New Jersey Health Care Cost Growth Target Benchmark Program

Provider Entity Frequently Asked Questions Log

Version 2.1

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NJHealth
New Jersey Department of Health
Office of Health Care Affordability and Transparency

Introduction

Overview

This **Provider Entity Frequently Asked Questions (FAQs) Log** (the FAQs Log) includes questions and responses collected from large provider entities (LPEs) regarding the New Jersey (NJ) Health Care Affordability, Responsibility, and Transparency (HART) Program's annual benchmark data collection and reporting cycle. The FAQ Log organizes information by the categories in the Table of Contents section below.

How to Use this Resource

This FAQs Log supplements the **State Benchmark Program Implementation Manual** (the Manual) and **Carrier Benchmark Data Submission Guide and Template** (the Guide and Template). LPEs should refer to the Manual for information on the benchmark analysis calculations and the Guide for the full set of carrier data reporting requirements. The NJ Department of Health posts these materials to its Office of Health Care Affordability and Transparency (OHCAT) webpage. The Department of Banking and Insurance (DOBI) also posts all of these materials in the General Information folder on the DOBI SharePoint Site (see **FAQ D.4** for SharePoint access instructions).

Version History

When the cost growth benchmark program team releases an updated version of this document, LPEs will be able to identify newly added FAQs by the publish month and year under each answer and modified FAQs by the update month and year. If we have not modified an FAQ that we published in an earlier version of this document, this indicates that the information is still current as of the document's release month and year.

ⓘ **Note:** For more general information about the HART Program, see the FAQs Accompanying Release of Executive Order 277. If you are an LPE with questions about the HART Program, please contact: hartprogram@doh.nj.gov.

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A. General Background Information

A.1. What is a cost growth benchmark?

A health care cost growth benchmark is a per capita target for an annual rate of total statewide health care growth. It is *not a cap* on spending, but, rather, a goal agreed upon by state leaders, health insurers, health care providers, businesses, and consumer advocates for achieving a sustainable rate of health care cost growth.

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A.2. Why is it important for NJ to implement a benchmark program?

The HART Program is a significant step forward in the state's collective effort, working with stakeholder groups, to make health care more accessible and affordable for all NJ residents.

For more information on the importance of implementing a benchmark program, see the FAQs Accompanying Release of Executive Order 277.

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A.3. How was NJ's benchmark program developed?

Recognizing the economic hardship of rising health care costs on residents and businesses, Governor Murphy signed Executive Order 217, on January 28, 2021, directing development of a health care cost growth benchmark to begin reining in health care cost growth. An Interagency Working Group led the development of the HART Program in collaboration with an Advisory Group of health care leaders throughout the state who signed a compact agreeing to the program goals and tenets.

For more information on the development of the program and the role of stakeholders in its development, see the FAQs Accompanying Release of Executive Order 277.

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A.4. How will the HART Program benefit New Jerseyans?

In the short term, the benchmark program will make it easier to understand health care cost growth and the factors driving that growth. Over time, the HART Program aims to not only increase transparency of health care spending but also work with stakeholders to help develop sustainable strategies to make health care more affordable throughout our state while also promoting quality outcomes.

For more information on the program's benefits to NJ residents and businesses, see the FAQs Accompanying Release of Executive Order 277.

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A.5. How was NJ's cost growth benchmark established?

Executive Order 277 established the health care cost growth benchmark values for calendar years 2023 through 2027. Table 1 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 1. Cost Growth Benchmark Values

Performance 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 HART Program calculated the cost growth benchmark based on a combination of Potential Gross State Product (25%) and forecasted Median Income (75%) to ensure the program better aligns the health care cost growth with the growth of the state's economy and the incomes of working New Jerseyans. This blended value translates to a target growth rate of 3.2%.

The program designated 2022 as a transition year, with no benchmark, to allow the health care system to continue recalibrating after the COVID-19 pandemic. The target is 3.5% for 2023 and then gradually declines to 2.8% in 2027. In setting the trajectory of the proposed benchmark path, the Interagency Working Group and its Advisory Groups sought to achieve meaningful reductions in cost growth while avoiding disruptions to NJ's health care market.

