New Jersey Health Care Cost Growth Target Benchmark Program

Carrier Benchmark Data Submission Guide

Version 4.0

September 2026

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Version History

Table 1 includes the key updates and changes to this **Carrier Benchmark Data Submission Guide** (the Guide) and the accompanying **Carrier Benchmark Data Submission Template** (the Template).

Table 1. Record of Changes

Version Number, Date Released	Description of Change(s)
V4.0, September 2026	The program made the following changes in the Guide and Template that impact carriers' data reporting requirements (yellow highlights in the Guide indicate these changes): • In Appendix A of this Guide and in the Template, updated the valid values for the Reporting Year fields (TM02, AS02, SD02, LB02, and RX02) from 2023 and 2024 to 2024 and 2025. • In the Submission Schedule subsection of this Guide, updated the submission due dates for each reporting cycle. • In the Large Provider Entity Codes subsection of this Guide and in the Template, updated the codes for provider entities as follows: – Removed Large Provider Entity Code 119 (NJPACO R, LLC/ NJ Physicians ACO) and added code 125 (NJPACO R, LLC/ NJ Physicians ACO/ Vanova Health Partners) due to acquisition. – Added Large Provider Code 126 (Consensus Medical Group LLC/ ilumed MSSP). – Added Large Provider Code 127 (Jefferson Health's Kennedy Medical Group Practice/ Einstein Care Partners ACO). – Added Large Provider Code 128 (Vytalize Health ACO/ Vytalize Health Enhanced ACO LLC). • In the Reporting on Large Provider Entities and Attribution subsection, updated the TIN list guidance to defer to carriers' internal records and contracts if you identify discrepancies. The program also made the following changes in the Guide and Template that **do not** impact carriers' data reporting requirements or affect the input tabs of the Template where you enter required data: • In the Large Provider Entity Codes subsection of this Guide and in the Template, updated the descriptions for provider entities as follows: – Changed Large Provider Entity Code 112 description from, "Partners in Care ACO" to, "Partners in Care ACO/ Continuum Health Alliance". – Changed Large Provider Entity Code 122 description from, "VillageMD/ Summit Health ACO/ Summit Health/ Summit Medical Group" to, "Summit Medical Group, PA dba Summit Health".
V3.0, November 2025	The program made the following changes in the Guide and Template that impact carriers' data reporting requirements (yellow highlights in the Guide indicate these changes): • In Appendix A of this Guide and in the Template, updated the valid values for the Reporting Year fields (TM02, AS02, SD02, LB02, and RX02) from 2021, 2022, and 2023 to 2023 and 2024. • In the Submission Schedule subsection of this Guide, updated the submission due dates for each reporting cycle. • In the Large Provider Entity Codes subsection of this Guide and in the Template, removed Large Provider Entity Code 103 (Atlantic ACO/ Atlantic Health System/ AHS ACO LLC/ Optimus Healthcare Partners, LLC) and split into code 123 (Atlantic Health System) and code 124 (Optimus Healthcare Partners, LLC).

Version Number, Date Released	Description of Change(s)
	• In the Reporting on Large Provider Entities and Attribution subsection, updated the guidance to use the TIN list for attributing primary care providers to Large Provider Entity Codes (when provided). • In Appendix A of this Guide and in the Mandatory Questions tab of the Template, added questions on the use of the TIN list for attribution (MQ36, MQ37, and MQ38). The program also made the following changes in the Guide and Template that **do not** impact carriers' data reporting requirements or affect the input tabs of the Template where you enter required data: • In the Glossary, updated the description of a large provider entity to clarify that they may include more than one organization, such as the affiliated health system, hospitals, clinically integrated networks, accountable care organizations, and so on. • In the Insurer Codes subsection of this Guide and in the Template, updated the description for Insurer Code 202 to Amerigroup/ Wellpoint and Insurer Code 207 to WellCare Health Plans of NJ, INC./ Fidelis Care. • In the Large Provider Entity Codes subsection of this Guide and in the Template, updated some of the entity descriptions to include affiliated organizations, and added a note about Medicare Shared Savings Programs, which are applicable only to traditional/ original Medicare beneficiaries. • In the Line of Business Category Codes subsection of this Guide, added a note to clarify that code 5 (student health plans) is applicable only to NJ residents (that is, carriers must exclude spending for out of state students attending a NJ school). • In the Validation Checks by Stage exhibit of this Guide, added the following stage four checks: – Flagging if the Standard Deviation PMPM field (SD07) does not appear reasonable. – Flagging if changes in TME PMPM compared to last year's submission for the same calendar year do not appear reasonable. • In Appendix A of this Guide, updated the descriptions for the following fields: – For the Standard Deviation PMPM field (SD07), clarified that carriers must calculate using truncated claims spending amounts. – For the Non-Claims: Recovery field (TM18), clarified that carriers must exclude repayments from providers for value-based payment arrangements (e.g., shared risk models), which you report under the Non-Claims: Performance Incentives field (TM15).
V2.0, October 2024	The program made the following changes in the Guide and Template that impact carriers' data reporting requirements: • In Appendix A of this Guide and in the Template, updated the valid values for the Reporting Year fields (TM02, AS02, SD02, LB02, and RX02) from 2018 and 2019 to 2021, 2022, and 2023. • In the Submission Schedule subsection of this Guide, updated the years of data DOBI is collecting (that is, in 2024, carriers submit three years instead of two years of data). • In the Large Provider Entity Codes subsection of this Guide and in the Template, updated the codes for provider entities as follows: – Added Large Provider Entity Code 119 (NJPACO R, LLC/ NJ Physicians ACO). – Removed Large Provider Entity Code 113 (Princeton Healthcare Partners) and added code 121 (Penn Medicine/ Princeton Health/ Princeton Healthcare Partners) due to acquisition. – Removed Large Provider Entity Code 114 (Riverside) and added code 120 (Optum) due to acquisition.

Version Number, Date Released	Description of Change(s)
	– Removed Large Provider Entity Code 117 (Summit Health/ Summit Medical Group) and added code 122 (VillageMD/ Summit Health ACO/ Summit Health/ Summit Medical Group) due to acquisition. • In Appendix A of this Guide and in the Standard Deviation tab of the Template, added the TCOC Member Months field (SD08) to collect member months for those enrolled in total cost of care contracts. • In Appendix A of this Guide and in the Mandatory Questions tab of the Template, added the question requesting National Association of Insurance Commissioner (NAIC) codes from each carrier (MQ35). The program also made the following changes in the Guide and Template that **do not** impact carriers' data reporting requirements or affect the input tabs of the Template where you enter required data: • In the Public Reporting of Benchmark Performance Results subsection of this Guide, updated the public reporting dates. • In the Large Provider Entity Codes subsection of this Guide, added information on how we determine which provider entities carriers submit data on. • In the Validation Checks by Stage exhibit of this Guide, added the following stage four checks: – Flagging if submission-to-submission changes in member months and TME PMPM do not appear reasonable. – Flagging if retail pharmacy rebate amount does not appear reasonable when compared to retail pharmacy claims TME spending for the associated insurance category. • In Appendix A of this Guide, updated description of the Claims: Retail Pharmacy field (TM12) to clarify that amount must include mail order prescriptions. • In the Data Validation Checks, Validation by Market, and Validation by Provider tabs of the Template, increased some of the thresholds for flagging and highlighting data, based on 2018-2019 data submissions.
V1.2, September 2023	The program made the following changes in the Guide and Template: • In the Line of Business Category Codes subsection of this Guide and in the Reference Tables tab of the Template, updated the LOB Category Code 10 description from, "SHBP & SEHBP active employee plans" to, "SHBP & SEHBP commercial plans" to encompass both active and retired employees enrolled in an SHBP or SEHBP commercial plan in the respective reporting year. • In the Line of Business Category Codes subsection of this Guide and in the Reference Tables tab of the Template, updated LOB Category Code 11 description from, "SHBP & SEHBP retiree plans" to, "SHBP & SEHBP MA plans" to encompass both active and retired employees enrolled in an SHBP or SEHBP MA plan in the respective reporting year. • In the Age and Sex Factors tab of the Template, corrected the data validation parameters to allow a value of zero for the Member Count with Truncated Claims (AS09) column. • In the Pharmacy Rebates tab of the Template, corrected the data validation formula for the Total Medical and Retail Pharmacy Rebate Amount (RX07) column. • In the Insurance Category Codes subsection of this Guide, clarified how carriers must report member months and expenditures if you covered both Medicare and Medicaid services for dually eligible members. • In the Reporting on Large Provider Entities and Attribution subsection of this Guide, clarified that carriers must use a member attribution approach that is consistent with your internal methodology, regardless of whether you had a total cost of care or other type of value-based care contract in place with the entity for the corresponding reporting year.

