New Jersey Health Care Cost Growth Target Benchmark Program

State Benchmark Program Implementation Manual

Version 1.1

May 2024

GOVERNOR'S OFFICE OF HEALTH CARE AFFORDABILITY AND TRANSPARENCY

STATE OF NEW JERSEY
DEPARTMENT OF BANKING & INSURANCE

Table of Contents

Version History

Table 1 will include key updates and changes to this **State Benchmark Implementation Manual** (the Manual) when the cost growth benchmark program team releases an updated version of this document.

Table 1. Record of Changes

Version number	Date released	Description of change(s)
1.1	May 2024	The state made the following changes in version 1.1 of the Manual: • In the CMS Reporting of TME subsection, revised the mapping for "Other Professionals." • In the DMAHS Reporting of TME subsection, updated the codes and categories in the Included DMAHS Claim Recipient Program Status Codes table and the Included DMAHS Reason Codes and Transaction Types table. • In the Calculation of Standard Weights subsection, revised to reflect that the denominator for calculating standard weights by insurance category, member age, and sex bands will be market PMPM spending rather than insurance category. • In the Measuring THCE and TME section, revised to reflect that the state will report spending values gross of pharmacy rebates rather than net of pharmacy rebates in most instances. • In the Conducting Statistical Testing section, revised to reflect that the state performs calculations at the market level rather than the line of business level. • In the Conducting Statistical Testing section, created a new subsection on Calculating Pooled Variance to clarify that process.
1.0	August 2023	—

Glossary

Claims payments	The allowed amount on provider claims to insurers. This includes the amount insurers 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 and that engages in total cost of care contracts for a significant proportion of the population they serve, for whom insurers 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 insurers' costs related to paying bills, advertising, sales commissions and other administrative costs, premium taxes, and other fees. It also includes insurers' profits (contribution to margin) or losses.
Non-claims payments	All payments that insurers 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.
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, geriatrics, internal medicine, and pediatrics.
Total health care expenditures (THCE)	The total medical expense incurred by NJ residents for all health care services that insurers report to the state, plus the insurers' 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 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 comprises two primary analytics workstreams (the cost growth benchmark and cost driver analyses) and involves communications and engagement with stakeholders to support the development and implementation of these workstreams. Together, the benchmark and cost driver analyses will focus attention on health care cost trends and inform actions to reduce cost growth.

Overview of Manual. This State Benchmark Program Implementation Manual (The Manual) outlines the health care cost growth benchmark workstream processes that the NJ Department of Banking and Insurance (DOBI) will follow to collect, validate, analyze, and report on benchmark data.

The Manual organizes information as follows:

- **Collecting and Validating Benchmark Data from Carriers (Section I)** includes information on how the state will collect benchmark data from government and commercial payers.
- **Calculating Net Cost of Private Health Insurance (Section II)** provides information on how the state will collect data to calculate the cost to NJ residents associated with the administration of private health insurance.
- **Risk-Adjusting TME for Insurers and Provider (Section III)** details how the state will perform age and sex risk-adjustment to these data, including how they will calculate and apply the weights.
- **Measuring THCE and TME (Section IV)** describes how the state will calculate total health care expenditures (THCE) and total medical expenses (TME), measure spending growth, and assess performance against the cost growth benchmark.
- **Conducting Statistical Testing (Section V)** includes information on how the state will conduct statistical testing on insurers' and large provider entities' calculated cost growth.
- **Public Reporting of Benchmark Performance Results (Section VI)** describes how the state will report on cost growth performance against the benchmark.

How to use this Manual. The Manual focuses on the annual data collection and reporting cycle processes that the *NJ HART program team and their support contractors* will follow; however, to promote transparency for the public reporting aspect of the program, it includes key information on the methodologies for calculating performance against the benchmark using the carrier-submitted data and other sources.

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

I. Collecting and Validating Benchmark Data from Carriers

Payer data reporting is an essential part of the state's ability to capture health care cost spending across NJ. The state will use the carrier-submitted data described in the sections that follow to calculate aggregate spending and determine cost growth at the state-, insurance market- (i.e., Medicare, Medicaid, and commercial), insurer-, and large provider entity-levels.

This section describes the processes for collecting and validating spending and enrollment data from public and private insurers.

A. Insurers Required to Submit

To obtain a full picture of health care spending in NJ, the state will collect and validate TME by payment service categories and enrollment data from the Centers for Medicare & Medicaid Services (CMS), the NJ Division of Medical Assistance & Health Services (DMAHS), and commercial payers in the state.[1] These spending and enrollment data will include all NJ residents who have comprehensive health care coverage through a Medicare, Medicaid, or commercial insurance product, regardless of the member's plan situs.

B. Submission Schedule for All Insurers

Insurers will submit benchmark data annually. Table 2 outlines the submission due date for each data collection and reporting cycle.

Table 2. 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: Schedule is subject to change.
PY = performance year; CY = calendar year; Q = quarter

[1] For the list of commercials payers required to report benchmark data, please see the **Carrier Benchmark Data Submission Guide**.

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

C. Data Required from Insurers

The subsections below include information on the carrier-submitted data that the state will collect and validate annually.

1. Medicare FFS Data

The subsections below include information on the Medicare fee-for-service (FFS) TME and enrollment data that the state will collect from CMS annually.

CMS Data Collection and Validation Process

To receive Medicare FFS TME and enrollment data, the state will make a formal request each year to Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copy: CMSProgramStatistics@cms.hhs.gov.[2] To ensure receipt of the data from CMS by the submission due dates listed in Table 2, the state will issue request at least three months before the carrier due date (i.e., DOBI will issue request in May to ensure receipt of data from CMS by August of the same calendar year).

Once the state receives the data from CMS, they will conduct validation checks to confirm the submission includes all expected data before combining with other carrier-submitted data for the analyses described in the sections that follow.

CMS Data Specification

CMS will share the following data for each requested reporting year in an Excel workbook with two tabs:

1. Enrollment figures for Medicare beneficiaries based on the resident location as of the end of each requested reporting year for Medicare Parts A, B, and D broken out between managed care and FFS; and
2. Total program payments and cost sharing broken out by service categories.

CMS Reporting of TME

Table 3 shows how the state will map CMS claims payment service categories to the cost growth benchmark service categories.

[2] CMS specifically requested that NJ staff make the official request (i.e., not one of the state's benchmark program support contractors).

Table 3. Mapping of CMS Claims Payment Service Categories to NJ's Benchmark Service Categories

CMS Service Category Description	Benchmark Service Category Mapping
Hospital Inpatient	Claims: Hospital Inpatient
Hospital Outpatient	Claims: Hospital Outpatient
Physician	Claims: Professional, Primary Care Providers and Claims: Professional, Specialty Providers (state will combine professional claims for primary and specialty care providers when reporting service level category spending with CMS data)
Home Health Agency	Claims: Long-Term Care
Skilled Nursing Facility	Claims: Long-Term Care
Part D	Claims: Retail Pharmacy
Durable Medical Equipment	Claims: Other
Hospice	Claims: Other
Non-Hospital Outpatient	Claims: Other
Other Professionals	Claims: Professional, Other Providers
Other Suppliers	Claims: Other

Note: For information on the benchmark payment service categories, please see the Carrier Benchmark Data Submission Guide.

CMS Payment Data Completeness

CMS believes that data for a particular calendar year will be at least ninety percent complete by September 1 of the following year.

2. Medicaid FFS and Non-Managed Care Data

The subsections below include information on the Medicaid FFS and non-managed care spending data that the state will collect from DMAHS annually.

DMAHS Data Collection and Validation Process

To receive Medicaid FFS and non-managed care TME and enrollment data, the state will make a formal request each year to DMAHS. To ensure receipt of the data from DMAHS by the submission due dates listed in Table 2, the state will issue request at least three months before the carrier due date (i.e., DOBI will issue request in May to ensure receipt of data from DMAHS by August of the same calendar year).