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B. Collecting & Validating Data for Benchmark Reports

B.1. What are the requirements for LPEs to submit data?

For the Pre-Benchmark Year (2018-2019 data), Transition Year (2021-2022 data), and Performance Year 1 (2022-2023 data) reporting cycles, the HART Program did not require LPEs to submit any data. Rather, those LPEs meeting the inclusion criteria for data collection had enrollment and spending attributed to them through data submitted by health insurance carriers.

Beginning with the Performance Year 2 (2023-2024 data) reporting cycle, the program will be requesting a list of associated Tax Identification Numbers (TINs) from LPEs. The program will share the TIN lists with carriers, and carriers will limit attribution for a given LPE to their associated TINs.

Although the program does not require LPEs to submit TINs, we strongly encourage you to submit this information to help address any discrepancies between carrier member attribution and LPEs' internal member counts. Note that if an LPE does not submit a list of TINs to the program, then carriers will rely on their provider rosters and provider contracting structures to attribute spending to the LPE.

Updated in August 2025

B.2. What is the rationale for limiting reporting to large providers and not including smaller ones?

LPEs must have sufficient patient volume for accurate and reliable identification of changes in annual per capita total medical expenses (TME). The HART Program seeks to avoid situations in which smaller provider entities may exceed the health care cost growth target due to a few unusually complex and expensive cases.

The program has two sets of member threshold criteria that are applicable to LPEs:

1. Threshold criteria to determine the list of LPEs that carriers include when performing attribution during the benchmark data submission process (see **FAQ B.3** for more information).
2. Threshold criteria to determine, at the market level, which LPEs will have their year-to-year percent change in truncated, risk-adjusted per member per month TME publicly reported (see **FAQ E.2** for more information).

Updated in August 2025

B.3. How does the HART Program determine which LPEs to include in its carrier data submission requirements?

Measuring health care spending at the LPE level for the HART Program requires attribution of both (a) members to a primary care provider and (b) primary care providers to an LPE.

The program reviews available information about total cost of care contracts to develop criteria for identifying and including LPEs in its data collection efforts. The Program identifies LPEs based on whether the entity met the following criteria using the most recent publicly available data on Medicare Accountable Care Organizations and survey responses from private health insurance carriers:

- 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 the entity had total cost of care contracts with at least one of the private carriers and the Centers for Medicare & Medicaid Services (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.

The program reviews and updates the LPE list during each reporting cycle, understanding that total cost of care contracting arrangements can change over time.

Lastly, note that not all LPEs will have their data publicly reported. For more information on the public reporting criteria, see Section E of this FAQs Log.

Updated in August 2025

B.4. How will carriers attribute spending at the LPE level?

The HART Program requires carriers to use their own primary care-based attribution methods to attribute members to a primary care provider and, in turn, attribute that primary care provider to an LPE.

Carriers attribute all spending associated with that member to the primary care provider and roll up to the LPE with which the clinician is affiliated. When carriers cannot attribute a member to a primary care provider or cannot attribute a primary care provider to an LPE, the carriers report enrollment and spending for such members as “unattributed.”

Lastly, please note that spending attributed to your organization will not align with other reports that you receive from carriers due to the different reporting requirements among health plans and programs.

Updated in August 2025

B.5. How does the HART Program validate benchmark data?

The HART Program 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. For example, the program flags issues related to completeness, formatting, and consistency of data. If a carrier's data submission fails any checks in stages one through three, the program requires them to correct and resubmit their data.

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. For example, the program flags if year-to-year changes in member months and TME per member per month (PMPM) spending by LPE do not appear reasonable. HART Program staff then meet with data submitters to discuss the results of these checks:

- If the carrier identifies any issues while affirming the flagged reasonableness check(s), they remediate and resubmit data; or
- If the carrier reviews findings and confirms that the flagged reasonableness check(s) do not indicate an error, the validation process is complete, and the program uses the carrier submitted data in the benchmark analysis.

