New Jersey Health Care Cost Growth Target Benchmark Program

Carrier Benchmark Data Submission Frequently Asked Questions Log

Version 1.0

September 2023

GOVERNOR'S OFFICE OF HEALTH CARE AFFORDABILITY AND TRANSPARENCY

STATE OF NEW JERSEY
DEPARTMENT OF BANKING & INSURANCE

Introduction

Overview

This **Carrier Benchmark Data Submission Frequently Asked Questions (FAQs) Log** (the FAQs Log) includes questions and responses collected from carriers regarding the New Jersey (NJ) Health Care Affordability, Responsibility, and Transparency (HART) program's annual benchmark data collection and reporting cycle. The FAQ Log organizes information by the categories in the Table of Contents section below.

How to Use this Resource

This FAQs Log supplements the **Carrier Benchmark Data Submission Guide and Template** (the Guide and Template), but it does not include new information; therefore, carriers should continue to refer to the Guide for the full set of reporting requirements relating to the Template. The NJ Department of Banking and Insurance (DOBI) posts the Guide and Template to their NJ HART program webpage on the Information for Data Submitters subpage and to their Benchmark Data Submission Site in the General Information folder.

Version History

When the cost growth benchmark program team releases an updated version of this document, carriers will be able to identify newly added FAQs by the publish month and year under each answer and modified FAQs by the update month and year.

ⓘ **Note:** For more general FAQs about the HART program, see the NJ Health Care Cost Growth Benchmark Program FAQs. If you are a carrier with questions about submitting data, please contact: CarrierDataSubmission@dobi.nj.gov.

Table of Contents

A. Member Details and Enrollment

A.1. What date should carriers use to calculate a member's age?

Carriers must 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.

For more information, see the Age Band Codes subsection of the Guide.

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A.2. If we covered both Medicare and Medicaid services for dually eligible members, which Insurance Category Code and Line of Business (LOB) Category Code should we report member months and spending under for such plans?

If the carrier covers both Medicare and Medicaid services for a member, the reporting of member months must occur as follows:

- For the Total Medical Expenses (TME), Age and Sex Factors, and Standard Deviation tabs—report member months under both Insurance Category Code 5 (Medicare Advantage [MA] dual eligible members) and 6 (Medicaid managed care organization [MCO] dual eligible members). For example, if a carrier had an enrollee in such a plan during January 2018 only, then they report one member month to both Insurance Category Code 5 and 6 for Reporting Year 2018.
- For the Line of Business Enrollment tab—report member months under both LOB Category Code 8 (MA dual eligible plans) and 9 (Medicaid MCO dual eligible plans).

Carriers must report spending for such plans in a mutually exclusive fashion and bucket into the appropriate Insurance Category Code depending on whether Medicare or Medicaid functions as the primary payer for a given service.

The state updated the Insurance Category Codes subsection of the Guide to clarify this requirement when they released Version 1.2 on September 11, 2023.

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A.3. Where the data calls for "NJ residents", does that mean regardless of the contract situs?

Yes, "NJ residents" means regardless of the contract situs. Carriers must include data in the 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.

For more information, see the Included Populations subsection of the Guide.

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A.4. How do we fill out the Age and Sex Factors tab if there were no members in a specific Age Band Code for the respective Reporting Year, Insurance Category Code, and Large Provider Entity Code?

If there were no members in a specific age band, carriers must either input a zero under every column in the respective row, or not include a row for that age band in the Age and Sex Factors tab. Also, make sure the values for fields that appear in more than one tab of the Template (i.e., Member Months, Claims Amount Excluded Due to Truncation, Member Count with Truncated Claims, and so on) are consistent across tabs for the respective row ID fields (i.e., Reporting Year, Insurance Category Code, Large Provider Entity Code, and so on). For example, if a carrier had members in Medicaid MCO plans, then the sum of Member Months for a given Reporting Year must be the same for the:

- Large Provider Entity Code and Insurance Category Codes 2 and 6 in the TME and Age and Sex Factors tabs;
- Large Provider Entity Code and Market Code 2 in the Standard Deviation tab; and
- LOB Category Codes 7 and 9 in the LOB Enrollment tab.

Carriers can use the Data Validation Checks tab of the Template to help confirm data are consistent across tabs.

