

# Health Care Cost Transparency Board's 2026 data call

Webinar for carriers

February 19, 2026

# Welcome

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- ▶ Today's goals:
  - ▶ Assist technical staff responding to the 2026 data call.
  - ▶ Provide 2026 data call technical detail updates.
  - ▶ Provide an overview of the submission template.
  - ▶ Answer questions.
- ▶ We'll post a recording of this training on the data call webpage.
  - ▶ [hca.wa.gov/about-hca/who-we-are/call-benchmark-data](https://hca.wa.gov/about-hca/who-we-are/call-benchmark-data)

# Agenda

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- ▶ Overview of the Health Care Cost Transparency Board (Cost Board)
- ▶ 2026 data call
  - ▶ Reporting timeline
  - ▶ Discussion of data call materials
    - ▶ Summary of technical detail changes
    - ▶ Technical manual
    - ▶ Data submission template
    - ▶ Special focus on updated primary care non-claims submission, cover page update
  - ▶ Suggested consistency and trend checks
  - ▶ Submission reminders
- ▶ Office hours
- ▶ Q&A

# Overview of Washington's health care cost benchmark efforts

# Washington's Health Care Cost Transparency Board

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- ▶ State law established the Cost Board, charged with:
  - ▶ Establishing a health care cost growth **benchmark** or target percentage for growth.
  - ▶ Analyzing **total health care expenditure**.
  - ▶ Identifying **trends** in health care cost growth.
  - ▶ Identifying **entities** that exceed the health care cost growth benchmark.
  - ▶ Providing recommendations to the Legislature for lowering health care cost growth.
- ▶ Additional information available online
  - ▶ [hca.wa.gov/about-hca/health-care-cost-transparency-board](https://hca.wa.gov/about-hca/health-care-cost-transparency-board)

# Washington's Health Care Cost Transparency Board

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- ▶ Governor-appointed experts and representatives of purchasers, consumers, and state agencies
- ▶ Advised by three formal committees:
  - ▶ Advisory Committee on Data Issues
  - ▶ Health Care Stakeholders Advisory Committee
  - ▶ Advisory Committee on Primary Care
- ▶ Reports annually to the legislature

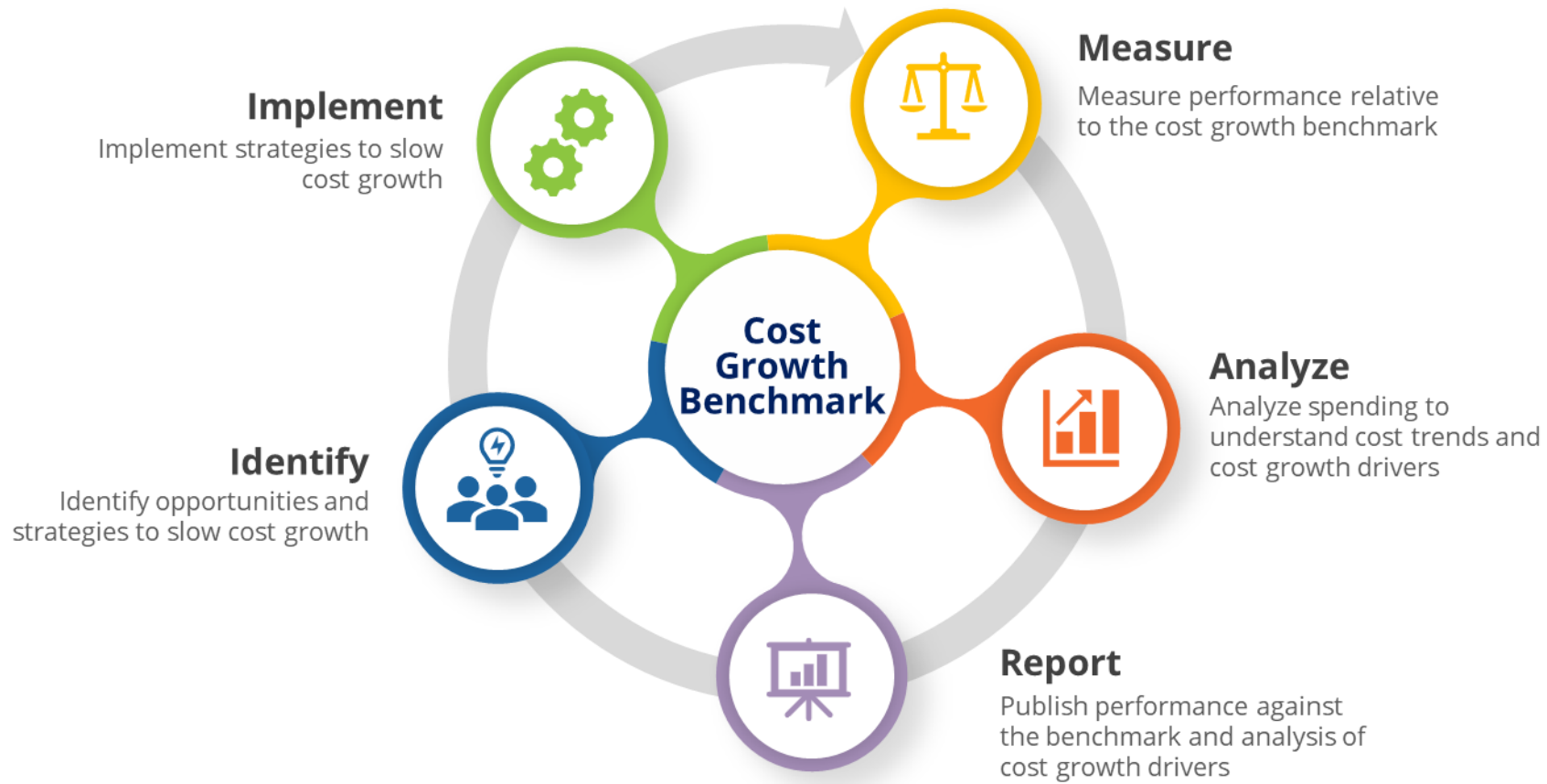
# Washington's health care cost growth benchmark

