New Jersey Health Care Cost Growth Target Benchmark Program

Carrier Benchmark Data Submission Guide

Version 1.2

September 2023

STATE OF NEW JERSEY
DEPARTMENT OF BANKING & INSURANCE

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Version History

Below are key updates and changes to this **Carrier Benchmark Data Submission Guide** (the Guide) and the accompanying **Carrier Benchmark Data Submission Template** (the Template).

Table 1. Record of Changes

Version Number	Date Released	Description of Change(s)
1.2	September 2023	The state made the following changes in versions 1.2 of the Guide and Template: • In the Reference Tables tab of the Template and the Line of Business Category Codes subsection of the Guide, updated the LOB Category Code 10 description from, “SHBP & SEHBP active employee plans” to, “SHBP & SEHBP commercial plans” to encompass both active and retired employees enrolled in an SHBP or SEHBP commercial plan in the respective reporting year. • In the Reference Tables tab of the Template and the Line of Business Category Codes subsection of the Guide, updated LOB Category Code 11 description from, “SHBP & SEHBP retiree plans” to, “SHBP & SEHBP MA plans” to encompass both active and retired employees enrolled in an SHBP or SEHBP MA plan in the respective reporting year. • In the Age and Sex Factors tab of the Template, revised the data validation parameters to allow a value of 0 for the Member Count with Truncated Claims (AS09) column. • In the Reporting on Large Provider Entities and Attribution subsection of the Guide, clarified that carriers must use a member attribution approach that is consistent with their internal methodology, regardless of whether they had a total cost of care contract in place with the entity for the corresponding reporting year. • In Appendix A of the Guide, updated the description for Claims: Professional, Specialty Providers (TM09) to include payments for services delivered by a primary care physician outside of the primary care setting. • In Appendix A of the Guide, updated the description for Claims: Professional, Other Providers (TM10) to include payments for services delivered by a primary care licensed practitioner other than an MD or DO outside of the primary care setting. • In Appendix C of the Guide, revised language to direct carriers to where Frequently Asked Questions will be posted periodically.
1.1	August 2023	The state made the following enhancements in versions 1.1 of the Guide and Template: • In the Validation by Provider tab of the Template, updated to flag if the sum of member months and non-truncated payment amounts for Large Provider Entity Codes 101 through 999 are inconsistent with Large Provider Entity Code 100 (carrier overall), and corrected formulas in the Data Validation Checks tab. • In the Validation Checks by Stage exhibit of the Guide, updated to clarify that carriers must report on Large Provider Entity Code 100 (carrier overall) in the TME, Age and Sex Factors, and Standard Deviation tabs, and ensure these data are consistent with other Large Provider Entity Codes for the respective row ID fields. Please note the updates described above **do not** change carriers’ data reporting requirements or affect the input tabs in the Template where you enter required data.
1.0	June 2023	—

Glossary

Claims payments	The allowed amount on provider claims to carriers. This includes the amount carriers paid to providers and any member cost sharing, such as copayments, deductibles, and co-insurance.
Health care cost growth benchmark	The targeted annual per member growth rate for total health care spending in the state. The benchmark is the percentage growth from the prior year's per member per year.
Insurer	A public or private organization or entity that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicaid managed care, or Medicare managed care. Also referred to as insurance carriers and payers.
Large provider entity	A term referring to an organization with primary care providers who engage in total cost of care contracts for a significant proportion of the population they serve, and for whom carriers attribute and report total medical expense data.
Net cost of private health insurance (NCPHI)	The cost to NJ residents associated with the administration of private health insurance. It is the difference between health premiums earned and claims paid. It consists of carriers' costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes carriers' profits (contribution to margin) or losses.
Non-claims payments	All payments that carriers make to providers other than providers' claims. This includes incentive payments, capitation or bundled payments, payments that support care transformation and infrastructure (e.g., care manager payments, lump sum investments, patient centered primary care home payments) and other payments that support provider services.
Performance year	The calendar year (January 1 – December 31) for which the program measures performance against the prior calendar year for purposes of calculating the growth in health care costs (e.g., performance year 1 measures cost growth between 2022 and 2023).
Primary care provider	For the purposes of reporting spending for the cost growth benchmark program, primary care providers include those practicing in the following specialties: family medicine, geriatric medicine, internal medicine, and pediatric medicine.
Total health care expenditures (THCE)	The total medical expense incurred by NJ residents for all health care services that carriers report to the state, plus the carriers' NCPHI.
Total medical expenses (TME)	The sum of total claims payments and total non-claims payments to providers health care services delivered to NJ residents.

Introduction

To help improve health care affordability for New Jerseyans, Governor Phil Murphy signed Executive Order 277 in December 2021, launching the state's health care cost growth benchmarking effort—the New Jersey (NJ) Health Care Affordability, Responsibility, and Transparency (HART) program. The HART program establishes targets aimed at slowing the rate of health care cost growth within the state and collects data to track progress in achieving those targets and improve overall cost transparency.

The program is the culmination of work that began in January 2021 through Executive Order 217, which called for an Interagency Working Group of NJ Department leaders—led by the Governor's Office of Health Care Affordability and Transparency—to design the program based on advice from a Health Care Affordability Advisory Group of stakeholders throughout the state, many of whom signed onto a compact promising to help achieve the benchmark targets and provide underlying data to track and promote progress on curbing cost growth.

Executive Order 277 also requires the NJ Department of Banking and Insurance (DOBI) to report on performance relative to benchmark. To do so, the state must collect spending data from insurance carriers and other sources annually. NJ is implementing the first annual benchmark data collection and reporting cycle in parallel with a strategy to rigorously analyze drivers of cost and cost growth. Together, the benchmark program and cost trends analyses will focus attention on health care cost drivers and inform actions to reduce cost growth.

Overview of Guide. This Guide details the technical specifications to assist insurers in preparing for the annual data collection and reporting cycle using the **Carrier Benchmark Data Submission Template**.

The Guide organizes information as follows:

- **Cost Growth Benchmark Program** (Section I) describes the HART program, benchmark methodology, and how the state will assess and report performance.
- **Carrier Reporting Requirements** (Section II) includes which carriers the state requires to report data via the Template and specifies the requirements for entering data in the Template.
- **Data Submission and Validation Process** (Section III) provides the timeline and steps for submitting and validating data.
- **Data Dictionary** (Appendix A) details the data element requirements in the Template.
- **Primary Care Definition and Codes** (Appendix B) includes the primary care provider taxonomy, payment, place of service, and modifier codes that carriers use to report primary spending.
- **Frequently Asked Questions** (Appendix C) will include questions and responses collected from carriers in future version releases of this Guide.

How to use this Guide. The Guide explains the technical aspects and requirements for carriers to report benchmark data via the Template; therefore, the primary audience is commercial carriers' personnel responsible for: (1) extracting the required data from their system(s) and entering in the applicable Template tab, (2) developing estimates in accordance with the reporting guidance, and (3) working with the state to discuss validation findings.

ⓘ **Note:** For more information, please see DOBI's NJ HART program webpage. If you are a carrier with questions about submitting data, please contact: CarrierDataSubmission@dobi.nj.gov.

I. Cost Growth Benchmark Program

This section provides an overview of the HART program, cost growth benchmark methodology, and how the state will assess and report performance.

A. HART Program Overview

The NJ HART program establishes targets aimed at slowing the rate of health care cost growth within the state and collects data to track progress in achieving those targets and improve overall cost transparency. The program's benchmarking effort encompasses all areas of health care costs inside the state, including insurance, hospital and provider, and pharmaceutical spending. Data collected through the program will improve understanding of the factors driving health care cost increases and help support data-driven policy solutions to address them.

The program comprises two primary analytics workstreams (the cost growth benchmark and cost driver analyses), and stakeholder engagement and communications to support development and implementation of these workstreams. The core programmatic functions for implementing and sustaining the HART program are as follows:

- Implementing the health care cost growth target;
- Collecting detailed health care spending information from public and private payers;
- Analyzing health care payer and provider performance relative to the cost growth target;
- Using claims data to examine drivers of health care spending and spending growth;
- Identifying opportunities for cost growth mitigation;
- Translating information into policies and meaningful action;
- Engaging stakeholders, including advisory bodies, in program activities and in developing strategies to slow health care cost growth;
- Convening annual public meetings or hearings, as needed;
- Developing and implementing a communications strategy to spread awareness of the program and obtain public buy-in;
- Conducting regular briefings with legislators; and
- Publicly reporting findings.

The program requires management of operations, data analytics, and strategic guidance, including developing policy solutions informed by analyses. As applicable, NJ will manage contractors performing analyses and providing technical assistance to data submitters.

ⓘ **Note:** For more information, please see Rutgers Center for State Health Policy's NJ HART program webpage and DOBI's NJ HART program webpage.

B. Cost Growth Benchmark Definition

The NJ health care cost growth benchmark is a targeted annual per capita growth rate for total health care spending in the state. The benchmark is a percentage of growth in per capita spending from the prior year.

The benchmark program will measure health care spending growth for all NJ residents with Medicare, Medicaid, and commercial (insured and self-insured) coverage, and assess cost growth against the benchmark. These benchmark percentage values are not a mandatory cap or index but reflect a shared goal for stakeholders and the state to work toward constraining the growth of health care costs.

C. Methodology for Calculating the Benchmark

Executive Order 277 establishes health care cost growth benchmark values for calendar years 2023 through 2027. Table 2 shows each performance year (i.e., the calendar year for which the program measures performance against the prior calendar year) and the associated cost growth benchmark value for the year.

Table 2. Cost Growth Benchmark Values

Year	Benchmark
PY 1 (CY 2023)	3.5%
PY 2 (CY 2024)	3.2%
PY 3 (CY 2025)	3.0%
PY 4 (CY 2026)	2.8%
PY 5 (CY 2027)	2.8%

Note: PY = performance year; CY = calendar year.

The cost growth benchmark value is based on a blend of twenty five percent potential gross state product and seventy five percent projected median household income. This blended value translates to a target growth rate of 3.2%.

D. Measuring THCE and TME

The state will use total health care expenditures (THCE), which includes claims spending, non-claims spending, consumer cost sharing, and carrier administrative costs, to measure health care cost growth. They will measure spending growth annually using THCE or total medical expenses (TME), in aggregate dollars and on a per member per year (PMPY) or per member per month (PMPM) basis. The aggregate dollar figure will be for informational purposes only.

To measure spending growth and assess performance against the benchmark applicable to the specific performance year, the state will use the percentage change in THCE/ TME on a PMPY/ PMPM basis between the performance year and the prior calendar year. Lastly, the state will calculate a year over year PMPY/ PMPM rate of growth at the state-, market-, insurer-, and large provider entity-levels as follows:

- **State:** PMPY using unadjusted, non-truncated THCE;
- **Insurance market (Medicare, Medicaid, and commercial):** PMPY using unadjusted, non-truncated TME;
- **Insurer, stratified by market:** PMPM using age/ sex risk adjusted, truncated TME; and
- **Large provider entity, stratified by market:** PMPM using age/ sex risk adjusted, truncated TME.

All spending data at the state-, market-, and insurer-reported levels are net of pharmacy rebates. Spending data at the large provider entity reported level are gross of pharmacy rebates because carriers provide aggregated rebate data; therefore, the state cannot attribute rebates to large provider entities.

ⓘ **Note:** For the detailed formulas that the state will use to calculate cost growth, please see the **State Benchmark Implementation Manual**.

E. Public Reporting of Benchmark Performance Results

Executive Order 277 requires DOBI to annually report on performance relative to the health care cost growth benchmark at four levels (the state-, insurance market-, insurer-, and large provider entity-levels). For the first annual data collection and reporting cycle, the state will collect data and analyze 2018-2019 health care spending to inform a baseline analysis. They will coordinate with stakeholders on analyzing and understanding the data before reporting health care spending and spending growth in aggregate form to promote transparency and facilitate discussion of strategies to make health care more affordable.

Table 3 includes a row for each annual reporting cycle and the associated years of data the state will collect (i.e., the calendar years for which the program will be measuring cost growth between), benchmark value, level of reporting, and when the state will publicly report performance.

Table 3. Health Care Cost Growth Benchmark Reporting Timeline

Reporting Cycle	Measuring Cost Growth Between	Benchmark	Level of Public Reporting	Public Reporting Date
Pre-benchmark year	CY 2018-2019	No benchmark	State & market	Q2 2024
Transition year	CY 2021-2022	No benchmark	State, market, insurer & provider	Q2 2025
PY 1	CY 2022-2023	3.5%	State, market, insurer & provider	Q2 2026
PY 2	CY 2023-2024	3.2%	State, market, insurer & provider	Q2 2027
PY 3	CY 2024-2025	3.0%	State, market, insurer & provider	Q2 2028
PY 4	CY 2025-2026	2.8%	State, market, insurer & provider	Q2 2029
PY 5	CY 2026-2027	2.8%	State, market, insurer & provider	Q2 2030

Note: Timing under the Public Reporting Date column is subject to change.
PY = performance year; CY = calendar year; Q = quarter

II. Carrier Reporting Requirements

Carriers must follow the state's cost growth benchmark specifications in this Guide when preparing the data for submission to ensure a standardized approach; however, there are several places that require carriers to make estimates. These opportunities for customized approaches recognize the systems payers use to report and analyze data vary.

