Connecticut Cost Growth Benchmark and Primary Care Target Data Submission
Frequently Asked Questions

Last updated: April 20, 2021

1. **When is the deadline for 2018-2019 data?**
   Based on feedback from carriers, OHS is extending the deadline for submitting calendar years 2018 and 2019 data to June 18, 2021. Carriers are highly encouraged to submit data as soon as possible before the June 18 deadline to allow OHS sufficient time to validate the data.

   To further assist carriers with this data request, Bailit Health will hold calls with individual carriers during the following dates and times to answer questions and provide guidance on the data specifications:

   - April 22, 12pm – 2pm
   - April 28, 10am – 12pm
   - May 6, 12pm – 2pm
   - May 12, 10am – 12pm
   - May 20, 12pm – 2pm

   Bailit Health can also hold calls outside of these times at carriers' request. Carriers that wish to take advantage of this opportunity should email Grace Flaherty at gflaherty@bailit-health.com to reserve a time slot.

2. **When is the deadline for 2020 data?**
   Calendar year 2020 data will be due to OHS by October 4, 2021.

3. **For which large provider entities should carriers report data?**
   Carriers should attribute primary care providers to the 11 large provider entities listed in the table below based on information from carriers' existing contracts. The table also lists entities that OHS has identified as affiliated with the large provider entities in their contracts with some carrier, which is provided as reference only. The list of large provider entities is for the 2018-2019 pre-benchmark reporting period and may be updated over time.

   Attribution of providers to the large provider entities listed in the table below 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. For spending not attributed to one of these large provider entities, either because the insurance carrier does not contract with the large provider entity or because the spending was outside of the named entities, please use Organizational ID 112.

   OHS recognizes that carriers have different contractual relationships with the large provider entities identified by OHS. In some cases, carriers hold contracts with a large provider entity listed in the table, encompassing one or more affiliated entities. In other cases, large provider entities identified by OHS may be an affiliated entity, not the contracting entity.

Each carrier should report when an identified ***large provider entity*** is the contracting entity for the performance period. If the entity that holds the contract with the carrier is not on the list of large provider entities identified by OHS in the table below, then the carrier should report that spending using Organizational ID 112 which is reserved for members that cannot be attributed to any one of the large provider entities in the table.

OHS understands that the roster of specific providers attributed to each large provider entity will be different from carrier to carrier since the participating providers within those contracts may change for each carrier over time, and each carrier may have different contractual relationships with entities affiliated with the large provider entities.

Large Provider Reporting Entities	**"Affiliated Entities" for Some Payers, Provided as a Courtesy**
1. Community Medical Group	- Fair Haven Community Health Care* (aka Fair Haven Clinic) - Greenwich Physicians Association
2. CT Children's Medical Center	- *None identified.*
3. CT State Medical Society IPA, CSMS IPA	- Bristol Health Medical Group - Day Kimball - Southwest Community Health Center, Inc. - Staywell
4. Integrated Care Partners	- Hartford Healthcare Medical Group* - St Vincent's Advanced Care Network* (aka St. Vincent's MultiSpecialty Group) - Soundview
5. Medical Professional Services	- *None identified.*
6. Northeast Medical Group	- PriMed - Yale New Haven Health
7. OptumCare Network of Connecticut / ProHealth	- Community Medical Group - Bristol Multi-Specialty Group - New Milford Medical Group
8. Prospect CT Medical Foundation, Inc.* (d/b/a Prospect Medical, Prospect Health Services, Prospect Holdings)	- Alliance Medical Group - Waterbury Health - Eastern Connecticut Health Network
9. Southern New England Health Care Organization (aka SOHO HEALTH, aka Trinity Health of New England ACO, LLC)	- Saint Francis Medical Group - Saint Mary's Physician Group
10. Value Care Alliance	- Griffin Health Services Corporation - Middlesex Family Health Medical Group - Nuvance Health, including Western Connecticut Health Network (aka Western Connecticut Medical Group) - Norwalk Primary care
11. ProHealth	- *None identified.*

4. **Will payer performance against the benchmark and target be reported for 2018-2019 or 2019-2020?**
   OHS will only be reporting cost growth at the state and insurance market levels for the pre-benchmark period, which includes analysis of data from calendar years 2018, 2019 and 2020. OHS will begin publicly reporting carriers' and large provider entities' cost growth in 2020-2021, when the cost growth benchmark and primary care spending target become effective.

5. **What is the population for whom data will need to be submitted?**
   Carriers should include spending data pertaining only to members who are residents of Connecticut, who at a minimum have medical benefits, and for whom the carrier is primary on a claim.

6. **How should individual members be attributed to a provider?**
   Carriers should attribute spending of individual members to a primary care provider using its own methodology. This could be based on a prospective method such as member selection or carrier assignment of a primary care provider, or a retrospective method based on members' utilization history. OHS is not requiring carriers to apply a standard methodology, but recommends using a methodology consistent with contracts that carriers have with the large provider entities.

7. **How should we use the validation tabs?**
   The validation tab in the reporting template includes a series of checks for data inconsistencies and tables that allow carriers to look at per member per month spending on service categories by market, and by large provider entity by market. This is provided as a tool to help carriers review summary level information to identify potential data issues. For example, a per member per month value of $1 for hospital inpatient claims would suggest an underreporting of spending in this category. Careful review of the information in the validation tab will help reduce the back and forth between OHS and the carrier after data submission as part of OHS' data validation process.

8. **We have a stand-alone Medicare prescription drug plan product. Do we need to report these data?**
   No. Carriers should exclude data from stand-alone Medicare prescription drug plans from their reporting.

9. **Should pharmacy spending be reported net of rebates?**
   In the Large Provider Entity tab, pharmacy spending should be reported gross of rebates. Carriers should report rebate amounts separately in the Rx Rebates tab.

10. **Can OHS provide examples of how to adjust the "partial claims" population?**
    Carriers must make adjustments to "partial claims" to estimate what total spending might be for this population if the carrier was responsible for the carved-out services. OHS is not requiring carriers to use a standard methodology for adjusting "partial claims." However, OHS will need to review carriers' methodology prior to the carrier's performing the adjustment. One potential strategy for performing the adjustment for carved out pharmacy services includes using the carrier's commercial market book-of-business average pharmacy

spending per member, per month for the same year, calculated on members who had primary coverage, applied to all member months for which the carve-out applied. Carriers should account for the relative risk differences between the "full claims" and "partial claims" populations in applying such as strategy to estimate the "partial claims" population's full spending.