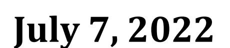
Washington State Health Care Authority

Washington's Health Care Cost Growth Benchmark Program

Technical Manual



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1.0	July 7. 2022	

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Overview

To address high and rising health care costs in the State, the Health Care Cost Transparency Board (Chapter 70.390 RCW) was signed into law in 2020, with the purpose of reducing health care cost growth and increasing price transparency. The Health Care Cost Transparency Board (the Board) is responsible for reducing the state's health care cost growth by:

- Determining the state's total health care expenditures;
- Identifying cost trends and cost drivers in the health care system;
- Setting a health care cost growth benchmark for providers and payers; and
- Reporting annually to the Legislature on health care cost growth in the state, including providing recommendations for lowering health care costs.

The purpose of the Benchmark and public reporting is to make health care costs more transparent to the public and policymakers, encourage providers and payers to keep costs at or below the Benchmark, and reduce the overall trend of health care cost growth in Washington State.

Every year, the Board will set a benchmark for the annual rate of growth of total health care expenditures (THCE). THCE is defined as the allowed amount of claims-based spending from payer to provider, all non-claims-based spending from payer to provider, and the net cost of private health insurance.

To implement the Benchmark program, the Board requires health care payers in Washington to submit data that will be used to identify the state's THCE and determine the annual rate of growth for the state, by insurance market, by payer, and for the largest health care providers in the State.

This year, the first year of the Benchmark data call, the Board will collect several years of data to establish a baseline. In future years, the Board will collect data for the measurement year and the calendar year preceding it.

This technical manual details the technical and operational steps to implement the Benchmark. It includes details the methodology the Board used to set the Benchmark, the methodologies for calculating performance against the Benchmark, and the technical specifications for data reporting and collection.

The document is organized as follows:

- Definition of Key Terms
- Section I: Health Care Cost Growth Benchmark Methodology
- Section II: Measuring Performance Against the Benchmark
- Section III: Payer Reporting of Data for the Cost Growth Benchmark
- Appendix A: Carrier Total Medical Expense Data Specifications

- Appendix B: Non-Managed Care Total Medical Expense Data Specifications for Medicaid
- Appendix C: Fee-for-Service Medicare Total Medical Expense Data Specifications
- Appendix D: Labor & Industries Total Medical Expense Data Specifications
- Appendix E: Department of Corrections Total Medical Expense Data Specifications
- Appendix F: Veterans Health Administration Total Medical Expense Data Specifications

Definition of Key Terms

Allowed amount: The amount the carrier paid a provider, plus any member cost sharing for a claim. Allowed amount is typically a dedicated data field in claims data. Allowed amount is the basis for measuring the claims component of total medical expense.

Health care cost growth benchmark (the Benchmark): The Benchmark is the value against which the Board has agreed to measure total health care expenditures and total medical expense. It is the value of 70% of Washington's historic median wage and 30% of Washington's potential gross state product (PGSP).

Potential gross state product (PGSP): PGSP is the total value of goods produced and services provided in a state at a constant inflation rate.

Health insurance carrier (carrier): A private health insurance company that offers one or more of the following: commercial insurance, Medicare Advantage and/or Medicaid managed care products.

Large provider entity: A term referring to provider organization that delivers health care services, employs primary care providers, and is large enough to enter into a total cost of care contract, for whom carriers must report total medical expense data.

Market: The highest levels of categorization of the health insurance market. For example, fee-for-service Medicare and Medicare Advantage are collectively referred to as the "Medicare market." Fee-for-service Medicaid and Medicaid managed care are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group products and student health insurance are collectively referred to as the "Commercial market."

Measurement year: The measurement year is the calendar year for which performance is measured against the prior calendar year for purposes of calculating the growth in health care costs.

Net cost of private health insurance (NCPHI): Measures the costs to Washington residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred, and consists of carriers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses. NCPHI is reported as a component of total health care expenditures at the state level.

Payer: A term used to refer collectively to both carriers and public programs that are submitting data to HCA.

Payer recoveries: Funds distributed by a payer and then later recouped (either through an adjustment from current or future payments, or a cash transfer) due to a review, audit or investigation of funds distribution by the payer. Payer recoveries is a separate, reportable field in carrier total medical expense reporting.

Pharmacy rebates: Any rebates provided by pharmaceutical manufacturers to payers for

prescription drugs, excluding manufacturer-provided fair market value bona fide service fees.[1] Spending at the state, market and payer level is net of pharmacy rebates (i.e., other expenditures are reduced by the amount of the pharmacy rebates).[2]

Provider: A term referring to an individual clinician, medical group, individual provider, large provider entity or similar entities.

Public program: A term used to refer to payers that are not carriers. This includes Medicare Fee-For-Service, Medicaid Fee-for-Service and similar programs.

Total health care expenditures (THCE): The total medical expense incurred by Washington residents for all health care services for all payers reporting to HCA, plus the carriers' net cost of private health insurance. Defining specifications of THCE are included in Section II.

Total health care expenditures per capita: Total health care expenditures (as defined above) divided by Washington's reported membership. The annual change in THCE per capita is compared to the Benchmark at the state, market and carrier levels.

Total medical expense (TME): The sum of the allowed amount of total claims and total non-claims spending paid to providers incurred by Washington residents for all health care services. TME is reported at multiple levels: state, market, payer and large provider entity level. TME is reported net of pharmacy rebates at the state, market and payer levels only. More detailed TME reporting specifications are contained in the Appendices of this manual.

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[1] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., carrier, pharmacy benefit manager, etc.) that represent fair market value for a bona fide, itemized service actuallyperformed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement (e.g., data service fees, distribution service fees, patient caremanagement programs, etc.)
[2] CMS is unable to report pharmaceutical rebates for traditional Medicare beneficiaries (i.e., FFS Medicare). Therefore, in the computations of THCE at the state and Medicare market levels, spendingwill be gross of Medicare FFS pharmaceutical rebates.

I. Health Care Cost Growth Benchmark Methodology

The health care cost growth benchmark (the Benchmark) is the targeted annual per capita growth rate for Washington's total health care spending, expressed as the percentage growth from the prior year's per capita spending. The health care cost growth benchmark is set on a calendar year basis.

To derive the cost growth Benchmark, the Board adopted a methodology that uses a 70/30 weighting of historical median wage growth and growth in potential gross state product. In doing so, the Board wished to emphasize affordability for consumers, recommending an expectation that health care spending not grow faster than a measure of consumer well-being. By also including PGSP in the methodology, the Board wished to acknowledge that health care spending should not grow faster than the state economy.

This 70/30 weighting of historical median wage and PGSP yielded a Benchmark value of 3.2%. The Board used this as a starting value but opted to phase it down over time, indicating that an assertive benchmark was necessary to mitigate the impact of rising health care costs on consumers. Table 1 presents the Benchmark values set by the Board for 2022 through 2026.

Table 1. Washington Health Care Cost Growth Benchmark Values, 2022-2026

Calendar year	Cost growth Benchmark values
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

The Board will annually review performance against the Benchmark and may consider any impacts on the overall health system, including cost of care, access to care, quality of care, and impact on specific populations, providers, or market sectors. In the event of extraordinary circumstances including highly significant changes in the economy or the health care system, the Board may consider changes to the Benchmark or to the Benchmark methodology.

To assist in this reassessment, the sources for each of the components of the Benchmark Methodology as calculated for the Board are included in Table 2.

Table 2. Data Sources for Calculating the Benchmark Value

Methodology Component	Source	Value
Historical median wage	Average annual growth in median hourly wage in Washington from 2000 to 2019 as reported by the Washington State Employment Security Department.	3.0%
Potential Gross State Product	Calculated as expected growth in national labor force productivity + expected growth in the state civilian labor force + expected national inflation – expected state population growth	3.8%
Expected growth in national labor force productivity	The Congressional Budget Office, The Budget and Economic Outlook: 2020-2030 published on February 2021.	1.5%
Expected growth in the state civilian labor force	Washington Office of Financial Management, Forecasting and Research Division, Long-Term Forecast Table 2-4. Forecast data are only available in 5-year increments and the average annual growth rate is calculated by assuming the 5 year growth is spread equally.	1.3%
Expected national inflation (Personal Consumption Expenditures)	The Congressional Budget Office, The Budget and Economic Outlook: 2020-2030 published on February 2021.	1.9%
Expected state population growth	Washington Office of Financial Management, Forecasting and Research Division, State Population Forecast.	0.8%

II. Measuring Performance Against the Benchmark

Chapter 70.390 RCW requires the Board to report annually on performance relative to the Benchmark at the state, health insurance market, individual payer, and large provider entity levels. Administration of the Board is housed in and supported by Washington's Health Care Authority (HCA), which will lead the state effort to measure performance against the Benchmark. The following section contains the methodology for measuring the growth in health care spending at each level of reporting and details the data sources that HCA will use.

Reporting of Performance Against the Benchmark

To assess health care spending growth, the HCA will measure THCE or TME annually, in aggregate dollars and on a per member per year (PMPY) or per member per month (PMPM) basis. The aggregate dollar figure will be for informational purposes only. The percentage change in THCE/TME on a PMPY/PMPM basis between the measurement year and the prior calendar year will be used to assess performance against the benchmark applicable to the specific measurement year. HCA will calculate spending at each of level or reporting as follows:

- **State:** Aggregate spending and PMPY spending using unadjusted, non-truncated THCE;
- **Market (Medicare, Medicaid, commercial):** Aggregate spending and PMPY spending using non-truncated, unadjusted TME;
- **Carrier, stratified by market:** PMPM spending using truncated, age/sex adjusted TME; and
- **Large provider entity stratified by market:** PMPM spending using truncated, age/sex adjusted TME.

All spending data at the state, market, and carrier levels are reported net of pharmacy rebates. Spending data at the large provider entity level are reported gross of pharmacy rebates since carriers provide rebate data in the aggregate, and HCA cannot attribute rebates to specific providers.

Data Sources

Data for THCE come from several sources. Carriers need to report TME for all lines of business and, in some instances, carriers need to report data for the State to calculate the NCPHI. Other data sources include the Centers for Medicare and Medicaid Services (CMS) and HCA. Table 3 outlines the data source by THCE category.

Table 3. Components of THCE Calculation by Data Source

Component of Total Health Care Expenditures	Category	Data Source
Total Medical Expenses	Carrier claims payments	Carrier data submission template
	Carrier non-claims payments	Carrier data submission template
	Carrier enrollment	Carrier data submission template
	Carrier pharmacy rebates	Carrier data submission template
	Medicare fee-for-service claims payments and enrollment, and all Part D spending	Centers for Medicare & Medicaid Services
	Non-managed care claims and non-claims payments and enrollment for Medicaid	Washington Health Care Authority submission template
	Veterans' Health Administration medical spending and enrollment	Department of Veterans' Affairs
	Medical spending for state workers' compensation and enrollment	Washington Department of Labor & Industries submission template
	Health care spending for incarcerated individuals and enrollment	Washington Department of Corrections submission template
Net Cost of Private Health Insurance	NCPHI for the commercial fully insured market	Federal commercial medical loss ratio (MLR) reports
	NCPHI for Medicare Advantage	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	NCPHI for Medicaid Managed Care	The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners (NAIC)
	Income from Fees of Uninsured Plans to calculate NCPHI for the commercial self-insured market	Carrier data submission template
	Number of member months in each market for calculating NCPHI	Carrier data submission template

Calculating Total Health Care Expenditures and Total Medical Expense

Statewide THCE

Below are the formulas for calculating statewide THCE, in aggregate and PMPY. HCA will calculate cost growth using non-truncated TME.

