Washington State Health Care Authority

Washington's Health Care Cost Transparency Board: Performance Against the Benchmark Program

Technical manual

Version history

Version number	Release date	Description of changes
1.0: pre-release	April 22, 2022	Draft to Advisory Committee on Data Issues for feedback.
1.0	July 7. 2022	
1.1	August 23, 2022	Clarified submission due dates, updated Table 4. Carriers requested to submit **TME data by market** specifically the Medicare Advantage column, updated Primary Care Provider Taxonomy Codes table specifically to correct nurse practitioner and physician assistant taxonomy codes
1.2	February 8, 2024	Updated code sets for reporting year, age, insurance, and market category codes. Updated dates for 2024 data call submission. Modified the truncated threshold explanation and added truncation example. Modified standard deviation explanation and added calculation example. Added Appendix H (list of Acronyms). Updated the email address to submit data. Added a box on checking data consistency across tabs.
1.3	February 21, 2024	Updated the data submission deadline.
1.4	April 01, 2024	Grouped 'Federal Employee Health Benefits (Insurance Category Codes 7 and 8)' and the 'Commercial (Insurance Category Codes 3 and 4)' into one market (i.e. ' Commercial (Insurance Category Codes 3, 4,7 and 8)').
1.5	April 15, 2024	Updated TME Data by Market chart.
1.6		Adopted Advisory Committee on Primary Care's definition of primary care. Added specifications on when to include Large Provider Entity Code 100 (Carrier Overall). Added a figure to illustrate how WA resident spending at non-WA provider locations should be attributed. Specified carriers should use the maximum number of days available and should be at least 180 days. Added guidance on collecting information on business name(s) and Federal Employee Identification Number(s) (FEIN) for Net Cost of Private Health Insurance (NCPHI) calculations. Changed carrier name Anthem Inc Group to Anthem Ins Co Inc to align with OIC records.

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Overview

To address high and rising health care costs in Washington, 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 (Cost 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 (the benchmark) for the state as a whole, markets, providers and payers;
- Implementing the Performance Against the Benchmark (PAB) Program, which reports annually to the public and Legislature on actual health care cost growth relative to the benchmark both for Washington State as a whole and for individual carriers and large provider organizations; and
- Providing recommendations to the Legislature 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.

For each year, the Cost Board will set a benchmark for the annual rate of growth of health care expenditures on a per capita level (i.e., total health care expenditures (THCE) and total medical expense (TME)). 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. TME is defined as 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.

To implement the PAB program, the Cost Board requires health care payers (carriers/ commercial payers and public payers) in Washington to submit data that will be used to identify the state's health care expenditures 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. For the 2025 data call, the Cost Board will collect 2022–2023 data.

This technical manual details the technical and operational steps to implement the PAB program. It includes details of the methodology the Cost 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 (FFS) Medicare total medical expense data specifications
- Appendix D: Department of Labor and Industries (L&I) total medical expense data specifications
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- Appendix F: Veterans Health Administration total medical expense data specifications
- Appendix G: Submitter attestation
- Appendix H: Common acronyms

Definition of key terms

Age/sex risk-adjusted total truncated claims expense PMPM: The truncated claims expense per member per month (PMPM) adjusted for differences in expense attributed to a carrier's or large provider's age and sex distribution differentials relative to the average carrier or provider.

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 Cost Board has agreed to measure the growth rate of THCE and TME on a per capita basis. It is the value of 70% of Washington's historic median wage growth rate and 30% of Washington's potential gross state product (PGSP) growth rate.

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 (PCPs), 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 the Washington Health Care Authority (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' NCPHI. 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 level.

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.

Truncated claims expense: All payments spent on members after spending above the truncation threshold has been deducted on a per member basis. Truncated claims are only considered when assessing if an entity exceeded the benchmark. This is to ensure that a small number of expensive covered lives does not push an entity's cost growth beyond the benchmark.

[1] Fair market value bona fide service fees are fees paid by a manufacturer to a third party (e.g., carrier, pharmacy benefit manager (PBM), etc.) that represent fair market value for a bona fide, itemized service actually performed 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 care management programs, etc.)

[2] The Centers for Medicare & Medicaid Services (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, spending will 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 Cost Board adopted a methodology that uses a 70/30 weighting of the growth rates of historical nominal median wage and nominal per capita potential gross state product (PGSP). In doing so, the Cost 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 Cost 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 per capita PGSP growth rates yielded a benchmark value of 3.2%. The Cost 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 Cost 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 Cost 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 Cost Board may consider changes to the benchmark or to the benchmark methodology.

To assist in the reassessment, the sources for each of the components of the benchmark methodology as calculated for the Cost Board are included in

Table 2.

Table 2. Data sources for calculating the benchmark value

Methodology component	Source	Value
Historical median wage growth rate	Average annual growth in median hourly wage in Washington from 2000 to 2019 as reported by the **Washington State Employment Security Department**.	3.0%
Per capita potential gross state product growth rate	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%

Methodology component	Source	Value
Expected growth in national labor force productivity	**The Congressional Budget Office, The Budget and Economic Outlook: 2020–2030** published in February 2021.	1.5%
Expected growth in the state civilian labor force	Washington Office of Financial Management (OFM), Forecasting and Research Division, **Long-Term Forecast Table 2–4**. Forecast data are only available in five-year increments and the average annual growth rate is calculated by assuming the five-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 in February 2021.	1.9%
Expected state population growth	Washington OFM, Forecasting and Research Division, **State Population Forecast**.	0.8%

II. Measuring performance against the benchmark

Chapter 70.390 RCW requires the Cost 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 Cost 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 Total health care expenditures (THCE) or Total medical expense (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 of 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 adjusted TME (i.e., the claims component will use truncated and risk-adjusted (by age/sex) amount); and
- **Large provider entity stratified by market:** PMPM spending using adjusted TME (i.e., the claims component will use truncated and risk-adjusted (by age/sex) amount).

