Oregon Cost Growth Target Program
2024 Data Submission Training

June 10, 2024

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET

Housekeeping

This training is being recorded, and the recording will be posted on the CGT Data Submission webpage.

Virtual Meetings:

- Please list your first and last name and organization when you log in
- There will be space for questions throughout the presentation and at the end

Training Purpose

Audience

Technical staff (of payer/data reporter organizations) who will be compiling and submitting the CGT-1 data files to OHA by September 6, 2024

Purpose

Provide an overview of technical submission requirements for the Oregon Cost Growth Target Program's annual data submission

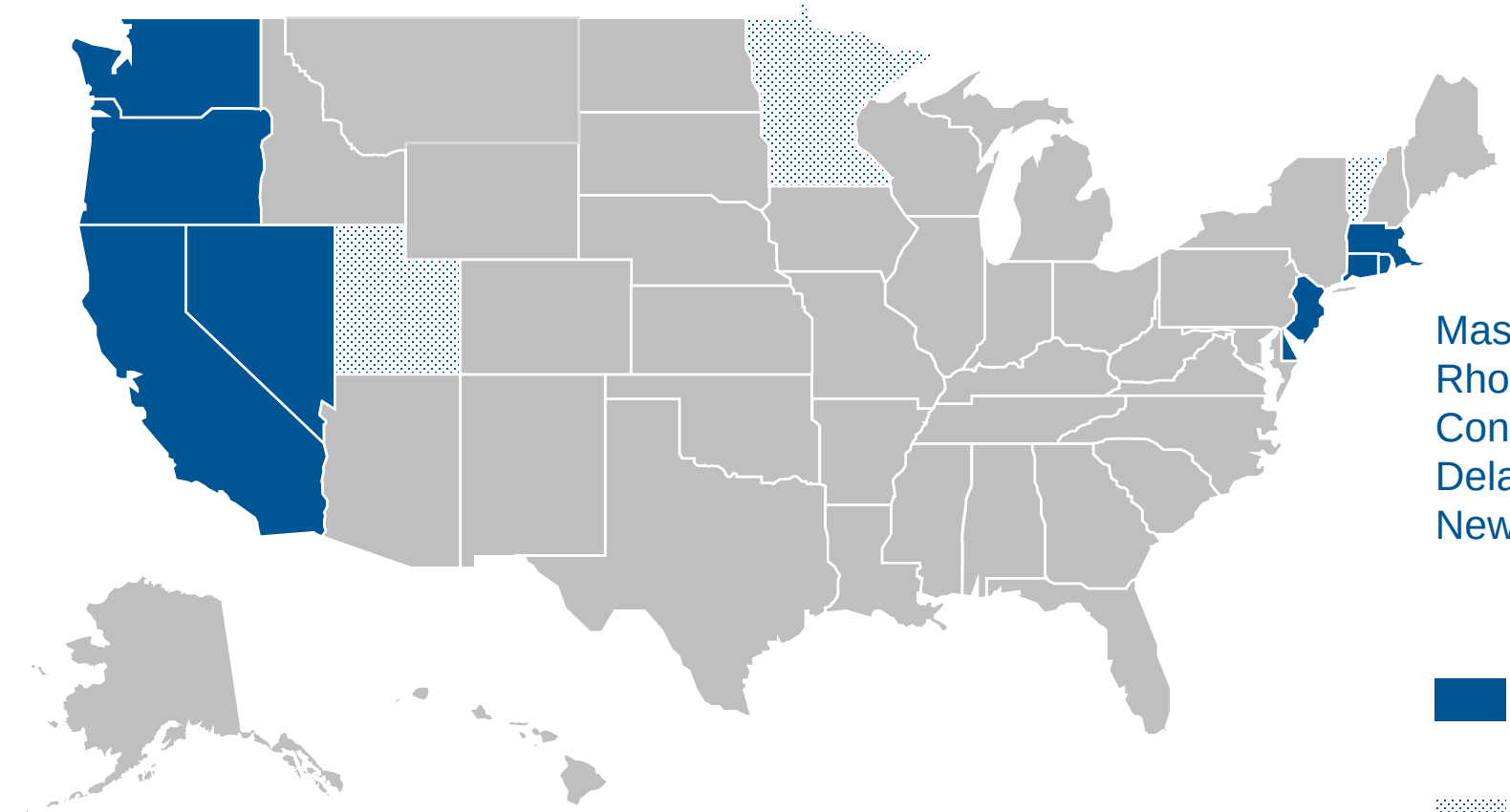
Call attention to areas where payers are able to customize their data wrangling and areas where all payers must be standardized

Agenda

- Overview of program
- File submission schedule
- Overview of data captured
- Data Submission Template
- Data Specification Manual
- Data collection + validation process
- Contact information + resources

Overview of program

Oregon was the 4th state to establish a statewide health care cost growth target program



Massachusetts
Rhode Island
Connecticut
Delaware
New Jersey

States with a cost growth target program

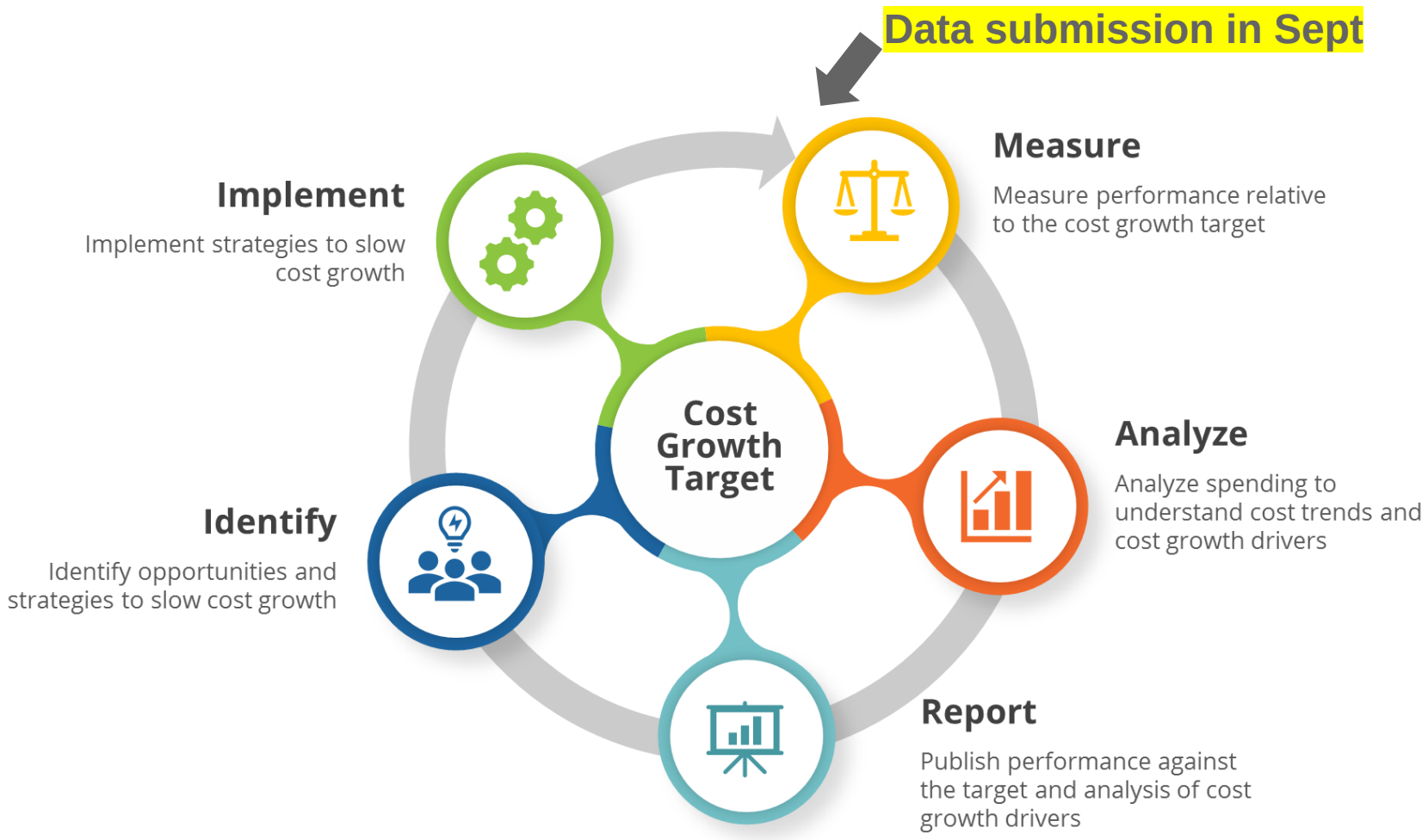
States that are considering a cost growth target

Oregon's Sustainable Cost Growth Target Program

- Established by Oregon Senate Bill 889 (2019); ORS 442.385, 442.386
  - Initial groundwork laid through SB419 (2017) Joint Interim Task Force on Health Care Costs (started with hospital rate setting)
  - Purpose is to create a more affordable and sustainable health care system in Oregon through transparency, a sustainable growth target, total cost of care approach, and a common goal
- Implementation Committee's final recommendations report was submitted to the OR Legislature Jan 2021
- Background and additional resources available online
  - https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

Oregon's cost growth target says that total health care spending should not grow more than 3.4% each year.