Once the state receives the data from DMAHS, they will conduct validation checks to confirm the submission includes all expected data before combining with other carrier-submitted data for the analyses described in the sections that follow.

DMAHS Data Specification

DMAHS will share the following data for each requested reporting year in an Excel workbook:

1. Beneficiary member months broken out by all Medicaid FFS beneficiaries, FFS non-dual eligible beneficiaries, and FFS dually eligible beneficiaries;
2. Total claims payments broken out by service categories;
3. Total non-claims payments broken out by service categories; and
4. Pharmacy rebate data.

DMAHS Reporting of TME

DMAHS will include only information pertaining to Medicaid beneficiaries who are residents of NJ and who receive full medical benefit coverage through Medicaid, regardless of whether providers rendered services in or out of the state. They will also adhere 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.[3]
- Include payment information on an incurred, not paid basis for the corresponding reporting year.
- Include payments for beneficiaries for whom DMAHS is the primary payer on a claim (i.e., exclude any paid claims for which they are the secondary or tertiary payer, such as claims for Medicare and Medicaid dually eligible individuals when Medicaid is not the primary payer).
- Include payments for beneficiaries who were not eligible for managed care or who were in the FFS waiting period before enrollment into a managed care organization (MCO).
- Include Medicaid MCO beneficiary FFS claims payments for out-of-plan spending, any wrap services, or Medicaid covered services that are not part of the MCO contract.
- Include other FFS expenditures for Medicaid populations or programs that they paid with state-only general funds.
- Include supplemental payments to providers, including Prospective Payment System (PPS) wrap payments made to Federally Qualified Health Centers (FQHCs) for the difference between the MCO payment and the FQHC PPS alternative payment methodology (APM) rate, and upper payment limit (UPL) payments made to hospitals to account for the difference between Medicaid and Medicare rates.
- Include premium payments, capitation, or lump sum payments to NJ's Program for All-Inclusive Care for the Elderly (PACE) organization(s), and to vendor(s) for non-emergency medical transportation (NEMT).
- Include federal and state supplemental pharmacy rebate collections.
- Exclude payments based on the categories under the Excluded Types of Payment subsection below.

The subsections below provide the technical details on the data that DMAHS will report and the steps that the state will follow to analyze their data submission.

[3] Because DMAHS will submit spending data in aggregate, they will not need to attribute beneficiaries to large provider entities or other providers.

Claims Payments

The claims data will include non-managed care Medicaid payments made to providers based on allowed amounts (i.e., the amount DMAHS paid plus any beneficiary cost sharing) for services incurred during the requested calendar year processed and paid for by DMAHS' Fiscal Agent, Gainwell Technologies. They will organize claims data by Claims Service Category Code (CLM_TYPE_CDE), Modified Category of Service (COS) Code (CLM_MODIFIED_COS_CDE), Claim Media Code (CLM_MEDIA_CDE), and Claim Recipient Program Status Code (CLM_RCP_PGM_STS_CDE).

Table 4 shows the claims payment service categories that the state will include and exclude from the claims data and how they will map DMAHS categories to the cost growth benchmark service categories.

Table 4. Mapping of DMAHS Claims Payment Service Categories to NJ's Benchmark Service Categories

Claims Service Category Code	DMAHS Description	Benchmark Service Category Mapping
Included Categories		
01	Inpatient Hospital	Claims: Hospital Inpatient
02	Long-term care	Claims: Long-Term Care
03	Outpatient Hospital	Claims: Hospital Outpatient
04	Physician	Claims: Professional, Primary Care Providers
05	Chiropractor	Claims: Professional, Other Providers
06	Home Health	Claims: Long-Term Care
07	Transportation	Claims: Other
08	Vision (Optical Appliances)	Claims: Other
09	Supplies (Durable Medical Equipment)	Claims: Other
10	Podiatry	Claims: Professional, Specialty Provider
11	Dental	Claims: Professional, Other Providers
12	Pharmacy	Claims: Retail Pharmacy
13	Early and Periodic Screening, Diagnostic and Treatment (EPSDT)	Claims: Other
16	Lab	Claims: Other
17	Prosthetic and Orthotics	Claims: Other
18	Independent Clinics	Claims: Professional, Primary Care Providers
19	Psychologists	Claims: Professional, Specialty Provider
21	Optometrists	Claims: Professional, Other Providers
22	Mid-Level Practitioner	Claims: Professional, Other Providers
23	Hearing Aid	Claims: Other
Excluded Categories		

Claims Service Category Code	DMAHS Description	Benchmark Service Category Mapping
14	Medicare Part A	Not applicable
15	Medicare Part B	Not applicable
24	Capitation	Not applicable

Note: For information on the benchmark payment service categories, please see the Carrier Benchmark Data Submission Guide.

Table 5 shows the Modified COS Codes that the state will use to exclude certain payments from the claims data.

Table 5. Mapping of DMAHS Modified COS Codes to NJ's Benchmark Service Categories

Modified COS Code	DMAHS Description
Included Categories	
01	Hospital Inpatient
1a	Acute Care General Hospital (Provider Type 60)
1b	Other Hospital (All others)
02	Residential Treatment Center
03	Inpatient Mental Hospital
03a	Inpatient Mental Hospital (Government)
03c	Inpatient Mental Hospital (All Other COS 03)
04	Outpatient Hospital Service (FFS only)
04a	Outpatient Non-EPSDT
04b	Outpatient EPSDT Clinic Code 27
04c	Outpatient EPSDT Claim Type 13
05	Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)
06	Targeted Case Management
07	Nursing Facility
08	Clinic
08a	Community Health Clinic (Pro Spec 950)
08b	Mental Health Clinic (Pro Spec 940)
08c	Other Clinic (All Other COS 08)
08d	Private Duty Nursing (PDN)-EPSDT
09	Optical Appliance
10	Physician

Modified COS Code	DMAHS Description
11	Dental
12	Freestanding Ambulatory Surgery Center (ASC)
13	Optometry
14	Chiropractor
15	Advanced Practice Nurse/Nurse Practitioner
16	Psychologist
17	Podiatrist
18	Prosthetic and Orthotic
19	Midwifery
20	Drugs
20a	Drugs (Long-Term Care Type 26)
20b	Drugs Retail
22	Rehabilitation
22a	Day Training (Specialty Code 725)
22b	Early Intervention (Specialty Code 730)
22c	Special Education (Specialty Code 740)
22d	Environmental Lead Screening
22E	PACT
23A	Department of Children and Families (DCF)/ Children's System of Care (CSOC) New Service
23B	DCF/CSOC Existing Service
25	FQHC
30	Medical Supplies
31	Durable Medical Equipment
32	Hearing Aid Services
40	Home Health
50	Hospice
60	Laboratory
65	Radiology
70	Transportation
80	Medical Day Care/Adult Day Health
81	Adult Mental Health Rehab (AMHR)/Personal Care
81a	Personal Care (Physical)

Modified COS Code	DMAHS Description
81b	Personal Care (Mental Health)
81c	Adult Mental Health Rehab
87	Department of Health and Senior Services (DHSS)/ Enhanced Community Options (ECO) Waiver
88	Traumatic Brain Injury (TBI) Waiver
89	Division of Youth and Family Service (DYFS)/ABC Waiver
90	Division of Developmental Disabilities (DDD)
91	Community Care Program for the Elderly and Disabled (CCPED)
92	AIDS Community Care Alternative Program (ACCAP)
93	Community Resources for People with Disabilities (CRPD)
93a	CRPD (Not Used)
93b	CRPD (No PDN)
93c	CRPD (PDN)
96	Home Care Expansion
Excluded Categories	
94	Garden State Health Plan
95	Managed Care
99	Other

Note: For information on the benchmark payment service categories, please see the Carrier Benchmark Data Submission Guide.