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[3]. 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 health care expenditure	Carrier claims payments	Carrier data submission template
	Carrier non-claims payments	Carrier data submission template
	Carrier enrollment	Carrier data submission template

[3] For more information about carrier identifying information needed to calculate NCPHI, please see Appendix A: Cover page tab.

	Carrier pharmacy rebates	Carrier data submission template
	Medicare fee-for-service claims payments and enrollment, and all Part D spending	CMS
	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 and Industries (L&I) submission template
	Health care spending for incarcerated individuals and enrollment	Washington Department of Corrections (DOC) submission template
	Net cost of private health insurance (NCPHI)	See next row.
NCPHI	NCPHI for the commercial fully insured market	Federal commercial Medical Loss Ratio (MLR) reports
	NCPHI for Medicare Advantage	The Supplemental Health Care Exhibits (SHCE) from the National Association of Insurance Commissioners (NAIC)
	NCPHI for Medicaid Managed Care	The Supplemental Health Care Exhibits (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 spending + L&I + DOC spending

Statewide THCE (PMPY)

$$= \frac{\begin{array}{c}\textit{Commercial TME + Medicare MCO TME + Medicare FFS TME +} \\ \textit{Medicaid MCO TME + Medicaid FFS TME + Insurer NCPHI + VA spending + L\&I spending + DOC spending}\end{array}}{\begin{array}{c}\textit{Commercial members + Medicare MCO members +} \\ \textit{Medicare FFS members + Medicaid MCO members +} \\ \textit{Medicaid FFS members - Medicaid dually eligible members +} \\ \textit{VA enrollees + DOC enrollees}\end{array}}$$

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)

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

Medicare market TME (PMPY)

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

Medicaid market TME (in aggregate)

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

Medicaid market TME (PMPY)

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

Commercial market TME (in aggregate)

$$= \textit{Commercial TME}$$

Commercial market TME (PMPY)

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

Carrier level TME

Below are the formulas for calculating Insurer TME PMPM. At the carrier level, HCA will calculate cost growth using the adjusted TME. Specifically, the claims component of the TME will be adjusted. The adjustment will include truncation (i.e., amount above the truncation threshold will be deducted on a per member basis) and risk-adjustment based on age/sex. The risk-adjustment will reflect the carrier's members' age and sex distribution differentials relative to that of the average carrier.

Carrier, by market (PMPM)

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

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 the adjusted TME (similar to the adjustment done at the carrier level).

Insurer, by market (PMPM)

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

At the carrier and large provider levels, HCA will calculate the point estimate and the 95% confidence interval of the growth rate of the adjusted TME PMPM for each market. These growth rates along with confidence intervals will be compared to the benchmark.[4]

Calculating the net cost of private health insurance (NCPHI)

The NCPHI captures the costs to Washington residents associated with the administration of private health insurance, Medicaid managed care, and Medicare Advantage. 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/Children's Health Insurance Program (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 the carriers in order to meet the reporting timeline.
- **Supplemental Health Care Exhibits (SHCE):** The SHCE 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 Washington State Office of the Insurance Commissioner (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 CCIIO,[5] 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)*

[4] Access the methodologies (i.e., risk adjustment, standard deviation pooling, and confidence interval calculation) used in **large provider organization** and **carrier** reporting through our website.
[5] Available on the Centers for Medicare & Medicaid Services webpage.

- 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 NAIC 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 the Affordable Care Act (ACA). The Medicare Advantage reporting combines stand-alone prescription drug plans (PDP) and the Medicare Advantage plans with Part D (MAPDs) inclusion. 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 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 SHCE from the NAIC 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 Cost Board will direct applicable carriers and public payers to submit data in response to the Cost Board's data call. Carriers are directed to submit TME data using the specifications outlined in Appendix A. Table 4 lists the carriers that are operating in each of the markets based on information available as of January 2025. These carriers, if operating in these markets (even if not captured in Table 4) must submit TME data to HCA for each market of operation. [6]

Table 4. Carriers requested to submit TME data by market

Carrier	Commercial fully and self- insured	Medicare managed care	Medicaid managed care
Anthem Ins Co Inc	—	Submit	Submit
Cambia Health Solutions Inc	Submit	Submit	—
Centene Corp Group	Submit	Submit	Submit
Cigna Health & Life Ins Co	Submit	Submit	—
Community Health Network Group	—	Submit	Submit
CVS Group	Submit	Submit	—
Health Alliance NW Health Plan	Submit	Submit	—
Humana Group	Submit	Submit	—
Kaiser Foundation Group	Submit	Submit	—
Molina Healthcare Inc Group	Submit	Submit	Submit
Premera Blue Cross Group	Submit	Submit	—
UnitedHealth Group	Submit	Submit	Submit

In addition, the Cost Board will obtain data from the following public payers through submission or direct download from their public databases:

- HCA for non-managed care spending data for Medicaid using the specifications in Appendix B.
- CMS for Medicare FFS data using the specifications in Appendix C.
- L&I for workers compensation data using the specifications in Appendix D.
- DOC for health care spending data of incarcerated Washington residents using the specifications in Appendix E.
- Veterans Affairs for veteran health care spending data using the specifications in Appendix F.

[6] This table represents the largest carriers in the Washington insurance market based on OIC's data on Top 40 Companies for Accident and Health (as of 2023). Because the market may change, this table may need to be updated over time.

Appendix A: Carrier total medical expense data specifications

This appendix provides technical details to assist carriers in reporting and filing data that HCA will be using 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. The performance against the 2023 benchmark will be calculated using the spending from the years 2022 and 2023.

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 benchmark data collection

Date	Files Due
April 18, 2025	CY 2022 and CY 2023 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. Spending for Washington residents should be reported regardless of whether the spending occurred in state or out of state. Please refer to **Figure 1** for clarification around out of state spending by Washington residents.