Statewide THCE (in aggregate)

= *Commercial TME + Medicare MCO TME + Medicare FFS TME +*
Medicaid MCO TME + Medicaid FFS TME + Insurer NCPHI + VA TME + L&I TME + DOC TME

Statewide THCE (PMPY)

$$= \frac{\text{Commercial TME + Medicare MCO TME + Medicare FFS TME + Medicaid MCO TME + Medicaid FFS TME + Insurer NCPHI + VA TME + L\&I TME + DOC TME}}{\text{Commercial members + Medicare MCO members + Medicare FFS members + Medicaid MCO members + Medicaid FFS members - Medicaid dually eligible members + VA enrollees + DOC enrollees}}$$

Market Level TME

Below are the formulas for calculating TME in aggregate and PMPY for the Medicare, Medicaid, and commercial markets. HCA will calculate cost growth using non-truncated TME.

Medicare Market TME (in aggregate)

$$= \text{Medicare MCO TME + Medicare FFS TME}$$

Medicare Market TME (PMPY)

$$= \frac{\text{Medicare MCO TME + Medicare FFS TME}}{\text{Medicare MCO members + Medicare FFS members}}$$

Medicaid Market TME (in aggregate)

$$= \text{Medicaid MCO TME + Medicaid FFS TME}$$

Medicaid Market TME (PMPY)

$$= \frac{\text{Medicaid MCO TME + Medicaid FFS TME}}{\text{Medicaid MCO members + Medicaid FFS members}}$$

Commercial Market TME (in aggregate)

$$= \text{Commercial TME}$$

Commercial Market TME (PMPY)

$$= \frac{\text{Commercial TME}}{\text{Commercial members}}$$

Carrier Level TME

Below are the formulas for calculating Insurer TME PMPM. At the carrier level, HCA will calculate cost growth using truncated TME.

Carrier, by Market (PMPM)

$$= \frac{\textit{Truncated TME for the Insurer for a given market}}{\textit{Member Months Reported for the carrier for a given market}}$$

Large Provider Entity Level TME

Below are the formulas for calculating provider TME PMPM. At the large provider entity level, HCA will calculate cost growth using truncated TME.

Insurer, by Market (PMPM) =

$$= \frac{\textit{Truncated TME for the Large Provider Entity for a Given Market}}{\textit{Member Months Attributed to the Large Provider Entity for a Given Market}}$$

Calculating the Net Cost of Private Health Insurance

The net cost of private health insurance (NCPHI) captures the costs to Washington residents associated with the administration of private health insurance. It is defined as the difference between health premiums earned and benefits incurred and consists of carriers' costs of paying bills, advertising, sales commissions and other administrative costs, premium taxes and profits or losses. NCPHI is reported as a component of THCE at the state level.

Because of substantial differences among segments of the Washington health insurance market, NCPHI will be calculated on a PMPM basis separately for the seven different lines of business:

- Individual Market;
- Large Group, Fully Insured;
- Small Group, Fully Insured;
- Self-insured;
- Student market;
- Medicare Advantage; and
- Medicaid/CHIP managed care.

Data needed to calculate Carriers' NCPHI for the above lines of business come from several sources:

- **Medical Loss Ratio (MLR) Data:** MLR data will be used to calculate NCPHI for the commercial fully insured market. The MLR Public Use Files can be downloaded from the CMS Center for Consumer Information and Oversight (CCIIO) website. These reports become publicly available in the fall, but if there is a delay in CMS publishing the data the MLR reports can be requested directly from Carriers in order to meet the reporting timeline.
- **Supplemental Health Care Exhibits (SHCE):** The SHCEs will be used to calculate NCPHI for the commercial self-insured, Medicare Advantage and Medicaid Managed Care markets.

These exhibits may be submitted directly to the OIC by carriers or purchased from the National Association of Insurance Commissioners (NAIC) InsData portal.

This following describes how to calculate NCPHI for each line of business and for the state as a whole.

Commercial – Fully Insured Market NCPHI

The fully insured commercial market consists of individual plans, the fully insured large and small group plans, and student plans. For this market, NCPHI is calculated using data from the federal commercial MLR reports. These reports, published by CMS Center for Consumer Information and Oversight (CCIIO),[3] become publicly available in the fall. The calculation is as follows:

NCPHI

= Premiums as of March 31 (Part 1, Line 1.1)
- Total Incurred Claims as of March 31 (Part 1, Line 2.1)
+ Advance Payments of Cost-Sharing Reductions (Part 2, Line 2.18)
- MLR Rebates Current Year (Part 3, Line 5.4)

Commercial – Self-Insured Market NCPHI

For the self-insured commercial market, NCPHI is calculated using additional data submitted by self-insured payers on the income from fees for uninsured plans. Payers with self-insured lines of business must provide total premiums received for self-insured accounts (in aggregate), following the instructions for Part 1, Line 12 on the NAIC SHCE for their Washington-situs self-insured accounts. This should be recorded on the Cover Page under table 1.4. The calculation of NCPHI for the self-insured commercial market is as follows:

NCPHI

= Income from Fees of Uninsured Plans
(as Reported by Carriers to HCA in the Data Submission Template)

Medicare Advantage NCPHI

For the Medicare Advantage market, data from the National Association of Insurance Commissioners' Supplemental Health Care Exhibit (SHCE) will be used to derive NCPHI. The SHCE can be obtained from OIC annually each April. The data elements that will be used in the calculation are from column 12 "Medicare Advantage Part C and Medicare Part D Stand-Alone Subject to ACA." The Medicare Advantage reporting combines stand-alone prescription drug plans (PDP) and the Medicare Advantage plans with Part D inclusion (MAPDs). Therefore, carriers that offer both PDP and MAPD will need to separately report health premiums earned, total incurred claims and members months for PDP and MAPD. The calculation of NCPHI for the Medicare Advantage is as

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[3] Available at www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

follows:

NCPHI

= Health Premiums Earned as of March 31 (Part 1, Line 1.1, Column 12)
- Total Incurred Claims as of March 31 (Part 1, Line 5.0, Column 12)

Medicaid MCO Market NCPHI

The Supplemental Health Care Exhibit (SHCE) from the National Association of Insurance Commissioners will be used to derive NCPHI of the Medicaid MCO market. HCA will obtain the SHCE from OIC annually each April. The data elements that will be used in the calculation are from column 10 "Government Business (Excluded by Statue)." The formula is included below:

NCPHI

= Health Premiums Earned as of March 31 (Part 1, Line 1.1, Column 10)
- Total Incurred Claims as of March 31 (Part 1, Line 5.0, Column 10)

Aggregate NCPHI

Upon calculating each market segment's NCPHI, HCA will calculate the aggregate NCPHI. To do so, HCA will first adjust commercial, Medicare Advantage, and Medicaid MCO data to use in situ information. HCA will calculate the average NCPHI PMPM by market segment by adding the total NCPHI by carrier within the segment and then dividing it by the total member months as reported in the MLR report for commercial market segments or total members months as reported in the SHCE for the Medicare Advantage and Medicaid CMO markets. Next, HCA will take the newly calculated average NCPHI PMPM and multiply it by each carrier's market segment member months as reported within the TME submission to get aggregate NCPHI for each carrier within each market segment.

III. Payer Reporting of Data for the Cost Growth Benchmark

Annually, the Board will direct applicable carriers to submit TME data using the specifications outlined in Appendix A. Table 4 lists the carriers the must submit TME data to HCA for each market.[4]

Table 4. Carriers Requested to Submit TME Data by Market

Carrier	Commercial Fully and Self-Insured	Medicare Managed Care	Medicaid Managed Care
Anthem Inc Group	X		X
Cambia Health Solutions Inc	X		
Centene Corp Group	X		X
Cigna Health & Life Ins Co	X		
Community Health Network Group	X	X	X
CVS Group	X		
Health Alliance NW Health Plan	X	X	
Humana Group	X	X	
Kaiser Foundation Group	X	X	
Molina Healthcare Inc Group	X	X	X
Premera Blue Cross Group	X	X	
UnitedHealth Group	X	X	X

HCA will also obtain the following data from public payers:

- Non-managed care spending data for Medicaid the specifications in Appendix B.
- Medicare FFS data using the specifications in Appendix C.
- L&I data using the specifications in Appendix D.
- Department of Corrections data using the specifications in Appendix E.
- Veterans Affairs data using the specifications in Appendix F.

[4] This table represents the largest carriers in the Washington insurance market as of June 2020. Because the market may change, this table may need to be updated over time.

Appendix A: Carrier Total Medical Expense Data Specifications

This Carrier Total Medical Expense Data Specifications document provides technical details to assist carriers in reporting and filing data that the Health Care Authority (HCA) will use to assess performance against the Benchmark. HCA may periodically update and revise these data specifications in subsequent versions.

TME File Submission Schedule

In general, HCA will annually request total medical expense (TME) data file(s) with dates of service for the measurement year and the calendar year prior to the measurement year. HCA may also request data for other past years.

Carriers will submit TME data using Excel templates provided by HCA using the schedule outlined in Table A-1.

Table A-1: Carriers' TME Filing Schedule for the Pre-Benchmark Data Collection

Date	Files Due
September 1, 2022	CY 2017, CY 2018, and CY 2019 TME

Included Populations

The populations for whom carriers should report TME include Washington residents who have comprehensive health care coverage through Medicare, Medicaid, or a commercial insurance product. Carriers should **not** report TME for policies that offer limited benefits. Table A-2 details the types of policies that should be included and excluded in carriers' reporting of TME.

Table A-2: Included and Excluded Policies in Carrier Reporting of TME

Included Policies	Excluded Policies
Commercial market policies ✓ Self-insured plans ✓ Short-term health plans ✓ Student health plans ✓ Fully insured individual and group plans ✓ The Washington Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB) Programs ✓ The Federal Employee Health Benefits Program (FEHB) The Medicare market policies: ✓ Medicare Advantage Health Maintenance Organization (HMO) ✓ Preferred Provider Organization (PPO) ✓ HMO Point of Service (HMOPOS) ✓ Medicare Medical Savings Account (MSA) ✓ Private Fee-for-Service (PFFS) ✓ Special Needs Plans (SNPs) Medicaid contracts ✓ Medicaid and CHIP managed care contracts with the Washington Health Care Authority	Policies offering limited benefits, including: ✗ Accident policy ✗ Disability policy ✗ Hospital indemnity policy ✗ Long-term care insurance ✗ Medicare supplemental insurance (AKA Medigap) ✗ Stand-alone prescription drug plans ✗ Specific disease policy ✗ Stop-loss plans ✗ Supplemental insurance that pays deductibles, copays, or coinsurance ✗ Vision-only insurance ✗ Workers compensation ✗ Dental-only insurance

General Specifications for TME Data Submissions

Reporting of TME

Carriers should report both claims and non-claims payments made directly to providers using service categories outlined and defined in further detail below.

