Oregon Cost Growth Target Program
2022 Data Submission Training

June 7, 2022

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET

Housekeeping

This training is being recorded, and the recording will be posted on the Data Submitter 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 Sep 2, 2022

Purpose

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

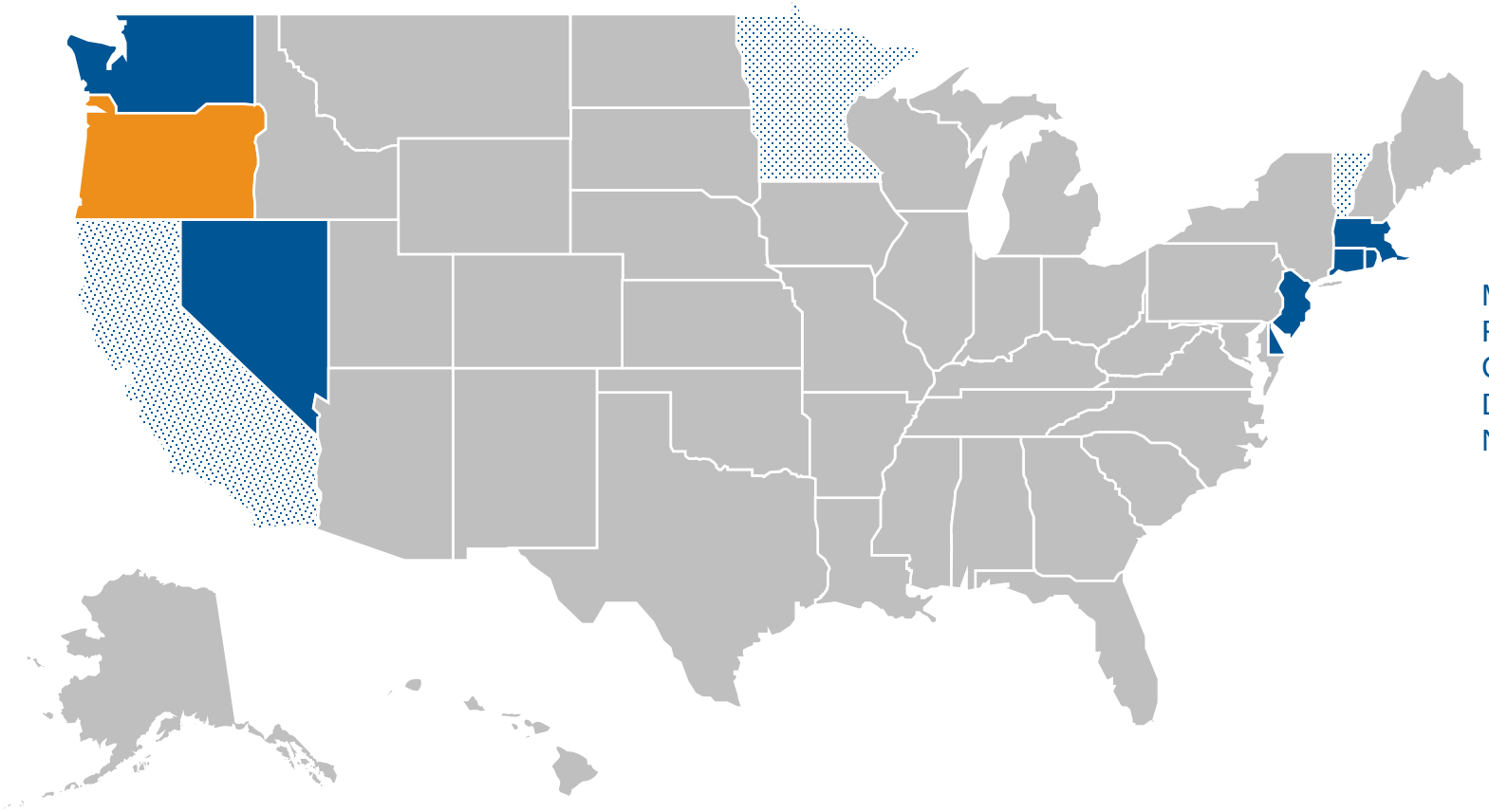
Call attention to areas where payers are able to customize their data wrangling and areas where all payers must be standardized

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 is the 4th state to adopt a cost growth target.