This section includes the data specifications and guidance carriers must follow to submit data in the **Carrier Benchmark Data Submission Template**.

ⓘ **Note:** The state will check each carrier data submission for adherence to all applicable requirements in the Data Dictionary appendix and in the subsections below. If a submission fails these validation checks, they will notify the carrier, and request that they correct and resubmit data. For more information on the validation checks, please see the Data Submission and Validation Process section.

A. Carriers Required to Submit

Data reporting is an essential part of the state's ability to capture health care cost spending across NJ. Using the most recent health insurance enrollment data available, the state identified the payers required to submit data based on the number of lives covered across all markets (Medicare, Medicaid, and commercial).

Table 4 lists the carriers required to report data via the Template and their associated markets for which they have business.

Table 4. Carriers Required to Submit by Market

Carrier	Medicare managed care	Medicaid managed care	Commercial fully and self-insured
Aetna Better Health	X	X	X
Amerigroup	X	X	
AmeriHealth Insurance Co.			X
Cigna Health & Life Insurance Co.	X		X
Horizon Healthcare of NJ	X	X	X
United HealthCare Insurance Co.	X		X
WellCare Health Plans of NJ, Inc.	X	X	

Note: The state will collect fee-for-service and other non-managed care spending data from the Centers for Medicare & Medicaid Services for Medicare and the NJ Division of Medical Assistance & Health Services for Medicaid.

B. Submission Schedule

Carriers will submit benchmark data annually. Table 5 outlines the submission due date for each data collection and reporting cycle.

Table 5. Benchmark Data Submission Schedule

Reporting Cycle	Years of Data Collected	Submission Due Date
Pre-benchmark year	**CY 2018-2019**	**September 25, 2023**
Transition year	CY 2021-2022	Q3 2024
PY 1	CY 2022-2023	Q3 2025
PY 2	CY 2023-2024	Q3 2026
PY 3	CY 2024-2025	Q3 2027
PY 4	CY 2025-2026	Q3 2028
PY 5	CY 2026-2027	Q3 2029

Note: Timing under the Submission Due Date column for the transition and performance years is subject to change.
PY = performance year; CY = calendar year; Q = quarter

ⓘ **Note:** For questions regarding data submission due dates, please contact: CarrierDataSubmission@dobi.nj.gov.

C. Data Specification

Carriers must report data using the **Carrier Benchmark Data Submission Template**. The Template is an Excel workbook with twelve tabs summarized below.

- **Reference tabs** to orient carriers to the Template and codes used to categorize certain data:
  - Contents
  - Reference Tables
- **Input tabs** where carriers enter required data:
  - 1. Cover Page
  - 2. Total Medical Expenses
  - 3. Age and Sex Factors
  - 4. Standard Deviation
  - 5. Line of Business Enrollment
  - 6. Pharmacy Rebates
  - 7. Mandatory Questions

- **Validation tabs** that carriers can use to check the accuracy and reasonability of their data submission:
  - Data Validation Checks
  - Validation by Market
  - Validation by Provider

The subsections below include data submission requirements and guidance for the input tabs in the Template.

ⓘ **Note:** For additional submission requirements, please see the File Specification subsection, and the Data Dictionary appendix for the list of valid value(s) and format for each data field in the input tabs.

1. Reporting Categories

For input tabs two through six in the submission Template, carriers must extract benchmark data from their own system(s) and enter in the applicable tab. These tabs require carriers to use a combination of data elements that have a set of valid value options or category codes, referred to as row ID fields in this Guide.

Table 6 shows the row ID fields for input tabs two through six. These fields must contain values that uniquely identify each row of data, meaning more than one row cannot have the same combination of row ID fields in each tab. The subsections that follow provide more information on the codes to identify the carrier, insurance category, large provider entity, market, line of business (LOB) category, member age band, and member sex at birth.

Table 6. Types of Data Records in Submission Template

Tab Name	Fields to Uniquely Identify Records (Row ID Fields)
2. Total Medical Expenses	Reporting Year; Insurance Category Code; Large Provider Entity Code
3. Age and Sex Factors	Reporting Year; Insurance Category Code; Large Provider Entity Code; Age Band Code; Sex Code
4. Standard Deviation	Reporting Year; Market Code; Large Provider Entity Code
5. Line of Business Enrollment	Reporting Year; Line of Business Category Code
6. Pharmacy Rebates	Reporting Year; Insurance Category Code

ⓘ **Note:** For the relationships between row ID fields in each tab, please see the Market, Insurance Category, and Line of Business Category Codes Crosswalk in the Reference Tables tab of the **Carrier Benchmark Data Submission Template**.

Insurer Codes

Table 7 includes the state-assigned three-digit code that carriers must use for data submitted in the TME, Age and Sex Factors, Standard Deviation, LOB Enrollment, and Pharmacy Rebates tabs of the Template.

Table 7. Insurer Codes

Insurer Code	Description
201	Aetna Better Health
202	Amerigroup
203	AmeriHealth Insurance Co.
204	Cigna Health & Life Insurance Co.
205	Horizon Healthcare of New Jersey
206	United HealthCare Insurance Co.
207	WellCare Health Plans of NJ, Inc.

Insurance Category Codes

Table 8 includes the insurance categories to use for data submitted in the TME, Age and Sex Factors, and Pharmacy Rebates tabs of the Template.

Table 8. Insurance Category Codes

Insurance Category Code	Description
1	MA non-dual eligible members (excluding SHBP & SEHBP members)
2	Medicaid MCO non-dual eligible members
3	Commercial full claims members (excluding SHBP & SEHBP members)
4	Commercial partial claims members (excluding SHBP & SEHBP members)
5	MA dual eligible members
6	Medicaid MCO dual eligible members
7	Commercial SHBP & SEHBP members
8	MA SHBP & SEHBP members

Note: The SHBP and SEHBP member population is applicable only to Aetna Better Health and Horizon Healthcare of NJ.
MCO = managed care organization; SHBP = State Health Benefits Program; SEHBP = School Employees' Health Benefits Program

Carriers must also submit data that adheres to the following insurance category guidance:

- Include data for all insurance categories that align with the markets for which they have business.
- To avoid double counting, all insurance categories are mutually exclusive.
- Separate the commercial market members into two categories:

  1) Commercial full claims (Insurance Category Code 3) for which the carrier can collect information on all direct medical claims and any claims paid by a delegated entity (i.e., comprehensive coverage with no carve-outs); and

2) Commercial partial claims (Insurance Category Code 4) for which they do not have all medical and subcarrier claims. Carriers make an adjustment for partial claims to allow for them to be comparable to full claims. 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 pharmacy benefit managers (PBMs) or behavioral health vendors. For example, for those members for whom the plan carves out pharmacy benefits, the carrier might include its commercial market book of business average pharmacy spending PMPM for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied.

- If a carrier enrolls Medicare and Medicaid dually eligible individuals, the state requires them to submit Medicare-related expenditures under Insurance Category Code 5 and Medicaid-related expenditures under Insurance Category Code 6. For example, if they cover dually eligible individuals, but are only responsible for Medicaid services, they include spending for those members under Insurance Category Code 6.
  - If a carrier has a fully integrated plan for which they cover both Medicare and Medicaid services for dually eligible individuals, the state requires them to report member months for them under both Insurance Category Code 5 and 6. Spending should for such members should be included in either Insurance Category Code 5 or 6 depending on whether Medicare or Medicaid is the primary payer for a given claim.

ⓘ **Note:** For more information on adjusting spending for commercial partial claims (Insurance Category Code 4), please see the Vendors and Carved-Out Services subsection.

Large Provider Entity Codes

Table 9 includes the large provider entities to use for data submitted in TME, Age and Sex Factors, and Standard Deviation tabs of the Template. The state may update the list of provider entities from time to time as the health care market changes.

Table 9. Large Provider Entity Codes

Large Provider Entity Code	Description
100	Carrier overall
101	Advocare
102	Aledade
103	Atlantic ACO/ Atlantic Health System/ AHS ACO LLC/ Optimus Healthcare Partners, LLC
104	AtlantiCare Health Solutions, Inc./ AtlantiCare
105	Capital Health Accountable Care Organization
106	ColigoCare, LLC
107	Cooper University Health Care/ AllCare Health Alliance
108	Englewood Health Medical Center

Large Provider Entity Code	Description
109	Hackensack Alliance ACO/ Hackensack Meridian Health/ Meridian ACO, LLC
110	Hunterdon Healthcare
111	Inspira Care Connect, LLC/ Inspira Health Network
112	Partners in Care ACO
113	Princeton Healthcare Partners
114	Riverside
115	RWJBH Accountable Care, LLC/ RWJBarnabas Health/ Barnabas Health
116	Shore Quality Partners ACO
117	Summit Health/ Summit Medical Group
118	Virtua Medical Group/ LHS Health Network
999	Unattributed

ⓘ **Note:** For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection

Age Band Codes

Table 10 includes the member age bands to use for data submitted in the Age and Sex Factors tab of the Template. Carriers should use an approach that is consistent with their internal methodology to calculate and report member age (e.g., use the first or last date of the reporting period), but they must calculate age for the associated reporting year(s), and not the year they are submitting these data.

Table 10. Age Band Codes

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old
3	19 to 39 years old
4	40 to 54 years old
5	55 to 64 years old
6	65 to 74 years old
7	75 to 84 years old
8	85 + years old

Sex Codes

Table 11 includes the assigned sex at birth codes to use for data submitted in the Age and Sex Factors tab of the Template. If a member's sex at birth is unknown, carriers should use an approach that is consistent with their internal policy, or they can defer to the category with more members.

Table 11. Sex Codes

Sex Code	Description
1	Female
2	Male

Market Codes

Table 12 includes the markets and their associated insurance categories to use for data submitted in the Standard Deviation tab. Note that each Market Code combines Insurance Category Codes (Medicare combines Insurance Category Codes 1, 5, and 8, Medicaid combines Insurance Category Codes 2 and 6, and commercial combines Insurance Category Codes 3, 4, and 7).

Table 12. Market Codes

Market Code	Description
1	Medicare
2	Medicaid
3	Commercial

Line of Business Category Codes

Table 13 includes the LOB categories to use for data submitted in the LOB Enrollment tab of the Template.

Table 13. Line of Business Category Codes

LOB Category Code	Description
1	Large group plans, 51 + employees, fully insured (excluding SHBP & SEHBP)
2	Small group plans, 2-50 employees, fully insured
3	Self-insured plans
4	Individual plans (buy coverage on their own)
5	Student plans
6	MA non-dual eligible plans (excluding SHBP & SEHBP)
7	Medicaid MCO non-dual eligible plans
8	MA dual eligible plans
9	Medicaid MCO dual eligible plans
10	SHBP & SEHBP commercial plans
11	SHBP & SEHBP MA plans

Note: The SHBP and SEHBP member populations are applicable only to Aetna Better Health and Horizon Healthcare of NJ.
MA = Medicare Advantage; MCO = managed care organization; SHBP = State Health Benefits Program; SEHBP = School Employees' Health Benefits Program

ⓘ **Note:** For the Insurance Category and Market Codes that correspond to each LOB Category Code, please see the mapping tables in the Reference Tables tab of the **Carrier Benchmark Data Submission Template**.

2. Included Populations

Carriers must include data in the **Carrier Benchmark Data Submission Template** for all NJ residents who have **comprehensive health care coverage** through a Medicare, Medicaid, or commercial insurance product, regardless of the member's plan situs. Exhibit 1 details the types of policies included and excluded in carriers' reporting of TME, which must align with the markets for which they have business.

Exhibit 1. Included and Excluded LOBs by Market

Medicare market **includes** the following LOBs:

- ✓ Medicare Advantage (MA) Health Maintenance Organization (HMO)
- ✓ Preferred Provider Organization (PPO)
- ✓ HMO Point of Service (HMOPOS)
- ✓ Medicare Medical Savings Account (MSA)
- ✓ Private Fee-for-Service (PFFS)
- ✓ Special Needs Plans (SNPs)
- ✓ NJ State Health Benefits Program (SHBP) MA plans
- ✓ NJ School Employees' Health Benefits Program (SEHBP) MA plans

Medicaid market **includes** Medicaid and CHIP, and managed long-term services and supports contracts with the NJ Department of Human Services Division of Medical Assistance and Health Services.

Commercial market **includes** the following LOBs:

- ✓ Self-insured plans
- ✓ Short-term health plans
- ✓ Student-health plans
- ✓ Fully insured individual and group plans
- ✓ NJ SHBP commercial plans
- ✓ NJ SEHBP commercial plans
- ✓ Federal Employee Health Benefits Program (FEHB)

Carriers must **exclude** the following types of plans that offer limited benefits:

- ✗ Accident policy
- ✗ Disability policy
- ✗ Hospital indemnity policy
- ✗ Long-term care insurance
- ✗ Medicare supplemental insurance (Medigap)
- ✗ Stand-alone prescription drug plans (PDPs)
- ✗ Specific disease policy
- ✗ Stop-loss plans
- ✗ Supplemental insurance that pays deductibles, copays, or coinsurance ◢

3. Reporting on Large Provider Entities and Attribution

Carriers must submit data in the TME, Age and Sex Factors, and Standard Deviation tabs of the Template by the applicable Large Provider Entity Codes to which they attribute the member, and that adheres to the following member attribution guidance:

- Carriers must use an approach that is consistent with their internal methodology to attribute members to a primary care provider, then attribute those primary care providers to a Large Provider Entity Code, regardless of whether they had a value-based care contract with the entity for the corresponding reporting year.