Figure 1: Health care spending on out-of-state services received by Washington (WA) residents

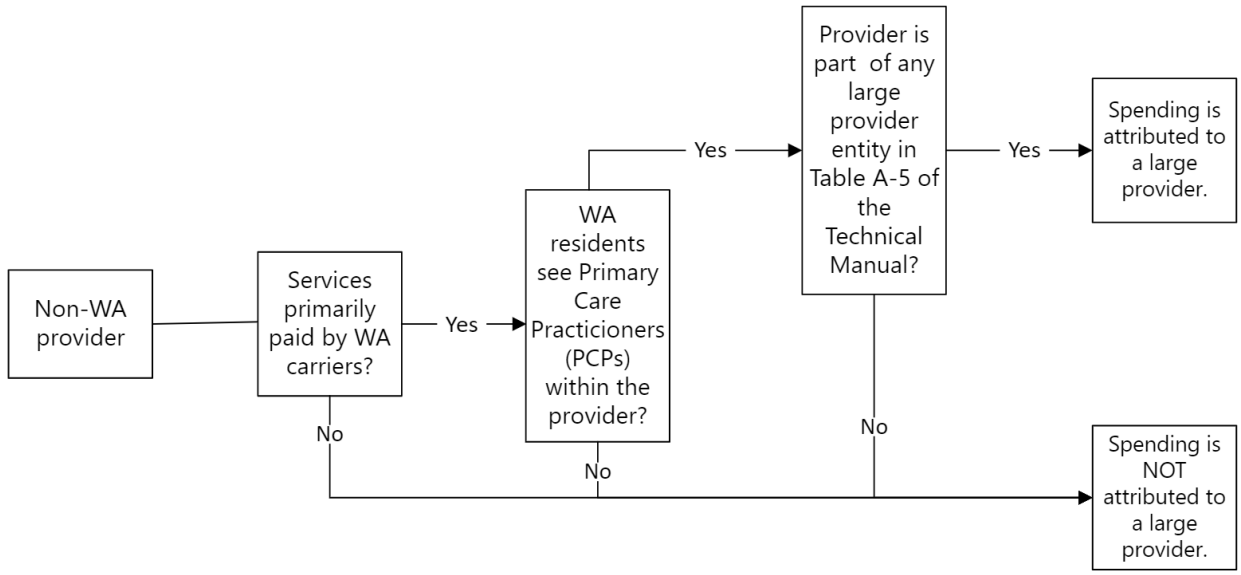

Table A-2 details the types of policies that should be included and excluded in carriers' reporting of TME.

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 (FEP) 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 (PDP) × 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 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. This run-out period can be longer than 180 days and carriers should use the maximum number of days available. The cover page in the submission template requests the total length of the run-out period for the data. 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 specified run-out period.

File submission naming conventions

Data submissions should follow the following naming conventions:

- CarrierCode_CarrierName_TME_YYYYMMDD.xlsx[7]
- YYYY is the four-digit year, MM is two-digit month, and DD is the two-digit day of submission. Make sure that the month and the day are each two-digits. For example, if the date of submission is March 5, 2025, the YYYYMMDD is 20250305.

[7] The carrier codes are in Table A-3 and are also in the Reference Tables tab of the data submission template.

- The file extension must be .xlsx

Below is an example of a valid file name:

> For hypothetical carrier 'InsuranceA' with carrier code '200' which submitted data on March 05, 2025, the file name would be:
>
> 200_InsuranceA _TME_20250305.xlsx

Submitting files to HCA

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

TME data tabs and field definitions

Carriers will submit data using an Excel Template provided by HCA. (You can access the template on the **data call webpage**.) 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_Enroll:** 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. Carriers must populate the data as instructed and must NOT do the following: create new columns, change the header names, nor include column or row totals in any of the tabs.

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. The carrier attests to the accuracy and completeness of their submission on this tab.

To aid in the calculation of NCPHI, the cover page has space to list the carrier's doing business as names in which they submit data to OIC. Additionally, there is space for the carrier's Federal Employer Identification Number (EIN) for pulling data from CMS's MLR report.

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 NCPHI. Carriers must follow the instructions from the NAIC 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.[8]

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

Table A-3. Carrier codes

Carrier code	Carrier
201	Anthem Ins Co Inc
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 benchmark data collection, carriers should report data for calendar years 2022 and 2023.

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 eight 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
7	Federal employee health benefits: full claims
8	Federal employee health benefits: partial claims

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 (PBMs) 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.

Federal Employee Health Benefits Plans (FEP) is a category of claims that applies only to carriers who have overlapping coverage of FEP benefits with another carrier. The intent is to ensure FEP members are not double counted when determining PMPM spending. All FEP spending will be rolled up into Commercial spending.

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). Do not provide Large Provider Entity Code 100 (Carrier Overall) in the TME tab.

Table A-5. Large provider entity codes

Large provider entity code	Large provider entity
100	Carrier overall (all provider entities)
101	Community Clinic Contracting Network (includes Yakima Valley, CHC Snohomish, Columbia Basin, Columbia Valley, International Community Health, 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

Large provider entity code	Large provider entity
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 age-sex risk adjustment 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 31 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
9	Unknown

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 (PCPs) for primary care services. Starting with the 2025 data call, the primary care definition should be based on the Cost Board's **Advisory Committee on Primary Care**'s approved definition (see **Appendix A of the HCCTB 2024 Annual Report to the Legislature)** and should no longer be based on the **OFM definition**. Appendix A, Attachment 1 specifies which provider and provider organization taxonomy codes, procedure codes, and place of service codes should be used to identify primary care services (See Cost Board's Advisory Committee on Primary Care's website to download the value sets in excel format.) For a claim to be considered primary care spending, the claim's taxonomy code, procedure code and place of service must be in these sets of codes. Appendix A Attachment 1 (Table A-12) identifies PCPs as family practice, geriatric, Federally Qualified Health Centers (FQHCs), internal medicine and pediatric providers (physicians, physician assistants, and nurse practitioners). 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.).

In addition to the taxonomy codes, primary care services are also identified using the procedure codes in

Table A-13. These include care management; care planning; counseling; domiciliary or rest home 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 PCPs, prescription drugs (including those covered by both medical and pharmacy benefits), vision, dental, laboratory, x-ray and imaging services.