Version Number, Date Released	Description of Change(s)
	• In Appendix A of this Guide, updated the Claims: Professional, Specialty Providers (TM09) description to include payments for services delivered by a primary care physician outside of the primary care setting. • In Appendix A of this Guide, updated the description for Claims: Professional, Other Providers (TM10) to include payments for services delivered by a primary care licensed practitioner other than an MD or DO outside of the primary care setting. • In Appendix C of this Guide, revised language to direct carriers to where the program periodically posts frequently asked questions.
V1.1. August 2023	The program made the following enhancements in the Guide and Template that **do not** impact carriers' data reporting requirements or affect the input tabs of the Template where you enter required data: • In the Validation by Provider tab of the Template, updated to flag if the sum of member months and non-truncated payment amounts for Large Provider Entity Codes 101 through 999 are inconsistent with Large Provider Entity Code 100 (carrier overall), and corrected formulas in the Data Validation Checks tab. • In the Validation Checks by Stage exhibit of this Guide, updated to clarify that carriers must report on Large Provider Entity Code 100 (carrier overall) in the TME, Age and Sex Factors, and Standard Deviation tabs, and ensure these data are consistent with other Large Provider Entity Codes for the respective row ID fields.
V1.0, June 2023	–

Glossary

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

Introduction

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

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

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

Overview of Guide. This Guide details the technical specifications to assist carriers in preparing for the annual data collection and reporting cycle using the Template.

The Guide organizes information as follows:

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

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

ⓘ **Note:** If you are a carrier with questions about submitting data, contact: CarrierDataSubmission@dobi.nj.gov.

I. Cost Growth Benchmark Program

This section provides an overview of the HART Program, cost growth benchmark methodology, and how the program assesses and reports performance.

A. HART Program Overview

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

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

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

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

ⓘ **Note:** For more information about the program, see the Department of Health (DOH) Office of Health Care Affordability and Transparency (OHCAT) webpage.

B. Cost Growth Benchmark Definition

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

The benchmark program measures health care spending growth for all NJ residents with Medicare, Medicaid, and commercial (insured and self-insured) coverage, and assesses cost growth against the

benchmark. These benchmark percentage values are not a mandatory cap or index but reflect a shared goal for stakeholders and the program to work toward constraining the growth of health care costs.

C. Methodology for Calculating the Benchmark

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

Table 2. Cost Growth Benchmark Values

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

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

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

D. Measuring THCE and TME

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

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

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

Unless otherwise specified, all spending data the HART Program reports are gross of pharmacy rebates.

ⓘ **Note:** For the detailed formulas that the program uses to calculate cost growth, see the **State Benchmark Implementation Manual** under the HART Program Implementation Resources section on the DOH OHCAT webpage.

E. Public Reporting of Benchmark Performance Results

Executive Order 277 requires DOBI to annually report on performance relative to the health care cost growth benchmark at four levels (the state-, insurance market-, carrier-, and large provider entity-levels). For the first annual data collection and reporting cycle, the program collected and analyzed 2018-2019 health care spending data to inform a baseline analysis. We will continue coordinating with stakeholders

before reporting aggregated health care spending and spending growth to promote transparency and facilitate discussion of strategies to make health care more affordable.

Table 3 includes the years of data the program collects (i.e., the calendar years for which the program measures cost growth between), benchmark value, level of reporting, and the year when the program publicly reports performance.

Table 3. Health Care Cost Growth Benchmarks and Spending Measurement

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

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

II. Carrier Reporting Requirements

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

This section includes the data specifications and guidance that carriers must follow to submit data in the Template.

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

A. Carriers Required to Submit

Carrier data submission is an essential part of the program's ability to capture health care cost spending across NJ. Using the most recent health insurance enrollment data available, the program reviewed each carrier's number of lives covered across all markets (commercial, Medicare Advantage [MA], and Medicaid Managed Care Organization [MCO]) for the associated years of data we need to collect.

Based on this assessment, carriers in the Insurer Codes subsection must submit data via the Template for each of your associated markets. In addition to the data that carriers submit, the program also collects Medicare and Medicaid fee-for-service and other non-managed care spending data from the Centers for Medicare & Medicaid Services (CMS) and the NJ Division of Medical Assistance & Health Services.

B. Submission Schedule

Carriers submit benchmark data annually. Table 4 outlines the submission due date for each data collection and reporting cycle.

Table 4. Benchmark Data Submission Schedule

Reporting Cycle	Years of Data Collected	Submission Due Date
Pre-benchmark year	CY 2018-2019	September 25, 2023
Transition year & PY1	CY 2021-2023	January 22, 2025
PY2	CY 2023-2024	February 10, 2026
PY3	**CY 2024-2025**	**January 13, 2027**
PY4	CY 2025-2026	Q1 2028
PY5	CY 2026-2027	Q1 2029

Note: Timing under the Submission Due Date column for PY3 through PY5 is subject to change.
PY = performance year; CY = calendar year; Q = quarter

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

C. Data Specification

Carriers must submit data using the Template, which is an Excel workbook with multiple tabs summarized below.

- **Reference tabs** to orient carriers to the Template and codes used to categorize certain data:
  - Contents
  - Reference Tables
- **Input tabs** where carriers enter required data:
  - 1. Cover Page
  - 2. Total Medical Expenses
  - 3. Age and Sex Factors
  - 4. Standard Deviation
  - 5. Line of Business Enrollment
  - 6. Pharmacy Rebates
  - 7. Mandatory Questions
- **Validation tabs** that carriers use to check the accuracy and reasonability of your data submission:
  - Data Validation Checks
  - Validation by Market
  - Validation by Provider

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

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

1. Reporting Categories

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

Table 5 shows the row ID fields for input tabs two through six. These fields must contain values that uniquely identify each row of data, meaning more than one row cannot have the same combination of row ID fields in each tab. The subsections that follow provide more information on the codes to identify carriers, insurance categories, large provider entities, markets, line of business (LOB) categories, member age bands, and member sex at birth.

Table 5. Types of Data Records in Submission Template

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

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

Insurer Codes

Table 6 includes the program-assigned three-digit code that carriers must use for data submitted in the TME, Age and Sex Factors, Standard Deviation, LOB Enrollment, and Pharmacy Rebates tabs of the Template.

Table 6. Insurer Codes

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

Insurance Category Codes

Table 7 includes the insurance categories to use for data submitted in the TME, Age and Sex Factors, and Pharmacy Rebates tabs of the Template.

Table 7. Insurance Category Codes

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

Note: The SHBP and SEHBP member population is applicable only to Aetna Better Health and Horizon Healthcare of NJ.

MCO = managed care organization; SHBP = State Health Benefits Program; SEHBP = School Employees' Health Benefits Program

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

- Include data for all insurance categories that align with the markets for which you have business.
- To avoid double counting, all insurance categories are mutually exclusive.
- For carriers that enrolled commercial members during the corresponding reporting year(s), separate information into two categories:

  - (1) Commercial full claims (Insurance Category Code 3) for which carriers have information on all direct medical claims and any claims paid by a delegated entity (i.e., comprehensive coverage with no carve-outs); and
  - (2) Commercial partial claims (Insurance Category Code 4) for which you do not have all medical and subcarrier claims. Carriers make an adjustment for partial claims to allow them to be comparable to full claims. The goal of the adjustment is to estimate what total spending might be for those members without having to collect claims data from carve-out vendors, such as pharmacy benefit managers (PBMs) or behavioral health vendors. For example, carriers might use their average pharmacy spending PMPM from your commercial members who had pharmacy coverage and apply to commercial members for whom their plan carved out pharmacy benefits.
- For carriers that enrolled dually eligible members during the corresponding reporting year(s), separate information as follows:
  - If a carrier covered either Medicare or Medicaid services, submit member months and spending for Medicare-related expenditures under Insurance Category Code 5 and Medicaid-related expenditures under Insurance Category Code 6. For example, if you covered dually eligible individuals, but were responsible only for Medicaid services, include spending for those members under Insurance Category Code 6.
  - If you covered both Medicare and Medicaid services, submit member months under both Insurance Category Code 5 and 6. Include spending attributed to those members in either Insurance Category Code 5 or 6 depending on whether Medicare or Medicaid was the primary payer for a given claim.

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

Large Provider Entity Codes

Table 8 includes the large provider entities to use for data submitted in TME, Age and Sex Factors, and Standard Deviation tabs of the Template. Carriers should use the Taxpayer Identification Number (TIN) list to attribute PCPs to the large provider entities below, as described in the Reporting on Large Provider Entities and Attribution subsection.

Table 8. Large Provider Entity Codes

Large Provider Entity Code	Description
100	Carrier overall
101	Advocare
102	Aledade/ NJ MSSP Enhanced
104	AtlantiCare Health Solutions, Inc./ AtlantiCare
105	Capital Health/ Capital Health Accountable Care Organization, LLC
106	ColigoCare/ Valley Health System
107	Cooper University Health Care/ AllCare Health Alliance
108	Englewood Health Medical Center
109	Hackensack Alliance ACO/ Hackensack Meridian Health/ Hackensack Meridian Health Partners/ Meridian ACO, LLC

Large Provider Entity Code	Description
110	Hunterdon Healthcare
111	Inspira Care Connect, LLC/ Inspira Health Network
112	Partners in Care ACO/ Continuum Health Alliance
115	RWJBH Accountable Care, LLC/ RWJBarnabas Health/ Barnabas Health/ RWJBarnabas Health Partners
116	Shore Quality Partners ACO
118	Virtua Medical Group/ LHS Health Network
120	Optum
121	Penn Medicine/ Princeton Health/ Princeton Healthcare Partners
122	Summit Medical Group, PA dba Summit Health
123	Atlantic Health System/ Atlantic ACO/ AHS Health Network LLC
124	Optimus Healthcare Partners, LLC/ Vista IPA
125	NJPACO R, LLC/ NJ Physicians ACO/ Vanova Health Partners
126	Consensus Medical Group LLC/ ilumed MSSP
127	Jefferson Health's Kennedy Medical Group Practice/ Einstein Care Partners ACO
128	Vytalize Health ACO/ Vytalize Health Enhanced ACO LLC
999	Unattributed

The program may update the list of provider entities for each reporting cycle as the health care market changes. Each year, the program identifies large provider entities based on whether the entity meets the following criteria using the most recent publicly available data on Medicare Accountable Care Organizations and carrier-submitted information about total cost of care contracts:

- Entity had total cost of care contracts with at least two of the private carriers that the program requires to submit data for the associated reporting years or they had total cost of care contracts with at least one of the private carriers and CMS via their participation in the Medicare Shared Savings Program for the associated reporting years; and
- There were at least 5,000 covered lives within each of those arrangements.