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B. Large Provider Entity Attribution

B.1. If we can attribute a member to one of the entities from the Large Provider Entity Codes in the Guide, but we did not have a value-based care contract in place with the entity for the respective reporting year, or the member was not associated with a value-based care contract, should we attribute that member to the entity or the unattributed category (Large Provider Entity Code 999)?

If a carrier's internal attribution methodology is such that a member can be attributed to one of the entities from the Large Provider Entity Codes in the Guide during the reporting year, then you must attribute the member to that entity, regardless of whether a value-based care contract was in place with the entity for the respective reporting year. Carriers must only submit payments using the unattributed category if they are unable to attribute a member to one of the entities from the Large Provider Entity Codes subsection of the Guide.

The state updated the Reporting on Large Provider Entities and Attribution subsection of the Guide to clarify this requirement when they released Version 1.2 on September 11, 2023.

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B.2. How should we report information for members who we cannot attribute to a PCP, or whose PCP was not associated with any of the entities from the Large Provider Entity Codes in the Guide?

For members who the carrier cannot attribute to a PCP, or whose PCP was not associated with any of the entities from the Large Provider Entity Codes, submit payments using the unattributed category (Large Provider Entity Code 999). The rationale is to help make sure that we capture all spending data from carriers, which the state will use to calculate total health care expenditures (THCE).

For more information, see the Reporting on Large Provider Entities and Attribution subsection of the Guide.

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B.3. How should we report information for members whose PCP moved between entities from the Large Provider Entity Codes in the Guide within the same reporting year?

To account for the scenario when a members' PCP was associated with more than one provider entity within the same reporting year, carriers must report spending based on the associated member months in which the PCP was associated with the entity. For example, if you attributed a member to provider X who was associated with Large Provider Entity Code 101 for the first two months of the reporting year, and associated with Large Provider Entity Code 102 for remainder of the same reporting year, then report the two months of member spending using Large Provider Entity Code 101, and the remaining ten months of member spending using Large Provider Entity Code 102.

To account for other nuances related to member attribution, carriers must use an approach that is consistent with their internal methodology for attributing members to a PCP and attributing PCPs to provider entities. The rationale for not requiring a standardized member attribution approach for all carriers is that it could significantly increase the reporting burden and timeliness of receiving these data from carriers given the complexity of attribution methodologies and the variability of systems payers use to analyze and report data.

For more information, see the Reporting on Large Provider Entities and Attribution subsection of the Guide.

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C. Claims Payments

C.1. How should we report claims payments for services delivered by a primary care provider in an inpatient setting (e.g., when a primary care physician bills an evaluation and management [E/M] code for checking on one of their patients while they are in the inpatient setting)?

Carriers must assign professional claims paid to primary care providers or primary care group practices (following the primary care taxonomy list table from the Primary Care Definition and Codes appendix of the Guide) for services that they did **not** deliver in a primary care setting (e.g., E/M codes for inpatient care) to Claims: Professional, Specialty Providers (TM09) if the rendering provider is a physician, or Claims: Professional, Other Providers (TM10) if the rendering provider is not a physician.

The state updated the descriptions for Claims: Professional, Specialty Providers (TM09) and Claims: Professional, Other Providers (TM10) in the Data Dictionary appendix of the Guide to clarify this requirement when they released Version 1.2 on September 11, 2023.

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C.2. Which services do we include under Claims: Hospital Inpatient (TM06)?

Inpatient services include claims 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 description for this field in the Data Dictionary appendix of the Guide.

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C.3. Which services do we include under Claims: Long-Term Care (TM11)?

Long-term care services include claims 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 description for this field in the Data Dictionary appendix of the Guide.

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C.4. How do we identify claims payments made for services provided at a hospital satellite clinic?

Carriers must be able to identify payments made for services provided at a hospital satellite clinic the same way they would for other hospital outpatient services.

For more information, see the description for Claims: Hospital Outpatient (TM07) in the Data Dictionary appendix of the Guide.

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C.5. How should we report claims payments for services delivered in a hospital-owned Ambulatory Surgery Center (ASC)?

If the hospital-owned ASC is a freestanding ASC, then carriers must include those payments in Claims: Other (TM13), otherwise, include payments in Claims: Hospital Outpatient (TM07).

For more information, see the descriptions for these fields in the Data Dictionary appendix of the Guide.