Unlike the OFM's definition, the new definition now defines primary care services based on place of service codes (see Table A-14) in addition to taxonomy and procedure codes. The place of service codes include clinics, home visits, FQHCs, telehealth, and various other facilities. **As in other spending categories, amounts reported should be based on the non-truncated allowed amount.**

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 updated definition of primary care (see TME10 description above). **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 not in the PCP classification, 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-alone 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 stand-alone 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 spending above the truncation threshold has been deducted on a per member basis. Truncated claims are only considered when assessing if an entity exceeded the benchmark. This is to ensure that a small number of expensive covered lives does not push an entity's cost growth beyond the benchmark. The truncation thresholds, by insurance category, are listed in **Table A-8**. This is the only column that will have truncated spending values made on a per member basis.

Table A-8. Truncation thresholds for insurance categories

Insurance category code	Insurance category	Truncation threshold
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
7	Federal Employee Health Benefits: Full Claims	$200,000
8	Federal Employee Health Benefits: Partial Claims	$200,000

A sample calculation is provided in Table A-9. Box 1 provides instructions on how to truncate when members are attributed to more than one large provider entity during the calendar year.

Table A-9 Sample calculation of truncated claims spending for commercial claims

Spending in calendar year	Member 1	Member 2	Member 3	Member 4	Member 5	Total claims spending	Additional notes
Untruncated claims spending: (A)	$150,000	$175,000	$200,000	$225,000	$250,000	$1,000,000	Sum of TME08 – TME15
Threshold for commercial (see Table 8: (B)	$200,000	$200,000	$200,000	$200,000	$200,000		
Amount Above truncation threshold: (C)	0	0	0	$25,000	$50,000	$75,000	
Truncated claims spending (TME22): (A-C)	$150,000	$175,000	$200,000	$200,000	$200,000	$925,000	Value for TME22 & SD06

Box 1. 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 threshold:

- 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 threshold would be $50,000 while Provider Y's spending above the truncation threshold 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.
- For data submission, both TME22 and SD06 should have $200,000 for their values for Provider X, Provider Y, and the payer. This is the total spending after truncation has been applied.

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 Box.2 below for an explanation of how to truncate partial claims spending).

Box 2. 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 full claims insurance category 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.

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 this benchmark data collection, carriers should report data for calendar years 2022 and 2023.

Market code (SD03): Code associated with the market being reported as defined in **Table A-10**. Please follow the same guidance for these codes as is found in the Insurance Category Code (TME03) definition.

Table A-10. 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)
4	Federal Employee Health Benefits (Insurance Category Codes 7 and 8)*

**Code for Federal Employee Benefit plans that are split between two carriers.*

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.

Please provide the standard deviation for Large Provider Entity Code 100 (Carrier Overall). The standard deviation for Large Provider Entity Code 100 will include all of the carrier's member months and spending and should be calculated as if the carrier is a single entity.

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 of truncated claims spending PMPM (SD07): The calculated standard deviation of truncated claims spending PMPM. The rows of this column should contain the standard deviation data:

- For each large provider entity (using the codes in Table A-5), by market (using the codes in Table A-10). Carriers should include standard deviation data for all large provider entities with whom they hold contracts; and
- For the carrier as a whole (using the codes in Table A-3), by market (using the codes in Table A-10. For this, the value of the 'Large Provider Entity Code' column should be '100' (Overall Provider Entities).

If for a particular year the carrier operates in two markets (e.g., Medicare and Medicaid) and has three large providers plus two non-large providers operating in the Medicare Market and two large providers in the Medicaid market, the number of rows with standard deviation data would be eight rows for that year:

- Two rows for overall standard deviation in Medicare and Medicaid markets
- Two rows for the four providers (one row for each of the three large providers and one row for the group of all non-large providers in the Medicare market). All non-large providers should be grouped under code = 999 or Unattributed to a large provider.
- Two rows for the two large providers in the Medicaid market

The following steps detail how carriers can calculate the standard deviation PMPM values for each large provider in each market:

1. Attribute members to the appropriate large provider entity in each market and in each year. Carriers should include all members attributed to a large provider entity, including members with no utilization.
2. Calculate the standard deviation using the following formula:

$$\mathrm{SD}_{\mathrm{p,m,t}} = \sqrt{\frac{\sum_{\mathrm{i}}^{\mathrm{N_{p,m,t}}} \mathrm{MM}_{\mathrm{i,p,m,t}} (\mathrm{X}_{\mathrm{i,p,m,t}} - \overline{\mathrm{X}}_{\mathrm{p,m,t}})^2}{\mathrm{MM}_{\mathrm{p,m,t}}}}$$

where

- $SD_{p,m,t}$ is the standard deviation of truncated claims PMPM for large provider *p* in market *m* at year *t*
- $X_{i,p,m,t}$ is the average monthly truncated claims PMPM for member *i* in large provider *p* in market *m* at year *t*
- $\overline{X}_{p,m,t}$ is the average per member average monthly truncated claims PMPM for ALL members in large provider p in market *m* at year *t*
- $MM_{i,p,m,t}$ is the total months of coverage for member *i* in large provider *p* in market *m* at year *t*

- $MM_{p,m,t}$ is the total member months or months of coverage for ALL members in large provider *p* in market *m* at year *t*

Carriers must ensure that the calculation uses claims-based allowed amount after partial claims adjustments and after truncation of member level spending and that non-claims expenditures are excluded. In addition, carriers should use the formula for population standard deviation (divided by $MM_{p,m,t}$) and not the sample standard deviation (divided by $MM_{p,m,t}$ -1).

Box 3 provides a sample calculation of the standard deviation of truncated claims PMPM for Provider A in the Commercial market in 2022.

To use Excel function STDEV.P() or other standard deviation commands in any other statistical software program in calculating $SD_{p,m,t}$, carriers must first arrange the data input such that for each member *i* in large provider *p* in market *m* at year *t*, the average monthly truncated claims PMPM appear as many times as the total months of coverage. The function/command should be applied on the average monthly PMPM and not on the actual monthly utilization of each member.