Massachusetts
Rhode Island
Connecticut
Delaware
New Jersey

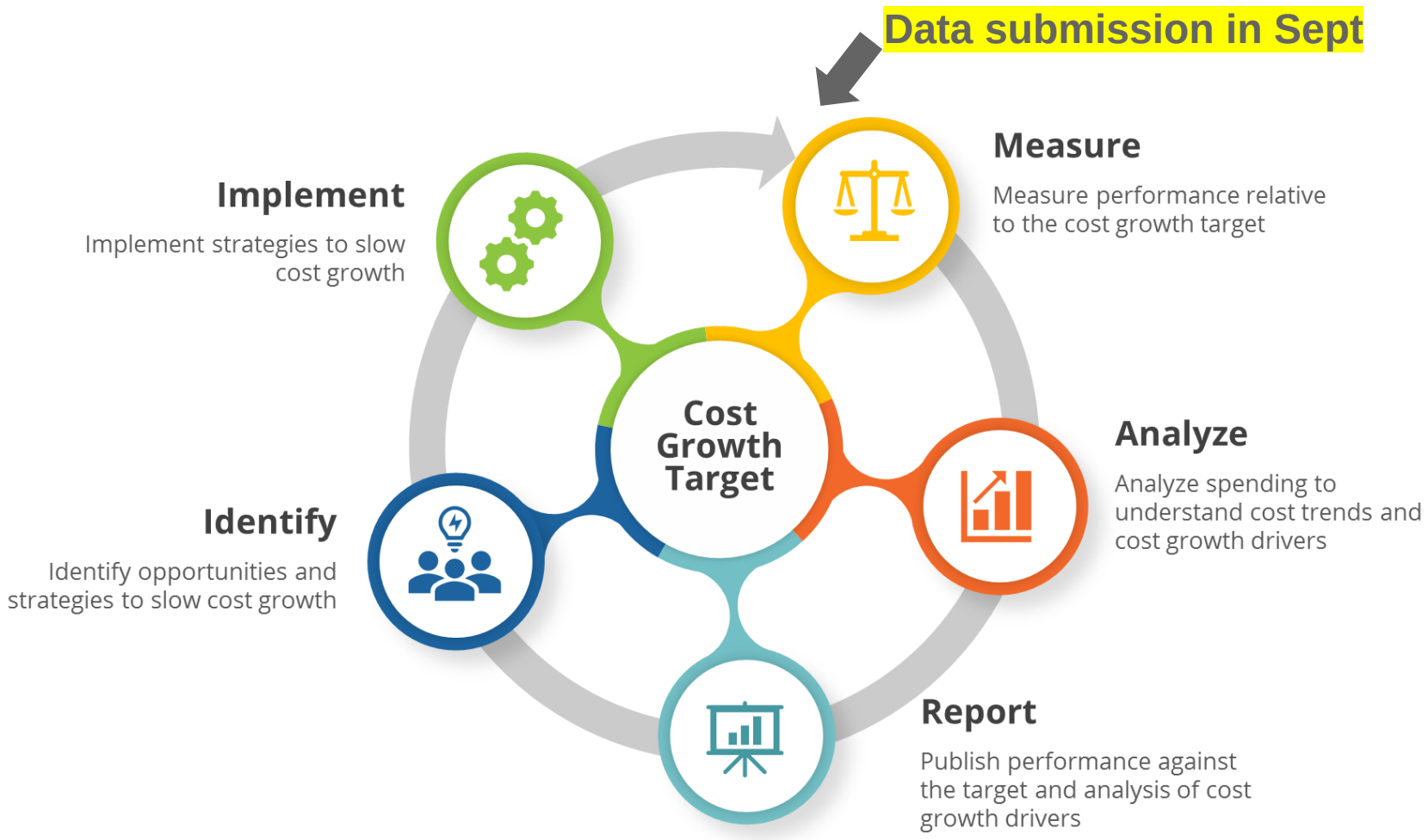
States with a cost growth target program

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
- 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

Annual Cost Growth Target Program Cycle



Annual CGT-1 file submission schedule

Due Date	Annual Data Submission
Sep 2, 2022	CY 2020 and 2021 TME
Sep 1, 2023	CY 2021 and 2022 TME
Sep 6, 2024	CY 2022 and 2023 TME

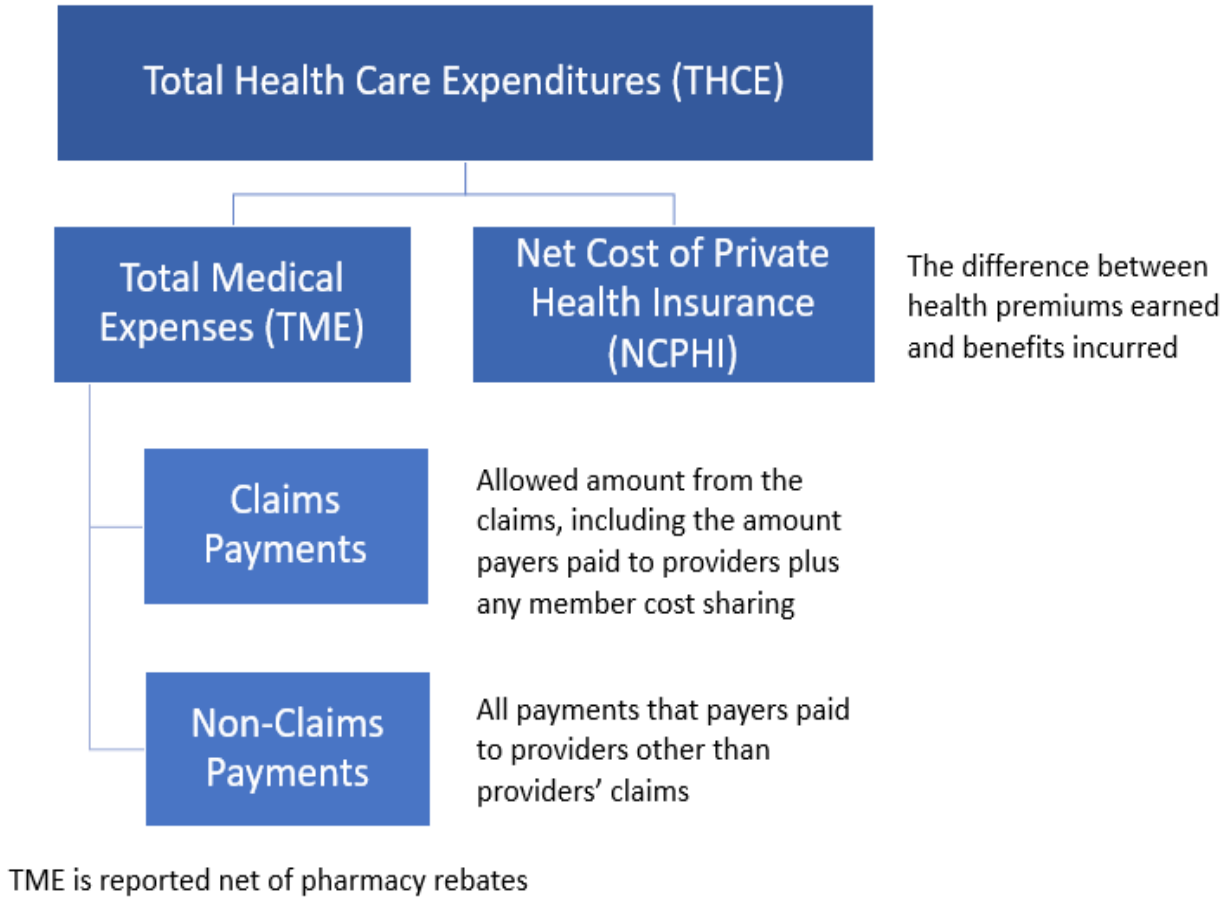
Files are due by the first Friday in September