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C.6. Should we use the Bill Type from claims to identify different outpatient settings?

Yes, carriers can use the type of bill codes from institutional claims and place of service codes from professional claims to identify the setting.

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C.7. How should we report payments from claims that are missing the rendering provider information?

Carriers must include payments under the service category that best aligns with the description of the TME tab fields in the Data Dictionary appendix of the Guide if the rendering provider's information is missing.

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C.8. How should we report claims payments for services delivered in an urgent care setting?

Carriers must include claims payments for urgent care centers in Claims: Other (TM13).

For more information, see the description for this field in the Data Dictionary appendix of the Guide.

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C.9. Should carriers only report on claims payments for which they are the primary payer?

Carriers must include payments for members for whom they are the primary payer on a claim (i.e., exclude any paid claims for which they are the secondary or tertiary payer).

For more information, see the Reporting of TME subsection of the Guide.

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D. Non-Claims Payments

D.1. How should we report spending when we cannot attribute service-level capitation payments (e.g., advanced imaging) to members of the providers and when the encounter data for the capitated services are incomplete?

Carriers must include all fixed capitation payments made outside of the claims system in Non-Claims: Capitation or Bundled Arrangements (TM14), including payments for secondary capitation agreements (i.e., when the HMO arranges a contract involving primary care physicians and a "secondary" healthcare service provider such as a diagnostic or imaging service provider or a specialist). If the plan excludes advanced imaging services from the capitation agreement, then include payments for these services in the respective claims payment service category.

Carriers must include payments that they cannot attribute to a member or primary care provider using the unattributed category (Large Provider Entity Code 999).

For more information, see the description for Non-Claims: Capitation or Bundled Arrangements (TM14) in the Data Dictionary appendix of the Guide.

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D.2. How should we report shared savings payments or global payment arrangements for bundled services payments made to specialty care providers and practices (e.g., episode-based payments for joint replacement)?

Carriers must include payments made to specialty care 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, in Non-Claims: Performance Incentives (TM15). 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 description for Non-Claims: Performance Incentives (TM15) in the Data Dictionary appendix of the Guide.

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D.3. How should we report a monthly care coordination fee (not flat but tied to performance)?

Carriers must include payments made to providers outside of the claims system for incentives tied to performance in Non-Claims: Performance Incentives (TM15). Include all other care coordination fee payments in Non-Claims: Pop Health and Practice Infrastructure (TM16).

For more information, see the descriptions for these fields in the Data Dictionary appendix of the Guide.

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D.4. How should we report payments made to health plan funded clinical pharmacists?

Carriers must include payments made outside of the claims system for salaries of health plan funded clinical pharmacists who delivered health care services not otherwise included in other claims and non-claims categories in Non-Claims: Provider Salaries (TM17).

For more information, see the description for Non-Claims: Provider Salaries (TM17) in the Data Dictionary appendix of the Guide.

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D.5. How should we report payments made for services under global payment arrangements such as maternity care (i.e., pregnancy with delivery) when there are no claims or encounter data submitted for prenatal visits?

Carriers must include global payment arrangements, including payments made outside of the claims system such as prenatal visits in this example, in Non-Claims: Capitation or Bundled Arrangements (TM14).

For more information, see the description for this field in the Data Dictionary appendix of the Guide.

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E. Applying Truncation

E.1. How should we apply truncation for members attributed to more than one provider and LOB during a reporting year?

Carriers must not prorate the $250,000 truncation point based on the months for which they attribute a member to a particular provider entity or LOB. In the example below, the carrier attributes a member to Provider X for the first seven months of 2018 and Provider Y for the final five months of 2018. In addition, the member is under the commercial market for the first eleven months of the year and the MA market for the last month of 2018. Specifically, they must attribute the members' spending as follows:

- Provider X's commercial market with full claims (Insurance Category Code 3/ Market Code 3) for seven months with $300,000 in claims;
- Provider Y's commercial market with full claims for four months with $275,000 in claims; and
- Provider Y's MA non-dual eligible market (Insurance Category Code 1/ Market Code 1) for one month with $50,000 in claims.