Box 3. Sample calculation of standard deviation of truncated claims spending PMPM for a provider

Suppose Provider A, which is considered a large provider, had three attributed members in the Commercial Market and had the following per member per month actual truncated claims spending data for year 2022:

2022 Actual truncated claims spending by month and attributed members

Month	Member 1	Member 2	Member 3
Jan-22	100	200	500
Feb-22	100	0	0
Mar-22	100	100	0
Apr-22	100	100	0
May-22	100	100	0
Jun-22	100	not covered	0
Jul-22	100	not covered	0
Aug-22	100	not covered	0
Sep-22	100	not covered	0
Oct-22	100	not covered	0
Nov-22	100	not covered	0
Dec-22	100	not covered	0

In aggregation, Provider A has the following annual data:

Provider A's 2022 annual data for commercial market

	Member 1	Member 2	Member 3	Overall
Total truncated claims spending	$1,200.00	$500.00	$500.00	$2,200.00
Months of coverage or member months	12	5	12	29

A. **The following are the steps in calculating the Standard Deviation of Truncated Claims PMPM using the formula:**

$$SD_{p,m,t} = \sqrt{\frac{\sum_i^{N_{p,m,t}} MM_{i,p,m,t}(X_{i,p,m,t} - \bar{X}_{p,m,t})^2}{MM_{p,m,t}}}$$

1. Calculate $X_{i,p,m,t}$ (Average monthly spending for each member *i* in large provider *p* in market *m* at year *t*) by dividing individual Total Truncated Claims by corresponding Months of Coverage. For example, to get $X_{1,A,com,2022}$ (Member 1's average monthly spending in provider A in the commercial market in 2022), divide $1200 by 12 to get $100.

	$X_{1,A,com,2022}$	$X_{2,A,com,2022}$	$X_{3,A,com,2022}$
	Member 1	**Member 2**	**Member 3**
Average monthly spend	$100.00	$100.00	$41.67

2. Calculate $\bar{X}_{p,m,t}$ (average per member average monthly PMPM for ALL members in large provider *p* in market *m* at year *t*) by dividing overall sum of truncated claims spending with overall sum of months of coverage. The $\bar{X}_{A,com,2022}$ (the average per person per month claims spending for Provider A in the commercial market for 2022) is $75.86. = $2200 / 29.

3. Calculate $(X_{i,p,m,t} - \bar{X}_{p,m,t})^2$ for each member. For example, Member 1 would have $582.74 = ($100 - $75.86)^2.

	Member 1	**Member 2**	**Member 3**
$(X_{i,p,m,t} - \bar{X}_{p,m,t})^2$	$582.74	$582.74	$1,169.18

4. Calculate $MM_{i,p,m,t}(X_{i,p,m,t} - \bar{X}_{p,m,t})^2$ for each member by multiplying the number derived in step 3 by each member's months of coverage. For example, Member 1 would have $6992.88 = $582.74 *12.

	Member 1	**Member 2**	**Member 3**
$MM_{i,p,m,t}(X_{i,p,m,t} - \bar{X}_{p,m,t})^2$	$6,992.88	$2,913.70	$14,030.21

5. Calculate $\sum_i^{N_{p,m,t}} MM_{i,p,m,t}(X_{i,p,m,t} - \bar{X}_{p,m,t})^2$ by summing the values calculated for all members in step 4: $6,992.88 + $2,913.70 + $14,030.21 = $23,936.78.

6. Calculate $\frac{\sum_i^{N_{p,m,t}} MM_{i,p,m,t}(X_{i,p,m,t} - \bar{X}_{p,m,t})^2}{MM_{p,m,t}}$ by dividing the total number derived in step 5 by Provider A's total months of coverage. This would be $825.41 = $23, 936.78/29.

7. Finally, calculate $\sqrt{\frac{\sum_i^{N_{p,m,t}} MM_{i,p,m,t}(X_{i,p,m,t} - \bar{X}_{p,m,t})^2}{MM_{p,m,t}}}$ by taking the square root of the number derived in step 6 to get the standard deviation. Specifically, the standard deviation of the truncated claims spending PMPM for Provider A's members in the commercial market in 2022 is $\sqrt{\$825.41} = \$28.73$.

B. Carriers may also use the Excel function STDEV.P() to calculate the standard deviation. To do this, the data input would need to be the average monthly spend of each member (and not the actual spending for the month):

Member	Month with coverage	Average claims spending PMPM for 2022
Member 1	Jan-22	$100.00
Member 1	Feb-22	$100.00
Member 1	Mar-22	$100.00
Member 1	Apr-22	$100.00
Member 1	May-22	$100.00
Member 1	Jun-22	$100.00
Member 1	Jul-22	$100.00
Member 1	Aug-22	$100.00
Member 1	Sep-22	$100.00
Member 1	Oct-22	$100.00
Member 1	Nov-22	$100.00
Member 1	Dec-22	$100.00
Member 2	Jan-22	$100.00
Member 2	Feb-22	$100.00
Member 2	Mar-22	$100.00
Member 2	Apr-22	$100.00
Member 2	May-22	$100.00
Member 3	Jan-22	$41.67
Member 3	Feb-22	$41.67
Member 3	Mar-22	$41.67
Member 3	Apr-22	$41.67
Member 3	May-22	$41.67
Member 3	Jun-22	$41.67
Member 3	Jul-22	$41.67
Member 3	Aug-22	$41.67
Member 3	Sep-22	$41.67
Member 3	Oct-22	$41.67
Member 3	Nov-22	$41.67
Member 3	Dec-22	$41.67

Applying the STDEV.P() on the third column would yield a standard deviation of $\$28.73$ as in step 8 of part A.

To calculate the standard deviation PMPM values for the carrier as a whole for each market and year, the same steps above should be followed but aggregation would be done at the market level.

Report the standard deviation values 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 the 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-11.