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)



Overview of data captured

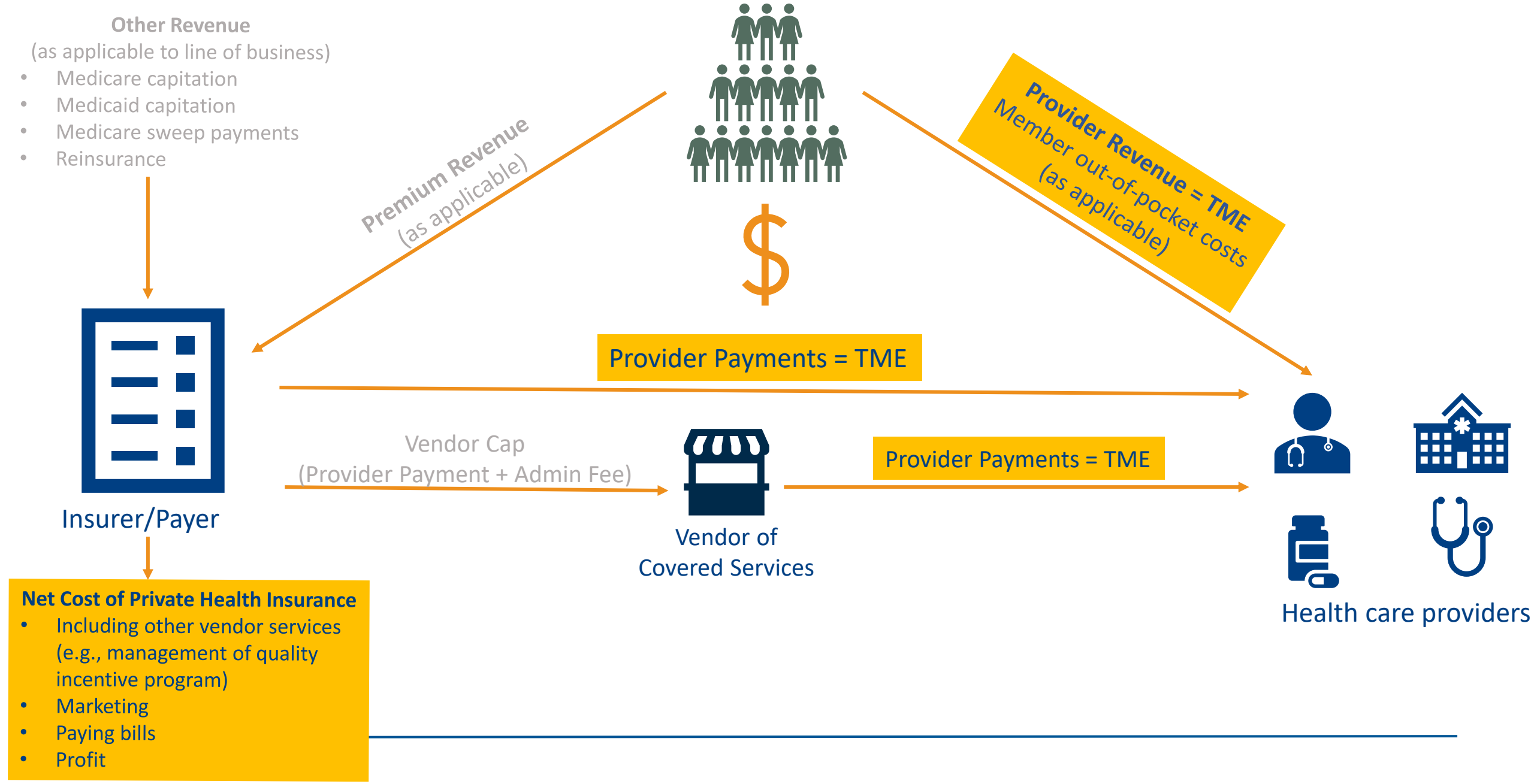
Include payment data for the following population…

- 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

* Medicaid CCOs who are the secondary payer for duals expenses should report that spending