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- ▶ The annual rate-of-growth target for total health care spending in the state
  - ▶ Considers historic median wage growth and per capita potential gross state product (PGSP) growth

Calendar year	Benchmark value
2022	3.2%
2023	3.2%
2024	3.0%
2025	3.0%
2026	2.8%

# Annual health care cost benchmark cycle



# 2026 data call

# 2026 data call overview

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- ▶ Collects 2023 and 2024 data
- ▶ Adds a breakdown of non-claims into primary care and non-primary care spending
- ▶ Adds to historical data (2017–2023)
- ▶ Compares with the benchmark (2022 and forward)
  - ▶ Statewide performance
  - ▶ Carrier performance
  - ▶ Large Provider Organization performance

# Updated 2026 data call reporting timeline

1

February 10:  
Launch data call

2

April 10:  
Receive data  
submission

3

April–June:  
Conduct data  
validation

4

July–October:  
Conduct analysis and  
generate carrier and  
provider reports

5

November 18:  
Report publicly on  
performance against  
the benchmark



# 2026 data call materials

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- ▶ Technical manual
- ▶ Data submission template
- ▶ FAQ
  - ▶ Found on the data call webpage:  
[hca.wa.gov/about-hca/who-we-are/call-benchmark-data](https://hca.wa.gov/about-hca/who-we-are/call-benchmark-data)
  - ▶ Updated regularly

# Summary of technical detail changes

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- ▶ Added a new tab to collect non-claims primary care spending, in line with the Advisory Committee on Primary Care's definition.
- ▶ Added questions to Cover Page to list any notable changes in methodology from previous data calls.

## Notes:

- ▶ See page 1 of technical manual for complete list of changes.
- ▶ Slides that are new or contain updates are noted with **New** or **Updated** sign.

# Technical manual

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- ▶ I. Health care cost growth benchmark methodology
- ▶ II. Measuring performance against the benchmark
  - ▶ More detailed documentation on carrier and provider reporting methodologies are in the cost board's webpage<sup>1</sup>
- ▶ III. Payer reporting of data for the cost growth benchmark
  - ▶ Provides detailed instructions to carriers on how to prepare and submit data
  - ▶ Directs submitters to populate the [data submission template](#)<sup>2</sup>

Notes: 1/See <https://www.hca.wa.gov/about-hca/who-we-are/health-care-cost-transparency/call-benchmark-data>

2/This can be downloaded here: [hca.wa.gov/assets/program/benchmark-data-call-submission-template-2026.xlsx](https://www.hca.wa.gov/assets/program/benchmark-data-call-submission-template-2026.xlsx)

# Data submission template | Overview

Tabs	Data Stratification	Data Fields
Cover Page		
2_TME	<ul style="list-style-type: none"> <li>• Carrier Code</li> <li>• Reporting Year</li> <li>• Insurance Category Code</li> <li>• Large Provider Entity Code</li> <li>• Age Band Code</li> <li>• Sex Code</li> </ul>	<ul style="list-style-type: none"> <li>• Member months</li> <li>• Claims-based spending fields (untruncated and truncated)</li> <li>• Non-claims-based spending fields</li> </ul>
3_SD	<ul style="list-style-type: none"> <li>• Carrier Code</li> <li>• Reporting Year</li> <li>• Large Provider Entity Code</li> <li>• Market Code</li> </ul>	<ul style="list-style-type: none"> <li>• Member Months</li> <li>• Total truncated claims spending</li> <li>• Standard deviation of truncated claims spend PMPM</li> </ul>
4_LOB_ENROLL	<ul style="list-style-type: none"> <li>• Carrier Code</li> <li>• Line of Business Category</li> </ul>	<ul style="list-style-type: none"> <li>• Member months</li> </ul>
5_RX_REBATE	<ul style="list-style-type: none"> <li>• Carrier Code,</li> <li>• Reporting Year</li> <li>• Insurance Category Code</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Pharmacy Rebate Amount</li> <li>• Retail Pharmacy Rebate Amount</li> <li>• Total Pharmacy Rebate Amount</li> </ul>

# Data submission template | Overview New Tabs

Tabs	Data Stratification	Data Fields
6_PC_Non_Claims	<ul style="list-style-type: none"><li>• Carrier Code</li><li>• Reporting Year</li><li>• Insurance category code</li><li>• Large provider entity code</li></ul>	Non-claims fields from TME split by primary care and not primary care
7_Reference Tables		

## Tab 1: Cover page

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- ▶ Contact information
  - ▶ Name of individual who should be contacted with data validation questions
  - ▶ Name and contact information for someone who can serve as a contact point for providers
- ▶ Data completeness and estimates
  - ▶ What is potentially missing from the data and what estimate methodologies were used
- ▶ Attestation
  - ▶ Confirm that the data submitted is current, complete, and accurate to the best of their knowledge
- ▶ Carrier “doing business” names and Federal Employer Identification Number (EIN) numbers
- ▶ Now collecting any methodological differences between the current data call and previous data calls
  - ▶ For example, “better identification of duals caused changes in enrollments and spending,” or “changes in the internal definitions of specialty and other professional spending affected the division of spending between those two categories”

# Data submission template

## Tab 2: Total medical expenditures (TME)

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TME01 code	TME02 year	TME03 code	TME04 code	TME05 code	TME06 code
Carrier code	Reporting year	Insurance category code	Large provider entity code	Age band code	Sex code

- ▶ Total medical expenditures (TME) data stratification
- ▶ These codes can be found in Tab 6: Reference tables

# Data submission template | Tab 2: TME

## Data stratification | Insurance category code

- ▶ Insurance category codes are mutually exclusive categories that indicate for which business the carrier is reporting data
- ▶ Commercial has two categories:
  - ▶ **Full claims:** for when the carrier holds the entire medical benefit and has all the data.
  - ▶ **Partial claims:** for when the carrier holds part of the benefit, and another part is carved out (e.g., pharmacy or behavioral health). Carriers should estimate partial claims data for which carriers do not have access.

Insurance category code	Description
1	Medicare Expenses for Non-Dual Eligible Members
2	Medicaid Expenses for Non-Dual Eligible Members
3	Commercial: Full Claims
4	Commercial: Partial Claims
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible
8	Federal Employee Health Benefits: Partial Claims

## Data stratification | Insurance category code, cont.

- ▶ Insurance category code for Federal Employee Health Benefits (FEP)
  - ▶ Insurance category code:
    - ▶ FEP Partial claims: 8
  - ▶ This code is only for carrier plans that cover a portion of benefits for a group of members while another carrier covers the other portion of benefits.
  - ▶ If you do not share coverage of FEP members with another carrier, **please categorize FEP spending in the commercial insurance categories.**

Insurance category code	Description
1	Medicare Expenses for Non-Dual Eligible Members
2	Medicaid Expenses for Non-Dual Eligible Members
3	Commercial: Full Claims
4	Commercial: Partial Claims
5	Medicare Expenses for Medicare/Medicaid Dual Eligible
6	Medicaid Expenses for Medicare/Medicaid Dual Eligible
8	Federal Employee Health Benefits: Partial Claims*

\* Code is only for Federal Employee Health Benefit plans that are split among two carriers.

# Data submission template | Tab 2: TME

## Data stratification | Age and sex codes

- ▶ Use TME data by age and sex groups to calculate the age –sex risk adjusted cost growth for carriers and providers.
- ▶ To submit spending information without age or sex stratification, use:
  - ▶ Sex code = 3
  - ▶ Age band code = 9

Sex code	Description
1	Female
2	Male
3	Other/Unknown

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

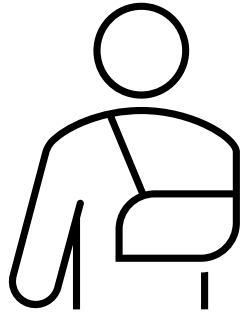
# Data submission template | Tab 2: TME

## Data stratification | Large provider entities

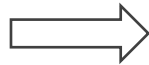
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TME01 code	TME02 year	TME03 code	TME04 code	TME05 code	TME06 code
Carrier code	Reporting year	Insurance category code	Large provider entity code	Age band code	Sex code

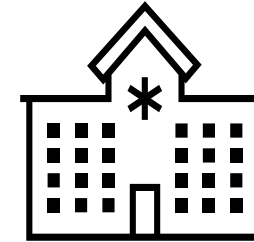
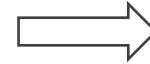
# Provider attribution methodology



**Individual members**



**Primary Care Provider (PCP)**



**Large Provider Entity**

**PCP attribution is based on the following order:**

- PCP selection by member (as required by plan)
- Contract arrangement between carrier and provider
- Utilization history

## List of large provider entities

Do not provide data for code=100 in 2\_TME tab

100	Overall 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
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

## Data submission template | Tab 2: TME

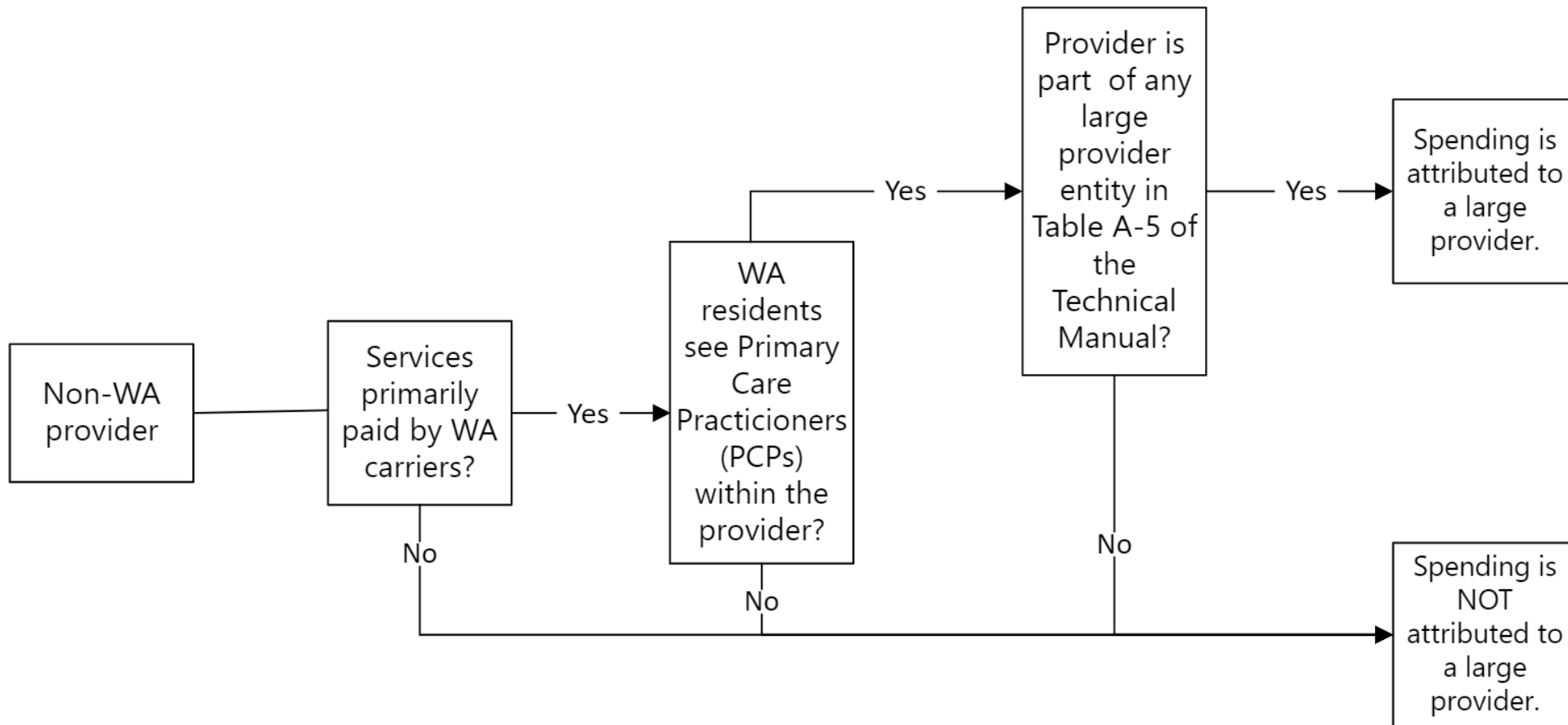
# Data inclusion criteria

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- ▶ Washington residents
- ▶ Report allowed amounts (i.e., amounts paid by the insurer and member cost sharing) for claims based on date incurred
- ▶ Only report spending on claims for which the insurer was the primary payer
- ▶ Allow for a claims run-out period and a non-claims reconciliation period of at least 180 days after December 31 of the performance year; if carrier has > 180 day use the maximum amount of run-out time
- ▶ Apply reasonable and appropriate incurred but not reported (IBNR) / incurred but not paid (IBNP) completion factors to each respective TME service category
- ▶ Apply reasonable and appropriate estimates of non-claims liability that are expected to be reconciled after the run-out period

# Data submission template | Tab 2: TME

## Out of state provider specification



# Data submission template | Tab 2: TME

## Data inclusion criteria | Included policies

### Included 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)

#### 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 Plan (SNPs)

#### Medicaid contract

- ✓ Medicaid and CHIP managed care contracts with the Washington Health Care Authority

# Data submission template | Tab 2: TME

## Data inclusion criteria | Excluded policies

### Excluded policies

Policies offering limited benefits, including:

- Accident policy
- Disability policy
- Hospital indemnity policy
- Long-term care insurance
- Medicare supplemental insurance (AKA Medigap)
- Stand-alone prescription drug plans
- Specific disease policy
- Stop-loss plans
- Supplemental insurance that pays deductibles, copays, or coinsurance
- Vision-only insurance
- Workers' compensation
- Dental-only insurance

# Data submission template | Tab 2: TME

## Data fields

TME07 non-negative number	TME08–15 non-negative number	TME16–21 non-negative number	TME22 non-negative number	TME23 non-negative integer
Member months	Claims-based spending	Non-claims-based spending	Truncated claims spending	Count of members with claims truncated

- ▶ Only TME22 should have truncated claims spending
- ▶ **Exception:** TME17 Non-claims: Performance incentives may be non-positive
- ▶ **Exception:** TME20 Non-claims: Recovery should be a non-positive number

# Data submission template | Tab 2: TME

## Claims: hospital inpatient

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- ▶ Sum of the allowed amount from the claims for hospital inpatient services.
- ▶ Includes:
  - ▶ All room and board and ancillary payments for all hospital types
  - ▶ 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
  - ▶ Inpatient services at non-hospital facilities (e.g., residential treatment facilities)

# Data submission template | Tab 2: TME

## Claims: hospital outpatient

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- ▶ 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
  - ▶ 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

## Data submission template | Tab 2: TME

# Claims: professional, primary care providers

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- ▶ Sum of the allowed amount from the claims paid to primary care providers for primary care services using the provider taxonomy, procedure, and place of service codes in Appendix A of the Implementation Manual.
- ▶ Now based on the Advisory Committee on Primary Care's definition.\*
- ▶ No longer based on primary care outlined in the Office of Financial Management's (OFM) Primary Care Expenditures Report.
- ▶ Changes include addition of place of service codes to the definition and updated provider taxonomy and procedure codes.
  - ▶ See Appendix A Attachment 1 in technical manual; or
  - ▶ See Cost Board's Advisory Committee on Primary Care's [webpage](#) to download the [value sets in excel format](#) (provider and subspecialty codes, procedure codes, and place of service codes tabs).

## Data submission template | Tab 2: TME

# Claims: professional, specialty care providers

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- ▶ 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 the Advisory Committee on Primary Care's definition of primary care.

## Data submission template | Tab 2: TME

# Claims: professional, other providers

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- ▶ Sum of the allowed amount from the claims paid to a licensed practitioner other than a PCP or specialty provider.
- ▶ Includes, but is not limited to:
  - ▶ Licensed podiatrists
  - ▶ Nurse practitioners
  - ▶ Physician assistants
  - ▶ Physical therapists
  - ▶ Occupational therapists
  - ▶ Speech therapists
  - ▶ Psychologists
  - ▶ Licensed clinical social workers
  - ▶ Counselors
  - ▶ Dieticians
  - ▶ Dentists
  - ▶ Chiropractors
- ▶ Includes any fees that do not fit other categories, including facilities fees of community health center services and freestanding ambulatory surgical center services.

## Data submission template | Tab 2: TME

# Claims: long-term care

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- ▶ 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
  - ▶ 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 program
  - ▶ Home health services
  - ▶ Adult daycare
  - ▶ Self-directed personal assistance services
  - ▶ 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.

## Data submission template | Tab 2: TME

### Claims: retail pharmacy

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- ▶ 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.
- ▶ 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.

## Data submission template | Tab 2: TME

### Claims: other

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- ▶ 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 service
  - ▶ Optical services
- ▶ Payments made to members for direct reimbursement of health care benefits and services may be reported in "Claims: other" if the carrier is unable to classify the service.

# Data submission template | Tab 2: TME

## Non-claims: capitation or bundled payments and performance incentive payments

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- ▶ Capitation or bundled payments
  - ▶ All non-claims-based payments made to cover health care services.
  - ▶ Examples include capitation, global budget, case rate, and episode-based payments.
- ▶ Performance incentive payments
  - ▶ 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.

# Data submission template | Tab 2: TME

## Non-claims: population health and practice infrastructure payments, provider salaries

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- ▶ Population health and practice infrastructure payments
  - ▶ All payments made to providers to develop capacity and practice infrastructure to help coordinate care, improve quality, and control costs.
  - ▶ This can include:
    - ▶ Electronic health record (EHR) or health information technology (HIT) infrastructure payments
    - ▶ Patient-centered medical home (PCMH) recognition payments
    - ▶ Primary care and behavioral health integration payments that are not reimbursable through claims
- ▶ Provider salaries
  - ▶ All payments for salaries of providers who provide health care services not otherwise included in claims and non-claims categories.

# Data submission template | Tab 2: TME

## Non-claims: recovery and other

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### ▶ Recovery

- ▶ All payments recouped during the measurement year as the result of a prior review, audit, or investigation, regardless of the time 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).

### ▶ Other

- ▶ All other payments made pursuant to the carrier's contract with a provider that were not based on a claim for health care benefits or 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 report payments made to providers; carrier administrative expenditures (including corporate allocations) are not included in TME.

# Data submission template | Tab 2: TME

## Truncated spending fields

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- ▶ The last two columns include the total truncated claims spending and the count of members with truncated claims.
- ▶ Truncation means that spending above a certain threshold is not included.
- ▶ Truncation is applied on:
  - ▶ All claims spending **including all** carve-out spending estimates for partial claims
  - ▶ Per member basis

# Data submission template | Tab 2: TME

## Truncation threshold

- ▶ Each insurance category has a separate truncation threshold

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
8	Federal Employee Health Benefits: Partial Claims*	\$200,000

\* Code is only for Federal Employee Health Benefit plans that are split among two carriers.

# Truncated claims calculation

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- ▶ **Common mistake:** Carriers submit the amount above the truncation threshold when it should be the amount **below or at** the truncation threshold.
- ▶ Once each member's spending has been truncated, the data submission template asks for the sum of claims spending after truncation has been applied.
- ▶ Calculating the truncated claims spending is required for the total medical expense tab (TME22) and standard deviation tab (SD06).

# Truncation calculation example

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

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

# Data submission template

## Tab 3: Standard deviation (SD)

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SD01 code	SD02 year	SD03 code	SD04 code	SD05 non-negative integer	SD06 Non- negative integer	SD07 Non-negative number
Carrier code	Reporting year	Market code	Large provider entity code	Member months	Total claims truncated spending	Standard deviation PMPM

# Data submission template | Tab 3: SD

## Standard deviation (SD), cont.

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- ▶ This deviation is used to calculate performance against the benchmark
- ▶ Please include the standard deviation for each large provider and the carrier overall for each market and year.
  - Large provider entity code = 100 for the overall carrier
    - ➔ Used only for 3\_SD tab and not in 2\_TME tab
  - Unattributed providers are grouped under large provider entity code = 999
- ▶ Must have rows for overall carrier standard deviation and provider standard deviation even if there is only one provider, regardless if large provider entity code = 999.

# Data submission template | Tab 3: SD

## Example of SD data stratification

- ▶ Suppose for a particular year, a carrier operates in the following markets with corresponding number of providers:

Markets	Number of providers
Medicare	3 large providers
	2 non-large providers
Medicaid	2 large providers
	0 non-large providers

- ▶ Then the number of rows with standard deviation data would be 8 rows for that year:
  - Overall markets: 2 rows for overall standard deviation in Medicare and Medicaid markets
  - Medicare market: 4 rows (1 row for each of the 3 large providers and 1 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".
  - Medicaid market: 2 rows for the 2 large providers

## Data submission template | Tab 3: SD

# Data stratification | Market code

- ▶ Aggregate the standard deviation by market using the following groups:

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 code 8)*

# Data submission template | Tab 3: SD

## Calculating standard deviation

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- ▶ Calculate average monthly spending amount of each member using:
  - ▶ Claims-based allowed amounts
  - ▶ After partial claims adjustments
  - ▶ Truncated spending
- ▶ Exclude non-claims-based spending

# Data submission template | Tab 3: SD

## Standard deviation example

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- ▶ We'll walk through an example in an Excel file

# Data submission template

## Tab 4: Line of business (LOB) enroll

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LOB01 code	LOB02	LOB03 non-negative integer	LOB04 non-negative integer
Carrier code	Line of business category	Year 2023 member months	Year 2024 member months

- ▶ LOB02 is prefilled in for each line of business
- ▶ Please make sure that LOB01 is filled out

# Data submission template

## Tab 5: Prescription (Rx) rebates

RXR01 code	RXR02 year	RXR03 code	RXR04 negative number	RXR05 negative number	RXR06 negative number
Carrier code	Reporting year	Insurance category code	Medical pharmacy rebate amount	Retail pharmacy rebate amount	Total pharmacy rebate amount

$\text{RXR04} + \text{RXR05} = \text{RXR06}$

- ▶ Rx Rebates should be reported as a negative
- ▶ RXR06 should be always be populated
- ▶ If medical and retail Rx can be separated, report in columns RXR04 and RXR05
  - ▶ RXR06 should be equal to RXR04 + RXR05

## Tab 6: Primary care non-claims

PCNC01 code	PCNC02 year	PCNC03 code	PCNC04 code	PCNC05 – PCNC16 non-negative number
Carrier code	Reporting year	Insurance category code	Large provider entity code	Non-claims spending

- ▶ **Exception:** PCNC07 and PCNC08 may be non-positive since both refer to Non-claims: Performance incentives
- ▶ **Exception:** PCNC13 and PCNC14 should be a non-positive number since both refer to Non-claims: Recovery

## Non-claims spending breakout

PCNC05 non-negative number	PCNC06 non-negative number	PCNC07 number	PCNC08 number	[...]
Primary care: capitation or bundled payments	Non-primary care: capitation or bundled payments	Primary care: performance incentive payments	Non-primary care: performance incentive payments	

- ▶ PCNC05 is for capitation or bundled payments spending that is related to primary care
- ▶ PCNC06 is for capitation or bundled payments spending that is **not** related to primary care
- ▶ PCNC05 and PCNC06 should add together to equal TME16 in the TME tab.
- ▶ This pattern continues for each pair of columns in the PC non-claims tab.

## Primary care non-claims definitions

PC non-claims category from PC Committee	PC non-claims category for data call
Capitated and sub-capitated spending	PCNC05 - PC: capitation or bundled payments
Salaried expenditures	PCNC11 - PC: provider salaries
Leakage adjustments on capitated or sub-capitated PC expenditure	PCNC05 - PC: capitation or bundled payments
Estimated PC portion of global capitated expenditures	PCNC05 - PC: capitation or bundled payments
Provider incentives – LAN category 2B	PCNC07 - PC: performance incentive payments
Provider incentives – LAN category 2C	PCNC07 - PC: performance incentive payments
Provider incentives – LAN category 3A	PCNC07 - PC: performance incentive payments
Provider incentives – LAN category 3B	PCNC07 - PC: performance incentive payments

▶ More information can be found in the [PC definition spreadsheet](#).

## Primary care non-claims definitions, cont.

PC non-claims category from PC Committee	PC non-claims category for data call
Provider incentives – LAN category 4A	PCNC07 - PC: performance incentive payments
Provider incentives – LAN category 4B	PCNC07 - PC: performance incentive payments
Provider incentives – LAN category 4C	PCNC07 - PC: performance incentive payments
Other PC benefit expenditures	PCNC15 - PC: non-claims other
Patient support fees and practice support fees	PCNC09 - PC: population health and practice infrastructure payments
Expenditures for Health Information Technology (HIT)	PCNC09 - PC: population health and practice infrastructure payments
Workforce expenditures	PCNC15 - PC: non-claims other
Other PC support and investment expenditures	PCNC15 - PC: non-claims other

▶ This mapping chart is also included in the [technical manual](#).

# Data submission template

## Tab 7: Reference Tables

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- ▶ Insurance category codes
- ▶ Market codes
- ▶ Line of business codes
- ▶ Age band codes
- ▶ Sex codes
- ▶ Large provider entity codes
- ▶ Carrier codes
- ▶ Valid years

# Suggested consistency and trend checks

# Suggested consistency checks

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- ▶ By large provider entity code, market code, and reporting year:
  - ▶ Sum of "TME22: Truncated claims spending" = Sum of "SD06: Total claims truncated spending"
  - ▶ Sum of "TME07: Member months" = Sum of "SD05: Member months" = Sum of member months from commercial lines of business in 4\_LOB\_ENROLL
    - ▶ The commercial lines of business in 4\_LOB\_ENROLL tab will need to be added together to the market level to be compared to the 2\_TME and 3\_SD tabs.

# Suggested consistency checks, cont.

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- ▶ By large provider entity code, insurance category code, and reporting year:
  - ▶ TME non-claims category = Sum of the two relevant PCNC categories.
  - ▶ For example, "TME16: Non-claims: capitation or bundled payments" = "PCNC05: Primary care: capitation or bundled payments" + "PCNC06: Non-primary care: capitation or bundled payments"

# Suggested trend checks

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- ▶ By large provider entity, market code, and service category:
  - ▶ Check accuracy and/or reasonableness of **member months** and **spending** (overall and by service categories)
    - ▶ Total spending
    - ▶ PMPM
    - ▶ Year-over-year absolute (in dollars) and percent changes of PMPM
      - ➔ Significant changes could be red flags or could signal other events (e.g., business changes such as entering or exiting a market or region)
      - ➔ Low member count: if there are only a handful of members, any changes in spending will look large

# Suggested trend checks, cont.

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- ▶ By large provider entity and market code:
  - ▶ Check for year-over-year absolute (in dollars) and percent changes in standard deviation on the SD tab
    - ▶ Impacts confidence interval of overall spending growth rate (which will be compared to benchmark)
    - ▶ Especially check for large changes in the standard deviations for provider code 100.

# Submission reminders

# When and how to submit

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- ▶ Data submission deadline: **April 10, 2026**
- ▶ We'll send reminders 2 weeks and 1 week before deadline
- ▶ Submit populated data submission template to [HCACostBoardData@hca.wa.gov](mailto:HCACostBoardData@hca.wa.gov)
  - ▶ **Do not** submit to [HCAHCCTBoard@hca.wa.gov](mailto:HCAHCCTBoard@hca.wa.gov)

# Using the data submission template

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- ▶ Please **do not** do the following:
  - ▶ Create new columns
  - ▶ Change the header names
  - ▶ Include column or row totals in any of the tabs
- ▶ If an unexpected code or value is put into a cell, the cell will turn red.
  - ▶ For example, if a provider entity is spelled out instead of the code for that provider entity, the cell will turn red
- ▶ Please delete calculations done to check for data accuracy and consistency in the sheets (e.g., column totals calculated to compare across tabs).
- ▶ Please follow the updated file-naming rule. Name the file using this format: "CarrierCode\_CarrierName\_TME\_YYYYMMDD.xlsx".

# Submission process

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- ▶ We'll validate the data and check for the following:
  - ▶ Cell syntax
  - ▶ Data consistency
  - ▶ Trends, YoY changes, and cost growth outliers
  - ▶ Others
- ▶ We'll contact you if there are data issues and questions
  - ▶ You'll have 1 week to resubmit data
  - ▶ Please update filename with the new date when resubmitting
- ▶ Iterative process continues until we fully validate and accept data

# Need help?

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- ▶ Carriers are welcome to ask questions anytime via email.
  - ▶ For data-related questions, please email [HCACostBoardData@hca.wa.gov](mailto:HCACostBoardData@hca.wa.gov).
- ▶ Carriers may set up a separate time to privately consult with Board staff using office hours. Appointments will be available at the following times:
  - ▶ March 17: 9–11 a.m.
  - ▶ March 18: 1–3 p.m.
  - ▶ March 19: 1–3 p.m.
  - ▶ March 20: 10 a.m.–noon
  - ▶ March 21: 9–11 a.m.
- ▶ Email [HCACostBoardData@hca.wa.gov](mailto:HCACostBoardData@hca.wa.gov) beforehand to set up an appointment. Appointments accepted on a first come, first served basis.

# Need help?, cont.

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- ▶ Please send questions ahead of the meeting so we have time to research answers if needed.
  - ▶ This especially true for PC non-claims related questions. We want time to consult PC committee staff to ensure accurate responses.

# Q&A