Washington State Health Care Authority

# 2022 Health Care Cost Transparency Board benchmark data call

## Frequently asked questions (FAQ)

This FAQ shares responses to questions from health insurance carriers and state agencies that are submitting data for the 2022 benchmark data call. Most of the questions are technical and ask the Health Care Cost Transparency Board to define or clarify how to submit data.

We will continue to update this FAQ as we receive additional questions.

1. **Please clarify the file submission schedule for this year's data. Should I submit by September 1 or October 1, 2022?**

   Please submit all data **by October 1**.

   Note: for this initial year, the board is providing a longer data submission period. We want to give you time to understand the submission process and submit your data. Please do not delay your data submission, and file as soon as possible.

2. **Can you confirm that I will report spending aggregated at the parent company level?**

   Yes, please report at the parent company level.

3. **What level of leadership should provide the data submission's attestation signature?**

   A chief financial officer, chief data officer, or other executive should sign the attestation.

4. **How will the board consider risk adjustments for the cost growth benchmark?**

   As part of the data submission, the board requires submitters to provide data stratified by age and sex. The board will calculate an adjustment factor, based on the submitted age and sex spending.

5. **Will the board calculate the net cost of private health insurance (NCPHI)? And will this be at the state level?**

   Yes, you are only required to report total medical expense. The board will calculate NCPHI at the state-level only.

6. **When will the board ask for calendar year 2020 or 2021 data?**

   In future data calls, the board will ask for two years of data to account for potential methodology changes and ensure accuracy. We have not yet determined the years that will be requested in the 2023 benchmark data call.

7. **In the Large Provider Entity Code list, what does code 100 "Over All Provider Entities" mean?**

   This code is used when you are reporting data that includes **all spending**. For example, you would use this code in the standard deviation tab where you provide all the standard deviation of all of the parent company's spending.

8. **In the Large Provider Entity Code list, what does code 999 "Unattributed to a Large Provider Entity" mean?**

   Please mark spending by assigning a member to a primary care provider, and then to a provider entity. If the assigned provider entity is not in the Large Provider Entity Code List, code the provider as "999" (meaning that associated spending is unattributed to a Large Provider Entity).

9. **Can the board provide a list of Taxpayer Identification Numbers (TINs) associated with the Large Provider Entity Codes?**

   No. The board does not have a list of provider TINs that we can share publicly.

10. **How do I associate spending for capitated payments if the member went to multiple provider entities, resulting in capitated payments to multiple provider entities?**

    Please assign a member to a primary care provider, and then that primary care provider to a sole provider entity. All spending for that member (and their member months) should be assigned to the sole provider entity.

11. **Should I report prescription drug (Rx) spending gross of rebates, even if another entity administered the benefit? Or if the submitter was not at risk for the benefit?**

    Please report Rx spending gross of rebate in the Total Medical Expense tab and use the Rx Rebate tab to report the rebate amounts. The board will calculate the net Rx spending.

12. **I consider some forms of payment to be incentive payments; however, they may also be associated with payments to enhance infrastructure. Should I report these in the Performance Incentive Payments category or the Health and Practice Infrastructure Payments category?**

    If the payment is contingent on the receiver of the payment to meet a certain metric (e.g., pay for performance, pay for value), then include the payment in the Performance Incentive Payments category.

    If the payment is not contingent on a certain metric being achieved, include the payment in the Health and Practice Infrastructure Payments category.