- Data reported for each large provider entity must include all attributed members' TME for each month the carrier attributed the member, so long as the member was a NJ resident at the time of attribution, even when the member received care outside of or not affiliated with the respective provider entity.
- Carriers may choose whether they establish member residency as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology.
- For members who the carrier cannot attribute to a primary care provider, or whose primary care provider they could not attribute to a large provider entity, submit payments using the unattributed category (Large Provider Entity Code 999).
- Submit payments for all members in the carrier overall category (Large Provider Entity Code 100).

4. Reporting of TME

Carriers must submit data in the Template that adheres to the following payment reporting guidance:

- Include payments made **directly to providers** based on the service categories under the Claims Payments and Non-Claims Payments subsections below.
- To avoid double counting, all payment service categories in the subsections below are mutually exclusive (except for Non-Claims: Total Primary Care Payments).
- Include payment information on an incurred, not paid basis for the corresponding reporting year.
- Include payments for members for whom the carrier is the primary payer on a claim (i.e., exclude any paid claims for which they are the secondary or tertiary payer); however, do not exclude payments for a member solely because they have additional coverage.
- Exclude payments based on the categories under the Excluded Types of Payment subsection below.

The subsections below include more payment service category guidance for completing this tab.

ⓘ **Note:** The inclusion and exclusion criteria in the subsections below are not an exhaustive list. If carriers have questions about how to categorize payments, please contact: CarrierDataSubmission@dobi.nj.gov. In addition, the state may request more information regarding how carriers mapped their data into these categories to improve consistency in reporting across all carriers. Lastly, carriers should provide any comments on the payment data in the Mandatory Questions tab.

Claims Payments

The claims payment fields in the TME tab are the total unadjusted, non-truncated allowed amounts for each of the following mutually exclusive service categories:

- Hospital inpatient
- Hospital outpatient
- Professional, primary care
- Professional, specialty

- Professional, other providers
- Long-term care
- Retail pharmacy
- Other claims payments not categorized above

ⓘ **Note:** For definitions of the categories above, please see the data dictionary in the Total Medical Expenses (Input Tab 2) appendix.

Non-Claims Payments

The non-claims payment fields are the total payments made to providers outside of the claims system for each of the following mutually exclusive service categories defined further below:

- Prospective payment arrangements
- Performance incentives
- Population health and practice infrastructure payments
- Provider salaries
- Recovery
- Other non-claims payments not categorized above
- Primary care non-claims payments (these services are the only category not mutually exclusive to the other non-claims categories)

If carriers cannot attribute non-claims payments to specific members, or if the attributed primary care provider is not associated with any of the Large Provider Entity Codes, submit payments using the unattributed category (Large Provider Entity Code 999).

ⓘ **Note:** For definitions of the categories above, please see the data dictionary in the Total Medical Expenses (Input Tab 2) appendix.

Excluded Types of Payments

Carriers exclude the following types of payments:

- Spending on contracts and vendors that provide strictly administrative functions for health plan operations
- Discounts and other member perks, such as gym membership benefits
- Carrier reinsurance recoveries or reinsurance premiums
- Centers for Medicare & Medicaid Services (CMS) reconciliation payments, such as Medicare sweep or Part D
- Premiums

5. Payment Data Completeness

Carriers must submit data in the Template following the payment data completeness guidance in the subsections below.

Claims Run-Out Period

For categories in the Claims Payments subsection, carriers should allow for a run-out period of at least 180 days after December 31 of the performance year. If any claims are still unpaid after 180 days, carriers must apply incurred but not reported (IBNR) and incurred but not paid (IBNP) completion factors based on commonly accepted actuarial principles to each respective service category, and attest that they are reasonable and appropriate in the Mandatory Questions tab.

Non-Claims Reconciliation Period

For categories in the Non-Claims Payments subsection, carriers must allow for a "run-out" period of at least 180 days after December 31 of the performance year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims payments. Submit non-claims payments on an incurred basis, not paid basis. For example, if a provider is eligible for a pay for performance bonus, include the non-claims payment in the year for which they earned the bonus (i.e., the year of submitted data) rather than the year they paid the bonus.

Carriers must also apply reasonable and appropriate estimations of non-claims liability to each large provider entity (including payments they expect to make to organizations not separately identified for TME reporting purposes) that they expect to reconcile after the 180-day review period.

6. Adjusting Payment Data

Carriers must submit data in the Template following the payment data adjustment guidance in the subsections below.

Vendors and Carved-Out Services

Some carriers carve out services (e.g., pharmacy and behavioral health) and may not have access to the claims or encounter data for these services to accurately categorize claims payments. In such cases, carriers estimate spending for these carved-out services following the general parameters below.

The goal of making such adjustments is to estimate what total spending might be for those members without having to collect claims data from the vendors of the carved-out services, such as pharmacy benefit managers (PBMs) or behavioral health vendors. Furthermore, there is some flexibility in how to account for these costs because of the different approaches that organizations use to identify and allocate these costs.

Carriers include payments for covered benefits in the TME calculation, regardless of how they deliver the benefit. They do not include payments for contracts and vendors that provide strictly administrative functions for health plan operations. If a carrier is unable to determine the total payments by service category for carved-out benefits, some options to estimate are to:

- Use encounter data (if available) to estimate payments and include them in the TME calculation allocated to the appropriate service category.
- Apply a reasonable estimate of spending per member per service category (if claims and encounter data for carved-out services are unavailable).

Exhibit 2 exemplifies how to handle carve-out services estimates.

Exhibit 2. Sample Methodology for Estimating Carved-Out Services Spending

For a plan that carves out pharmacy services, the insurer could estimate based on pharmacy spending of commercial members for which they have full claims information. The Insurer could calculate the PMPM spending on members who had pharmacy coverage and apply that amount to members for whom the plan carves out pharmacy services. Insurers must develop these estimates on a PMPM basis.

ⓘ **Note:** Carriers must review adjustments with the state before submitting data under commercial partial claims (Insurance Category Code 4) and describe how they calculated the estimate in the Mandatory Questions tab of the Template. If carriers have questions about adjustments, please contact: CarrierDataSubmission@dobi.nj.gov.

Truncation

To minimize the impact of high-cost outliers on carrier and provider cost growth, the state will not include member level spending above certain dollar amounts in the calculation of cost growth. As a component of TME submission, carriers must submit dollar amounts excluded from claims spending after applying truncation at the member level, truncated claims spending, and the count of members with claims truncated.

While the state recognizes that some carriers separately truncate medical and pharmacy claims spending, they request that they apply truncation to members' total claims spending (medical and pharmacy) if it exceeds the **per member truncation point of $250,000** for the respective insurance category and reporting year. For carriers reporting commercial partial claims (Insurance Category Code 4), apply the member level truncation *after* making estimates of carve-out spending, so that you are applying to an estimate of each members' total claims spending.

Exhibit 3 explains how to truncate partial claims spending for carved-out pharmacy benefits to a PBM.

Exhibit 3. Applying Truncation to Commercial Partial Claims

Example with a carved-out pharmacy benefit to a PBM:

- Carrier uses its commercial full claims population (Insurance Category Code 3) as a benchmark to estimate PMPM spending on pharmacy for its commercial partial claims members (Insurance Category Code 4):
  - For example, carriers could calculate average pharmacy spending PMPM for its commercial market book of business for members who had pharmacy coverage during the associated reporting year(s) and apply to members for whom the carrier carves out pharmacy benefits.
- Carrier adds this PMPM estimate to member level spending by multiplying the estimated pharmacy PMPM from commercial partial claims by the number of member months within each age and sex band.
- Carrier would then apply the per member $250,000 truncation point to commercial partial claims.

ⓘ **Note:** Carriers must review adjustments with the state before submitting data under commercial partial claims (Insurance Category Code 4) and describe how they calculated the estimate in the Mandatory Questions tab of the Template. If carriers have questions about adjustments, please contact: CarrierDataSubmission@dobi.nj.gov.

In addition, for members attributed to more than one large provider entity during the year, carriers must "reset the clock." To reset, first calculate the individual's total spending attributed to each large provider entity for the respective insurance category and reporting year, then separately apply truncation to their spending attributed to each large provider entity.

Exhibit 4 provides an example of how to apply truncation for members attributed to more than one provider entity.

Exhibit 4. Handling Truncation for Members Attributed to More than One Entity During the Calendar Year

Example with the $250,000 truncation point:

- Carrier attributes a member in the commercial market with full claims (Insurance Category Code 3) to Provider X for eight months with $300,000 in claims.
- Carrier attributes member to Provider Y for four months with $275,000 in claims.
- Provider X's spending above the truncation would be $50,000 while Provider Y's spending above the truncation would be $25,000.
- Since the member cost the payer $575,000 in total, the total dollars above the truncation point for the carrier overall (Large Provider Entity 100) would be $325,000.

Risk Adjustment

The state collects member months, amount of claims payments excluded because of truncation, count of members with truncated claims, total non-truncated spending for all claims payment service categories, and total truncated spending amounts by member age bands and sex. They will use this information to develop one set of weights and apply uniformly across all carriers and large provider entities within each LOB.

The state will conduct statistical significance testing to assess carriers' and large provider entities' performance against the cost growth benchmark. This will involve developing confidence intervals around each carrier's and large provider entity's cost growth and determine whether the confidence interval intersects with the benchmark.

ⓘ **Note:** For more information on the statistical testing that the state will conduct, please see the **State Benchmark Implementation Manual**.

To support the development of confidence intervals, carriers must provide standard deviation information on non-risk-adjusted TME after truncating spending for high-cost outliers. Carriers will need to provide standard deviation information for:

- Each market (Medicare, Medicaid, and commercial) for the carrier overall; and
- Each provider entity by market

ⓘ **Note:** For instructions to calculate standard deviation, please the Standard Deviation Tab subsection.

D. File Specification

The subsections below describe the data submission format the state requires carriers to follow.

1. Data Submission Template

Carriers must report data using the **Carrier Benchmark Data Submission Template**. The subsections that follow provide an overview of each tab below and include additional tab-specific requirements and guidance.

ⓘ **Note:** For additional requirements, including the valid value(s) and format for each data field in the input tabs, please see the Data Dictionary appendix.

Contents Tab

This tab lists and provides a high-level summary of each tab in Template.

Reference Tables Tab

This tab includes lookup and mapping tables for the row ID fields in input tabs two through six. The row ID fields are a combination of data elements that have a set of valid value options or category codes. The Reference Tables tab includes the following tables:

- Insurer Code Valid Values
- Insurance Category Code Valid Values

- Large Provider Entity Code Valid Values
- Age Band code Valid Values
- Sex Code Valid Value
- Market code Valid Values
- Line of business code Valid Values
- Market, Insurance Category, and Line of Business Category Codes Crosswalk

ⓘ **Note:** For more information on the row ID fields that uniquely identify records, please see the Reporting Categories subsection.

Cover Page Tab

This tab is for carriers to enter their organization name and contact information for the individual(s) who the state will connect with for data validation questions and feedback.

ⓘ **Note:** For the data element requirements in this tab, please see the data dictionary in the Cover Page (Input Tab 1) appendix.

Total Medical Expenses Tab

This tab is for carriers to report member months, TME for each service category in the Claims Payments and Non-Claims Payments subsections, and the truncated spending amount by the applicable reporting years, insurance categories for which they have business, and large provider entities. The state will use these data to compute THCE and TME.

Carriers must also submit data in the Template that adheres to the guidance in the Reporting of TME subsection.

ⓘ **Note:** For the data element requirements in this tab, including the definitions for the payment service categories, please see the data dictionary in the Total Medical Expenses (Input Tab 2) appendix.

Age and Sex Factors Tab

This tab is for carriers to report member months, total claims payments excluded because of truncation, count of members with truncated claims, total non-truncated claims spending, and total truncated claims spending amounts by the applicable reporting years, insurance categories for which they have business, large provider entities, member age bands, and member sex. The state will use these data to risk adjust TME for carriers and large provider entities.

Note: For the data element requirements in this tab, please see the data dictionary in the Age and Sex Factors (Input Tab 3) appendix.

Standard Deviation Tab

This tab is for carriers to report member months, total truncated claims spending, and standard deviation by the applicable reporting years, markets for which they have business, and large provider entities, which the state will use to calculate confidence intervals for year-to-year cost growth.

To support the development of confidence intervals, carriers provide standard deviation information on non-risk-adjusted TME after truncating spending for high-cost outliers. Input values for the Standard Deviation PMPM field by calculating standard deviation values as follows:

1) Attribute members, including those with no utilization, to the appropriate large provider entity (for more information on attributing members, see the Reporting on Large Provider Entities and Attribution subsection).
2) After partial claims adjustments and truncation of member level spending, calculate the average monthly spending amount of each member using claims allowed amounts for each reporting year, market, and large provider entity. Exclude non-claims expenditures from this average.
3) Use the per month average for each individual and multiply that value by the number of enrolled member months for that individual. Sum the values for all members and divide by the total number of member months to produce a PMPM dollar amount that is specific to a given market and large provider entity. Use each member's average cost applied to *each month the member was enrolled*, instead of the actual utilization each month.
4) With the average claims expenses value for each large provider entity, calculate the standard deviation. Figure 1 shows the standard deviation formula. Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, carriers can calculate the risk-adjusted standard deviation of the PMPM costs for a given market. Lastly, when calculating standard deviation, use the formula for *population standard deviation* (divided by N), NOT the formula for sample standard deviation (divided by N-1).