Claims and non-claims spending must be reported based on the date the service was **rendered** or the spending was **incurred**, and not by the date of payment.

Carriers must include all **allowed amounts** for all claims data for members, regardless of whether services are provided by providers located in or out of Washington, and regardless of the situs of the member's plan.

Carriers should report spending for members for whom the carrier is the **primary insurer** on a claim. Paid claims for which the carrier is the secondary or tertiary payer should be excluded. However, carriers should not exclude spending for a member solely because they have additional coverage.

Reporting by Large Provider Entity and Attribution

Carriers must report TME by large provider entity, which requires attribution of individual patients to a primary care provider (PCP), and of those PCPs to a large provider entity. To attribute members to a PCP, carriers should follow the hierarchy outlined below:

1) **Member Selection:** Members who were required to select a PCP by plan design should be

assigned to that PCP.

2) **Contract Arrangement:** Members not included in #1 and who were attributed to a PCP during the performance period pursuant to contract between the carrier and the provider, should be attributed to that PCP.

3) **Utilization:** Members not included in #1 or #2, and who can be attributed to a PCP based on the member's utilization history should be attributed to that PCP. Carriers may apply their own primary care-based methodology when attributing a member to a PCP based on utilization.

Attribution of PCPs to a large provider entity should be performed consistent with carriers' contracts for financial and quality performance assessment purposes that were in place with the large provider entity during the reporting periods.

Spending on members who cannot be attributed to a PCP, or whose PCP cannot be attributed to a large provider entity should be reported in aggregate to large provider entity code "999, Unattributed to a Large Provider Entity."

The data reported for each provider entity must include **all TME** for all attributed members for each month a member was attributed, so long as the member was a Washington resident at the time of attribution, even when care was rendered by providers outside of or not affiliated with the respective provider entity. Carriers may choose whether residency is established as of the first of the month, last of the month, or another day of the month, consistent with their monthly attribution methodology.

Run-Out Period Specifications

Carriers shall allow for a claims run-out period of at least 180 days after December 31 of the reporting year. Carriers should apply reasonable and appropriate incurred but not reported (IBNR) and incurred but not paid (IBNP) completion factors to each respective claims service category based on commonly accepted actuarial principles and will be required to attest that they are reasonable and appropriate.

Carriers shall allow for a non-claims "run-out" period of at least 180 days after December 31 of the measurement year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. Carriers should apply reasonable and appropriate estimations of non-claims liability to each provider entity ID (including payments expected to be made to organizations not separately identified for TME reporting purposes) that are expected to be reconciled after the 180-day "run-out" period.

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

- Carrier Name_TME_YYYY_Version.xls
- YYYY is the four-digit year of submission.
- Version is optional and indicates the submission number.

- The file extension must be .xlsx

Below are examples of valid file names:

- TME_2018_01.xlsx or TME_2018_1.xlsx or TME_2018.xlsx

Submitting Files to HCA

Electronic files should be submitted to HCAHCCTBoard@hca.wa.gov

TME Data Tabs and Field Definitions

Carriers will submit data using an Excel Template provided by HCA. The template contains the following seven tabs:

- **Contents:** Provides an overview of the contents of the workbooks.
- **1_Cover_Page:** Collects information about the Carrier, requires Carriers to attest to the accuracy of the data submission, and asks a series of questions to confirm that Carriers' data submission follows HCA's specifications.
- **2_TME:** Collects spending and enrollment information used to compute THCE and TME.
- **3_SD:** Collects standard deviation information used to calculate confidence intervals for annual cost growth.
- **4_LOB:** Collects member month information by line of business, used to calculate NCPHI.
- **5_Rx Rebates:** Collects pharmacy rebate information by insurance category code.
- **6_Reference Tables:** Defines codes used to categorize spending data.

Each tab is described below in more detail.

Cover Page Tab

The Cover Page contains a series of questions on the completeness of data, whether and how the Carrier applied any estimates to complete the data, inclusion and exclusion criteria applied by the Carrier in defining the population, how the Carrier calculated standard deviation information. The intent of these questions is to confirm that Carrier's data submission follows the specifications outlined by HCA. Carriers attest to the accuracy and completeness of their submission on this tab.

This tab also includes space for carriers with self-insured lines of business to provide income from fees of uninsured plans (in aggregate). This information is used to calculate the net cost of private health insurance (NCPHI). Carriers must follow the instructions from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE), Part 1, Line 12, Income from Fees of Uninsured Plans.

TME Tab

Carriers will report their spending data in the TME tab. The following provides details on each of the variables.

Carrier Code (TME01): The HCA assigned organization ID for the carrier submitting the file as detailed in the Table A-3, which can also be found in the "Reference Tables" tab of the data submission template.[5]

Table A-3. Carrier Codes

Carrier Code	Carrier
201	Anthem Inc Group
202	Cambia Health Solutions Inc
203	Centene Corp Group
204	Cigna Health & Life Ins Co
205	Community Health Network Group
206	CVS Group
207	Health Alliance NW Health Plan
208	Humana Group
209	Kaiser Foundation Health Plan of NW
210	Kaiser Foundation Health Plan of WA
211	Molina Healthcare Inc Group
212	Premera Blue Cross Group
213	UnitedHealth Group

Reporting Year (TME02): The calendar year represented by the reported data. All reporting should be based on the date of service for claims spending, and the date the spending was incurred for non-claims spending. For the pre-benchmark data collection, carriers should report data for calendar years 2017, 2018 and 2019.

Insurance Category Code (TME03): A number that indicates the insurance category that is being reported. Carriers should report spending for all insurance categories for which they have business. There are six insurance categories as outlined in Table A-4, which can also be found in the "Reference Tables" tab of the data submission template. All data reported by Insurance Category Code should be mutually exclusive.

Table A-4. Insurance Category Codes

Insurance Category Code	Definition
1	Medicare Expenses for Non- Dual Eligible Members
2	Medicaid Expenses for Non-Dual Eligible Members
3	Commercial — Full Claims
4	Commercial — Partial Claims, Adjusted
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible

[5] This table may be updated from time to time as the carrier market in Washington changes.

Commercial claims should be categorized into:

- **Commercial – Full Claims** for when the carrier can collect information on all direct medical claims and any claims paid by a delegated entity.

- **Commercial – Partial Claims** for when services are "carved out" or provided separately by other benefit providers and the carrier does not have access to the claims for the carved out services. Carriers should make adjustments to any "partial claims" to make them to be comparable to full claims. The goal of the adjustment is to estimate what total expenses might be for those members without having to collect claims data from the carve-out vendors, such as pharmacy benefit managers or behavioral health vendors. For example, for those members for whom pharmacy benefits are carved out, the carrier might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. **Such an adjustment must be reviewed with HCA prior to implementing.**

If a carrier enrolls Medicare/Medicaid dual eligibles, HCA requires the carrier to report Medicare-related expenditures under insurance category code 5 and Medicaid-related expenditures under insurance category code 6. For example, if a carrier covers Medicare/Medicaid dual eligibles but is only responsible for Medicaid services, expenditures for those dual eligibles are reported under insurance category code 6.

Large Provider Entity Code (TME04): The ID for the large provider entity to which spending is attributed. Carriers must provide spending data for large provider entities using the codes assigned to them in Table A-5, which is also detailed in the "Reference Tables" tab of the data submission template. TME data for members who cannot be attributed to a large provider entity should be reported in aggregate as "Unattributed to a Large Provider Entity (Large Provider Entity Code 999)."

Table A-5. Large Provider Entity Codes

Large Provider Entity Code	Large Provider Entity
100	Overall All Provider Entities
101	Community Clinic Contracting Network (includes Yakima Valley, CHC Snohomish, Columbia Basin, Columbia Valley, International Community Health, Mariposa, Peninsula Community Health, Unity Care, & Sea Mar)
102	Community Health Association of Spokane
103	Community Health Care
104	Community Health of Central Washington
105	Confluence Health
106	Country Doctor Community Health Centers
107	Cowlitz Family Health Center
108	Evergreen Health
109	Family Care Network
110	Family Health Centers
111	Franciscan Health - including Virginia Mason Franciscan Health (part of Pacific NW Division of Common Spirit)
112	HealthPoint

113	Kaiser Permanente of Washington (medical centers in Western WA and Spokane)
114	Kaiser Permanente NW (medical centers in SW WA)
115	Legacy Health
116	Lewis County Community Health Services (Valley View Health Center)
117	Moses Lake Community Health Center
118	MultiCare Health includes Mary Bridge Children's Hospital; Navos
119	Wellfound Behavioral Health Hospitals – partnership with CHI Franciscan and MultiCare
120	NeighborCare Health
121	NEW Health Programs Association
122	North Olympic Healthcare Network PC
123	OptumCare (includes Everett Clinic, Polyclinic, and Northwest Physician's Network)
124	Overlake Medical Center
125	PeaceHealth
126	Providence Health/Swedish Health Services/PacMed/Kadlec
127	Rose Medical
128	Seattle Children's Care Network
129	Seattle-King County Public Health Dept (Health Care for the Homeless Network)
130	The Vancouver Clinic
131	Tri-Cities Community Health
132	UW Medicine (Valley Medical Center, Neighborhood Clinics)
133	Yakima Neighborhood Health Services
999	Unattributed to a Large Provider Entity

Age Band Code (TME05): The age group of the covered lives the data represent. This is used in conjunction with the Sex Code to calculate risk adjusters for the spending data. The age bands and associated codes are detailed in Table A-6 and in the "Reference Tables" tab of the data submission template. The age of the member should be determined as of December 31st of the calendar year for which data are being reported.

Table A-6. Age Band Codes

Age Band Code	Description
1	0 to 1 year old
2	2 to 18 years old
3	19 to 39 years old
4	40 to 54 years old
5	55 to 64 years old
6	65 to 74 years old
7	75 to 84 years old
8	85 + years old

Sex Code (TME06): The sex of the covered lives the data represent. This is used in conjunction with the "Age Band Code" to calculate risk adjustment for the data. The sex and associated codes are

detailed in Table A-7 and in the "Reference Tables" tab of the data submission template.

Table A-7. Sex Codes

Sex Code	Description
1	Female
2	Male
3	Other/Unknown

Member Months (TME07): The number of members enrolled in a plan over the reporting calendar year expressed in months of membership.