Since the member cost the payer $575,000 for the commercial market with full claims and $50,000 for the MA non-dual eligible market, the claims amount excluded due to truncation (TM21/AS08/SD06) for this member is as follows:

Reporting Year	Insurance Category Code	Large Provider Entity Code	Member Months	Claims Amount Excluded Due to Truncation	Member Count with Truncated Claims	Total Non-Truncated Claims Spending
2018	3	X	7	$50,000	1	$300,000
2018	3	Y	4	$25,000	1	$275,000
2018	3	100	11	$325,000	1	$575,000
2018	1	Y	1	$0	0	$50,000
2018	1	100	1	$0	0	$50,000

Note: The table above is meant to provide an example of how to handle truncation for a member attributed to more than provider and LOB. Note that carriers do not report data at the member level in the Template. Also note that carriers must use one of the valid values from the Large Provider Entity Codes subsection of the Guide.

For more information, see the Truncation subsection of the Guide.

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E.2. How should we apply truncation to medical and pharmacy spending?

While some carriers separately truncate medical and pharmacy spending, carriers must apply truncation to members' total claims spending (medical and pharmacy) if it exceeds the per member truncation point of $250,000. Carriers do not truncate payments for value-based care contracts that fall under the non-claims payment service categories in the TME tab of the Template.

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F. Pharmacy Spending

F.1. How should we report pharmacy rebate amounts for members without drug coverage and retail pharmacy rebates?

For the instances where carriers have members without drug coverage, do not have their retail pharmacy rebate amounts, but have their medical pharmacy rebate amounts, carriers must input estimates in the Retail Pharmacy Rebate Amount field (RX05) following the guidance in the Estimating Pharmacy Rebates subsection of the Guide. If carriers populate the Medical Pharmacy Rebate Amount field (RX04) and leave RX05 blank in the same row, this will be flagged as an issue in the completeness validation checks, which are based on the field-level requirements under the Required Value column in the Data Dictionary appendix tables of the Guide. Alternatively, if carriers have an Insurance Category Code for which they are unable to separate out medical and retail pharmacy rebates for reporting, carriers must report all pharmacy rebates in aggregate in the Total Pharmacy Rebate Amount field (RX06).

Lastly, if carriers are estimating rebate amounts, they must describe how they calculated the rebate estimate in the Mandatory Questions tab of the Template.

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F.2. If a carrier has a retail rebate of $1,000,000 for 2018, but only 96% of membership lives in NJ, how should we report the rebate amount?

Based on the above example, carriers must report $960,000 because that is equivalent to the percentage of membership that lived in NJ for 2018.

For more information, see the Estimating Pharmacy Rebates subsection of the Guide.

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G. Miscellaneous

G.1. Is the standard deviation calculation of PMPM only for members' medical costs or for both members' medical and pharmacy costs? If both, should we include imputed carve-out pharmacy costs (non-claims costs)?

The standard deviation of PMPM calculation includes members' total claims spending (medical and pharmacy). 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. Exclude non-claims expenditures in the calculation.

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G.2. Can we paste data directly into the Template from another spreadsheet?

Yes, but use the **paste special: values** function to copy over data to the Template. This will ensure that you only copy the values over, so that the data validation within the Template is unaffected. If carriers are still receiving an error, double-check that all values are within the existing data validation parameters of the Template.

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G.3. How will DOBI notify carriers of inconsistencies found in the submitted data during the validation process?

DOBI has assembled a data validation team to undertake a comprehensive review and validation process on each carrier's data submission. If there is any issue or inconsistency found in a submission, DOBI will notify the carrier and work with them to rectify the issue.

For more information on the data validation checks and process, see the Data Submission and Validation Process section of the Guide.

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G.4. How will catastrophic claims reported in the Claims Payment section not skew the TME performance measurement?

The state will only report non-truncated claims service category spending at the state- and market- level, which will make the impact of high-cost outliers less of a concern. They will apply truncation at the provider- and carrier-levels to minimize year-to-year swings in PMPM spending that might be affected by high-cost outliers.

For more information on how the state will calculate cost growth, see the State Benchmark Implementation Manual.

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G.5. How do current and future contracts that carriers have with providers impact the data reporting through CY 2027?

Carrier data reporting is based on contracts they had with providers during the requested reporting years of data. For future data collection and reporting cycles, the state will continue to engage stakeholders, including advisory bodies, in determining whether they will update the list of carriers required to report and other calculations to account for health care market changes.

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