Figure 1. Standard Deviation Equation

$$SD = \sqrt{\frac{\sum_i (X_i - \bar{X})^2}{N}}$$

5) Input the standard deviation values in the Standard Deviation tab of the Template for the corresponding reporting year, market, and large provider entity.

ⓘ **Note:** For the data element requirements in this tab, please see the data dictionary in the Standard Deviation (Input Tab 4) appendix.

Line of Business Enrollment Tab

This tab is for carriers to report member months by the applicable reporting years and LOBs for which they have business.

ⓘ **Note:** For the data element requirements in this tab, please see the data dictionary in the Line of Business Enrollment (Input Tab 5) appendix.

Pharmacy Rebates Tab

This tab is for carriers to report pharmacy rebate data by the applicable reporting years and insurance categories for which they have business. Carriers must submit data that adheres to the following pharmacy rebate reporting guidance:

- Submit both medical and retail pharmacy rebate amounts as a negative number in the respective fields.
- Submit rebate amounts as the estimated value of total federal and state supplemental rebates provided by pharmaceutical manufacturers for prescription drugs that medical providers and retail pharmacies administer to NJ resident members.
- Medical pharmacy rebates may include drugs with J codes or part of facility fees for administering infusions in the outpatient setting under the professional claims category.
- Include the PBM rebate guarantee amount, and any additional rebate amount transferred by the PBM in the respective fields.
- Submit rebate information based on the fill dates during the corresponding reporting year.
- Do not try to allocate pharmacy rebates at the member- or provider-level.
- Report total rebates without regard to how the carrier received payments (e.g., through regular aggregate payments, on a claim-by-claim basis, and so on). The only exception is for Medicaid managed care organizations (MCOs). MCOs must not report pharmacy rebates that they pass to the state, and only include medical and retail pharmacy rebate amounts beyond the state negotiated rebates.
- Exclude manufacturer-provided fair market value bona fide service fees for retail prescription drugs and for pharmaceuticals that they pay for under the member's medical benefit.
- Exclude stand-alone PDPs.
- If carriers are unable to separate out medical and retail pharmacy rebates for reporting, report all pharmacy rebates in aggregate in the Total Pharmacy Rebate Amount field.

The subsections below include more guidance for completing this tab.

ⓘ **Note:** For the data element requirements in this tab, please see the data dictionary in the Pharmacy Rebates (Input Tab 6) appendix.

Estimating Pharmacy Rebates

Pharmacy rebates may have long tails (e.g., 12 or more months) and carriers may not have complete pharmacy rebate data for the associated reporting year(s) by the benchmark data submission due date. In such cases, they apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the reporting year.

If carriers are unable to report rebates specifically for NJ residents, they should report estimated rebates attributed to NJ residents in a proportion equal to the proportion of pharmacy spending for NJ residents compared to pharmacy spending for total members, by Insurance Category Code. For example, if NJ commercial member spending represents 10% of a carrier's total commercial members, then report 10% of the total pharmacy rebates for its commercial book of business.

If carriers are unable to identify the percentage of pharmacy spending for NJ residents, then they should calculate the pharmacy rebates attributable to NJ residents using percentage of membership.

ⓘ **Note:** Carriers must describe how they calculated the rebate estimate in the Mandatory Questions tab of the Template.

Pharmacy Rebates Passed Back to Employers

Some self-funded employer groups ask carriers to pass portions of the rebates to them. Carriers should report any rebates they receive, regardless of whether they pass along to employers.

Mandatory Questions Tab

This tab is for carriers to attest that the information they submit in the Template is current, complete, and accurate to the best of their knowledge. This tab also requires carriers to answer a series of questions that confirm the data submission follows the specifications and are sound and correct.

Lastly, this tab includes space for carriers with self-insured lines of business to provide income from fees of uninsured plans (in aggregate), which the state will use to calculate the NCPHI. Carriers follow the instructions from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE), Part 1, Line 12, Income from Fees of Uninsured Plans.

ⓘ **Note:** For the data element requirements in this tab, please see the data dictionary in the Mandatory Questions (Input Tab 7) appendix.

Data Validation Checks Tab

This tab is for carriers to review the consistency and reasonableness of data prior to submitting. The summary tables in this tab help carriers validate their own data prior to submission. The state does not require carriers to input any data in this tab, but they must review it prior to submitting to ensure the data are correct.

Validation by Market Tab

This tab is for carriers to review the calculated spend and trend by market and service category prior to submitting. The summary tables in this tab help carriers validate their own data prior to submission. The state does not require carriers to input any data in this tab, but they must review it prior to submitting to ensure the data are correct.

Validation by Provider Tab

This tab is for carriers to review the calculated spend and trend by large provider entity and insurance category prior to submitting. The summary tables in this tab help carriers validate their own data prior to submission. The state does not require carriers to input any data in this tab, but they must review it prior to submitting to ensure the data are correct.

2. File Naming Convention

Carriers must submit data in the **Carrier Benchmark Data Submission Template** with the following naming convention: **Dyyyy_Innn_Vnn_TME.xlsx** (e.g., D2023_I201_V01_TME.xlsx), where:

- "Dyyyy" is the four-digit year (yyyy) when the carrier submits data (i.e., the year when they upload file to the DOBI submission site).
- "Innn" is the three-digit Insurer Code to identify each carrier (i.e., one of the following Insurer Codes: 201 = Aetna Better Health, 202 = Amerigroup; 203 = AmeriHealth Insurance Co., 204 = Cigna Health & Life Insurance Co., 205 = Horizon Healthcare of NJ, 206 = United HealthCare Insurance Co., or 207 = WellCare Health Plans of NJ, Inc.).
- "Vnn" is the submission number (i.e., use "V01" for first submission, "V02" if first submission requires corrections, and so on).
- ".xlsx" is the required file extension to use when saving and submitting the file.

III. Data Submission and Validation Process

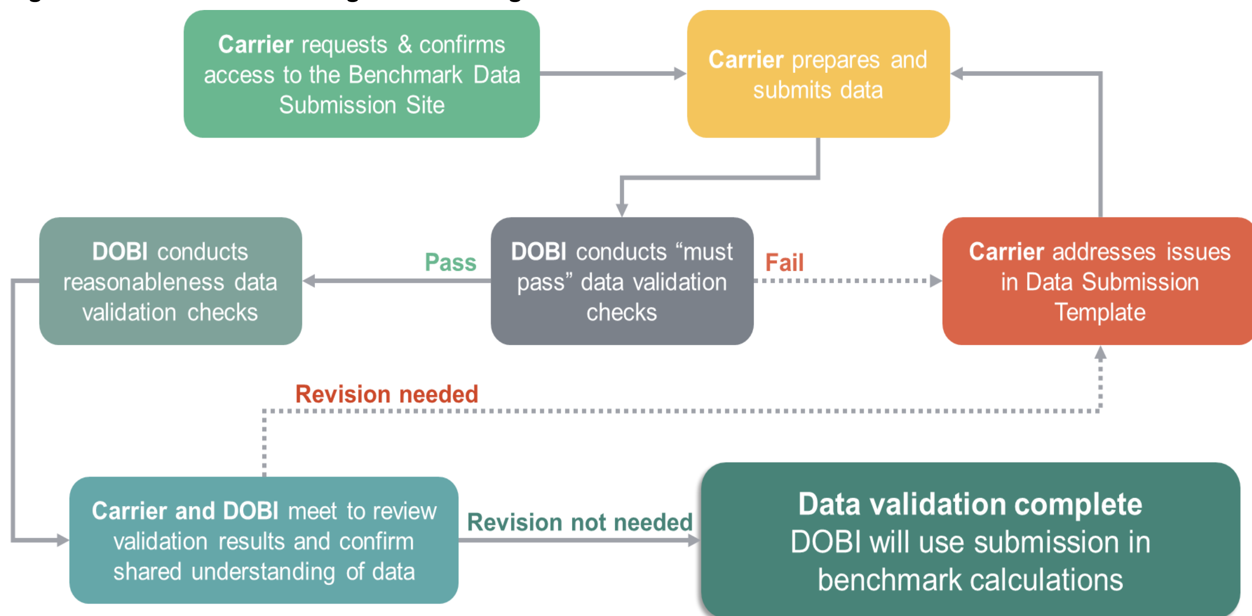
This section details how and when carriers submit spending data for the cost growth benchmark data analysis, including the process they should expect to go through following data submission and before the state reports data publicly.[1]

A. Process Overview

The data submission and validation process is iterative and may require carriers to resubmit data at various stages throughout the process. The goal of validation is to confirm that carrier submitted data are reasonable before combining with other payer data for the statewide, market, and provider organization analyses described in the Measuring THCE and TME subsection.

Figure 2 is an overview of the required annual data submission and validation process. The subsections below detail the steps necessary to complete this process.

Figure 2. Process for submitting and validating data



1. Carrier Requests and Confirms Access to the Benchmark Data Submission Site

The subsections that follow provide information on the Benchmark Data Submission Site that carriers must use to upload their completed **Carrier Benchmark Data Submission Template** and access their data validation report for their submission.

[1] In the first data collection and reporting cycle, DOBI will measure cost growth information for insurers and provider entities and share with them confidentially; in future cycles, the state will publicly report cost growth information at the insurer- and provider entity-levels, and eventually compare against the benchmark.

Access to the Benchmark Data Submission Site

At least two people from each carrier (primary contact and a backup contact), must obtain login credentials to access the DOBI SharePoint site where they upload their completed Template.

To request access for new users, email the following information to DOBI at CarrierDataSubmission@dobi.nj.gov:

- Organization name
- First and last names of primary and backup contacts
- Email addresses for primary and backup contacts

Carriers should request access as soon as possible to avoid any delays in uploading their Template by the data submission due date. Once DOBI grants access, each user will receive an email from no-reply@sharepointonline.com. Confirm access to the site by clicking the link in the email, which should take you to the login screen of the Benchmark Data Submission Site (https://sonj.sharepoint.com/sites/DOBI-HART).

Uploading Files to the Submission Site

Once you have access to the site, confirm you can upload a file by completing the following steps:

1) Navigate to your organization's folder:
   a. If uploading a test file, click the subfolder labeled "Test file upload - fake data."
   b. If uploading your completed Template, make sure to save it with the required file naming convention (for the file name requirements, see the File Naming Convention subsection), then continue to the next step.
2) Click the "Upload" drop-down at the top of the page, then select "Files."
3) Choose the file you wish to upload from your local directory, then click the "Open" button and the file should appear on the submission site page.

This is the process carriers follow to submit the completed Template to DOBI. Please do not overwrite existing Templates uploaded to the site if you are resubmitting corrected data.

Forgotten Login Credentials to the Submission Site

Submission site users' login with their email address and a security code that they receive via email for each login. The site does not require users to login with a password; therefore, users should avoid clicking the reset password link if it is visible. Users will have three opportunities to enter the correct security code that they receive via email, after which the site will lock them out.

ⓘ **Note:** For questions or help troubleshooting any issues with the Benchmark Data Submission Site, please contact: CarrierDataSubmission@dobi.nj.gov.

Deactivating Submission Site Users

Submission site users' login links to their company email address, so if they leave the organization, it is the company's responsibility to deactivate their email address, which would preclude them from accessing the submission site. In addition to the company disabling the user's email address, carriers should also notify DOBI by emailing the following information to CarrierDataSubmission@dobi.nj.gov:

- Organization name
- First and last name of user to deactivate
- Email address of user to deactivate

2. Carrier Prepares and Submits Data

Carriers must report data using the **Carrier Benchmark Data Submission Template** and according to the specifications outlined in this Guide (that is, failure to follow requirements will result in the state's non-acceptance of the data submission). Exhibit 5 includes the steps carriers take to prepare for data submission. Although it is common for a carrier to submit data multiple times, following this guidance will help mitigate the number of resubmissions needed and decrease the overall time for completing this process.

Exhibit 5. Data Submission Checklist

☐ **Request and confirm access to the Benchmark Data Submission Site.**

- ✓ Carrier must complete steps in the Carrier Requests and Confirms Access to the Benchmark Data Submission Site subsection at least a month or more before the data submission due date.

☐ **Complete the Carrier Benchmark Data Submission Template.**

- ✓ Carrier must review and reference the Carrier Reporting Requirements section and the Data Dictionary appendix when completing the workbook to ensure data align with the specifications.
- ✓ Ensure there are no leading or trailing spaces when entering data into cells in the Template; extra spaces may result in the submission failing validation check(s) that require the carrier to update data and resubmit to the state.
- ✓ Do not rearrange or move tabs, columns, or rows in the Template; inputting data in the wrong cells may result in the submission failing validation check(s) that require the carrier to update and resubmit data to the state.