The Relationship Between Health Insurance Revenue and Total Medical Expense



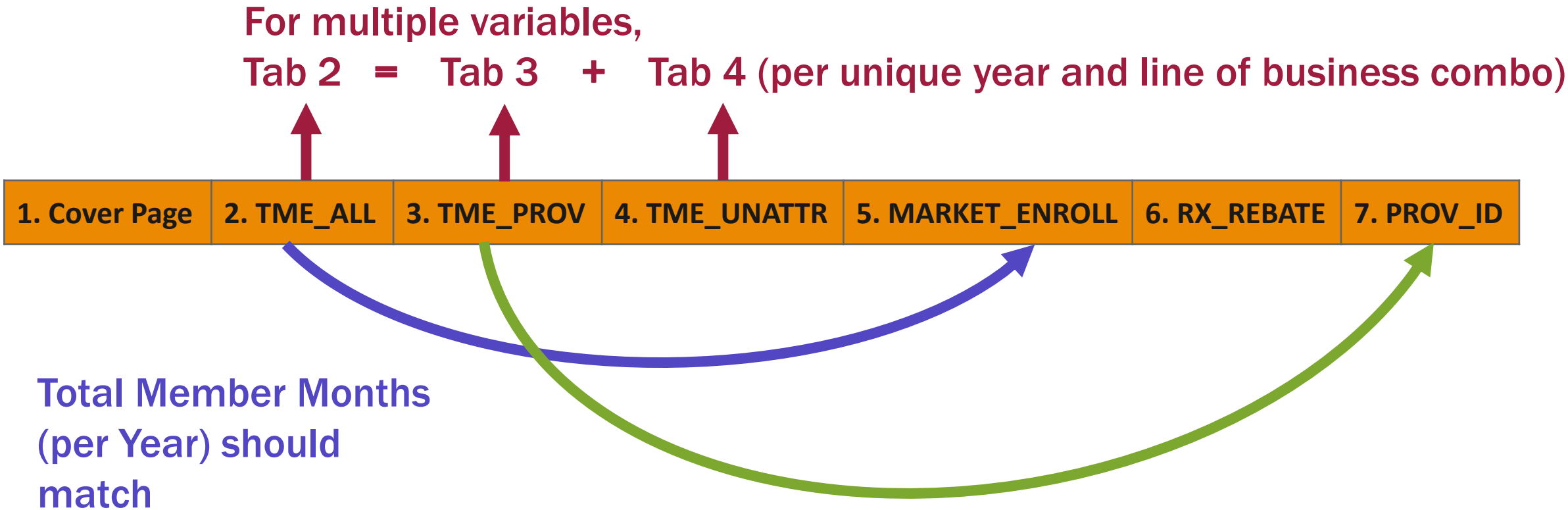
Data Submission Template

CGT-1

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_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



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 18-38 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_REBATE	7. 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_REBATE	7. 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_REBATE | 7. PROV_ID

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

Data field TMEPRV03 Provider Organization Name can be used to report an individual provider; please ensure the value is matched 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_REBATE | 7. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 - 17	TMEPRV18 - 23	TMEPRV24	TMEPRV25 - 30
Year	Code	free text, blank is not allowed	Code	non-negative integer	positive number	non-negative number	non-negative number	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation	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_REBATE | 7. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 - 17	TMEPRV18 - 23	TMEPRV24	TMEPRV25 - 30
Year	Code	free text, blank is not allowed	Code	non-negative integer	positive number	non-negative number	non-negative number	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation	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_REBATE | 7. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 - 30
Year	Code	free text, blank is not allowed	Code	non-negative integer	positive number	non-negative number	non-negative number	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation	Auto-calculated fields
2018	**1**	**Hospital System Z**	**1**	…	…	…	…	…	…
2018	**1**	**Hospital System Z**	**2**	…	…	…	…	…	…
2018	**2**	**Hospital System Z**	**1**	…	…	…	…	…	…
2018	**1**	**Clinic W**	**1**	…	…	…	…	…	…
2019	**1**	**Hospital System Z**	**1**	…	…	…	…	…	…

Tabs 2-4, TME tabs: data stratification

1. Cover Page | 2. TME_ALL | 3. TME_PROV | 4. TME_UNATTR | 5. MARKET_ENROLL | 6. RX_REBATE | 7. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV03	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 – 30
Year	Code	free text, blank is not allowed	Code	non-negative integer	positive number	non-negative number	non-negative number	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation	Auto-calculated fields
2018	**1**			…	…	…	…	…	…
2018	**2**			…	…	…	…	…	…
2019	**1**			…	…	…	…	…	…
2019	**3**			…	…	…	…	…	…
2020	**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_REBATE | 7. PROV_ID

TMEPRV01	TMEPRV02	TMEPRV04	TMEPRV06	TMEPRV07	TMEPRV08	TMEPRV09 – 17	TMEPRV18 – 23	TMEPRV24	TMEPRV25 – 30
Year	Code	free text, blank is not allowed	Code	non-negative integer	positive number	non-negative number	non-negative number	non-negative number	
Reporting Year	Line of Business Code	Provider Organization Name	Attribution Hierarchy Code	Member Months	Demographic Score	Claims: XXXX	Non-Claims: XXXX	Demographic Adjusted Standard Deviation	Auto-calculated fields
2018	**1**			…	…	…	…	…	…
2018	**2**			…	…	…	…	…	…
2019	**1**			…	…	…	…	…	…
2019	**3**			…	…	…	…	…	…
2020	**3**			…	…	…	…	…	…

Tabs 2-4, TME tabs: Line of business

See Manual pages 38-39

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 during 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.

Reporting for **dual eligible LOBs 5** (Medicare-expenses) **and 6** (Medicaid expenses) to report 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

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 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 39-43 for more category details.