Table 6 shows the Claim Media Codes that DMAHS will include in the claims data.

Table 6. Included DMAHS Claim Media Codes

Claim Media Code	DMAHS Description
0	Paper Claim
1	Electronic Data Interchange (EDI) Proprietary Format
2	Web/Data Entry
3	Financial
4	POS (Point of Service)
5	Released/Pended POS Claim Returned from mainframe
6	POS Reversal Review
7	Encounters Fee for Services
8	HIPPAA Transaction (Electronic Claims)

Claim Media Code	DMAHS Description
9	Pharmacy Encounters Processed through POS FFS Logic

Table 7 shows the Claim Recipient Program Status Codes that DMAHS will include in the claims data.

Table 7. Included DMAHS Claim Recipient Program Status Codes

Claim Recipient Program Status Code	DMAHS Description
110	OAA CN - SSI Money Payment (MP) - (Federal Match (FM))
120	OAA CN - Medicaid only, No Money Payment (NMP) - FM
140	OAA CN- Institutional Resident - NFM
170	Aged MN - No Spenddown - FM
180	Aged MN - Spenddown - FM
190	NJC - Aged OCN - Optional Categorically Needy - FM
210	Disability - CN SSI MP – FM
220	Disability - CN Medicaid only - NMP - FM
230	Disability - CN categorically related, NMP, NFM
240	Disability - CN Institutional resident, NFM
260	Disability - CN HCEP
270	DA - MN - No Spend-down - FM
280	DA - MN - Spend-down - FM
290	NJC - Disabled, Optional Categorically Needy - FM
291	NJ Workability, 100-150% FPL - FM
292	NJ Workability, 151-185% FPL - FM
293	NJ Workability, 186-200% FPL - FM
294	NJ Workability, 201-250% FPL - FM
295	Breast and Cervical Cancer - FM
310	AFDC Children 0-18-FM
320	AFDC Parents – FM
330	Household of One (State Use Only) NMP-FM
40	Household of One (State Use Only) NMP-FM
350	MN - Pregnant Women - No Spenddown - FM
360	MN - Pregnant Women - Spenddown - FM
370	MN - Child - No Spenddown - FM

Claim Recipient Program Status Code	DMAHS Description
380	MN - Child - Spenddown - FM
381	Parent 19-64, >AFDC ≤ 133% FPL - FM
390	Plan First Family Planning-Parent w/dependent children 138-205% FPL
391	PAPW - Presumptively Elig. Pregnant Women - FM
461	NJ Suppl Prenatal Care Pgm Other Pregnant Women - NFM
461	Child 6-18, 107-142% FPL-FM
462	Medicaid Special 19-21, 0-58% FPL-FM
481	Child 1-5, >AFDC ≥ 142% FPL-FM
482	Newborn <1, >AFDC ≥ 194% FPL-FM
483	Child 6-18,>AFDC ≤ 107% FPL-FM
485	MCHIP Uninsured Child 6-18, 107-142% FPL-FM
486	Plan B Child 142%-10% FPL-FM
487	CHIP Child 1-18, 1500185% FPL, Plan C-FM
488	CHIP Child 1-18, 185%-200% FPL, Newborn 194-200% FPL, Plan C- FM
489	NJFC FFS Newborns > 194% to < or = 200% FPL-FM
490	Pregnant Women 0-194% FPL - FM
492	NJC pregnant, 133%-185% - FM
493	CHIP Child 0-18, 200-250% FPL, Plan D-FM
494	CHIP Child 0-18, 250-300% FPL, Plan D-FM
495	CHIP Child 0-18, 300-350% FPL, Plan D-FM
496	NJFC, FFS< Newborn 201%-350% FPL-FM
499	CHIP Pregnant Women, 194-200% FPL-FM
510	AB - CN SSI MP – FM
520	AB - CN NMP – FM
540	AB - CN Institutional Resident - NFM
570	Blind - MN - No Spend-down - FM
580	Blind - MN - Spend-down - FM
590	NJC - Blind - Optional Categorically Needy - FM
591	NJ Workability, 100-150% FPL - FM
592	NJ Workability, sliding premium scale 151-185% - FM
593	NJ Workability, sliding premium scale186-200% - FM

Claim Recipient Program Status Code	DMAHS Description
594	NJ Workability, sliding premium scale 201-250% - FM
600	DCP&P - Optional Foster Care - Adoption Assistance
620	DCP&P Medicaid Extension for Young Adults - FM
630	ISS - First Two Bytes of Current ID > 21 - AFDC Related AFDC Recipient - FM
640	ISS - Institutional Resident - NFM
641	DCF/DSOC - Only – NFM
650	DCP&P - State Program - NFM
730	PAAD Under 65 - Disabled Casino Fund
740	PAAD Over 65 - Upper Income Casino Fund
750	PAAD Over 65 - Lower Income General Fund
762	Single Adult/Childless Couple 19-64, 0-133% FPL - FM
764	Plan First Family Planning - Single Adult/Childless Couple 138%-205%
770	Cystic Fibrosis – NFM
780	ADDP - NFM (DOH receives Ryan White funds)
800	Juvenile Services NFM
801	DOC (Department of Corrections) - NFM (No On The RHMF, Assigned Internally)
810	County Juvenile Services - NFM
830	Senior Gold – Disabled
840	Senior Gold – Aged

Non-Claims Payments

The financial transactions data will include non-managed care Medicaid payments made to providers outside of the claims system, credits, and adjustments processed for services incurred during the requested calendar year. They will organize financial transactions data by Non-Claims Service Category Code (Clm Fin Pgm Sub Class Cde), Reason Code (Reason Code), and Transaction Type (Clm Fin Trans Type Cde Desc).

Table 8 shows the non-claims payment service categories that the state will use to exclude certain payments from the financial transactions data.

Table 8. Mapping of DMAHS Non-Claims Payment Service Categories to NJ's Benchmark Service Categories

Non-Claims Service Category Code	DMAHS Description
Included Categories	
41	DCF

Non-Claims Service Category Code	DMAHS Description
200	DDD PERS
245	CHIP
253	ICF/MR
279	DSRIP
281	DCF
312	DDD CCW
353	GME
361	PIP/EHR
367	ACA Health Insurance Providers Fees
383	PACE
454	DSH
508	Inpatient
509	Drugs
510	Outpatient
511	Physician
519	Clinic
521	Transportation
522	Other
537	Nursing Home
Excluded Categories	
205	Managed Care

Note: For information on the benchmark payment service categories, please see the Carrier Benchmark Data Submission Guide.

Table 9 shows the Transaction Types and Reason Codes that the state will include and exclude from the financial transactions data and how they will map DMAHS categories to the cost growth benchmark service categories.

Table 9. Included DMAHS Reason Codes and Transaction Types

Transaction Type	Reason Code	DMAHS Description	Benchmark Service Category Mapping
Transaction Type 1 - issue payment	2150	Audit payment	Non-Claims: Capitation or Bundled Arrangements
	2151	Gross payment	Non-Claims: Capitation or Bundled Arrangements

Transaction Type	Reason Code	DMAHS Description	Benchmark Service Category Mapping
	2158	Disp. Share payment	Non-Claims: Capitation or Bundled Arrangements
	2284	Initial PIP (Provider Incentive Payment)	Non-Claims: Performance Incentives
Transaction Type 4 - Establish Receivable	2102	Audit Recoupment	Non-Claims: Recovery
	2108	Provider Recoupment	Non-Claims: Recovery
	2114	Other Recoupment	Non-Claims: Recovery
	2115	Provider Recoupment Interest - no ffp	Non-Claims: Recovery
	2117	Provider Recoupment: damages/penalty	Non-Claims: Recovery
	2285	PIP Recoupment	Non-Claims: Recovery

Note: For information on the benchmark payment service categories, please see the Carrier Benchmark Data Submission Guide.