Annual Cost Growth Target Program Cycle



Annual CGT-1 file submission schedule

Due Date	Annual Data Submission
Sep 6, 2024	CY 2022 and 2023 TME
Sep 5, 2025	CY 2023 and 2024 TME
Sep 4, 2026	CY 2024 and 2025 TME

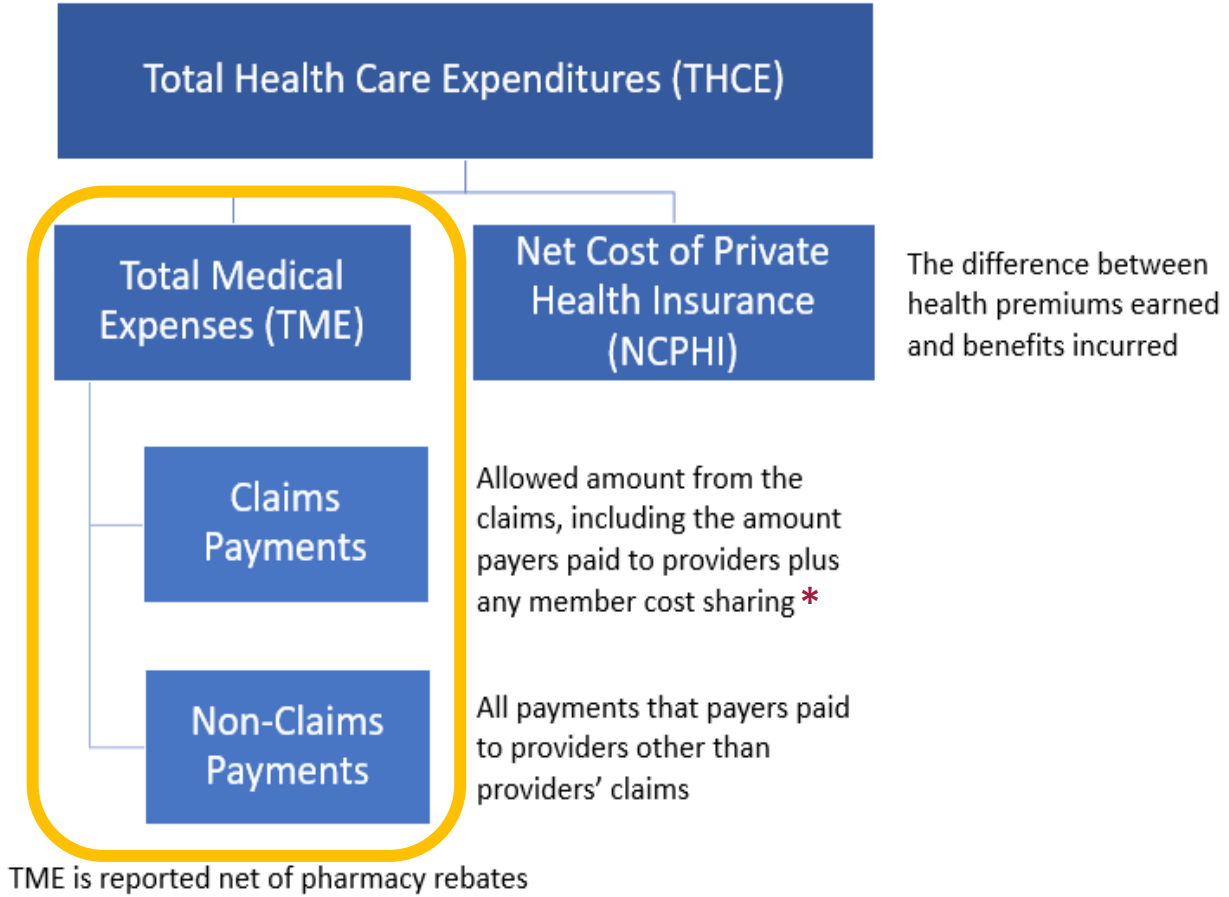
Files are due by the first Friday in September

Overview of data captured

Overview of data captured

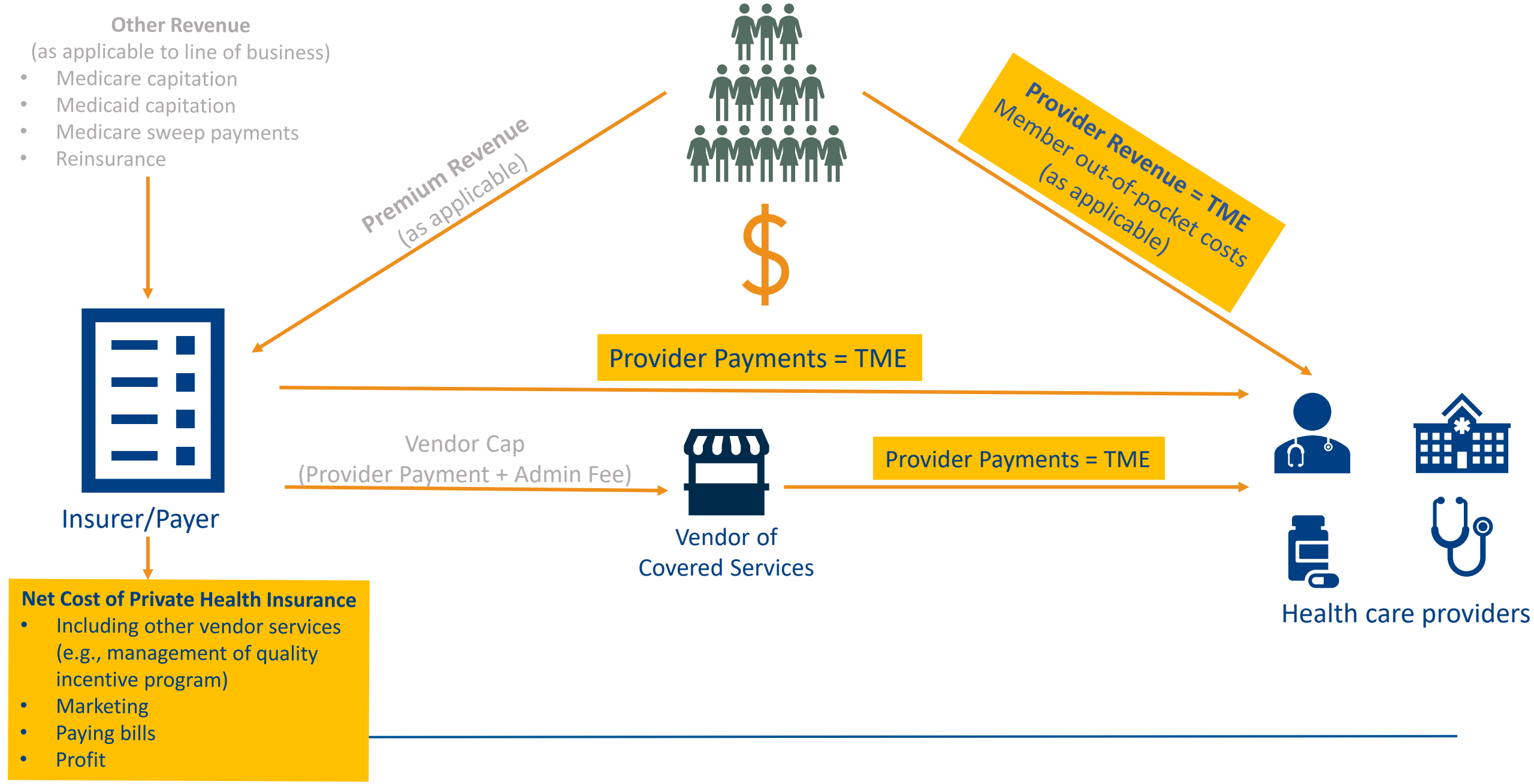
Data reporters (public and private payers) are submitting Total Medical Expenses (TME) using the excel-based Data Submission Template (CGT-1)

TME is a component of Total Health Care Expenditures (THCE)



