CONNECTICUT COST GROWTH BENCHMARK AND PRIMARY CARE SPENDING TARGET INITIATIVES

Implementation Manual

Version 4.0

June 18, 2024

Version History

Version Number	Release Date	Summary of Changes
1.1	March 25, 2021	
1.2	March 30, 2021	• Clarifies definition of "line of business" for the purposes of reporting standard deviation data. • Added Symphonix to the list of organizations under which UnitedHealthcare also conducts business.
1.3	April 5, 2021	• Removed Fair Haven Community Center from the list of Advanced Networks and renumbered the assigned Organizational Identification Numbers accordingly.
1.4	April 19, 2021	• Added ProHealth to the list of Advanced Networks and renumbered the assigned Organization Identification Numbers accordingly. Clarified that attribution should be based on contractual relationships in place during the reporting period. Updated the due date for submission of calendar years 2018 and 2019 data to June 18, 2021.
1.5	April 21, 2021	• Clarified the parameters for completing clinical risk adjustment.
2.0	June 6, 2022	• Updated the methodology for measurement of TME to include risk-adjustment using age/sex factors and truncation of spending for high-cost outliers. • Renamed "Large Provider Entities" as "Advanced Networks" and added additional Advanced Networks required for reporting. • Removed Harvard Pilgrim from the list of Insurance Carriers required to report. • Specified that pharmacy rebates should be reported separately as medical and retail pharmacy.

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		• Changed from collecting variance to collecting standard deviation for the purposes of statistical testing. • Clarified that the denominator for cost growth at the state level is the population of reported members, not the state census population. • Added DSS CT DSS Medicaid TME and primary care spending data specifications. • Added Medicare FFS Primary Care Data Specification Using APCD Data.
2.1	June 22, 2022	• Updated Appendix B. CT DSS Medicaid TME and Primary Care Spending Data Specification.
2.2	November 18, 2022	• Revised Standard Deviation instructions.
3.0	June 23, 2023	• Removed Medical Professional Services (ID 105) from the list of Advanced Networks to be reported on. • Added Wellcare to the list of insurance carriers required to report Medicare Advantage data. • Clarified that carriers should attribute providers to Advanced Networks based on contracts in place during the reporting periods, and not along current contracts. • Added guidance for how to handle members without a documented sex (male/female). • Added Appendix L describing OHS' methodology for risk adjusting TME using age/sex factors.
4.0	June 18, 2024	• Added "reinsurance recoveries or reinsurance premiums" to list of line of business exclusions. • Added request for payers to estimate pharmacy rebates for Commercial: Partial Claims. • Clarified member month (annual) definition in comprehensive plans to not duplicate member

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		months for members with both medical and pharmacy benefits.
		• Updated Advanced Network names and organizational IDs as follows:
		  ○ Name change for Advanced Network ID 102 from Connecticut Children's Medical Center to Connecticut Children's Care Network for clarity.
		  ○ Name change for Advanced Network ID 101 from Community Medical Group to Privia Quality Network of Connecticut (PQN CT) after purchase.
		  ○ Removed ProHealth (Advanced Network ID 111) from the list of Advanced Networks to be reported on.
		  ○ Name change for Advanced Network ID 129 from WestMed Medical Group to Summit Health following partnership.
		• Added guidelines for a new member attribution methodology utilizing Taxpayer Identification Numbers (TINs) provided by Advanced Networks.
		• Revised the payer primary care attribution methodology to include a hierarchical approach and added reporting by hierarchical tier to Total Medical Expense reporting.
		• Added new primary care procedure codes (99424-99427, 99437), revised description for primary care procedure codes (99242-99245, 99341-99345, 99347-99350, 99359, 99417, 99491), and deleted primary care procedure codes (99241, 99339, 99340, 99343).
		• Added request for submission of Medical Loss Ratio (MLR) reports to OHS.
		• Updated 2024 Cost Growth Benchmark value from 2.9% to 4.0%.

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I. Overview

On January 22, 2020, Governor Lamont signed Executive Order No. 5 directing the establishment of a statewide healthcare cost growth benchmark. With the goal of slowing the growth of healthcare spending and making healthcare more affordable for the citizens of Connecticut, Executive Order No. 5 directed the Office of Health Strategy (OHS) to develop annual healthcare cost growth benchmarks for calendar years (CY) 2021-2025. Connecticut became the fifth state to adopt a statewide healthcare cost growth benchmark, following Massachusetts, Connecticut, Delaware and Oregon. New Jersey, Nevada, and Washington have since also adopted cost growth benchmarks.

Executive Order No. 5 also required OHS to implement several additional, related initiatives, including:

- establishing targets for raising primary care spending as a percentage of total healthcare spending to reach 10 percent by 2025;
- developing quality benchmarks across all public and private payers beginning in 2022, which may include clinical quality measures, over- and under-utilization measures, and patient safety measures;
- annually monitoring and reporting on healthcare spending growth across public and private payers; and
- monitoring accountable care organizations and the adoption of alternative payment models.

During the 2022 legislative session, Connecticut General Statute 19a-754g et. Seq. codified Executive Order No. 5's provisions into law. It also introduced new reporting requirements for the healthcare cost growth benchmark, primary care spending targets and OHS' related initiatives, including requiring that OHS:

- hold at least one informational public hearing prior to adopting the healthcare cost growth benchmarks and primary care spending

targets for each subsequent five-year period and submit five-year benchmark recommendations to the General Assembly for approval if certain conditions are met[1];
- annually review the current and projected rate of inflation and determine whether the rate of inflation requires modification of the healthcare cost growth; and
- collect and report on healthcare cost growth benchmark and primary care spending data according to a specified timeline, detailed in Section V.D of this manual.

This manual contains the technical and operational procedures that OHS employs to implement the healthcare cost growth benchmark and primary care spending targets. It details the methodology that OHS used to set the healthcare cost growth benchmark and the primary care target values, and the methodologies for evaluating performance against the benchmark and target. This manual also provides technical specifications for data reporting and collection.

OHS Contact Information: For questions about this manual or the data submission template, please contact Lisa Sementilli at Lisa.Sementilli@ct.gov.

The following supplemental materials are available on the Office of Health Strategy's website:

Attachment 1. Medicare Expenditure and Enrollment Request Template https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Cost-Growth-Benchmark-Implementation-Manual

Attachment 2. Cost Growth Benchmark Performance Submission Template https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Cost-Growth-Benchmark-Implementation-Manual

[1] Connecticut General Statute 19a-754g et. Seq.

Attachment 3. OSC Cost Growth Benchmark Performance Submission Template

https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Cost-Growth-Benchmark-Implementation-Manual

Attachment 4. DSS Cost Growth Benchmark Performance Submission Template

https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Cost-Growth-Benchmark-Implementation-Manual

II. Definitions of Key Terms

Advanced Network:[2] An organized group of clinicians that come together for the purposes of contracting, or are an established billing unit that, at a minimum, includes primary care providers, and that collectively, during any given calendar year, has enough attributed lives to participate in total cost of care contracts, even if it is not engaged in a total cost of care contract. This term is equivalent to "provider entities" referenced in Connecticut General Statute 19a-754g et. Seq.

Allowed Amount: The amount the payer paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of Total Medical Expense.

Coinsurance: The percentage of costs of a covered healthcare services the member pays after they have paid their deductible. For example, if an insurance plan's allowable cost for a service is $100 and the member's coinsurance is 20 percent, if the member has met their deductible, they paid 20 percent of $100, or $20. If the member has not met their deductible, they pay $100, the full allowed amount for the service.

Confidence interval lower/upper bound: OHS conducts statistical significance testing to assess insurer and Advanced Network performance against the cost growth benchmark. This involves developing confidence intervals around each insurer and Advanced Network's cost growth and determining whether the confidence interval intersects with the benchmark. A confidence interval, in statistics, refers to the range of values for which we are fairly certain our population parameter lies within. In the case of the cost growth benchmark, the confidence interval lower and upper bounds

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[2] The term "Advanced Network" as used in this manual is equivalent to the term "provider entity" as used in Connecticut General Statute 19a-754g et. Seq.

represent the range of values within which we can be 95 percent certain that an insurer or Advanced Network's cost growth lies in. If an entity's confidence interval lower bound is above the cost growth benchmark, that means we can be 95 percent certain the entity has exceeded the cost growth benchmark. If an entity's confidence interval upper bound is below the cost growth benchmark, that means we can be 95 percent certain the entity has met the cost growth benchmark. If an entity's confidence interval (the distance between their upper and lower confidence interval bounds) intersects with the cost growth benchmark, that means we cannot determine with 95 percent certainty whether the entity has exceeded or met the cost growth benchmark.

Copayment: The fixed amount the member pays for a covered service after the member has paid their deductible. For example, if an insurance plan's allowable cost for a service is $100 and the member's copayment for the service is $20, if the member has met their deductible, they pay $20 for the service. If the member has not met their deductible, they pay $100, the full allowed amount for the service.

Deductible: The amount the member pays for covered health services before their insurance plan starts to pay. For example, with a $2,000 deductible, the member pays for the first $2,000 of covered services themselves.

Did not meet the benchmark: If an entity's cost growth benchmark performance is marked "Did not meet the benchmark" this means that the entity's confidence interval lower bound is above the cost growth benchmark, meaning that we can be 95 percent certain that the entity's risk-adjusted TME growth rate has exceeded the cost growth benchmark.

Healthcare Cost Growth Benchmark ("Benchmark"): The healthcare cost growth benchmark ("benchmark") is the targeted annual per person growth rate for Connecticut's total healthcare spending, expressed as the

percentage growth from the prior year’s per person spending. The benchmark is set on a calendar year basis (i.e., benchmarks for each calendar year).

Insurance Carriers (Carriers): A private health insurance company that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, and Medicare Advantage plans.

Market: The highest levels of categorization of the health insurance market. Medicare and Medicare Advantage are collectively referred to as the “Medicare market.” Medicaid Fee-for-Service is referred to as the “Medicaid market.” Individual, self-insured, small and large group, and student health insurance markets are collectively referred to as the “commercial market.”

Medical Pharmacy Rebates: The estimated value of rebates attributed to Connecticut resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair maker value bona fide service fees for pharmaceuticals that are paid for under the member’s medical benefit. These drugs may be included in the professional claims category with J codes or part of facility fees for drug infusions administered in the outpatient setting. This amount should include PBM rebate guarantee amounts, and any additional rebate amounts transferred by the PBM. The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).

Met the benchmark: If an entity's cost growth benchmark performance is marked "Met the benchmark" this means that the entity's confidence interval upper bound is below the cost growth benchmark, meaning that we can be 95 percent certain that the entity's risk-adjusted TME growth rate has exceeded the cost growth benchmark (see "confidence interval lower/upper bound" definition).

Minimum lives requirement not met: If an Advanced Network's cost growth benchmark performance is marked as "minimum lives requirement not met", this means the Advanced Network did not have at least 60,000 attributed member months for the given market. OHS only reports publicly on the risk-adjusted TME growth of Advanced Networks that have a minimum of 60,000 attributed members months for the commercial, Medicare Advantage, or Medicaid FFS markets

Net Cost of Private Health Insurance (NCPHI): Measures the costs to Connecticut residents associated with the administration of private health insurance (including Medicare Advantage). It is defined as the difference between premiums earned and benefits incurred, and includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs, net additions or subtractions from reserves, rate credits and dividends, premium taxes and profits or losses.

Payer: A payer, including Medicaid, Medicare and governmental and nongovernment health plans, and includes any organization acting as payer that is a subsidiary, affiliate or business owned or controlled by a payer that, during a given calendar year, pays healthcare providers for healthcare services or pharmacies or provider entities for prescription drugs designated by the executive director.

Payer Recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payment recoveries is a separate, reportable field in total medical expense (TME) reporting.

Performance Year: The most recent calendar year for which data were submitted for the applicable healthcare cost growth benchmark, primary care spending target or healthcare quality benchmark.

Primary Care Spending Target ("Target"): This target is Connecticut's annual primary care spending as a percentage of total medical expenditures. The target should reach 10 percent by calendar year 2025, as directed in Connecticut General Statute 19a-754g et. Seq. Interim targets are set on an annual calendar year basis (i.e., a target for each calendar year).

Retail Pharmacy Rebates: The estimated value of rebates attributed to Connecticut resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding to the reporting period, excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.[3] This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. The computation of THCE at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[4]

Risk-adjusted TME: Risk-adjusted TME refers to an entity's risk-adjusted, truncated claims spending plus its non-claims spending. OHS risk-adjusts claims spending using risk scores developed using payer-submitted age/sex spending data. Risk-adjusted TME is used to assess performance against the cost growth benchmark at the insurer and Advanced Network level.

Total Healthcare Expenditures (THCE): The sum of all healthcare expenditures in this state from public and private sources for a given

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[3] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

[4] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spending will be gross of Medicare FFS pharmaceutical rebates.

calendar year, including: all claims-based spending paid to providers, net of pharmacy rebates, all patient cost-sharing amounts, and the Net Cost of Private Health Insurance. Defining specifications of THCE are included in Section III.B.

Total Healthcare Expenditures Per Member Per Year: Total Healthcare Expenditures (as defined above) divided by Connecticut's covered population as reported in the total medical expense (TME) data. The annual change in THCE per member per year is compared to the benchmark at the state level.

Total Medical Expense (TME): The total cost of care for the patient population of a payer or provider entity for a given calendar year, where cost is calculated for such year as the sum of: all claims-based spending paid to providers by public and private payers, and net of pharmacy rebates; all nonclaims payments for such year, including, but not limited to, incentive payments and care coordination payments; and all patient cost-sharing amounts expressed on a per person basis for the patient population of a payer or provider entity in this state. TME is reported at multiple levels: market, payer and provider level. TME is reported net of Pharmacy Rebates at the state, market and payer levels only. Payers report TME by line of business (e.g., individual, self-insured, large group, small group, Medicare, Medicaid, Medicare/Medicaid dually eligible) and at the Advanced Network level whenever possible. More detailed TME reporting specifications are contained in the Appendices of this manual.

Truncation: Truncation is applied to individuals' total spending, inclusive of all medical and pharmacy spending. The truncation point for: Medicaid expenses for non-dual eligible members is $250,000; Medicaid expenses for Medicare/Medicaid dual eligible is $250,000; Medicare expenses for non-dual eligible members is $150,000; and commercial full or partial claims is $150,000.

Unable to determine: If an entity's cost growth benchmark performance is marked "unable to determine" this means that the entity's confidence interval intersected with the cost growth benchmark, meaning we cannot determine with 95 percent certainty whether the entity's risk-adjusted TME growth rate has exceeded or met the cost growth benchmark.

III. Healthcare Cost Growth Benchmark Methodology

The benchmark is based on a calculated and pre-determined blend of the growth in the forecasted per capita potential gross state product (PGSP), and the forecasted growth in median income, determined in advance of the performance period.

Table 1 below presents the healthcare cost growth benchmark methodology, which is a weighted blend of PGSP and median income with a two-year add-on factor. The add-on factor recognized that the weighted methodology's initial value of 2.9% would have been difficult for the payers and providers to meet immediately given typical contracting cycles and the 2020 anticipated effect of COVID-19 on healthcare utilization patterns. As shown in **Table 1,** the methodology provided for a two-year adjustment to ease into the final target.

Table 1. Cost Growth Benchmark Methodology

Calendar Year	Cost Growth Benchmark Methodology	Add-on Factor
2021	20% PGSP / 80% Median Income	0.5%
2022	20% PGSP / 80% Median Income	0.3%
2023	20% PGSP / 80% Median Income	0.0%
2024	20% PGSP / 80% Median Income	0.0%
2025	20% PGSP / 80% Median Income	0.0%

To calculate the forecasted long-term (2026-2030) per capita PGSP, Connecticut uses the same formula used by Massachusetts, Delaware and Connecticut. The source for the formula listed below is available in **Appendix J**:

PGSP = (expected growth in national labor force productivity + expected growth in the state's labor force + expected national inflation) – expected state population growth

As calculated by OHS, the forecasted per capita PGSP for Connecticut is 3.7%. The forecasted median household income growth for 2026 – 2030 in Connecticut is 2.7%.[5] **Table 2** below presents the benchmark values, using the blended formula defined in **Table 1.**

Table 2. Healthcare Cost Growth Benchmark Values 2021-2025

Calendar Year	Cost Growth Benchmark Values
2021	3.4%
2022	3.2%
2023	2.9%
2024	4.0%
2025	2.9%

Pursuant to Connecticut General Statute 19a-754g et. Seq., OHS annually reviews the inflation. If OHS determines that the rate of inflation requires modification of the healthcare cost growth benchmark, OHS may modify the benchmark. Following its annual inflation review, OHS publishes the inflation review findings, including the reasons for making or not making a modification to the healthcare cost growth benchmark.

Following its 2023 annual review of inflation, OHS modified the benchmark value for 2024 from 2.9% to 4.0% due to elevated general inflation in the Connecticut economy in 2022.

[5] Based on annual growth rate data purchased from IHS Markit by the Connecticut Office of Policy and Management and made available to OHS.

IV. Primary Care Spending Target Methodology

OHS developed the definition of primary care providers and spending with the assistance of its advisory bodies. OHS uses this definition, as detailed in section VI below, to calculate statewide spending against the target established in Executive Order No. 5 and codified in Connecticut General Statute 19a-754g et. Seq. The advisory bodies recommended that OHS separately calculate spending associated with primary care services provided by obstetrics/gynecology (OB/GYN) providers and midwifery for monitoring purposes.

The primary care spending target for calendar years 2021 through 2025 are listed in **Table 3** below. The target for calendar year 2021 was set based on OHS' best estimate of statewide spending on primary care. The target for calendar year 2022 was set at 5.3 percent, the baseline level calculated for 2019. The targets for calendar years 2023-2025 include near-equal annual increases of 1.6 percentage points. The 2023-2025 targets were established by OHS after receiving guidance from its advisory bodies.

Table 3. Primary Care Spending Target Values 2021-2025

Calendar Year	Primary Care Spending Target Values
2021	5.0%
2022	5.3%
2023	6.9%
2024	8.5%
2025	10.0%

V. Methodology for Assessing Performance Against the Healthcare Cost Growth Benchmark

OHS annually reports performance relative to the healthcare cost growth benchmark at four levels: (1) the State, (2) health insurance market (e.g., Medicare, Medicaid and commercial), (3) individual payer by market, and (4) Advanced Network (for provider entities of a pre-defined size). Data at the individual payer and Advanced Network levels are risk adjusted. To do so, OHS collects and performs analyses on data from payers in the state. This section contains the methodology for measuring the growth in healthcare spending at each level, including which data are necessary to collect and which calculations need to be performed.[6] This section is organized as follows:

A. Methodology for Measuring Total Healthcare Expenditures (THCE)
B. Data Sources for THCE
C. Public Reporting of Cost Growth Benchmark Performance
D. Timeline for Measuring and Reporting the Healthcare Cost Growth Benchmark

A. Methodology for Measuring Total Healthcare Expenditures

To assess changes in the amount of healthcare spending, OHS calculates THCE annually. The THCE data sources are described in Section III.B. below and include insurance carriers, the Centers for Medicare and Medicaid Services (CMS), the Connecticut Department of Social Services (DSS), the Connecticut

[6] These methodologies and reporting specifications are derived, in part, from materials published by the Massachusetts Center for Health Information and Analysis, the Delaware Health Care Commission, and the Connecticut Health Care Cost Trends Steering Committee. These materials have been edited from previously published materials to reflect the Connecticut Healthcare Benchmark Initiative.

Department of Correction (DOC), and the Veterans Health Administration (VHA).

OHS measures THCE on an aggregate dollar and per member per year (PMPY) basis. The aggregate dollar figure is for informational purposes only. The change in THCE on a PMPY basis is used to assess performance against the benchmark.