☐ **Review inputted data and validation tabs in the Template and make corrections, if needed.**

- ✓ After entering all required data in the Template, carrier must review the input tabs and **correct any issues in cells highlighted in red**. Cells turn red if input does not adhere to the requirements under the Valid Value(s) columns in the Data Dictionary appendix tables (e.g., cell turns red if input for the row ID fields in the Reporting Categories subsection do not align with the coded values, for the member months fields if input is not a non-negative integer, and so on); however, please note if carriers copy and paste data into template, it may override the data validation checks that highlight cells when there are issues.
- ✓ After fixing any data in red highlighted cells, carrier must review the three auto-calculated validation tabs in the Template (i.e., the Data Validation Checks, Validation by Market, and Validation by Provider tabs) and **correct any potential data quality issues that the Template identified via the tables in the validation tabs**. These three validation tabs contain some of the validation checks that the state will

Exhibit 5. Data Submission Checklist

perform upon receiving each submission uploaded to the submission site, which allows the submitter to identify potential issues before submission.

- ✓ Provide any comments that may help the state better understand inconsistencies, anomalies, trends, and so on, in the Mandatory Questions tab.

☐ **Upload completed Template to the submission site with the required file naming convention.**

- ✓ After making corrections to the data in the Template, carrier must upload the completed Template to the submission site (for instructions on how to upload the Template, see the Uploading Files to Data Submission Site subsection). ◢

ⓘ **Note:** The built-in Excel Template validation checks do not cover all requirements; therefore, the state will perform additional checks that may identify more issues beyond those flagged in the Template.

3. State Validates Data

Before the cost growth analysis can begin, DOBI will conduct validation checks on the carrier-submitted data in four stages. Validation checks in stages one through three flag obvious errors or omissions in the submitted data, and validation checks in stage four are more in-depth, and will flag numbers that do not seem reasonable at face value or based on publicly available data sources.

Each of the four validation stages can end in two ways, described further below. If DOBI requires the carrier to resubmit data, they will **restart the validation process and re-check everything** within the new submission (i.e., not just the updated data) to ensure that it meets the requirements and does not warrant further clarification from the carrier.

1) **Stage one preliminary data checks.** DOBI completes these checks upon receiving each submission to validate that the submission meets the requirements in the File Specification subsection):
   - If submission *fails checks*, DOBI provides a validation report to the carrier that outlines the issue(s) and includes instructions for how to correct and resubmit data.
   - If submission *passes checks*, DOBI continues to the next stage of checks.
2) **Stage two completeness and formatting checks.** These intra-tab checks validate that the data adheres to the field-level requirements under the Required Value and Valid Value(s) columns in the Data Dictionary appendix tables:
   - If submission *fails checks*, DOBI provides a validation report.
   - If submission *passes checks*, DOBI continues to the next stage of checks.
3) **Stage three consistency checks.** These intra- and inter-tab checks validate that the submission meets the record-level requirements, and that data aligns within and across each applicable tab:
   - If submission *fails checks*, DOBI provides a validation report.
   - If submission *passes checks*, DOBI continues to the next stage of checks.

4) **Stage four reasonableness checks.** These are more in-depth checks to validate whether member months, TME PMPM spending, and other submitted data, are reasonable compared to publicly available data sources, across payment service and insurance categories, among each provider entity, and so on. The results of stage four checks will not be "pass" or "fail;" therefore, DOBI will engage with carriers one-on-one to discuss findings and questions, including clarifications on any *potential* issues identified during this stage:
   - If the *carrier identifies any issues while affirming the flagged reasonableness check(s)*, they will remediate and resubmit data.
   - If *DOBI and the carrier agree that the flagged reasonableness check(s) do not indicate an error*, the validation process is complete, and DOBI will use carrier submitted data in the benchmark analysis.

Exhibit 6 includes examples of the validation checks DOBI will perform.

ⓘ **Note:** The validation checks below are not an exhaustive list and are subject to change based on findings in carrier data submissions.

Exhibit 6. Validation Checks by Stage

Stage one checks

- Data is in the **Carrier Benchmark Data Submission Template**.

Stage two checks

- Required data is not missing (e.g., data adheres to the conditions under the Required Value columns in the Data Dictionary appendix tables).
- Data is in the correct format (e.g., data adheres to the conditions under the Valid Value[s] columns in the Data Dictionary appendix tables).

Stage three checks

- The combination of values in the row ID fields are unique for each record (e.g., more than one row in a tab cannot have the same combination of Reporting Year, Insurance Category or Market Code, and so on).
- Input aligns with the carriers' markets for which they have business, and data is consistent within and across tabs.
- The combination of values in the row ID fields in the TME tab have corresponding records in the Standard Deviation, LOB Enrollment, and Pharmacy Rebates tabs, and vice versa (e.g., if carrier inputs data for Insurance Category Code 1 in the TME tab, then they must also input data for Market Code 1 in the Standard Deviation tab, LOB Category Code 6 in the LOB Enrollment tab, and so on).
- Input includes data for carrier overall (Large Provider Entity Code 100 in the TME, Age and Sex Factors, and Standard Deviation tabs), and is consistent with data for other Large Provider Entity Codes (e.g., sum of member months entered for other provider entity codes must equal Large Provider Entity Code 100).

Exhibit 6. Validation Checks by Stage

Stage four checks

- TME PMPM spending across service categories appear reasonable (e.g., flagging if PMPM was less than $10, if long-term care claims spending for the commercial market was more than expected, and so on).
- Difference in TME PMPM between commercial full and partial claims appear reasonable (e.g., flagging if PMPM difference was more than 9%).
- Percentages of members' sex at birth appear reasonable (e.g., flagging if less than 50% and/or more than 70% of members were female).
- Percentages of members' age appear reasonable (e.g., flagging if more than 20% of MA non-dual eligible members were under 65 years old, more than 60% of dual eligible members were under 65 years old, and/or less than 80% of commercial or Medicaid MCO non-dual members were under 65 years old).
- Year-to-year changes in member months appear reasonable (e.g., flagging if change increased or decreased more than 10%).
- Year-to-year changes in non-truncated TME (net of pharmacy rebates) PMPM appear reasonable (e.g., flagging if change increased or decreased more than 5%).
- Year-to-year changes in TME payment service category PMPMs appear reasonable (e.g., flagging if change increased or decreased more than 10%).
- Year-to-year changes in TME PMPM by provider entity appear reasonable (e.g., flagging if change increased or decreased more than 10%).
- Percentages of members with truncated spending appear reasonable.
- Methodology for estimating costs for commercial partial claims that carrier described in the Mandatory Questions tab is appropriate and aligns with the specifications in the Vendors and Carved-Out Services subsection.
- Member months for the commercial market appear reasonable compared to the CMS MLR Data.
- Member months for the MA market appear reasonable compared to the CMS Medicare Advantage/ Part D Contract and Enrollment Data.
- Member months for the Medicaid MCO market appear reasonable compared to the CMS Medicaid Enrollment Data.

4. Carrier and DOBI Discuss Validation Results

Once DOBI completes the stage four checks that assess reasonableness of the data submission, they will engage with carriers one-on-one to discuss findings and questions, including clarifications on any potential issues identified during this stage. More information on the communications and meeting scheduling process with carriers are forthcoming.

5. Post-Validation Process

After DOBI completes the validation process with all carriers and performs the computations referenced in the **State Benchmark Implementation Manual**, they will provide an opportunity for carriers to review

the results before they report information, as outlined in the Public Reporting of Benchmark Performance Results subsection.

In addition to sharing carrier-level results, the state will share preliminary results with each large provider entity that they reported on, and request that provider entities direct any questions about their data to carriers in advance of public reporting.

B. Process Timeline

Insurers must submit data according to the specifications in the Carrier Reporting Requirements section and due dates in the Submission Schedule subsection. If the state identifies issues in a data submission, they request that the carrier remediate and submit a corrected Template within three weeks of receiving the validation report (if they find issues in stages one through three), or within three weeks of the meeting with DOBI (if carrier identifies any issues while affirming the flagged reasonableness checks).

C. Technical Assistance Available to Carriers

If carriers have questions about the data submission and validation process, please contact: CarrierDataSubmission@dobi.nj.gov. In addition, the state will post materials and resources to the following places:

- DOBI’s NJ HART program webpage in the Information for Data Submitters subpage; and
- DOBI’s Benchmark Data Submission Site in the General Information folder.

Appendix A. Data Dictionary

This appendix provides the data dictionaries for the input tabs in the **Carrier Benchmark Data Submission Template**. To ensure data aligns with the specifications, carriers must reference the requirements and guidance in the subsections below, which include the following information about each data element:

- **Name** – Field name as it appears in the tab.
- **ID** – Unique identifier for the field.
- **Required Value** – Indicates whether the field requires input; if carrier omits required data, the state will require corrected resubmission.
- **Valid Value(s)** – Lists the required field input options separated by a semi-colon or the required format for input; if data does not adhere to requirements under this column, the state will require corrected resubmission.
- **Description** – Explains the field, and includes the associated subsections with additional requirements, if applicable; if data does not adhere to requirements under this column, carrier must correct and resubmit.

ⓘ **Note:** The state checks each carrier data submission for adherence to all applicable specifications in the Carrier Reporting Requirements section and in this appendix. If a submission fails the validation checks, the state will provide a validation report outlining which data have issues, and request that they correct and resubmit. For more information on validating data, please see the Data Submission and Validation Process section.

Cover Page (Input Tab 1)

Table 14 includes the data dictionary for the Cover Page tab.

Table 14. Data Fields in Cover Page Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Name	CP01	Yes	Aetna Better Health; Amerigroup; AmeriHealth Insurance Co.; Cigna Health & Life Insurance Co.; Horizon Healthcare of NJ; United HealthCare Insurance Co.; WellCare Health Plans of NJ, Inc.	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.

Name	ID	Required Value	Valid Value(s)	Description
Primary Contact Name	CP02	Yes	<Free text>	Input first and last name of the individual who can answer and address data validation questions from the state.
Primary Contact Email	CP03	Yes	<Free text>	Input company email address for the primary contact.
Secondary Contact Name (Optional)	CP04	No	<Free text>	Optionally input first and last name of additional contact who the state should include on data submission and validation communications.
Secondary Contact Email (Optional)	CP05	No	<Free text>	Optionally input company email address for the secondary contact.

Total Medical Expenses (Input Tab 2)

Table 15 includes the data dictionary for the TME tab.

Table 15. Data Fields in TME Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	TM01	Yes	201; 202; 203; 204; 205; 206; 207	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab. For descriptions of each valid value option, see the Insurer Codes subsection.
Reporting Year	TM02	Yes	2018; 2019	Input calendar year of data in the row.
Insurance Category Code	TM03	Yes	1; 2; 3; 4; 5; 6; 7; 8	If data does not align with the markets for which they have business, state will request resubmission to update data. For information on how Insurance Category Codes align with LOB Category and Market Codes, see the code mappings in the Reference Tables tab of the Template. For descriptions of each valid value option, see the Insurance Category Codes subsection.
Large Provider Entity Code	TM04	Yes	100; 101; 102; 103; 104; 105; 106; 107; 108; 109; 110; 111; 112; 113; 114; 115; 116; 117; 118; 999	If row for carrier overall (Large Provider Entity Code 100) is missing, state will request resubmission to update data. For descriptions of each valid value option, see the Large Provider Entity Codes subsection. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.