Claims: Hospital Inpatient (TME08): Sum of the allowed amount from the claims for hospital inpatient services. Includes all room and board and ancillary payments for all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific Carrier's payment rules. Does not include payments made for observation services, payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician, or inpatient services at non-hospital facilities (e.g., residential treatment facilities). **This is the non-truncated allowed amount.**

Claims: Hospital Outpatient (TME09): Sum of the allowed amount from the claims for hospital outpatient service. Includes all hospital types and payments made for hospital-licensed satellite clinics, emergency room services not resulting in admittance; and observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician. **This is the non-truncated allowed amount.**

Claims: Professional, Primary Care Providers (TME10): Sum of the allowed amount from the claims paid to primary care providers for primary care services using the provider taxonomy and procedure codes in Appendix A, Attachments 1 and 2. **Amounts reported should be based on the non-truncated allowed amount.**

This is based on the narrow definition of primary care is outlined in the Office of Financial Management's (OFM) Primary Care Expenditures Report. This definition identifies primary care providers as family practice, geriatric, FQHCs, internal medicine and pediatric providers (physicians, physician assistants, and nurse practitioners) using taxonomy codes in Attachment 1, Table A- 11. It excludes providers performing roles not traditionally contained within a strict definition of primary care (e.g., obstetricians, midwife, registered nurse, psychologist, psychiatrist, social worker, etc.).

Primary care services are defined using the codes in Attachment 1, Table A-12. These include care management; care planning; counseling; domiciliary, rest home, or custodial care; FQHC visits; health risk and screenings; home health services; immunization administrations; office visits and preventive medicine visits. They do not include inpatient services billed by primary care providers, prescription drugs (including those covered by both medical and pharmacy benefits), laboratory, x-ray and imaging services.

Claims: Professional, Specialty Providers (TME11): Sum of the allowed amount from the claims paid to physicians or physician group practices that are not defined as a PCP. Includes services

provided by a doctor of medicine or osteopathy in clinical areas other than family practice, geriatrics, internal medicine, and pediatrics as defined above using OFM's narrow definition of primary care. **Amounts reported should be based on the non-truncated allowed amount.**

Claims: Professional, Other Providers (TME12): Sum of the allowed amount from the claims paid to a licensed practitioner other than a PCP or specialty provider. Includes, but is not limited to, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, chiropractors, and any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services. **This is the non-truncated allowed amount.**

Claims: Long-Term Care (TME13): Sum of the allowed amount from the claims paid to health care providers for skilled or custodial nursing facility services, intermediate care facilities and services for persons with developmental disabilities, hospice, and providers of home- and community-based services including personal care (e.g., assistance with dressing, bathing, eating, etc.), homemaker and chore services, home delivered meal programs, home health services, adult daycare, self-directed personal assistance services, and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE or Roads to Community Living. Does not include payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner. **This is the non-truncated allowed amount.**

Claims: Retail Pharmacy (TME14): Sum of the allowed amount from the claims paid to retail pharmacies for prescription drugs, biological products or vaccines as defined by the carrier's prescription drug benefit. This category should not include claims paid for pharmaceuticals under the carrier's medical benefit. Pharmacy payments made under the medical benefit should be attributed to the setting in which it was delivered (e.g., drugs delivered in a hospital inpatient setting should be attributed to the "Claims: Hospital Inpatient" category). Medicare Advantage carriers that offer stand-alone prescription drug plans (PDPs) should exclude stand-along PDP spending from their reporting. Pharmacy data should be reported **gross of applicable rebates. This is the non-truncated allowed amount.**

Claims: Other (TME15): Sum of the allowed amount from the claims paid to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of health care benefits/services may be reported in "Claims: Other" if the carrier is unable to classify the service.

If there is uncertainty about how to classify a service, carriers should consult with HCA about the appropriate placement of the service prior to categorizing it as "Claims: Other." Optical/vision services should only be included if they are covered under a comprehensive medical benefit and not a standalone vision plan. TME data for non-health care benefits/services, such as fitness club reimbursements, are not to be reported in any category. Payments for fitness club membership discounts whether given to the provider or given in the form of a capitated payment to an organization that assists the carrier with enrolling members in gyms is not a valid payment to include. **This is the non-truncated allowed amount.**

Non-Claims: Capitation or Bundled Payments (TME16): All non-claims based payments made to cover health care services. Examples include capitation, global budget, case rate, and episode-based

payments.

Non-Claims: Performance Incentive Payments (TME17): All payments made to providers for achievement of specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., pay-for-reporting and pay-for-performance payments). This includes shared savings distributions and shared risk recoupments.

Non-Claims: Population Health and Practice Infrastructure Payments (TME18): All payments made to providers to develop capacity and practice infrastructure to help coordinate care, improve quality, and control costs. This can include EHR/HIT infrastructure payments, patient-centered medical home (PCMH) recognition payments, and primary care and behavioral health integration payments that are not reimbursable through claims.

Non-Claims: Provider Salaries (TME19): All payments for salaries of providers who provide health care services not otherwise included in claims and non-claims categories.

Non-Claims: Recovery (TME20): All payments recouped during the measurement year as the result of a prior review, audit, or investigation, regardless of the time period of the initial payment. This field should be reported as a negative number. Only report data in this column that is not otherwise included elsewhere (e.g., if Inpatient Hospital is reported net of Recovery, do not separately report the same Recovery amount in this column).

Non-Claims: Other (TME21): All other payments made pursuant to the carrier's contract with a provider that were not made based on a claim for health care benefits/services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. It may also include Medicaid Transformation Project (MTP) payments made directly by Carriers to providers. Only payments made to providers are to be reported; carrier administrative expenditures (including corporate allocations) are not included in TME.

Truncated Claims Spending (TME22): All payments spent on members after truncation has been applied on a per member basis. This is the only column that will have truncated spending values made on a per member basis. The amounts by which to truncate member spending are listed in Table A-8 and are based on insurance category.

Table A-8. Truncation Thresholds for Insurance Categories

Insurance Category Code	Insurance Category	Amount to Truncate on a Per Member Basis
1	Medicare Expenses for Non- Dual Eligible Members	$125,000
2	Medicaid Expenses for Non-Dual Eligible Members	$125,000
3	Commercial — Full Claims	$200,000
4	Commercial — Partial Claims, Adjusted	$200,000
5	Medicare Expenses for Medicare/Medicaid Dual Eligible	$125,000
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible	$125,000

HCA requests that truncation be applied to individuals' total spending, inclusive of all medical and pharmacy spending. For carriers reporting Insurance Category Code 4 (Commercial: Partial Claims), the member level truncation should be applied after estimates of carve-out spending have been made, so that truncation is being applied to an estimate of individual members' total claims spending (see inset below for an explanation of how to truncate partial claims spending).

How to Apply Truncation to Insurance Category Code 4 (Commercial: Partial Claims)

- A carrier reporting Insurance Category Code 4 (Commercial: Partial Claims) data has carved out its pharmacy benefit to a PBM and does not have access to claims level spending.
- The carrier would develop an estimate for what Insurance Category Code 4's PMPM spending on pharmacy would have been using its Insurance Category Code 3 (Commercial: Full Claims) population experience as a benchmark.
  - For example, for those members for whom pharmacy benefits are carved out, the carrier might include its commercial market book of business average pharmacy spending per-member per-month for the same year, calculated on members who had pharmacy coverage, and applied to all member months for which the carve out applied. **Note: Such an adjustment must be reviewed with HCA before the adjustment is made.**
- The carrier would add this PMPM estimate to member level spending by multiplying the estimated Insurance Category 4 Rx PMPM by the number of member months within each age/sex band.
- The carrier would then apply the per-member truncation to Insurance Category Code 4.

How to Handle Truncation When Members Are Attributed to More than One Large Provider Entity During the Calendar Year

Example with a $200,000 truncation point:

- A member in Insurance Category Code 3 was attributed to Provider X for 8 months with $250,000 in claims.
- The member is then attributed to Provider Y for 4 months with $225,000 in claims.
- Provider X's spending above the truncation would be $50,000 while Provider Y's spending above the truncation would be $25,000.
- Since the member cost the payer $475,000 in total, the total dollars above the truncation point for the payer would be $275,000.

In addition, for members who are attributed to more than one large provider entity during the year, carriers should "reset the clock" and calculate truncated spending for the member for each of the large provider entities, and for the carrier as a whole. This is done by first calculating the member's total spending that is attributed to each large provider entity, and separately applying truncation to the member's spending that is attributed to each large provider entity.

Count of Members with Claims Truncated (TME23): This field is for the number of members whose spending was truncated for the "Truncated Claims Spending" value.

Standard Deviation Data (SD) Tab

The SD data will give HCA the basis for calculating confidence intervals for comparison against the benchmark. Below are details on each of the variables.

Carrier Code (SD01): The HCA-assigned organization for the carrier submitting the file as detailed in Table A-3, which can also be found in the "References Tables" tab of the data submission template.

Reporting Year (SD02): The calendar year of time represented by the reported data. For pre-benchmark data collection, carriers should report data for calendar years 2017, 2018, and 2019.

Market Code (SD03): Code associated with the market being reported as defined in Table A-9. Market Codes.

Table A-9. Market Codes

Market Code	Description
1	Medicare (Insurance Category Codes 1 and 5)
2	Medicaid (Insurance Category Codes 2 and 6)
3	Commercial (Insurance Category Codes 3 and 4)

Large Provider Entity Code (SD04): The ID for the large provider entity whose standard deviation in monthly claims spending is being reported. The codes assigned to each large provider entity is detailed in Table A-5, which is also included in the "References Tables" tab of the data submission template.

Member Months (SD05): The number of members enrolled in a plan over the reporting calendar year expressed in months of membership.

Total Claims Truncated Spending (SD06): Total truncated claims spending associated with the large provider entity and market.

Standard Deviation PMPM (SD07): The calculated standard deviation for all members for the applicable large provider entity and market, reported as a PMPM value. Carriers must calculate and report standard deviation data as follows:

- For each large provider entity (using the codes in Table A-5), by market (using the codes in Table A-9); and
- For the Carrier as a whole (using the codes in Table A-3), by market (using the codes in

Table A-9).

Carriers should include standard deviation data for all large provider entities with whom they hold contracts. The following steps detail how carriers can calculate standard deviation PMPM values for the data submission:

1) Attribute members to the appropriate large provider entity. Carriers should include all members attributed to a large provider entity, including members with no utilization.

2) For each market, for each large provider entity, the carrier must calculate the average monthly spending amount of each member using claims-based allowed amounts. Carriers should calculate the average claims-based allowed amount after partial claims adjustments and after truncation of member level spending. Non-claims expenditures should be excluded from this average.

3) Use the per-month average for each individual and multiply that value by the number of enrolled member months for that member. Sum the values for all members and divide by the total number of member months to produce a per member per month dollar amount that is specific to a given market and large provider entity. Note that when calculating the standard deviation of the population for the cost growth benchmark program, carriers must use each member's average cost applied to each month they were enrolled, instead of the actual utilization each month.