Excluded Types of Payments

DMAHS will exclude the following types of payments:

- Any payments for individuals enrolled in premium support or co-pay programs
- Medicare premium payments for dually eligible individuals, including Qualified Medicare Beneficiary Program and Specified Low-Income Medicare Beneficiary premium assistance payments
- Part D clawback payments
- Any payments made to Medicaid MCOs, including premium payments and any non-claims expenditures that DMAHS distributes to providers through the MCOs, as MCOs are reporting their spending and administrative expenses separately

DMAHS Payment Data Completeness

For categories in the Claims Payments subsection, DMAHS will 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, insurers 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.

For categories in the Non-Claims Payments subsection, DMAHS will 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. They will submit non-claims payments on an incurred basis, not paid basis. For example, if a provider is eligible for a pay for performance bonus, they will 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. They will also apply

reasonable and appropriate estimations of non-claims liability that they expect to reconcile after the 180-day review period.

DMAHS Pharmacy Rebate Data

DMAHS will report pharmacy rebate data, following the guidance in the **Carrier Benchmark Data Submission Guide**.

3. Commercial, MA, and Medicaid Managed Care Data

For information on the commercial, Medicare Advantage (MA), and Medicaid managed care organizations (MCO) TME and enrollment data that the state will collect from private payers, including which carriers they require to report and detailed technical specifications for reporting data, please see the **Carrier Benchmark Data Submission Guide**. The guide also includes details on the validation process for commercial insurers, which is more involved than the processes with CMS and DMAHS.

II. Calculating Net Cost of Private Health Insurance

After the state completes the carrier data collection and validation processes outlined in the previous section, they will calculate the net cost of private health insurance (NCPHI). NJ will report NCPHI as a component of total health care expenditures (THCE) at the state-level, and they will exclude from the calculation of cost growth at the insurance market-, insurer-, and large provider entity-levels.

This section describes the data sources that the state will use to calculate NCPHI and how they will use these data to calculate NCPHI for the following commercial lines of business (LOBs):

1. Individual plans (buy coverage on their own);
2. Large group plans (51 + employees), fully insured;
3. Small group plans (2-50 employees), fully insured;
4. Student plans;
5. Self-insured plans;
6. MA plans; and
7. Medicaid MCO plans.

A. Data Required to Calculate NCPHI

The subsections below detail the data sources to calculate insurers' NCPHI for each of the commercial LOBs (individual, large group, small group, student, self-insured, MA, and Medicaid MCO plans). Text in blue are direct references to data fields or field IDs and tables or tabs from the following sources:

- **Carrier Benchmark Data Submission Template:** The state will use data that insurers submit via the LOB Enrollment and Mandatory Questions tabs of the template to calculate NCPHI.
- **CMS Medical Loss Ratio (MLR) data**: The state will use the CMS MLR data to calculate NCPHI for the individual, large group, small group, and student plans commercial LOBs. They will access these data for the respective reporting years by downloading the MLR Public Use Files from the CMS Center for Consumer Information and Oversight website.[4, 5] CMS makes the files publicly available in the fall of each

[4] MLR Public Use Files are available at: https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.
[5] For information on the source for the MLR Public Use Files, please review the MLR Reporting Form Instructions at https://www.cms.gov/cciio/resources/forms-reports-and-other-resources#Medical_Loss_Ratio.

year, but if there is a delay in publishing the files, the state may request the MLR reports directly from insurers to meet the benchmark program's reporting timeline. Lastly, the state will identify the relevant insurers' data in the MLR Public Use Files by using the MR_Submission_Template_Header table and filtering the BUSINESS_STATE column to NJ and COMPANY_NAME column to all names that the carrier is doing business as to determine the insurer's associated unique identifiers (i.e., the MR_SUBMISSION_TEMPLATE_ID column).[6]

- **Supplemental Health Care Exhibits (SHCEs):** The state will use the SHCEs to calculate NCPHI for the commercial self-insured, MA, and Medicaid MCO LOBs. They will access these data for the respective reporting years either by purchasing from the National Association of Insurance Commissioners InsData portal or by requesting the exhibits directly from insurers.[7,8]

1. Individual, Large Group, Small Group, and Student Plan LOBs

Table 10 lists the data that the state will pull for all relevant commercial insurers and years to derive each element (i.e., Health Premiums Earned, Total Incurred Claims, and so on) needed to calculate NCPHI for individual, large group, small group, and student health plans.

Table 10. Data Required to Calculate Individual, Large Group, Small Group, and Student Plan NCPHI

Element	Individual	Large Group	Small Group	Student Plan
Premiums Earned	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_DIRECT_PREMIUM_EARNED category, then use data from the CMM_INDIVIDUAL_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_DIRECT_PREMIUM_EARNED category, then use data from the CMM_LARGE_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_DIRECT_PREMIUM_EARNED category, then use data from the CMM_SMALL_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_DIRECT_PREMIUM_EARNED category, then use data from the SHP_INDIVIDUAL_Q1 column.

[6] To identify insurers with multiple names in the MLR Public Use Files, the state will use the responses to the "Doing Business As" question (data field ID MQ32) in the Mandatory Questions tab from the Benchmark Data Submission Template that they require commercial insurers to submit.

[7] SCHEs are available at: https://www.naic.org/insdata_home.htm.

[8] MA reporting in the SHCEs combines stand-alone prescription drug plans (PDP) and the MA plans with Part D inclusion (MAPDs); therefore, insurers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims, and members months for PDP and MAPD.

Element	Individual	Large Group	Small Group	Student Plan
Incurred Claims	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_INCURRED_CLAIMS_PT1 category, then use data from the CMM_INDIVIDUAL_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_INCURRED_CLAIMS_PT1 category, then use data from the CMM_LARGE_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_INCURRED_CLAIMS_PT1 category, then use data from the CMM_SMALL_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to TOTAL_INCURRED_CLAIMS_PT1 category, then use data from the SHP_INDIVIDUAL_Q1 column.
Advanced Payments of Cost-Sharing Reductions	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to CSR category, then use data from the CMM_INDIVIDUAL_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_C table, filter ROW_LOOKUP_CODE column to CSR category, then use data from the CMM_LARGE_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to CSR category, then use data from the CMM_SMALL_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to CSR category, then use data from the SHP_INDIVIDUAL_Q1 column.
MLR Rebates	MLR Public Use Files, Part3_MLR_Rebate_Calculation table, filter ROW_LOOKUP_CODE column to REBATE_AMT_CREDIBILITY_ADJ_MLR category, then use data from the CMM_INDIVIDUAL_TOTAL column.	MLR Public Use Files, Part3_MLR_Rebate_Calculation table, filter ROW_LOOKUP_CODE column to REBATE_AMT_CREDIBILITY_ADJ_MLR category, then use data from the CMM_LARGE_GROUP_TOTAL column.	MLR Public Use Files, Part3_MLR_Rebate_Calculation table, filter ROW_LOOKUP_CODE column to REBATE_AMT_CREDIBILITY_ADJ_MLR category, then use data from the CMM_SMALL_GROUP_TOTAL column.	MLR Public Use Files, Part3_MLR_Rebate_Calculation table, filter ROW_LOOKUP_CODE column to REBATE_AMT_CREDIBILITY_ADJ_MLR category, then use data from the SHP_INDIVIDUAL_TOTAL column.
MLR Member Months	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to MEMBER_MONTHS category, then use data from the CMM_INDIVIDUAL_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to MEMBER_MONTHS category, then use data from the CMM_LARGE_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to MEMBER_MONTHS category, then use data from the CMM_SMALL_GROUP_Q1 column.	MLR Public Use Files, Part1_2_Summary_Data_Premium_CI table, filter ROW_LOOKUP_CODE column to MEMBER_MONTHS category, then use data from the SHP_INDIVIDUAL_Q1 column.
LOB Enrollment Member Months	Benchmark Data Submission Template, LOB Enrollment tab, filter Line of Business Category Code column (LB03) to 4 and	Benchmark Data Submission Template, Line of Business Enrollment tab, filter LOB Category Code column (LB03) to 1 and 10	Benchmark Data Submission Template, Line of Business Enrollment tab, filter LOB Category Code column (LB03) to 2 and	Benchmark Data Submission Template, Line of Business Enrollment tab, filter LOB Category Code column (LB03) to 5 and

Element	Individual	Large Group	Small Group	Student Plan
	Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).	and Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).	Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).	Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).