Name	ID	Required Value	Valid Value(s)	Description
Member Months	TM05	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Calculate member months by taking the number of members with a medical benefit (regardless of whether they have any paid claims) and multiplying that sum by the number of months in the member's policy. Carrier must exclude Medigap members but include members in Dual Special Needs Plans. Value must be consistent across tabs for the respective row ID fields (e.g., if carrier had members in Medicaid MCO plans for the corresponding reporting years, then sum of TM05 for Insurance Category Codes 2 and 6 must equal sum of AS07 for Insurance Category Codes 2 and 6, sum of SD05 for Market Code 2, and sum of LB04 for LOB Category Codes 7 and 9). Value must also be more than zero if Total Non-Truncated Claims and Non-Claims Spending (TM25) is more than zero.
Claims: Hospital Inpatient	TM06	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from institutional claims paid to all hospital types for inpatient services for the respective row ID fields. Hospital inpatient services include payments made for all room and board, ancillary services, and emergency room (ER) services when the hospital admits member from the ER, in accordance with the specific carrier's payment rules. This category excludes payments made for observation services, physician services provided during an inpatient stay that a physician or a group practice billed directly, and inpatient services at non-hospital facilities. For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Hospital Outpatient	TM07	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from institutional claims paid to all hospital types for outpatient services for the respective row ID fields. Hospital outpatient services include payments made for hospital-licensed satellite clinics, ER services not resulting in admittance, and observation services. This category excludes payments made for physician services provided on an outpatient basis that a physician or a group practice billed directly. For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Professional, Primary Care Providers	TM08	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from professional claims paid to primary care providers or primary group practices for primary care services delivered at a primary care site, using the state's primary care definition and codes to identify primary care providers, services, and sites of care for the respective row ID fields**.** For more information, see the Primary Care Definition and Codes appendix and the Reporting of TME and Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Claims: Professional, Specialty Providers	TM09	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from professional claims paid to specialty care physicians or specialty physician group practices for the respective row ID fields. Specialty care services include payments made to: (1) a Doctor of Medicine or Osteopathy (MD or DO) practicing in clinical areas other than the family medicine, geriatric medicine, internal medicine, and pediatric medicine specialties (i.e., not in the primary care taxonomy code list in Appendix B); or (2) an MD or DO practicing family medicine, geriatric medicine, internal medicine, and/or pediatric medicine (i.e., in the primary care taxonomy code list in Appendix B) for services they delivered outside of the primary care setting (e.g., for inpatient evaluation and management [E/M] services). For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Professional, Other Providers	TM10	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from professional claims paid to licensed practitioners other than a physician or primary care provider for the respective row ID fields. Other provider services include payments made to: (1) licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, any professional fees that do not fit other categories, and services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services; or (2) a primary care licensed practitioner (i.e., in the primary care taxonomy code list in Appendix B) other than an MD or DO for services they delivered outside of the primary care setting (e.g., for inpatient E/M services). For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Long-Term Care	TM11	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from claims paid to providers for long-term care services for the respective row ID fields. Long-term care services include payments made to providers for services delivered in: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for people with intellectual disability (ICF/ ID) and assisted living facilities; and (3) providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, and so on), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, and so on), and programs designed to assist people with long-term care needs who receive care in their home and community. This category excludes payments made for professional services rendered during a facility stay that an individual practitioner or physician group practice billed directly. For more information, see the Reporting of TME and Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Claims: Retail Pharmacy	TM12	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from claims paid to providers for retail pharmacy for the respective row ID fields. Retail pharmacy includes payments made to providers for prescription drugs, biological products, and vaccines as defined by the carrier's prescription drug benefit and gross of applicable rebates. This category excludes payments made for pharmaceuticals under the carrier's medical benefit. Attribute pharmacy payments made under the medical benefit to the setting in which they delivered the pharmaceuticals (e.g., attribute pharmaceuticals delivered in a hospital inpatient setting to Claims: Hospital Inpatient). This category also excludes payments made for the cost of vaccines administered in the primary care setting. As noted in the Included Populations subsection, exclude payments made under stand-alone PDPs in the submission. For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Other	TM13	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from claims paid to providers for medical services not otherwise included in other categories for the respective row ID fields. Other services include durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center and urgent care center services, hospice facility or services, freestanding diagnostic facility services, hearing aid services, optical services, and the cost of vaccine products administered in the primary care setting. This category excludes payments made for non-health care benefits and services, such as fitness club reimbursements and membership discounts – whether given to the provider or given in the form of a capitated payment to an organization that assists the carrier with enrolling members in gyms. For any other services that the carrier is unable to classify, consult with DOBI about the appropriate placement of the service prior to including in this service category. For more information, see the Reporting of TME and Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Non-Claims: Capitation or Bundled Arrangements	TM14	Yes	Non-negative number	Input payment amount made to providers outside of the claims system for services delivered under capitation or bundled payment arrangements for the respective row ID fields. Capitation or bundled arrangements include: (1) capitation payments (i.e., per capita payments to providers to provide healthcare services over a defined period of time); (2) global budget payments (i.e., prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits such as behavioral health or pharmacy are carved out); (3) case rate payments (i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time); and (4) prospective episode-based payments (i.e., payments received by providers, which can span multiple provider organizations, for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period). For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Performance Incentives	TM15	Yes	Number	Input payment amount made to providers outside of the claims system for performance incentives tied to achieving quality or cost-savings goals, or payments for reducing costs that exceed a defined pre-determined risk-adjusted target for the respective row ID fields. Performance incentive payments include: (1) pay-for-performance (i.e., payments to reward providers for achieving a set absolute, relative, or improvement-based target for quality or efficiency metrics); (2) pay-for-reporting (i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance payments); and (3) shared savings distributions (i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, such as payments providers recoup if costs of services are above a pre-determined, risk-adjusted target). For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Pop Health and Practice Infrastructure	TM16	Yes	Non-negative number	Input payment amount made to providers outside of the claims system for developing practice capacity and infrastructure to help coordinate care, improve quality, and control costs for the respective row ID fields. Population health and practice infrastructure payments include: (1) support for care management, care coordination, and population health; (2) health information technology infrastructure payments, health information exchange, and other data analytics payments; (3) patient-centered medical home administration and recognition payments; and (4) behavioral health integration that are not reimbursable through claims. For more information, see the Reporting of TME and Non-Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Non-Claims: Provider Salaries	TM17	Yes	Non-negative number	Input payment amount made outside of the claims system for salaries of providers who delivered health care services not otherwise included in other claims and non-claims categories for the respective row ID fields. This category typically only applies to closed delivery systems. For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Recovery	TM18	Yes	Non-positive number	**This is the only service category where carriers input a negative number for payment amount.** Input payment amount made outside of the claims system to providers, members/ beneficiaries, or other carriers, for which the carrier later recouped due to a review, audit, or investigation for the respective row ID fields. Recovery may include infrastructure payments recouped under total cost of care arrangements if a provider does not generate savings. This category excludes payments under other categories (e.g., if amount for Claims: Hospital Inpatient is net of recovery, do not separately report the same recovery amount in this category). For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Other	TM19	Yes	Non-negative number	Input payment amount made to providers outside of the claims system, pursuant to the carrier's contract with a provider, and not otherwise included in other categories for the respective row ID fields. Other non-claims may include governmental carrier shortfall payments, grants, or other surplus payments. This category excludes carrier administrative expenditures (including corporate allocations). For any other services that the carrier is unable to classify, consult with DOBI about the appropriate placement of the service prior to including in this service category. For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Total Primary Care	TM20	Yes	Non-negative number	**This is the only service category not mutually exclusive to other non-claims categories**. Input payment amount made outside of the claims system to primary care providers or primary care provider organizations for the respective row ID fields. This category must be a sub-set of payments reported in the other non-claims categories. Value must be less than or equal to Total Non-Claims Spending (TM24). For more information, see the Reporting of TME and Non-Claims Payments subsections.
Claims Amount Excluded Due to Truncation	TM21	Yes	Non-negative number	Input total claims-based spending amount excluded because of the $250,000 truncation point for the respective row ID fields. Value must be zero if Member Count with Truncated Claims (TM22) is zero, or more than zero if value for TM22 is greater than zero. Value must also be consistent with AS08 for the respective row ID fields. For more information, see the Truncation subsection.

Name	ID	Required Value	Valid Value(s)	Description
Member Count with Truncated Claims	TM22	Yes	Non-negative integer	Input number of members who had spending above the $250,000 truncation threshold for the respective row ID fields. Value must be zero if Claims Amount Excluded Due to Truncation (TM21) is zero, or more than zero if value for TM21 is greater than zero. Value must also be consistent with AS08 for the respective row ID fields. Value must also be consistent with AS09 for the respective row ID fields. Lastly, value must be less than total members for the respective row ID fields (i.e., TM05 divided by twelve).
Total Non-Truncated Claims Spending	TM23	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness**. Total unadjusted, non-truncated allowed amount from all claims payment service categories for the respective row ID fields (i.e., sum of TM06 through TM13). Value must be consistent with AS10 for the respective row ID fields.
Total Non-Claims Spending	TM24	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total amount from mutually exclusive non-claims payment service categories for the respective row ID fields (i.e., sum of TM14 through TM19).
Total Non-Truncated Claims and Non-Claims Spending	TM25	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total Non-Truncated Claims Spending and Total Non-Claims Spending for the respective row ID fields (i.e., sum of TM23 and TM24).
Total Truncated Claims Spending	TM26	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total Non-Truncated Claims Spending less Claims Amount Excluded Due to Truncation for the respective row ID fields (i.e., difference of TM23 and TM21). Value must be consistent with AS11 and SD06 for the respective row ID fields.
Total Truncated Expenses	TM27	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total Non-Claims Spending and Total Truncated Claims Spending for the respective row ID fields (i.e., sum of TM24 and TM26).
Non-Truncated TME PMPM	TM28	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total Non-Truncated Claims and Non-Claims Spending PMPM for the respective row ID fields (i.e., TM25 divided by TM05).
Truncated TME PMPM	TM29	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total Truncated Expenses PMPM for the respective row ID fields (i.e., TM27 divided by TM05).

Age and Sex Factors Tab (Input Tab 3)

Table 16 includes the data dictionary for the Age and Sex Factors tab.

Table 16. Data Fields in Age and Sex Factors Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	AS01	Yes	201; 202; 203; 204; 205; 206; 207	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab. For descriptions of each valid value option, see the Insurer Codes subsection.
Reporting Year	AS02	Yes	2018; 2019	Input calendar year of data in the row.
Insurance Category Code	AS03	Yes	1; 2; 3; 4; 5; 6; 7; 8	If data does not align with the markets for which they have business, state will request resubmission to update data. For information on how Insurance Category Codes align with LOB Category and Market Codes, see the code mappings in the Reference Tables tab of the Template. For descriptions of each valid value option, see the Insurance Category Codes subsection.
Large Provider Entity Code	AS04	Yes	100; 101; 102; 103; 104; 105; 106; 107; 108; 109; 110; 111; 112; 113; 114; 115; 116; 117; 118; 999	If row for carrier overall (Large Provider Entity Code 100) is missing, state will request resubmission to update data. For descriptions of each valid value option, see the Large Provider Entity Codes subsection. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.
Age Band Code	AS05	Yes	1; 2; 3; 4; 5; 6; 7; 8	For descriptions of each valid value option, see the Age Band Codes subsection.
Sex Code	AS06	Yes	1; 2	For descriptions of each valid value option, see the Sex Codes subsection.
Member Months	AS07	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Calculate member months by taking the number of members with a medical benefit (regardless of whether they have any paid claims) and multiplying that sum by the number of months in the member's policy. Carrier must exclude Medigap members but include members in Dual Special Needs Plans. Value must be consistent across tabs for the respective row ID fields (e.g., if carrier had members in Medicaid MCO plans for the corresponding reporting years, then sum of AS07 for Insurance Category Codes 2 and 6 must equal sum of TM05 for Insurance Category Codes 2 and 6, sum of SD05 for Market Code 2, and sum of LB04 for LOB Category Codes 7 and 9).
Claims Amount Excluded Due to Truncation	AS08	Yes	Non-negative number	Input total claims-based spending amount excluded because of the $250,000 truncation point for the respective row ID fields. Value must be zero if Member Count with Truncated Claims (AS09) is zero, or more than zero if value for AS09 is greater than zero. Value must be consistent with TM21 for the respective row ID fields. For more information, see the Truncation subsection.

Name	ID	Required Value	Valid Value(s)	Description
Member Count with Truncated Claims	AS09	Yes	Non-negative integer	Input number of members who had spending above the $250,000 truncation threshold. Value must be zero if Claims Amount Excluded Due to Truncation (AS08) is zero, or more than zero if value for AS08 is greater than zero. Value must also be consistent with TM22 for the respective row ID fields.
Total Non-Truncated Claims Spending	AS10	Yes	Non-negative number	Input total unadjusted, non-truncated allowed amount from all claims payment service categories for the respective row ID fields. Value must be consistent with TM23 for the respective row ID fields.
Total Truncated Claims Spending	AS11	Yes	Non-negative number	Input total truncated claims spending amount for the respective row ID fields. Value must be consistent with TM26 and SD06 for the respective row ID fields.

Standard Deviation Tab (Input Tab 4)

Table 17 includes the data dictionary for the Standard Deviation tab.

Table 17. Data Fields in Standard Deviation Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	SD01	Yes	201; 202; 203; 204; 205; 206; 207	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab. For descriptions of each valid value option, see the Insurer Codes subsection.
Reporting Year	SD02	Yes	2018; 2019	Input calendar year of data in the row.
Market Code	SD03	Yes	1; 2; 3	If data does not align with the markets for which they have business, state will request resubmission to update data. For information on how Market Codes align with Insurance and LOB Category Codes, please see the code mappings in the Reference Tables tab of the Template. For descriptions of each valid value option, see the Market Codes subsection.
Large Provider Entity Code	SD04	Yes	100; 101; 102; 103; 104; 105; 106; 107; 108; 109; 110; 111; 112; 113; 114; 115; 116; 117; 118; 999	If row for carrier overall (Large Provider Entity Code 100) is missing, state will request resubmission to update data. For descriptions of each valid value option, see the Large Provider Entity Codes subsection. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.

Name	ID	Required Value	Valid Value(s)	Description
Member Months	SD05	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Calculate member months by taking the number of members with a medical benefit (regardless of whether they have any paid claims) and multiplying that sum by the number of months in the member's policy. Carrier must exclude Medigap members but include members in Dual Special Needs Plans. Value must be consistent across tabs for the respective row ID fields (e.g., if carrier had members in Medicaid MCO plans for the corresponding reporting years, then sum of SD05 for Market Code 2 must equal sum of AS07 for Insurance Category Codes 2 and 6, sum of TM05 for Insurance Category Codes 2 and 6, and sum of LB04 for LOB Category Codes 7 and 9).
Total Truncated Claims Spending	SD06	Yes	Non-negative number	Input total truncated claims spending amount. Value must be consistent with TM26 and AS11 for the respective row ID fields.
Standard Deviation PMPM	SD07	Yes	Non-negative number	Input calculated standard deviation PMPM for all members, including those with no utilization, for the respective row ID fields. Base on PMPM spending and calculate the standard deviation PMPM after partial claims adjustments. Exclude non-claims expenditures in the calculation. For more information, see the Standard Deviation Tab subsection.

Line of Business Enrollment (Input Tab 5)

Table 18 includes the data dictionary for the LOB Enrollment tab.

