Washington State Health Care Authority

2024 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 2024 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.**

   Please submit all data on or before **May 15, 2024**.

2. **Is there a change of email address for submitting our data?**

   Yes, please email data submission to HCACostBoardData@hca.wa.gov and no longer to HCAHCCTBoard@hca.wa.gov.

3. **What are some tips for avoiding common validation errors?**

   - The reported amounts in the columns "TME22: Truncated Claims Spending" and "SD06: Total Claims Truncated Spending" in the 2_TME and 3_SD tabs should be the sum of spending after truncation has been applied. In other words, these columns should be the sum of spending that did not exceed the threshold. Please see the sample calculation in the Technical Manual.

   - The sum of "TME22: Truncated Claims Spending" stratified by large provider entity code, market code, and reporting year from the 2_TME tab should have the same sum as "SD06: Total Claims Truncated Spending" in the 3_SD tab also stratified by large provider entity code, market code, and reporting year. The 3_SD tab stratifies data at the market level instead of the insurance category level like the 2_TME tab does. Insurance categories will need to be rolled up to their market level for comparison (Please refer to reference tab in the submission template for how to roll up from insurance category code level to market code level). For example, Commercial Full Claims and Commercial Partial Claims will need to be added together for the Commercial market. Submitters can do a quick check by comparing aggregated truncated claims spending across these two tabs and making sure that the numbers are equal for each provider entity for each reporting year.

   - Similar to the previous bullet point, the sum of member months stratified by large provider entity code, market code, and reporting year should be equal between the 2_TME and 3_SD tabs. Submitters can do a quick check by comparing aggregated market level member months across these two sheets and making sure that the numbers are equal.

   - The sum of member months by reporting year should be equal across the following tabs: 2_TME, 3_SD, and 4_LOB_ENROLL. As a note, the 4_LOB_ENROLL tab has a section for Medicare, Medicare Duals, Medicaid, and Medicaid Duals, but not for Commercial Full and Commercial Partial. The

Commercial lines of business will need to be added together to the market level to be compared to the 2_TME and 3_SD tabs. Submitters can do a quick check by comparing aggregated member months for each year across these tabs and making sure that the numbers are equal.

- Carriers should provide the standard deviation for the overall spending at the carrier level (i.e., large provider entity code = 100) in the 3_SD tab. Additionally, please ensure that you provide the standard deviation for each large provider entity for each market and reporting year in which you are reporting spending.

- Please follow the updated file-naming rule. Please ensure that you name the file using this format: "CarrierCode_CarrierName_TME_YYYYMMDD.xlsx". Please see technical manual for more information regarding the file-naming rule and examples.

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

   Yes, please report at the parent company level.

5. **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.

6. **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.

7. **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.

8. **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.

9. **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 as detailed by the methodology found in the technical manual, 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).

10. **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.

11. **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.

12. **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.

13. **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.