4) With the average claims expenses value for each large provider entity, carriers can now calculate the standard deviation. The formula is:

$$SD = \sqrt{\frac{\sum_i (X_i - \bar{X})^2}{N}}$$

   Using the Excel function STDEV.P() or other standard deviation commands in any other statistical software program, carriers can calculate the risk-adjusted standard deviation of the PMPM costs for a given market.

   Note that when calculating standard deviation, carriers should use the formula for population standard deviation (divided by N). Carriers should NOT use the formula for sample standard deviation (divided by N-1).

5) Report the standard deviation values for in the data submission template in Tab "3_SD." Each row should correspond to either a large provider entity or the market for the Carrier overall.

Line of Business Enrollment (LOB_ENROLL) Tab

The line of business enrollment file will be the source of the carrier's member months by market that HCA will use to compute net cost of private health insurance (NCPHI). Carriers will report their member months by market in this tab.

Carrier Code (LOB01): The HCA-assigned organization for the carrier submitting the file as detailed in Table A-3, which can also be found in the "References Tables" tab of the data submission template.

Line of Business Category (LOB02): The code corresponding to the line of business for plans categorized by the insurer as individual, large group – fully insured, small group – fully insured, self-insured, student market, Medicare managed care, Medicaid/CHIP managed care, and Medicare/Medicaid duals. These market enrollment category codes are listed in Table A-10.

Table A-10. Line of Business Codes

Line of Business Category	Description
1	Large group (51+ employees), fully insured
2	Small group (2-50 employees), fully insured
3	Self-insured
4	Individual
5	Student plans
6	Medicare (Non-dual eligible)
7	Medicaid (Non-dual eligible)
8	Medicare (Dual eligible)
9	Medicaid (Dual eligible)

Member Months (annual) (LB03 – LB05): The number of unique members participating in a plan by the above categories each month with at least a medical benefit. Member months should be calculated by summing each member's number of months with a medical benefit during the calendar year.

Pharmacy Rebate (RX_REBATE) Tab

This tab is for carriers to report pharmacy rebates data by insurance category code. Carriers should **not** try to allocate pharmacy rebates at the member or large provider entity level.

Total rebates should be reported without regard to how they are paid to the insurer (e.g., through regular aggregate payments, on a claim-by-claim basis, etc.). The only exception is for Medicaid managed care carriers which should not report pharmacy rebates that are passed to the State. They should only report those rebates beyond the state-negotiated rebates.

Carriers should report both retail pharmacy rebates and medical pharmacy rebates. Pharmacy rebates should be reported as a negative number.

Guidance for Reporting Pharmacy Rebates

Pharmacy rebates may have long tails (e.g., 12 or more months) and carriers may not have complete pharmacy rebate data for a measurement period in time for the annual cost growth benchmark data submission. Carriers should apply IBNR factors to preliminary prescription drug rebate data to estimate total anticipated rebates related to fill dates in the reporting period.

If carriers are unable to report rebates specifically for Washington residents, carriers should report estimated rebates attributed to Washington residents in a proportion equal to the proportion of pharmacy spending for Washington residents compared to pharmacy spending for total members, by insurance category code. For example, if Washington commercial member spending represents 10% of a carrier's total commercial members, then 10% of the total pharmacy rebates for its commercial book of business should be reported.

If carriers are unable to identify the percentage of pharmacy spending for Washington residents, then carriers should calculate the pharmacy rebates attributable to Washington residents using percentage of membership. Some self-funded employer groups ask for portions of the rebates to be passed along to them.

Carriers should report any rebates they receive, regardless of whether they are passed along to employers.

Carrier Code (RXR01): Code associated with the carrier submitting data on pharmacy rebates. See Table A-3 or the "Reference Tables" tab of the data submission template.

Reporting Year (RXR02): Year for which data are being reported.

Insurance Category Code (RXR03): Code associated with the insurance category for which the carrier is reporting pharmacy rebates. See Table A-4 or the "Reference Tables" tab of the data submission template.

Medical Pharmacy Rebate Amount (RXR04): The estimated value of federal and state supplemental rebates attributed to Washington residents provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill corresponding with the reporting period. This excludes 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. This amount should include pharmacy benefit manager (PBM) rebate guarantee amounts and any additional rebate amounts transferred by the PBM.

Retail Pharmacy Rebate Amount (RXR05): The estimated value of the federal and state supplemental rebates attributed to Washington residents provided by pharmaceutical manufacturers for prescription drugs that are administered by retail pharmacies and have specified dates of fill corresponding to the reporting period. This amount should include PBM rebate guarantee amounts and any additional rebate amounts transferred by the PBM. This excludes manufacturer-provided fair market value bona fide services fees for retail prescription drugs.

Total Pharmacy Rebate Amount (Optional) (RXR06): The total pharmacy rebate amount reported only if carriers are unable to separately report medical and retail pharmacy rebates in RXR04 and RXR05. If this field is used, RXR04 and RXR05 should be blank.

Reference Tables Tab

The data submission template uses various codes to categorize the spending data. The codes are listed in the "Reference Tables" tab of the data submission template, and includes the following:

- Insurance category code
- Market code
- Line of business categories code
- Age band code
- Sex code
- Large provider entity code
- Carrier code

Appendix A, Attachment 1: Primary Care Taxonomy Codes

Table A-11 lists select provider taxonomy codes for the primary care specialties included in OFM's definition of primary care providers (e.g., family practice, geriatrics, internal medicine and pediatrics) and certain provider organization taxonomy codes (e.g., federally qualified health centers). Carriers should identify primary care providers first by searching for provider taxonomy codes in Table A-11 in the rendering provider field and then the billing provider field. If the carrier does not use the provider taxonomy codes in Table A- 11, it may apply its provider codes to match the description of the provider taxonomy codes in Table A- 11.

Table A- 11. Primary Care Provider Taxonomy Codes

Taxonomy Code	Description
207Q00000X	Family Medicine
207QA0000X	Family Medicine, Adolescent Medicine
207QA0505X	Family Medicine, Adult Medicine
207QG0300X	Family Medicine, Geriatric Medicine
261QF0400X	Federally Qualified Health Center
208D00000X	General Practice
207R00000X	Internal Medicine
207RG0300X	Internal Medicine, Geriatric Medicine
175F00000X	Naturopath
208000000X	Pediatrics
2080A0000X	Pediatrics, Adolescent Medicine
2083P0500X	Preventive Medicine, Preventive Medicine/Occupational Environmental Medicine
261QP2300X	Primary care clinic
261QR1300X	Rural health clinic
63L00000X	Nurse Practitioner
63LA2100X	Nurse Practitioner, Acute Care
63LA2200X	Nurse Practitioner, Adult Health
63LC1500X	Nurse Practitioner, Community Health
63LC0200X	Nurse Practitioner, Critical Care Medicine
63LF0000X	Nurse Practitioner, Family
63LG0600X	Nurse Practitioner, Gerontology
63LN0000X	Nurse Practitioner, Neonatal
63LN0005X	Nurse Practitioner, Neonatal, Critical Care
63LX0001X	Nurse Practitioner, Obstetrics & Gynecology
63LX0106X	Nurse Practitioner, Occupational Health
63LP0200X	Nurse Practitioner, Pediatrics
63LP0222X	Nurse Practitioner, Pediatrics, Critical Care
63LP1700X	Nurse Practitioner, Perinatal
63LP2300X	Nurse Practitioner, Primary Care
63LP0808X	Nurse Practitioner, Psychiatric/Mental Health

Taxonomy Code	Description
63LS0200X	Nurse Practitioner, School
63LW0102X	Nurse Practitioner, Women's Health
63A00000X	Physician Assistant
63AM0700X	Physician Assistant, Medical
63AS0400X	Physician Assistant, Surgical

Appendix A, Attachment 2: Primary Care Procedure Codes

Table A-12 lists procedure codes for services that Carriers should include in the "Claims: Professional, Primary Care Providers (TME10)" spending category in the TME tab. Services must be performed by a primary care provider as defined by OFM using the taxonomy codes in Table A-11.

Table A-12. Primary Care Procedure Codes

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99497	Advance Care Planning Evaluation & Management Services	ADVANCE CARE PLANNING FIRST 30 MINS
99498	Advance Care Planning Evaluation & Management Services	ADVANCE CARE PLANNING EA ADDL 30 MINS
99450	Basic Life and/or Disability Exam	BASIC LIFE AND/OR DISABILITY EXAMINATION
99455	Basic Life and/or Disability Exam	WORK RELATED/MED DBLT XM TREATING PHYS
99456	Basic Life and/or Disability Exam	WORK RELATED/MED DBLT XM OTH/THN TREATING PHYS
99366	Case Management Services	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN
99367	Case Management Services	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN
99368	Case Management Services	TEAM CONFERENCE NON-FACE-TO-FACE NONPHYSICIAN
99487	Chronic Care Management Services	CMPLX CHRON CARE MGMT W/O PT VST 1ST HR PER MO
99489	Chronic Care Management Services	CMPLX CHRON CARE MGMT EA ADDL 30 MIN PER MONTH
99490	Chronic Care Management Services	CHRON CARE MANAGEMENT SRVC 20 MIN PER MONTH
G0506	Chronic Care Management Services	COMP ASMT OF & CARE PLNG PT RQR CC MGMT SRVC
99241	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 15 MIN
99242	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 30 MIN
99243	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 40 MIN
99244	Consultation Services	OFFICE CONSULTATION NEW/ESTAB PATIENT 60 MIN
G0438	Counseling, Screening, & Prevention Services	ANNUAL WELLNESS VISIT; PERSONALIZ PPS INIT VISIT
G0439	Counseling, Screening, & Prevention Services	ANNUAL WELLNESS VST; PERSONALIZED PPS SUBSQT VST
G0442	Counseling, Screening, & Prevention Services	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES
G0443	Counseling, Screening, & Prevention Services	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN
99324	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT VISIT LOW SEVER 20 MIN
99325	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT VISIT MOD SEVER 30 MIN
99326	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT HI-MOD SEVER 45 MINUTES
99327	Domiciliary, Rest Home or Custodial Care	DOMICIL/REST HOME NEW PT VISIT HI SEVER 60 MIN