THCE (in aggregate) =

> Commercial TME + Medicare Advantage TME + Medicare FFS TME + DSS Medicaid TME + DOC TME + VHA TME + Insurer NCPHI

THCE (per member per year) =

$$\frac{\left(\begin{array}{l}\text{Commercial TME + Medicare Advantage TME + Medicare FFS TME +}\\ \text{DSS Medicaid TME + DOC TME + VHA TME + Insurer NCPHI}\end{array}\right)}{\text{Connecticut members as reported in TME Data}}$$

The percentage change in THCE PMPY between the Performance Year and the prior calendar year is used to assess performance against the benchmark applicable to the specific Performance Year.

The defining specifications of THCE are as follows.

- THCE includes spending on behalf of Connecticut residents who are insured by Medicare, Medicaid or commercial carriers, as well as residents who obtain coverage from self-insured employers.
- It includes spending on behalf of Connecticut residents who receive care from any provider in or outside of Connecticut, inclusive of those patients who seek care in border states, who may be Connecticut residents but spend part of their time living in another state (i.e., students or “snowbirds”), or those who received care in another state while traveling.

- It excludes spending for out-of-state residents receiving care from in-state providers.
- It includes spending for Connecticut residents who receive healthcare coverage through the Veterans Health Administration, as well as spending for Connecticut residents incarcerated in a state correctional facility.
- It excludes spending for uninsured individuals.
- It includes spending on healthcare services/benefits. It excludes non-medical spending, even if such spending is made by a payer (e.g., gym memberships).
- Vision and dental spending are generally excluded except in instances where vision and dental services are covered as a medical benefit or are a covered benefit under Medicaid and Medicare.
- It represents the total Allowed Amount, which is inclusive both of amounts covered by payers and out-of-pocket spending associated with insured medical expenditures (e.g., copays and deductibles). To avoid double counting expenditures, healthcare premium payments are not included. Also, due to the lack of available data, spending not recorded by insurance carriers or public payers are not included (e.g., spending for medical care by residents of Connecticut who privately purchase healthcare services).
- It includes all insurance market segments, including public and private payers listed in this manual, fully and self-insured, and student insurance.
- The administrative costs and underwriting gain/loss of insurance carriers, referred to as the NCPHI, are included (see Section III.B. for more detail).
- TME data are only collected from a payer when it is the primary payer for a claim. The primary payer will report on the allowed amount. If the secondary payer of the claim were to report, it would cause double counting of a portion of the Allowed Amount by the primary payer.

- TME is adjusted to account for any pharmacy rebates received by the payer, by subtracting the rebates (revenue) from the payer's total medical expense. The exception to this practice occurs with Medicare FFS spending as CMS will not share this information at the state level.
- Provider resources applied in the delivery of care for uninsured Connecticut residents should not be included in calculations of healthcare spending because they are technically not "spending" as defined herein.[7]

B. Data Sources for THCE

Data for THCE come from several sources. Payers need to report TME for all lines of business and, in some instances, payers need to report data for the State to calculate the NCPHI. Other data sources include CMS, DSS, DOC and the VHA. **Table 4** below outlines the data source by THCE category and the location of the detailed specification or collection process within this manual.

[7] Recognizing that the definition of THCE is limited to individuals with health insurance coverage and that financial burden of healthcare for those without health insurance is high, OHS' advisory bodies requested that OHS conduct supplemental tracking and reporting of costs for uninsured individuals to the extent such data are available.

Table 4. Data Sources for THCE

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures from Payers		
Payer full claim (comprehensive coverage with no carve-outs)	TME reported by payers	Appendix A
Payer partial claim (coverage with carve-outs, such as pharmacy) calculated values (applicable to commercial carriers only)	TME reported by payers, with estimates produced by payers	Appendix A
Payer non-claim payments	TME reported by payers	Appendix A
Prescription drug spending for Medicare Advantage organization, for market-level reporting only (*For insurer-level reporting, the data source is in insurer-reported TME.*)[8]	CMS	Appendix E

[8] CMS will provide OHS with allowed amounts for Medicare FFS beneficiaries with stand-alone prescription drug plans (PDP) and for Medicare Advantage beneficiaries with stand-alone PDP and Medicare Advantage Prescription Drug Plans (MAPD) in aggregate. CMS should be the source of pharmacy expenditure data for market-level spending as it will include all stand-alone PDP spending, even by insurance carriers not reporting TME to OHS and insurance carriers specifically excluding stand-alone PDP spending from TME. For reporting at the insurer-level, each individual insurer should be the source of spending. However, stand-alone PDP spending has been excluded from reporting at the insurer-level because doing so would compromise the integrity of the spending calculations.

THCE Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures from Public Programs		
Medicaid claim and other included spending calculated values	DSS	Appendix B
Medicare FFS claim (Parts A, B and D) calculated values	CMS	Appendix E
DOC summarized data	DOC	Appendix C
VHA summarized data	VHA	Appendix G
Net Cost of Private Health Insurance		
Insurer NCPHI	Calculated from regulatory reports submitted by the insurance carriers or obtained through public sources	Appendix H
Pharmacy Rebates		
Insurance carriers	Pharmacy rebate data filing by insurance carriers	Appendix A
Medicaid Program	Pharmacy rebate data filing by DSS	Appendix B
Population Statistics		
Connecticut population	Population reported by payers, CMS, DOC and VHA	Appendices A, B, C, E and G

Insurance Carrier TME Data

TME represents all payments for medical expenses for the Connecticut resident population and should be reported by payers for all members

(including fully and self-insured members). TME is adjusted (reduced) to account for pharmacy rebates.

Annually, OHS directs applicable insurance carriers to submit TME data using the specifications outlined in **Appendix A** and the template provided as **Attachment 2**. (Specifications for public programs to submit their TME are included in **Appendices B, C, E** and **G**, with the Medicare template provided as **Attachment 1). Table 5** below lists which insurance carriers must report for their commercial and Medicare Advantage markets.[9]

Table 5. Insurance Carriers Requested to Report TME Data by Market

Carrier	Commercial Fully and Self-Insured	Medicare Advantage
Aetna Health & Life	X	X
Anthem	X	X
Cigna	X	
ConnectiCare	X	X
UnitedHealthcare[10]	X	X
Wellcare		X

The TME data include claims and non-claims payments[11] incurred for a single calendar year. Insurance carriers should submit these data based on Allowed Amounts. Carriers are expected to adjust expenditure data for a reasonable and appropriate estimate of unpaid claims liability (i.e., incurred but not

[9] Because the market may change, this table may need to be updated over time.
[10] UnitedHealthcare also does business as Oxford Health, Sierra Health and Life and Symphonix.
[11] Claims payments are payments to providers associated with a healthcare claim. Non-claims payments are payments to providers that are not associated with a claim and include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc.

reported (IBNR) or incurred but not paid (IBNP)), when claims run-out alone is not sufficient. TME spending is only reported by a carrier when it is the primary insurer on the claim, as secondary coverage expenditures would generally double count a portion of the Allowed Amount by the primary insurer.

In some circumstances, carriers are only able to report claims payments for a subset of medical services due to benefit design in which the contracting employer may “carve out” some services, such as pharmacy or behavioral health. In other carve-out instances, however, carriers may be unable to obtain the payment information and do not hold the insurance risk for the carved-out services. Thus, carriers need to report this type of TME data separately in the partial-claim category (see **Appendix A** for more information). To estimate the full TME amount for the partial claim population, the insurer must to adjust the reported partial-claim TME data using its full-claim population as an estimate. This adjustment allows OHS to estimate the full spending amount without having to collect data from carve-out vendors. For example, for those members for whom pharmacy benefits are carved out, the insurance carrier might include its commercial market book-of-business average pharmacy spending per-member, per-month (PMPM) for the same year, calculated on members who had primary coverage, applied to all member months for which the carve-out applied. Before this adjustment is made, insurance carriers should discuss appropriate methodologies with OHS, recognizing there is no standard approach to performing this estimate.

Appendix A includes instructions for insurance carriers to submit medical and retail pharmacy rebate data so that OHS can subtract pharmacy rebates from THCE and TME at the market and insurer levels. Carriers need to proportionally allocate total pharmacy rebates by line of business to Connecticut resident members, unless rebates can be directly associated with a specific line of business.

NCPHI Data

The final component of THCE is NCPHI. This element captures the costs to Connecticut residents associated with the administration activities and underwriting gain/loss of insurance carriers. It is the difference between health premiums earned and benefits incurred. It includes all categories of administrative expenditures, net of additions to reserves, rate credits, dividends, and profits or losses.

OHS calculates NCPHI for all Connecticut residents whose insurance carriers submit data to OHS, using information obtained from insurance carriers and other public sources. **Appendix H** details the methodology for calculating NCPHI.

C. Public Reporting of Cost Growth Benchmark Performance

To publicly report on performance against the benchmark and as directed in Executive Order No. 5 and Connecticut General Statute 19a-754g et. Seq., OHS reports at the statewide level, with several "drill-down" analyses. Table 6 outlines the minimum level at which OHS publicly reports performance. When reporting TME, OHS reports on a per member per year (PMPY) or per member per month (PMPM) basis, which calculates the average amount of spending per member for a particular market segment.

Table 6. Levels at Which Public Reporting of Performance Against Benchmark Occurs

Level of Reporting	THCE/TME Components
State level	• Report TME net of rebates and including NCPHI components, DOC and VHA spending • Report aggregate and PMPY amounts • Compare PMPY rate of change against benchmark
Commercial market	• Report TME net of rebates PMPY • Compare PMPY rate of change against benchmark

Level of Reporting	THCE/TME Components
Medicare market	• Report TME net of rebates PMPY • Compare PMPY rate of change against benchmark
Medicaid market	• Report TME net of rebates PMPY • Compare PMPY rate of change against benchmark
Insurance carrier[12]	• Compare TME (net of rebates) PMPM rate of change against the benchmark by market
Advanced Network	• Compare TME (gross of rebates) PMPM rate of change against benchmark by market

Reporting TME by Service Category

A goal with the collection of TME data is to obtain summary-level payer data segmented into a manageable number of distinct service categories that all payers can consistently and accurately report. By analyzing service category spending, OHS is be able to understand the relative size of TME spending going toward each service category and each service category's contribution TME trend.

OHS requests that payers report the following individual service categories using the definitions provided in the Appendices of this manual:

- Hospital Inpatient
- Hospital Outpatient
- Professional (Primary Care)
- Professional (Specialty Care)
- Professional Other
- Long-Term Care

[12] OHS intends on reporting the performance of the state employee health plan through the Office of the State Comptroller (OSC's) as a stand-alone insurance carrier. Data representing state employees will also appear in OSC's TPAs and therefore, when analyzing the data, OHS must ensure to not duplicate OSC spending at the commercial market or state levels.

- Pharmacy[13]
- Pharmacy Rebates
- Other
- Non-Claims

More information on what insurance carriers and DSS should include within each of the respective service categories can be found in **Appendix A** and **B**, respectively. Given that most of these categories are not defined with specific codes, OHS acknowledges that there may be some limitations in consistent interpretation across payers when analyzing and reporting these data publicly. In future years, additional, more detailed categories of services may be added, such as medical pharmacy, for example, to deepen OHS' analysis capabilities.

Reporting TME by Advanced Network and Members Unattributed to an Advanced Network

To measure and publicly report performance against the benchmark at the Advanced Network level, individual patients must be attributed or assigned to a primary care provider, and those primary care providers must be organized into provider entities. OHS' requests that insurance carriers use their own primary care attribution methodology to attribute patients to a primary care provider. OHS' requests that carriers use the provided list of TINs for attributing spending to OHS' defined list of Advanced Networks.

Data are reported at the Advanced Network level by line of business for each payer, which is outlined in the TME specification in **Appendix A.** Data must include all TME for all attributed members, including when care was provided by providers outside of or not affiliated with the respective Advanced Network.

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[13] Insurance carriers that have both Medicare Advantage and stand-alone PDP lines of business must exclude their stand-alone PDP data from their TME submission. Stand-alone PDP expenditure data will be obtained from CMS.

Furthermore, for OHS to calculate market performance, insurance carriers must report spending in aggregate for members not attributed to an Advanced Network. **Appendix A** contains the details of insurer attribution to an Advanced Network**.**

To publicly report on Connecticut Advanced Network performance, OHS has established a minimum threshold of 5,000 attributed lives for all markets required to report provider performance.

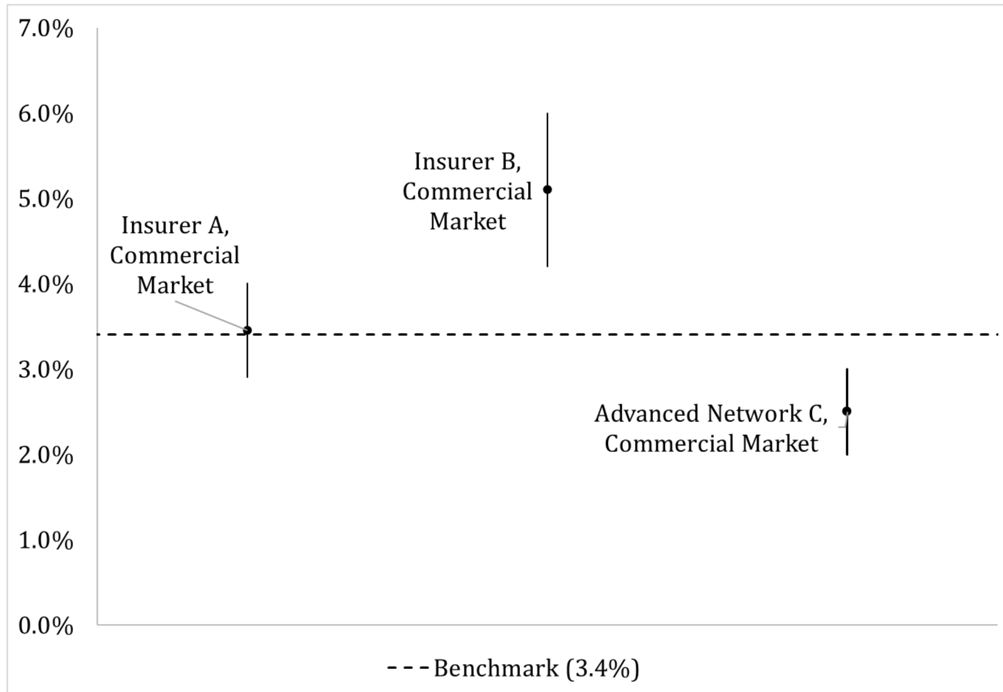
OHS requests insurance carriers to submit non-adjusted TME data. OHS adjusts TME based age/sex factors outlined in the TME specification in **Appendix A**. Insurance carriers are required to report clinical risk-adjustment scores and which risk-adjustment tool they use and the underlying methodology in order to support transparency and understanding of the tools.

Development of Confidence Intervals to Determine Performance Against the Benchmark

OHS conducts statistical significance testing to assess insurance carriers' and provider entities' performance against the cost growth benchmark. This involves developing confidence intervals around each insurer and Advanced Network's cost growth, and determining whether the confidence interval intersects with the benchmark. OHS categorizes payers and providers as illustrated below:

- **Confidence interval intersects with benchmark** – under this circumstance, OHS would be unable to determine whether an insurer or Advanced Network's performance did or did not meet the benchmark. (Insurer A in the illustration below)
- **Lower confidence interval is over the benchmark** – this would indicate that the insurer or Advanced Network exceeded the benchmark. (Insurer B in the illustration below)

- **Upper confidence interval is fully below the benchmark** – this would indicate that the insurer or Advanced Network has achieved the benchmark. (Advanced Network C in the illustration below)



To support the development of confidence intervals, OHS requests insurance carriers provide standard deviation information on non-adjusted TME data. Insurance carriers need to provide standard deviation information for:

- each line of business; and
- each Advanced Network by line of business.

Since healthcare cost growth is calculated using age/sex-adjusted claims spending, OHS also adjusts the standard deviation used to calculate the confidence intervals. This is done by applying the same OHS-calculated age/sex risk-adjustment factor that is used to risk-adjust TME. The formula for adjusting the standard deviation is as follows:

Adjusted Standard Deviation =

Unadjusted Standard Deviation / $(\text{OHS Calculated Risk Score})^2$

Details on how OHS calculates the confidence intervals are included in **Appendix K**.

D. Timeline for Measuring and Reporting the Cost Growth Benchmark

OHS publishes THCE statistics annually. It follows a specific timeline to collect and report baseline data, as required by Connecticut General Statute 19a-754g et. Seq:

- Not later than **August 15**, each payer shall submit aggregated data.
- Not later than **March 31**, OHS shall prepare and post a report concerning total healthcare expenditures including, but not limited to, a breakdown of such population-adjusted total medical expenses by payer and Advanced Network. The report may also include trends in major service category spending; primary care spending as a percentage of total medical expenses; NCPHI by market segment; and any other factors the executive director deems relevant to providing context on the data, including impact of inflation and medical inflation, impacts, if any, on access to care, and responses to public health crises or similar emergencies.
- Not later than **May 1**, OHS shall identify, and notice within 30 days, each payer or Advanced Network that exceeded the healthcare cost growth benchmark or failed to meet the primary care spending target for the performance year.[14]

[14] Pursuant to Connecticut General Statute 19a-754g et. Seq., upon request, OHS will meet with payers and advanced networks subject to the cost growth benchmark or primary care spending target to review and validate collected TME data and, if necessary, amend findings prior to the identification of payers or advanced networks that exceeded the healthcare cost growth benchmark or failed to meet the primary care spending target for the performance year.

- Not later than **June 30**, OHS shall hold an informational public hearing to compare the growth in total healthcare expenditures in the performance year to the cost growth benchmark, including:
  - the information reported by March 31 as outlined above;
  - the expenditures of provider entities and payers, including, but not limited to, healthcare cost trends, primary care spending as a percentage of total medical expenses and the factors contributing to such costs and expenditures.
- Not later than **October 15**, OHS shall prepare and submit a report to the General Assembly. The report shall:
  - describe healthcare spending trends in the state, including but not limited to, trends in primary care spending as a percentage of total medical expense, and the factors underlying such trends;
  - include the information reported by March 31st as outlined above;
  - describe a plan for monitoring any unintended adverse consequences resulting from the adoption of the cost growth benchmarks and primary care spending targets and the results of any findings form the implementation of such plan; and
  - disclose OHS' recommendations, if any, concerning strategies to increase the efficiency of the healthcare system, including, but not limited to, any recommended legislation.

OHS publishes THCE statistics annually following the respective reporting year. Due to the timing of alternative model payment settlements, insurance carriers need to annually submit two years' worth of data: (1) the performance year data (which is the calendar year immediately preceding the year in which TME data are reported) which should contain insurer estimates of alternative payment model settlements, and (2) the TME data for the calendar year prior to the performance year, which should be resubmitted to reflect final settlements that had to be estimated in prior year reporting.

VI. Methodology for Assessing Performance Against the Primary Care Spending Target

OHS annually reports performance relative to the primary care spending target at the State level, by health insurance market (e.g., Medicaid and commercial) and by individual payer by line of business, for payers with a minimum of 5,000 attributed lives within a given market).[15]

This section contains the methodology for measuring primary care spending at each level, including which data are necessary to collect and which calculations need to be performed. OHS collects data for the primary care spending target and the healthcare cost growth benchmark using one template. Therefore, this section frequently refers to Section III, which outlines the methodology for the benchmark. OHS, however, separately performs calculations for the target. This section is organized as follows:

A. Methodology for Measuring Primary Care Spending
B. Data Sources for Primary Care Spending
C. Public Reporting of Primary Care Spending Target Performance
D. Timeline for Measuring and Reporting the Primary Care Spending Target

A. Methodology for Measuring Primary Care Spending

To assess primary care spending as a percentage of TME, OHS calculates both statewide primary care spending and TME annually. The primary care spending sources are described in Section IV.C below and include insurance carriers and DSS.