2. Self-Insured Plans LOB

Table 11 lists the data that the state will pull for all relevant commercial insurers and years to derive each element needed to calculate NCPHI for commercial self-insured health plans.

Table 11. Data Required to Calculate Self-Insured NCPHI

Element	Self-Insured
Income from Fees of Uninsured Plans	Benchmark Data Submission Template, Mandatory Questions tab, Income from Fees of Uninsured Plans Questions table, field IDs MQ29 or MQ31 depending on which year's NCPHI the state is calculating.
SHCE Member Months	SHCE, Part 1, Other Indicators 4 for the Uninsured Plans column.
LOB Enrollment Member Months	Benchmark Data Submission Template, LOB Enrollment tab, filter Line of Business Category Code column (LB03) to 3 and Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).

3. MA and Medicaid MCO Plans LOBs

Table 12 lists the data that the state will pull for all relevant commercial insurers and years to derive each element needed to calculate NCPHI for MA and Medicaid MCO health plans.

Table 12. Data Required to Calculate MA and Medicaid MCO NCPHI

Element	MA	Medicaid MCO
Premiums Earned	SHCE, Part 1, Line 1.1, column 12 (Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA).	SHCE, Part 1, Line 1.1, column 10 (Government Business (excluded by statute).

Element	MA	Medicaid MCO
Incurred Claims	SHCE, Part 1, Line 5.0, column 12 (Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA).	SHCE, Part 1, Line 5.0, column 10 (Government Business (excluded by statute).
SHCE Member Months	SHCE, Part 1, Other Indicators 4, column 12 (Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA).	SHCE, Part 1, Other Indicators 4, column 10 (Government Business (excluded by statute).
LOB Enrollment Member Months (Duals and Non-Duals)	Benchmark Data Submission Template, LOB Enrollment tab, filter Line of Business Category Code column (LB03) to 6, 8, and 11 and Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).	Benchmark Data Submission Template, LOB Enrollment tab, filter Line of Business Category Code column (LB03) to 7 and 9 and Reporting Year column (LB02) to applicable year, then use data from the Member Months column (LB04).

Note: Although the state collects MA member months separately via LOB Category Codes 6, 8, and 11 in the LOB Enrollment tab of the Carrier Benchmark Data Submission Template, they will combine these codes when calculating MA NCPHI PMPM by insurer. Although the state collects Medicaid MCO member months separately via LOB Category Codes 7 and 9, they will combine these codes when calculating Medicaid MCO NCPHI PMPM by insurer.

B. Calculation of Insurers' NCPHI

Because of substantial differences among segments of the NJ health insurance market, the state will calculate insurers' NCPHI on a per member per month (PMPM) basis separately for each of the commercial LOBs (individual, large group, small group, student, self-insured, MA, and Medicaid MCO plans) using the elements they derived from the subsection above.

ⓘ **Note:** The state will not use member months from the CMS MLR data or SHCEs to calculate NCPHI PMPM because they are based on in situ information, whereas the NJ spending benchmark intends to capture NJ residents. Instead, they will calculate a PMPM value based on MLR data and SHCE member months and multiply by the member months as reported in the LOB Enrollment tab of the Carrier Benchmark Data Submission Template to get resident-based NCPHI. By using member months as reported in the template, the state will be assuming that the experience of the insurer across all of its NJ business (regardless of whether it insures a member from another state) is the same experience as NJ residents.

1. Individual, Large Group, Small Group, and Student Plan LOBs

The state will use the formulas below and compute for each insurer.

Individual, Large Group, Small Group, and Student Plans Situs-Based NCPHI

$$= \text{Premiums Earned} - \text{Incurred Claims} + \text{Advanced Payments of Cost-Sharing Reductions} - \text{MLR Rebates}$$

Individual, Large Group, Small Group, and Student Plans Situs-Based NCPHI PMPM

$$= \frac{\text{Situs-Based NCPHI}}{\text{MLR Member Months}}$$

Individual, Large Group, Small Group, and Student Plans NJ Resident-Based NCPHI

$$= \text{Situs-Based NCPHI PMPM} \times \text{LOB Enrollment Member Months}$$

Individual, Large Group, Small Group, and Student Plans NJ Resident-Based NCPHI PMPM

$$= \frac{\text{NJ Resident-Based NCPHI}}{\text{LOB Enrollment Member Months}}$$

2. Self-Insured Plans LOB

The state will use the formulas below and compute for each insurer.

Self-Insured Plans Situs-Based NCPHI PMPM

$$= \frac{\text{Income from Fees of Uninsured Plans}}{\text{Self-Insured SHCE Member Months}}$$

Self-Insured Plans NJ Resident-Based NCPHI

$$= \text{Self-Insured Plans Situs-Based NCPHI PMPM} \times \text{Self-Insured Plans LOB Enrollment Member Months}$$

Self-Insured Plans NJ Resident-Based NCPHI PMPM

$$= \frac{\text{Self-Insured NJ Resident-Based NCPHI}}{\text{Self-Insured LOB Enrollment Member Months}}$$

3. MA Plans LOB

The state will use the formulas below and compute for each insurer.

MA Plans Situs-Based NCPHI

$$= \text{MA Premiums Earned} - \text{MA Incurred Claims}$$

MA Plans Situs-Based NCPHI PMPM

$$= \frac{\text{MA Plans Situs-Based NCPHI}}{\text{MA SHCE Member Months}}$$

MA Plans NJ Resident-Based NCPHI

$$= \text{MA Plans Situs-Based NCPHI PMPM} \times \text{MA Plans LOB Enrollment Member Months (Duals and Non-Duals)}$$

MA Plans NJ Resident-Based NCPHI PMPM

$$= \frac{\text{MA Plans NJ Resident-Based NCPHI}}{\text{MA Plans LOB Enrollment Member Months (Duals and Non-Duals)}}$$

4. Medicaid MCO Plans LOB

The state will use the formulas below and compute for each insurer.

Medicaid MCO Plans Situs-Based NCPHI

$$= \text{Medicaid MCO Premiums Earned} - \text{Medicaid MCO Incurred Claims}$$

Medicaid MCO Plans Situs-Based NCPHI PMPM

$$= \frac{\text{Medicaid MCO Plans Situs-Based NCPHI}}{\text{Medicaid MCO SHCE Member Months}}$$

Medicaid MCO Plans NJ Resident-Based NCPHI

$$= \text{Medicaid MCO Plans Situs-Based NCPHI PMPM} \times \text{Medicaid MCO Plans LOB Enrollment Member Months (Duals and Non-Duals)}$$

Medicaid MCO Plans NJ Resident-Based NCPHI PMPM

$$= \frac{\text{Medicaid MCO Plans NJ Resident-Based NCPHI}}{\text{Medicaid MCO Plans LOB Enrollment Member Months (Duals and Non-Duals)}}$$

III. Risk-Adjusting TME for Insurers and Providers

The state will risk adjust commercial, MA, and Medicaid MCO TME data for insurance categories, member age, and sex using standard weights when evaluating performance against the benchmark at the insurer- and large provider entity-levels. To develop the weights, they will use the carrier-submitted data from the Age and Sex Factors tab of the Carrier Benchmark Data Submission Template within reported insurance category, member age, and sex bands.[9]

This section outlines how the state will calculate standard weights, develop insurer- and large provider entity-specific risk scores, and use those scores to risk adjust truncated claims spending.