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

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

Payers must report the following individual non-claims payment categories (Manual pages 43-45):

- 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 39-43 for more category details.

Tabs 3-4, TME tabs: Standard deviation

- 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 45-47**
- 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_REBATE	7. 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 to 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_REBATE	7. PROV_ID

Walk-through of Supplemental Standard Deviation Calculation (XLSX)

Tab 5. Market enrollment

Manual page 48

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_REBATE	7. 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. Pharmacy rebates

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_REBATE	7. 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.

- Starting in 2022, payers may report rebates to the provider entity level if data is available (see **Manual pages 49-51**)

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.

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

Tab 6. Pharmacy rebates

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_REBATE	7. 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 6. Pharmacy rebates

1. Cover Page	2. TME_ALL	3. TME_PROV	4. TME_UNATTR	5. MARKET_ENROLL	6. RX_REBATE	7. 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.

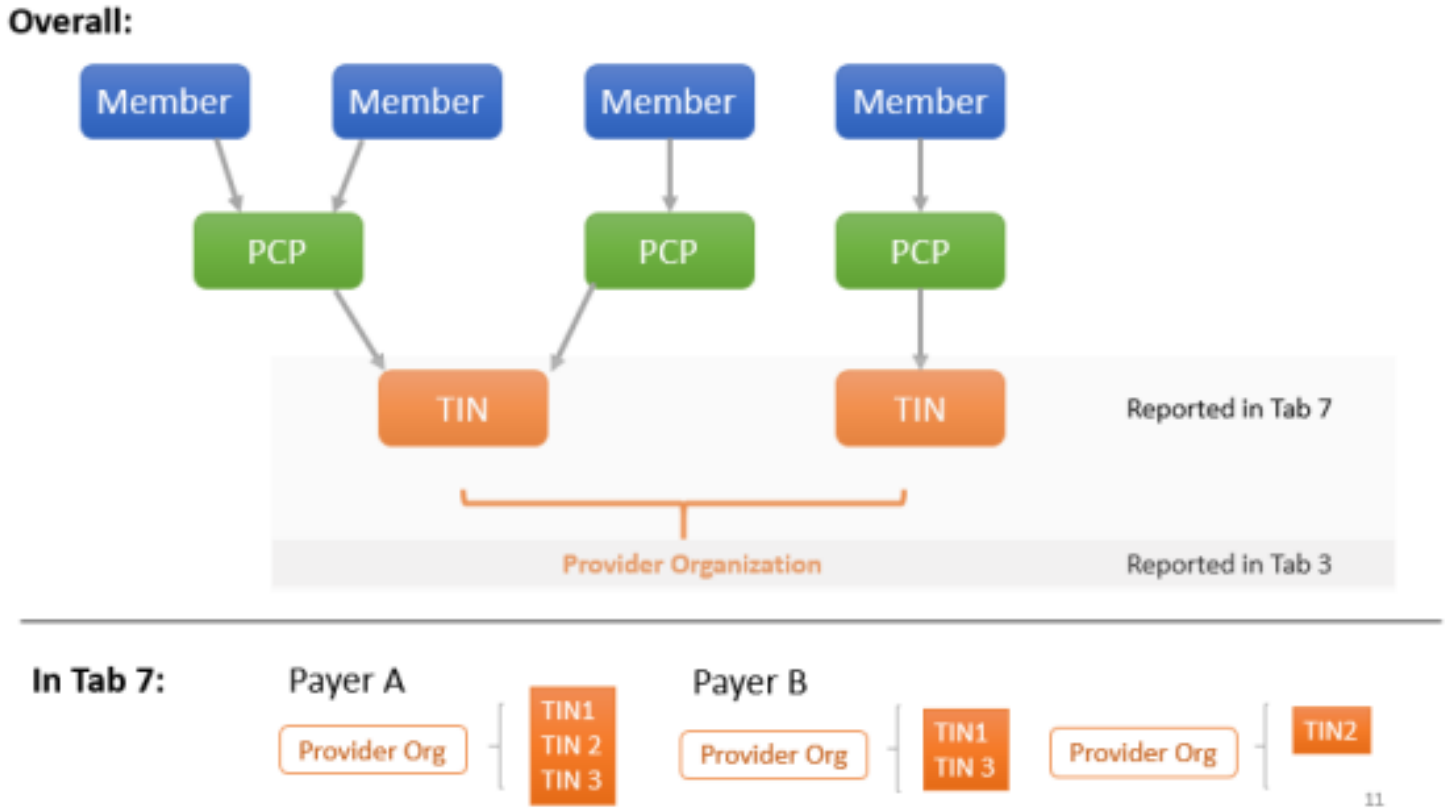
- If payers are unable to report rebates specifically for Oregon residents, payers should report estimated rebates attributed to Oregon residents, see Manual page 50

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 7. Provider Organization Information

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

To assist with matching provider organizations across multiple payer data submissions, Tab 7 collects multiple identifiers (taxpayer identification numbers, TINs) for provider organizations identified in Tab 3



Tab 7. Provider Organization Information

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

Suppose in 2018, Hospital System Z had 6 TINs associated with its various sites of services of business entities.