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[15] OHS will also collect and perform analyses on additional data from payers to monitor spending associated with primary care services provided by OB/GYN providers and midwifery.

Statewide primary care spending is a weighted average calculation based on TME. It is calculated by multiplying each insurance market's percentage of spending on primary care by its total market share based on TME.

Statewide primary care spending (in aggregate) =

$$\left(\textit{Commercial primary care spending} \times \frac{\textit{Commercial TME}}{\textit{TME}}\right) +$$

$$\left(\textit{Medicare Advantage primary care spending} \times \frac{\textit{Medicare Advantage TME}}{\textit{TME}}\right) +$$

$$\left(\textit{Medicare FFS primary care spending} \times \frac{\textit{Medicare FFS TME}}{\textit{TME}}\right) +$$

$$\left(\textit{Medicaid primary care spending} \times \frac{\textit{Medicaid TME}}{\textit{TME}}\right)$$

TME for the primary care spending target is different than for the healthcare cost growth benchmark. TME for the target includes all the spending categories captured for the benchmark less long-term care (LTC).

TME, less LTC (in aggregate) =

(Commercial TME – Commercial LTC) + (Medicare Advantage TME – Medicare Advantage LTC) + (Medicare FFS TME – Medicare FFS LTC) + (Medicaid TME – Medicaid LTC)

Statewide primary care spending as a percentage of TME, less LTC =

$$\frac{\textit{Statewide primary care spending (in aggregate)}}{\textit{TME, Less LTC (in aggregate)}}$$

The defining specifications for primary care spending and TME are almost identical to the defining specifications of TME included in Section III.A with the following exceptions:

- The target does not include spending for Connecticut residents who receive coverage through the Veterans Health Administration or who are incarcerated in a state correctional facility.
- The target does not include NCPHI.

B. Data Sources for Primary Care Spending

Data for primary care spending comes from several sources. Payers need to report primary care spending for all lines of business. Other data sources include DSS. **Table 7**, below, outlines the data source by primary care spending category and the location of the detailed specification or collection process within this manual.

Table 7. Data Sources for Primary Care Spending

Primary Care Spending Category	Data Source	Location of Data Specification/Collection Process in Manual
Expenditures from Payers		
Payer full claim (comprehensive coverage with no carve-outs)	Primary care spending reported by payers	Appendix A
Payer partial claim (coverage with carve-outs, such as pharmacy) calculated values (applicable to commercial carriers only)	Primary care spending reported by payers, with estimates produced by payers	Appendix A
Payer non-claim payments	Primary care spending reported by payers	Appendix A
Expenditures from Public Programs		
Medicaid claim and other included spending calculated values	DSS	Appendix B
Medicare FFS claim (Parts A, B and D) calculated values	APCD	Appendix F

C. Insurance Carrier TME, less LTC and Primary Care Spending Data

TME represents all payments for medical expenses for the Connecticut resident population and should be reported by payers for all members (included fully and self-insured members) for the benchmark. It is adjusted (reduced) to account for pharmacy rebates. Primary care spending is one component of TME and is analyzed separately for the target. OHS utilizes the TME data payers submit for the benchmark, less LTC, in addition to the primary care spending submitted for the benchmark and the target, to

calculate statewide primary care spending as a percentage of TME, less LTC annually.

Annually, OHS directs applicable insurance carriers to submit TME and primary care spending data using the specifications outlined in **Appendix A** and the template provided as **Attachment 2**. (Specifications for public programs to submit their TME are included in **Appendices B, C, E** and **G**, with the Medicare template provided as **Attachment 1**). For more information on the requirements for insurer TME data submissions, see Section III.B.

D. Public Reporting of Primary Care Spending Target Performance

OHS publicly reports on performance against the target at the statewide level, with several "drill-down" analyses. For more information on the reporting parameters, see Section III.C.

Of note, CMS does not have the resources to report primary care spending using the OHS' definition, included in **Appendix A**. Therefore, OHS separately calculates Medicare FFS primary care spending using data from the APCD. Due to the delay in availability of Medicare FFS data in the APCD, however, OHS releases two calculations – primary care spending without Medicare FFS spending, published with the benchmark, and primary care spending with Medicare FFS spending once data are available.

E. Timeline for Measuring and Reporting the Primary Care Spending Target

OHS publishes primary care spending statistics, without Medicare FFS spending, on the same timeline as THCE statistics for the benchmark. For more information on the timeline for measuring and reporting, see Section V.D. OHS publishes primary care spending statistics, with Medicare FFS spending, once Medicare FFS data are available in the State's APCD.

Appendix A:
Insurance Carrier TME and Primary Care Spending Data Specification

This insurance carrier TME and primary care spending data specification provides technical details to assist carriers in reporting and filing data to enable OHS to calculate TME and statewide primary care spending as a percentage of TME, less LTC.

OHS annually requests TME data file(s) with dates of service during the performance year and one year prior to the performance. Insurance carriers should submit one Excel file with multiple record types in each tab, including:

- **Header Record Tab**, which includes summary data and payer comments.
- **Advanced Network Record Tab**, which includes TME by Advanced Network for the insurance carrier overall by insurance category.
- **Pharmacy Rebate Record Tab**, which includes medical and retail pharmacy rebates by insurance category.
- **Line of Business Enrollment Tab**, which includes detailed member month information and request for total premiums earned on self-insured accounts (e.g., income from fees of uninsured plans).
- **Standard Deviation Information Tab**, which includes standard deviation by Advanced Network and insurance carrier.
- **Age/Sex Factors Tab**, which includes spending by age band and by sex for the purposes of risk adjustment.
- **Mandatory Questions Tab**, which asks insurance carriers to answer a series of questions about their data for validation purposes.

This insurance carrier TME and primary care spending data specification appendix was informed by Massachusetts', Delaware's and Rhode Island's TME data collection specification as well as the New England States Consortium Systems Organization's primary care spending data collection specifications, modified to meet the needs of Connecticut. In addition, the file

format was designed to be similar to Massachusetts', Delaware's and Rhode Island's to aid insurance carriers that operate in one or multiple of the other markets. OHS may periodically update and revise these data specifications in subsequent versions but aims to update this manual no more frequently than once per calendar year.

A. TME and Primary Care Spending Excel File Submission Instructions and Schedule

TME file layouts for insurance carriers are included in this appendix. Further file submission instructions will be available on OHS' website. Carriers should submit TME, inclusive of primary care spending, data using Excel templates provided by OHS according to the schedule outlined in Table A-1. Carriers should submit TME data annually. Of note, OHS may request prior year data with each annual TME submission.

Table A-1. Insurance carriers' TME Filing Schedule

Date	Files Due
August 15, 2024	CY 2022 and CY 2023 TME
August 15, 2025	CY 2023 and CY 2024 TME
August 15, 2026	CY 2024 and CY 2025 TME

After carriers submit their data according to the filing schedule, they must actively engage with OHS as it validates the data to ensure such data were submitted using the specifications outlined in this Implementation Manual. OHS engages the carriers one-on-one to discuss the initial analysis of data, and once again to review final data before it is published. OHS also expects carriers to engage in data sharing with Advanced Networks whose performance are publicly reported to explain any discrepancies in performance between TME and total cost of care or other value-based payment contracts.

B. Required Markets and Excluded Types of Coverage

Insurance carriers must report TME for their commercial and Medicare members. The commercial market includes the following lines of business:

- self-insured plans
- short-term health plans
- student health plans
- fully insured individual and group plans
- the State of Connecticut Employee Health Plans
- the Federal Employee Health Benefits Program (FEHB)

The Medicare market includes the following types of plans:

- Medicare Advantage Health Maintenance Organization (HMO)
- Medicare Advantage Preferred Provider Organization (PPO)
- Medicare Advantage HMO Point of Service (HMOPOS)
- Medicare Medical Savings Account (MSA)
- Medicare Advantage Private Fee-for-Service (PFFS)
- Special Needs Plans (SNPs)

Insurance carriers should **not** report TME for plans that offer limited benefits, including the following:

- accident policy
- disability policy
- hospital indemnity policy
- long-term care insurance
- Medicare supplemental insurance (AKA Medigap)
- reinsurance policy
- stand-alone prescription drug plans
- specific disease policy
- stop-loss plans
- supplemental insurance that pays deductibles, copays, or coinsurance
- vision-only insurance
- workers compensation
- dental-only insurance

C. TME and Primary Care Spending Data Submission

Insurance carriers must report TME, inclusive of primary care spending, data based on Allowed Amounts (i.e., the amount the insurer paid plus any member cost sharing).

Carriers must include only information pertaining to members:

- who are residents of Connecticut,
- who, at a minimum, have medical benefits[16], and

[16] Members who only have a non-medical benefit should be excluded as insurance carriers who hold the medical benefit for those members will be making estimates of TME for those non-medical benefits.

- for which the payer is primary on a claim (exclude any paid claims for which it was the secondary or tertiary payer), however do not exclude a member solely because they have additional coverage.

It is necessary for insurance carriers to attribute or assign individual patients to a primary care provider, and to organize those primary care providers into provider entities (i.e., Advanced Networks) large enough for their performance to be statistically valid. Insurance carriers are asked to use a primary care attribution methodology to attribute patients to a primary care provider (PCP). For each year reported, please use the corresponding member-to-PCP mapping (e.g., if submitting data for 2022 and 2023, use the 2022 network mapping for 2022 attribution and the 2023 network mapping for 2023 attribution).

Carriers should attribute providers to Advanced Networks using the Taxpayer Identification Numbers (TINs) that OHS will provide for all Advanced Networks for each year. Carriers must also report spending in aggregate for members not attributed to an Advanced Network. If carriers do not hold any type of contract with any of the TINs listed for an Advanced Network, the carrier should report that spending in aggregate as spending that cannot be attributed to any one of the Advanced Networks.

To assist Advanced Networks in understanding how carriers are attributing members and spending – members who chose their provider (Tier 1), members who were attributed through contractual arrangements (Tier 2), and members who were attributed to a provider organization based on utilization or other factors (Tier 3) – carriers must report them in separate categories (i.e., tiers) in the Advanced Network tabs of the Data Submission Template. Payers must attribute members using the three tiers in hierarchical order (**Table A-2**).

Members who cannot be attributed to primary care providers using any of the three tiers above should be reported in aggregate under Advanced Network

ID 999, as "unattributed member months" with Attribution Hierarchy Code 4. A member should only be attributed to one provider organization at a given point in time.

Members may be attributed to more than one primary care provider during a calendar year. If the primary care providers are all affiliated with the same Advanced Network, the member and their corresponding TME would be attributed to that Advanced Network – regardless of any change in primary care providers.

If members are attributed to more than one primary care provider during a calendar year and the providers are affiliated with different Advanced Networks, their total medical expenses should be mutually exclusively allocated to each of the Advanced Networks, based on the respective member months allocated to each Advanced Networks (please see the "reset the clock" approach).

Table A-2. Member Attribution Hierarchy Tiers/Codes

Tier	Description
Tier 1	**Member selection**: Members who were required to select a primary care provider by plan design should be assigned to that primary care provider's organization.
Tier 2	**Contractual arrangement**: Members not included in Tier 1 who were attributed to primary care provider during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care provider's organization. For example, if a provider is engaged in a total cost of care arrangement, then the payer may use its attribution model for that contract to attribute members.
Tier 3	**Utilization**: Members not included in Tier 1 or 2 may be attributed to a primary care provider based on the member's utilization, using the payer's own attribution methodology.
Tier 4	**Unattributed Member Months**
Tier 5	**Carrier Overall**

Carriers must report two categories of data, by Insurance Category Code:

1. TME data applicable to Advanced Networks with attributed members, for which the insurer is contracted, reported by Advanced Network and by hierarchy field code.
2. Member spending not attributable to an Advanced Network, reported in aggregate.

Member Attribution Example

Suppose in 2022, Payer A has a total of 26,000 member months attributed to Advanced Network ID 101 in the Commercial: Full Claims (Insurance Category Code 3). Out of the 26,000 member months, 12,000 are assigned to the Advanced Network by plan design (Tier 1), 6,000 are attributed to it because of contract arrangement (Tier 2), and 8,000 are attributed to it based on the members' utilization (Tier 3).

Payer A would enter these numbers in "Advanced Network – 2022" in the Data Submission Template like the table below. Data should only be report by hierarchal codes within the "Advanced Network" tabs (i.e., hierarchical reporting is not necessary by report expenses by age/sex band or standard deviation).

Advanced Network ID	Insurance Category Gode	Attribution Hierarchy Code	Member Months
101	3	1	12,000
101	3	2	6,000
101	3	3	8,000

Unattributed member months (X) should be reported under Advanced Network ID 999 and Attribution Hierarchy Code 4. Payer overall member months (Y) should be reported in a single row under Advanced Network ID 100 and Attribution Hierarchy Code 5.

Advanced Network ID	Insurance Category Gode	Attribution Hierarchy Code	Member Months
999	3	4	X
100	3	5	Y

Carriers must include all Allowed Amounts for all TME data for members, regardless of whether services are provided by providers located in or out of Connecticut, and regardless of the situs of the member's plan.[17] Payments should be reported on an incurred basis, not paid basis.

The data reported for each Advanced Network must include all TME for all attributed members for each month a member was attributed, so long as the member was a resident at the time of attribution, even when care was provided by providers outside of or not affiliated with the respective Advanced Network. Insurance carriers may choose whether residency is established as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology.

D. Claims Run-Out and Non-Claims Payment Reconciliation Period Specifications

Insurance carriers should allow for a claims run-out period of at least 180 days after December 31 of the performance year. Carriers should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category and are required to attest that they are reasonable and appropriate.

Insurance carriers should allow for a non-claims reconciliation 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-based payments. Insurance carriers should apply reasonable and appropriate estimations of non-claims liability to each Advanced Network (including payments expected to be made to

[17] If the insurer pays claims for another organization's members (e.g., Blue Card members in the Blue Cross Blue Shield network) those members should not be included in TME.

organizations not separately identified for TME reporting purposes) that are expected to be reconciled after the 180-day review period.

E. Advanced Network/Carrier Overall IDs

Insurance carriers should report on Advanced Networks using the organizational identification number for TME reporting listed in Table A-3 below. The table also includes an identification number for reporting on the Insurance Carrier Overall, Organizational ID 100. The list of Advanced Networks below is for the 2022-2023 reporting period and may be updated over time.

Insurance carriers are asked to use a primary care attribution methodology to attribute patients to a primary care provider (PCP). For each year reported, please use the corresponding member-to-PCP mapping (e.g., if submitting data for 2022 and 2023, use the 2022 network mapping for 2022 attribution and the 2023 network mapping for 2023 attribution).

Attribution of providers to the Advanced Networks listed in Table A-3 should be based on the provided TINs list. For spending not attributed to one of these Advanced Networks because the insurance carrier does do not hold any type of contract with any of the TINs listed for an Advanced Network, please use Organizational ID 999.

OHS recognizes that carriers have different contractual relationships with the Advanced Networks identified by OHS. In some cases, carriers hold contracts with an Advanced Network listed in Table A-3, encompassing one or more affiliated entities. In other cases, Advanced Networks identified by OHS may be an affiliated entity, not the contracting entity.

Table A-3. Advanced Network/Carrier Overall Organizational Identification Numbers for TME Reporting

Advanced Network / Insurance Carrier	Organizational Identification Number
Carrier Overall	100
Privia Quality Network of Connecticut (PQN CT) (formerly Community Medical Group)	101
Connecticut Children's Care Network	102
Connecticut State Medical Society IPA	103
Integrated Care Partners	104
NA [18]	105
Northeast Medical Group	106
OptumCare Network of Connecticut (including ProHealth)	107
Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	108
Southern New England Health Care Organization (aka SOHO Health, Trinity Health of New England ACO, LLC)	109
Value Care Alliance	110
NA[19]	111
Charter Oak Health Center	112
CIFC Greater Danbury Community Health Center	113
Community Health and Wellness Center of Greater Torrington	114
Community Health Center	115

[18] Advanced Network ID 105 was previously assigned to Medical Professional Services, which became a non-operating entity effective 2/15/2022. Any 2021 and 2022 spending attributed to Medical Professional Services should be assigned to Advanced Network ID 999 (Members Not Attributed to an Advanced Network).

[19] Advanced Network ID 111 was previously assigned to ProHealth. In 2023, OptumCare Network of Connecticut acquired ProHealth's administrative operations.

Advanced Network / Insurance Carrier	Organizational Identification Number
Community Health Services	116
Cornell Scott Hill Health Center	117
Fair Haven Community Health Center	118
Family Centers	119
First Choice Community Health Centers	120
Generations Family Health Center	121
Norwalk Community Health Center	122
Optimus Health Care, Inc.	123
Southwest Community Health Center, Inc.	124
Stamford Health Medical Group	125
Starling Physicians	126
UConn Medical Group	127
United Community and Family Services	128
Summit Health (formerly WestMed Medical Group)	129
Wheeler Clinic	130
Yale Medicine	131
Members Not Attributed to an Advanced Network	999

F. TME File Specifications

Insurance carriers must submit one Excel template provided by OHS that includes its TME data, inclusive of primary care spending. The Excel template includes tabs with multiple record types: Header Record, Advanced Network Record, Pharmacy Rebate Record, Line of Business Enrollment, Standard Deviation, Age/Sex Factors, and Mandatory Questions. The subsections below describe the detailed information that carriers must submit within each tab.

Header Record Tab

Insurance Carrier Org ID: The OHS-assigned organization ID for the carrier submitting the file, which is outlined in Table A-4 below.[20]

Table A-4. Insurance carriers' Organizational Identification Number for TME Reporting

Insurer	Organizational ID
Aetna Health & Life	201
Anthem	202
Cigna	203
ConnectiCare	204
UnitedHealthcare	206
Wellcare	208

Period Beginning and Ending Dates: The period represented by the reported data. These periods beginning and ending dates should always be January 1 and December 31, respectively, unless an insurance carrier newly enters or exits the market during other parts of the year. All reporting is based on the date of service related to the TME data.

Clinical Risk Adjustment Tool: The clinical risk adjustment tool, software or product used to calculate the clinical risk score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

Clinical Risk Adjustment Version: The version number of the clinical risk adjustment tool used to calculate the clinical risk adjustment score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

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[20] This table may need to be updated from time to time as the insurer market in Connecticut changes.

"Doing Business As:" Any Medicare Advantage organization must submit all names for which it is "doing business as" in the state of Connecticut.

Advanced Network Record Tab

The Advanced Network record file will be the source of the insurance carrier's expenditure data that will be used by OHS to compute THCE. Carriers will report their permissible claims and non-claims payments in this file.

Advanced Network/Carrier Overall ID: The OHS-assigned organizational ID of the Advanced Network or the Carrier Overall as outlined in Table A-3. For TME data for members who are unattributed to an Advanced Network, their data are to be reported in aggregate as "Members Not Attributed to an Advanced Network (Advanced Network Identification Number 999)."

Insurance Category Code: A number that indicates the insurance category that is being reported, as defined in Table A-5 below. All data reported by Insurance Category Code should be mutually exclusive. Commercial claims should be separated into two categories, as shown in Table A-5 below. Commercial self -insured or fully insured data for large providers for which the insurance carrier can collect information on all direct medical claims and any claims paid by a delegated entity should be reported in the "Full Claims" category. Commercial self-insured or fully insured data that does not include all medical and subcarrier claims should be reported in the "Partial Claims," category. An adjustment should be made to "Partial Claims" to allow for them to be comparable to full claims. Such an adjustment must be reviewed with OHS before the adjustment is made.[21] 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 PBMs or behavioral health vendors. For example, for those members for whom pharmacy benefits are

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[21] Email Lisa Sementilli at lisa.sementilli@ct.gov with the insurance carrier's proposed approach for making an actuarial sound adjustment to its Partial Claims.

carved out, the insurance carrier might include its commercial market book of business average pharmacy spending PMPM for the same year, calculated on members who had pharmacy coverage, applied to all member months for which the carve out applied.