It is important to note that because the program does not have access to carriers' internal data systems, they cannot directly verify the carrier-submitted data and so comprises review using the program's own validation systems and protocols, described above.

For more examples of data validation checks that the program conducts and information about the data validation process, see the **Carrier Benchmark Data Submission Guide**.

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B.6. How do we know whether carriers used the correct National Provider Identifiers (NPIs) and TINs for our entity when attributing members and spending?

The HART Program understands that provider affiliations may change. Without a state provider registry, the program must rely on the current processes that carriers and LPEs have developed to ensure that carriers account for these changes in their data submissions.

In order review lists of NPIs and TINs used in attribution, LPEs should reach out directly to carriers to request this information.

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B.7. Do carriers attribute spending for members not associated with total cost of care contracts to LPEs, and if so, why?

Carriers attribute all spending associated with a member to LPEs regardless of whether the carrier had a total cost of care or other type of value-based care contract with the entity for the corresponding reporting year. This decision was informed by discussions with stakeholders when the HART Program was in development.

As described in **FAQ B.3**, the program has thresholds for identifying LPEs to include in the benchmark data collection process. Those thresholds are based on the number of total cost of care contract arrangements in place and the number of members covered under each arrangement. These thresholds mean that data collection is limited to entities that have some experience with population health management and the program believes that they can be reasonably expected to influence total health care costs of their full patient population.

The program recognizes that carriers will attribute some members to LPEs when there is not a value-based care arrangement in place between the LPE and the carrier. If a member saw a primary care provider regularly enough for a carrier's internal attribution methodology to attribute the member to the primary care provider, and that primary care provider is part of a large provider entity, the program believes it is appropriate to attribute spending for that member to the entity.

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B.8. Because attribution methodologies differ between carriers, won't this result in inaccurate TME analyses across the LPEs?

During the development stage, the HART Program acknowledged that allowing each carrier to use an attribution approach that consistent with its internal methodology would lead to varied approaches by different carriers. The program discussed the risks of this approach with carriers and providers during Technical Subgroup meetings, including that the variation may not be ideal for supporting provider entity comparisons across carriers. However, the substantial reporting burden of requiring carriers to use the same methodology posed a greater risk to the program's overall ability to collect benchmark data.

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B.9. Why is the per member truncation point $250,000 for carriers' data submission?

The HART Program developed the truncation methodology and threshold based on discussions with carriers and providers during Technical Subgroup meetings. These discussions informed the program's decision to apply truncation to members' total claims spending (medical and pharmacy) if it exceeds the per member truncation point of $250,000.

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C. Measuring Cost Growth for Benchmark Reports

C.1. How is health care cost growth measured?

New Jersey will measure total health care expenditures (THCE), the sum of TME plus the net cost of private health insurance (NCPHI) incurred by New Jersey residents covered by Medicare, Medicaid, and individual and employer-sponsored health insurance. Carriers submit aggregate information to the HART Program to enable calculations of per capita spending growth.

To assess performance relative to the benchmark target at the state and market levels, NJ will calculate spending growth based on the year-over-year percent change in per capita THCE. For example, to track performance relative to its targeted growth rate of 3.5%, the program will measure the per capita THCE growth rate from 2022 to 2023.

THCE includes the following components:

- Total Medical Expenses (TME)
  - All payments on providers' claims for reimbursement of the cost of health care provided.
  - All other payments not included on providers' claims.
  - All member cost-sharing including but not limited to copayments, deductibles and coinsurance.
- Net cost of private health insurance (NCPHI)

For carriers and providers, the program assesses performance relative to the benchmark target using truncated, risk-adjusted TME PMPM at the market level. The program will report this year-to-year percent change value with confidence intervals. Specifications for the risk adjustment process and calculation of confidence intervals can be found in Sections III and V of the **State Benchmark Program Implementation Manual**.