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99328	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M NEW PT SIGNIF NEW PROB 75 MINUTES
99334	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT SELF-LMTD/MINOR 15 MINUTES
99335	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT LW MOD SEVERITY 25 MINUTES
99336	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT MOD HI SEVERITY 40 MINUTES
99337	Domiciliary, Rest Home or Custodial Care	DOM/R-HOME E/M EST PT SIGNIF NEW PROB 60 MINUTES
99078	Educational Service Group Setting	PHYS/QHP EDUCATION SVCS RENDERED PTS GRP SETTING
G0466	FQHC Visits	FEDERALLY QUALIFIED HEALTH CENTER VISIT NEW PT
G0467	FQHC Visits	FEDERALLY QUALIFIED HEALTH CENTER VISIT ESTAB PT
G0468	FQHC Visits	FEDERALLY QUALIFIED HEALTH CENTER VISIT IPPE/AWV
G0469	FQHC Visits	FED QUAL HEALTH CNTR VISIT MENTAL HEALTH NEW PT
G0470	FQHC Visits	FED QUAL HEALTH CNTR VST MENTAL HEALTH ESTAB PT
T1015	FQHC Visits - T1015	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE
96160	Health Risk Assessment & Screenings	PT-FOCUSED HLTH RISK ASSMT SCORE DOC STND INSTRM
96161	Health Risk Assessment & Screenings	CAREGIVER HLTH RISK ASSMT SCORE DOC STND INSTRM
99339	Health Risk Assessment & Screenings	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 15-29 MIN
99340	Health Risk Assessment & Screenings	INDIV PHYS SUPVJ HOME/DOM/R-HOME MO 30 MIN/>
99483	Health Risk Assessment & Screenings	ASSMT & CARE PLANNING PT W/COGNITIVE IMPAIRMENT
G0396	Health Risk Assessment & Screenings	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN
G0397	Health Risk Assessment & Screenings	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN
G0444	Health Risk Assessment & Screenings	ANNUAL DEPRESSION SCREENING 15 MINUTES
G0505	Health Risk Assessment & Screenings	COGN & FUNCT ASMT USING STD INST OFF/OTH OP/HOME
99341	Home Health Services	HOME VISIT NEW PATIENT LOW SEVERITY 20 MINUTES
99342	Home Health Services	HOME VISIT NEW PATIENT MOD SEVERITY 30 MINUTES
99343	Home Health Services	HOME VST NEW PATIENT MOD-HI SEVERITY 45 MINUTES
99344	Home Health Services	HOME VISIT NEW PATIENT HI SEVERITY 60 MINUTES
99345	Home Health Services	HOME VISIT NEW PT UNSTABL/SIGNIF NEW PROB 75 MIN
99347	Home Health Services	HOME VISIT EST PT SELF LIMITED/MINOR 15 MINUTES
99348	Home Health Services	HOME VISIT EST PT LOW-MOD SEVERITY 25 MINUTES
99349	Home Health Services	HOME VISIT EST PT MOD-HI SEVERITY 40 MINUTES
99350	Home Health Services	HOME VST EST PT UNSTABLE/SIGNIF NEW PROB 60 MINS
99374	Home Health Services	SUPVJ PT HOME HEALTH AGENCY MO 15-29 MINUTES
99375	Home Health Services	SUPERVISION PT HOME HEALTH AGENCY MONTH 30 MIN/>

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99376	Home Health Services	CARE PLAN OVERSIGHT/OVER
G0179	Home Health Services	PHYS RE-CERT MCR-COVR HOM HLTH SRVC RE-CERT PRD
G0180	Home Health Services	PHYS CERT MCR-COVR HOM HLTH SRVC PER CERT PRD
G0181	Home Health Services	PHYS SUPV PT RECV MCR-COVR SRVC HOM HLTH AGCY
G0463	Hospital Outpatient Clinic Visit	HOSPITAL OUTPATIENT CLIN VISIT ASSESS & MGMT PT
90460	Immunization Administration for Vaccines/Toxoids	IM ADM THRU 18YR ANY RTE 1ST/ONLY COMPT VAC/TOX
90461	Immunization Administration for Vaccines/Toxoids	IM ADM THRU 18YR ANY RTE ADDL VAC/TOX COMPT
90471	Immunization Administration for Vaccines/Toxoids	IM ADM PRQ ID SUBQ/IM NJXS 1 VACCINE
90472	Immunization Administration for Vaccines/Toxoids	IM ADM PRQ ID SUBQ/IM NJXS EA VACCINE
90473	Immunization Administration for Vaccines/Toxoids	IM ADM INTRANSL/ORAL 1 VACCINE
90474	Immunization Administration for Vaccines/Toxoids	IM ADM INTRANSL/ORAL EA VACCINE
G0402	Initial Services for Medicare Enrollment	INIT PREV PE LTD NEW BENEF DUR 1ST 12 MOS MCR
96372	Injections	THERAPEUTIC PROPHYLACTIC/DX INJECTION SUBQ/IM
11055	Minor Procedures and Tests	PARING/CUTTING BENIGN HYPERKERATOTIC LESION 1
11056	Minor Procedures and Tests	PARING/CUTTING BENIGN HYPERKERATOTIC LESION 2-4
11200	Minor Procedures and Tests	REMOVAL SKN TAGS MLT FIBRQ TAGS ANY AREA UPW/15
11201	Minor Procedures and Tests	REMOVAL SK TGS MLT FIBRQ TAGS ANY AREA EA 10
11719	Minor Procedures and Tests	TRIMMING NONDYSTROPHIC NAILS ANY NUMBER
11720	Minor Procedures and Tests	DEBRIDEMENT NAIL ANY METHOD 1-5
11721	Minor Procedures and Tests	DEBRIDEMENT NAIL ANY METHOD 6/>
11740	Minor Procedures and Tests	EVACUATION SUBUNGUAL HEMATOMA
11900	Minor Procedures and Tests	INJECTION INTRALESIONAL UP TO & INCLUD 7 LESIONS
11901	Minor Procedures and Tests	INJECTION INTRALESIONAL >7 LESIONS
15851	Minor Procedures and Tests	REMOVAL SUTURES UNDER ANESTHESIA OTHER SURGEON
16020	Minor Procedures and Tests	DRS&/DBRDMT PRTL-THKNS BURNS 1ST/SBSQ SMALL
17110	Minor Procedures and Tests	DESTRUCTION BENIGN LESIONS UP TO 14
17111	Minor Procedures and Tests	DESTRUCTION BENIGN LESIONS 15/>
24640	Minor Procedures and Tests	CLTX RDL HEAD SUBLXTJ CHLD NURSEMAID ELBW W/MANJ
30300	Minor Procedures and Tests	REMOVAL FOREIGN BODY INTRANASAL OFFICE PROCEDURE
36415	Minor Procedures and Tests	COLLECTION VENOUS BLOOD VENIPUNCTURE
36416	Minor Procedures and Tests	COLLECTION CAPILLARY BLOOD SPECIMEN
43760	Minor Procedures and Tests	CHANGE GASTROSTOMY TUBE PERCUTANEOUS W/O GDNCE

HCPCs or CPT codes	Procedure Category	Procedure Long Description
51702	Minor Procedures and Tests	INSJ TEMP NDWELLG BLADDER CATHETER SIMPLE
54150	Minor Procedures and Tests	CIRCUMCISION W/CLAMP/OTH DEV W/BLOCK
57170	Minor Procedures and Tests	DIAPHRAGM/CERVICAL CAP FITTING W/INSTRUCTIONS
69200	Minor Procedures and Tests	RMVL FB XTRNL AUDITORY CANAL W/O ANES
69210	Minor Procedures and Tests	REMOVAL IMPACTED CERUMEN INSTRUMENTATION UNILAT
81000	Minor Procedures and Tests	URINLS DIP STICK/TABLET REAGNT NON-AUTO MICRSCPY
81001	Minor Procedures and Tests	URNLS DIP STICK/TABLET REAGENT AUTO MICROSCOPY
81002	Minor Procedures and Tests	URNLS DIP STICK/TABLET RGNT NON-AUTO W/O MICRSCP
81025	Minor Procedures and Tests	URINE PREGNANCY TEST VISUAL COLOR CMPRSN METHS
82044	Minor Procedures and Tests	URINE ALBUMIN SEMIQUANTITATIVE
82270	Minor Procedures and Tests	BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1 DETER
82272	Minor Procedures and Tests	BLOOD OCCULT PEROXIDASE ACTV QUAL FECES 1-3 SPEC
82465	Minor Procedures and Tests	CHOLESTEROL SERUM/WHOLE BLOOD TOTAL
82947	Minor Procedures and Tests	GLUCOSE QUANTITATIVE BLOOD XCPT REAGENT STRIP
82948	Minor Procedures and Tests	GLUCOSE BLOOD REAGENT STRIP
82950	Minor Procedures and Tests	GLUCOSE POST GLUCOSE DOSE
82962	Minor Procedures and Tests	GLUC BLD GLUC MNTR DEV CLEARED FDA SPEC HOME USE
83718	Minor Procedures and Tests	LIPOPROTEIN DIR MEAS HIGH DENSITY CHOLESTEROL
85013	Minor Procedures and Tests	BLOOD COUNT SPUN MICROHEMATOCRIT
85014	Minor Procedures and Tests	BLOOD COUNT HEMATOCRIT
85018	Minor Procedures and Tests	BLOOD COUNT HEMOGLOBIN
86580	Minor Procedures and Tests	SKIN TEST TUBERCULOSIS INTRADERMAL
87205	Minor Procedures and Tests	SMR PRIM SRC GRAM/GIEMSA STAIN BCT FUNGI/CELL
87880	Minor Procedures and Tests	IAADIADOO STREPTOCOCCUS GROUP A
92551	Minor Procedures and Tests	SCREENING TEST PURE TONE AIR ONLY
92567	Minor Procedures and Tests	TYMPANOMETRY
93000	Minor Procedures and Tests	ECG ROUTINE ECG W/LEAST 12 LDS W/I&R
93005	Minor Procedures and Tests	ECG ROUTINE ECG W/LEAST 12 LDS TRCG ONLY W/O I&R
93010	Minor Procedures and Tests	ECG ROUTINE ECG W/LEAST 12 LDS I&R ONLY
93040	Minor Procedures and Tests	RHYTHM ECG 1-3 LEADS W/INTERPRETATION & REPORT
93268	Minor Procedures and Tests	XTRNL PT ACTIV ECG TRANSMIS W/R&I </30 DAYS
93270	Minor Procedures and Tests	XTRNL PT ACTIVATED ECG RECORD MONITOR 30 DAYS
93272	Minor Procedures and Tests	XTRNL PT ACTIVTD ECG DWNLD W/R&I </30 DAYS
93784	Minor Procedures and Tests	AMBL BLD PRESS W/TAPE&/DISK 24/> HR ALYS I&R
94010	Minor Procedures and Tests	SPMTRY W/VC EXPIRATORY FLO W/WO MXML VOL VNTJ
94060	Minor Procedures and Tests	BRNCDILAT RSPSE SPMTRY PRE&POST-BRNCDILAT ADMN

