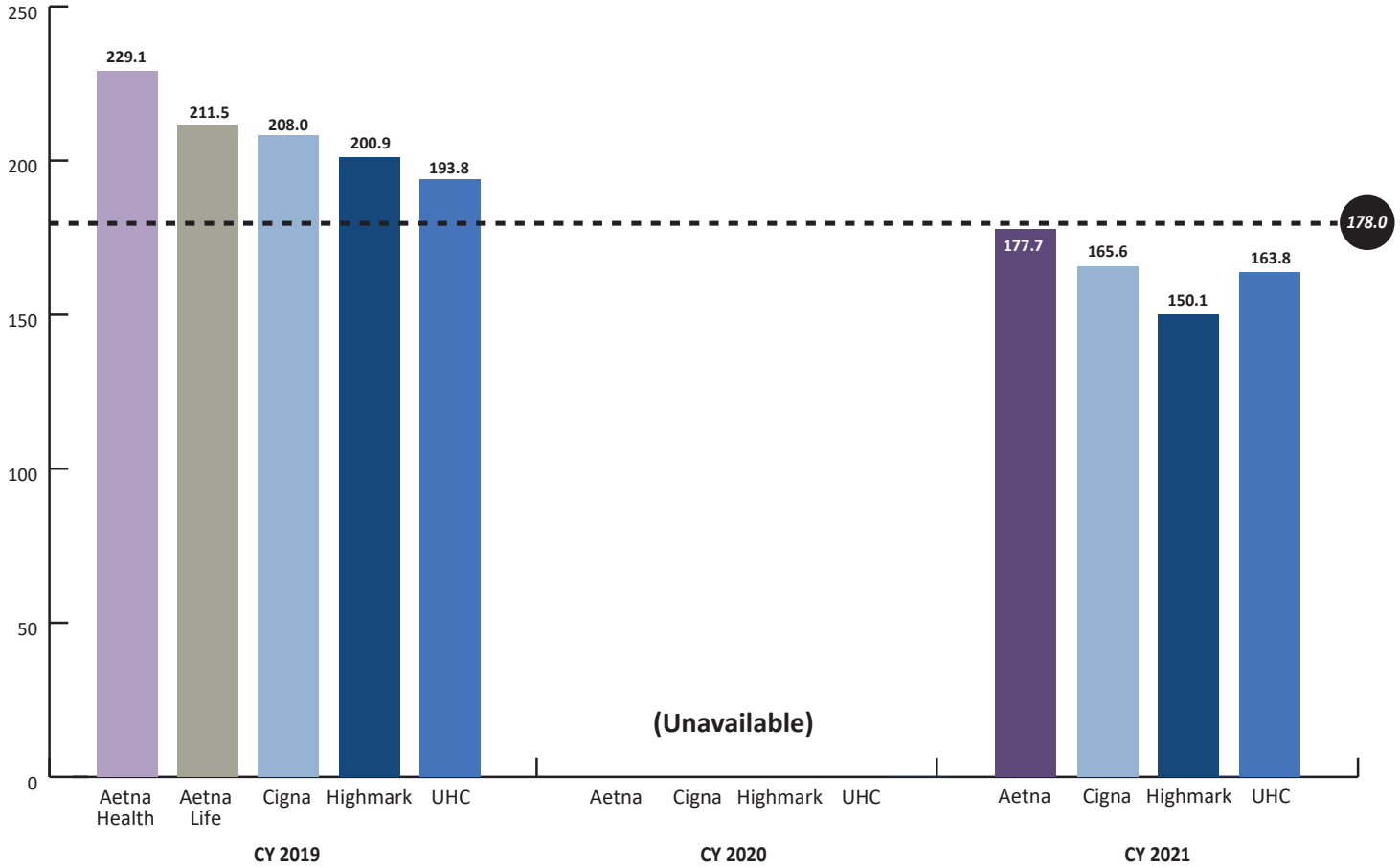
*Results reflect data submitted by Highmark and ACDE. Demographic data may be underreported and not truly representative of the total population.

For the three quality measures specific to the Commercial and/or Medicaid managed care markets, insurer-specific results can be computed from the data provided. The respective quality benchmarks are applicable at the Market level only, but results by insurer can provide additional information and insights.