ⓘ **Note:** Some entities above are Medicare Shared Savings Programs (i.e., Medicare Accountable Care Organizations), which are applicable only to traditional/ original Medicare beneficiaries, but private carriers only report data for commercial, MA, and Medicaid MCO members. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.

Age Band Codes

Table 9 includes the member age bands to use for data submitted in the Age and Sex Factors tab of the Template. Carriers must use an approach that is consistent with your internal methodology to calculate and submit member age (e.g., use the first or last date of the reporting period), but you must calculate age for the associated reporting year(s), and not the year you are submitting these data.

Table 9. Age Band Codes

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old

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

Sex Codes

Table 10 includes the assigned sex at birth codes to use for data submitted in the Age and Sex Factors tab of the Template. If a member's sex at birth is unknown, carriers must use an approach that is consistent with your internal policy or defer to the category with more members.

Table 10. Sex Codes

Sex Code	Description
1	Female
2	Male

Market Codes

Table 11 includes the markets codes to use for data submitted in the Standard Deviation tab. Note that each Market Code combines Insurance Category Codes (Medicare combines Insurance Category Codes 1, 5, and 8, Medicaid combines Insurance Category Codes 2 and 6, and commercial combines Insurance Category Codes 3, 4, and 7).

Table 11. Market Codes

Market Code	Description
1	Medicare
2	Medicaid
3	Commercial

Line of Business Category Codes

Table 12 includes the LOB categories to use for data submitted in the LOB Enrollment tab of the Template.

Table 12. Line of Business Category Codes

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

Note: The SHBP and SEHBP member populations are applicable only to Aetna Better Health and Horizon Healthcare of NJ. The student health plans population is applicable only to NJ residents (i.e., you must exclude spending for out of state students attending an NJ school).

MA = Medicare Advantage; MCO = managed care organization; SHBP = State Health Benefits Program; SEHBP = School Employees' Health Benefits Program

ⓘ **Note:** For the Insurance Category and Market Codes that correspond to each LOB Category Code, see the Market, Insurance Category, and Line of Business Category Codes Crosswalk in the Reference Tables tab of the Template.

2. Included Populations

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. Exhibit 1 details the types of policies included and excluded in carriers' submission of TME, which must align with the markets for which you have business.

Exhibit 1. Included and Excluded LOBs by Market

Medicare market **includes** the following LOBs:

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

Medicaid market **includes** Medicaid MCOs, Children's Health Insurance Program (CHIP), and managed long-term services and supports contracts with the NJ Department of Human Services Division of Medical Assistance and Health Services.

Commercial market **includes** the following LOBs:

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

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

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

3. Reporting on Large Provider Entities and Attribution

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

- Carriers must use an approach that is consistent with your internal methodology to attribute members to a PCP, then attribute those PCPs to a Large Provider Entity Code (see guidance for attributing PCPs to entities below), regardless of whether you had a value-based care contract with the provider entity for the corresponding reporting year.
- Carriers should attribute PCPs to a large provider entity based on the TIN list that you access from your organization's folder in the DOBI Benchmark Data Submission Site; specifically:
  - For **large provider entities with TIN(s) in the list**, limit attribution of PCPs billing under those TIN(s) to the entity for the market and dates provided. If you identify discrepancies between the TIN list and/or an entity's affiliated organizations, defer to your internal records and contract arrangements. In addition, provide information on the discrepancies in the Mandatory Questions tab.
  - For **large provider entities without TIN(s) in the list**, use internal data to identify TINs affiliated with the entity for the corresponding reporting year (i.e., follow the process you used for previous reporting cycles to attribute PCPs to each entity).
- Data reported for each large provider entity must include all attributed members' TME for each month carriers attributed the member, so long as the member was a NJ resident at the time of attribution, even when the member received care outside of or not affiliated with the respective provider entity.
- Carriers may choose whether to establish member residency as of the first of the month, last of the month, or another day of the month, consistent with your internal monthly attribution methodology.
- For members who you cannot attribute to a PCP, or whose PCP you cannot attribute to a large provider entity, submit payments using the unattributed category (Large Provider Entity Code 999).
- Submit payments for all members in the carrier overall category (Large Provider Entity Code 100).

4. Reporting of TME

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

- Include payments made **directly to providers** based on the service categories under the Claims Payments and Non-Claims Payments subsections below.
- To avoid double counting, all payment service categories in the subsections below are mutually exclusive (except for Non-Claims: Total Primary Care Payments).
- Include payment information on an incurred, not paid basis for the corresponding reporting year.
- Include payments for members for whom the carrier is the primary payer on a claim (i.e., exclude any paid claims for which you are the secondary or tertiary payer); however, do not exclude payments for a member solely because they had additional coverage:
  - The only exception is for dual eligible plans in which carriers cover both Medicare and Medicaid services. In this scenario, submit member months under both Insurance Category Code 5 (MA dual eligible members) and 6 (Medicaid MCO dual eligible members), but only submit Medicare payments under Insurance Category Code 5 and Medicaid payments under Insurance Category Code 6 (i.e., payment data must be mutually exclusive based on whether Medicare or Medicaid paid the claim).
- Exclude payments based on the categories under the Excluded Types of Payment subsection below.

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

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

Claims Payments

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

- Hospital inpatient (IP)
- Hospital outpatient (OP)
- Professional, primary care
- Professional, specialty
- Professional, other providers
- Long-term care
- Retail pharmacy
- Other claims payments not categorized above

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

Non-Claims Payments

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

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

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

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

Excluded Types of Payments

Carriers exclude the following types of payments:

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

5. Payment Data Completeness

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

Claims Run-Out Period

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

Non-Claims Reconciliation Period

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

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

6. Adjusting Payment Data

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

Vendors and Carved-Out Services

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

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

Carriers include payments for covered benefits in the TME calculation, regardless of how you deliver the benefit. Do not include payments for contracts and vendors that provide strictly administrative functions for health plan operations.

If a carrier is unable to determine the total payments by service category for carved-out benefits, some options to estimate are to:

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

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

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

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

ⓘ **Note:** Carriers must describe how you calculated estimates for commercial partial claims (Insurance Category Code 4) in the Mandatory Questions tab of the Template. If carriers have questions about adjustments, contact: CarrierDataSubmission@dobi.nj.gov.

Truncation

To minimize the impact of high-cost outliers on carrier and provider cost growth, the program excludes member level spending above certain dollar amounts in the calculation of cost growth. As a component of TME submission, carriers must submit dollar amounts excluded from claims spending after applying truncation at the member level, truncated claims spending, and the count of members with claims truncated.

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

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

Exhibit 3. Applying Truncation to Commercial Partial Claims

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

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

ⓘ **Note:** Carriers must describe how you calculated estimates for commercial partial claims (Insurance Category Code 4) in the Mandatory Questions tab of the Template. If carriers have questions about adjustments, contact: CarrierDataSubmission@dobi.nj.gov.

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

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

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

Example with the $250,000 truncation point:

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

Risk Adjustment

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

The program conducts statistical significance testing to assess carriers' and large provider entities' performance against the cost growth benchmark. This involves developing confidence intervals around each carrier's and large provider entity's cost growth and determining whether the confidence interval intersects with the benchmark.

ⓘ **Note:** For more information on the statistical testing that the program conducts, see the **State Benchmark Implementation Manual** under the HART Program Implementation Resources section on the DOH OHCAT webpage.

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

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

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

D. File Specification

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

1. Data Submission Template

Carriers must submit data using the Template. The subsections that follow provide an overview of each tab below and include additional tab-specific requirements and guidance.

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

Contents Tab

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

Reference Tables Tab

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

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

Cover Page Tab

This tab is for carriers to enter your organization name and contact information for the individual(s) who the program connects with for data validation questions and feedback.

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

Total Medical Expenses Tab

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

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

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

Age and Sex Factors Tab

This tab is for carriers to submit member months, total claims payments excluded because of truncation, count of members with truncated claims, total non-truncated claims spending, and total truncated claims spending amounts by the applicable reporting years, insurance categories for which you have business,

large provider entities, member age bands, and member sex. The program uses these data to risk adjust TME for carriers and large provider entities.

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

Standard Deviation Tab

This tab is for carriers to submit member months, total truncated claims spending, standard deviation, and total cost of care member months by the applicable reporting years, markets for which you have business, and large provider entities, which the program uses to calculate confidence intervals for year-to-year cost growth.

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

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

Figure 1. Standard Deviation Equation

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

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

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

Line of Business Enrollment Tab

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

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

Pharmacy Rebates Tab

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

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

The subsections below include more guidance for completing this tab.