Table 18. Data Fields in LOB Enrollment Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	LB01	Yes	201; 202; 203; 204; 205; 206; 207	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab. For descriptions of each valid value option, see the Insurer Codes subsection.
Reporting Year	LB02	Yes	2018; 2019	Input calendar year of data in the row.
Line of Business Category Code	LB03	Yes	1; 2; 3; 4; 5; 6; 7; 8; 9; 10; 11	If data does not align with the markets for which they have business, state will request resubmission to update data. For information on how LOB Category Codes align with Market and Insurance Category Codes, please see the code mappings in the Reference Tables tab of the Template. For descriptions of each valid value option, see the LOB Category Codes subsection.

Name	ID	Required Value	Valid Value(s)	Description
Member Months	LB04	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Calculate member months by taking the number of members with a medical benefit (regardless of whether they have any paid claims) and multiplying that sum by the number of months in the member's policy. Carrier must exclude Medigap members but include members in Dual Special Needs Plans. Value must be consistent across tabs for the respective row ID fields (e.g., if carrier had members in Medicaid MCO plans for the respective corresponding years, then sum of LB04 for LOB Category Codes 7 and 9 must equal sum of SD05 for Market Code 2, sum of AS07 for Insurance Category Codes 2 and 6, and sum of TM05 for Insurance Category Codes 2 and 6).

Pharmacy Rebates (Input Tab 6)

Table 19 includes the data dictionary for the Pharmacy Rebates tab.

Table 19. Data Fields in Pharmacy Rebates Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	RX01	Yes	201; 202; 203; 204; 205; 206; 207	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab. For descriptions of each valid value option, see the Insurer Codes subsection.
Reporting Year	RX02	Yes	2018; 2019	Input calendar year of data in the row.
Insurance Category Code	RX03	Yes	1; 2; 3; 4; 5; 6; 7; 8	If data does not align with the markets for which they have business, state will request resubmission to update data. For information on how Insurance Category Codes align with LOB Category and Market Codes, see the code mappings in the Reference Tables tab of the Template. For descriptions of each valid value option, see the Insurance Category Codes subsection.

Name	ID	Required Value	Valid Value(s)	Description
Medical Pharmacy Rebate Amount	RX04	Yes, if carrier can separate out medical and retail pharmacy rebates	Negative number	Input federal and state supplemental rebates provided by pharmaceutical manufacturers for prescription drugs that *medical providers* administered to NJ resident members or input zero if they did not provide rebates for the respective row ID fields. Amount includes PBM rebate guarantee amount, and any additional rebate amount transferred by the PBM. If carrier populates RX04 and RX05, they do not need to populate amount for RX06. For more information, see the Pharmacy Rebates Tab subsection.
Retail Pharmacy Rebate Amount	RX05	Yes, if carrier can separate out medical and retail pharmacy rebates	Negative number	Input federal and state supplemental rebates provided by pharmaceutical manufacturers for prescription drugs that *retail pharmacies* administered to NJ resident members or input zero if there is no rebate amount for the respective row ID fields. Amount includes PBM rebate guarantee amount, and any additional rebate amount transferred by the PBM. If carrier populates RX04 and RX05, they do not need to populate amount for RX06. For more information, see the Pharmacy Rebates Tab subsection.
Total Pharmacy Rebate Amount	RX06	Yes, if Medical Pharmacy Rebate Amount (RX04) and Retail Pharmacy Rebate Amount (RX05) are missing/ blank; otherwise no	Negative number	Input pharmacy rebate amount *only* if carrier is unable to separately report medical and retail pharmacy rebates (i.e., they cannot input values in RX04 and RX05 for the respective row ID fields). For more information, see the Pharmacy Rebates Tab subsection.
Total Medical and Retail Pharmacy Rebate Amount	RX07	No, Template calculates value	Negative number	**Carrier reviews for reasonableness**. Total pharmacy rebate amount for the respective row ID fields (i.e., sum of RX04 and RX05 if RX04 is NOT missing/ blank; else RX06).

Mandatory Questions (Input Tab 7)

Table 20 includes the data dictionary for the Mandatory Questions tab. Carriers should also input more information related to the question, if applicable, in the Comments fields (MQ03C-MQ34C).

Table 20. Data Fields in Mandatory Questions Tab

Name	ID	Required Value	Valid Value(s)	Description
Attestation				
Authorized Signatory	MQ01	Yes	<Free text>	Input authorized signature (must be typed) attesting that data entered in tabs 1 through 6 are current, complete, and accurate to the best of knowledge.
Sign Date	MQ02	Yes	yyyy-mm-dd	Input signature date. If date is implausible (i.e., date before the state issued the benchmark data request or after carrier submits file), state will request resubmission to update date.
Data Completeness and Estimation Questions				
What is the overall completeness of the claims data (please report as %)?	MQ03	Yes	Percentage	If response is less than 98% and response to IBNR and IBNP factors question (MQ06) is "No," state will request resubmission to calculate and apply reasonable and appropriate IBNR and IBNP completion factors and update response to MQ06, or correct response (if they entered the wrong percentage). For more information, see the Claims Run-Out Period subsection.
How long was the run-out period for claims payments (please report as days)?	MQ04	Yes	Integer	If response is less than 180 days and response to IBNR and IBNP factors question (MQ06) is "No," state will request resubmission to calculate and apply reasonable and appropriate IBNR and IBNP completion factors and update response to MQ06, or correct response (if they entered the wrong number of days). For more information, see the Claims Run-Out Period subsection.
How long was the run-out period for non-claims payments (please report as days)?	MQ05	Yes	Integer	If response is less than 180 days, state will request resubmission to update data or correct response (if they entered the wrong number of days). For more information, see the Non-Claims Reconciliation Period subsection.
Are IBNR and IBNP factors applied to claims payments?	MQ06	Yes	Yes; No	Confirm whether carrier applied IBNR and IBNP to claims payment service categories. For more information, see the Claims Run-Out Period subsection.
Is pharmacy rebate data estimated?	MQ07	Yes	Yes; No	For more information, see the Estimating Pharmacy Rebates subsection.

Name	ID	Required Value	Valid Value(s)	Description
If yes, please enter how you estimated the rebate amounts.	MQ08	Yes, if response to pharmacy rebate estimation question (MQ07) is "Yes"; otherwise no	<Free text>	If carrier populates field and MQ07 response is "No," state will request resubmission to update response to "Yes" or remove text from this field and enter in Comments field, if applicable. For more information, see the Estimating Pharmacy Rebates subsection.
Are carve-out services for commercial partial claims estimated?	MQ09	Yes	Yes; No; Not applicable	If response is "Not applicable" and carrier reported data using Insurance Category Code 4, state will request resubmission to update data or correct response (if they selected "Not applicable" in error). For more information, see the Vendors and Carved-Out Services subsection.
If yes, please enter which carve-out services you estimated and describe how you calculated the estimate.	MQ10	Yes, if response to carve-out estimation question (MQ09) is "Yes"; otherwise no	<Free text>	If carrier populates field and MQ09 response is "No," state will request resubmission to update response to "Yes" or remove text from this field and enter in Comments field, if applicable. For more information, see the Vendors and Carved-Out Services subsection.
TME Inclusion and Exclusion Questions				
Are claims payments reported as allowed amounts, including both payments that insurer paid to providers and member cost sharing?	MQ11	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Claims Payments subsection.
Is the spending reported in a manner consistent with the payment service category definitions in the Benchmark Data Submission Guide?	MQ12	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Claims Payments by Service Category and Non-Claims Payments by Service Category subsections.
Does the TME include NJ residents only?	MQ13	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Included Populations subsection.
Does the TME include services rendered by providers, regardless of location of provider?	MQ14	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more

Name	ID	Required Value	Valid Value(s)	Description
				information, see the Reporting on Large Provider Entities and Attribution subsection.
Does the TME include services rendered by providers, regardless of the situs of the member's plan?	MQ15	Yes	Yes; No	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). For more information, see the Included Populations subsection.
Are data limited only to members for whom the insurer is primary on the claim?	MQ16	Yes	Yes; No	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). For more information, see the Reporting of TME subsection.
Are members attributed to provider organizations consistent with your contracts with each provider?	MQ17	Yes	Yes; No	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). For more information, see the Reporting on Large Provider Entities and Attribution subsection.
Are TME submitted based on the incurred date/ date of service?	MQ18	Yes	Yes; No	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). For more information, see the Reporting of TME subsection.
Is truncation applied at the member level?	MQ19	Yes	Yes; No	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). For more information, see the Truncation subsection.
Does the truncated spending include only claims data?	MQ20	Yes	Yes; No	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). For more information, see the Truncation subsection.
Are spending estimates on carved out services (commercial partial claims) included in the calculation of claims at the member level before applying truncation?	MQ21	Yes	Yes; No; Not applicable	If response is “No,” state will request resubmission to update data or correct response (if they selected “No” in error). If response is “Not applicable” and carrier reported data using Insurance Category Code 4, state will request resubmission to update data or correct response (if they selected “Not applicable” in error). For more information, see the Vendors and Carved-Out Services subsection.
Standard Deviation Questions				

Name	ID	Required Value	Valid Value(s)	Description
Are standard deviations calculated using the formula for population standard deviation?	MQ22	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Standard Deviation Tab subsection.
Are non-claims expenses excluded from the standard deviation calculations?	MQ23	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Standard Deviation Tab subsection.
Are spending estimates on carved out services (commercial partial claims) at the member month level included in the standard deviation calculations?	MQ24	Yes	Yes; No; Not applicable	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error. If response is "Not applicable" and carrier reported data using Insurance Category Code 4, state will request resubmission to update data or correct response (if they selected "Not applicable" in error). For more information, see the Standard Deviation Tab subsection.
When calculating the standard deviation, did you include all the member months, regardless of whether the member has paid claims for that month?	MQ25	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Standard Deviation Tab subsection.
When calculating the standard deviation, did you use each member's average cost per month applied to each month they were enrolled, instead of the actual utilization each month?	MQ26	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Standard Deviation Tab subsection.
Is standard deviation calculated by market, which combines certain Insurance Category Codes?	MQ27	Yes	Yes; No	If response is "No," state will request resubmission to update data or correct response (if they selected "No" in error). For more information, see the Standard Deviation Tab subsection.
Income from Fees of Uninsured Plans Questions				
Did you have members in self-insured plans during calendar year 2018?	MQ28	Yes	Yes; No	If response does not align with the markets for which they have business and the member months in the LOB Enrollment tab, state will request resubmission to update data or correct response (if they selected "No" in error).

Name	ID	Required Value	Valid Value(s)	Description
If yes, please enter the income from fees of uninsured plans for 2018.	MQ29	Yes, if response to 2018 self-insured LOB question (MQ28) is “Yes”; otherwise no	Non-negative number	Input Income from Fees of Uninsured Plans, NAIC SHCE Part 1, Line 12.
Did you have members in self-insured plans during calendar year 2019?	MQ30	Yes	Yes; No	If response does not align with the markets for which they have business and the member months in the LOB Enrollment tab, state will request resubmission to update data or correct response (if they selected “No” in error).
If yes, please enter the income from fees of uninsured plans for 2019.	MQ31	Yes, if response to 2019 self-insured LOB question (MQ30) is “Yes”; otherwise no	Non-negative number	Input Income from Fees of Uninsured Plans, NAIC SHCE Part 1, Line 12.
"Doing Business As" Information				
For Medicare managed care organizations, what are all the names under which you are "doing business as” in the state of NJ?	MQ32	Yes, if carrier has members enrolled in Medicare managed care plans; otherwise no	<Free text>	Input any names carrier is “doing business” as in the state of NJ.

Appendix B. Primary Care Definition and Codes

This appendix details how to define spending on primary care services for inclusion under Claims: Professional, Primary Care (TM08) in the TME tab. This payment service category includes TME from claims paid to primary care providers and practices that delivered care in a primary care setting using the provider taxonomy codes, primary care payment codes, and place of service and modifier codes in this appendix.

In Claims: Professional, Primary Care (TM08), the carrier must include payments for services that meet all the following requirements:

- The rendering or billing provider practices any of the following specialties: family medicine, geriatric medicine, internal medicine, or pediatric medicine. This category excludes payments made to obstetricians and gynecologists. To identify primary care providers, carriers must first search for payments made to rendering providers with any of the taxonomy codes in the Primary Care Specialty Codes subsection, then check for payments made to the billing provider with any of the specialty codes in the same subsection.
- The care delivered included any of the following services: care management, care planning, consultation services, health risk assessments, screenings, counseling, home visits, hospice, immunization administrations, office visits, and preventive medicine visits. This category excludes payments made for prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray, and other imaging services. To identify primary care services, carriers must use the procedure codes in the Primary Care Service Payment Codes subsection.
- The setting where they delivered services was at any of the following sites of care: primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center, school-based health center, or via telehealth. This category excludes payments made for services delivered in urgent care centers, retail pharmacy clinics, and via a stand-alone telehealth vendor (i.e., a third-party telehealth vendor). To identify primary care services delivered via telehealth, carriers must either use the telephone and internet services codes in the Primary Care Service Payment Codes subsection, or another payment code with a place of service and/ or modifier code in the Telehealth Place of Service and Modifier Codes subsection.