Table A-11. 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 comprehensive 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. Box 4 provides guidance for reporting pharmacy rebates.

Box 4. 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 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 for the reporting period. If RXR04 and RXR05 are filled out, then RXR06 should be the sum of RXR04 and RXR05. If carriers are unable to separately report RXR04 and RXR05, then this column should be the total pharmacy rebate with RXR04 and RXR05 left 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 include the following:

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

Box 5 provides suggested data consistency checks across tabs.

Box 5. Data consistency across tabs

Data across tabs could be checked for data consistency by ensuring the following:

- The sum of TME22: Truncated Claims Spending stratified by large provider entity code, market code, and reporting year from the 2_TME tab should have the same sum as SD06: Total Claims Truncated Spending in the 3_SD tab also stratified by large provider entity code, market code, and reporting year. The 3_SD tab stratifies data at the market level instead of the insurance category level like the 2_TME tab does. Insurance categories will need to be rolled up to their market level for comparison. For example, Commercial Full Claims and Commercial Partial Claims will need to be added together for the Commercial market. Submitters can do a quick check by comparing aggregated truncated claims spending across these two tabs and making sure that the numbers are equal for each provider entity for each reporting year.
- Similar to the previous bullet point, the sum of member months stratified by large provider entity code, market code, and reporting year should be equal between the 2_TME and 3_SD tabs. Submitters can do a quick check by comparing aggregated market level member months across these two sheets and making sure that the numbers are equal.
- The sum of member months by reporting year should be equal across the following tabs: 2_TME, 3_SD, and 4_LOB_ENROLL. As a note, the 4_LOB_ENROLL tab has a section for Medicare, Medicare Duals, Medicaid, and Medicaid Duals, but not for Commercial Full and Commercial Partial. The Commercial lines of business will need to be added together to the market level to be compared to the 2_TME and 3_SD tabs. Submitters can do a quick check by comparing aggregated member months for each year across these tabs and making sure that the numbers are equal.

Before submitting, please ensure that any calculation done to check for data accuracy and consistency in the sheets (e.g., column totals calculated to compare across tabs) are deleted.

Appendix A, Attachment 1: Primary care definition

In 2024, the Health Care Cost Transparency Board adopted a new definition of primary care at the recommendation of its Advisory Committee on Primary Care. The new definition uses a combination of provider specialty taxonomy code (Table A-12), service code (

Table **A-13**), and place of service code (Table A-14) to identify primary care spending. For more information on the primary care definition and to download the value sets in excel format, please visit the Advisory Committee on Primary Care's website.

Carriers should identify PCPs first by searching for provider taxonomy codes in Table A-12 in the rendering provider field and then the billing provider field.

Table A-12. Primary care provider taxonomy codes

Provider taxonomy code	Specialty description	Subspecialty description
261QP2300X	Clinic/Center	Primary Care

Provider taxonomy code	Specialty description	Subspecialty description
261QF0400X	Clinic/Center	Federally Qualified Health Center (FQHC)
261QC0050X	Clinic/Center	Critical Access Hospital
261QU0200X	Clinic/Center	Urgent Care
261QR1300X	Clinic/Center	Rural Health
364SF0001X	Clinical Nurse Specialist	Family Health
364S00000X	Clinical Nurse Specialist	—
364SP0200X	Clinical Nurse Specialist	Pediatrics
364SG0600X	Clinical Nurse Specialist	Gerontology
364SA2200X	Clinical Nurse Specialist	Adult Health
364SW0102X	Clinical Nurse Specialist	Women's Health
364SC2300X	Clinical Nurse Specialist	Chronic Care
364SH1100X	Clinical Nurse Specialist	Holistic
207QG0300X	Family Medicine	Geriatric Medicine
207Q00000X	Family Medicine	—
207QA0000X	Family Medicine	Adolescent Medicine
207QA0505X	Family Medicine	Adult Medicine
208D00000X	General Practice	—
207R00000X	Internal Medicine	—
207RG0300X	Internal Medicine	Geriatric Medicine
207RA0000X	Internal Medicine	Adolescent Medicine
175F00000X	Naturopath	—
363L00000X	Nurse Practitioner	—
363LP0200X	Nurse Practitioner	Pediatrics
363LP2300X	Nurse Practitioner	Primary Care
363LA2200X	Nurse Practitioner	Adult Health
363LF0000X	Nurse Practitioner	Family
208000000X	Pediatrics	—
2080A0000X	Pediatrics	Adolescent Medicine
363A00000X	Physician Assistant	—
363AM0700X	Physician Assistant	Medical

Provider taxonomy code	Specialty description	Subspecialty description
2083P0500X	Preventive Medicine	Preventive Medicine/Occupational Environmental Medicine

Table A-13 Primary care procedure codes

Code	Description
11976	Remove Contraceptive Capsule
11981	Insert Drug Implant Device
11982	Remove Drug Implant Device
11983	Remove W/ Insert Drug Implant
57170	Fitting Of Diaphragm/Cap
58300	Insert Intrauterine Device
58301	Removal of IUD
90460	Immunization Admin 1St/Only Component 18 Years<
90461	Immunization Admin Each Addl Component 18 Years<
90471	Immunization Admin 1 Vaccine Single/Combo
90472	Immunization Admin Each Add-On Single/Combo
90473	Immunization Admin Oral/Nasal Single/Combo
90474	Immunization Admin Oral/Nasal Addl Single/Combo
96110	developmental screening, including autism
96127	Brief developmental or behavioral health screening
96160	Pt-Focused Hlth Risk Assmt
96161	Caregiver Health Risk Assmt
96372	Ther/Proph/Diag Inj Sc/Im
98925	Osteopath Manj 1-2 Regions
98926	Osteopath Manj 3-4 Regions
98927	Osteopath Manj 5-6 Regions
98928	Osteopath Manj 7-8 Regions
98929	Osteopath Manj 9-10 Regions
98966	Hc Pro Phone Call 5-10 Min
98967	Non-Physician Telephone Services 11-20 Min
98968	Non-Physician Telephone Services 21-30 Min