Payer will report Hospital System Z and associated TINs in Tab 7 like so:

PRV01	PRV02
free text	text, 9 digits including leading zero
Provider Organization Name	**Provider Organization TIN**
Hospital System Z	000000001
Hospital System Z	000000002
Hospital System Z	000000003
Hospital System Z	000000004
Hospital System Z	000000005
Hospital System Z	000000006

Tab 7. Provider Organization Information

1. Cover Page | 2. TME_ALL | 3. TME_PROV | 4. TME_UNATTR | 5. MARKET_ENROLL | 6. RX_REBATE | 7. PROV_ID

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Hospital System Z	000000001
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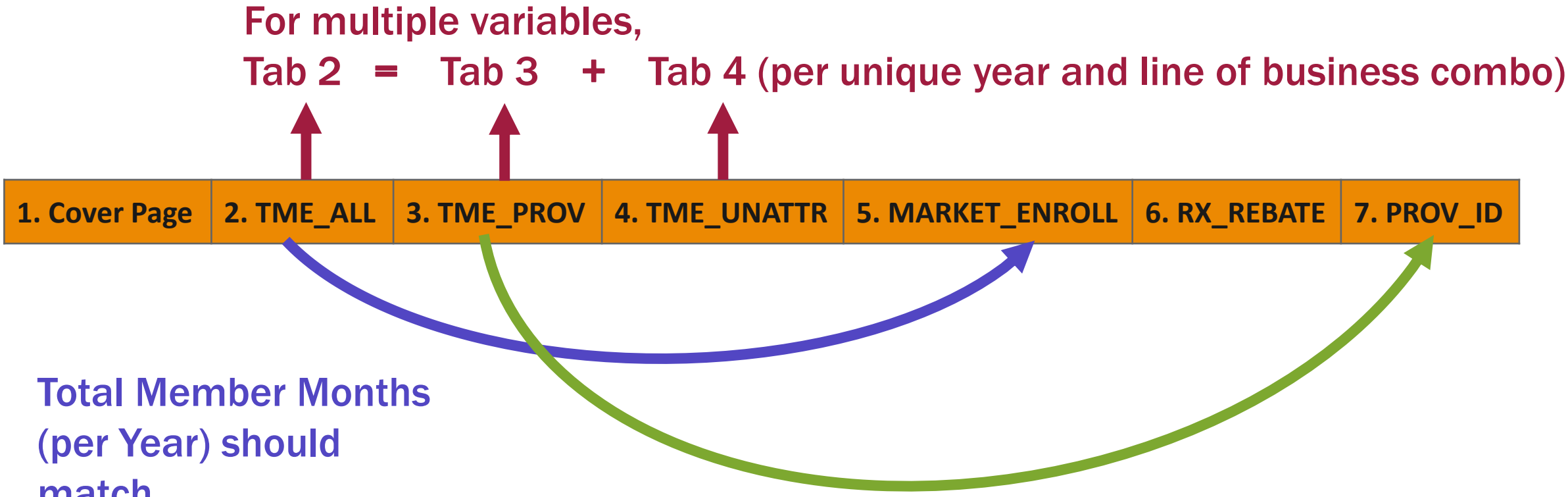
Hospital System Z	000000003
Hospital System Z	000000004
Hospital System Z	000000005
Hospital System Z	000000006

Inter-tab data



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 11-16

Member Attribution Hierarchy (for tab 3. TME_PROV data)	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 home 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 #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.
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	

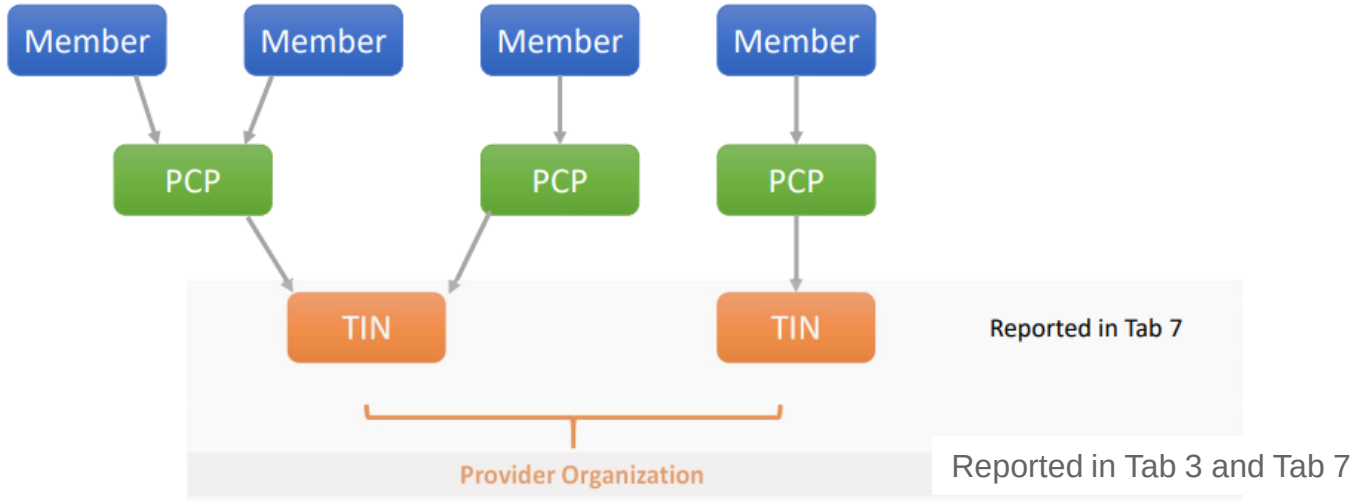
Primary care-based member attribution hierarchy

Manual pages 11-16

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 7) and covered elsewhere in the presentation.

Overall:



Demographic adjustment

Manual pages 17-18

- Payers should use OHA-provided statewide demographic scores when reporting 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

TME inclusion/exclusions

Manual pages 21-22

Included and excluded lines of business

- Medicaid CCO-specific guidance, page 22

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@dhsoha.state.or.us 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 23

- 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. 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 25

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 25

- 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.