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C.2. What data sources will the HART Program use to measure THCE?

The HART Program measures THCE using aggregated carrier-reported data that support spending analysis at the state, market (e.g., commercial, Medicare, and Medicaid), carrier, and LPE levels. Other data sources for the benchmark program include:

- CMS data for Medicare fee-for-service (FFS) claims and Part D (pharmacy) spending;
- NJ Division of Medical Assistance and Health Services (DMAHS) data for non-managed care spending on Medicaid; and
- Regulatory reports that detail net cost of private health insurance (NCPHI).

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C.3. How will the HART Program account for NJ residents who seek care from health systems that are in neighboring states?

Wanting to capture the complete picture of spending for the state, the HART Program will measure spending for all NJ residents, regardless of where they seek care. Understanding the concerns related to patients seeking care from out-of-state providers and based on the Advisory Group's input, one of the first areas that the program assessed in the commercial "cost driver" was patient "outmigration" and the related impact of care provided out of state on NJ health care costs.

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C.4. Are cost growth data risk-adjusted at the LPE level?

At the LPE and carrier levels, the HART Program adjusts spending trends using age and sex factors. The program does not adjust year-over-year spending trends at the market or statewide levels, since these populations are large enough to be stable over time.

For more information on the risk adjustment calculations, see Section III of the **State Benchmark Program Implementation Manual.**

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C.5. Does the risk adjustment methodology account for health status or patient acuity?

The HART Program uses an age and sex-based risk adjustment methodology, informed by discussions with carriers and providers during meetings of the Technical Subgroup, which does not account for clinical risk for several reasons:

- **Measuring year-over-year growth**. The purpose of the program is to measure the year-over-year change in health care spending. Health status of the population (and subsequently clinical risk) should remain relatively stable in this year-over-year assessment.
- **Clinical risk skewed by coding practices**. Evidence has shown that overall changes in clinical risk scores tend to be driven more by changes in coding practices rather than changes in patient acuity or population health status (Chernew et al., 2021).[1] This can mean that two providers that serve roughly equivalent populations may receive different clinical risk scores depending on their coding practices.
- **Uniform application of risk adjustment across carriers**. Carriers each have their own clinical risk adjustment methodologies that they rely on, which may result in differing standard deviation calculations that would be improper to pool across carriers in calculating providers' standard deviations. Therefore, the program standardizes the calculation across carriers using an age and sex-based risk adjustment process.

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[1] Chernew, M., Carichner, J., Impreso, J., McWilliams, J. M., McGuire, T., Alam, S., Landon, B., & Landrum, M. B. (2021). Coding-Driven Changes in Measured Risk in Accountable Care Organizations. Health Affairs, 40(12), 1909-1917. https://doi.org/https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00361

D. LPE First Look Reports

D.1. What are the LPE First Look Reports?

Prior to the release of the public benchmark report, the HART Program will share "first look reports" with each LPE that include the LPE's results. The intent of these First Look Reports is to allow LPEs to review their results and ask questions before any public release of information.

The First Look Reports include the market-level (i.e., across all private carriers) year-to-year percent change in truncated, risk-adjusted Total Medical Expenses. The program will publicly report this value beginning in the Transition Year reporting cycle (see Table 2 in Section E.1 of this FAQ log for more details on the annual reporting cycles). The program will report this percent change value with confidence intervals calculated according to the specifications in the **State Benchmark Program Implementation Manual**.

In addition to the figure that will be publicly reported, the First Look Reports contain key values that will support LPEs understanding of spending change calculations such as: carrier market-level member attribution totals (in member months), non-truncated spending totals, truncated spending totals, and counts of members impacted by truncation.

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D.2. Will the NJ HART Program provide LPEs' member attribution and claim-level files that the program used to generate the LPE First Look Reports?

The HART Program does not receive member attribution and claim-level information from the carriers, rather the carriers submit claims and non-claims TME data (spending and enrollment) that they aggregate by reporting year, insurance category code, and LPE. The LPE First Look Report shares those aggregated TME data with LPEs at the level at which they were shared with the program.