A. Calculation of Standard Weights

For each insurance category, member age, and sex band the state will complete the following steps to develop one set of standard weights for all insurers and large provider entities:

1. Aggregate truncated claims spending and member months across all submissions for each combination of insurance category, member age, and sex for the first year of the reporting period (e.g., calendar year 2018 in the pre-benchmark year):[10]
   - The state **will not** use non-claims-based spending.
   - The state **will not** limit the population to members attributed to large provider entities.
2. Calculate market-level truncated claims spending PMPM by dividing the total truncated claims spending for each market with the total number of member months for the market.[11]
3. Calculate truncated claims spending PMPM for each combination of insurance category, member age, and sex by dividing the aggregated truncated claims spending with the associated aggregated member months.
4. Calculate the standard weight for each combination of insurance category, member age, and sex by dividing the truncated claims spending PMPM (calculated in Step 3) with the associated market-level truncated claims spending PMPM (calculated in Step 2).

B. Calculation of Insurer and Large Provider Entity Risk Scores

For each insurer that the state requires to submit benchmark data and for each large provider entity that insurers attributed members to during benchmark data collection, the state will complete the following steps to develop a risk score, stratified by market:

1. For each insurer or large provider entity, aggregate member months for each combination of insurance category, member age, sex, and year.

[9] For information on the insurance categories, please see the Carrier Benchmark Data Submission Guide.
[10] For information on how the state instructs insurers to truncate spending, please see the Carrier Benchmark Data Submission Guide.
[11] For information on the insurance categories that correspond to each market, see the mapping tables in the Reference Tables tab of the Carrier Benchmark Data Submission Template.

2. For each insurer or large provider entity, roll up aggregated member months to the market-level.
3. For each insurer or large provider entity, calculate a population distribution value for each combination of insurance category, member age, sex, and year by dividing the insurer or large provider entity's member months for the combination (calculated in Step 1) with the associated market-level member months for the insurer or large provider entity (calculated in Step 2).
4. For each insurer or large provider entity, multiply the population distribution for each insurance category, member age, and sex band (calculated in Step 3) by the associated standard weight for the earliest year from the Calculation of Standard Weights subsection above.
5. For each insurer or large provider entity, calculate the market-level risk scores by summing the values calculated in Step 4 above to the market level.

C. Application of Insurer and Large Provider Entity Risk Scores to Spending Data

To apply the insurer and large provider entity risk scores to spending data, the state will complete the following steps:

1. **Insurers.** Calculate each insurer's age and sex risk-adjusted claims spending for each market by dividing the insurer's unadjusted, truncated claims spending PMPM for the market from the Calculation of Standard Weights subsection above by the insurer's risk score from the Calculation of Insurer and Large Provider Entity Risk Scores subsection above.
2. **Large Provider Entities.** Calculate each large provider entity's age and sex risk-adjusted claims spending for each market by dividing the large provider entity's truncated claims PMPM for the market by the entity's risk score from the Calculation of Large Provider Entity Risk Scores subsection above.

IV. Measuring THCE and TME

After the state risk adjusts TME as outlined in the previous section, they will assess health care spending growth by measuring THCE, which includes claims spending, non-claims spending, consumer cost sharing, and insurer administrative costs. They will measure spending growth annually using THCE or TME, in aggregate dollars and on a per member per year (PMPY) or 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 following levels:

1. **State:** PMPY using unadjusted, non-truncated THCE;
   - **Insurance market (Medicare, Medicaid, and commercial):** PMPY using unadjusted, non-truncated TME;
2. **Insurer, stratified by market:** PMPM using ICC, age, and sex risk adjusted, truncated TME; and
3. **Large provider entity, stratified by market:** PMPM using ICC, age, and sex risk adjusted, truncated TME[12]

Because of differences in how carriers report rebates, most spending data are report gross of pharmacy rebates.

The section provides the detailed formulas for calculating cost growth at each reporting level.

A. State-Level THCE

Below are the formulas the state will use to calculate statewide THCE, in aggregate and PMPY. They will calculate cost growth using unadjusted TME.

State-level THCE (in aggregate)

$$= \text{Commercial TME} + \text{MA TME} + \text{Medicare FFS TME} + \text{Medicaid MCO TME} + \text{Medicaid FFS TME} + \text{Insurer NJ Resident-Based NCPHI}$$

State-level THCE (PMPY)

$$= \frac{\text{State-level THCE (in aggregate)}}{\text{Commercial members} + \text{MA members} + \text{Medicare FFS members} + \text{Medicaid MCO members} + \text{Medicaid FFS members} - \text{Medicaid dually eligible members}}$$

[12] The state will limit benchmark performance reporting at the provider entity-level to those organizations that are sufficiently large such that the state can accurately and reliably measure performance.

B. Insurance Market-Level TME

Below are the formulas the state will use to calculate TME in aggregate and PMPY for the Commercial, Medicare, and Medicaid markets. In all instances "members" is equal to the number of member months for the group divided by 12.

Commercial Market TME (in aggregate)

$$= \text{Unadjusted, non-truncated claims TME} + \text{Non-claims TME}$$

Commercial Market TME (PMPY)

$$= \frac{\boldsymbol{Commercial\ Market\ TME\ (in\ aggregate)}}{\boldsymbol{Commercial\ Members}}$$

Medicare Market TME (in aggregate)

$$= \text{MA unadjusted, non-truncated claims TME} + \text{MA non-claims TME} + \text{Medicare FFS unadjusted, non-truncated claims TME}$$

Medicare Market TME (PMPY)

$$= \frac{\text{Medicare Market TME (in aggregate)}}{\text{MA members} + \text{Medicare FFS Part A and/or B members}}$$

Medicaid Market TME (in aggregate)

$$= \text{Medicaid MCO unadjusted, non-truncated claims TME} + \text{Medicaid MCO non-claims TME} + \text{Medicaid FFS non-truncated claims TME} + \text{Medicaid FFS non-claims TME}$$

Medicaid Market TME (PMPY)

$$= \frac{\text{Medicaid Market TME (in aggregate)}}{\text{Medicaid MCO members} + \text{Medicaid FFS members}}$$

C. Insurer-Level TME

Below is the formula the state will use to calculate insurer TME PMPM for a given market.

Insurer, by Market (PMPM)

$$= \frac{\text{Risk-adjusted, truncated claims TME} + \text{non-claims TME}}{\text{Member months}}$$

D. Large Provider Entity-Level TME

Below is the formula the state will use to calculate large provider entity TME PMPM for a given market.

Large Provider Entity, by Market (PMPM) =

$$= \frac{\text{Risk adjusted, truncated claims TME} + \text{non-claims TME}}{\text{Member months}}$$

V. Conducting Statistical Testing

After the state measures THCE and TME as described in the previous section, they will conduct statistical testing and develop confidence intervals to determine whether an insurer or large provider entity met or did not meet the benchmark. They will use risk-adjusted, truncated TME PMPM, the number of members months, and the standard deviation of TME PMPM costs to calculate the confidence intervals for the following:

- **PMPM health care cost growth, by market, for each insurer:** The state will use the standard deviation for commercial insurer's population of members that they submit via the Standard Deviation tab of the Carrier Benchmark Data Submission Template.
- **PMPM health care cost growth, by market, for each large provider entity:** When multiple commercial insurers report data on the same large provider entity, the state will pool the variances (i.e., take a weighted average) for each large provider entity by market such that, if applicable, commercial spending has a pooled variance, MA spending has a pooled variance, and Medicaid MCO has a pooled variance. Then the state will pool the variances across multiple years within each market to calculate the confidence intervals of the large provider entity's Commercial, MA, and Medicaid MCO growth.