Primary Care Specialty Codes

Table 21 below lists select provider taxonomy codes for the four primary care specialties included in the state's definition of primary care providers (i.e., family medicine, geriatrics, internal medicine, and pediatrics) and certain provider organization taxonomy codes (e.g., federally qualified health centers). Carriers must identify primary care providers first by searching for the provider taxonomy codes from the table below in the rendering provider field and then the billing provider field. If the carrier does not use the provider taxonomy codes in the table below, it may apply its provider codes to match the description of the codes below.

Table 21. Primary Care Taxonomy Codes

Taxonomy Code	Description	Notes or Restrictions
208D00000X	General Practice	
207Q00000X	Family Medicine	
207QA0000X	Family Medicine, Adolescent Medicine	
207QA0505X	Family Medicine, Adult Medicine	
207QG0300X	Family Medicine, Geriatric Medicine	
207QH0002X	Family Medicine, Hospice Palliative	Restrict to only home health and hospice procedure codes
208000000X	Pediatrics	
2080A0000X	Pediatrics, Adolescent Medicine	
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
207R00000X	Internal Medicine	
207RG0300X	Internal Medicine, Geriatric Medicine	
207RA0000X	Internal Medicine, Adolescent Medicine	
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Restrict to only home health and hospice procedure codes
363A00000X	Physician Assistant	
363AM0700X	Physician Assistant, Medical	
363L00000X	Nurse Practitioner	
363LA2200X	Nurse Practitioner, Adult Health	
363LF0000X	Nurse Practitioner, Family	
363LG0600X	Nurse Practitioner, Gerontology	
363LP0200X	Nurse Practitioner, Pediatrics	
363LP2300X	Nurse Practitioner, Primary Care	
363LC1500X	Nurse Practitioner, Community Health	Always restrict on the procedure code list
363LS0200X	Nurse Practitioner, School	Always restrict on the procedure code list
261QF0400X	Federally Qualified Health Center (FQHC)	Restrict by procedure code list AND restrict on revenue codes for clinic and professional services 0510, 0515, 0517, 0520, 0521, 0523, 0960, 0983
261QR1300X	Clinic/ center, Rural Health	
261QP2300X	Clinic/ center, Primary Care	
282NR1301X	Rural Hospital	
261QC0050X	Critical Access Hospital	
282NC0060X	Critical Access Hospital	

Primary Care Service Payment Codes

Table 22 below contains payment codes for primary care services. Carriers must only include TME in Claims: Professional, Primary Care (TM08) for the services in the table below if a primary care provider delivered service at a primary care site of care.

Table 22. Primary Care Payment Codes

Procedure Code	Description	Reporting Procedure Category
99201	OFFICE OUTPATIENT NEW 10 MINUTES	Office Visits
99202	OFFICE OUTPATIENT NEW 20 MINUTES	Office Visits
99203	OFFICE OUTPATIENT NEW 30 MINUTES	Office Visits
99204	OFFICE OUTPATIENT NEW 45 MINUTES	Office Visits
99205	OFFICE OUTPATIENT NEW 60 MINUTES	Office Visits
99211	OFFICE OUTPATIENT VISIT 5 MINUTES	Office Visits
99212	OFFICE OUTPATIENT VISIT 10 MINUTES	Office Visits
99213	OFFICE OUTPATIENT VISIT 15 MINUTES	Office Visits
99214	OFFICE OUTPATIENT VISIT 25 MINUTES	Office Visits
99215	OFFICE OUTPATIENT VISIT 40 MINUTES	Office Visits
99381	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR	Preventive Medicine Visits
99382	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS	Preventive Medicine Visits
99383	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS	Preventive Medicine Visits
99384	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR	Preventive Medicine Visits
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	Preventive Medicine Visits
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	Preventive Medicine Visits
99387	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>	Preventive Medicine Visits
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	Preventive Medicine Visits
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	Preventive Medicine Visits
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	Preventive Medicine Visits
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	Preventive Medicine Visits
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	Preventive Medicine Visits
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	Preventive Medicine Visits
99397	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER	Preventive Medicine Visits
99241	OFFICE CONSULTATION NEW/ ESTAB PATIENT 15 MIN	Consultation Services
99242	OFFICE CONSULTATION NEW/ ESTAB PATIENT 30 MIN	Consultation Services
99243	OFFICE CONSULTATION NEW/ ESTAB PATIENT 40 MIN	Consultation Services
99244	OFFICE CONSULTATION NEW/ ESTAB PATIENT 60 MIN	Consultation Services

Procedure Code	Description	Reporting Procedure Category
99245	OFFICE CONSULTATION NEW/ ESTAB PATIENT LEVEL 5	Consultation Services
G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT	HCPC Visit Codes
G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT	HCPC Visit Codes
G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/ AWV	HCPC Visit Codes
T1015	CLINIC VISIT/ ENCOUNTER ALL-INCLUSIVE	HCPC Visit Codes
S9117	BACK SCHOOL VISIT	HCPC Visit Codes
G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR	HCPC Visit Codes
G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT	HCPC Visit Codes
G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST	HCPC Visit Codes
G0463	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT	HCPC Visit Codes
99401	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 30 MIN	Preventive Medicine Services
99403	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 45 MIN	Preventive Medicine Services
99404	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 60 MIN	Preventive Medicine Services
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	Preventive Medicine Services
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	Preventive Medicine Services
99408	ALCOHOL/ SUBSTANCE SCREEN & INTERVEN 15-30 MIN	Preventive Medicine Services
99409	ALCOHOL/ SUBSTANCE SCREEN & INTERVENTION >30 MIN	Preventive Medicine Services
99411	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M	Preventive Medicine Services
99412	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M	Preventive Medicine Services
99420	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT	Preventive Medicine Services
99429	UNLISTED PREVENTIVE MEDICINE SERVICE	Preventive Medicine Services
99341	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES	Home Visits
99343	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES	Home Visits
99344	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES	Home Visits

Procedure Code	Description	Reporting Procedure Category
99345	HOME VISIT NEW PT UNSTABL/ SIGNIF NEW PROB 75 MIN	Home Visits
99347	HOME VISIT EST PT SELF LIMITED/ MINOR 15 MINUTES	Home Visits
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	Home Visits
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	Home Visits
99350	HOME VST EST PT UNSTABLE/ SIGNIF NEW PROB 60 MINS	Home Visits
99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES	Hospice/ Home Health Services
99375	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>	Hospice/ Home Health Services
99376	CARE PLAN OVERSIGHT/ OVER	Hospice/ Home Health Services
99377	SUPERVISION HOSPICE PATIENT/ MONTH 15-29 MIN	Hospice/ Home Health Services
99378	SUPERVISION HOSPICE PATIENT/ MONTH 30 MINUTES/>	Hospice/ Home Health Services
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD	Hospice/ Home Health Services
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD	Hospice/ Home Health Services
G0181	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY	Hospice/ Home Health Services
G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE	Hospice/ Home Health Services
99339	INDIV PHYS SUPVJ HOME/ DOM/ R-HOME MO 15-29 MIN	Domiciliary, Rest Home Multidisciplinary Care Planning
99340	INDIV PHYS SUPVJ HOME/ DOM/ R-HOME MO 30 MIN/>	Domiciliary, Rest Home Multidisciplinary Care Planning
99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE	Transitional Care Management Services
99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE	Transitional Care Management Services
99497	ADVANCE CARE PLANNING FIRST 30 MINS	Advance Care Planning E/M Services
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS	Advance Care Planning E/M Services
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	Case Management Services
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	Case Management Services
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	Case Management Services
99487	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO	Chronic Care Management Services
99489	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH	Chronic Care Management Services
99490	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH	Chronic Care Management Services

Procedure Code	Description	Reporting Procedure Category
99491	CHRON CARE MANAGEMENT SRVC 30 MIN PER MONTH	Chronic Care Management Services
G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC	Chronic Care Management Services
99358	PROLNG E/M SVC BEFORE&/ AFTER DIR PT CARE 1ST HR	Prolonged Services
99359	PROLNG E/M BEFORE&/ AFTER DIR CARE EA 30 MINUTES	Prolonged Services
99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES	Prolonged Services
G0513	PROLONG PREV SVCS FIRST 30M	Prolonged Services
G0514	PROLONG PREV SVCS ADDL 30M	Prolonged Services
99441	PHYS/ QHP TELEPHONE EVALUATION 5-10 MIN	Telephone and Internet Services
99442	PHYS/ QHP TELEPHONE EVALUATION 11-20 MIN	Telephone and Internet Services
99443	PHYS/ QHP TELEPHONE EVALUATION 21-30 MIN	Telephone and Internet Services
99444	PHYS/ QHP ONLINE E&M SERVICE	Telephone and Internet Services
99446	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 5-10 MIN	Telephone and Internet Services
99447	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 11-20 MIN	Telephone and Internet Services
99448	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 21-30 MIN	Telephone and Internet Services
99449	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 31/> MIN	Telephone and Internet Services
99451	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 5/> MIN	Telephone and Internet Services
99452	NTRPROF PHONE/ NTRNET/ EHR REFERRAL SVC 30 MIN	Telephone and Internet Services
98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN	Telephone and Internet Services
98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN	Telephone and Internet Services
98968	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN	Telephone and Internet Services
98969	NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT	Telephone and Internet Services
90460	IM ADM THRU 18YR ANY RTE 1ST/ ONLY COMPT VAC/ TOX	Immunization Administration for Vaccines/ Toxoids
90461	IM ADM THRU 18YR ANY RTE ADDL VAC/ TOX COMPT	Immunization Administration for Vaccines/ Toxoids
90471	IM ADM PRQ ID SUBQ/ IM NJXS 1 VACCINE	Immunization Administration for Vaccines/ Toxoids
90472	IM ADM PRQ ID SUBQ/ IM NJXS EA VACCINE	Immunization Administration for Vaccines/ Toxoids

Procedure Code	Description	Reporting Procedure Category
90473	IM ADM INTRANSL/ ORAL 1 VACCINE	Immunization Administration for Vaccines/ Toxoids
90474	IM ADM INTRANSL/ ORAL EA VACCINE	Immunization Administration for Vaccines/ Toxoids
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	Immunization Administration for Vaccines/ Toxoids
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	Immunization Administration for Vaccines/ Toxoids
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	Immunization Administration for Vaccines/ Toxoids
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counselings
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counselings
99078	PHYS/ QHP EDUCATION SVCS RENDERED PTS GRP SETTING	Health Risk Assessment, Screenings, and Counselings
99483	ASSMT & CARE PLANNING PT W/ COGNITIVE IMPAIRMENT	Health Risk Assessment, Screenings, and Counselings
G0396	ALCOHOL &/ SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	Health Risk Assessment, Screenings, and Counselings
G0397	ALCOHOL &/ SUBSTANCE ABUSE ASSESSMENT >30 MIN	Health Risk Assessment, Screenings, and Counselings
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counselings
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	Health Risk Assessment, Screenings, and Counselings
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	Health Risk Assessment, Screenings, and Counselings
G0505	COGN & FUNCT ASMT USING STD INST OFF/ OTH OP/ HOME	Health Risk Assessment, Screenings, and Counselings
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	Preventive Medicine Services
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	Preventive Medicine Services
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	Preventive Medicine Services
58300	INSETION OF IUD	Contraceptive Insertion/ Removal
58301	REMOVAL OF IUD	Contraceptive Insertion/ Removal
57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS	Contraceptive Insertion/ Removal

Procedure Code	Description	Reporting Procedure Category
S4981	INSERTION OF LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM	Contraceptive Insertion/ Removal
11981	INSERTION, NON-BIODEGRADBLE DRUG DELIVERY IMPLANT	Contraceptive Insertion/ Removal
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	Contraceptive Insertion/ Removal
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	Contraceptive Insertion/ Removal
S0610	ANNUAL GYNECOLOGICAL EXAM, ESTABLISHED PATIENT	Gynecological Services
S0612	ANNUAL GYNECOLOGICAL EXAM, NEW PATIENT	Gynecological Services
S0613	ANNUAL GYNECOLOGICAL EXAM, BREAST EXAM W/O PELVIC	Gynecological Services
G0101	CERV/ VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM	Gynecological Services
Q0091	SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB	Gynecological Services

Telehealth Place of Service and Modifier Codes

Table 23 below contains the place of service and modifier codes for telehealth services. Carriers must only include TME for primary care delivered via telehealth in Claims: Professional, Primary Care (TM08) if they identify using the taxonomy codes in Table 21 and telephone and internet services procedure codes in Table 22 or another code in Table 22 with the place of service and/ or modifier codes in the table below.

Table 23. Telehealth Place of Service and Modifier Codes

Place of Service/ Modifier Code	Description
02	Place of service code for telemedicine services provided other than in patient's home, through telecommunication technology.
10	Place of service code for telemedicine services provided in patient's home, through telecommunication technology.
95	Modifier code for synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system.
GT	Modifier code for telemedicine service rendered via a real-time interactive audio and video telecommunications system.

Sources: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set; https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00144501

Appendix C. Frequently Asked Questions

The state will periodically release frequently asked questions (FAQs) and responses collected from carriers and post them to the following places:

- DOBI's NJ HART program webpage in the NJ Program Resources or Information for Data Submitters subpages; and
- DOBI's Benchmark Data Submission Site in the General Information folder.