Table A-5. Insurance Category Code Definitions for TME Reporting

Insurance Category Code	Definition
1	Medicare Advantage (excluding Medicare/Medicaid Dual Eligibles)[22]
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

If an insurance carrier enrolls Medicare/Medicaid dual eligibles, OHS requires the carrier to report Medicare-related expenditures under Insurance Category Code 5 and Medicaid-related expenditures under Insurance Category Code 6. For example, if a carrier covers Medicare/Medicaid dual eligibles, but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under Insurance Category Code 6. However, if a carrier is an integrated care entity providing both Medicare and Medicaid benefits to dual eligibles, the carrier should use both Insurance Category Codes 5 and 6, respectively, to report applicable expenditures. If direct assignment of the

[22] Medicare Advantage Organization should submit spending within special needs plan products, but not spending within stand-alone prescription drug plan products.

expenditure cannot be made to code 5 or 6, the carrier should use reasonable and appropriate methods to allocate expenditures to the respective Insurance Category Code. This allows OHS to include the Medicare- or Medicaid-related expenditure for dual eligibles in the respective Market for reporting purposes.

Insurance carriers should report for all insurance categories for which they have business. For carriers reporting in the "Other" category, carriers should describe in the Comments field (HD004) what is included in the "Other" category.

Member Months (annual): The number of unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Clinical Risk Score: A value that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Insurance carriers must disclose the clinical risk adjustment tool, version number and underlying methodology in the Header Record File. **While this information will not be used to adjust payer data, OHS will still collect this information to compare results of payer-reported risk-adjustment with the new methodology to use age/sex factors first applied by CY 2019, CY 2020 and CY 2021 data.**

Insurance carriers must submit a clinical risk score that represents all members attributed to an Advanced Network, and all members who are unattributed by Insurance Category Code. Insurance carriers are permitted to use a clinical risk adjustment tool and software of their own choosing, but

must disclose the tool (e.g., ACG, DxCG, etc.), the version and underlying methodology in the Header Record File. **TME data are not to be adjusted.**

Note: Clinical risk scores should be normalized for every annual data submission (regardless of how many calendar years of data are included in submission), to ensure accurate comparison of trend across years (e.g., when payers submit 2021-2022 data, clinical risk scores should be based on 2021; when payers submit 2023 data, health risk scores should be normalized to 2022).

Insurance carriers are to report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive. OHS may request additional information regarding how carriers mapped their data into these categories to improve consistency in reporting across all insurance carriers.

Claims: Hospital Inpatient: The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

Claims: Hospital Outpatient: The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Claims: Professional, Primary Care: The TME paid to primary care providers delivered at a primary care site of care generated from claims using the following code-level definition:

Primary Care Taxonomy and Proce

Insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC. For telehealth services, insurers should use the place of service and modifier codes in the code list to identify primary care services delivered via telehealth. For primary care outpatient or FQHC services, insurance carriers should adhere to the existing taxonomy list (i.e., there is not a specific POS code list for care delivered in a primary care outpatient or FQHC setting).

The definition of primary care site of care excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors.

Claims: Professional, Primary Care (for Monitoring Purposes): The TME paid to primary care providers, including OB/GYNs and midwifery, generated from claims using the following code-level definition:

Primary Care Taxonomy and Proce

Insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC. For telehealth services, insurers should use the place of service and modifier codes in the code list to identify primary care services delivered via telehealth. For primary care outpatient or FQHC services, insurance carriers should adhere to the existing taxonomy list (i.e., there is not a specific POS code list for care delivered in a primary care outpatient or FQHC setting).

The definition of primary care site of care excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors. **Note:** TME paid to OB/GYNs and midwifery included in the "Claims: Professional, Primary Care (for Monitoring Purposes)" category should also be included in the "Claims: Professional, Specialty" category.

Claims: Professional, Specialty: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a

doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition above. **Note:** TME paid to OB/GYNs and midwifery included in the "Claims: Professional, Primary Care (for Monitoring Purposes)" category should also be included in the "Claims: Professional, Specialty" category.

Claims: Professional Other: The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician but is not identified as primary care in the first primary care definition above. This includes, but is not limited to, licensed podiatrists, non-primary care nurse practitioners, non-primary care physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any professional fees that do not fit other categories.

Claims: Pharmacy: The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by the insurance carrier's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the carrier's medical benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). Medicare Advantage, insurance carriers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. Pharmacy data should be reported gross of applicable rebates.

Claims: Long-Term Care: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals 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, etc.), homemaker and

chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner.

Claims: Other: All TME paid from claims to healthcare providers for medical services not otherwise included in other categories. Includes but is not limited to durable medical equipment, facility fees of community health center services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services. Payments made to members for direct reimbursement of healthcare benefits/services may be reported in "Claims: Other" if the insurance carrier is unable to classify the service. If this is the case, the carrier should consult with OHS about the appropriate categorization of the service before including it as "Claims: Other." However, TME data for non-healthcare benefits/services, such as fitness club reimbursements, should not be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the insurance carrier with enrolling members in gyms is not a valid payment to include.

Non-Claims: Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits (e.g., behavioral health, 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.

Non-Claims: Performance Incentive Payments: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target, and pay-for-reporting, i.e., payments to providers for reporting on a set of metrics, usually to build capacity for pay-for-performance, payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a set target, and shared risk recoupments, i.e., payments providers must recoup if costs of services are above a set target.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population; data analytics; EHR/HIT infrastructure payments; medication reconciliation; patient-centered medical home (PCMH) recognition payments and primary care and behavioral health integration *that are not reimbursable through claims*.

Non-Claims: Provider Salaries: All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories. This category is typically only applicable to closed delivery systems.

Non-Claims: Recovery: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as a **negative number**. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this category).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for healthcare benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Non-Claims: Total Primary Care Non-Claims-Based Payments: All non-claims-based payments included in the above six categories that are specifically made to a primary care provider or provider organization. Payments in this category should be a sub-set of payments reported in the other non-claims categories. *This category is the only category not mutually exclusive to the other non-claims categories.*

Total Claims Excluded because of Truncation: The total claims-based spending truncated using the truncation points listed in Table A-6 below. This variable is collected by Insurance Category Code for each Advanced Network and for the Carrier Overall.

While OHS recognizes that some insurance carriers separately truncate medical and pharmacy spending in their total cost of care contracts, OHS

requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending.

For insurance carriers reporting Insurance Category Code 4 spending (Commercial: Partial Claims), the member level truncation should be applied *after* estimates of carve-out spending have been made, so that truncation is being applied to an estimate of individual members' total claims spending *(see inset below for an explanation of how to truncate partial claims spending).*

Table A-6. Truncation Points

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
3	Commercial: Full Claims	$150,000
4	Commercial: Partial Claims	$150,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

How to Apply Truncation to Insurance Category Code 4 (Commercial: Partial Claims)

- An Insurer reporting Insurance Category Code 4 (Commercial: Partial Claims) data has carved-out its pharmacy benefit to a PBM and does not have access to claims level spending.
- The Insurer would develop an estimate for what Insurance Category Code 4's PMPM spending on pharmacy would have been using its Insurance Category Code 3 (Commercial: Full Claims) population experience as a benchmark.
    - For example, for those members for whom pharmacy benefits are carved out, the Insurer might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. **Note: Such an adjustment must be reviewed with the State before the adjustment is made.**
- The Insurer would add this PMPM estimate to member level spending by multiplying the estimated Insurance Category 4 Rx PMPM by the number of member months in Insurance Category Code 4.
- The Insurer would then apply the per-member truncation to Insurance Category Code 4.

In addition, for members who are attributed to more than one Advanced Network during the year, insurance carriers should "reset the clock" and calculate truncated spending for the member for each of the Advanced Networks, and for the Insurer as a whole. This is done by first calculating the member's total spending that is attributed to each Advanced Network, and separately applying truncation to the member's spending that is attributed to

each Advanced Network *(see inset below for how to apply truncation in this case).*

How to Handle Truncation When Members Are Attributed to More than One Advanced Network During the Calendar Year
Example with a $150,000 truncation point: • A member in Insurance Category Code 1 was attributed to Advanced Network X for 8 months with $200,000 in claims. • The member is then attributed to Advanced Network Y for 4 months with $175,000 in claims. • Advanced Network X's spending above the truncation would be $50,000 while Advanced Network Y's spending above the truncation would be $25,000. • Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.

Count of Members with Claims Truncated: The number of members whose spending was above the truncation threshold applicable to the Insurance Category Code and Advanced Network to which the member was attributed. This variable is collected by Insurance Category Code for each Advanced Network and for the Carrier Overall.

Pharmacy Rebate Record Tab

The pharmacy rebate file will be the source of the insurance carrier's pharmacy rebate and will be used by OHS to compute THCE and TME. Carriers will report their rebate data in this file.

Insurance Category Code: A number that indicates the insurance category that pharmacy rebates are being reported on. Use the applicable Insurance Category Code as defined previously in the Advanced Network Record File (not all Insurance Category Codes may be applicable to pharmacy rebates).

Retail Pharmacy Rebates: The estimated value of rebates attributed to Connecticut resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, corresponding to the reporting period excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs.[23] This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Pharmacy rebate data should exclude stand-alone prescription drug plans.

When retail pharmacy rebate data are not available for Insurance Category Code 4 (Commercial Partial Claims), carriers should estimate the rebates using data from Insurance Category Code 3 (Commercial Full Claims). OHS recommends applying the pharmacy rebates to pharmacy spending ratio observed in Insurance Category Code 3. Carriers can then apply this ratio to the pharmacy spending within Insurance Category Code 4.

Medical Pharmacy Rebates: The estimated value of rebates attributed to Connecticut resident members provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting

[23] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., insurer, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient care management programs, etc.).

period, excluding manufacturer-provided fair maker value bona fide service fees for pharmaceuticals that are paid for under the member's medical benefit. These drugs may be included in the professional claims category with J codes or part of facility fees for drug infusions administered in the inpatient, outpatient, and long-term care settings. Pharmacy rebate data should exclude stand-alone prescription drug plans.

When medical pharmacy rebate data are not available for Insurance Category Code 4 (Commercial Partial Claims), carriers should estimate the rebates using data from Insurance Category Code 3 (Commercial Full Claims). OHS recommends applying the pharmacy rebates to pharmacy spending ratio observed in Insurance Category Code 3. Carriers can then apply this ratio to the pharmacy spending within Insurance Category Code 4.

This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. **This value should always be reported as a negative number.**

Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.) or whether they are passed on to an employer. The only exception is for Medicaid managed care payers which should not report pharmacy rebates that are passed to the State. They should only report those rebates above and beyond the state-negotiated rebates.

Carriers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the calendar year for which reporting will be done. If insurance carriers are unable to report rebates specifically for Connecticut residents, insurance carriers should report estimated rebates attributed to Connecticut resident members in a proportion equal to the proportion of pharmacy spending for Connecticut resident members compared to pharmacy spending for total members, by line of business. For example, if Connecticut resident commercial member

spending represents 10% of an insurer's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported. If the insurer is unable to identify the percentage of pharmacy spending for Connecticut resident members, then the insurer should calculate the pharmacy rebates attributable to Connecticut resident members using percentage of membership. **This value should always be reported as a negative number.**

Line of Business Enrollment Tab

The line of business file is the source of the insurance carrier's member months by market OHS will use to compute NCPHI. Carriers should report their member months by market in this file. Carriers should also report spending to calculate NCPHI for self-insured plans in this file.

Line of Business Category Code: The number of members participating in a plan categorized by the insurance carrier as individual, large group – fully insured, small group – fully insured, self-insured, student market, Medicare Advantage and Medicare/Medicaid duals. Carriers should not include Medigap members but should include D-SNP members. Insurance carriers should report member months (see definition below) by line of business category listed in Table A-7 below.

Table A-7. Insurance carriers' Line of Business Category Code Definitions

Line of Business Category Code	Definition
901	Individual
902	Large group, fully insured
903	Small group, fully insured
904	Self-insured
905	Student market
906	Medicare Advantage
908	Medicare/Medicaid duals

Member Months (annual): The number of unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Income from Fees of Uninsured Plans: OHS requests insurance carriers report aggregate information on the premiums earned from their self-insured accounts (e.g., "fees from uninsured plans"). Carriers should follow the instructions for Part 1, Line 12 on the NAIC SCHE for their Connecticut-situs self-insured accounts. Carriers must report this for self-insured plans since this is not typically reported in the SHCE filed with the Connecticut Insurance Department.

Standard Deviation Information Tab

The standard deviation information file is the source of each Advanced Network and insurance carrier's standard deviation information for the purposes of conducting statistical testing and developing confidence

intervals around cost growth rates. Carriers should report standard deviation information for:

- each line of business; and
- each Advanced Network by line of business (see below for definition of line of business).

Advanced Network/Insurance Carrier Org ID: The OHS-assigned organizational ID of the Advanced Network/insurance carrier submitting the file, as outlined in Table A-3. TME data for members who are unattributed to an Advanced Network should be reported in aggregate as "Members Not Attributed to an Advanced Network (Advanced Network Identification Number 999)."

Market Code: Code referring to the to the Medicare, Medicaid and commercial markets, and combines Insurance Category Codes.

Table A-8. Market Codes

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

Standard Deviation of Claims Expenditures: The calculated standard deviation for all members for the applicable market and Advanced Network, reported as a PMPM value. Insurance carriers should include all members attributed to an Advanced Network, including members with no utilization. Standard deviation should be based on per member per month (PMPM) spending. Insurance carriers should calculate the standard deviation PMPM after partial claims adjustments. Non-claims expenditures should be excluded from the calculation.

The following steps detail how insurance carriers can calculate standard deviation values for the data submission:

- **Step 1:** Attribute members to the appropriate Advanced Network for a specific market. Insurance carriers should include all members attributed to an Advanced Network, *including members with no utilization*.
- **Step 2**: For each market, for each Advanced Network, the insurance carrier must calculate the average monthly spending amount of each member using claims-based allowed amounts (in the Example spreadsheet, the result is in the column "Average Per Member Month Amount After Applying Truncation"). Insurance carriers should calculate the average claims-based allowed amount *after partial claims adjustments and after truncation of member level spending* (Claims: Annual Total After Applying Truncation). Non-claims expenditures should be *excluded* from this average.
  Note: The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.
- **Step 3**: For each market, for each Advanced Network, sum "Average Per Member Month Amount After Applying Truncation" (result from Step 2) and divide by total member months (across all members) to produce a per member per dollar amount that is specific to that given market and Advanced Network.

- **Step 4**: With the average claims expenses value for each Advanced Network, insurance carriers can now calculate the standard deviation. The formula is:

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

Where:

s^2 = sample variance

x_1 = value of the one observation

$\bar{x}$ = the mean value of all observations

n = the number of observations (count of member months, **not** individual members)

Validation check: Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, insurance carriers can calculate the standard deviation of the PMPM costs for a given market.

Note that when calculating standard deviation, insurance carriers should use the formula for *population standard deviation* (divided by N). Insurance carriers should NOT use the formula for sample standard deviation (divided by N-1).

- **Step 5**: Report the standard deviation values in the data submission template in the Standard Deviation tab. Each row should correspond to either an Advanced Network or the market for the insurance carrier overall (using Insurance Carrier Overall ID, 100).

Age/Sex Factors Tab

The age/sex risk-adjustment tabs are where insurers should report spending categorized by age/sex bands and for data on member level truncation. Information in these tabs are used to calculate risk-adjustment scores that are applied at the payer and Advanced Network level and to truncate high-cost outliers from the TME data. Field definitions are listed below.

Age Band Code: Code associated with the age band of the members whose spending is being reported. See Table A-9 below.

Table A-9 Age Band Codes

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

Sex Band Code: Code associated with the sex of the members whose spending is being reported. See Table A-10 below. Please see guidance below for how to handle members that have no recorded sex information.

Table A-10 Sex Codes

Sex Code	Description
1	Female
2	Male

How to Handle Members Without Recorded Sex Information

For members that have no recorded sex information, insurance carriers should use their own predetermined rules for assigning the unreported member to a specific sex group (an insurance carrier's predetermined rule could be based on the demographic distribution of the overall population or any other relevant factor).

If an insurance carrier does not have a predetermined rule for categorizing unassigned members, it should use one of the following options to assign the member:

- **Attribute the member to the larger group**: In this approach, the member with unreported sex information would be assigned to the sex group (male or female) that has the largest representation in the submission/ICC code as measured by member months.
- **Impute missing sex data**: This approach involves using statistical methods to estimate the missing sex data based on other available information for the insurance member. Techniques such as regression imputation, nearest neighbor imputation, or multiple imputation could be used.

Total Member Months by Age/Sex Band: The number of unique Connecticut resident members for the age/sex cell participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year. The age of the member should be determined as of January 1st of the calendar year.

Total Spending before Truncation is Applied: The annual total claims-based spending attributed to each member participating in a plan each month with

a medical benefit consistent with aforementioned specifications on how to calculate claims-based spending. The spending in these cells should be before member-level truncation is applied. Do not include any non-claims spending categories.

Count of Members whose Spending was Truncated: The number of members whose spending was above the truncation threshold applicable to the Insurance Category Code and Advanced Network to which the member was attributed. This variable is collected by Insurance Category Code for each Advanced Network.

Total Spending After Applying Truncation at the Member Level: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be after member-level truncation is applied using the truncation points listed in Table A-6 above. Do not include any non-claims spending categories.

Some insurers will attribute members to Advanced Networks on a monthly basis. If a member is attributed to more than one Advanced Network during the year, the payer should “reset the clock” by calculating total spending attributed to the Advanced Network for all Advanced Networks to which the member was reported and identify the total spending above the truncation point by each Advanced Network *(see inset above for example calculation).*

For insurers reporting in Insurance Category Code 4 (Partial Claims, Adjusted), the member level truncation should be applied after estimates of carve-out spending have been made, so that truncation is being applied to an estimate of individual members’ total claims spending *(see inset above for example calculation.)*

Total Dollars Excluded from Spending After Applying Truncation at the Member Level: The sum of all dollars that were removed from total spending after applying truncation at the member level.

G. MLR Reports

As of the 2022-2023 data collection cycle, OHS requests that carriers submit MLR reports at the time of their submission to CMS. The 2024 CMS deadline for filing MLR reports is July 31, 2024, but CMS considers submissions "on time" if filed by August 15, 2024. Therefore, carriers must submit MLR reports by August 15, 2024, or at the time of submission to CMS, whichever is later.

H. File Submission

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

Insurance Carrier Name_TME_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

CARRIER A_TME_2018_01.xlsx or CARRIER A_TME_2018_1.xlsx or CARRIER A_TME_2018.xlsx

Submitting Files to OHS

Electronic files are to be submitted through the State's secure file transfer (SFT) server at https://sft.ct.gov/ to OHS.

OHS will provide a form at https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Implementation-Manual for the carrier's contact(s) to fill out and email to OHS. This information is required:

- To facilitate user access to the State's SFT Web Client;
- To confirm the user is the authorized and designated contact for the carrier at registration;
- To facilitate securing and protecting confidential data;
- To enable OHS communicate with the contact about data error correction and validation, system or process changes and updates.