A. Risk Adjustment of the Reported Standard Deviation

Since the state will calculate health care cost growth using age and sex risk-adjusted claims spending, they will also adjust the standard deviation used to calculate the confidence intervals. They will do this by applying standard state-calculated age and sex risk adjustment weights used to risk adjust the insurer-reported standard deviation. The formula for adjusting the standard deviation is as follows:

Adjusted Standard Deviation

$$= \frac{\text{Unadjusted Standard Deviation}}{\text{State Calculated Risk Score}}$$

B. Calculation of Pooled Variance

The following describes the formulas the state will use to pool variances for large provider entities at the market-level across carriers.

Notation Table	
i	Carrier index, i = first carrier, j = second carrier
N_i	Population size for carrier i (measured in member months)
σ_i	Standard deviation for carrier i
$\bar{X}_i$	Mean per member per month cost for carrier i (market population-level mean)

The formula for pooling the variance is as follows:

$$V_{pool} = \frac{\overbrace{\sum_i N_{X_i} \sigma^2_{X_i}}^{\text{First Section}}}{\sum_i N_{X_i}} + \frac{\overbrace{\sum_{i<j} N_{X_i} N_{X_j} \left(\bar{X}_i - \bar{X}_j\right)^2}^{\text{Second Section}}}{\left(\sum N_{X_i}\right)^2}$$

Within the pooled variance formula, the second section includes calculations for each unique pair of carriers i and j. For example, if there are three carriers (a, b, and c) there will be three combinations—a and b, a and c, b and c — and the second section of the pooled variance formula will be the summation of each of those pairs' values in the formula. If there are four carriers (a, b, c, and d) there will be six combinations—a and b, a and c, a and d, b and c, b and d, c and d.

C. Calculation of Confidence Intervals

The following describes the formulas the state will use to calculate confidence intervals.

Notation Table	
i	Year index, 1 = prior year, 2 = current year
df	Degrees of freedom
N_i	Population size for year i (or number of member months for year i)
V_i	Variance for year i (standard deviation squared for carriers, pooled variance for large provider entities)
$\bar{X}_i$	Mean per member per month cost for year i (population-level mean)
ρ	Growth target ratio

The state will use the following formula for calculating confidence intervals with unequal variances:

$$CI = \frac{\bar{X}_1 \bar{X}_2 \pm \sqrt{\bar{X}_1^2 \bar{X}_2^2 - \left(\bar{X}_1^2 - t^2_{\hat{df},\alpha} \frac{V_1}{N_1}\right)\left(\bar{X}_2^2 - t^2_{\hat{df},\alpha} \frac{V_2}{N_2}\right)}}{\bar{X}_1^2 - t^2_{\hat{df},\alpha} \frac{V_1}{N_1}}$$

Where $t_{\hat{df},\alpha}$ equals the t statistic given the degrees of freedom ($\hat{df}$) and the value of alpha (α). For 95% confidence interval with a large sample, the ($\hat{df}$) is ∞ and the alpha value is 0.05, which means:

$$t_{\hat{df},0.05} = 1.96$$

After performing the confidence interval calculation, the state will categorize insurers and providers as illustrated below:

- **Confidence interval intersects with benchmark**: Under this circumstance, the state would be unable to determine whether an insurer or provider entity's performance did or did not meet the benchmark (Insurer A in Figure 1 below).

- **Lower confidence interval is over the benchmark**: This would indicate that the insurer or provider entity exceeded the benchmark (Insurer B in Figure 1 below).
- **Upper confidence interval is fully below the benchmark:** This would indicate that the insurer or provider has achieved the benchmark (Large Provider Entity C in Figure 2 below).

Figure 1. Example Confidence Intervals for Insurer A and B

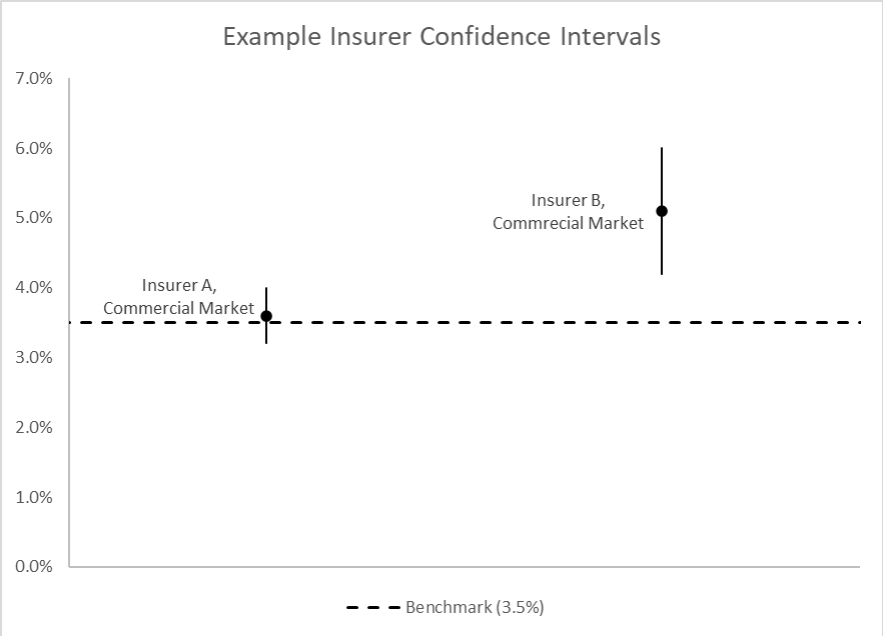
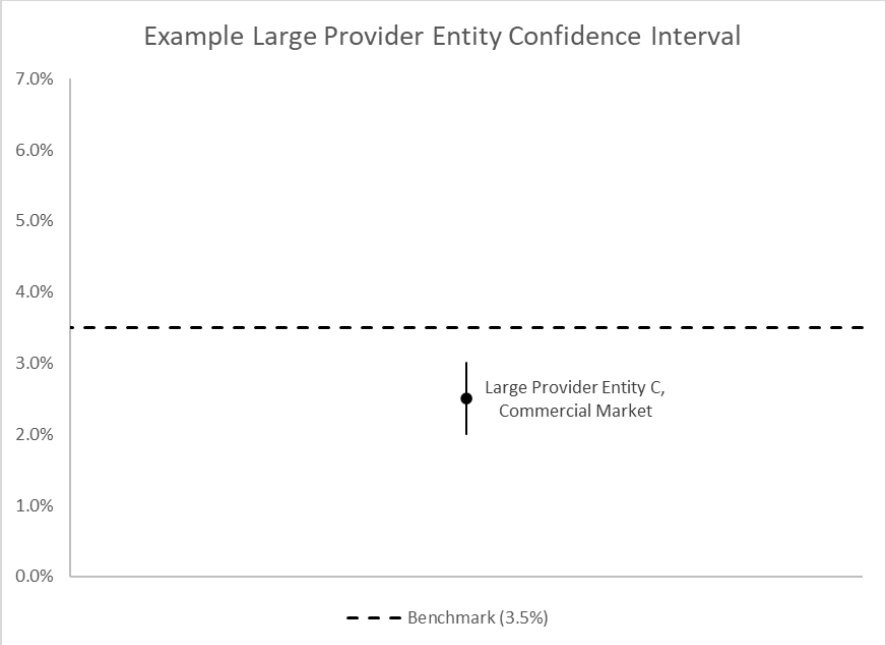


Figure 2. Example Confidence Intervals for Large Provider Entity C



D. Sample Calculations Using Mock Data

The following walks through examples of calculating growth rates and confidence intervals around the growth rates using the above formula with mock data.