If an LPE has questions about specific enrollment or spending values that were submitted by a given carrier, they will need to contact that carrier directly to ask questions. The program maintains a carrier contact list for these purposes, which can be found in the General Information folder on the DOBI SharePoint Site. Please note that the spending attributed to your organization will not align with other reports that you receive from carriers due to the different reporting requirements among health plans and programs.

For more information about the data that carriers submit for the benchmark program, see the **Carrier Benchmark Data Submission Guide**.

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D.3. Why do the LPE First Look Reports exclude Medicare and Medicaid FFS insurance markets?

CMS and DMAHS (the carriers for traditional Medicare and Medicaid FFS) do not apply LPE member attribution in their data submissions. Because their data submissions do not include LPE-level data, the HART Program is unable to provide Medicare and Medicaid FFS spending amounts for each organization in their LPE First Look Report.

For more information on the data that CMS and DMAHS submit, see the **State Benchmark Program Implementation Manual**.

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D.4. How do we access our LPE First Look Report?

LPEs must access reports from the DOBI SharePoint Site (same location as the Pre-Benchmark reports):

- **Requesting access to the SharePoint Site.** If you do not have access to this site, email your name and organization to DOBI at hartprogram@dobi.nj.gov, as soon as possible to avoid any delays in accessing your report. Once DOBI grants access, each user will receive an email from no-reply@sharepointonline.com. Confirm access to the site by clicking the link in the email, which should take you to the login screen of the site.
- **Forgotten login credentials to the SharePoint Site.** Site users will log in with your email address and a security code that you receive via email each time you log in. The site does not require users to log in with a password; therefore, you should avoid clicking the reset password link if it is visible. You will have three opportunities to enter the correct security code that you receive via email, after which the site will lock you out.

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E. Public Reporting of Benchmark Performance Results

E.1. What is the annual public reporting cycle?

Below is the HART Program reporting plan. Table 2 includes the years of data the state collects (i.e., the calendar years between which the program measures cost growth), benchmark value, level of reporting, and the year when the state publicly reports performance.

For the first (pre-benchmark year) data collection cycle, the program reported state and market level spending and per capita spending growth only. For the second (transition year) cycle, the program will begin publicly reporting carrier- and LPE-level performance, and beginning with the Performance Year 1 report spending will be compared relative to the cost growth benchmark. The program does not measure cost growth between 2019-2020 and 2020-21 because of the impact of the COVID-19 pandemic.

Table 2. 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 & LPE	2025
PY 1	CY 2022 & 2023	3.5%	State, market, carrier & LPE	2025
PY 2	CY 2023 & 2024	3.2%	State, market, carrier & LPE	2026
PY 3	CY 2024 & 2025	3.0%	State, market, carrier & LPE	2027
PY 4	CY 2025 & 2026	2.8%	State, market, carrier & LPE	2028
PY 5	CY 2026 & 2027	2.8%	State, market, carrier & LPE	2029

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

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E.2. Is there a minimum member month threshold for public reporting of LPE performance?

The HART Program limits public reporting of LPEs for which they will publicly report market-level percent change in risk-adjusted, truncated TME PMPM with confidence intervals to those LPEs that meet both of the following criteria for a given market:

1. At least 60,000 attributed member months across all private carriers in the market for each of the two years covered in a report (e.g., CY 2021 and 2022 for the Transition Year); and
2. At least 30% of attributed member months are associated with total cost of care contracts across all markets for the two years covered in a report.

These criteria were established based on discussions with the Advisory Group and Technical Subgroup.

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E.3. How will the HART Program report outlier performance numbers?

The HART Program will make case-by-case decisions for when they exclude outlier performance values (percent change in risk-adjusted, truncated TME PMPM with confidence intervals) from reporting figures. If the program elects to remove the values from a reporting figure because it is an outlier value and could obscure interpretation of values for other entities, they will communicate the outlier values in writing within the report.

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