Table 7-1: Quality Measure by Insurer

Quality Measure	Commercial Insurer	Medicaid Managed Care Insurer
Emergency Department Utilization	• Aetna Health Inc. (Aetna Health) • Aetna Life Insurance Company (Aetna Life) • Cigna • Highmark • UHC	N/A
Persistence of Beta-Blocker After a Heart Attack	• Aetna • Cigna • Highmark • UHC	• ACDE • Highmark
Statin Therapy for Patients with Cardiovascular Disease	• Aetna • Cigna • Highmark • UHC	• ACDE • Highmark

Figure 7-7: Emergency Department Utilization Quality Measure



2021 Benchmark

184.0
2020 Benchmark

190.0
2019 Benchmark

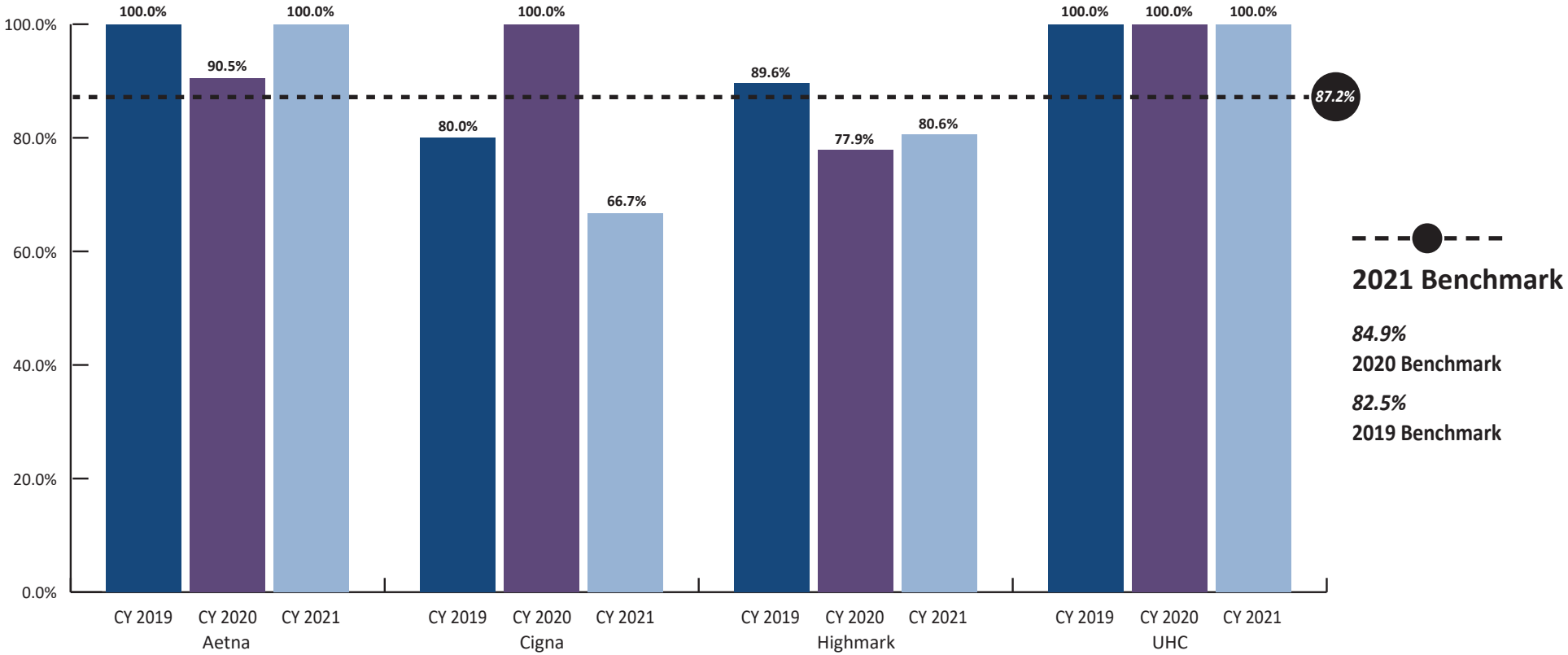
The 2021 result was calculated using the updated measure year (MY) 2021 methodology. The benchmark, however, was determined using the (MY) 2018 methodology. Therefore, caution should be exercised when interpreting this result.

Per the National Committee for Quality Assurance (NCQA), the measure steward, this measure was given first year status for (MY) 2020 due to significant changes in the methodology. There is no public reporting of EDU data for 2020.

Emergency Department Utilization

All of the Commercial insurers met the CY 2021 benchmark.