The contact should fill out the form and email it to OHS@ct.gov. OHS will acknowledge receipt of the filled form, credential and grant the contact/new user access to the State's network within two business days. Upon receiving the credentials to access the server, the authorized user should upload the required data files. The contact must alert OHS through email after uploading the file(s).

Appendix B:
CT DSS Medicaid TME and Primary Care Spending Data Specification

This CT DSS Medicaid TME and Primary Care Spending Data Specification provides technical details to assist DSS in reporting and filing data to enable OHS to calculate TME and primary care spending for the healthcare cost growth benchmark initiative.

A. TME File Submission Instructions and Schedule

DSS will submit TME data using Excel templates provided by OHS. OHS will annually request TME data file(s) from DSS, according to the schedule in Table B-1 below.

Table B-1. DSS' TME Filing Schedule

Date	Files Due
August 15, 2024	CY 2022 and CY 2023 TME
August 15, 2025	CY 2023 and CY 2024 TME
August 15 2026	CY 2024 and CY 2025 TME

B. Data Inclusions and Exclusions

DSS data submission should include TME data for the following categories:

- Spending for members for which the DSS is primary on a claim (exclude any paid claims for which it was the secondary or tertiary insurer), however do not exclude a member solely because they have additional coverage.
- All claims expenditures for Husky A, B, C and D coverage groups plus limited benefit services where Medicaid is primary payer. Limited benefit services include but are not limited to behavioral health services for children in custody of Department of Children and Families, HUSKY Tuberculosis Limited Benefit program, CT Family Planning Limited Benefit program, and the COVID-19 coverage group.

- Other DSS claims expenditures not included in any of the aforementioned categories such as expenditures for populations or programs that are paid with State-only general funds.
- DSS's capitation payments to a vendor(s) for non-emergency medical transportation (NEMT). NEMT payments are considered non-claims payments.
- DSS's other non-claims expenditures, including any incentive payments made to providers, or Advanced Networks, as applicable. (E.g., incentive payments made as part of the PCMH+ program). Data for incentive payments will not be found within the Medicaid Management Information System (MMIS). When reporting payments for CY 2020 (and possibly beyond) this may also include payments made directly to providers to support clinical and business operations during the CY 2020 global COVID-19 pandemic.
- Federal and state supplemental pharmacy rebate collections. There is a separate tab to report DSS pharmacy rebate data. See below for more details.

DSS data submission should not include:

- Data related to spending for populations when Medicaid is not the primary payer, including for members dually eligible for Medicaid and Medicare. The allowed amount of claims associated with dual populations or populations with other third-party liability, should be included when Medicaid is the primary payer.
- Medicare Part D premiums, deductibles and co-pays that are paid on behalf of individuals who qualify for the Low Income Subsidy (LIS).

C.TME and Primary Care Spending Data Submission

DSS will report TME data based on paid amounts (i.e., the amount which the insurer originally paid to the claim) instead of Allowed Amounts (i.e., the

amount the payer paid plus any member cost sharing).[24] DSS should include all paid amounts for all TME data for members, regardless of whether services are rendered by providers located in or out of Connecticut.

DSS should attribute providers to Advanced Networks using the Taxpayer Identification Numbers (TINs) that OHS will provide for all Advanced Networks for each year.

DSS must report data for **Insurance Category Code 2** (Medicaid Expense for Non-Dual Eligible Members) and for **Insurance Category Code 6** (Medicaid Expense for Medicare/Medicaid Dual Eligibles).

The data reported for each Advanced Network must include all TME for all attributed members for each month a member was attributed, so long as the member was a resident at the time of attribution, even when care was rendered by providers outside of or not affiliated with the respective Advanced Network.

To assist Advanced Networks in understanding how DSS is attributing members and spending – members who chose their provider (Tier 1), members who were attributed through contractual arrangements (Tier 2), and members who were attributed to a provider organization based on utilization or other factors (Tier 3) – DSS must report them in separate categories (i.e., tiers) in the Advanced Network tabs of the Data Submission Template. DSS must attribute members using the three tiers in hierarchical order (**Table B-2**).

Members who cannot be attributed to primary care providers using any of the three tiers above should be reported in aggregate under Advanced Network ID 999, as "unattributed member months" with Attribution Hierarchy Code 4. A

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[24] DSS will report paid amounts to align with financial reporting at the state and federal levels. In addition, although DSS will report TME based on date of payment, DSS' attribution of members to providers will be based on date of service.

member should only be attributed to one provider organization at a given point in time.

Members may be attributed to more than one primary care provider during a calendar year. If the primary care providers are all affiliated with the same Advanced Network, the member and their corresponding TME would be attributed to that Advanced Network – regardless of any change in primary care providers.

A member should only be attributed to one provider organization at a given point in time. If members are attributed to more than one primary care provider during a calendar year and the providers are affiliated with different Advanced Networks, their total medical expenses should be mutually exclusively allocated to each of the Advanced Networks, based on the respective member months allocated to each Advanced Networks (please see the “reset the clock” approach).

Table B-2. Member Attribution Hierarchy Tiers/Codes

Tier	Description
Tier 1	**Member selection**: Members who were required to select a primary care provider by plan design should be assigned to that primary care provider’s organization.
Tier 2	**Contractual arrangement**: Members not included in Tier 1 who were attributed to primary care provider during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care provider’s organization. For example, if a provider is engaged in a total cost of care arrangement, then the payer may use its attribution model for that contract to attribute members.
Tier 3	**Utilization**: Members not included in Tier 1 or 2 may be attributed to a primary care provider based on the member’s utilization, using the payer’s own attribution methodology.
Tier 4	**Unattributed Member Months**
Tier 5	**Carrier Overall**

The data reported for each Advanced Network must include all TME for all attributed members for each month a member was attributed, so long as the member was a resident at the time of attribution, even when care was provided by providers outside of or not affiliated with the respective Advanced Network. DSS may choose whether residency is established as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology.

Member Attribution Example

Suppose in 2022, DSS has a total of 26,000 member months attributed to Advanced Network ID 101 in the Medicaid including CHIP, excluding Medicare/Medicaid Dual Eligibles (Insurance Category Code 2). Out of the 26,000 member months, 12,000 are assigned to the Advanced Network by plan design (Tier 1), 6,000 are attributed to it because of contract arrangement (Tier 2), and 8,000 are attributed to it based on the members' utilization (Tier 3).

DSS would enter these numbers in "Advanced Network – 2022" in the Data Submission Template like the table below. Data should only be report by hierarchal codes within the "Advanced Network" tabs (i.e., hierarchical reporting is not necessary by report expenses by age/sex band or standard deviation).

Advanced Network ID	Insurance Category Gode	Attribution Hierarchy Code	Member Months
101	2	1	12,000
101	2	2	6,000
101	2	3	8,000

Unattributed member months (X) should be reported under Advanced Network ID 999 and Attribution Hierarchy Code 4. DSS's overall member months (Y) should be reported in a single row under Advanced Network ID 301 and Attribution Hierarchy Code 5.

Advanced Network ID	Insurance Category Gode	Attribution Hierarchy Code	Member Months
999	2	4	X
301	2	5	Y

D. Claims and Non-Claims Payment Run-Out Period Specifications

DSS should allow for a claims run-out period of at least 180 days after December 31 of the performance year. DSS should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

DSS should also allow for a 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-based payments. DSS should apply reasonable and appropriate estimations of non-claims liability to each Advanced Network (including payments expected to be made to organizations not separately identified for TME reporting purposes) that are expected to be reconciled after the 180-day reconciliation period.

E. Advanced Network IDs

DSS should report on the following Advanced Networks using the identification number for TME reporting in Table B-3. Attribution of providers to the Advanced Networks listed in Table B-3 should be based on contracts in place during the performance period (i.e., calendar year for which data are being submitted), and not along contracts in place at the time of reporting.

Table B-3. Advanced Network/Carrier Overall Organizational Identification Numbers for TME Reporting

Advanced Network / Insurance Carrier	Organizational Identification Number
DSS Overall	100
Privia Quality Network of Connecticut (PQN CT) (formerly Community Medical Group)	101
Connecticut Children's Medical Center	102
Connecticut State Medical Society IPA	103
Integrated Care Partners	104
NA [25]	105
Northeast Medical Group	106
OptumCare Network of Connecticut (including ProHealth)	107
Prospect Connecticut Medical Foundation Inc. (dba Prospect Medical, Prospect Health Services, Prospect Holdings)	108
Southern New England Health Care Organization (aka SOHO Health, Trinity Health of New England ACO, LLC)	109
Value Care Alliance	110
NA[26]	111
Charter Oak Health Center	112
CIFC Greater Danbury Community Health Center	113
Community Health and Wellness Center of Greater Torrington	114
Community Health Center	115

[25] Advanced Network ID 105 was previously assigned to Medical Professional Services, which became a non-operating entity effective 2/15/2022. Any 2021 and 2022 spending attributed to Medical Professional Services should be assigned to Advanced Network ID 999 (Members Not Attributed to an Advanced Network).

[26] Advanced Network ID 111 was previously assigned to ProHealth. In 2023, OptumCare Network of Connecticut acquired ProHealth's administrative operations.

Advanced Network / Insurance Carrier	Organizational Identification Number
Community Health Services	116
Cornell Scott Hill Health Center	117
Fair Haven Community Health Center	118
Family Centers	119
First Choice Community Health Centers	120
Generations Family Health Center	121
Norwalk Community Health Center	122
Optimus Health Care, Inc.	123
Southwest Community Health Center, Inc.	124
Stamford Health Medical Group	125
Starling Physicians	126
UConn Medical Group	127
United Community and Family Services	128
Summit Health (formerly WestMed Medical Group)	129
Wheeler Clinic	130
Yale Medicine	131
Members Not Attributed to an Advanced Network	999

F. TME Data File Layouts and Field Definitions

Each section below represents a tab in the data submission template that DSS will use to submit TME data to OHS. The data required to be input in each tab are described below in more detail.

Header Record Tab

Insurance Carrier Org ID: For this submission, DSS should input “301” as the value for this field.

Period Beginning and Ending Dates: The period of time represented by the reported data. These dates should always be January 1 and December 31,

respectively. All reporting is based on the date of service related to the TME data.

Clinical Risk Adjustment Tool: The clinical risk adjustment tool, software or product used to calculate the clinical risk score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

Clinical Risk Adjustment Version: The version number of the clinical risk adjustment tool used to calculate the clinical risk adjustment score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

Advanced Network Record Tab

The Advanced Network record file will be the source of DSS's expenditure data that OHS will use by OHS to compute THCE. DSS will report its permissible claims and non-claims payments in this file.

Advanced Network/Insurance Carrier Org ID: The OHS Org ID of the Advanced Network or for the Carrier Overall. For TME data for members who are unattributed to an Advanced Network, DSS should report their data in aggregate as "Members Not Attributed to an Advanced Network (Advanced Network Identification Number 999)."

Insurance Category Code: A number that indicates the insurance category that is being reported, as defined in Table B-4 below. All data reported by Insurance Category Code should be mutually exclusive.

Table B-4. DSS Insurance Category Code Definitions for TME Reporting

Insurance Category Code	Definition
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles

Member Months (annual): The number of members for which DSS is reporting TME over the specified period of time expressed in member months. It should include unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Clinical Risk Score: A value that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. While this information will not be used to adjust payer data, OHS will still collect this information to compare results of payer-reported risk-adjustment with the new methodology to use age/sex factors first applied by CY 2019, CY 2020 and CY 2021 data.

DSS will provide a clinical risk score for each Advanced Network for which DSS reports spending data, as well as for members who are unattributed and whose spending is reported in aggregate under "999, Members Not Attributed

to an Advanced Network." DSS should calculate the Advanced Network level risk scores based on a monthly attribution logic (rather than annual). Risk scores will not be provided for dual-eligible members whose spending will be reported in total and not attributed to specific provider entities. DSS may use a clinical risk adjustment tool and software of its own choosing, but must disclose the tool (e.g., ACG, DxCG, etc.), the version and underlying methodology in the Header Record File. TME data are not to be adjusted.

DSS' risk scores will be normalized to the entire Medicaid population for each year, so OHS will normalize risk scores to the anchor year for reporting trend.

DSS should report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive. OHS may request additional information regarding how DSS mapped its data into these categories to improve consistency in reporting across all insurers.

Claims: Hospital Inpatient: The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

Claims: Hospital Outpatient: The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient

basis that have been billed directly by a physician group practice or an individual physician.

Claims: Professional, Primary Care:
The TME paid to primary care providers delivered at a primary care site of care generated from claims using the following code-level definition:

Primary Care Taxonomy and Proce

Insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC. For telehealth services, insurers should use the place of service and modifier codes in the code list to identify primary care services delivered via telehealth. For primary care outpatient or FQHC services, insurance carriers should adhere to the existing taxonomy list (i.e., there is not a specific POS code list for care delivered in a primary care outpatient or FQHC setting).

The definition of primary care site of care excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors.

Claims: Professional, Primary Care (for Monitoring Purposes): The TME paid to primary care providers, including OB/GYNs and midwifery, generated from claims using the following code-level definition:

Primary Care
Taxonomy and Proce

Insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not use the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC. For telehealth services, insurers should use the place of service and modifier codes in the code list to identify primary care services delivered via telehealth. For primary care outpatient or FQHC services, insurance carriers should adhere to the existing taxonomy list (i.e., there is not a specific POS code list for care delivered in a primary care outpatient or FQHC setting).

The definition of primary care site of care excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors. **Note:** TME paid to OB/GYNs and midwifery included in the "Claims: Professional, Primary Care (for Monitoring Purposes)" category should also be included in the "Claims: Professional, Specialty" category.

Claims: Professional, Specialty: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition above. **Note:** TME paid to OB/GYNs and midwifery included in the "Claims: Professional, Primary Care (for Monitoring Purposes)" category should also be included in the "Claims: Professional, Specialty" category.

Claims: Professional Other: The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician but is not identified as primary care in the first primary care definition above. This includes, but is not limited to, licensed podiatrists, non-primary care nurse practitioners, non-primary care physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any fees that do not fit other categories.

Claims: Pharmacy: The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by DSS's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the insurer's medical benefit. Pharmacy data is to be reported gross of applicable rebates.

Claims: Long-Term Care: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals 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, etc.), homemaker and chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with

long-term care needs who receive care in their home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner.

Claims: Other: All TME paid from claims to healthcare providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, facility fees of community health center services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of healthcare benefits/services may be reported in "Claims: Other" if DSS is unable to classify the service. However, TME data for non-healthcare benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists DSS with enrolling members in gyms is not a valid payment to include.

Non-Claims: Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits (e.g., behavioral health, 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.

Non-Claims: Performance Incentive Payments: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target, and pay-for-reporting, i.e., payments to providers for reporting on a set of metrics, usually to build capacity for pay-for-performance, payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a set target, and shared risk recoupments, i.e., payments providers must recoup if costs of services are above a set target.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population; data analytics; EHR/HIT infrastructure payments; medication reconciliation; patient-centered medical home (PCMH) recognition payments and primary care and behavioral health integration that are not reimbursable through claims.

Non-Claims: Provider Salaries: All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories. This category is typically only applicable to closed delivery systems.

Non-Claims: Recovery: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as a negative number. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of

Recovery, do not separately report the same Recovery amount in this category).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for healthcare benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, supplemental payments, or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Non-Claims: Total Primary Care Non-Claims-Based Payments: All non-claims-based payments included in the above six categories that are specifically made to a primary care provider or provider organization. Payments in this category should be a sub-set of payments reported in the other non-claims categories. This category is the only category not mutually exclusive to the other non-claims categories.

Total Claims Excluded because of Truncation: The total claims-based spending truncated using the truncation points listed in Table B-5 below. This variable is collected by Insurance Category Code for each Advanced Network and for the Carrier Overall.

Table B-5. Truncation Points

Insurance Category Code	Definition	Per Member Truncation Point
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

While OHS recognizes that some insurance carriers separately truncate medical and pharmacy spending in their total cost of care contracts, OHS requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending.

For members who are attributed to more than one Advanced Network during the year, DSS should "reset the clock" and calculate truncated spending for the member for each of the Advanced Networks, and for DSS as a whole. This is done by first calculating the member's total spending that is attributed to each Advanced Network, and separately applying truncation to the member's spending that is attributed to each Advanced Network (see inset below for how to apply truncation in this case).

How to Handle Truncation When Members Are Attributed to More than One Advanced Network During the Calendar Year

Example with a $150,000 truncation point:

- A member in Insurance Category Code 1 was attributed to Advanced Network X for 8 months with $200,000 in claims.
- The member is then attributed to Advanced Network Y for 4 months with $175,000 in claims.
- Advanced Network X's spending above the truncation would be $50,000 while Advanced Network Y's spending above the truncation would be $25,000.
- Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.

Count of Members with Claims Truncated: The number of members whose spending was above the truncation threshold applicable to the Insurance Category Code and Advanced Network to which the member was attributed. This variable is collected by Insurance Category Code for each Advanced Network and for the Carrier Overall.

Pharmacy Rebate Record Tab

The pharmacy rebate file will be the source of DSS' pharmacy rebate data and will be used by OHS to compute THCE and TME. DSS will report its rebate data in this file.

Insurance Category Code: A number that indicates the insurance category that pharmacy rebates are being reported on. Use the applicable Insurance Category Code as defined previously in the Advanced Network Record File (not all Insurance Category Codes may be applicable to pharmacy rebates).

Pharmacy Rebates:[27] The estimated or actual value of total federal and state supplemental rebates attributed to Connecticut resident members provided by pharmaceutical manufactures for prescription drugs with specified dates of fill corresponding to the period beginning date through end date of the respective calendar year, excluding manufacturer-provided fair market value bona fide service fees. This amount shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM. Total rebates should be reported without regard to how they are paid to DSS (e.g., through regular aggregate payments, on a claims-by-claim basis, etc.).

Line of Business Enrollment Tab

The line of business file will be the source of DSS' member months by line of business, which OHS will use to compute NCPHI. DSS will report their member months by market in this file.

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[27] For 2019-2021 data, DSS will submit pharmacy rebates in aggregate due to data availability (i.e., not submit retail and medical pharmacy rebates separately).

Line of Business Category Code: The number of members participating in a plan categorized by DSS as Medicaid/CHIP and Medicare/Medicaid duals, reported using the line of business category codes listed in Table B-6 below.

Table B-6. Insurance carriers' Line of Business Category Code Definitions

Line of Business Category Code	Definition
907	Medicaid/CHIP Managed Care
908	Medicare/Medicaid duals

Member Months (annual): The number of unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Standard Deviation Information Tab

The standard deviation information file will be the source of each Advanced Network standard deviation information for the purposes of conducting statistical testing and developing confidence intervals around cost growth rates. DSS will report standard deviation information for:

- each Advanced Network with attributed members by market (see Table B-7 for definition of market)

Advanced Network ID: The OHS Org ID of the Advanced Network. See Table B-3 above.

Market Code: Code referring to the Medicaid market (Medicaid Expenses for Non-Dual Eligible Members).

Table B-7. DSS Market Code

Market Code	Description
2	Medicaid (Insurance Category Code 2 - Medicaid Expenses for Non-Dual Eligible Members)

Member Months (annual): The number of unique members participating in a plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Total Truncated Spending: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be after member-level truncation is applied using the truncation

points listed in Table B-5 above. Do not include any non-claims spending categories.

Some insurers will attribute members to Advanced Networks on a monthly basis. If a member is attributed to more than one Advanced Network during the year, the payer should "reset the clock" by calculating total spending attributed to the Advanced Network for all Advanced Networks to which the member was reported and identify the total spending above the truncation point by each Advanced Network (see inset above for example calculation).