** When reporting dual member spending, report on a Paid Amount basis*

The Relationship Between Health Insurance Revenue and Total Medical Expense

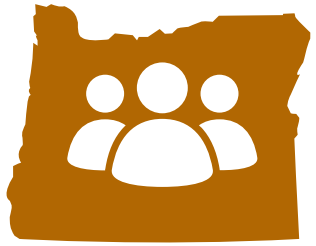


Overview of data captured

Include payment data for the following population…

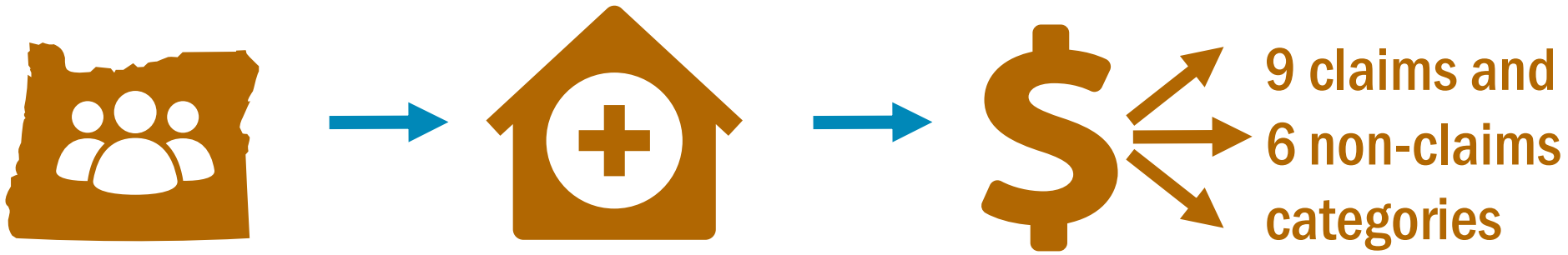
- Oregon residents who are insured (and payer is primary payer*) by…
- Medicare, Medicaid, or commercial insurance and
- received care from any provider in or outside of Oregon

Do not include out-of-state residents who receive care from Oregon providers



* Dual member caveat: payers should report dual spending on a Paid Amount basis regardless of whether they are the primary or secondary payer

Overview of data captured



Attribute members to provider entity using primary care-based methodology

Allocate spending amongst mutually exclusive payment categories to provider entities

Data Submission Template

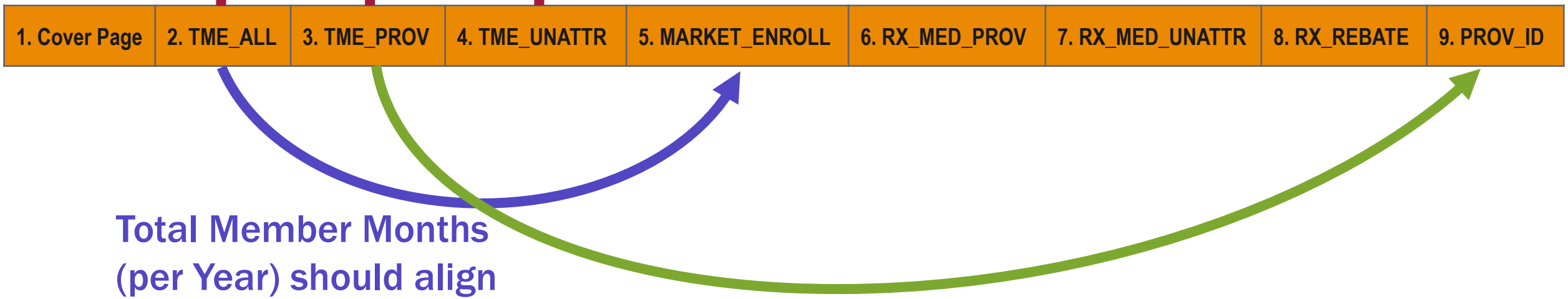
CGT-1

Data Submission Template structure

	Tab Name	Contents
	1. Cover Page	Payer info and data submission confirmation
TME data	**2. TME_ALL**	Total Medical Expenses for all of the payer's members by line of business, **regardless of attribution**.
TME data	**3. TME_PROV**	Total Medical Expenses for all of the payer's member months who **are attributed** to provider organizations. Data reported by line of business and by provider organization.
TME data	**4. TME_UNATTR**	Total Medical Expenses for all of the payer's member months who **are not attributed** to any provider organization. Data reported by line of business only.
	5. MARKET_ENROLL	Payer's member months by market segments.
New tabs	**6. RX_MED_PROV**	Claims expenses for medical pharmacy services for members who can be attributed to a provider organization. Data reported by line of business and provider organization
New tabs	**7. RX_MED_UNATTR**	Claims expenses for medical pharmacy services for members that are not attributed to a provider organization. Data reported by line of business only.
	6. RX_REBATE	Pharmacy rebates data by line of business.
	7. PROV_ID	Identifier for provider organizations using federal taxpayer ID number (TIN)
	Line of Business Code	Lookup Table for Line of Business Code for Tab 2-4, and 6
	Attribution Hierarchy Code	Lookup Table for Attribution Hierarchy Code for Tab 3. TME_PROV
	Demographic Tables	Demographic adjustment factors by age bands, sex, and line of business
	TME Validation	Three validation tables to show 1) the number of rows with 0 member month in TME_PROV, 2) the difference of member months and dollars between TME_ALL and TME_PROV + TME_UNATTR, 3) the difference of demographic scores between TME_ALL and TME_PROV + TME_UNATTR, and 4) the difference of member months between TME_ALL and MARKET_ENROLL.
	Provider Check	Validation table to check if all the provider organization names in TME_PROV are in PROV_ID.
	Demographic Scores for Validation	Demographic scores from TME_ALL and TME_PROV to produce the table in TME_Validation

Inter-tab data

For multiple variables,
Tab 2 = Tab 3 + Tab 4 (per unique year and line of business combo)



Total Member Months (per Year) should align

Each unique provider org in tab 3 must also exist in tab 9

Walk-through of the CGT-1 file

Switch presenter view to screenshare CGT-1 template

- This CGT-1 excel with mock data will be posted online under the Training slides

Slides 19-40 of this slide deck can be viewed later for more detail

Tab 1. Cover Page

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Includes payer's name and contact information, information about risk adjustment software used, information about data completeness, and estimates applied to the data.

Payers will also answer questions to confirm that their data submission follows the specifications and that are sound and correct.

Tabs 2-4, TME tabs: variations on a theme

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Tab 2 = Tab 3 + Tab 4

#	Tab Name	Includes
2	TME ALL– All	Total Medical Expenses for all of the payer's member months by line of business, regardless of attribution tier.
3	TME PROV – Attributed to Provider Organizations	Total Medical Expenses for all of the payer's member months who are attributed to provider organizations (see Attribution section above). Data reported by line of business and by provider organization and attribution tier.
4	TME UNATTR – Unattributed Members	Total Medical Expenses for all of the payer's member months who are not attributed to any provider organization. Data reported by line of business only.

Tabs 2-4, TME tabs: data elements

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 - 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields

Data field TMEPRV03 Provider Organization Name value must also be present in tab 7. PROV_ID

Tabs 2-4, TME tabs: data elements

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV05	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 – 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields

No provider org data elements

Tabs 2-4, TME tabs: data elements

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 – 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields

No provider org data elements

N/A

Tabs 2-4, TME tabs: data stratification

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 - 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields
2022	**1**	**Physician Practice X**	Total Cost of Care Contract A	**1**	…	…	…	…	…	…
2022	**1**	**Physician Practice Y**	Total Cost of Care Contract A	**1**	…	…	…	…	…	…
2022	**1**	**Physician Practice X**		**1**	…	…	…	…	…	…
2022	**2**	**Physician Practice X**		**1**	…	…	…	…	…	…
2022	**1**	**Physician Practice X**		**2**	…	…	…	…	…	…
2022	**3**	**Total Cost of Care Contract B**	Total Cost of Care Contract B	**2**	…	…	…	…	…	…

Tabs 2-4, TME tabs: data stratification

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV15 – 23	TMEPRV24	TMEPRV25 – 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields
2022	**1**									
2022	**3**									
2023	**1**									
2023	**3**									

Tabs 2-4, TME tabs: data stratification

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 – 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields
2022	**1**									
2022	**3**									
2023	**1**									
2023	**3**									

Tabs 2-4, TME tabs: Line of business

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

See Manual pages 43-44

Line of Business Code	Description
1	Medicare
2	Medicaid
3	Commercial: Full Claims
4	Commercial: Partial Claims
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible

Members may change their lines of business from one to another within a calendar year. In this case, member months are allocated based on the number of months associated with each of the business lines, and their TME data are mutually exclusively allocated to each of the business lines based on the respective member months.

All payers (whether primary or secondary) should report for **dual eligible LOBs 5** (Medicare-expenses) **and 6** (Medicaid expenses) using **Paid Amounts.**

- All other LOBs use Allowed Amounts
- Medicaid CCOs who are the ***secondary*** payer for duals should report spending

Tabs 2-4, TME tabs: Claims by service categories

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Report original amounts, not demographic-adjusted amounts

To avoid double counting, all categories must be mutually exclusive. OHA may request additional information regarding how payers mapped their data into these categories to improve consistency in reporting across all payers.

Payers must report the following 9 individual claims service categories:

- Hospital Inpatient
- Hospital Outpatient
- Professional, Primary Care Providers
- Professional, Specialty Providers
- Professional, Behavior Health Providers
- Professional, Other Providers
- Long Term Care
- Retail Pharmacy
- Other

See Manual pages 37-40 for more category details.

Tabs 2-4, TME tabs: Non-claims payment categories

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Non-claims payments are all payments payers make to providers *outside of claims*.

Payers must report the following 6 individual non-claims payment categories:

- Non-Claims: Prospective Payments
- Non-Claims: Performance Incentive Payments
- Non-Claims: Payments to Support Population Health and Practice Infrastructure
- Non-Claims: Provider Salaries
- Non-Claims: Recovery
- Non-Claims: Other

See Manual pages 41-42 for more category details.

Tabs 3-4, TME tabs: Standard deviation

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

- For OHA to conduct the statistical confidence calculations, payers will need to report information about the distribution of costs associated with their enrollees (i.e., demo-adjusted standard deviation (SD) of PMPM per row in tabs 3-4)
  - Note: this calculation *does not* include dollars from non-claims categories
- Instructions are provided on **Manual pages 43-45**
- Additional resources are
  - A full description of OHA's statistical methodology (PDF)
  - Supplemental SD Calculation (XLSX)

Tabs 3-4, TME tabs: Standard deviation

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Step 1: Attribute members (and their expenses) to the appropriate provider organization

- Note: a member could be attributed to one provider organization from January to July, and a different provider organization from August to December.

Step 2: : For each line of business, for each provider organization, and for each attribution hierarchy, calculate the average per month amount for each member and apply member-specific risk adjustment – this is x_i

Step 3: Use the risk-adjusted per month average for each individual and multiply that value by the number of enrolled months for that member. Sum the values for all members and divide by the total number of member months to produce a risk-adjusted per member per month dollar amount that is specific to a given line of business, provider organization, and attribution hierarchy – this is $\bar{x}$

Step 4: Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, data submitters can calculate the risk-adjusted standard deviation of the PMPM costs for a given line of business, provider organization, and attribution hierarchy.

Step 5: report the STDEV values in tabs 3 (attributed members' data) and tab 4 (unattributed members' data)

Tabs 3-4, TME tabs: Standard deviation

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Walk-through of Supplemental Standard Deviation Calculation (XLSX)

- Instructions are provided on **Manual pages 43-45**
- Additional resources: a full description of OHA's statistical methodology (PDF); Supplemental SD Calculation (XLSX)

Tab 5. Market enrollment

Manual page 46

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Member Months (annual) are 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 reported across the following markets:

1. Large group fully insured (51 + employees)
2. Small group fully insured (2 – 50 employees)
3. Self-insured
4. Individual
5. Student plans
6. Medicare Advantage
7. Medicaid Managed Care
8. Medicare Medicaid duals

Tab 6. Medical pharmacy (attr) NEW

Manual page 47

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Beginning with the 2024 data submission cycle, OHA is requiring payers to provide an additional breakout of total medical expenses for medical pharmacy claims, to allow the State, payers, and provider organizations to track what proportion of spending is going to ***drugs administered or provided in a clinical setting.***

Data submitters can filter their medical claims for claim lines that meet any of the following criteria:

- Any lines that have a valid/non-null **National Drug Code (NDC) value** on them should be included, if that is a field available in the data submitter's system; or
- Any lines with a **CPT/HCPCS code** that matches the list provided by OHA as a supplement to the data manual (Appendix E, a supplemental file on the data submission website); or
- Any lines with a **revenue code** of 025x, 063x, 086x, 0343,0344, 0262, or 0547 that also have a null CPT/HCPCS code.

Tab 7. Medical pharmacy (unattr) NEW

Manual page 47

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Same data pull as Tab 6. (RX_MED_PROV) only spending is not stratified by provider entity.

There is no change in reporting for tabs 3-4 (TME_PROV & TME_UNATTR). Tabs 3-4 should be fully representative of all claims in each of the subcategory, while the data in Tabs 6-7 will be used to examine medical pharmacy costs and cost growth in more detail.

Tab 8. Pharmacy rebates

Manual page 48-50

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

The pharmacy rebates data are the source of the payers' pharmacy rebates at state, market, and payer levels. Report data by line of business.

- Payers may report rebates to the provider entity level if data is available (see **Manual pages 48-50**)

Total rebates should be reported without regard to how they are paid to the payer (e.g., through regular aggregate payments, on a claim-by-claim basis, etc.). Pharmacy rebates should be reported as a *negative number*.

Amounts shall include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

Medicaid CCOs: for Medicaid, OHA will be reporting pharmacy rebates and will apply these at the Medicaid market level.

Tab 8. Pharmacy rebates

Manual page 48-50

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Payers should report both retail pharmacy rebates and medical pharmacy rebates.

Retail Pharmacy: the estimated value of rebates attributed to Oregon residents provided by pharmaceutical manufactures for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair market value bona fide service fees *for retail prescription drugs.*

Medical Pharmacy: the estimated value of rebates attributed to Oregon residents provided by pharmaceutical manufactures for prescription drugs with specified dates of fill corresponding with the reporting period, excluding manufacturer-provided fair market 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.

Tab 8. Pharmacy rebates

Manual page 48-50

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

If data submitters are unable to separate out retail and medical pharmacy rebates for reporting, report all pharmacy rebates in aggregate in the optional field RXR05

Rebate estimation: if necessary, payers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the reporting period.

- If payers are unable to report rebates specifically for Oregon residents, payers should report estimated rebates attributed to Oregon residents, see Manual page 56

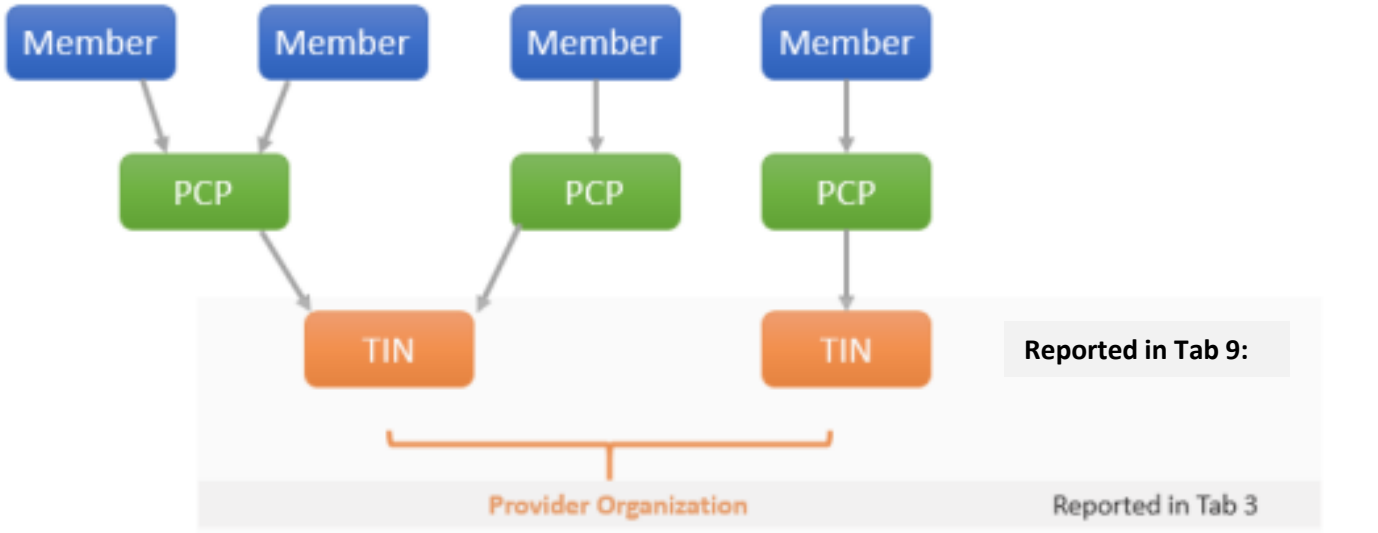
Rebates to employers: some self-funded employer groups ask for portions of the rebates to be passed along to them. Payers should report any rebates they receive, regardless of whether they are passed along to employers.

Tab 9. Provider Organization Identifier

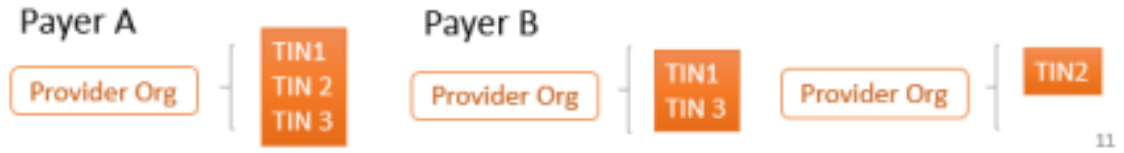
1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

To assist with matching provider organizations across multiple payer data submissions, Tab 9 collects multiple identifiers (taxpayer identification numbers, TINs) for provider organization names present in Tab 3

Overall:



In Tab 9:



Tab 9. Provider Organization Identifier

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_MED_PROV	7. RX_MED_UNATTR	8. RX_REBATE	9. PROV_ID

Suppose in 2022, Physician Practice X had 3 TINs associated with its various sites of services of business entities.

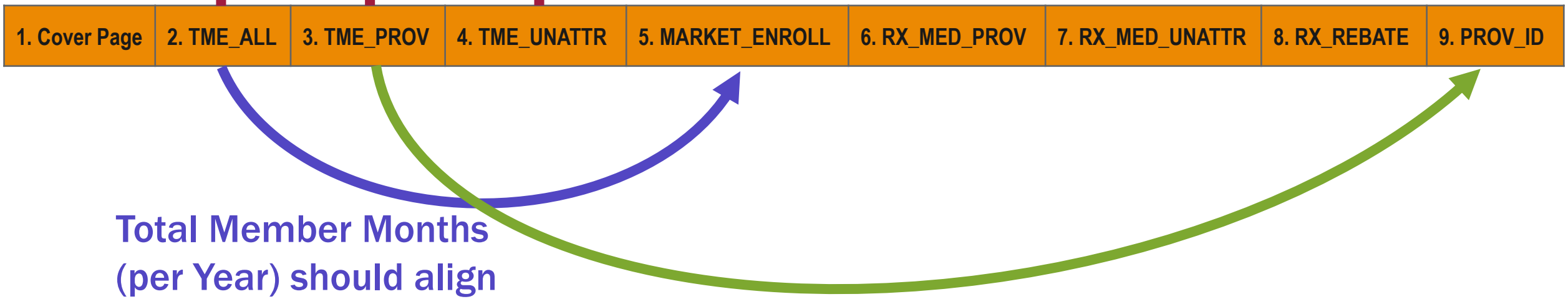
Payer will report Physician Practice X and associated TINs in Tab 9 like so:

PRV01	PRV03	PRV02
free text	free text	text, 9 digits including leading zero
Provider Organization Name	**IPA or Contract Name (If applicable/available)**	**Provider Organization TIN**
Physician Practice X	Total Cost of Care Contract A	000000001
Physician Practice X	Total Cost of Care Contract A	000000002
Physician Practice Y	Total Cost of Care Contract A	000000004
Physician Practice X		000000001
Physician Practice X		000000002
Physician Practice X		000000003
Physician Practice Y		000000004
Total Cost of Care Contract B	Total Cost of Care Contract B	000000008

Inter-tab data

For multiple variables,

Tab 2 = Tab 3 + Tab 4 (per unique year and line of business combo)



Total Member Months (per Year) should align

Each unique provider org in tab 3 must also exist in tab 9

Data Specification Manual

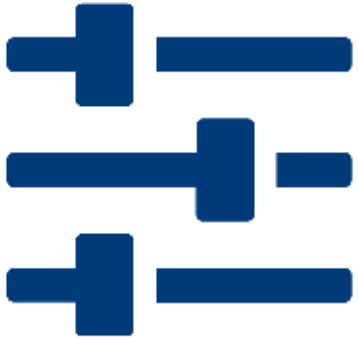
CGT-2

Data Specifications

This manual provides the technical specifications to assist payers in preparing the annual health care cost growth target data submission.

- An overview of how the cost growth target will be calculated at each of the four levels and the data sources for each
- A description of which payers need to report and sources for other data
- Submission timeline and process
- Data submission template field descriptions and specifications for inclusion/exclusion
- Appendices including a data dictionary and provider taxonomy codes

Standardization or Payer Customization



Payers must follow the specifications for the data submission outlined in this document to ensure a standardized approach; however, there are several places where payers have flexibility in how they prepare the data for submission. These opportunities for customized approaches recognize the systems payers use to report and analyze data vary and are indicated throughout this document with this icon.

Primary care-based member attribution hierarchy

Manual pages 5-12

Member Attribution Hierarchy	Tier description
Tier 1	**Member selection**: Members who were required to select a primary care provider or a primary care home by plan design should be assigned to that primary care provider's organization.
Tier 2	**Contract arrangement**: Members not included in #1 who were attributed to a primary care provider or a primary care medical group during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care provider's highest-level accountable entity. If the contracted entity is an IPA that does not provide primary care services, then the payer should attempt to re-attribute to an entity who provides the primary care. 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 #1 or #2 who can be attributed to a primary care provider or a primary care home based on the member's utilization, using the payer's own attribution methodology. Utilization-based attribution methods should only attribute each member month and associated costs to one provider organization at a time. Payers should attempt to align utilization-based algorithms with reporting on attributed populations that has been shared with provider organizations wherever possible. Payers who use tier 3 must provide a summary of their methodology in Tab 1. COVER_PAGE.

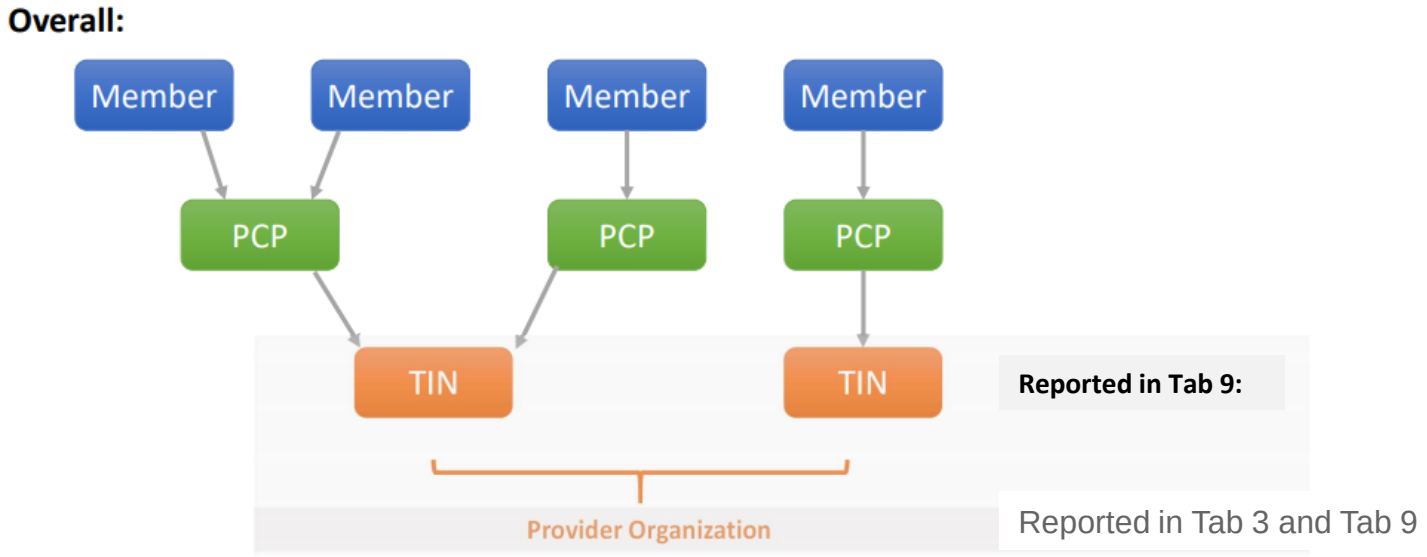
Members who cannot be attributed to primary care providers or a primary care home using any of the three tiers above should be reported in aggregate in tab 4. TME_UNATTR

Primary care-based member attribution hierarchy

Manual pages 5-12

Provider organizations will have TIN(s) associated with their practice or organization, and large health systems or other provider organizations may have multiple TINs.

The collection of this data is included in the Data Submission Template (tab 9) and covered elsewhere in the presentation.