Data collection + validation process

Data collection

Email CGT-1 excel files to the CGT program inbox by **Fri Sept 2, 2022**

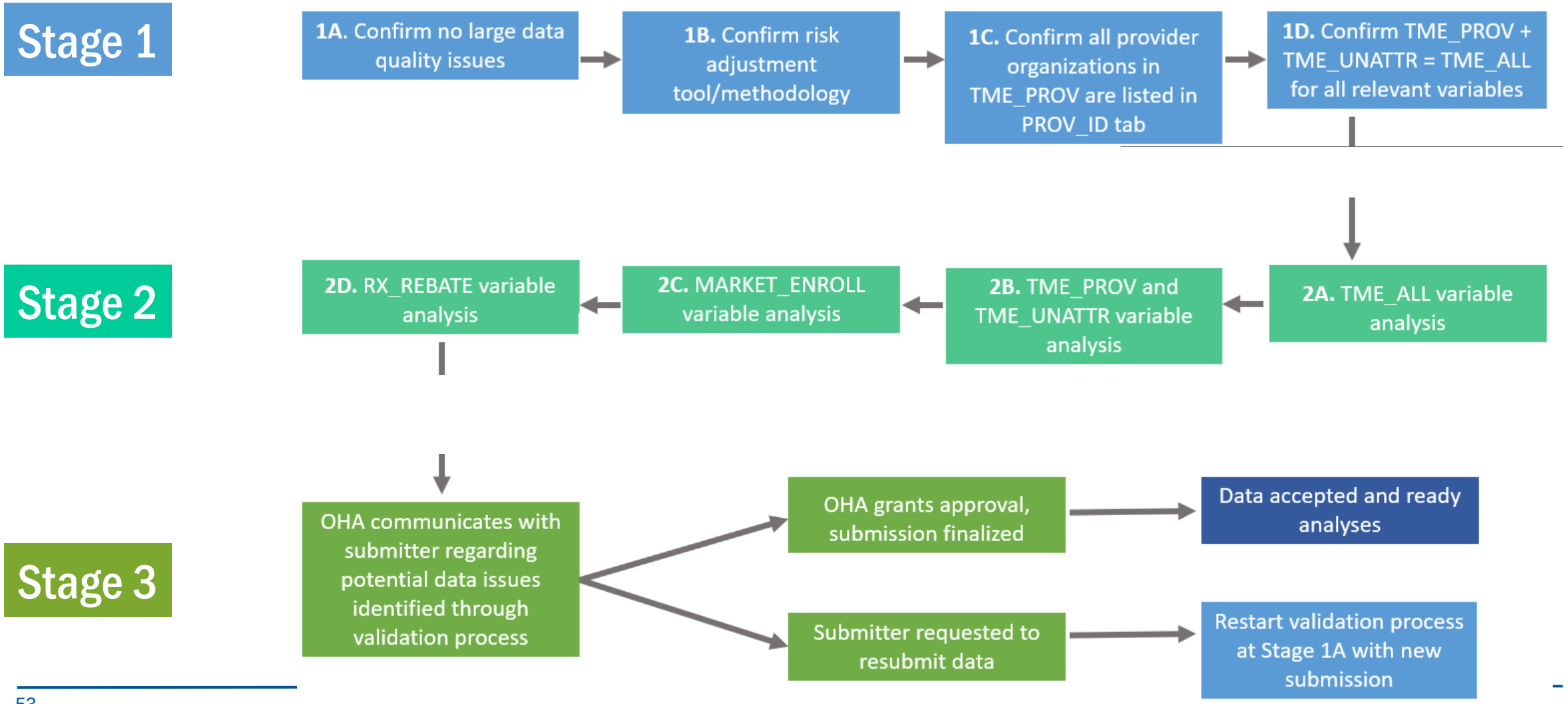
- *HealthCare.CostTarget@dhsoha.state.or.us*
- For file naming convention and other submission process topics see Manual page 28