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

Estimating Pharmacy Rebates

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

If carriers are unable to submit rebates specifically for NJ residents, you must submit estimated rebates attributed to NJ residents based on the proportion of pharmacy spending for NJ residents compared to pharmacy spending for total members, by Insurance Category Code. For example, if NJ commercial member pharmacy spending represents 10% of a carrier's total commercial member pharmacy spending, then submit 10% of the total pharmacy rebates for your commercial book of business.

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

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

Pharmacy Rebates Passed Back to Employers

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

Mandatory Questions Tab

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

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

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

Data Validation Checks Tabs

These tabs are for carriers to review the consistency and reasonableness of data prior to submitting. The program does not require carriers to input any data into these tabs, but you must review them prior to submitting them to ensure the data are correct.

Validation by Market Tabs

These tabs are for carriers to review the calculated spending and trend by market and service category prior to submitting. The program does not require carriers to input any data into these tabs, but you must review them prior to submitting them to ensure the data are correct.

Validation by Provider Tabs

These tabs are for carriers to review the calculated spending and trend by large provider entity and insurance category prior to submitting. The program does not require carriers to input any data into these tabs, but you must review them prior to submitting them to ensure the data are correct.

2. File Naming Convention

Carriers must submit data in the Template with the following naming convention:
Dyyyy_Innn_Vnn_TME.xlsx (e.g., D2026_I201_V01_TME.xlsx), where:

- "Dyyyy" is the four-digit year (yyyy) when DOBI issued the data request to carriers (i.e., use "2026" for the PY3 submission, "2027" for the transition year and PY4 submission, and so on).
- "Innn" is the three-digit code to identify each carrier (i.e., one of the codes from the Insurer Codes subsection).
- "Vnn" is the submission number (i.e., use "V01" for first submission, "V02" if first submission requires corrections, and so on).
- ".xlsx" is the required file extension to use when saving and submitting the file.

III. Data Submission and Validation Process

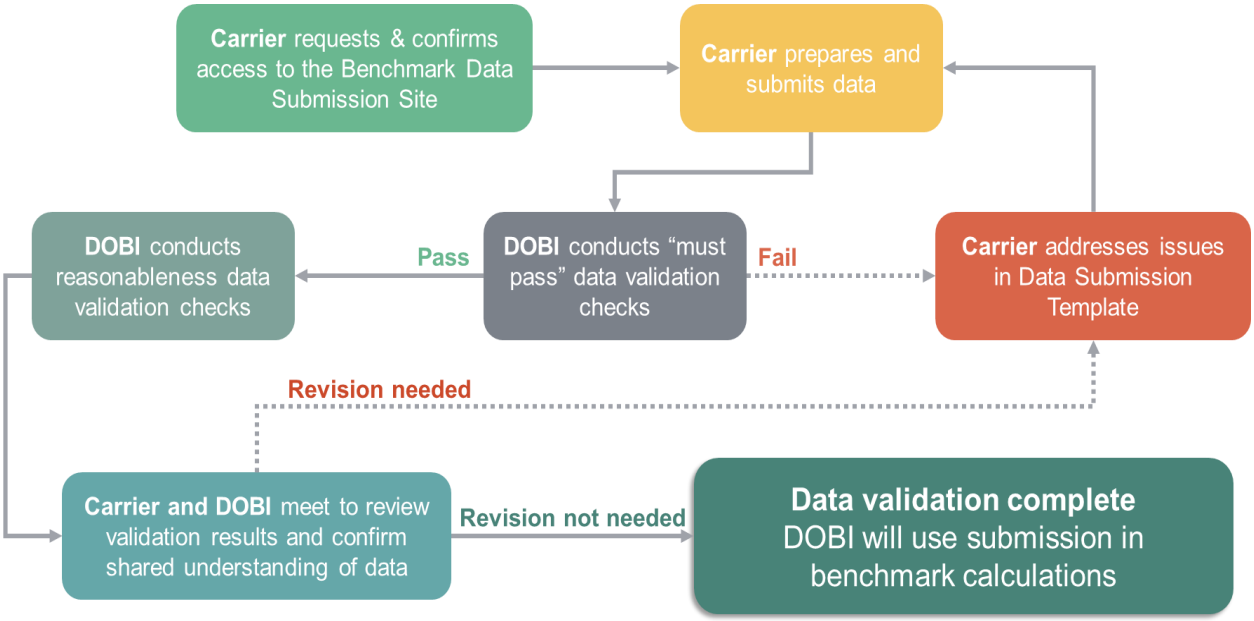
This section details how and when carriers submit spending data for the cost growth benchmark data analysis, including the process you should expect to go through following data submission and before the program reports data publicly.

A. Process Overview

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

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

Figure 2. Process for submitting and validating data



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

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

Access to the Benchmark Data Submission Site

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

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

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

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

Uploading Files to the Submission Site

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

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

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

Forgotten Login Credentials to the Submission Site

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

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

Deactivating Submission Site Users

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

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

2. Carrier Prepares and Submits Data

Carriers must submit data using the Template and according to the specifications outlined in this Guide (i.e., failure to follow requirements results in the program's non-acceptance of the data submission). Exhibit 5 includes the steps carriers take to prepare for data submission. Although it is common for a

carrier to submit data multiple times, following this guidance helps mitigate the number of resubmissions needed and decreases the overall time for completing this process.

Exhibit 5. Data Submission Checklist

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

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

☐ **Complete the Template.**

- ✓ Carrier must review and reference the Carrier Reporting Requirements section and the Data Dictionary appendix when completing the workbook to ensure data align with the specifications.
- ✓ Ensure there are no leading or trailing spaces when entering data into cells in the Template; extra spaces may result in the submission failing validation check(s) that require carriers to update data and resubmit to the program.
- ✓ Do not rearrange or move tabs, columns, or rows in the Template; inputting data in the wrong cells may result in the submission failing validation check(s) that require carriers to update and resubmit data to the program.
- ✓ If copying and pasting data into the template, paste values only to avoid overriding the data validation checks that highlight cells when there are issues.

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

- ✓ After entering all required data in the Template, carrier must review the input tabs and **correct any issues in cells highlighted in red**. Cells turn red if input does not adhere to the requirements under the Valid Value(s) columns in the Data Dictionary appendix tables (e.g., cell turns red if input for the row ID fields in the Reporting Categories subsection do not align with the coded values, for the member months fields if input is not a non-negative integer, and so on); however, note if carriers copy and paste data into template, it may override the data validation checks that highlight cells when there are issues.
- ✓ After fixing any data in red highlighted cells, carrier must review the three auto-calculated validation tabs in the Template (i.e., the Data Validation Checks, Validation by Market, and Validation by Provider tabs) and **correct any potential data quality issues that the Template identified via the tables in the validation tabs**. These validation tabs contain some of the validation checks that the program performs upon receiving each submission uploaded to the submission site, which allows the submitter to identify potential issues before submission.
- ✓ Provide any comments that may help the program better understand inconsistencies, anomalies, trends, and so on, in the Mandatory Questions tab.

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

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

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

3. State Validates Data

Before the cost growth analysis can begin, DOBI conducts validation checks on carrier-submitted data in four stages. Validation checks in stages one through three flag more obvious errors or omissions in the

submitted data, and validation checks in stage four are more in-depth, and flag numbers that do not seem reasonable at face value or based on publicly available data sources.

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

1) **Stage one preliminary data checks.** DOBI completes these checks upon receiving each submission to validate that the submission meets the requirements in the File Specification subsection):
   - If submission *fails checks*, DOBI provides a validation report to the carrier that outlines the issue(s) and includes instructions for how to correct and resubmit data.
   - If submission *passes checks*, DOBI continues to the next stage of checks.

2) **Stage two completeness and formatting checks.** These intra-tab checks validate that the data adheres to the field-level requirements under the Required Value and Valid Value(s) columns in the Data Dictionary appendix tables:
   - If submission *fails checks*, DOBI provides a validation report.
   - If submission *passes checks*, DOBI continues to the next stage of checks.

3) **Stage three consistency checks.** These intra- and inter-tab checks validate that the submission meets the record-level requirements, and that data aligns within and across each applicable tab:
   - If submission *fails checks*, DOBI provides a validation report.
   - If submission *passes checks*, DOBI continues to the next stage of checks.

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

Exhibit 6 includes examples of the validation checks that DOBI performs.

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

Exhibit 6. Validation Checks by Stage

Stage one checks

- Data are in the correct version of the Template.