Standard Deviation PMPM: The calculated standard deviation for all members for the applicable market and Advanced Network, reported as a PMPM value. Insurance carriers should include all members attributed to an Advanced Network, including members with no utilization. Standard deviation should be based on per member per month (PMPM) spending. Insurance carriers should calculate the standard deviation PMPM after partial claims adjustments. Non-claims expenditures should be excluded from the calculation.

The following steps detail how insurance carriers can calculate standard deviation values for the data submission:

- **Step 1:** Attribute members to the appropriate Advanced Network for a specific market. Insurance carriers should include all members attributed to an Advanced Network, *including members with no utilization*.
- **Step 2**: For each market, for each Advanced Network, the insurance carrier must calculate the average monthly spending amount of each member using claims-based allowed amounts (in the Example spreadsheet, the result is in the column "Average Per Member Month Amount After Applying Truncation"). Insurance carriers should calculate the average claims-based allowed amount *after partial claims adjustments and after truncation of member level spending* (Claims:

Annual Total After Applying Truncation). Non-claims expenditures should be *excluded* from this average.
Note: The unit of analysis is member months, not individual members. This ensures that the weight of monthly spending for each member is accurately reflected in the average.

- **Step 3**: For each market, for each Advanced Network, sum "Average Per Member Month Amount After Applying Truncation" (result from Step 2) and divide by total member months (across all members) to produce a per member per dollar amount that is specific to that given market and Advanced Network.
- **Step 4**: With the average claims expenses value for each Advanced Network, insurance carriers can now calculate the standard deviation. The formula is:

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

Where:

s^2 = sample variance

x_1 = value of the one observation

$\bar{x}$ = the mean value of all observations

n = the number of observations (count of member months, **not** individual members)

Validation check: Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, insurance carriers can calculate the standard deviation of the PMPM costs for a given market.

Note that when calculating standard deviation, insurance carriers should use the formula for *population standard deviation* (divided by N). Insurance carriers should NOT use the formula for sample standard deviation (divided by N-1).

- **Step 5**: Report the standard deviation values in the data submission template in the Standard Deviation tab. Each row should correspond to either an Advanced Network or the market for the insurance carrier overall (using Insurance Carrier Overall ID, 100).

Age/Sex Factors Tab

The age/sex risk-adjustment tabs are where DSS should report spending categorized by age/sex bands and data on member level truncation. Information in these tabs will be used to calculate risk-adjustment scores that will be applied at the payer and Advanced Network level and to truncate high-cost outliers from the TME data.

DSS will report age/sex factor and member level truncation data for:

- each Advanced Networks with attributed members reported by Advanced Network using the IDs in Table B-3.

Age Band Code: Code associated with the age band of the members whose spending is being reported. See Table B-8 below.

Table B-8 Age Band Codes

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

Sex Band Code: Code associated with the sex of the members whose spending is being reported. See Table B-9 below. Please see guidance below for how to handle members that have no recorded sex information.

Table B-9 Sex Codes

Sex Code	Description
1	Female
2	Male

How to Handle Members Without Recorded Sex Information

For members that have no recorded sex information, insurance carriers should use their own predetermined rules for assigning the unreported member to a specific sex group (an insurance carrier's predetermined rule could be based on the demographic distribution of the overall population or any other relevant factor).

If an insurance carrier does not have a predetermined rule for categorizing unassigned members, it should use one of the following options to assign the member:

- **Attribute the member to the larger group**: In this approach, the member with unreported sex information would be assigned to the sex group (male or female) that has the largest representation in the submission/ICC code as measured by member months.
- **Impute missing sex data**: This approach involves using statistical methods to estimate the missing sex data based on other available information for the insurance member. Techniques such as regression imputation, nearest neighbor imputation, or multiple imputation could be used.

Total Member Months by Age/Sex Band: The number of unique Connecticut resident members for the age/sex cell participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year. The age of the member should be determined as of January 1st of the calendar year.

Total Spending before Truncation is Applied: The annual total claims-based spending attributed to each member participating in a plan each month with

a medical benefit consistent with aforementioned specifications on how to calculate claims-based spending. The spending in these cells should be before member-level truncation is applied. Do not include any non-claims spending categories.

Count of Members whose Spending was Truncated: The number of members whose spending was above the truncation threshold applicable to the Insurance Category Code and Advanced Network to which the member was attributed. This variable is collected by Insurance Category Code for each Advanced Network.

Total Spending After Applying Truncation at the Member Level: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be after member-level truncation is applied using the truncation points listed in Table B-5 above. Do not include any non-claims spending categories.

Some insurers will attribute members to Advanced Networks on a monthly basis. If a member is attributed to more than one Advanced Network during the year, the payer should "reset the clock" by calculating total spending attributed to the Advanced Network for all Advanced Networks to which the member was reported and identify the total spending above the truncation point by each Advanced Network (see inset above for example calculation).

Total Dollars Excluded from Spending After Applying Truncation at the Member Level: The sum of all dollars that were removed from total spending after applying truncation at the member level.

Appendix C:
CT DOC TME Data Specification

The Connecticut Department of Correction (DOC) annually reports general fund expenditures for inmate medical services to the Connecticut legislature. The reported expenditures include all personal services for all inmate medical services staff and other expenditures. The reported expenditures represent general fund appropriations expenditures.

Personal services include wages and salaries for all inmate medical services staff, including medical, dental and behavioral staff. It does not include the cost of fringe benefits or grant-funded positions. It does not include addiction services staff or the cost of DOC business office staff that support inmate medical services operations (e.g., accounts payable, finance and budget, asset management, contracting, procurement).

Other expenditures include spending for medical supplies, office supplies, laboratory costs, pharmaceutical and pharmacy services costs, minor medical equipment, minor office equipment, miscellaneous administrative costs, licensing costs, leasing costs, temporary medical staffing costs, emergency transportation costs, miscellaneous IT costs, outpatient costs and specialty services costs. It does not include capital equipment procurements and grant-funded expenditures.

It is important to note that DOC expenditures are reported on a state fiscal year basis (July-June) and not on a CY basis. Therefore, OHS will utilize the fiscal year that most recently contains six months of the reporting CY (e.g., state fiscal year 2023 data should be used in lieu of CY 2022 data). This is not consistent with the reporting from other payers and should be footnoted as such but is not expected to make a large impact.

DOC TME is only reported at the state level. Therefore, when reporting data at the service category level, DOC data will have to be excluded.

To receive TME data from DOC, OHS needs to make a formal request by emailing Michael Regan, Chief of Fiscal/Administrative Services (Michael.Regan@ct.gov).

Appendix D:
CT OSC TME Data Specification

This Office of the State Comptroller (OSC) TME data specification provides technical details to assist OSC in reporting and filing data to enable OHS to calculate TME on state employees, their dependents and retirees. For definitions of key terms, please see the full Implementation Manual. It is important to note that spending data for state employees, their dependents and retirees will be reported both by OSC, as defined by the specifications outlined in this appendix, as well as by OSC's third-party administrators (TPA). This allows OHS to: (1) understand the TME for OSC independent of other business reported by its TPA(s); and (2) hold OSC's TPAs accountable for their total Connecticut population. **Therefore, to avoid double counting state employee healthcare spending, OHS should only use data reported by OSC to assess OSC's performance against the Cost Growth Benchmark and use data reported by OSC's TPAs to calculate THCE at the commercial and Medicare levels.**

OHS annually requests TME data file(s) for dates of service covering prior calendar years. OSC should submit one Excel file with multiple record types in each tab, including:

- **Header Record Tab**, which includes, summary data and OSC comments
- **TME Record Tab**, which includes TME
- **Line of Business Tab**, which includes detailed member month information
- **Standard Deviation Tab**, which includes standard deviation by insurance carrier
- **Age/Sex Factor Tab**, which includes which includes spending by age band and by sex for the purposes of risk adjustment
- **Mandatory Questions Tab**, which asks insurance carriers to answer a series of questions about their data for validation purposes.

OHS may periodically update and revise these data specifications in subsequent versions, but aims to update this manual no more frequently than once per calendar year.

A. TME File Submission Specifications and Schedule

This appendix includes TME data file layouts for OSC. Further file submission instructions will be available on OHS' website. OSC should submit TME data using Excel templates provided by OHS according to the schedule outlined in Table D-1. After collection of initial pre-benchmark data, OSC should submit TME data annually. Of note, OHS may request prior year data with each annual TME submission.

Table D-1. OSC' TME Filing Schedule

Date	Files Due
August 15, 2024	CY 2022 and CY 2023 TME
August 15, 2025	CY 2023 and CY 2024 TME
August 15 2026	CY 2024 and CY 2025 TME

B. TME Data Submission

OSC must report TME based on Allowed Amounts (i.e., the amount OSC paid plus any member cost-sharing).

OSC must include only information pertaining to members:

- who are residents of Connecticut,
- who, at a minimum, have medical benefits[28], and

[28] Members who only have a non-medical benefit should be excluded as insurance carriers who hold the medical benefit for those members will be making estimates of TME for those non-medical benefits.

- for which OSC is primary on a claim (i.e., exclude any paid claims for which it was the secondary or tertiary payer, but do not exclude a member solely because they have additional coverage).

Spending should be calculated on a member month basis and OSC may choose whether residency of a member is established as of the first of the month, the last of the month, or another day of the month.

C. Claims Run-Out Period Specifications

OSC shall allow for a claims run-out period of at least 180 days after December 31 of the performance year. OSC should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category and will be required to attest that they are reasonable and appropriate. Claims payments should be reported on an incurred basis, not paid basis.

D. Non-Claims Payment Reconciliation Period Specifications

OSC shall allow for a non-claims reconciliation 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-based payments. This includes non-claims payments on OSC's behalf by a TPA or another vendor. OSC should apply reasonable and appropriate estimations of non-claims liability that are expected to be reconciled after the 180-day review period. Non-claims payments should be reported on an incurred basis, not paid basis.

E. TME File Specifications

OSC must submit one Excel template provided by OHS that includes its TME data, inclusive of primary care spending. The subsections below describe the detailed information that OSC must submit within each tab of the Excel template.

Header Record Tab

OSC Org ID: The OHS-assigned organization ID for the payer submitting the file, as defined in Table D-2.

Table D-2. OHS' Organizational Identification Number

Payer	Organizational ID
OSC	207

Period Beginning and Ending Dates: The period of time represented by the reported data. These period beginning and ending dates should always be January 1 and December 31, respectively. All reporting is based on the date of service related to the TME data.

Clinical Risk Adjustment Tool: The clinical risk adjustment tool, software or product used to calculate the clinical risk score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

Clinical Risk Adjustment Version: The version number of the clinical risk adjustment tool used to calculate the clinical risk adjustment score required in the TME file. While this will not be used to adjust spending, it remains a mandatory data element.

TME Record Tab

The TME Record File will be the source of OSC's TME data that OHS will use to assess OSC's performance against the benchmark. OSC will report its permissible claims and non-claims payments in this file.

OSC Org ID: For this submission, OSC will input "207" as the value for this field.

Insurance Category Code: A number that indicates the insurance category that is being reported. All data reported by Insurance Category Code should be mutually exclusive. For this submission, OSC should input its data under two insurance categories as outlined in Table D-3 below.

Table D-3. OHS' Insurance Category Code Definitions

Insurance Category Code	Definition
1	Medicare Advantage (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims

Member Months (annual): The number of unique members participating in an OSC plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Clinical Risk Score: A value that measures a member's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Insurance carriers must disclose the clinical risk adjustment tool, version number and underlying methodology in the Header Record File. **While this information will not be used to adjust payer data, OHS will still collect this information to compare results of payer-reported risk-adjustment with the new methodology to use age/sex factors first applied by CY 2019, CY 2020 and CY 2021 data.**

OSC must submit a clinical risk score that represents all of its members by line of business. OSC can use a clinical risk adjustment tool and software of its own choosing, but must disclose the tool (e.g., ACG, DxCG, etc.), the version and underlying methodology in the Header Record Tab. **TME data are not to be adjusted.**

Note that clinical risk scores should be normalized for every annual data submission (regardless of how many calendar years of data are included in

submission), to ensure accurate comparison of trend across years (e.g., when payers submit 2019- 2020 data, clinical risk scores should be based on 2019; when payers submit 2021 data, health risk scores should be normalized to 2020).

OSC should report TME data using the following claims and non-claims categories. To avoid double counting, all categories must be mutually exclusive. OHS may request additional information on how OSC mapped its data into these categories to improve consistency in reporting across all payers.

Claims: Hospital Inpatient: The TME paid to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.

Claims: Hospital Outpatient: The TME paid to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.

Claims: Professional, Primary Care: The TME paid to primary care providers delivered at a primary care site of care generated from claims using the following code-level definition:

Insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC. For telehealth services, insurers should use the place of service and modifier codes in the code list to identify primary care services delivered via telehealth. For primary care outpatient or FQHC services, insurance carriers should adhere to the existing taxonomy list (i.e., there is not a specific POS code list for care delivered in a primary care outpatient or FQHC setting).

The definition of primary care site of care excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors.

Claims: Professional, Primary Care (for Monitoring Purposes): The TME paid to primary care providers, including OB/GYNs and midwifery, generated from claims using the following code-level definition:

Primary Care Taxonomy and Proce

Insurance carriers should identify primary care providers first by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field. If the carrier does not utilize the provider taxonomy codes in the file above, it may apply its provider codes to match the description of the provider taxonomy codes included.

A primary care site of care is defined as a primary care outpatient setting (e.g., office, clinic, or center), federally qualified health center (FQHC), or via telehealth delivered by a PCP that is part of a primary care outpatient setting or FQHC. For telehealth services, insurers should use the place of service and modifier codes in the code list to identify primary care services delivered via telehealth. For primary care outpatient or FQHC services, insurance carriers should adhere to the existing taxonomy list (i.e., there is not a specific POS code list for care delivered in a primary care outpatient or FQHC setting).

The definition of primary care site of care excludes primary care spending delivered at urgent care centers, retail pharmacy clinics and via stand-alone, third-party telehealth vendors. **Note:** TME paid to OB/GYNs and midwifery included in the "Claims: Professional, Primary Care (for Monitoring Purposes)" category should also be included in the "Claims: Professional, Specialty" category.

Claims: Professional, Specialty: The TME paid to physicians or physician group practices generated from claims. Includes services provided by a

doctors of medicine or osteopathy in clinical areas other than family medicine, internal medicine, general medicine or pediatric medicine, not defined as primary care in the first primary care definition above. **Note:** TME paid to OB/GYNs and midwifery included in the "Claims: Professional, Primary Care (for Monitoring Purposes)" category should also be included in the "Claims: Professional, Specialty" category.

Claims: Professional Other: The TME paid from claims to healthcare providers for services provided by a licensed practitioner other than a physician but is not identified as primary care in the first primary care definition above. This includes, but is not limited to, licensed podiatrists, non-primary care nurse practitioners, non-primary care physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors and any professional fees that do not fit other categories.

Claims: Pharmacy: The TME paid from claims to healthcare providers for prescription drugs, biological products or vaccines as defined by OSC's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the carrier's medical benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be attributed to Claims: Hospital Inpatient). Medicare Advantage, insurance carriers that offer stand-alone prescription drug plans (PDPs) should exclude stand-alone PDP data from their TME. For OSC only, pharmacy data is to be reported **net** of applicable rebates.

Claims: Long-Term Care: All TME data from claims to providers for: (1) nursing homes and skilled nursing facilities; (2) intermediate care facilities for individuals 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, etc.), homemaker and

chore services, home-delivered meal programs, home health services, adult daycare, self-directed personal assistance services (e.g., assistance with grocery shopping, etc.), and programs designed to assist individuals with long-term care needs receive care in their home and community, such as PACE and Money Follows the Person. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner.

Claims: Other: All TME paid from claims to healthcare providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, facility fees of community health center services, freestanding ambulatory surgical center services, freestanding diagnostic facility services, hospice, hearing aid services and optical services. Payments made to members for direct reimbursement of healthcare benefits/services may be reported in “Claims: Other” if OSC is unable to classify the service. If this is the case, the carrier should consult with OHS about the appropriate placement of the service prior to categorizing it as “Claims: Other.” However, TME data for non-healthcare benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists OSC with enrolling members in gyms is not a valid payment to include.

Non-Claims: Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time; (2) global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits (e.g., behavioral health, 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, such as OSC's Episodes of Care program with Signify Health, 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.

Non-Claims: Performance Incentive Payments: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target, and pay-for-reporting, i.e., payments to providers for reporting on a set of metrics, usually to build capacity for pay-for-performance, payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a set target, and shared risk recoupments, i.e., payments providers must recoup if costs of services are above a set target. This also includes reconciliation payments for OSC's Episodes of Care program with Signify Health so long as the episodes are retrospectively reconciled.

Non-Claims: Payments to Support Population Health and Practice Infrastructure: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes, but is not limited to payments that support care management, care coordination and population; data analytics; EHR/HIT infrastructure payments; medication reconciliation; patient-centered medical home (PCMH) recognition payments and primary care and behavioral health integration *that are not reimbursable through claims*.

Non-Claims: Provider Salaries: All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-

claims categories. This category is typically only applicable to closed delivery systems.

Non-Claims: Recovery: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation. This field should be reported as a **negative number**. Only report data in this category not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this category).

Non-Claims: Other: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for healthcare benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. For CY 2020, this may also include supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic. Only payments made to providers are to be reported; insurer administrative expenditures (including corporate allocations) are not included in TME.

Non-Claims: Total Primary Care Non-Claims-Based Payments: All non-claims-based payments included in the above six categories that are specifically made to a primary care provider or provider organization. Payments in this category should be a sub-set of payments reported in the other non-claims categories. *This category is the only category not mutually exclusive to the other non-claims categories.*

Total Claims Excluded Because of Truncation: The total claims-based spending truncated using the truncation points listed in Table D-4 below. OSC will report this variable by Insurance Category Code. OHS requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending.

Table D-4. Truncation Points

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
3	Commercial: Full Claims	$150,000

Count of Members with Claims Truncated: The number of members whose spending was above the truncation threshold applicable to the Insurance Category Code. OSC will report this variable by Insurance Category Code.

Line of Business Enrollment Tab

The line of business enrollment file will be the source of OSC's spending and member months by market in that OHS will used to compute OSC's net cost of operating its program. OSC will report its spending and member months by market in this file.

Line of Business Category Code: The number of members participating in an OSC plan categorized by OSC by line of business category. For this submission, OSC should input its data under the two line of business categories as outlined in Table D-4 below.

Table D-5. OHS' Line of Business Category Code Definitions

Line of Business Category Code	Definition
904	Self-insured
906	Medicare Advantage

Member Months (annual): The number of unique members participating in an OSC plan each month with at least a medical benefit, regardless of whether the member has any paid claims. Member months should be

calculated by taking the number of members with a medical benefit and multiplying that sum by the number of months in the member's policy. Member months for members with comprehensive health plans should be non-duplicative between medical benefits and pharmacy benefits.

Standard Deviation Information Tab

The standard deviation information file will be the source of OSC's standard deviation information for the purposes of conducting statistical testing and developing confidence intervals around cost growth rates. OSC will report standard deviation information for each line of business as defined below.

Insurance category codes should be mapped to line of business as follows:

- **Medicare:** includes Medicare Advantage and Medicare Expenditures for Medicare/Medicaid Dual Eligibles (i.e., ICC 1 and ICC 5)
- **Commercial:** includes Commercial – Full Claims and Commercial – Partial Claims (for the commercial partial population, standard deviation should be calculated based on adjusted data for the partial population) (i.e., ICC 3 and ICC 4)

OSC Org ID: For this submission, OSC will input "207" as the value for this field.

Market ID: Code referring to the to the Medicare, Medicaid and commercial markets, and combines Insurance Category Codes.

Table D-6. Market Codes

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

Standard Deviation of Claims Expenditures: The calculated standard deviation for all members for the applicable market, reported as a PMPM

value. OSC should include all members, including members with no utilization. Standard deviation should be based on per member per month (PMPM) spending. Non-claims expenditures should be excluded from the calculation.

Note that when calculating standard deviation, OSC should use the formula for *population standard deviation* (divided by N). OSC should NOT use the formula for sample standard deviation (divided by N-1).

Age/Sex Factors Tab

The age/sex risk-adjustment tabs are where OSC should report spending categorized by age/sex bands and data on member level truncation. OSC will report age/sex data by Insurance Category Code. Information in these tabs will be used to calculate risk scores that will be applied at the payer level and to truncate high-cost outliers from the TME data. Field definitions are listed below.

Age Band Code: Code associated with the age band of the members whose spending is being reported. See Table D-7 below.

Table D-7 Age Band Codes

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

Sex Band Code: Code associated with the sex of the members whose spending is being reported. See Table D-8 below. Please see guidance below for how to handle members that have no recorded sex information.

Table D-8 Sex Codes

Sex Code	Description
1	Female
2	Male

How to Handle Members Without Recorded Sex Information

For members that have no recorded sex information, insurance carriers should use their own predetermined rules for assigning the unreported member to a specific sex group (an insurance carrier's predetermined rule could be based on the demographic distribution of the overall population or any other relevant factor).

If an insurance carrier does not have a predetermined rule for categorizing unassigned members, it should use one of the following options to assign the member:

- **Attribute the member to the larger group**: In this approach, the member with unreported sex information would be assigned to the sex group (male or female) that has the largest representation in the submission/ICC code as measured by member months.
- **Impute missing sex data**: This approach involves using statistical methods to estimate the missing sex data based on other available information for the insurance member. Techniques such as regression imputation, nearest neighbor imputation, or multiple imputation could be used.

Total Member Months by Age/Sex Band: The number of unique Connecticut resident members for the age/sex cell participating in a plan each month with a medical benefit, regardless of whether the member has any paid claims. Member months should be calculated by summing the number of months each member was enrolled in a plan with a medical benefit for one calendar year. The age of the member should be determined as of January 1st of the calendar year.

Total Spending before Truncation is Applied: The annual total claims-based spending attributed to each member participating in a plan each month with a medical benefit consistent with aforementioned specifications on how to calculate claims-based spending. The spending in these cells should be before member-level truncation is applied. Do not include any non-claims spending categories.

Count of Members whose Spending was Truncated: The number of members whose spending was above the truncation threshold.

Total Spending After Applying Truncation at the Member Level: The total claims-based spending after truncation attributed to each member participating in a plan each month with a medical benefit consistent with the general cost growth target specifications on how to calculate claims-based spending. The spending in these cells should be after member-level truncation is applied using the truncation points listed in Table A-6 above. Do not include any non-claims spending categories.

Total Dollars Excluded from Spending After Applying Truncation at the Member Level: The sum of all dollars that were removed from total spending after applying truncation at the member level.

F. File Submission

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

OSC_TME_YYYY_Version.xls

YYYY is the four-digit year of submission (which will generally be one year later than the year of the data reflected in the report).

Version is optional and indicates the submission number.

The file extension must be .xls or .xlsx

Below are examples of valid file names:

OSC_TME_2018_01.xlsx or OSC_TME_2018_1.xlsx or OSC_TME_2018.xlsx

Submitting Files to OHS

Electronic files are to be submitted through the State's secure file transfer (SFT) server at https://sft.ct.gov/ to OHS.

OHS will provide a form at https://portal.ct.gov/OHS/Pages/Guidance-for-Payer-and-Provider-Groups/Implementation-Manual for the carrier's contact(s) to fill out and email to OHS. This information is required:

- To facilitate user access to the State's SFT Web Client;
- To confirm the user is the authorized and designated contact for the carrier at registration;
- To facilitate securing and protecting confidential data;
- To enable OHS communicate with the contact about data error correction and validation, system or process changes and updates.

The contact will fill out the form and email it to OHS@ct.gov. OHS will acknowledge receipt of the filled form, credential and grant the contact/new user access to the State's network within two business days. Upon receiving

the credentials to access the server, the authorized user will upload the required data files. The contact must alert OHS through email after uploading the file(s).

Appendix E:
Medicare FFS TME Data Specification

OHS will be able to receive TME and enrollment data from Medicare FFS annually by September 1 of the year following the measurement period (e.g., 2023 data will be available September 1, 2022). CMS believes that data will be at least 90% complete by September 1.

Specifically, CMS will share total program payments and cost sharing for the following services:

- Hospital inpatient
- Hospital outpatient
- Non-hospital outpatient
- Home health agency
- Hospice
- Skilled nursing facility
- Physician
- Other professionals
- Durable medical equipment
- Other suppliers
- Part D[29]

These services are mapped to the TME reporting categories as outlined in Table E-1 below:

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[29] As part of the TME data received from CMS, CMS will be providing OHS Part D data for individuals enrolled in FFS stand-alone PDPs as well as Medicare Advantage enrollees in MAPD or MA-only plans.

Table E-1. Mapping of Medicare Service Categories to TME Service Categories

Medicare Service Categories	TME Service Mapping
Hospital Inpatient	Hospital Inpatient
Hospital Outpatient	Hospital Outpatient
Non-Hospital Outpatient	Other
Home Health Agency	Long-Term Care
Hospice	Other
Skilled Nursing Facility	Long-Term Care
Physician	Professional, Primary Care and Professional, Specialty (must be combined when reporting service level category spending with CMS data)
Other Professionals	Other
Durable Medical Equipment	Other
Other Suppliers	Other
Part D	Retail Pharmacy

CMS will also share enrollment figures for Medicare Parts A, B and D broken out between Medicare Advantage and FFS. CMS reports beneficiaries based on the resident location as of the end of the calendar year.

To receive Medicare FFS TME data from CMS, OHS needs to make a formal request to CMS by emailing the attached Excel file **(Attachment 1)** to Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.gov) and copying: CMSProgramStatistics@cms.hhs.gov. **Please note, CMS has specifically requested that Connecticut staff (not a contractor) make the official request.**

CMS is willing to share the data with OHS by September 1 if the data request is made by June 1.

Appendix F:
Medicare FFS Primary Care Data Specification Using APCD Data

OHS will use APCD data to determine Medicare FFS performance against the primary care spending target because CMS does not report primary care spending using OHS' definition (included in Appendix A).

The formula for Medicare FFS' contribution to the calculation of the overall statewide primary care spending target as defined in Section IV-A of the Implementation Manual is as follows:

$$\textit{Medicare FFS primary care spending} \times \frac{\textit{Medicare FFS TME}}{\textit{TME}}$$

A. Medicare FFS Primary Care Spending

OHS will perform two calculations of aggregate claims-based spending on Medicare FFS primary care.[30] The two calculations are defined as follows:

1. **Professional Primary Care Claims for the Primary Care Spending Target:** This includes the TME paid to: (1) doctors of osteopathic medicine (DOs) and doctors of medicine (MDs) in geriatric and internal medicine (when practicing primary care), family medicine, and pediatric and adolescent medicine; and (2) nurse practitioners and physician assistants, when practicing primary care. This is the figure that will be used for "Medicare FFS primary care spending" in the formula above when calculating Medicare FFS performance against the primary care target. The specific steps for calculating spending are as follows:

[30] The calculation of primary care spending as a percentage of TME is based only on claims spending. The data from the APCD used to calculate the numerator and the Medicare FFS data from CMS used to calculate the denominator do not include non-claims based spending.

- **Step 1:** Using Table F-1 below, pull claims from “Primary Care” providers only as defined in Column 3. Identify primary care providers by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field.
- **Step 2:** Limit claims for “Primary Care” providers identified in Step 1 to the procedure codes listed in Table F-2 below.
- **Step 3:** Sum up all claims spending identified.

2. **Professional Primary Care Claims for Monitoring Purposes**: This includes the TME paid to: (1) DOs and MDs in geriatric and internal medicine (when practicing primary care), family medicine, pediatric and adolescent medicine, and obstetrics and gynecology; and (2) nurse practitioners and physician assistants, when practicing primary care or obstetrics and gynecology, and nurse midwives. This is the figure that will be used for “Medicare FFS primary care spending” in the formula above when calculating Medicare FFS spending for monitoring purposes. The specific steps for calculating spending are as follows:
    - **Step 1:** Using Table F-1 below, pull claims from “Primary Care” and “OB/GYN” providers as defined in Column 3. Identify primary care providers by searching for relevant provider taxonomy codes in the rendering provider field and then the billing provider field.
    - **Step 2:** Limit claims for “Primary Care” and “OB/GYN” providers identified in Step 1 to the procedure codes listed in Table F-2.
    - **Step 3:** Sum up all claims spending identified.

Table F-1: List of Provider Taxonomy Codes

Taxonomy	Description	Primary Care or OB/GYN	Primary Care Definition	Specialty Category
208D00000X	General Practice	Primary Care	Primary and Supplemental	General Practice
207Q00000X	Family Medicine	Primary Care	Primary and Supplemental	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine	Primary Care	Primary and Supplemental	Family Medicine
207QA0505X	Family Medicine, Adult Medicine	Primary Care	Primary and Supplemental	Family Medicine
207QG0300X	Family Medicine, Geriatric Medicine	Primary Care	Primary and Supplemental	Family Medicine
207QH0002X	Family Medicine, Hospice Palliative	Primary Care	Primary and Supplemental	Family Medicine
208000000X	Pediatrics	Primary Care	Primary and Supplemental	Pediatrics
2080A0000X	Pediatrics, Adolescent Medicine	Primary Care	Primary and Supplemental	Pediatrics
2080H0002X	Pediatrics, Hospice and Palliative Medicine	Primary Care	Primary and Supplemental	Pediatrics
207R00000X	Internal Medicine	Primary Care	Primary and Supplemental	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine	Primary Care	Primary and Supplemental	Internal Medicine
207RA0000X	Internal Medicine, Adolescent Medicine	Primary Care	Primary and Supplemental	Internal Medicine

Taxonomy	Description	Primary Care or OB/GYN	Primary Care Definition	Specialty Category
207RH0002X	Internal Medicine, Hospice and Palliative Medicine	Primary Care	Primary and Supplemental	Internal Medicine
363A00000X	Physician Assistant	Primary Care	Primary and Supplemental	Physician Assistant
363AM0700X	Physician Assistant, Medical	Primary Care	Primary and Supplemental	Physician Assistant
363L00000X	Nurse Practitioner	Primary Care	Primary and Supplemental	Physician Assistant
363LA2200X	Nurse Practitioner, Adult Health	Primary Care	Primary and Supplemental	Physician Assistant
363LF0000X	Nurse Practitioner, Family	Primary Care	Primary and Supplemental	Physician Assistant
363LG0600X	Nurse Practitioner, Gerontology	Primary Care	Primary and Supplemental	Physician Assistant
363LP0200X	Nurse Practitioner, Pediatrics	Primary Care	Primary and Supplemental	Physician Assistant
363LP2300X	Nurse Practitioner, Primary Care	Primary Care	Primary and Supplemental	Physician Assistant
363LC1500X	Nurse Practitioner, Community Health	Primary Care	Primary and Supplemental	Physician Assistant
363LS0200X	Nurse Practitioner, School	Primary Care	Primary and Supplemental	Physician Assistant
261QF0400X	Federally Qualified Health Center (FQHC)	Primary Care	Primary and Supplemental	FQHC AHC Facility Taxonomy
261QR1300X	Clinic/Center, Rural Health	Primary Care	Primary and Supplemental	RHC AHC Facility Taxonomy

Taxonomy	Description	Primary Care or OB/GYN	Primary Care Definition	Specialty Category
261QP2300X	Clinic/Center, Primary Care	Primary Care	Primary and Supplemental	Primary Care AHC Facility Taxonomy
282NR1301X	Rural Hospital	Primary Care	Primary and Supplemental	Rural Hospital Taxonomy
261QC0050X	Critical Access Hospital	Primary Care	Primary and Supplemental	Critical Access Hospital Taxonomy
282NC0060X	Critical Access Hospital	Primary Care	Primary and Supplemental	Critical Access Hospital Taxonomy
363LX0001X	Nurse Practitioner, Obstetrics & Gynecology	OB/GYN	Supplemental Only	Obstetrics & Gynecology
363LW0102X	Nurse Practitioner, Women's Health	OB/GYN	Supplemental Only	Obstetrics & Gynecology
207V00000X	Obstetrics & Gynecology	OB/GYN	Supplemental Only	Obstetrics & Gynecology
207VG0400X	Obstetrics & Gynecology, Gynecology	OB/GYN	Supplemental Only	Obstetrics & Gynecology
176B00000X	Midwife	OB/GYN	Supplemental Only	Obstetrics & Gynecology
367A00000X	Midwife, Certified Nurse	OB/GYN	Supplemental Only	Obstetrics & Gynecology

Table F-2: List of Procedure Codes

Reporting Procedure Category	Procedure Code	Description
Office Visits	99202	OFFICE OUTPATIENT NEW 20 MINUTES
	99203	OFFICE OUTPATIENT NEW 30 MINUTES
	99204	OFFICE OUTPATIENT NEW 45 MINUTES
	99205	OFFICE OUTPATIENT NEW 60 MINUTES
	99212	OFFICE OUTPATIENT VISIT 10 MINUTES
	99213	OFFICE OUTPATIENT VISIT 15 MINUTES
	99214	OFFICE OUTPATIENT VISIT 25 MINUTES
	99215	OFFICE OUTPATIENT VISIT 40 MINUTES
	99417	Prolonged office or other outpatient evaluation and management service(s) requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483. Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416).
	G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact
Consultation Services	99242	OFFICE CONSULTATION NEW/ESTAB PATIENT 20 MIN

Reporting Procedure Category	Procedure Code	Description
	99243	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN
	99244	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN
	99245	OFFICE CONSULTATION NEW/ESTAB PATIENT 55 MIN
Prolonged Services	99358	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR
	99359	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES (use in conjunction with 99358)
	99360	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES
	G0513	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC;1ST 30 M
	G0514	PRLNG PREV SRVC OFC/OTH O/P DIR CTC;EA ADD 30 M
Telephone and Internet Services	98966	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN
	98967	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN
	98968	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN
	98970	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
	98971	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

Reporting Procedure Category	Procedure Code	Description
	98972	Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
	99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
	99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
	99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
	99441	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN
	99442	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN
	99443	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN
	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

Reporting Procedure Category	Procedure Code	Description
Preventive Medicine Services	99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT
	99401	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN
	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
	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

Reporting Procedure Category	Procedure Code	Description
Preventive Medicine Visits	99381	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR
	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
Preventive Medicine Services/Preventive Dental Care	99429	UNLISTED PREVENTIVE MEDICINE SERVICE
	99499	UNLISTED EVALUTION AND MANAGEMENT SERVICE

Reporting Procedure Category	Procedure Code	Description
Preventive Dental Services	99188	APPLICATION OF TOPICAL FLUORIDE VARNISH BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
Health Risk Assessment, Screenings, and Counseling	96160	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM
	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
Immunization Administration for Vaccines/Toxoids	90460	IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX
	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

Reporting Procedure Category	Procedure Code	Description
	G0008	ADMINISTRATION OF INFLUENZA VIRUS VACCINE
	G0009	ADMINISTRATION OF PNEUMOCOCCAL VACCINE
	G0010	ADMINISTRATION OF HEPATITIS B VACCINE
Advance Care Planning Evaluation & Management Services	99497	ADVANCE CARE PLANNING FIRST 30 MINS
	99498	ADVANCE CARE PLANNING EA ADDL 30 MINS
Case Management Services	99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN
	99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN
	99368	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN
Chronic Care Management Services	99424	Initial 30 minutes per calendar month of principal care management services, including creation of a disease-specific care plan by a physician or qualified health care provider.
	99425	Each additional 30 minutes per calendar month of principal care management services, as carried out by a physician or qualified health care professional.
	99426	Initial 30 minutes per calendar month of principal care management clinical staff time, as carried out by clinical staff (such as nursing professionals) under the direction and guidance of a physician or qualified health professional.
	99427	Each additional 30 minutes per calendar month of principal care management clinical staff time, as carried out by clinical staff (such as nursing professionals) under the

Reporting Procedure Category	Procedure Code	Description
		direction and guidance of a physician or qualified health professional.
	99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each 30 minutes by a physician or other qualified health care professional, per calendar month.
	99439	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month
	99487	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO
	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 1ST 30 MIN PER MONTH
	G0506	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC
HCPC Visit Codes	G0402	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR
	G0438	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT

Reporting Procedure Category	Procedure Code	Description
	G0439	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST
	G0463	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT
	G0466	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT
	G0467	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT
	G0468	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV
	S9117	BACK SCHOOL VISIT
	T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE
Contraceptive Insertion/Removal	11982	Removal, non- biodegradable drug delivery implant
	58301	Removal of IUD
	11981	Insertion, non- biodegradable drug delivery implant
	11983	Removal with reinsertion, non- biodegradable drug delivery implant
	57170	Diaphragm or cervical cap fitting with instructions
	58300	Insertion of IUD
	S4981	Insertion of levonorgestrel- releasing intrauterine system
Gynecological Services	G0101	CERV/VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM
	Q0091	SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB
	S0610	ANNUAL GYNECOLOGICAL EXAM, ESTABLISHED PATIENT

Reporting Procedure Category	Procedure Code	Description
	S0612	ANNUAL GYNECOLOGICAL EXAM, NEW PATIENT
	S0613	ANNUAL GYNECOLOGICAL EXAM, BREAST EXAM W/O PELVIC
Home Visits for Newborns	99502	HOME VISIT FOR NEWBORN CARE AND ASSESSMENT
Home Visits	99341	HOME VISIT NEW PATIENT STRAIGHTFORWARD 15 MINUTES
	99342	HOME VISIT NEW PATIENT LOW SEVERITY 30 MINUTES
	99344	HOME VISIT NEW PATIENT MODERATE SEVERITY 60 MINUTES
	99345	HOME VISIT NEW PATIENT HIGH SEVERITY 75 MINUTES
	99347	HOME VISIT EST PATIENT STRAIGHTFORWARD 20 MINUTES
	99348	HOME VISIT EST PATIENT LOW SEVERITY 30 MINUTES
	99349	HOME VISIT EST PATIENT MODERATE SEVERITY 40 MINUTES
	99350	HOME VISIT EST PATIENT HIGH SEVERITY 60 MINUTES
Hospice/Home Health Services	99374	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES
	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/>

Reporting Procedure Category	Procedure Code	Description
	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
	G0182	PHYS SUPV PT UNDER MEDICARE-APPROVED HOSPICE
Transitional Care Management Services	99495	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE
	99496	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE

B. Medicare FFS TME

"Medicare FFS TME" is collected from CMS and further defined in Appendix E. It is the "Total Expenditures" in Column O of the CMS reporting template.

C. TME

The formula for TME for the purposes of the primary care spending target is:

TME = Commercial TME + Medicare Advantage TME + Medicare FFS TME + DSS Medicaid TME

Inputs for calculating "Commercial TME" and "Medicare Advantage TME" are detailed in Appendix A. Inputs for calculating "DSS Medicaid TME," are detailed in Appendix B.

D. Timeline

CMS sends annual Medicare FFS updates to the APCD in December, which includes data up to the end of the previous calendar year. Based on this

schedule for data receipt, OHS will complete analysis of Medicare FFS primary care spending according to the timeline outlined in Table F-3:

Table F-3. OHS' Medicare FFS Primary Care Spending Analysis Schedule

Date	Analysis Completed
August 2024	CY 2021 and CY 2022 Medicare FFS primary care spend
August 2025	CY 2022 and CY 2023 Medicare FFS primary care spend
August 2026	CY 2023 and 2024 Medicare FFS primary care spend
August 2027	CY 2024 and CY 2025 Medicare FFS primary care spend

Due to the delay in availability of Medicare FFS data,[31] OHS will release two calculations: (1) primary care spending using data from the calendar year before the year for which performance against the benchmark is being measured; and (2) primary care spending with Medicare FFS primary care spending updated for the calendar year during which benchmark and primary care spending target performance is being measured. This reporting schedule is detailed in Table F-4 below.