IPA and contract group attribution

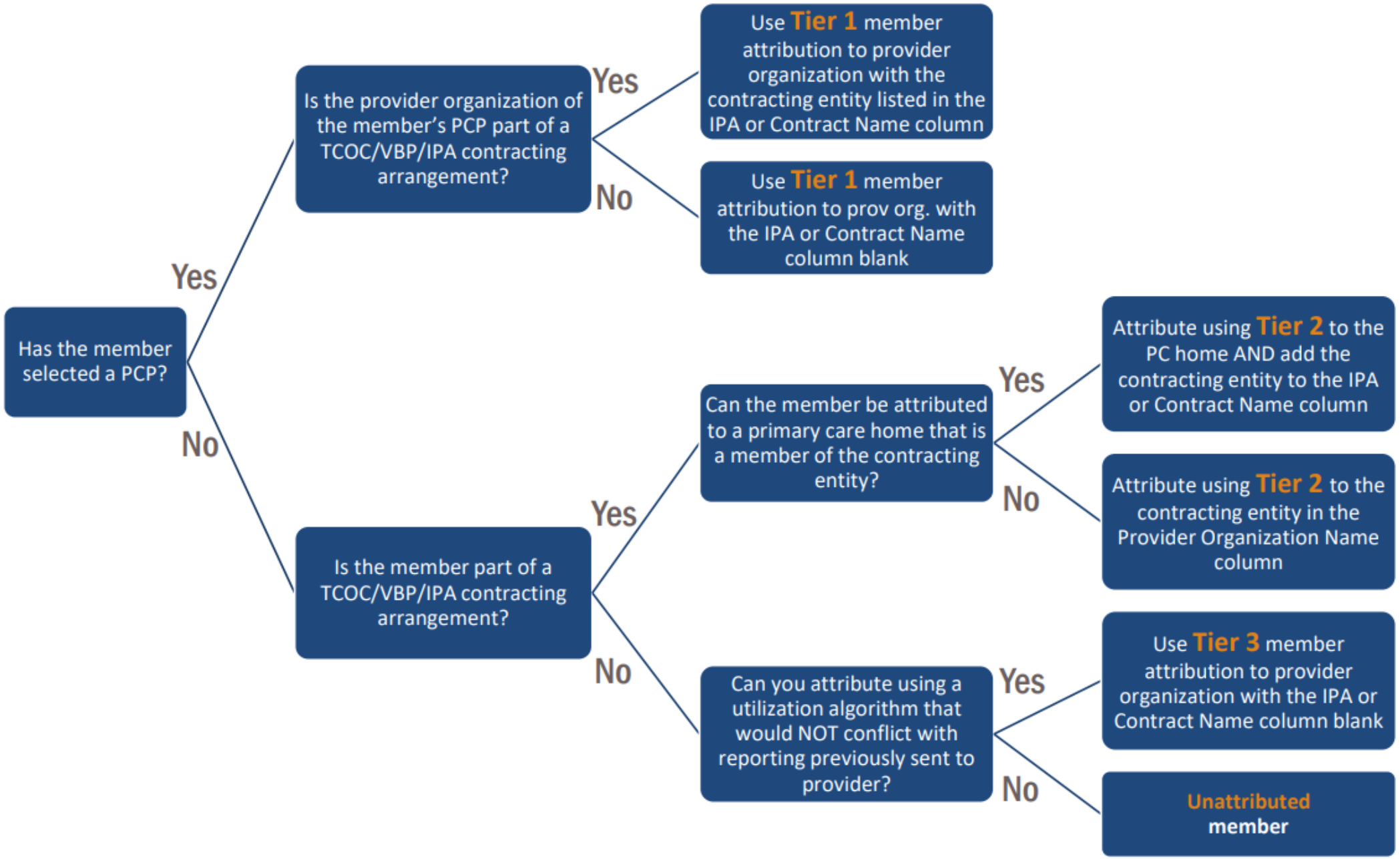
Manual pages 9-11

In some cases, a provider organization may be a part of a larger umbrella organization or entity, such as in the case of independent physician associations (IPAs) or a total cost of care (TCOC) contract. If such affiliations are known to the data submitter, they can be detailed in the data submission template through the IPA or Contract Name field.

Filling out this field is encouraged if the payer has the data to do so, as it will allow OHA to break down costs by either the larger umbrella organization/contract or the participating entity depending on the specifics of the arrangement. *Filling out this field may help prevent the need for resubmissions to break down costs to the sub-organizations or provide detail about the umbrella organization/contract later on.*

Appendix D: Attribution and Contracting Diagram

Link



Snapshot tab 3. TME_PROV example showing *Provider Org name* and/or *IPA or Contract Name*

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 - 30
Year	Code	free text, blank is not allowed	free text, blank allowed	Code	positive integer	non-negative number	non-negative number	---	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	IPA or Contract Name (If applicable/available)	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation PMPM	Auto-calculated fields
2022	**1**	**Physician Practice X**	Total Cost of Care Contract A	**1**	…	…	…	…	…	…
2022	**1**	**Physician Practice Y**	Total Cost of Care Contract A	**1**	…	…	…	…	…	…
2022	**1**	**Physician Practice X**		**1**	…	…	…	…	…	…
2022	**2**	**Physician Practice X**		**1**	…	…	…	…	…	…
2022	**1**	**Physician Practice X**		**2**	…	…	…	…	…	…
2022	**3**	**Total Cost of Care Contract B**	Total Cost of Care Contract B	**2**	…	…	…	…	…	…

Demographic adjustment

Manual pages 12-14

- Payers should use OHA-provided statewide demographic factors to calculate and report demographic score and demographic-adjusted standard deviation PMPM in TME tabs
- Demographic score reference tables provided in CGT-1 template in tab "Demographic tables"

Medicare and Duals - LoB 1, 5, 6		
Sex	Age Band	Factor
M	0-1	8.765
	2-18	5.769
	19-39	1.089
	40-54	1.433
	55-64	1.386
	65-74	0.764
	75-84	1.119
	85+	1.377
F	0-1	8.765
	2-18	5.392
	19-39	1.338
	40-54	1.580
	55-64	1.514
	65-74	0.789
	75-84	1.062
	85+	1.302

Medicaid - LoB 2		
Sex	Age Band	Factor
M	0-1	0.677
	2-18	0.441
	19-39	0.865
	40-54	1.612
	55-64	2.548
	65-74	2.246
	75-84	1.962
	85+	2.579
F	0-1	0.593
	2-18	0.419
	19-39	1.132
	40-54	1.667
	55-64	2.385
	65-74	1.736
	75-84	1.544
	85+	2.654

Commercial - LoB 3, 4		
Sex	Age Band	Factor
M	0-1	1.011
	2-18	0.451
	19-39	0.494
	40-54	0.934
	55-64	1.691
	65-74	2.724
	75-84	5.493
	85+	4.667
F	0-1	0.857
	2-18	0.442
	19-39	0.969
	40-54	1.295
	55-64	1.728
	65-74	2.701
	75-84	5.704
	85+	5.163

Resources for calculating demographic-adjusted standard deviation:

- Instructions are provided on **Manual pages 43-45**
- Additional resources: a full description of OHA's statistical methodology (PDF); Supplemental SD Calculation (XLSX)

TME inclusion/exclusions

Manual pages 17-18

Included and excluded lines of business

- Medicaid CCO-specific guidance, page 18

Table 5 lists items that payers should exclude from TME. This is a non-exhaustive list and if there are other items that payers are not sure about whether to include or exclude in the cost growth target data submission, payers should contact OHA at HealthCare.CostTarget@oha.oregon.gov to discuss.

Table 5. Excluded Items

Discounts and other member perks, such as gym membership benefits
Payer reinsurance recoveries or reinsurance premiums
CMS reconciliation payments, such as Medicare sweep or Part D
Premiums
ACA risk transfer payments
COVID-related funds that are *not* paid to providers[2]

Data completeness

Manual page 19

- Allow for 180 day run-out period after Dec 31 of the measurement year
- Reported based on the incurred date or date of service, not the paid or reconciled date.

Claims completeness

Payers should report their overall completeness of the claims data in Tab 1 Cover Page. If completeness of the claims data drops below 98%, OHA reserves the right to request payers to calculate IBNR and/or provide supplemental information.

Non-claims estimation

- Payers should apply reasonable and appropriate estimations of non-claims liability for each provider organization (including payments expected to be made to organizations not separately identified in the reporting) that are expected to be reconciled after the 180-day reconciliation period. OHA may request additional detail from payers about their estimations.

Carved-out services and vendor payments

Manual page 21

Payers should follow the general parameters below but are given flexibility in how they account for these costs because of the different approaches in how payers identify and allocate these costs.

- Spending for covered benefits should be included in the TME calculation, regardless of how the payer is delivering the benefits. If a payer is unable to determine the total spending by service category for carved-out benefits, and…
    - …has encounter data, the payer should estimate payments and include them in the TME calculation allocated to the appropriate service category.
    - …does not have access to claims or encounter data for carved-out services, the payer should apply a reasonable estimate of spending per member per service category and describe how they calculated the estimate in Tab 1 of their data submission.

Carved-out services and vendor payments

Manual page 21

- Spending on the administrative fees of carved-out vendor contracts should be included or excluded in accordance with payer reporting on federal financial forms such as the NAIC Medical Loss Ratio form.
- Spending for contracts and vendors that provide strictly administrative functions for health plan operations should not be included in the TME calculation.

NEW! Medical pharmacy

Manual page 47

Payers should follow methodology outlined in the manual. Briefly, Data submitters can filter their medical claims for claim lines that meet any of the following criteria:

- Any lines that have a valid/non-null **National Drug Code (NDC) value** on them should be included, if that is a field available in the data submitter's system; or
- Any lines with a **CPT/HCPCS code** that matches the list provided by OHA as a supplement to the data manual (Appendix E, a supplemental file on the data submission website); or
- Any lines with a **revenue code** of 025x, 063x, 086x, 0343,0344, 0262, or 0547 that also have a null CPT/HCPCS code.

There is no change in reporting for tabs 3-4 (TME_PROV & TME_UNATTR). Tabs 3-4 should be fully representative of all claims in each of the subcategory, while the data in Tabs 6-7 will be used to examine medical pharmacy costs and cost growth in more detail.