Code	Description
98969	Online Service By Hc Pro
99202	Office/OutPt Visit New 15-29 Min
99203	Office/OutPt Visit New 30-44 Min
99204	Office/OutPt Visit New 45-59 Min
99205	Office/OutPt Visit New 60-74 Min
99211	Office/OutPt Visit Est
99212	Office/OutPt Visit Est 10-19 Min
99213	Office/OutPt Visit Est 20-29 Min
99214	Office/OutPt Visit Est 30-39 Min
99215	Office/OutPt Visit Est 40-54 Min
99241	Office Or Other OutPt Consultations 15 Min
99242	Office Or Other OutPt Consultations 30 Min
99243	Office Or Other OutPt Consultations 40 Min
99244	Office Or Other OutPt Consultations 60 Min
99245	Office Or Other OutPt Consultations 80 Min
99304	Initial Nursing Facility Care/Day 25 Min
99305	Initial Nursing Facility Care/Day 35 Min
99306	Initial Nursing Facility Care/Day 45 Min
99307	Sbsq Nursing Facility Care/Day E/M Stable 10 Min
99308	Sbsq Nursing Facil Care/Day Minor Complj 15 Min
99309	Sbsq Nursing Facil Care/Day New Problem 25 Min
99310	Sbsq Nurs Facil Care/Day Unstabl/New Prob 35 Min
99315	Nursing Facility Discharge Management 30 Min<
99316	Nursing Facility Discharge Management 30 Min>
99318	E/M Annual Nursing Facility Assess Stable 30 Min
99339	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 15-29 Min
99340	Individual Physician Supervision Of Pt (W/OutPt) In Home, Domiciliary Or Rest Home Complex 30 Min
99341	Home Visit New Pt 20 Min
99342	Home Visit New Pt 30 Min
99343	Home Visit New Pt 45 Min

Code	Description
99344	Home Visit New Pt 60 Min
99345	Home Visit New Pt 75 Min
99347	Home Visit Established Pt 15 Min
99348	Home Visit Established Pt 25 Min
99349	Home Visit Established Pt 40 Min
99350	Home Visit Established Pt 60 Min
99354	Prolonged Service OutPt 60 Min
99355	Prolonged Service OutPt Add 30 Min
99356	Prolonged Service Requiring Unit/Floor 60 Min
99357	Prolonged Service Requiring Unit/Floor Add 30 Min
99358	Prolong Service W/O Contact
99359	Prolong Serv W/O Contact Add 30 Min
99360	Standby Service
99366	Team Conf W/ Pt By Healthcare Prof 30 Min W/Physician
99367	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Physician
99368	Team Conf W/Out Pt By Healthcare Prof 30 Min W/Out Physician
99381	Init Pm E/M New Pat Infant
99382	Init Pm E/M New Pat 1-4 Yrs
99383	Prev Visit New Age 5-11
99384	Prev Visit New Age 12-17
99385	Prev Visit New Age 18-39
99386	Prev Visit New Age 40-64
99387	Office Visit - New Pt 65+ Yrs
99391	Periodic Pm Reeval Est Pat Infant 1>
99392	Prev Visit Est Age 1-4
99393	Prev Visit Est Age 5-11
99394	Prev Visit Est Age 12-17
99395	Prev Visit Est Age 18-39
99396	Prev Visit Est Age 40-64
99397	Per Pm Reeval Est Pat 65+ Yr
99401	Preventive Counseling Indiv 15 Min
99402	Preventive Counseling Indiv 30 Min

Code	Description
99403	Preventive Counseling Indiv 45 Min
99404	Preventive Counseling Indiv 60 Min
99406	Behav Chng Smoking 3-10 Min
99407	Behav Chng Smoking > 10 Min
99408	Audit/Dast 15-30 Min
99409	Alcohol/Substance Screen & Intervention >30 Min
99411	Preventive Counseling Group 30 Min
99412	Preventive Counseling Group 60 Min
99429	Unlisted Preventive Service
99441	Phys/Qhp Telephone Evaluation 5-10 Min
99442	Phone E/M Phys/Qhp 11-20 Min
99443	Phys/Qhp Telephone Evaluation 21-30 Min
99450	Basic Life And/Or Disability Exam
99451	Interprofessional Electronic Health Assessment 5 Min >
99452	Interprofessional Electronic Health Record Referral Service(S) Provided By A Treating Physician Health Care Professional, > 16 Min
99453	Remote Monitoring Physiologic Parameters Initial
99454	Remote Monitoring Physiologic Parameters Programed Transmission
99455	Work Related Disability Exam
99456	Disability Examination
99457	Remote Physiologic Monitoring Treatment Management Services, First 20 Min
99483	Assmt & Care Planning Pt W/Cognitive Impairment
99484	Care Mgmt Svc Bhvl Health Conditions 20 Min
99487	Complex Care W/O Pt Vsit 60 Min
99489	Complex Chronic Care Addl 30 Min
99490	Chron Care Mgmt Srvc 20 Min
99494	1St/Sbsq Psyc Collab Care
99495	Trans Care Mgmt 14 Day Disch
99496	Trans Care Mgmt 7 Day Disch
99497	Advncd Care Plan 30 Min

Code	Description
99498	Advncd Care Plan Addl 30 Min
G0008	Admin Influenza Virus Vaccine
G0009	Admin Pneumococcal Vaccine
G0010	Admin Hepatitis B Vaccine
G0101	Cancer Screen; Pelvic/Breast Exam
G0102	Prostate Cancer Screening; Digital Rectal Examination
G0179	Phys Re-Cert Mcr-Covr Hom Hlth Srvc Re-Cert Prd
G0180	Phys Cert Mcr-Covr Hom Hlth Srvc Per Cert Prd
G0181	Home/Nursing Facility Visits W/Out Pt Medicare Approved
G0182	Hospice Facility Visits Medicare Approved
G0396	Alcohol/Subs Misuse Intervention 15-30 Min
G0397	Alcohol/Subs Misuse Intervention 30 Min <
G0402	Welcome to Medicare visit
G0438	Ppps, Initial Visit
G0439	Ppps, Subseq Visit
G0442	Annual Alcohol Screen 15 Min
G0443	Brief Alcohol Misuse Counsel
G0444	Depression Screen Annual 15 Min
G0463	Hospital Outpt Clinic Visit
G0466	FQHC Visit, New Pt
G0467	FQHC Visit, Established Pt
G0468	FQHC Preventive Visit
G0469	FQHC Visit, Mh New Pt
G0470	FQHC Visit, Mh Estab Pt
G0506	Comprehensive Asses Care Plan Chronic Care Mgmt Services
G0513	Prolong Preventative Services, First 30 Min
G0514	Prolonged Preventive Service Addl 30 Min
Q0091	Obtaining Screen Pap Smear
T1015	Clinic Service All-Inclusive

Table A-14 Primary care place of service codes

Place of service code	Place of service description	Comment

2	Telehealth / Telehealth provided other than in patient's home	—
3	School	—
5	Indian health service free-standing facility	—
6	Indian health service provider-based facility	—
7	Tribal 638 free-standing facility	—
8	Tribal 638 provider-based facility	—
10	Telehealth Provided in Patient's Home	—
11	Office	—
12	Home	—
19	Off campus - outpatient hospital	—
22	On campus - outpatient hospital	—
31	Skilled nursing facility	—
32	Nursing facility	—
49	Independent clinic	—
50	Federally qualified health center	—
72	Rural health clinic	—

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 HCA in reporting and filing data to measure Medicaid's performance against the benchmark.

TME file submission schedule

In general, the Cost Board 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. The Cost Board 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 benchmark data collection

Date	Files due
April 18, 2025	CY 2022 and CY 2023 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 implementation 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:

- 216_HCA_TME_YYYYMMDD.xls[9]
- YYYY is the four-digit year, MM is two-digit month, and DD is the two-digit date of submission. Make sure that the month and the date are each two-digits. For example, if the date of submission is March 5, 2025, the YYYYMMDD is 20250305.
- The file extension must be .xlsx

Below are examples of a valid file name:

- If HCA submits data on March 05, 2025, the file name would be: 216_HCA_TME_20250305.xlsx

Submitting files to HCA

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

[9] 216 is payer code assigned by the Cost Board to HCA.

TME data tabs and field definitions

Data should be submitted using the 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_SD:** Collects the truncated claims spending standard deviations.
- **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 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.[10]

Claims-based payments

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

Non-claims-based payments

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

[10] Starting with the 2025 data call, a new definition of primary care is adopted. Please ensure that data on primary care is based on the updated value sets provided in Appendix A, Attachments 1-3.

Standard deviation tab

This tab is where HCA should report the standard deviation of the truncated claims spending by year, market, and large provider entity. The standard deviation for Medicaid FFS overall (large provider entity code = 100) should also be reported in this tab.

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, HCA will request FFS Medicare spending and enrollment data from 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[11]

HCA will map out these services to the TME reporting categories according as outlined in

Table **C-1**.

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 Claims
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 Claims
Other Suppliers	Other Claims
Part D	Retail Pharmacy

[11] 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.

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: Department of Labor and Industries (L&I) total medical expense data specifications

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 this reporting 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.

File data using the schedule outlined in Table B-1.

Table D-2. L&I's spending filing schedule for the benchmark data collection

Date	Files due
April 18, 2025	CY 2022 and CY 2023 TME

Appendix E: Department of Corrections total medical expense data specifications

The 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 this reporting period, DOC should report expenditures in aggregate for calendar year(s) 2022 and 2023, along with a monthly count of individuals who are eligible for the Washington 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.

File data using the schedule outlined in Table B-1.

Table E-3. DOC's spending filing schedule for the benchmark data collection

Date	Files due
April 18, 2025	CY 2022 and CY 2023 TME

Appendix F: Veterans Health Administration total medical expense data specifications

Statistics on Washington veteran health care spending is published in the summer by the Veterans Health Administration (VHA) National Center for Analysis and Statistics. You can **access this information online.** 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 70.390.020, and as described by reporting guidelines directed by the Health Care Cost Transparency Board in the 2025 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 benchmark.

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: HCACostBoardData@hca.wa.gov. **Please note that failure to sign and submit this Attestation will result in the Cost 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

Appendix H: Common acronyms

ACA	Affordable Care Act
CCIIO	CMS Center for Consumer Information and Oversight
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DOC	Washington Department of Corrections
DSH	Disproportionate Share Hospital
DSHS	Washington State Department of Social and Health Services
EIN	Employer Identification Number
FEP	Federal Employee Health Benefits Plans
FFS	Fee-for-service
FQHC	Federally Qualified Health Center
HCA	Washington Health Care Authority
HMO	Health Maintenance Organization
HMOPOS	HMO Point of Service
IBNP	Incurred but not paid
IBNR	Incurred but not reported
L&I	Washington Department of Labor and Industries
MAPD	Medicare Advantage Plan with Part D
MLR	Medical Loss Ratio
MSA	Medicare Medical Savings Account
NAIC	National Association of Insurance Commissioners
NCPHI	Net cost of private health insurance
NEMT	Non-emergency medical transportation
OFM	Office of Financial Management
OIC	Washington State's Office of the Insurance Commissioner
PBM	Pharmacy Benefit Manager
PCP	Primary Care Provider
PDP	Prescription Drug Plans
PEBB	The Washington Public Employees Benefits Board
PFFS	Private Fee-for-Service

PGSP	Potential gross state product
PMPM	Per member per month
PMPY	Per member per year
PPO	Preferred Provider Organization
SEBB	The Washington School Employees Benefits Board
SHCE	Supplemental Health Care Exhibits
SNPs	Special Needs Plans
THCE	Total Health Care Expenditures
TME	Total Medical Expense
VHA	Veterans' Health Administration