HCPCs or CPT codes	Procedure Category	Procedure Long Description
94640	Minor Procedures and Tests	PRESSURIZED/NONPRESSURIZED INHALATION TREATMENT
94664	Minor Procedures and Tests	DEMO&/EVAL OF PT UTILIZ AERSL GEN/NEB/INHLR/IP
94760	Minor Procedures and Tests	NONINVASIVE EAR/PULSE OXIMETRY SINGLE DETER
94761	Minor Procedures and Tests	NONINVASIVE EAR/PULSE OXIMETRY MULTIPLE DETER
95115	Minor Procedures and Tests	PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS 1 NJX
95117	Minor Procedures and Tests	PROF SVCS ALLG IMMNTX X W/PRV ALLGIC XTRCS NJXS
97597	Minor Procedures and Tests	DEBRIDEMENT OPEN WOUND 20 SQ CM/<
97602	Minor Procedures and Tests	RMVL DEVITAL TISS N-SLCTV DBRDMT W/O ANES 1 SESS
99000	Minor Procedures and Tests	HANDLG&/OR CONVEY OF SPEC FOR TR OFFICE TO LAB
99050	Minor Procedures and Tests	SERVICES PROVIDED OFFICE OTH/THN REG SCHED HOURS
99051	Minor Procedures and Tests	SVC PRV OFFICE REG SCHEDD EVN WKEND/HOLIDAY HRS
99058	Minor Procedures and Tests	SVC PRV EMER BASIS IN OFFICE DISRUPTING SVCS
A4627	Minor Procedures and Tests	SPACR BAG/RESRVOR W/WO MASK W/METRD DOSE INHAL
A6448	Minor Procedures and Tests	LT COMPRS BANDGE ELAST WDTH < 3 IN PER YARD
A6449	Minor Procedures and Tests	LT COMPRS BANDGE ELAST WDTH >/= 3 & <5 IN PER YD
A7003	Minor Procedures and Tests	ADMN SET SM VOL NONFILTR PNEUMAT NEBULIZR DISPBL
A7015	Minor Procedures and Tests	AREO MASK USED W/ DME NEB
G0403	Minor Procedures and Tests	ECG RTN ECG W/12 LEADS SCR INIT PREVNTV PE W/I&R
G0404	Minor Procedures and Tests	ECG RTN ECG W/12 LEADS TRACING ONLY W/O I&R
G0405	Minor Procedures and Tests	ECG RTN ECG W/12 LEADS INTERPR & REPORT ONLY
S8100	Minor Procedures and Tests	HOLDING CHAMB/SPACR W/INHAL/NEBULIZR; W/O MASK
S8101	Minor Procedures and Tests	HOLDING CHAMB/SPACR W/AN INHAL/NEBULIZR; W/MASK
99460	Newborn Care Services	1ST HOSP/BIRTHING CENTER CARE PER DAY NML NB
99461	Newborn Care Services	1ST CARE PR DAY NML NB XCPT HOSP/BIRTHING CENTER
99462	Newborn Care Services	SUBQ HOSPITAL CARE PER DAY E/M NORMAL NEWBORN
99463	Newborn Care Services	1ST HOSP/BIRTHING CENTER NB ADMIT & DSCHG SM DAT
98969	Non-Face-to-Face Non-Physician Services	NONPHYSICIAN ONLINE ASSESSMENT AND MANAGEMENT
99441	Non-Face-to-Face Physician Services	PHYS/QHP TELEPHONE EVALUATION 5-10 MIN
99442	Non-Face-to-Face Physician Services	PHYS/QHP TELEPHONE EVALUATION 11-20 MIN
99443	Non-Face-to-Face Physician Services	PHYS/QHP TELEPHONE EVALUATION 21-30 MIN
99444	Non-Face-to-Face Physician Services	PHYS/QHP ONLINE EVALUATION & MANAGEMENT SERVICE
99446	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5-10 MIN
99447	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 11-20 MIN

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99448	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 21-30 MIN
99449	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 31/> MIN
99451	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR ASSMT&MGMT 5/> MIN
99452	Non-Face-to-Face Physician Services	NTRPROF PHONE/NTRNET/EHR REFERRAL SVC 30 MIN
99453	Non-Face-to-Face Physician Services	REM MNTR PHYSIOL PARAM 1ST SET UP PT EDUCAJ EQP
99454	Non-Face-to-Face Physician Services	REM MNTR PHYSIOL PARAM 1ST DEV SUPPLY EA 30 D
99457	Non-Face-to-Face Physician Services	REMOTE PHYSIOLOGIC MONITORING 20 MIN+ PER MONTH
98966	Non-Physician Telephone Services	NONPHYSICIAN TELEPHONE ASSESSMENT 5-10 MIN
98967	Non-Physician Telephone Services	NONPHYSICIAN TELEPHONE ASSESSMENT 11-20 MIN
98968	Non-Physician Telephone Services	NONPHYSICIAN TELEPHONE ASSESSMENT 21-30 MIN
99201	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 10 MINUTES
99202	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 20 MINUTES
99203	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 30 MINUTES
99204	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 45 MINUTES
99205	Office/Other Outpatient Services	OFFICE OUTPATIENT NEW 60 MINUTES
99211	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 5 MINUTES
99212	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 10 MINUTES
99213	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 15 MINUTES
99214	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 25 MINUTES
99215	Office/Other Outpatient Services	OFFICE OUTPATIENT VISIT 40 MINUTES
98925	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 1-2 BODY REGIONS
98926	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 3-4 BODY REGIONS
98927	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 5-6 BODY REGIONS
98928	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 7-8 BODY REGIONS
98929	Osteopathic Manipulation	OSTEOPATHIC MANIPULATIVE TX 9-10 BODY REGIONS
11981	Preventive Medicine Services	INSJ NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11982	Preventive Medicine Services	REMOVAL NON-BIODEGRADABLE DRUG DELIVERY IMPLANT
11983	Preventive Medicine Services	RMVL W/RINSJ NON-BIODEGRADABLE DRUG DLVR IMPLT
58300	Preventive Medicine Services	INSERTION INTRAUTERINE DEVICE IUD
83655	Preventive Medicine Services	ASSAY OF LEAD
99173	Preventive Medicine Services	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT
99381	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PATIENT <1YEAR
99382	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 1-4 YRS
99383	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 5-11 YRS
99384	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 12-17 YR
99385	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PT AGE 18-39YRS
99386	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PATIENT 40-64YRS

HCPCs or CPT codes	Procedure Category	Procedure Long Description
99387	Preventive Medicine Services	INITIAL PREVENTIVE MEDICINE NEW PATIENT 65YRS&>
99391	Preventive Medicine Services	PERIODIC PREVENTIVE MED ESTABLISHED PATIENT <1Y
99392	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 1-4YRS
99393	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 5-11YRS
99394	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 12-17YRS
99395	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 18-39 YRS
99396	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 40-64YRS
99397	Preventive Medicine Services	PERIODIC PREVENTIVE MED EST PATIENT 65YRS& OLDER
99401	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 15 MIN
99402	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 30 MIN
99403	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 45 MIN
99404	Preventive Medicine Services	PREVENT MED COUNSEL&/RISK FACTOR REDJ SPX 60 MIN
99406	Preventive Medicine Services	TOBACCO USE CESSATION INTERMEDIATE 3-10 MINUTES
99407	Preventive Medicine Services	TOBACCO USE CESSATION INTENSIVE >10 MINUTES
99408	Preventive Medicine Services	ALCOHOL/SUBSTANCE SCREEN & INTERVEN 15-30 MIN
99409	Preventive Medicine Services	ALCOHOL/SUBSTANCE SCREEN & INTERVENTION >30 MIN
99411	Preventive Medicine Services	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 30 M
99412	Preventive Medicine Services	PREV MED COUNSEL & RISK FACTOR REDJ GRP SPX 60 M
99420	Preventive Medicine Services	ADMN & INTERPJ HEALTH RISK ASSESSMENT INSTRUMENT
99429	Preventive Medicine Services	UNLISTED PREVENTIVE MEDICINE SERVICE
G0101	Preventive Medicine Services	CERV/VAGINAL CANCER SCR; PELV&CLIN BREAST EXAM
G0102	Preventive Medicine Services	PROS CANCER SCREENING; DIGTL RECTAL EXAMINATION
G0436	Preventive Medicine Services	SMOKE TOB CESSATION CNSL AS PT; INTRMED 3-10 MIN
G0437	Preventive Medicine Services	SMOKING & TOB CESS CNSL AS PT; INTENSIVE >10 MIN
J1050	Preventive Medicine Services	INJECTION MEDROXYPROGESTERONE ACETATE 1 MG
Q0091	Preventive Medicine Services	SCREEN PAP SMEAR; OBTAIN PREP &C ONVEY TO LAB
G0513	Prolonged Preventive Services	PRLNG PREV SRVC OFC/OTH O/P RQR DIR CTC; 1ST 30 M
G0514	Prolonged Preventive Services	PRLNG PREV SRVC OFC/OTH O/P DIR CTC; EA ADD 30 M
99354	Prolonged Services	PROLNG E&M/PSYCTX SVC OFFICE O/P DIR CON 1ST HR
99355	Prolonged Services	PROLNG E&M/PSYCTX SVC OFFICE O/P DIR CON ADDL 30
99358	Prolonged Services	PROLNG E/M SVC BEFORE&/AFTER DIR PT CARE 1ST HR
99359	Prolonged Services	PROLNG E/M BEFORE&/AFTER DIR CARE EA 30 MINUTES
99360	Prolonged Services	PHYS STANDBY SVC PROLNG PHYS ATTN EA 30 MINUTES
99495	Transitional Care Management Services	TRANSITIONAL CARE MANAGE SRVC 14 DAY DISCHARGE
99496	Transitional Care Management Services	TRANSITIONAL CARE MANAGE SRVC 7 DAY DISCHARGE

HCPCs or CPT codes	Procedure Category	Procedure Long Description
G0008	Vaccine Administration	ADMINISTRATION OF INFLUENZA VIRUS VACCINE
G0009	Vaccine Administration	ADMINISTRATION OF PNEUMOCOCCAL VACCINE
G0010	Vaccine Administration	ADMINISTRATION OF HEPATITIS B VACCINE

Appendix B: Non-Managed Care Total Medical Expense Data Specifications for Medicaid

This non-managed care total medical expense (TME) data specifications for Medicaid provides technical details to assist the Washington Health Care Authority (HCA) in reporting and filing data to measure Medicaid's performance against the Health Care Cost Growth Benchmark (the Benchmark).

TME File Submission Schedule

In general, HCA will annually request total medical expense (TME) data file(s) with dates of service for the measurement year and the calendar year prior to the measurement year. HCA may also request data for other past years.

Data should be submitted using Excel templates provided by HCA using the schedule outlined in Table B-1.