Figure 7-8: Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark

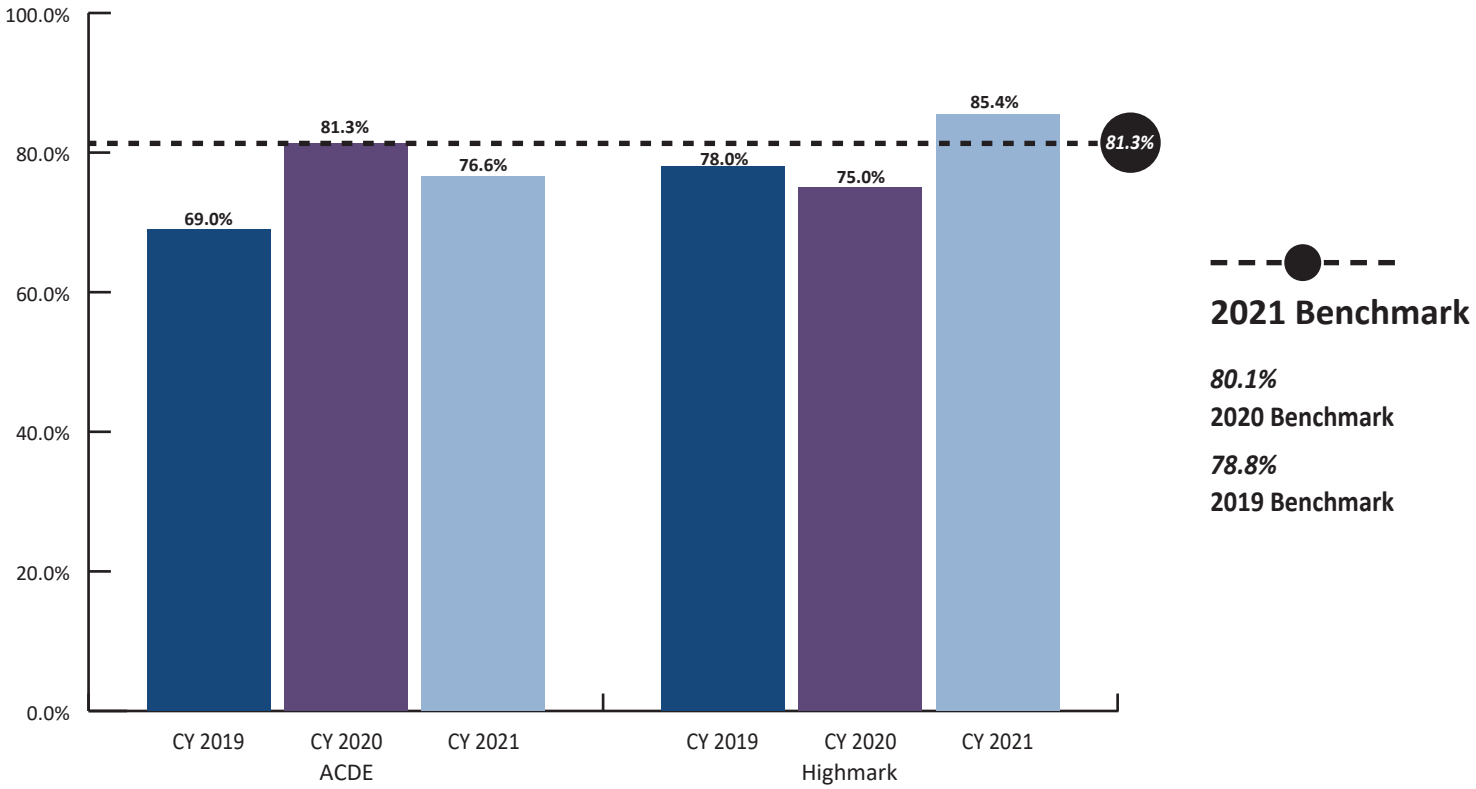


Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result is better for this measure

Two of the four Commercial insurers did better than the CY 2021 benchmark.

Figure 7-9: **Persistence of Beta-Blocker Treatment After a Heart Attack Quality Measure - Actual Results versus Benchmark**

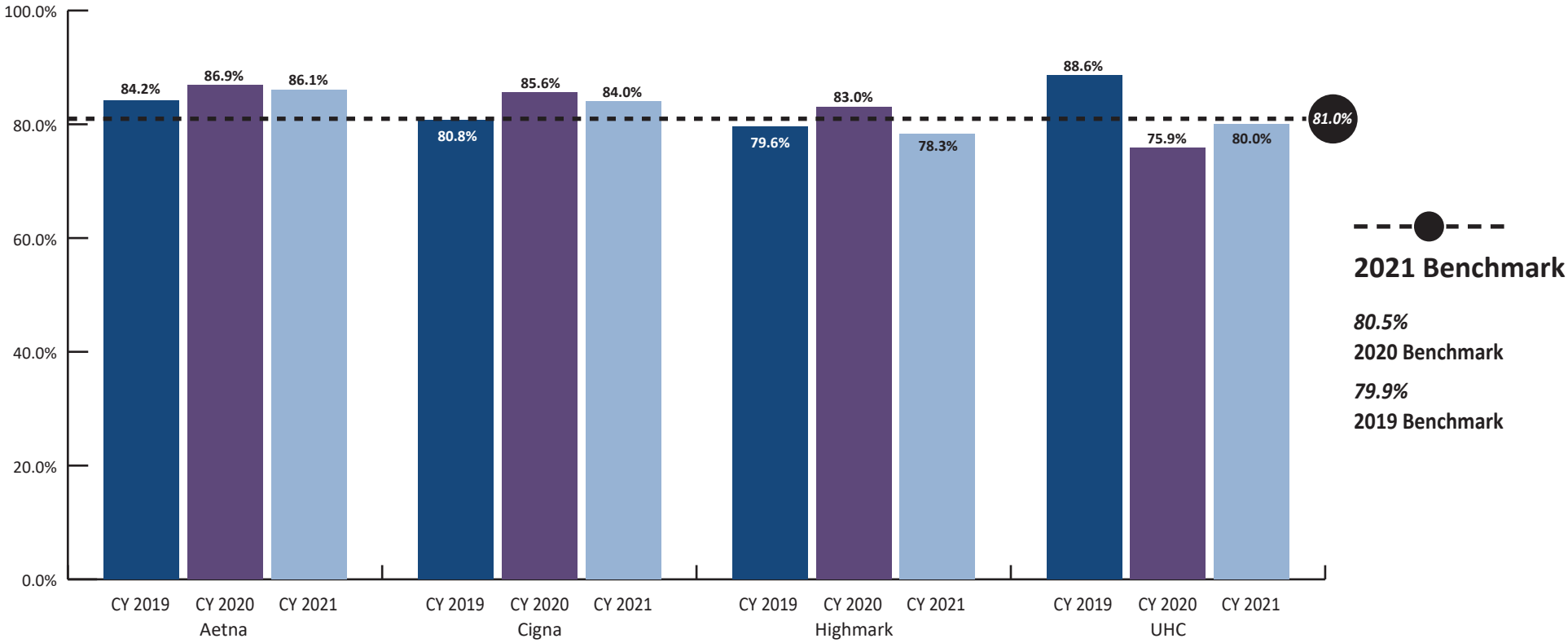


Persistence of Beta-Blocker Treatment After a Heart Attack

A higher result is better for this measure

Highmark did better than the CY 2021 Medicaid benchmark.

Figure 7-10: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark

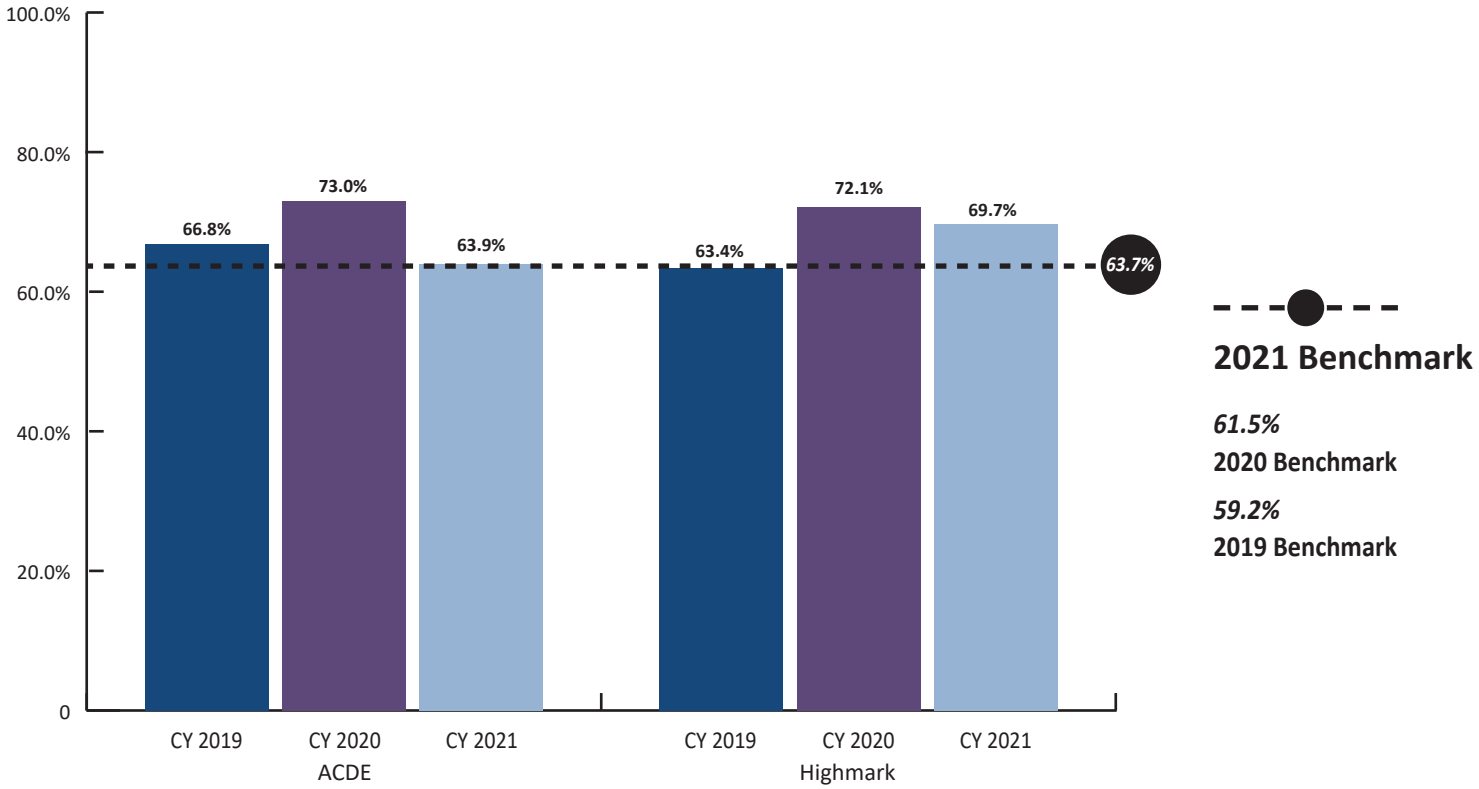


Statin Therapy

A higher result is better for this measure

Two of the four Commercial insurers did better than the CY 2021 benchmark.

Figure 7-11: Statin Therapy for Patients with Cardiovascular Disease Quality Measure - Actual Results versus Benchmark



Statin Therapy

A higher result is better for this measure

Both Medicaid managed care insurers did better than the CY 2021 benchmark.

8. Glossary of Key Terms

Allowed Amount: The amount the payer paid plus any member cost sharing for a claim. Allowed amount is the basis for measuring the claims component of medical expenses for purposes of the benchmark spending data.

Centers for Medicare & Medicaid Services (CMS): Federal government entity responsible for Medicare, Medicaid and CHIP program oversight, administration and monitoring.

Claims Data: Medical expense spending that payers reported that are associated with incurred claims. Examples include hospital inpatient, hospital outpatient, professional: primary care, long term care and other.

Department of Health and Social Services (DHSS): The State agency responsible for overseeing and administration of the benchmark data collection and reporting processes. The DHSS is also responsible for selecting and/or updating the benchmark quality measures.

Division of Medicaid and Medical Assistance (DMMA): The State agency responsible for oversight, administration and monitoring of Delaware's Medicaid/CHIP program.

Health Risk Adjustment: A process that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors.

Insurer: A private health insurance company that offers one or more of the following: commercial insurance, Medicare managed care products and/or are Medicaid/CHIP managed care organization products.

Market: The highest level of categorization of the health insurance market. For example, Medicare fee-for-service (FFS) and Medicare managed care are collectively referred to as the "Medicare market." Medicaid/CHIP FFS and Medicaid/CHIP MCO managed care are collectively referred to as the "Medicaid market." Individual, self insured, small and large group markets and student health insurance are collectively referred to as the "Commercial market."

Net Cost of Private Health Insurance (NCPHI): Measures 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, and consists of insurers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits (or contributions to reserves) or losses.

Non-Claims: Medical expense spending data reported by payers that was not associated with a specific incurred claim. Examples include provider capitation payments, provider incentives, recoveries or risk settlements.

Payer: A term used to refer collectively to all entities submitting data to DHSS.

Pharmacy Rebates: Any rebates provided by pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer provided fair market value bona fide service fees.

Quality Benchmark: The annual target results for the selected quality measures.

Spending Benchmark: The annual target change in the per capita THCE measured at the State level.

Total Health Care Expenditures (THCE): The total medical expense (TME) incurred by Delaware residents for all health care benefits/services by all payers reporting to the DHSS plus insurers' NCPHI.

Total Health Care Expenditures Per Capita: Total health care expenditures (as defined above) divided by Delaware's total state population.

Total Medical Expense (TME): The total claims and non-claims medical expense incurred by Delaware residents for all health care benefits/services as reported by payers submitting data to the DHSS.

Veterans Health Administration (VHA): The federal agency responsible for provision of health care benefits to veterans.