Stage two checks

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

Stage three checks

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

Stage four checks

- TME PMPM spending across service categories appear reasonable (e.g., flagging if PMPM was less than $10).
- TME PMPM spending based on insurance market and/or age appear reasonable (e.g., flagging if PMPM for commercial members who were 0-1 year old was higher than the PMPM for Medicaid members in the same age band because we expect a higher incidence of babies in neonatal intensive care units in the Medicaid population, flagging if PMPM for male members who were 19-39 years old was higher than the PMPM for female members in the same age band because we expect higher costs for females during child-bearing years, and so on).
- Difference in TME PMPM between commercial full and partial claims appear reasonable.
- Percentages of members' sex at birth appear reasonable (e.g., flagging if less than 40% and/or more than 70% of members were female).
- Percentages of members' age appear reasonable (e.g., flagging if more than 20% of MA non-dual eligible members were under 65 years old, more than 60% of dual eligible members were under 65 years old, and/or less than 80% of commercial or Medicaid MCO non-dual members were under 65 years old).
- Year-to-year changes in member months, non-truncated TME PMPM, TME payment service category PMPMs, and TME PMPM by provider entity appear reasonable.
- Submission-to-submission changes (including previous reporting cycle's submissions, when applicable) in member months and TME PMPM appear reasonable (e.g., flagging if change from previous submission for the same reporting years increased or decreased substantially).
- Standard deviation PMPM for carrier overall (Large Provider Entity Code 100) compared to the standard deviation PMPMs for other Large Provider Entity Codes appear reasonable (e.g., sum of standard deviation PMPMs entered for other provider entity codes do not equal Large Provider Entity Code 100).
- Percentages of members with truncated spending appear reasonable.
- Retail pharmacy rebate amount appears reasonable when compared to retail pharmacy claims TME spending for the associated insurance category.
- Methodology for estimating costs for commercial partial claims that carrier described in the Mandatory Questions tab is appropriate and aligns with the specifications in the Vendors and Carved-Out Services subsection.
- Member months for the MA market appear reasonable compared to the CMS MA Enrollment Data.
- Member months for the Medicaid MCO market appear reasonable compared to the CMS Medicaid MCO Enrollment Data.

4. Carrier and DOBI Discuss Validation Results

Once DOBI completes the stage four checks that assess reasonableness of the data submission, then we engage with carriers one-on-one to discuss findings and questions, including clarifications on any potential issues identified during this stage.

5. Post-Validation Process

After DOBI completes the validation process with all carriers and performs the computations referenced in the **State Benchmark Implementation Manual**, then we provide an opportunity for carriers to review the results before we report information, as outlined in the Public Reporting of Benchmark Performance Results subsection.

In addition to sharing carrier-level results, the program shares preliminary results with each large provider entity that you reported on and allows provider entities the opportunity to ask questions about their data in advance of public reporting.

B. Process Timeline

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

C. Technical Assistance Available to Carriers

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

- HART Program Implementation Resources section on the DOH OHCAT webpage; and
- General Information folder in the DOBI Benchmark Data Submission Site.

Appendix A. Data Dictionary

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

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

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

Cover Page (Input Tab 1)

Table 13 includes the data dictionary for the Cover Page tab.

Table 13. Data Fields in Cover Page Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Name	CP01	Yes	See the Insurer Codes subsection	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.
Primary Contact Name	CP02	Yes	<Free text>	Input first and last name of the individual who can answer and address data validation questions from the program.
Primary Contact Email	CP03	Yes	<Free text>	Input company email address for the primary contact.
Secondary Contact Name (Optional)	CP04	No	<Free text>	Optionally input first and last name of additional contact who the program should include on data submission and validation communications.

Name	ID	Required Value	Valid Value(s)	Description
Secondary Contact Email (Optional)	CP05	No	<Free text>	Optionally input company email address for the secondary contact.

Total Medical Expenses (Input Tab 2)

Table 14 includes the data dictionary for the TME tab.

Table 14. Data Fields in TME Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	TM01	Yes	See the Insurer Codes subsection	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.
Reporting Year	TM02	Yes	2024; 2025	Input calendar year of data in the row.
Insurance Category Code	TM03	Yes	See the Insurance Category Codes subsection	If data does not align with the markets for which you have business, the program requires resubmission to update data. For information on how Insurance Category Codes align with LOB Category and Market Codes, see the code mappings in the Reference Tables tab of the Template.
Large Provider Entity Code	TM04	Yes	See the Large Provider Entity Codes subsection	If row for carrier overall (Large Provider Entity Code 100) is missing, the program requires resubmission to update data. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.
Member Months	TM05	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Calculate member months by taking the number of members with a medical benefit (regardless of whether they have any paid claims) and multiplying that sum by the number of months in the member's policy. Carrier must exclude Medigap members but include members in Dual Special Needs Plans. To attribute members to Large Provider Entity Codes 101 through 999, carriers must follow guidance under the Reporting on Large Provider Entities and Attribution subsection. Value must be consistent across tabs for the respective row ID fields (e.g., if carrier had members in Medicaid MCO plans for the corresponding reporting years, then sum of TM05 for Insurance Category Codes 2 and 6 must equal sum of AS07 for Insurance Category Codes 2 and 6, sum of SD05 for Market Code 2, and sum of LB04 for LOB Category Codes 7 and 9). Value must also be more than zero if Total Non-Truncated Claims and Non-Claims Spending (TM25) is more than zero.

Name	ID	Required Value	Valid Value(s)	Description
Claims: Hospital Inpatient	TM06	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from institutional claims paid to all hospital types for IP services for the respective row ID fields. Hospital IP services include payments made for all room and board, ancillary services, and emergency room (ER) services when the hospital admits member from the ER, in accordance with the specific carrier's payment rules. This category excludes payments made for observation services, physician services provided during an IP stay that a physician or a group practice billed directly, and IP services at non-hospital facilities. For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Hospital Outpatient	TM07	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from institutional claims paid to all hospital types for OP services for the respective row ID fields. Hospital OP services include payments made for hospital-licensed satellite clinics, ER services not resulting in admittance, and observation services. This category excludes payments made for physician services provided on an OP basis that a physician or a group practice billed directly. For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Professional, Primary Care Providers	TM08	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from professional claims paid to PCPs or primary group practices for primary care services delivered at a primary care site, using the program's primary care definition and codes to identify PCPs, services, and sites of care for the respective row ID fields**.** For more information, see the Primary Care Definition and Codes appendix and the Reporting of TME and Claims Payments subsections.
Claims: Professional, Specialty Providers	TM09	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from professional claims paid to specialty care physicians or specialty physician group practices for the respective row ID fields. Specialty care services include payments made to: (1) a Doctor of Medicine or Osteopathy (MD or DO) practicing in clinical areas other than the family medicine, geriatric medicine, internal medicine, and pediatric medicine specialties (i.e., not in the primary care taxonomy code list in Appendix B); or (2) an MD or DO practicing family medicine, geriatric medicine, internal medicine, and/or pediatric medicine (i.e., in the primary care taxonomy code list in Appendix B) for non-primary care services (i.e., services not included in the primary care service code list) delivered in the primary care setting and for services they delivered outside of the primary care setting (e.g., for IP evaluation and management [E/M] services). For more information, see the Reporting of TME and Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Claims: Professional, Other Providers	TM10	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from professional claims paid to licensed practitioners other than a physician or PCP for the respective row ID fields. Other provider services include payments made to: (1) licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, any professional fees that do not fit other categories, and services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services; or (2) a primary care licensed practitioner (i.e., in the primary care taxonomy code list in Appendix B) other than an MD or DO for non-primary care services (i.e., services not included in the primary care service code list) delivered in the primary care setting and for services they delivered outside of the primary care setting (e.g., for IP E/M services). For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Long-Term Care	TM11	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from claims paid to providers for long-term care services for the respective row ID fields. Long-term care services include payments made to providers for services delivered in: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for people with intellectual disability (ICF/ ID) and assisted living facilities; and (3) providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating, and so on), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, and so on), and programs designed to assist people with long-term care needs who receive care in their home and community. This category excludes payments made for professional services rendered during a facility stay that an individual practitioner or physician group practice billed directly. For more information, see the Reporting of TME and Claims Payments subsections.
Claims: Retail Pharmacy	TM12	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from claims paid to providers for retail pharmacy for the respective row ID fields. Retail pharmacy includes payments made to providers for prescription drugs, including mail order prescriptions, biological products, and vaccines as defined by the carrier's prescription drug benefit and gross of applicable rebates. This category excludes payments made for pharmaceuticals under the carrier's medical benefit. Attribute pharmacy payments made under the medical benefit to the setting in which they delivered the pharmaceuticals (e.g., attribute pharmaceuticals delivered in a hospital IP setting to Claims: Hospital Inpatient). This category also excludes payments made for the cost of vaccines administered in the primary care setting. As noted in the Included Populations subsection, exclude payments made under stand-alone PDPs in the submission. For more information, see the Reporting of TME and Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Claims: Other	TM13	Yes	Non-negative number	Input unadjusted, non-truncated allowed amount from claims paid to providers for medical services not otherwise included in other categories for the respective row ID fields. Other services include durable medical equipment, freestanding fees of community health center services, free standing ambulatory surgical center and urgent care center services, hospice facility or services, freestanding diagnostic facility services, hearing aid services, optical services, and the cost of vaccine products administered in the primary care setting. This category excludes payments made for non-health care benefits and services, such as fitness club reimbursements and membership discounts – whether given to the provider or given in the form of a capitated payment to an organization that assists the carrier with enrolling members in gyms. For any other services that carriers are unable to classify, consult with DOBI about the appropriate placement of the service prior to including in this service category. For more information, see the Reporting of TME and Claims Payments subsections.
Non-Claims: Capitation or Bundled Arrangements	TM14	Yes	Non-negative number	Input payment amount made to providers outside of the claims system for services delivered under capitation or bundled payment arrangements for the respective row ID fields. Capitation or bundled arrangements include: (1) capitation payments (i.e., per capita payments to providers for health care services over a defined period of time); (2) global budget payments (i.e., prospective payments made to providers for a comprehensive set of services for a designated patient population or a more narrowly defined set of services where certain benefits such as behavioral health or pharmacy are carved out); (3) case rate payments (i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time); and (4) prospective episode-based payments (i.e., payments received by providers, which can span multiple provider organizations, for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period). For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Performance Incentives	TM15	Yes	Number	Input payment amount made to providers outside of the claims system for performance incentives tied to achieving quality or cost-savings goals, or payments for reducing costs that exceed a defined pre-determined risk-adjusted target for the respective row ID fields. Performance incentive payments include: (1) pay-for-performance (i.e., payments to reward providers for achieving a set absolute, relative, or improvement-based target for quality or efficiency metrics); (2) pay-for-reporting (i.e., payments to providers for reporting on a set of quality or efficiency metrics, usually to build capacity for pay-for-performance payments); and (3) shared savings distributions (i.e., payments received by providers if costs of services are below a pre-determined, risk-adjusted target, and shared risk recoupments, such as payments providers recoup if costs of services are above a pre-determined, risk-adjusted target). For more information, see the Reporting of TME and Non-Claims Payments subsections.