Table B-1. HCA's TME Filing Schedule for the Pre-Benchmark Data Collection

Date	Files Due
June 30, 2022	CY 2017, CY 2018, and CY 2019 TME

Data Inclusions and Exclusions

Medicaid data submission should include TME data for the following categories:

- FFS claims expenditures for managed care enrollees, including any out-of-plan payments for behavioral health or services for persons with developmental disabilities.
- FFS claims expenditures for individuals not eligible for managed care or in the "FFS waiting period." Expenditures should include data on individuals excluded from managed care, and data on managed care-eligible individuals during their "FFS waiting period" prior to enrollment in managed care.
- Other FFS claims expenditures not included in any of the aforementioned categories such as FFS expenditures for populations or programs that are paid with State-only general funds.
- Non-emergency medical transportation (NEMT) payments for Washington Apple Health clients, including individuals enrolled in managed care.
- Dental services payments for Washington Apple Health clients, including individuals enrolled in managed care.
- HCA's other non-claims expenditures, including any supplemental, incentive or

infrastructure payments made to providers, including:

- Ground Emergency Medical Transportation cost based settlements for participating publicly owned emergency transportation providers
- Disproportionate Share Hospital (DSH) payments
- Supplemental payments for certain trauma centers/hospitals
- Professional Services Supplemental Payments to bring professional payments to the average commercial rate for certain publicly owned providers
- Airlift Services Supplemental Payments to bring payments to the average commercial rate for publicly owned emergency airlift providers
- Hospital Safety Net payments
- Certified Public Expenditure Inpatient Hospital settlements
- Certified Public Expenditure Hold Harmless payments
- Critical Access Hospital Settlements
- Kidney Disease Program payments
- Primary Care Case Management payments

Any non-claims expenditures that Medicaid distributes to providers through the MCOs should **not** be reported. The MCOs will report this information in their non-claims-based payments category.

The Medicaid data submission should **not** include:

- Any expenditures made from or to HCA from or to Medicaid MCOs that are not considered claims (e.g., monthly capitation payments, maternity supplemental payments, risk mitigation payments, incentives/penalties). For example, HCA should not include capitation payments made to MCOs for managing the managed care population. (However, FFS claims that were not covered under managed care should be reported in the FFS claims for non-managed care enrollees.)

HCA may periodically update and revise these data specifications in subsequent versions of this technical manual.

General Specifications for TME Data Submission

HCA should report TME data in aggregate based on **allowed amounts** (i.e., the amount HCA paid plus any member cost sharing).

Claims and non-claims spending must be reported based on the date the service was **rendered** or the spending was **incurred**, and not by the date of payment.

HCA should report spending for Apple Health clients for whom HCA is the **primary insurer** on a claim. Paid claims for which HCA is the secondary of tertiary payer should be excluded. However, HCA should not exclude spending for a member solely because they have additional coverage.

Run-Out Period Specifications

HCA should allow for a claims run-out period of at least 180 days after December 31 of the measurement year. HCA should apply reasonable and appropriate IBNR/IBNP completion factors to each respective TME service category based on commonly accepted actuarial principles.

HCA should allow for a non-claims reconciliation period of at least 180 days after December 31 of the measurement year to reconcile non-claims payments, including incentives, capitation and risk-settlements, or other non-claims-based payments. HCA should apply reasonable and appropriate estimates of non-claims liability that are expected to be reconciled after the 180-day run-out period.

File Submission Naming Conventions

Data submissions should follow the following naming conventions:

- HCA_TME_YYYY_Version.xls
- YYYY is the four-digit year of submission.
- Version is optional and indicates the submission number.
- The file extension must be .xlsx

Below are examples of valid file names:

- TME_2018_01.xlsx or TME_2018_1.xlsx or TME_2018.xlsx

Submitting Files to HCA

Electronic files should be submitted to HCAHCCTBoard@hca.wa.gov

TME Data Tabs and Field Definitions

Data should be submitted using an Excel Template provided by HCA. The template contains the following four tabs:

- **Contents:** Provides an overview of the contents of the workbooks.
- **1_Cover_Page:** Collects information about the data submitter, requires data submitters to attest to the accuracy of the data submission, and asks a series of questions to confirm that data submission follows HCA's specifications.
- **2_TME:** Collects spending and enrollment information used to compute THCE and TME.

- **3_Rx Rebates:** Collects pharmacy rebate information by insurance category code.
- **4_Reference Tables:** Defines codes used to categorize spending data.

Each tab is described below in more detail.

Cover Page Tab

The Cover Page contains a series of questions on the completeness of data, whether and how any estimates were applied to complete the data, and inclusion and exclusion criteria applied in defining the population and spending reported. The intent of these questions is to confirm that the data submission follows the specifications outlined by HCA.

TME Tab

Spending data must be reported in the TME tab. Spending must be categorized according to the claims and non-claims categories identified below, and defined more fully in Appendix A.

Claims-Based Payments

- Claims: Hospital Inpatient
- Claims: Hospital Outpatient
- Claims: Professional, Primary Care Providers
- Claims: Professional, Specialty Providers
- Claims: Professional, Other Providers
- Claims: Long-Term Care
- Claims: Retail Pharmacy
- Claims: Other

Non-Claims-Based Payments

- Non-Claims: Capitation or Bundled Payments
- Non-Claims: Performance Incentive Payments
- Non-Claims: Population Health and Practice Infrastructure Payments
- Non-Claims: Provider Salaries
- Non-Claims: Recovery

Pharmacy Rebate Tab

This tab is where HCA should report pharmacy rebates data in aggregate, by insurance category code.

Total rebates should be reported without regard to how they are paid to HCA (e.g., through regular aggregate payments, on a claim-by-claim basis, etc.). HCA should report both retail pharmacy rebates and medical pharmacy rebates. Pharmacy rebates should be reported as a negative number. Further guidance in reporting pharmacy rebates in included in Appendix A.

Reference Tables Tab

The data submission template uses various codes to categorize the spending data. The codes are listed in the "Reference Tables" tab of the data submission template, and includes the following:

- Insurance category code
- Market code
- Line of business categories code
- Age band code
- Sex code
- Carrier code

Appendix C: Fee-for-Service Medicare Total Medical Expense Data Specifications

Annually, the Washington Health Care Authority (HCA) will request fee-for-service (FFS) Medicare spending and enrollment data from the Centers for Medicare & Medicaid Services (CMS). Data will be available by September 1, following the measurement period (e.g., 2019 data will be available by September 1, 2020). CMS estimates that by September 1, following the measurement period, data will be at least 90% complete.

Specifically, CMS shares total program payments and cost sharing for the following services:

- Hospital inpatient
- Hospital outpatient
- Non-hospital outpatient
- Home health agency
- Hospice
- Skilled nursing facility
- Physician
- Other professionals
- Durable medical equipment
- Other suppliers
- Part D[6]

HCA will map out these services to the TME reporting categories according as outlined in Table C-1.

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[6] As part of the TME data received from CMS, CMS will provide HCA Part D data for individuals enrolled in FFS stand-along PDP as well as Medicare managed care enrollees in MAPD or MA-only plans.

Table C-1. Mapping of Medicare Service Categories to Benchmark TME Service Categories

Medicare Service Categories	TME Service Mapping
Hospital Inpatient	Hospital Inpatient
Hospital Outpatient	Hospital Outpatient
Non-Hospital Outpatient	Other
Home Health Agency	Long-Term Care
Hospice	Long-Term Care
Skilled Nursing Facility	Long-Term Care
Physician (Primary Care)	Professional, Primary Care Providers
Physician (Specialty Care)	Professional, Specialty Providers
Other Professionals	Professional, Other Providers
Durable Medical Equipment	Other
Other Suppliers	Other
Part D	Retail Pharmacy

CMS also shares enrollment figures for Medicare Parts A, B and D broken out between managed care and FFS. CMS reports beneficiaries based on the resident location as of the end of the calendar year.

To receive Medicare FFS TME data from CMS, HCA will make a formal request to CMS by emailing the Excel file template to **Stephanie Bartee, Director of the Information Products and Analytics Group in the Office of Enterprise Data Analytics, (stephanie.bartee@cms.hhs.gov)** and **copying: CMSProgramStatistics@cms.hhs.gov.** HCA will make the data request to CMS by June 1, to receive data by September 1.

Appendix D: Labor & Industries Total Medical Expense Data Specifications

The Washington Department of Labor & Industries (L&I) provides medical benefits to state employees who are injured on the job. Annually, HCA will request data from L&I on the medical claims portion of worker's compensation benefits.

For the pre-benchmark period, L&I should report expenditures in aggregate for the calendar year(s) requested, along with a monthly count of individuals who are eligible for medical worker's compensation benefits.

L&I TME will only be reported at the state level. Therefore, when reporting data at the service category level, L&I data will be excluded.

Appendix E: Department of Corrections Total Medical Expense Data Specifications

The Washington Department of Correction (DOC) provides medically necessary health and mental health care to incarcerated individuals in its facilities through the Washington DOC Health Plan. Annually, HCA will request data from the DOC on health care spending for its incarcerated population.

For the pre-benchmark period, DOC should report expenditures in aggregate for the calendar year(s) requested, along with a monthly count of individuals who are eligible for the WA DOC Health Plan.

DOC TME will only be reported at the state level. Therefore, when reporting data at the service category level, DOC data will be excluded.

Appendix F: Veterans Health Administration Total Medical Expense Data Specifications

Statistics on Washington veteran healthcare spending is published in the summer by the Veterans Health Administration (VHA) National Center for Analysis and Statistics. The information can be accessed at: www.va.gov/vetdata/Expenditures.asp. The figure "Medical Care" is reported as "VHA TME" in the calculation of state level THCE.

Per the notes on the VHA expenditure report, "Medical Care" includes expenditures for medical services, medical administration, facility maintenance, educational support, research support and other overhead items. Medical care expenditures do not include dollars for construction or other non-medical support.

It is important to note that VHA expenditure report data is reported on a federal fiscal year basis (October–September) and not on a CY basis. Therefore, HCA will use the fiscal year that contains nine months of the reporting CY (e.g., fiscal year 2020 data should be used in lieu of CY 2020 data). This is not consistent with the reporting from other payers and should be noted as such, but it is not expected to make a large impact.

More detailed TME data on veterans has not been identified yet. If other sources of veterans' health data are identified in the future, HCA will update this manual.

VHA TME is only reported at the state level. Service category detail has not been available in the VHA expenditure report. Therefore, when reporting data at the service category level, VHA data will be excluded.

Appendix G: Submitter Attestation

Pursuant to Washington's establishment of a health care cost growth benchmark under RCW 70.380.020, and as described by reporting guidelines directed by the Health Care Cost Transparency Board in the 2022 benchmark technical manual, certain health insurers operating in the state of Washington must annually submit the data requested to calculate insurer and provider performance relative to Washington's target

Instructions: Please enter all requested information in the blank spaces provided below and have an authorized signatory sign the attestation. Insurers should submit one "Attestation of the Accuracy and Completeness of Reported Data" per submission period. Scanned copies of the signed attestations should be emailed to: hcahcctboard@hca.wa.gov. **Please note that failure to sign and submit this Attestation will result in the Board's non-acceptance of the attached reports.**

Attestation of the Accuracy and Completeness of Reported Data

Insurer: ______________________________

Performance Period Being Reported: ______________________________

I attest that the reported data is current, complete, and accurate to the best of my knowledge. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the reports may be prosecuted under any applicable state laws.

______________________________ Signature

______________________________ Date

______________________________ Printed Name

______________________________ Title