[31] Medicare FFS data are not available until 18 months after the end of the performance year (e.g., CY 2020 data will not be available until June 2022).

Table F-4. OHS' Primary Care Spending Reporting Schedule

Interim Report			Final Report	
Publication Date	Non-Medicare FFS Primary Care Spend Data Used	Medicare FFS Primary Care Spend Data Used	Publication Date	Primary Care Spend Data Used for All Payers
Q1 2025	CY 2022 and CY 2023	CY 2022	Q2 2025	CY 2022 and CY 2023
Q1 2026	CY 2023 and CY 2024	CY 2023	Q2 2026	CY 2023 and CY 2024
Q1 2027	CY 2024 and CY 2025	CY 2024	Q2 2027	CY 2024 and CY 2025

Appendix G:
VHA TME Data Collection Process

Statistics on Connecticut veteran healthcare spending are published in the summer by the Veterans Health Administration (VHA) National Center for Analysis and Statistics. The information is accessed here: www.va.gov/vetdata/Expenditures.asp. The figure "Medical Care" is what is reported as "VHA TME".

Per the notes on the VHA expenditure report, "Medical Care" includes expenditures for medical services, medical administration, facility maintenance, educational support, research support and other overhead items. Medical care expenditures do not include dollars for construction or other non-medical support.

It is important to note that VHA expenditure report data is reported on a federal fiscal year basis (October–September) and not on a CY basis. Therefore, OHS will utilize the fiscal year that contains nine months of the reporting CY (e.g., fiscal year 2020 data should be used in lieu of CY 2020 data). This is not consistent with the reporting from other payers and should be footnoted as such, but it is not expected to have a large impact.

More detailed TME data on veterans has not been identified yet. If other sources of veterans' data are identified in the future, this manual will need to be updated.

VHA TME is only reported at the state level. Service category detail has not been available in the VHA expenditure report; only the total for all "Medical Care" is provided. Therefore, when reporting data at the service category level, VHA data will have to be excluded.

Appendix H:
NCPHI Data Specification

The net cost of private health insurance (NCPHI) captures the costs to Connecticut residents associated with the administration of private health insurance. It is defined as the difference between health premiums earned and benefits incurred and consists of insurance carriers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses. **NCPHI is reported as a component of THCE at the State level.**

Because of substantial differences among segments of the Connecticut health insurance market, NCPHI will be calculated on a PMPM basis separately for the seven different market segments: (1) Individual Market; (2) Large Group, Fully Insured; (3) Small Group, Fully Insured; (4) Self-insured; (5) Student market; and (6) Medicare Advantage. The methodology and data sources for the calculation of NCPHI for each market segment are described below.

A. Individual, Small Group, Fully Insured, Large Group, Fully Insured and Student Markets (collectively, the "commercial fully insured market")

The federal commercial medical loss ratio (MLR) reports will be used to calculate NCPHI for the commercial fully insured market and need to be requested from the insurance carriers as part of their TME data submission, or obtained from CMS Center for Consumer Information and Oversight (CCIIO).[32] These reports become publicly available in the fall, but should be requested from insurance carriers when they submit their TME data in order to meet the reporting timeline. In an instance in which the MLR report submitted to OHS on

[32] Available at: www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html. April 7, 2020.

the TME deadline differs from the final submission an insurer makes to CCIIO, the insurer must notify OHS in writing as soon as possible. To get NCPHI applicable for CT residents, one must first calculate the NCPHI using situs-based information before applying it to CT residents. Doing so assumes that the cost of administering private health insurance is the same for CT residents is the same as for providing it to employers whose employees are not CT residents. This calculation must be performed for each insurer. The data elements that will be used in the calculation are detailed below:

Commercial Fully-Insured NCPHI =

Premium as of March 31 (Part 1, Line 1.1) – Total Incurred Claims as of March 31 (Part 1, Line 2.1) + Advance Payments of Cost-Sharing Reductions (Part 2, Line 2.18) – MLR Rebates Current Year (Part 3, Line 5.4)

Situs-Based Commercial Fully-Insured NCPHI PMPM =

$$\frac{\textit{Commercial Fully-Insured NCPHI}}{\textit{Member Months as reported on the MLR}}$$

CT Resident-Based Commercial Fully-Insured NCPHI =

Situs-based Commercial Fully-Insured NCPHI PMPM X Member Months as reported on the Market Enrollment tab of the TME Data[33]

B. Medicare Advantage

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC) will be used to derive NCPHI of the Medicare

[33] OHS should not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the spending benchmark is intended to capture Connecticut residents. By using member months reported by market segment within the TME data, OHS will be assuming that the experience of the insurer across all of its Connecticut business (regardless of whether it insurers a member from another state) is the same experience as Connecticut residents.

Advantage market. The SHCE can be obtained from The Medicare Advantage reporting combines stand-alone prescription drug plans (PDP) and the Medicare Advantage plans with Part D inclusion (MAPDs). Therefore, insurance carriers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims and members months for PDP and MAPD.

Insurance carriers must also submit names for which they are "Doing Business As" for Medicare and Medicare Advantage on an annual basis.

The data elements that will be used in the calculation are detailed below.

Medicare Advantage NCPHI =

Health Premiums Earned (Part 1, Line 1.1) - Total Incurred Claims (Part 1, Line 5.0)

Medicare Advantage NCPHI PMPM =

$$\frac{\textit{Medicare Advantage NCPHI}}{\textit{Member Months as reported on the Market Enrollment Tab of the TME data}}$$

C. Self-Insured Market

OHS requests insurance carriers to report aggregate information on the premiums earned from their self-insured accounts (e.g., "fees from uninsured plans"). Carriers should follow the instructions for Part 1, Line 12 on the NAIC SCHE for their Connecticut-situs self-insured accounts. This will be used to derive NCPHI of the self-insured market. To get NCPHI applicable for CT residents, one must first calculate the NCPHI using situs-based information before applying it to CT residents. Doing so assumes that the cost of administering private health insurance is the same for CT residents is the same as for providing it to employers whose employees are not CT residents. This calculation must be performed for each insurer. The data elements that will be used in the calculation are detailed below:

Self-Insured NCPHI =

Carrier data reported pursuant to Part 1, Line 12 of the SHCE

Situs-Based Self-Insured NCPHI PMPM =

$$\frac{\textit{Self-Insured NCPHI}}{\textit{Member Months as reported by carriers pursuant to Part 1, Line 12 of the SHCE}}$$

CT Resident-Based Self-Insured NCPHI =

Situs-Based Self-Insured NCPHI PMPM X Member Months as reported on the Market Enrollment tab of the TME Data[34]

Table H-1 below provides the columns associated with each line of business/market in the SHCE and the MLR reports.

Table H-1. Columns Associated with Each Line of Business in SHCE and MLR Reports

Line of Business/Market	SHCE Column	MLR Column (Parts 1 and 2)	MLR Column (Part 3)
Individual	N/A	2	4
Small Group, Fully Insured	N/A	7	8
Large Group, Fully Insured	N/A	12	12
Student	N/A	36	36
Medicare Advantage and PDP	12	N/A	N/A
Self-Insured	14	N/A	N/A

[34] OHS should not use the member months that are reported on the MLR or SHCE forms as those forms are based on in situ information, whereas the spending benchmark is intended to capture Connecticut residents. By using member months reported by market segment within the TME data, OHS will be assuming that the experience of the insurer across all of its Connecticut business (regardless of whether it insures a member from another state) is the same experience as Connecticut residents.

Appendix I:
Insurance Carrier Attestation

Attestation of the Accuracy and Completeness of Reported Data

Instructions: Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation. Insurance carriers should submit one "Attestation of the Accuracy and Completeness of Reported Data" per calendar year. Scanned copies of the signed attestations should be emailed to: lisa.sementilli@ct.gov.

Insurer:

____

Calendar Year(s) Being Reported: ________________________________

Pursuant to Connecticut's establishment, monitoring and implementation of annual Healthcare Cost Growth Benchmark and a Primary Care Spending Targets pursuant to Connecticut General Statute 19a-754g et. Seq. and State-defined reporting guidelines which can be found in the Connecticut Healthcare Benchmark Initiative Implementation Manual, certain health insurance carriers operating in the state of Connecticut must annually submit certain data requested to calculate insurer and provider performance relative to Connecticut's Benchmark.

I hereby attest that the information submitted in the reports herein is current, complete and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under any applicable state laws. Failure to sign this Attestation of the Accuracy and Completeness of Reported Data will result in OHS' non acceptance of the attached reports.

Signature	Date
Printed Name	Title

Appendix J:
Sources for Potential Gross State Product (PGSP) Formula

Components	Source
Expected growth in national labor force productivity	The source was the most recently published Congressional Budget Office Budget and Economic Outlook, 10-Year Economic Projections (January 2020).[35] The CBO projected the nonfarm business sector labor productivity in its data supplement located here: (https://www.cbo.gov/system/files/2020-01/51135-2020-01-economicprojections_0.xlsx). In general, the figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.
Expected growth in the state civilian labor force	The source is CT Office of Policy and Management, using IHS Markit projections as of May 21, 2020.
Expected national inflation	The source was the most recently published Congressional Budget Office Budget and Economic Outlook, 10-Year Economic Projections (January 2020).[36] The CBO projected the Price Index, Personal Consumption Expenditures (PCE) in its data supplement located here: (https://www.cbo.gov/system/files/2020-01/51135-2020-01-economicprojections_0.xlsx In general, the figure used to calculate PGSP should be the value of the "PCE price index" percentage change from

[35] As of February 9, 2021, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

[36] As of February 9, 2021, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

	year to-year that is forecast for five through 10 years into the future.
Expected state population growth	The source is CT Office of Policy and Management, using IHS Markit projections as of May 21, 2020.

Appendix K:
Statistical Testing to Determine Performance Against the Benchmark

To determine whether an insurer or Advanced Network met or did not meet the benchmark, OHS will conduct hypothesis testing using confidence intervals. OHS will first develop confidence intervals around each insurer and Advanced Network's performance. These confidence intervals indicate the range of reasonable estimates of actual healthcare cost growth. If the 95% percent confidence interval contains the benchmark value, then OHS would not be able to determine that the insurer or Advanced Network's performance is significantly different from the benchmark. However, if the benchmark value lies outside of the 95% confidence interval, OHS would be able to determine that the insurer or Advanced Network either met or exceeded the healthcare cost growth benchmark.

OHS will use average TME PMPY, the number of members/attributed patients, and the standard deviation information TME PMPY costs to calculate the confidence intervals for the following:

- **Per member healthcare cost growth, by line of business, for each insurer.** Each insurer will report the standard deviation by line of business, thus OHS will not need to pool standard deviations.
- Per member healthcare growth, by insurance line of business, for an Advanced Network whose data are listed in multiple insurance carriers' data submission. OHS will pool the standard deviations (i.e., take a weighted average) for each Advanced Network by line of business such that commercial spending has a pooled standard deviation and Medicare Advantage spending has a pooled standard deviation. Then OHS will pool the standard deviations across multiple years within each line of business to calculate the confidence intervals of the Advanced Network's commercial growth. This would be repeated to calculate the confidence interval for the Advanced Network's Medicare Advantage growth.

A. Formulae for Calculating Confidence Intervals

The following describes the formulas needed to pool variances and calculate confidence intervals.

Notations Used in Formulas for Calculating Pooled Variance

Notations	
i	Year index, 1 = prior year, 2 = current year
df	Degrees of freedom
N_i	Population size for year i (or number of member months for year i)
V_i	Variance for year i
σ_i	Standard deviation (when squared it equals variance)
$\bar{X}_i$	Mean per member per month cost for year i (population-level mean)
ρ	Growth target ratio
R_i	Age-sex risk adjustment Score for year i

All standard deviations are age/sex adjusted using the following formula:

$$\sigma_{R_i, X_i} = \frac{\sigma_{X_i}}{R^2_{X_i}}$$

The formula for pooling the variance is as follows:

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

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

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

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

$t_{\widehat{df},0.05}$ = 1.644861 (when using a one-sided test)

B. Sample Calculations Using Mock Data

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

Hypothetical Spending and Variance Data for Insurer A

Year	Paid entity	Market	Average PMPM Spending	Member Months	Standard Deviation
2019	Advanced Network 1	Medicare	$416.67	240,000	$166.67
	Advanced Network 1	Commercial	$666.67	660,000	$250.00
	Advanced Network 2	Medicare	$66.67	93,000	$29.17
	Advanced Network 2	Commercial	$83.33	384,000	$39.59
	Overall	Medicare	$318.92	333,000	$211.93
	Overall	Commercial	$452.11	1,044,000	$292.32
2020	Advanced Network 1	Medicare	$458.33	204,000	$165.71
	Advanced Network 1	Commercial	$650.00	720,000	$375.00
	Advanced Network 2	Medicare	$70.83	72,000	$41.67
	Advanced Network 2	Commercial	$175.00	480,000	$56.25
	Overall	Medicare	$357.24	276,000	$223.47
	Overall	Commercial	$460.00	1,200,000	$426.63

Hypothetical Spending and Variance Data for Insurer B

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

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

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

Medicare spending growth = ($357.25 / $318.92) - 1 = 13.2%

Commercial spending growth = ($460.00 / $452.11) - 1 = 1.3%

Calculating Confidence Intervals for Each Insurer by Market

The confidence intervals for the Insurer's PMPM growth in Medicare spending is calculated as follows:

Confidence Interval for Medicare Growth

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

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

Calculating Confidence Intervals for Each Advanced Network by Market

At the provider level, OHS will calculate growth using only TME. Using the above data, the weighted average of Advanced Network 1's Medicare spending and pooled variance for 2019 and 2020 are calculated as follows:

Advanced Network 1's weighted average PMPM spending for Medicaid:

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

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

Pooled variance for 2019 Medicare:

First section, Second Section

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

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

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

For 2019 Medicare , all sections combined: 24,022.81

Pooled variance for 2020 Medicare:

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

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

For 2020 Medicare , all sections combined: 28,925.95

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

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

$= \frac{182{,}068.19 \pm \sqrt{77{,}702.63}}{168{,}383.94} =$ **8.1 to 8.3**

Thus the growth rate from 2019 to 2020 was 8.1% and the 95% confidence interval range is 8.0% and 8.3%. Therefore, we can say with 95% certainty that Advanced Network 1's growth in Medicaid costs did not meet the cost growth benchmark by growing more than 3.4%. This calculation would then be

repeated for Advanced Network 1's commercial and Medicare Advantage spending.

Appendix L:
Statistical Testing to Determine Performance Against the Benchmark

OHS risk-adjusts total medical expenses (TME) data when evaluating performance against the Cost Growth Benchmark at Insurer and Advanced Network levels. Risk-adjustment is done for age and sex by Insurance Category Code (see **Table L-1** below for Insurance Category Code definitions), using standard weights developed by OHS.

To develop the weights, OHS collects TME data and member months data by age/sex bands (see **Table L-2** below for age bands) at the Insurer overall and Advanced Network levels and calculates two set of weights for each Insurance Category Code (one set at the Insurer level and one set at the Advanced Network level).[37] These standard weights are applied uniformly across all Insurers and Advanced Networks respectively within each Insurance Category Code.

This section outlines how OHS calculates standard weights and develops Insurer and Advanced Network-specific age/sex risk scores.

A. Calculation of Standard Weights

For each Insurance Category Code, using base year data (for the 2021-2022 analysis, this would be 2021 data):

- OHS calculates the statewide claims-based, truncated TME (see **Table L-3** below for truncation points) and member months within each age/sex band by combining data across Insurer submissions. Non-claims-based spending is **NOT** included in this calculation.

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[37] OHS calculates two sets of weights (one set at the Insurer level and one set at the Advanced Network level) because for members who are attributed to more than one Advanced Network during the year, insurance carriers "reset the clock" and calculate truncated spending for the member for each of the Advanced Networks, and for the Insurer as a whole, which may result in different truncated spending amounts.

- OHS then calculates statewide per member per month (PMPM) spending for each age/sex band by taking the statewide claims-based, truncated TME and dividing it by the statewide member months.
- To calculate standard weights for each age-sex band, OHS takes the PMPM spending for an age-sex band and divides by overall PMPM spending.
- This is conducted at the Insurer and at the Advanced Network level (note that spending data at the Insurer and Advanced Network levels do not necessarily align due to the "reset the clock" approach for truncating claims).

B. Calculation of Insurer Risk Scores

OHS calculates a risk score for each Insurer being reported on, stratified by Insurance Category Code. To do this, using Insurer level data for each Insurance Category Code:

- OHS calculates the population distribution of attributed members across age/sex bands for each Insurer. This is done by taking the member months for each age/sex band and dividing it by the member months for the Insurer.
- OHS then multiplies the standard Insurer weights for the age-sex band calculated in **Section A** above to the respective population distribution.
- OHS then sums the values calculated above across age/sex bands for Insurer. This is the Insurer's risk score for the specific Insurance Category Code.

C. Calculation of Advanced Network Risk Scores

Within each Insurer's submission, OHS calculates a risk score for each Advanced Network being reported on, stratified by Insurance Category Code. To do this, within an Insurer submission, for each Insurance Category Code:

- OHS calculates the population distribution of attributed members across age/sex bands for the Advanced Network. This is done by taking the member months for each age/sex band and dividing it by the member months for the Advanced Network.
- OHS then applies the standard Advanced Network weights for the age-sex band calculated in **Section A** above to the respective population distribution.
- OHS then sums the values calculated above across age/sex bands for each Advanced Network. This will be the Advanced Network's risk score for the specific Insurance Category Code.

D. Application of Insurer and Advanced Network Risk Scores to Spending Data

To calculate the age/sex risk-adjusted spending for each Insurer, OHS divides the unadjusted, truncated claims spending for the insurer overall by Insurance Category Code by the Insurer risk scores developed in **Section B** above and adds its respective non-claims spending. To calculate the age/sex risk-adjusted spending for each Advanced Network, within each Insurer's submission for each Insurance Category Code, OHS divides the unadjusted, truncated claims spending for each Advanced Network by the Advanced Network's risk score developed in **Section C** above and adds its respective non-claims spending. OHS does not sum risk-adjusted Advanced Network level spending to derive risk-adjusted Insurer level spending, as this approach does not take into account the "reset the clock" methodology for truncated spending.

Table L-1. Insurance Category Code Definitions for TME Reporting

Insurance Category Code	Definition
1	Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)
2	Medicaid including CHIP (excluding Medicare/Medicaid Dual Eligibles)
3	Commercial — Full Claims
4	Commercial — Partial Claims
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles
6	Medicaid Expenditures for Medicare/Medicaid Dual Eligibles
7	Other

Table L-2. Age Bands

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

Table L-3. Truncation Points for Insurer and Advanced Network Claims Expenses [38]

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare Expenses for Non-Dual Eligible Members	$150,000
2	Medicaid Expenses for Non-Dual Eligible Members	$250,000
3	Commercial: Full Claims	$150,000
4	Commercial: Partial Claims	$150,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$150,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$250,000

[38] For members who are attributed to more than one Advanced Network during the year, insurance carriers are asked to "reset the clock" and calculate truncated spending for the member for each of the Advanced Networks and for the Insurer as a whole. This is done by first calculating the member's total spending that is attributed to each Advanced Network, and then separately applying truncation to the member's spending that is attributed to each Advanced Network.