Data collection + validation process

Data collection

Email CGT-1 excel files to the CGT program inbox by **Fri Sept 6, 2024**

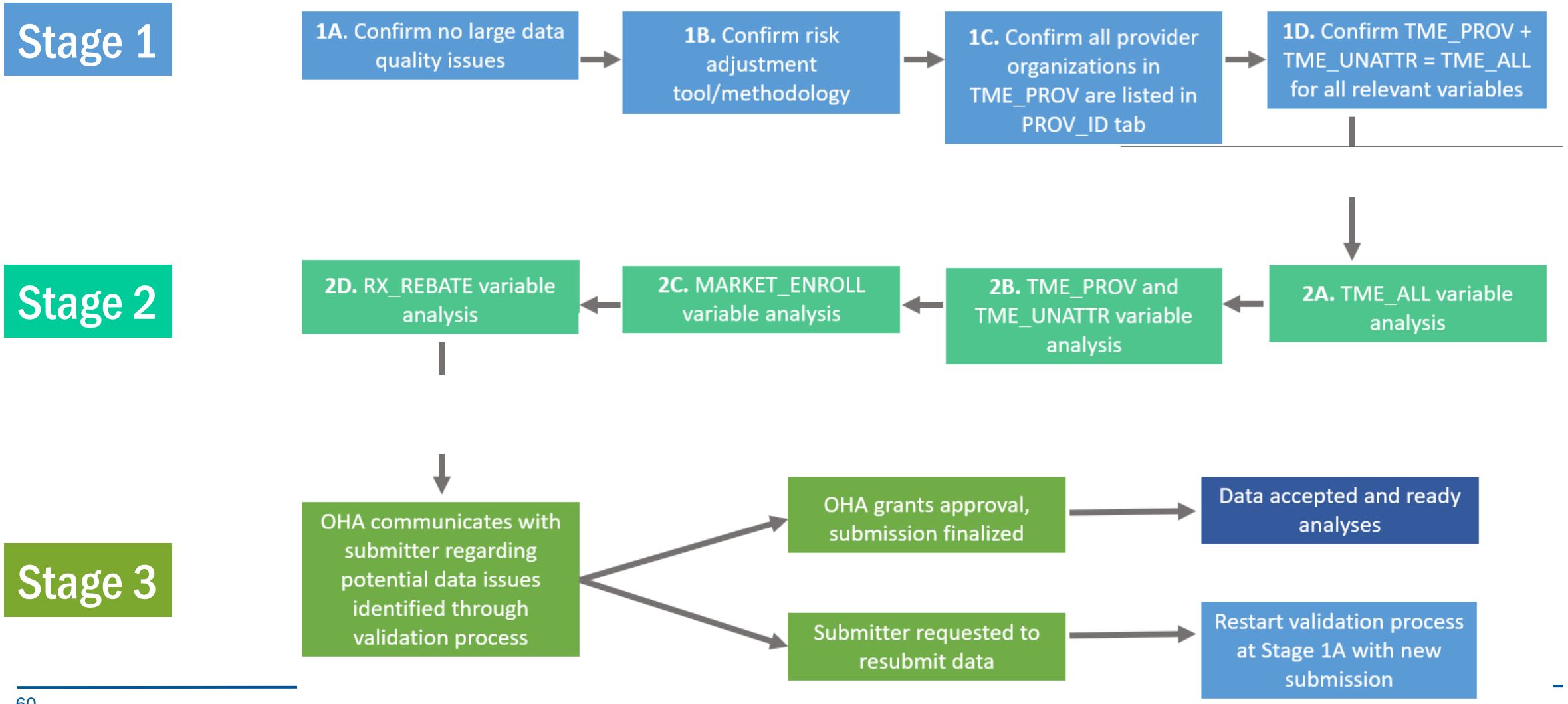
- *HealthCare.CostTarget@oha.oregon.gov*
- For file naming convention and other submission process topics see Manual page 24

Data validation

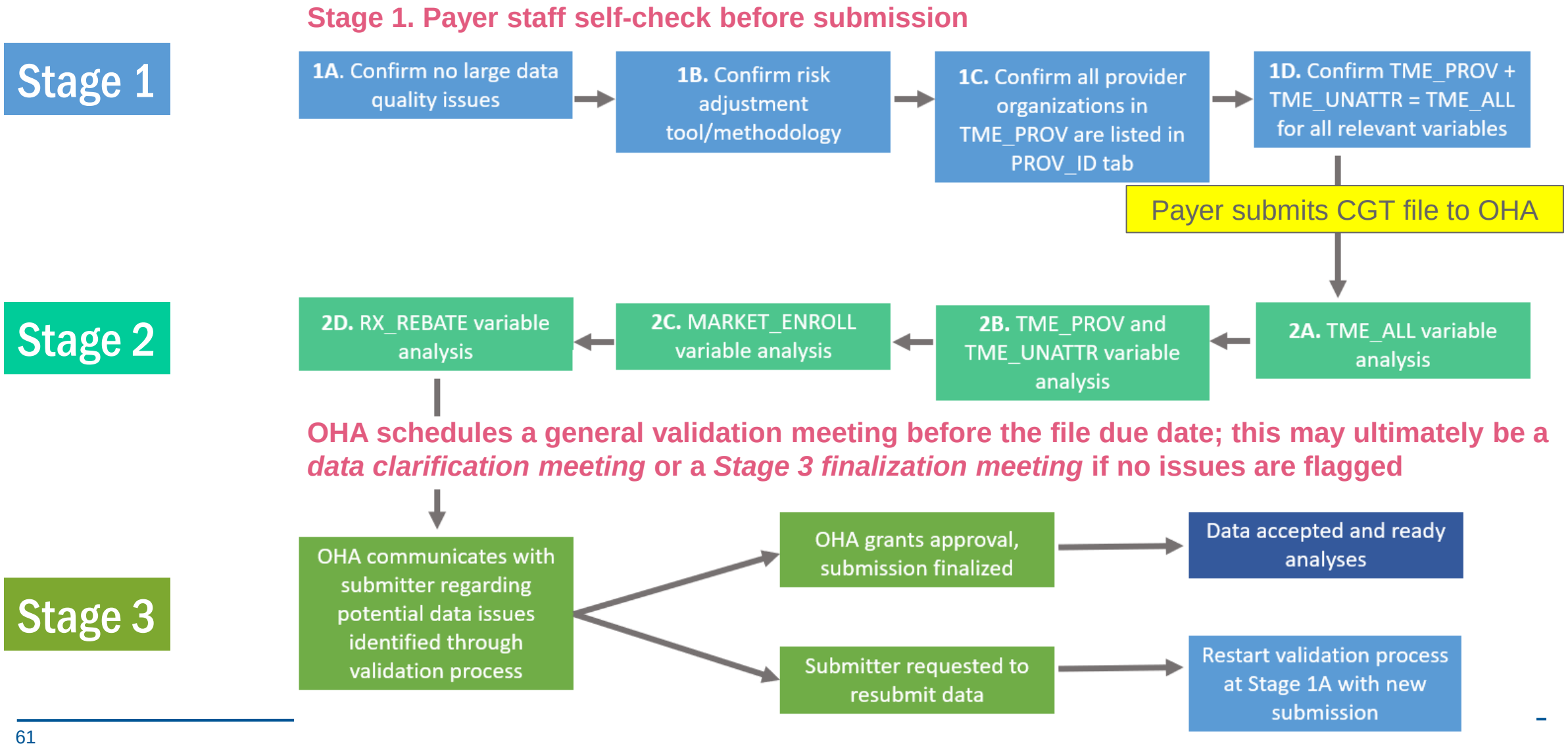
Data validation will consist of three ‘stages’

- Stage 1. Initial review of data submission
    - Data completeness and formatting
- Stage 2. Detailed review of data submission
    - Trend outputs, identifying outliers
- Stage 3. Communication and finalization
    - Discuss data outputs, clarifications

Data validation



Data validation



Data Submission Template structure

Tab Name	Contents
1. Cover Page	Payer info and data submission confirmation
2. TME_ALL	Total Medical Expenses for all of the payer's members by line of business, **regardless of attribution**.
3. TME_PROV	Total Medical Expenses for all of the payer's member months who **are attributed** to provider organizations. Data reported by line of business and by provider organization.
4. TME_UNATTR	Total Medical Expenses for all of the payer's member months who **are not attributed** to any provider organization. Data reported by line of business only.
5. MARKET_ENROLL	Payer's member months by market segments.
6. RX_MED_PROV	Claims expenses for medical pharmacy services for members who can be attributed to a provider organization. Data reported by line of business and provider organization
7. RX_MED_UNATTR	Claims expenses for medical pharmacy services for members that are not attributed to a provider organization. Data reported by line of business only.
6. RX_REBATE	Pharmacy rebates data by line of business.
7. PROV_ID	Identifier for provider organizations using federal taxpayer ID number (TIN)
Line of Business Code	Lookup Table for Line of Business Code for Tab 2-4, and 6
Attribution Hierarchy Code	Lookup Table for Attribution Hierarchy Code for Tab 3. TME_PROV
Demographic Tables	Demographic adjustment factors by age bands, sex, and line of business
TME Validation	Three validation tables to show 1) the number of rows with 0 member month in TME_PROV, 2) the difference of member months and dollars between TME_ALL and TME_PROV + TME_UNATTR, 3) the difference of demographic scores between TME_ALL and TME_PROV + TME_UNATTR, and 4) the difference of member months between TME_ALL and MARKET_ENROLL.
Provider Check	Validation table to check if all the provider organization names in TME_PROV are in PROV_ID.
Demographic Scores for Validation	Demographic scores from TME_ALL and TME_PROV to produce the table in TME_Validation