Name	ID	Required Value	Valid Value(s)	Description
Non-Claims: Pop Health and Practice Infrastructure	TM16	Yes	Non-negative number	Input payment amount made to providers outside of the claims system for developing practice capacity and infrastructure to help coordinate care, improve quality, and control costs for the respective row ID fields. Population health and practice infrastructure payments include: (1) support for care management, care coordination, and population health; (2) health information technology infrastructure payments, health information exchange, and other data analytics payments; (3) patient-centered medical home administration and recognition payments; and (4) behavioral health integration that are not reimbursable through claims. For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Provider Salaries	TM17	Yes	Non-negative number	Input payment amount made outside of the claims system for salaries of providers who delivered health care services not otherwise included in other claims and non-claims categories for the respective row ID fields. This category typically applies only to closed delivery systems. For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Recovery	TM18	Yes	Non-positive number	**This is the only service category where carriers input a negative number for payment amount.** Input payment amount made outside of the claims system to providers, members/ beneficiaries, or other carriers, for which you later recouped due to a review, audit, or investigation for the respective row ID fields. Recoupments may be the result of litigation or fraud, waste, and abuse investigations. This category excludes payments under other categories (e.g., if amount for Claims: Hospital Inpatient is net of recovery, do not separately report the same recovery amount in this category). This category also excludes repayments from providers made as part of value-based payment arrangements (e.g., shared risk models). For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Other	TM19	Yes	Non-negative number	Input payment amount made to providers outside of the claims system, pursuant to the carrier's contract with a provider, and not otherwise included in other categories for the respective row ID fields. Other non-claims may include governmental carrier shortfall payments, grants, or other surplus payments. This category excludes carrier administrative expenditures (including corporate allocations). For any other services that carriers are unable to classify, consult with DOBI about the appropriate placement of the service prior to including in this service category. For more information, see the Reporting of TME and Non-Claims Payments subsections.
Non-Claims: Total Primary Care	TM20	Yes	Non-negative number	**This is the only service category not mutually exclusive to other non-claims categories**. Input payment amount made outside of the claims system to PCPs or PCP organizations for the respective row ID fields. This category must be a sub-set of payments reported in the other non-claims categories. Value must be less than or equal to the sum of TM14 through TM17 and TM19. For more information, see the Reporting of TME and Non-Claims Payments subsections.

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

Name	ID	Required Value	Valid Value(s)	Description
Truncated TME PMPM	TM29	No, Template calculates value	Non-negative number	**Carrier reviews for reasonableness.** Total Truncated Expenses PMPM for the respective row ID fields (i.e., TM27 divided by TM05).

Age and Sex Factors Tab (Input Tab 3)

Table 15 includes the data dictionary for the Age and Sex Factors tab.

Table 15. Data Fields in Age and Sex Factors Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	AS01	Yes	See the Insurer Codes subsection	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.
Reporting Year	AS02	Yes	2024; 2025	Input calendar year of data in the row.
Insurance Category Code	AS03	Yes	See the Insurance Category Codes subsection	If data does not align with the markets for which you have business, the program requires resubmission to update data. For information on how Insurance Category Codes align with LOB Category and Market Codes, see the code mappings in the Reference Tables tab of the Template.
Large Provider Entity Code	AS04	Yes	See the Large Provider Entity Codes subsection	If row for carrier overall (Large Provider Entity Code 100) is missing, the program requires resubmission to update data. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.
Age Band Code	AS05	Yes	See the Age Band Codes subsection	Input age band group for data in the row.
Sex Code	AS06	Yes	See the Sex Codes subsection	Input member sex for data in the row.
Member Months	AS07	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Value must be consistent with TM05 for the respective row ID fields.
Claims Amount Excluded Due to Truncation	AS08	Yes	Non-negative number	Input total claims-based spending amount excluded because of the $250,000 truncation point for the respective row ID fields. Value must be consistent with TM21 for the respective row ID fields.

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

Standard Deviation Tab (Input Tab 4)

Table 16 includes the data dictionary for the Standard Deviation tab.

Table 16. Data Fields in Standard Deviation Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	SD01	Yes	See the Insurer Codes subsection	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.
Reporting Year	SD02	Yes	2024; 2025	Input calendar year of data in the row.
Market Code	SD03	Yes	See the Market Codes subsection	If data does not align with the markets for which you have business, the program requires resubmission to update data. For information on how Market Codes align with Insurance and LOB Category Codes, see the code mappings in the Reference Tables tab of the Template.
Large Provider Entity Code	SD04	Yes	See the Large Provider Entity Codes subsection	If row for carrier overall (Large Provider Entity Code 100) is missing, the program requires resubmission to update data. For information on member attribution, see the Reporting on Large Provider Entities and Attribution subsection.
Member Months	SD05	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Value must be consistent with TM05 for the respective row ID fields.
Total Truncated Claims Spending	SD06	Yes	Non-negative number	Input total truncated claims spending amount for the respective row ID fields. Value must be consistent with TM26 and AS11 for the respective row ID fields.

Name	ID	Required Value	Valid Value(s)	Description
Standard Deviation PMPM	SD07	Yes	Non-negative number	Input calculated standard deviation PMPM for all members, including those with no utilization, for the respective row ID fields. Use the PMPM truncated spending to calculate the standard deviation PMPM after partial claims adjustments. Exclude non-claims expenditures in the calculation. For more information, see the Standard Deviation Tab subsection.
TCOC Member Months	SD08	Yes, if Large Provider Entity Code (SD04) ≠ 100 or 999; otherwise no	Non-negative integer	Input annual number of unique members enrolled in total cost of care contracts each month for the respective row ID fields (for the program's definition of total cost of care contracts, see the Glossary). The program uses this information to determine if the large provider entity meets the criteria for public reporting. Value must be less than or equal to Member Months (SD05) for the respective row ID fields.

Line of Business Enrollment (Input Tab 5)

Table 17 includes the data dictionary for the LOB Enrollment tab.

Table 17. Data Fields in LOB Enrollment Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	LB01	Yes	See the Insurer Codes subsection	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.
Reporting Year	LB02	Yes	2024; 2025	Input calendar year of data in the row.
Line of Business Category Code	LB03	Yes	See the LOB Category Codes subsection	If data does not align with the markets for which you have business, the program requires resubmission to update data. For information on how LOB Category Codes align with Market and Insurance Category Codes, see the code mappings in the Reference Tables tab of the Template.
Member Months	LB04	Yes	Non-negative integer	Input annual number of unique members enrolled each month for the respective row ID fields. Value must be consistent with TM05 for the respective row ID fields.

Pharmacy Rebates (Input Tab 6)

Table 18 includes the data dictionary for the Pharmacy Rebates tab.

Table 18. Data Fields in Pharmacy Rebates Tab

Name	ID	Required Value	Valid Value(s)	Description
Insurer Code	RX01	Yes	See the Insurer Codes subsection	Input must align with the Insurer Code in the file name and the Insurer Name (CP01) selected on the Cover Page tab.
Reporting Year	RX02	Yes	2024; 2025	Input calendar year of data in the row.
Insurance Category Code	RX03	Yes	See the Insurance Category Codes subsection	If data does not align with the markets for which you have business, the program requires resubmission to update data. For information on how Insurance Category Codes align with LOB Category and Market Codes, see the code mappings in the Reference Tables tab of the Template.
Medical Pharmacy Rebate Amount	RX04	Yes, if carrier can separate out medical and retail pharmacy rebates	Negative number	Input federal and state supplemental rebates provided by pharmaceutical manufacturers for prescription drugs that *medical providers* administered to NJ resident members or input zero if they did not provide rebates for the respective row ID fields. Amount includes PBM rebate guarantee amount, and any additional rebate amount transferred by the PBM. If carrier populates RX04 and RX05, you do not need to populate amount for RX06. For more information, see the Pharmacy Rebates Tab subsection.
Retail Pharmacy Rebate Amount	RX05	Yes, if carrier can separate out medical and retail pharmacy rebates	Negative number	Input federal and state supplemental rebates provided by pharmaceutical manufacturers for prescription drugs that *retail pharmacies* administered to NJ resident members or input zero if there is no rebate amount for the respective row ID fields. Amount includes PBM rebate guarantee amount, and any additional rebate amount transferred by the PBM. If carrier populates RX04 and RX05, you do not need to populate amount for RX06. For more information, see the Pharmacy Rebates Tab subsection.
Total Pharmacy Rebate Amount	RX06	Yes, if Medical Pharmacy Rebate Amount (RX04) and Retail Pharmacy Rebate Amount (RX05) are missing/ blank; otherwise no	Negative number	Input pharmacy rebate amount *only* if carrier is unable to separately report medical and retail pharmacy rebates (i.e., you cannot input values in RX04 and RX05 for the respective row ID fields). For more information, see the Pharmacy Rebates Tab subsection.

Name	ID	Required Value	Valid Value(s)	Description
Total Medical and Retail Pharmacy Rebate Amount	RX07	No, Template calculates value	Negative number	**Carrier reviews for reasonableness**. Total pharmacy rebate amount for the respective row ID fields (i.e., sum of RX04 and RX05 if RX06 is missing/ blank or zero; else RX06).

Mandatory Questions (Input Tab 7)

Table 19 includes the data dictionary for the Mandatory Questions tab. Carriers must also input more information related to the question, if applicable, in the Comments fields (MQ03C-MQ35C).

Table 19. Data Fields in Mandatory Questions Tab

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

Name	ID	Required Value	Valid Value(s)	Description
How long was the run-out period for non-claims payments (report as days)?	MQ05	Yes	Integer	If response is less than 180 days, the program requires resubmission to update data or correct response if you entered the wrong number of days. For more information, see the Non-Claims Reconciliation Period subsection.
Are IBNR and IBNP factors applied to claims payments?	MQ06	Yes	Yes; No	Confirm whether carrier applied IBNR and IBNP to claims payment service categories. For more information, see the Claims Run-Out Period subsection.
Is pharmacy rebate data estimated?	MQ07	Yes	Yes; No	For more information, see the Estimating Pharmacy Rebates subsection.
If yes, enter how you estimated the rebate amounts.	MQ08	Yes, if response to pharmacy rebate estimation question (MQ07) is "Yes"; otherwise no	<Free text>	If carrier populates field and MQ07 response is "No," state requests resubmission to update response to "Yes" or remove text from this field and enter in Comments field, if applicable. For more information, see the Estimating Pharmacy Rebates subsection.
Are carve-out services for commercial partial claims estimated?	MQ09	Yes	Yes; No; Not applicable	If response is "Not applicable" and carrier reported data using Insurance Category Code 4, the program requires resubmission to update data or correct response if you selected "Not applicable" in error. For more information, see the Vendors and Carved-Out Services subsection.
If yes, enter which carve-out services you estimated and describe how you calculated the estimate.	MQ10	Yes, if response to carve-out estimation question (MQ09) is "Yes"; otherwise no	<Free text>	If carrier populates field and MQ09 response is "No," state requests resubmission to update response to "Yes" or remove text from this field and enter in Comments field, if applicable. For more information, see the Vendors and Carved-Out Services subsection.
TME Inclusion and Exclusion Questions				
Are claims payments reported as allowed amounts, including both payments that insurer paid to providers and member cost sharing?	MQ11	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Claims Payments subsection.
Is the spending reported in a manner consistent with the payment service category definitions in the Benchmark Data Submission Guide?	MQ12	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, including the definitions for the payment service categories, see the data dictionary in the Total Medical Expenses (Input Tab 2) appendix.

Name	ID	Required Value	Valid Value(s)	Description
Does the TME include NJ residents only?	MQ13	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Included Populations subsection.
Does the TME include services rendered by providers, regardless of location of provider?	MQ14	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Reporting on Large Provider Entities and Attribution subsection.
Does the TME include services rendered by providers, regardless of the situs of the member's plan?	MQ15	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Included Populations subsection.
Are data limited only to members for whom the insurer is primary on the claim?	MQ16	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Reporting of TME subsection.
Are members attributed to provider organizations using an approach that is consistent with your internal attribution methodology?	MQ17	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Reporting on Large Provider Entities and Attribution subsection.
Are TME submitted based on the incurred date/ date of service?	MQ18	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Reporting of TME subsection.
Is truncation applied at the member level?	MQ19	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Truncation subsection.
Does the truncated spending include only claims data?	MQ20	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Truncation subsection.
Are spending estimates on carved out services (commercial partial claims) included in the calculation of claims at the member level before applying truncation?	MQ21	Yes	Yes; No; Not applicable	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. If response is "Not applicable" and carrier reported data using Insurance Category Code 4, the program requires resubmission to update data or correct response if you selected "Not applicable" in error. For more information, see the Vendors and Carved-Out Services subsection.
Standard Deviation Questions				

Name	ID	Required Value	Valid Value(s)	Description
Are standard deviations calculated using the formula for population standard deviation?	MQ22	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Standard Deviation Tab subsection.
Are non-claims expenses excluded from the standard deviation calculations?	MQ23	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Standard Deviation Tab subsection.
Are spending estimates on carved out services (commercial partial claims) at the member month level included in the standard deviation calculations?	MQ24	Yes	Yes; No; Not applicable	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. If response is "Not applicable" and carrier reported data using Insurance Category Code 4, the program requires resubmission to update data or correct response if you selected "Not applicable" in error. For more information, see the Standard Deviation Tab subsection.
When calculating the standard deviation, did you include all the member months, regardless of whether the member has paid claims for that month?	MQ25	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Standard Deviation Tab subsection.
When calculating the standard deviation, did you use each member's average cost per month applied to each month they were enrolled, instead of the actual utilization each month?	MQ26	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Standard Deviation Tab subsection.
Is standard deviation calculated by market, which combines certain Insurance Category Codes?	MQ27	Yes	Yes; No	If response is "No," state requests resubmission to update data or correct response if you selected "No" in error. For more information, see the Standard Deviation Tab subsection.
Income from Fees of Self-Insured Plans Questions				
Did you have members in self-insured plans during calendar year 2024?	MQ28	Yes	Yes; No	If response does not align with the markets for which you have business and the member months in the LOB Enrollment tab, the program requires resubmission to update data or correct response if you selected "No" in error.
If yes, enter the income from fees of self-insured plans for 2024.	MQ29	Yes, if response to 2023 self-insured LOB question (MQ28) is "Yes"; otherwise no	Non-negative number	Input Income from Fees of Uninsured Plans, NAIC SHCE Part 1, Line 12.

Name	ID	Required Value	Valid Value(s)	Description
Did you have members in self-insured plans during calendar year 2025?	MQ30	Yes	Yes; No	If response does not align with the markets for which you have business and the member months in the LOB Enrollment tab, the program requires resubmission to update data or correct response if you selected "No" in error.
If yes, enter the income from fees of self-insured plans for 2025.	MQ31	Yes, if response to 2024 self-insured LOB question (MQ30) is "Yes"; otherwise no	Non-negative number	Input Income from Fees of Uninsured Plans, NAIC SHCE Part 1, Line 12.
"Doing Business As" Questions				
For Medicare managed care organizations, what are all the names under which you are "doing business as" in the state of NJ?	MQ32	Yes, if carrier has members enrolled in Medicare managed care plans; otherwise no	<Free text>	Input any names carrier is "doing business" as in the state of NJ.
What are all the NAIC codes under which you are doing business as in the state of NJ (include all markets)?	MQ35	Yes	<Free text>	Input all NAIC codes associated with carrier's NJ business.
TIN List and Attribution Questions				
Did you use the TIN list in the attribution process?	MQ36	Yes	Yes; No	For more information, see the Reporting on Large Provider Entities and Attribution subsection.
Did you identify any discrepancies between the TIN list provided by LPEs and your internal records?	MQ37	Yes	Yes; No	For more information, see the Reporting on Large Provider Entities and Attribution subsection.
If yes, enter information about the discrepancies you identified.	MQ38	Yes, if response to TIN list discrepancies question (MQ37) is "Yes"; otherwise no	<Free text>	Input any feedback on the TINs submitted by large provider entities.

Appendix B. Primary Care Definition and Codes

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

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

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

Primary Care Specialty Codes

Table 20 below lists select provider taxonomy codes for the four primary care specialties included in the program's definition of PCPs (i.e., family medicine, geriatrics, internal medicine, and pediatrics) and certain provider organization taxonomy codes (e.g., federally qualified health centers). Carriers must identify PCPs first by searching for the provider taxonomy codes from the table below in the rendering provider field and then the billing provider field. If carriers do not use the provider taxonomy codes in the table below, you may apply your provider codes to match the description of the codes below.

Table 20. Primary Care Taxonomy Codes

Taxonomy Code	Description	Notes or Restrictions
208D00000X	General Practice	
207Q00000X	Family Medicine	

Taxonomy Code	Description	Notes or Restrictions
207QA0000X	Family Medicine, Adolescent Medicine	None
207QA0505X	Family Medicine, Adult Medicine	
207QG0300X	Family Medicine, Geriatric Medicine	
208000000X	Pediatrics	
2080A0000X	Pediatrics, Adolescent Medicine	
207R00000X	Internal Medicine	
207RG0300X	Internal Medicine, Geriatric Medicine	
207RA0000X	Internal Medicine, Adolescent Medicine	
363A00000X	Physician Assistant	
363AM0700X	Physician Assistant, Medical	
363L00000X	Nurse Practitioner	
363LA2200X	Nurse Practitioner, Adult Health	
363LF0000X	Nurse Practitioner, Family	
363LG0600X	Nurse Practitioner, Gerontology	
363LP0200X	Nurse Practitioner, Pediatrics	
363LP2300X	Nurse Practitioner, Primary Care	
207QH0002X	Family Medicine, Hospice Palliative	Restrict to only home health and hospice procedure codes
2080H0002X	Pediatrics, Hospice and Palliative Medicine	
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	
363LC1500X	Nurse Practitioner, Community Health	Restrict to the procedure code list
363LS0200X	Nurse Practitioner, School	
261QF0400X	Federally Qualified Health Center (FQHC)	Restrict to procedure code list AND restrict on revenue codes for clinic and professional services 0510, 0515, 0517, 0520, 0521, 0523, 0960, 0983
261QR1300X	Clinic/ center, Rural Health	
261QP2300X	Clinic/ center, Primary Care	
282NR1301X	Rural Hospital	
261QC0050X	Critical Access Hospital	
282NC0060X	Critical Access Hospital	

Primary Care Service Payment Codes

Table 21 below contains payment codes for primary care services. Carriers must only include TME in Claims: Professional, Primary Care (TM08) for the services in the table below if a PCP delivered service at a primary care site of care.

Table 21. Primary Care Payment Codes

Procedure Code	Description	Procedure Category
99201	OFFICE OP NEW 10 MINUTES	Office Visits
99202	OFFICE OP NEW 20 MINUTES	
99203	OFFICE OP NEW 30 MINUTES	
99204	OFFICE OP NEW 45 MINUTES	
99205	OFFICE OP NEW 60 MINUTES	
99211	OFFICE OP VISIT 5 MINUTES	
99212	OFFICE OP VISIT 10 MINUTES	
99213	OFFICE OP VISIT 15 MINUTES	
99214	OFFICE OP VISIT 25 MINUTES	
99215	OFFICE OP VISIT 40 MINUTES	
99381	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR	Preventive Medicine Visits
99382	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS	
99383	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS	
99384	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR	
99385	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS	
99386	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS	
99387	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>	
99391	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y	
99392	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS	
99393	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS	
99394	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS	
99395	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS	
99396	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS	
99397	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER	
99241	OFFICE CONSULTATION NEW/ ESTAB PATIENT 15 MIN	Consultation Services
99242	OFFICE CONSULTATION NEW/ ESTAB PATIENT 30 MIN	
99243	OFFICE CONSULTATION NEW/ ESTAB PATIENT 40 MIN	
99244	OFFICE CONSULTATION NEW/ ESTAB PATIENT 60 MIN	
99245	OFFICE CONSULTATION NEW/ ESTAB PATIENT LEVEL 5	
G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT	HCPC Visit Codes
G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT	
G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/ AWV	
T1015	CLINIC VISIT/ ENCOUNTER ALL-INCLUSIVE	

Procedure Code	Description	Procedure Category
S9117	BACK SCHOOL VISIT	
G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR	
G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT	
G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST	
G0463	HOSPITAL OP CLIN VISIT ASSESS & MGMT PT	
99401	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 15 MIN	Preventive Medicine Services
99402	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 30 MIN	
99403	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 45 MIN	
99404	PREVENT MED COUNSEL&/ RISK FACTOR REDJ SPX 60 MIN	
99406	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES	
99407	TOBACCO USE CESSATION INTENSIVE >10 MINUTES	
99408	ALCOHOL/ SUBSTANCE SCREEN & INTERVEN 15-30 MIN	
99409	ALCOHOL/ SUBSTANCE SCREEN & INTERVENTION >30 MIN	
99411	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M	
99412	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M	
99420	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT	
99429	UNLISTED PREVENTIVE MEDICINE SERVICE	
99341	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES	Home Visits
99342	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES	
99343	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES	
99344	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES	
99345	HOME VISIT NEW PT UNSTABL/ SIGNIF NEW PROB 75 MIN	
99347	HOME VISIT EST PT SELF LIMITED/ MINOR 15 MINUTES	
99348	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES	
99349	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES	
99350	HOME VST EST PT UNSTABLE/ SIGNIF NEW PROB 60 MINS	
99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES	Hospice/ Home Health Services
99375	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>	
99376	CARE PLAN OVERSIGHT/ OVER	
99377	SUPERVISION HOSPICE PATIENT/ MONTH 15-29 MIN	
99378	SUPERVISION HOSPICE PATIENT/ MONTH 30 MINUTES/>	
G0179	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD	
G0180	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD	
G0181	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY	

Procedure Code	Description	Procedure Category
G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE	
99339	INDIV PHYS SUPVJ HOME/ DOM/ R-HOME MO 15-29 MIN	Domiciliary, Rest Home; Multidisciplinary Care Planning
99340	INDIV PHYS SUPVJ HOME/ DOM/ R-HOME MO 30 MIN/>	
99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE	Transitional Care Management Services
99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE	
99497	ADVANCE CARE PLANNING FIRST 30 MINS	Advance Care Planning E/M Services
99498	ADVANCE CARE PLANNING EA ADDL 30 MINS	
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	Case Management Services
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	
99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN	
99487	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO	Chronic Care Management Services
99489	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH	
99490	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH	
99491	CHRON CARE MANAGEMENT SRVC 30 MIN PER MONTH	
G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC	
99358	PROLNG E/M SVC BEFORE&/ AFTER DIR PT CARE 1ST HR	Prolonged Services
99359	PROLNG E/M BEFORE&/ AFTER DIR CARE EA 30 MINUTES	
99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES	
G0513	PROLONG PREV SVCS FIRST 30M	
G0514	PROLONG PREV SVCS ADDL 30M	
99441	PHYS/ QHP TELEPHONE EVALUATION 5-10 MIN	Telephone and Internet Services
99442	PHYS/ QHP TELEPHONE EVALUATION 11-20 MIN	
99443	PHYS/ QHP TELEPHONE EVALUATION 21-30 MIN	
99444	PHYS/ QHP ONLINE E&M SERVICE	
99446	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 5-10 MIN	
99447	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 11-20 MIN	
99448	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 21-30 MIN	
99449	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 31/> MIN	
99451	NTRPROF PHONE/ NTRNET/ EHR ASSMT&MGMT 5/> MIN	
99452	NTRPROF PHONE/ NTRNET/ EHR REFERRAL SVC 30 MIN	
98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN	
98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN	
98968	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN	

Procedure Code	Description	Procedure Category
98969	NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT	
90460	IM ADM THRU 18YR ANY RTE 1ST/ ONLY COMPT VAC/ TOX	Immunization Administration for Vaccines/ Toxoids
90461	IM ADM THRU 18YR ANY RTE ADDL VAC/ TOX COMPT	
90471	IM ADM PRQ ID SUBQ/ IM NJXS 1 VACCINE	
90472	IM ADM PRQ ID SUBQ/ IM NJXS EA VACCINE	
90473	IM ADM INTRANSL/ ORAL 1 VACCINE	
90474	IM ADM INTRANSL/ ORAL EA VACCINE	
G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE	
G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE	
G0010	ADMINISTRATION OF HEPATITIS B VACCINE	
96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM	Health Risk Assessment, Screenings, and Counseling
96161	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM	
99078	PHYS/ QHP EDUCATION SVCS RENDERED PTS GRP SETTING	
99483	ASSMT & CARE PLANNING PT W/ COGNITIVE IMPAIRMENT	
G0396	ALCOHOL &/ SUBSTANCE ABUSE ASSESSMENT 15-30 MIN	
G0397	ALCOHOL &/ SUBSTANCE ABUSE ASSESSMENT >30 MIN	
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES	
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN	
G0444	ANNUAL DEPRESSION SCREENING 15 MINUTES	
G0505	COGN & FUNCT ASMT USING STD INST OFF/ OTH OP/ HOME	
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT	Preventive Medicine Services
G0102	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION	
G0436	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN	
G0437	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN	
58300	INSETION OF IUD	Contraceptive Insertion/ Removal
58301	REMOVAL OF IUD	
57170	DIAPHRAGM OR CERVICAL CAP FITTING WITH INSTRUCTIONS	
S4981	INSERTION OF LEVONORGESTREL-RELEASING INTRAUTERINE SYSTEM	
11981	INSERTION, NON-BIODEGRADBLE DRUG DELIVERY IMPLANT	
11982	REMOVAL, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	
11983	REMOVAL WITH REINSERTION, NON-BIODEGRADABLE DRUG DELIVERY IMPLANT	
S0610	ANNUAL GYNECOLOGICAL EXAM, ESTABLISHED PATIENT	Gynecological Services
S0612	ANNUAL GYNECOLOGICAL EXAM, NEW PATIENT	

Procedure Code	Description	Procedure Category
S0613	ANNUAL GYNECOLOGICAL EXAM, BREAST EXAM W/O PELVIC	
G0101	CERV/ VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM	
Q0091	SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB	

Telehealth Place of Service and Modifier Codes

Table 22 below contains the place of service and modifier codes for telehealth services. Carriers must only include TME for primary care delivered via telehealth in Claims: Professional, Primary Care (TM08) if you identify using the taxonomy codes in Table 20 and telephone and internet services procedure codes in Table 21 or another code in Table 21 with the place of service and/ or modifier codes in the table below.

Table 22. Telehealth Place of Service and Modifier Codes

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

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

Appendix C. Frequently Asked Questions

The program periodically releases frequently asked questions (FAQs) and responses collected from carriers and posts them to the following places:

- HART Program Implementation Resources section on the DOH OHCAT webpage; and
- General Information folder in the DOBI Benchmark Data Submission Site.