Data validation

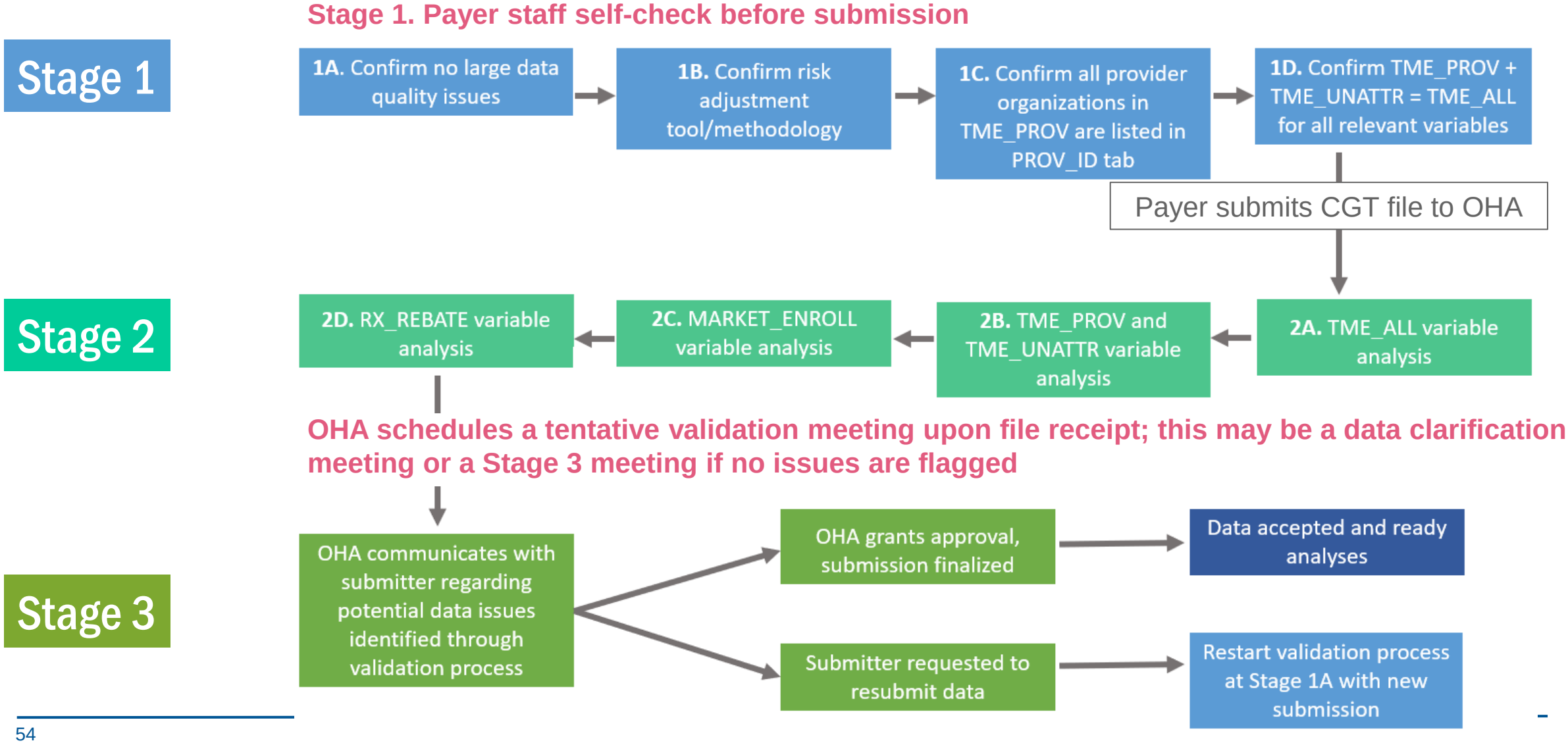
Data validation will consist of three ‘stages’

- 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_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

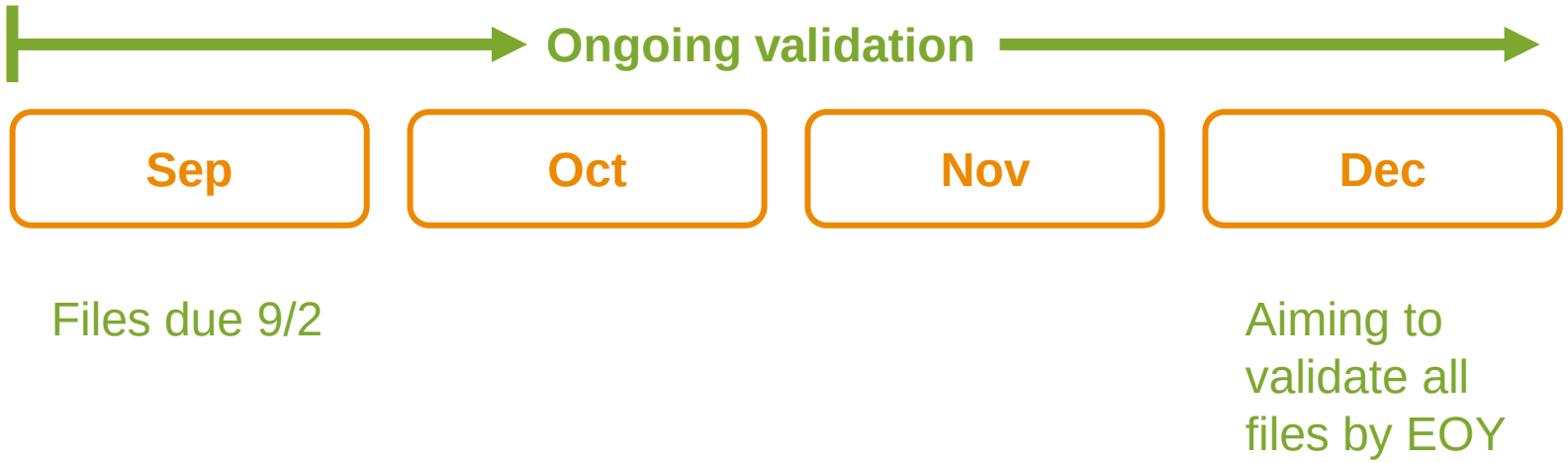
Unique provider organization name from TME_PROV	Provider organization name from PROV_ID
Main St Provider Group	Main St Provider Group
Hospital System Z	Hospital System Z
0	0

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

- Aiming for scheduling within 1-3 weeks after OHA's receipt of the CGT file
  - Timing is flexible and dependent on OHA and payer staff availability
  - **Be ready to schedule and feel free to reach out and initiate if your team is ready!**



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)
- Statistical Analysis (PDF)
- Data Submission FAQ (PDF)

Contact info and other 2022 resources

Questions?

CGT email: *HealthCare.CostTarget@dhsoha.state.or.us*

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 18 11:00-12:00pm PST
- August 8 11:00-12:00pm PST

Thank You

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET