Payers and Data Contributors Spending and Quality
Data Benchmark Frequently Asked Questions (FAQs)

Last Update: 11/3/2021

Summary: The "Payers and Data Contributors Spending and Quality Data Benchmark FAQs" document houses frequently asked questions (FAQs) related to the spending and quality benchmarks data collection process from various payers and data contributors in order to help mitigate re-occurring questions to the DHCC that have previously been asked by other payers/data contributors. It is an evolving document that will be updated on an ongoing basis as new questions come in, and should be utilized as the first source of reference after the Implementation Manual as new questions arise. Please reach out to the DHCC for more information or if a specific question cannot be answered through utilizing this document.

#	Date	Quality/ Spending	Question	Answer
1	6/22/2021	Spending	Where should dual-eligible members with both Medicare and Medicaid be reported within the spending template?	Dual-eligible members should only be reported within the dual line in the spending template.
2	6/22/2021	Quality	Should the same top 10 providers as last year be used when submitting the provider level data?	Insurers should evaluate their providers to determine the top 10 high-volume providers applicable to each respective data reporting year.
3	6/22/2021	Spending	Should the premium revenue data element be limited to premiums for Delaware residents only?	Yes, the premium revenue data element should only reflect information for Delaware residents only. If the payers need to estimate what the Delaware resident portion only is, please share the proposed methodology with DHCC/Mercer to review.
4	6/22/2021	Quality	Historically HEDIS information is provided with only three months of runout, since the NCQA data submission is due prior to June 15 and a six month runout period is not possible. Can an exception be made so the insurer can provide information with only three months of runout?	DHCC encourages payers to leverage HEDIS data outputs whenever applicable. If the process to generate HEDIS results is contingent on only 90 days of runout, then that is an acceptable approach to apply to DHCC quality benchmarks. In circumstances in which the measures are non-HEDIS or require manual computation, DHCC requests payers ensure a minimum of 180 days runout.
5	7/28/2021	Quality	For the ED utilization to expected ratio, the instructions include two data points from NCQA results. Payers put their data into the IDSS tool, and then once the NCQA information is released, they calculate a rate. Since the NCQA results come in after the data submission is due back to the DHCC/Mercer, can payers provide the IDSS results and then Mercer can complete the calculation once NCQA is released?	Yes, that is acceptable. Payers should provide the standardized rate, and Mercer can then do the calculation. Payers will then not have to wait for the Quality Compass® data to come in first before submitting their data.
6	8/18/2021	Spending	The Pharmacy Claims definition includes the following statement: "Pharmacy data in this category is to be reported gross of applicable rebates. Rebates will be reported separately." The term "gross" implies rebates should be included in the number report. Is this what is expected, or should we actually be reporting costs "net" of rebates since they are being reported elsewhere on the report?	For the TME spending data, the claims service category of Pharmacy is to be reported gross of rebates. "Gross of rebates" is a commonly used term to specify that the reported spending must be the total allowed amount before any rebate dollars are obtained/applied. The pharmacy rebate amount actually obtained/collected by the insurer is reported separately. For example: • If the allowed amount before any rebates is $100 and the rebate attributed to/collected is $5, the insurer is to report $100 in the Claims: Pharmacy service category (column A13) and separately report the $5 in the Pharmacy Rebates column (column A6). • Do not report $95 net pharmacy spend in the Claims: Pharmacy service category (column A13).

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#	Date	Quality/ Spending	Question	Answer
7	10/7/2021	Spending	How should risk sharing transfers to providers related to value based programs be reported in columns A4 Total Net Paid Expenditures (for NCPHI) and also in claims and non-claims columns A8 through A28?	Please include any risk sharing transfers incurred to providers for DE residents in column A4 Total Net Paid Expenditures (for NCPHI) for each reporting year. In addition, include risk sharing transfer payments or other positive or negative payments to providers related to value based programs in the calculation of the claims and/or non-claims data fields A8 through A24 of the benchmark template.
8	10/7/2021	Spending	Do the MLR rebates payments and CMS Risk Adjustment transfers need to be included in the calculation of the A3 Premium Revenues (for NCPHI) field?	Yes, as part of the calculation of the Premium Revenues in column A3, please include any MLR rebate payments made to residents of DE in the appropriate line of business category for each reporting year. Similarly, any CMS risk transfers received or paid in association to DE residents should be included in the Premium Revenue calculations.
9	11/3/2021	Spending	What should or should not be included in column A4 Total Net Paid Expenditures (for NCPHI) for each of the Commercial/Medicare lines of business (LOB)?	**All LOBs except Self-Insured LOB 904:** Include direct claims or indirect payments for incentives and bonuses, including under capitation contracts, paid to or received by physicians, and other non-physician providers whose services are covered by the policy for services or supplies covered by the policy. Amounts should reflect the insurer paid net of any provider contract discounts, member cost sharing, third party liability, pharmacy rebates, etc. Please include any risk sharing transfers incurred to providers for DE residents in column A4 Total Net Paid Expenditures (for NCPHI) for each reporting year. In addition, include risk sharing transfer payments or other positive or negative payments to providers related to value based programs. Amounts should be reported on a direct basis, so gross of any private reinsurance arrangements. Report amounts on CY incurred basis, including any remaining incurred but not reported or paid claims reserves. Do not include any quality improvement, claims utilization, and claims processing expenses, premium taxes/assessments, and expenses paid to third-party vendors. **Individual LOB 901:** Amounts should be adjusted for any federal or state subsidy programs such as state-based reinsurance or federal high risk pool program payments or accruals in the ACA market (e.g., 1332 waiver program). Do not include estimated or reported risk adjustment transfer payments or accruals from the federal ACA risk adjustment program. **Small Group Fully-Insured LOB 903:** Do not include estimated or reported risk adjustment transfer payments or accruals from the federal ACA risk adjustment program. **Medicare Managed Care LOB 906:** Adjust for the low-income cost-sharing portion of subsidy payments or accruals in the Medicare Part D program. In addition, include Medicare reinsurance program payments or accruals. Do not include Part D Risk Corridor estimated transfers or payments. **Self-Insured LOB 904:** Please leave blank.