For this example, Table 13 shows mock data that Insurer A submitted to the state.

Table 13. Hypothetical Spending and Variance Data for Insurer A

Year	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
2019	Large Provider Entity 1	Medicaid	$416.67	240,000	$166.67
	Large Provider Entity 1	Commercial	$666.67	660,000	$250.00
	Large Provider Entity 2	Medicaid	$66.67	93,000	$29.17
	Large Provider Entity 2	Commercial	$83.33	384,000	$39.59
	Overall	**Medicaid**	**$318.92**	**333,000**	**$211.93**
	Overall	**Commercial**	**$452.11**	**1,044,000**	**$292.32**
2020	Large Provider Entity 1	Medicaid	$458.33	204,000	$165.71
	Large Provider Entity 1	Commercial	$650.00	720,000	$375.00
	Large Provider Entity 2	Medicaid	$70.83	72,000	$41.67
	Large Provider Entity 2	Commercial	$175.00	480,000	$56.25
	Overall	**Medicaid**	**$357.25**	**276,000**	**$223.47**
	Overall	**Commercial**	**$460.00**	**1,200,000**	**$426.63**

Table 14 shows mock data that Insurer B submitted to the state.

Table 14. Hypothetical Spending and Variance Data for Insurer B

Year	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
2019	Large Provider Entity 1	Medicaid	$398.22	125,000	$128.79
	Large Provider Entity 1	Commercial	$635.13	300,000	$224.08
	Large Provider Entity 2	Medicaid	$70.12	50,000	$67.24
	Large Provider Entity 2	Commercial	$65.12	201,000	$42.71
	Overall	**Medicaid**	**$304.48**	**175,000**	**$233.08**
	Overall	**Commercial**	**$406.44**	**501,000**	**$274.83**
2020	Large Provider Entity 1	Medicaid	$415.24	105,000	$174.78
	Large Provider Entity 1	Commercial	$640.51	380,000	$387.83
	Large Provider Entity 2	Medicaid	$75.25	45,000	$50.84
	Large Provider Entity 2	Commercial	$100.35	223,000	$82.92
	Overall	**Medicaid**	**$313.24**	**150,000**	**$230.74**
	Overall	**Commercial**	**$440.75**	**603,000**	**$396.03**

From the insurer-submitted data, the state will calculate weighted PMPM spending averages for each market in each year. The state will calculate the weighted spending averages by taking data for all providers in the market, multiplying the spending in each row by the number of member months, summing the products, and then dividing the grand total by the total number of member months.

At the insurer level, the state will report growth in TME. Using the above data, where ***$\bar{X}$ is the average PMPM TME***, they will calculate growth in the insurer A's PMPM spending from 2019 to 2020 as follows:

- Medicaid spending growth = (($357.25 / $318.92) – 1) * 100 = 12.01%
- Commercial spending growth = (($460.00 / $452.11) – 1) * 100 = 1.75%

1. Calculating Confidence Intervals for Each Insurer by Market

The state will calculate confidence intervals for the insurer's PMPM growth in Medicaid spending as follows:

Confidence Interval for Medicaid Growth

$$= \frac{\bar{X}_1\bar{X}_2 \pm \sqrt{\bar{X}_1^2\bar{X}_2^2 - \left(\bar{X}_1^2 - t^2_{\widehat{df},\alpha}\frac{V_1}{n_1}\right)\left(\bar{X}_2^2 - t^2_{\widehat{df},\alpha}\frac{V_2}{n_2}\right)}}{\bar{X}_1^2 - t^2_{\widehat{df},\alpha}\frac{V_1}{n_1}}$$

$$= \frac{318.92 \times 357.25 \pm \sqrt{\left(318.92^2 \times 357.25^2\right) - \left(318.92^2 - 1.644861^2\frac{211.93^2}{333{,}000}\right)\left(357.25^2 - 1.644861^2\frac{223.47^2}{276{,}000}\right)}}{318.92^2 - 1.644861^2\frac{211.93^2}{333{,}000}}$$

2. Calculating Confidence Intervals for Each Large Provider Entity by Market

At the provider level, the state will calculate growth using only TME. Using the above data, they will calculate weighted average of Large Provider Entity 1's Medicaid spending and pooled variance for 2019 and 2020 as follows:

Large Provider Entity 1's weighted average PMPM spending for Medicaid:

For 2019 = ($416.67 x 240,000 + $398.22 x 125,000) / (240,000 + 125,000) = $410.35

For 2020 = ($458.33 x 204,000 + $415.24 x 105,000) / (204,000 + 105,000) = $443.69

Pooled variance for 2019 Medicaid:

First Section Second Section

$$V_{pool} = \frac{\sum_i N_{X_i}\sigma^2_{X_i}}{\sum_i N_{X_i}} + \frac{\sum_{i<j} N_{X_i}N_{X_j}\left(\bar{X}_i - \bar{X}_j\right)^2}{\left(\sum N_{X_i}\right)^2}$$

For 2019 Medicaid, first section: $\frac{(240{,}000\times 166.67^2)+(125{,}000\times 128.79^2)}{240{,}000+125{,}000}$

For 2019 Medicaid, second section: $\frac{240{,}000\times 125{,}000\,(416.67-398.22)^2}{(240{,}000+125{,}000)^2}$

For 2019 Medicaid, all sections combined: 24,022.66

Pooled variance for 2020 Medicaid:

For 2020 Medicaid, first section= $\frac{(204{,}000\times 165.71^2)+(105{,}000\times 174.78^2)}{204{,}000+105{,}000}$

For 2020 Medicaid, second section= $\frac{204{,}000\times 105{,}000\,(458.33-415.24)^2}{(204{,}000+105{,}000)^2}$

For 2020 Medicaid, all sections combined: 28,925.75

Using the above formula for calculating confidence intervals, the confidence interval for Large Provider Entity 1's Medicaid cost growth is as follows:

$$= \frac{410.35\times 443.69 \pm \sqrt{\left(410.35^2\times 443.69^2\right)-\left(410.35^2-1.644861^2\frac{24{,}022.81}{365{,}000}\right)\left(443.69^2-1.644861^2\frac{28{,}925.95}{309{,}000}\right)}}{410.35^2-1.644861^2\frac{24{,}022.81}{365{,}000}}$$

$$= \frac{182{,}068.19 \pm \sqrt{77{,}702.63}}{168{,}386.94} = 1.0796 \text{ to } 1.0829, \text{ expressed as a percent: } 7.96\% \text{ to } 8.29\%$$

Thus, the growth rate from 2019 to 2020 was 8.12% and the 95% confidence interval range is 7.96% and 8.29%.[13] Therefore, we can say with 95% certainty that Large Provider Entity 1's growth in Medicaid costs did not meet the cost growth benchmark because the 3.4% benchmark is less than the confidence interval. The state would then repeat this calculation for Large Provider Entity 1's commercial and MA spending.

[13] The state will perform calculations without rounding, but will report values rounded to the hundredths place.

VI. Public Reporting of Benchmark Performance Results

After the state conducts the statistical testing as outlined in the previous section, Executive Order 277 requires them 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, they will collect data and analyze 2018-2019 health care spending to inform a baseline analysis.

The state will coordinate with stakeholders on analyzing and understanding the data to promote transparency and facilitate discussion of strategies to make health care more affordable. Before reporting health care spending and spending growth in aggregate form, they will provide an opportunity for insurers to review the results before they report information. In addition to sharing insurer-level results, the state will share preliminary results with each large provider entity that the insurer reported on, and request that provider entities direct any questions about their data to insurers in advance of public reporting.

Table 15 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 15. 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