TME validation tab

* The validation tabs are auto-populated; no input needed *

TME validation | **Provider Check**

TAB: TME Validation	
Table 1. # of Rows MM > than MM threshold in TME_PROV	# of rows should be zero
Table 2. TME_ALL Compared to TME_PROV + TME_UNATTR	*Claims* and *non-claims* spending category columns should equal zero or ~zero*
Table 3. TME_ALL Demographic Score Compared to the Weighted Average Demographic Score from TME_PROV+TME_UNATTR	*Difference* column should equal zero or ~zero*
Table 4. Member Months by Line of Business from TME_ALL Compared to MARKET_ENROLL	*Difference* column should equal zero or ~zero*

TME Validation tab

TME validation | **Provider Check**

Table 1. # of Rows MM > than MM threshold in TME_PROV

MM Threshold: *12 months*

This table shows number of rows in TME_PROV with Member Months under the threshold by year and by line of business.

Member months are rounded to whole number. In TME_PROV, when rows with member months less than or equal to 12, please roll them up to line of business le

When there are rows in TME_PROV with less than or equal to 12 member month, the cell will become red.

Year	Line of Business Code	TME_PROV # of Rows <= MM threshold
2020	1	0
2020	2	0
2020	3	0
2020	4	0
2020	5	0
2020	6	0
2021	1	0
2021	2	0
2021	3	0
2021	4	0
2021	5	0
2021	6	0

# of rows should be zero

If a provider organization row in Tab 3. TME_PROV has a member month value less than or equal to 12, payers must transfer this data to the appropriate row in Tab 4. TME_UNATTR.

TME Validation tab

TME validation | **Provider Check**

Claims and *non-claims* spending category columns should equal zero or ~zero*

Table 2. TME_ALL Compared to TME_PROV + TME_UNATTR

This tables shows the relationship between the 2.TME_ALL tab and the 3.TME_PROV + 4.TME_UNATTR tabs

Positive values have a higher value in 2.TME_ALL, negative values have a higher value in 3.TME_PROV + 4.TME_UNATTR

Discrepancies of a few cents should be acceptable due to rounding.

Year	Line of Business Code	Member Months	Claims: Hospital Inpatient	Claims: Hospital Outpatient	Claims: Professional, Primary Care Providers	Claims: Professional, Specialty Providers	C
2020	1						
2020	2						
2020	3						
2020	4						
2020	5						
2020	6						
2021	1						
2021	2						
2021	3						

TME Validation tab

TME validation | **Provider Check**

Table 3. TME_ALL Demographic Score Compared to the Weighted Average Demographic Score from TME_PROV+TME_UNATTR

This tables shows the relationship between the 2.TME_ALL demographic scores and the calculated 3.TME_PROV+4.TME_UNATTR weighted average demographic scores

Positive values have a higher value in 2.TME_ALL, negative values have a higher value in 3.TME_PROV+4.TME_UNATTR

Year	Line of Business Code	TME_ALL Member Months*	TME_ALL Demographic Score	Weighted Average Demographic Score from TME_PROV + TME_UNATTR	Difference
2020	1	-	0.00000	0.00000	0.00000
2020	2	-	0.00000	0.00000	0.00000
2020	3	-	0.00000	0.00000	0.00000
2020	4	-	0.00000	0.00000	0.00000
2020	5	-	0.00000	0.00000	0.00000
2020	6	-	0.00000	0.00000	0.00000
2021	1	-	0.00000	0.00000	0.00000
2021	2	-	0.00000	0.00000	0.00000

Difference column should equal zero or ~zero*

See “CGT-1 with mock data” excel posted on the CGT Data Submission webpage for an example and a weighted average formula in TME_ALL

TME Validation tab

TME validation | **Provider Check**

Table 4. Member Months by Line of Business from TME_ALL Compared to MARKET_ENROLL

This tables shows the relationship between the 2.TME_ALL member months by line of business and the 5.MARKET_ENROLL member months by market.

Four main categories are created: Medicare, Medicaid, Commercial, and Duals.

Positive values have a higher value in 2.TME_ALL, negative values have a higher value in 5.MARKET_ENROLL

Year	Market	Line of Business Code	Market Enrollment Category	TME_ALL Member Month	MARKET_ ENROLL Member Month	Difference
2020	Medicare	1	Medicare Advantage	-	-	-
2020	Medicaid	2	Medicaid Managed Care	-	-	-
2020	Commercial	3 4	Large Group Small Group Self-insured Individual Student Plans	-	-	-
2020	Duals	5 6	Medicare and Medicaid Duals	-	-	-
2020	Total	All Lines of Business	All Markets	-	-	-
2021	Medicare	1	Medicare Advantage	-	-	-

Difference column should equal zero or ~zero*

Provider check tab

* The validation tabs are auto-populated; no input needed *

TME validation	Provider Check

TAB: Provider Check	
Table 4. Provider Organization Name Comparison between TME_PROV and PROV_ID	No cells should be red (i.e., each provider org in TME_PROV is also listed in PROV_ID

Provider check tab

TME validation	Provider Check

Validation Checks

No input needed, this entire sheet is auto-calculated

Table 4. Provider Organization Name Comparison between TME_PROV and PROV_ID

This tables shows the relationship between the 2.TME_ALL tab and the 3.TME_PROV+4.TME_UNATTR tabs

All provider names listed in TME_PROV must also be listed in PROV_ID

Scroll down to see entire table! If cell is red and says "NOT IN PROV_ID"

PROVIDERS MISSING IN PROV_ID:	0

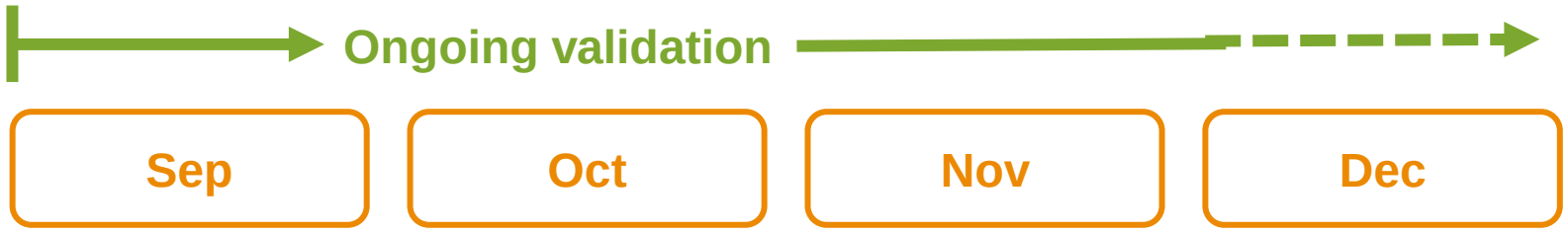
Unique provider organization name from TME_PROV	Provider organization name from PROV_ID
Main St Provider Group	Main St Provider Group
Hospital System Z	Hospital System Z
0	0

Providers missing from PROV_ID tab should be zero

If there is a missing provider org, scroll down the table to see the red cell

Data validation meetings

- Scheduling in August, before OHA's receipt of the CGT file
  - Timing is flexible and dependent on OHA and payer staff availability (by end of November if possible)
  - **Be ready to schedule and feel free to reach out and initiate if your team is ready!**



Files due 9/6

Aiming to validate all files by EOY

Contact information + resources

Online submission materials

CGT Data Submission webpage

- https://www.oregon.gov/oha/HPA/HP/Pages/cost-growth-target-data.aspx

- Data Submission Template [CGT-1] (XLSX)
- Data Specification Manual [CGT-2] (PDF)
- Supplemental Standard Deviation (SD) Calculation (XLSX)
- Supplemental Behavioral Health (BH) Codes (XLSX)
- Medical pharmacy codelist (XLSX)
- Statistical Analysis (PDF)
- Data Submission FAQ (PDF)

New!

Contact info and other 2024 resources

Questions?

CGT email: *HealthCare.CostTarget@oha.oregon.gov*

CGT Data Submission webpage:
https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx

Upcoming Office Hours (email CGT for Teams invite link):

- July 24 (TAG) 11:00-12:00pm PST
- August 14 11:00-12:00pm PST

Thank You

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET