Health Care Cost Transparency Board's 2025 data call

Webinar for carriers

March 12, 2025

Washington State Health Care Authority

Welcome

- Today's goals:
  - Assist technical staff responding to the 2025 data call.
  - Provide 2025 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

Agenda

- Overview of the Health Care Cost Transparency Board (Cost Board)
- 2025 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 definition, provider attribution, truncation, standard error calculation
  - 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

- 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 costs.
- Additional information available online
  - hca.wa.gov/about-hca/health-care-cost-transparency-board

Washington's Health Care Cost Transparency Board

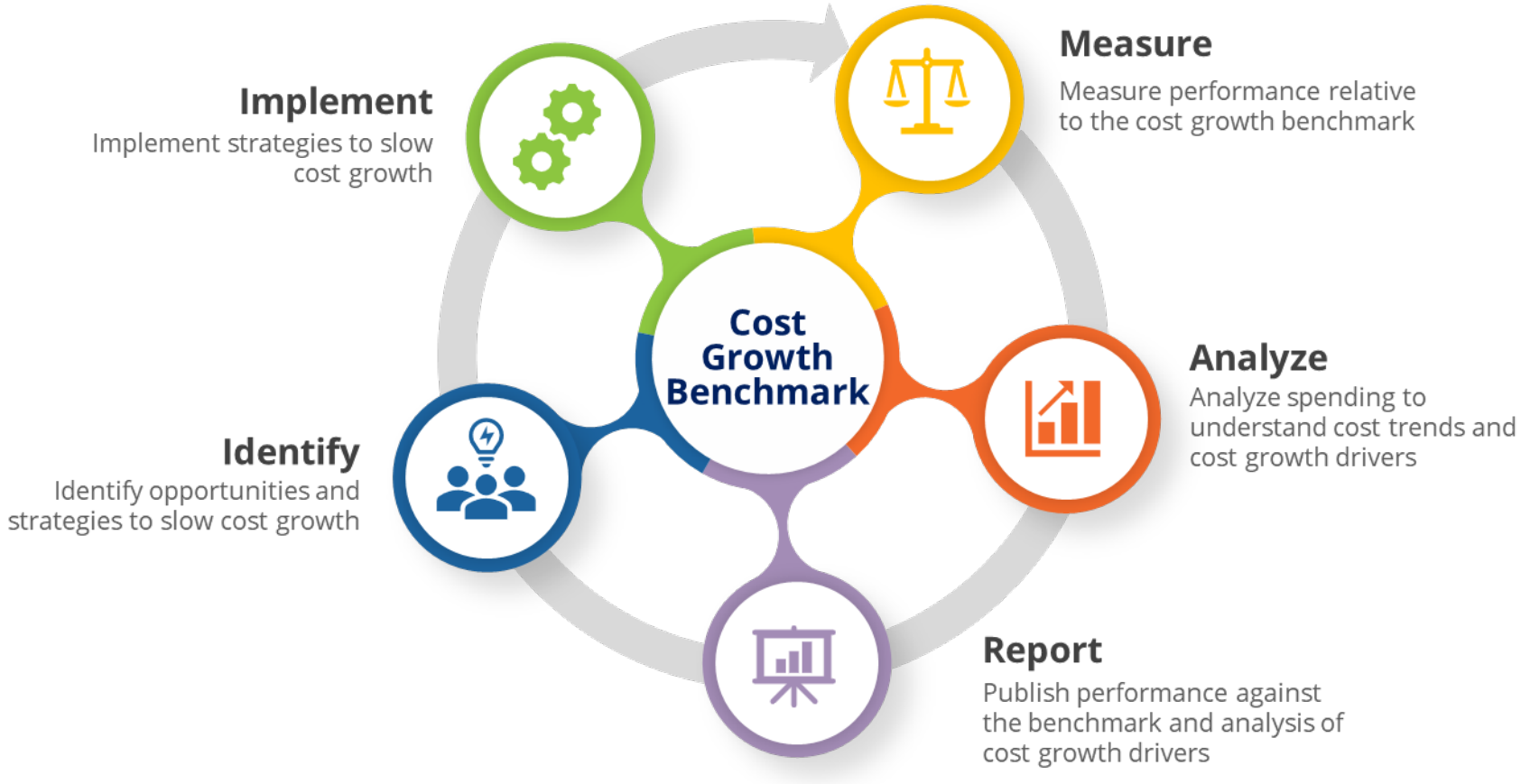
- Governor-appointed experts and representatives of purchasers, consumers, and state agencies
- Advised by three formal committees:
  - Advisory Committee on Data Issues
  - Health Care Stakeholders Advisory Committee
  - Advisory Committee on Primary Care
- Reports annually to the legislature

Washington's health care cost growth benchmark

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

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



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2025 data call

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2025 data call overview

- Collects 2022 and 2023 data
- Adds to historical data (2017–2022)
- Updates 2022 data from the 2024 data call to match our new primary care definition
- Compares with the benchmark (2022 and forward)

Updated 2025 data call reporting timeline

1

February 18:
Launch data call

2

April 18:
Receive data submission

3

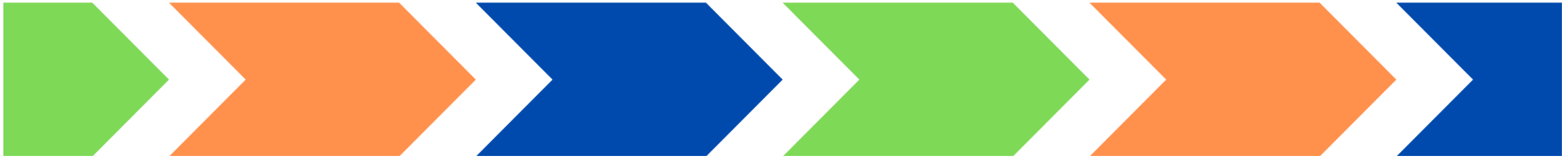
April–June:
Conduct data validation

4

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

5

November:
Report publicly on performance against the benchmark



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2025 data call materials

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

New

Summary of technical detail changes

- Updated the value sets for primary care to align with Advisory Committee on Primary Care's definition.
- Specified that while the minimum run-out period is 180 days, submitters should use the maximum amount of run-out time.
- Asked carriers to submit “doing business as” names and federal employer identification numbers (EINs) in the cover page submission.

Notes:

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

Technical manual

- I. Health care cost growth benchmark methodology
- II. Measuring performance against the benchmark
- 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[1]

Notes: 1/ This can be downloaded here: hca.wa.gov/assets/program/benchmark-data-call-submission-template-2025.xlsx

Data submission template | Overview

Tabs	Data Stratification	Data Fields
Cover Page		
2_TME	• Carrier Code • Reporting Year • Insurance Category Code • Large Provider Entity Code • Age Band Code • Sex Code	• Member Months • Claims-based spending fields (untruncated and truncated) • Non-claims-based spending fields
3_SD	• Carrier Code • Reporting Year • Large Provider Entity Code • Market Code	• Member Months • Total Claims Truncated Spending • Standard Deviation of Claims Spend PMPM
4_LOB_ENROLL	• Carrier Code • Line of Business Category	• Member Months
5_RX_REBATE	• Carrier Code, • Reporting Year • Insurance Category Code	• Medical Pharmacy Rebate Amount • Retail Pharmacy Rebate Amount • Total Pharmacy Rebate Amount (Optional)
6_Reference Tables		

Data submission template

Updated

Tab 1: Cover page

- Contact information
  - Name of individual who should be contacted with data validation questions
- 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
- Now collecting carrier “doing business” names and Federal Employer Identification Number (EIN) numbers

Data submission template

Tab 2: Total medical expenditures (TME)

TME01 code Carrier code	TME02 year Reporting year	TME03 code Insurance category code	TME04 code Large provider entity code	TME05 code Age band code	TME06 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
7	Federal Employee Health Benefits: Full Claims
8	Federal Employee Health Benefits: Partial Claims

Data submission template | Tab 2: TME

Data stratification | Insurance category code, cont.

- Insurance category code for Federal Employee Health Benefits (FEP)
  - This is only for carriers that cover a portion of benefits for a group of members while another carrier covers the other portion of benefits
  - Insurance category code:
    - FEP Full claims: 7
    - FEP Partial claims: 8

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
7	Federal Employee Health Benefits: Full Claims
8	Federal Employee Health Benefits: Partial Claims

Data submission template | Tab 2: TME

Data stratification | Age and sex codes

- To submit spending information without age or sex stratification

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

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

Updated

Data submission template | Tab 2: TME

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

Note: This list may be revised in future years of data collection.

Data submission template | Tab 2: TME

Provider reporting and attribution

- Attribute individual patients to a primary care provider (PCP) and those PCPs to a large provider entity. To attribute member to a PCP, carriers should follow the hierarchy below:
  - Member selection
    - Members who were required to select a PCP by plan design
  - Contract arrangement
    - Members not included in the above and who can be attributed to a PCP during the performance period pursuant to contract between the carrier and the provider
  - Utilization
    - Member not included in the above who can be attributed to a PCP based on the member's utilization history

Data submission template | Tab 2: TME

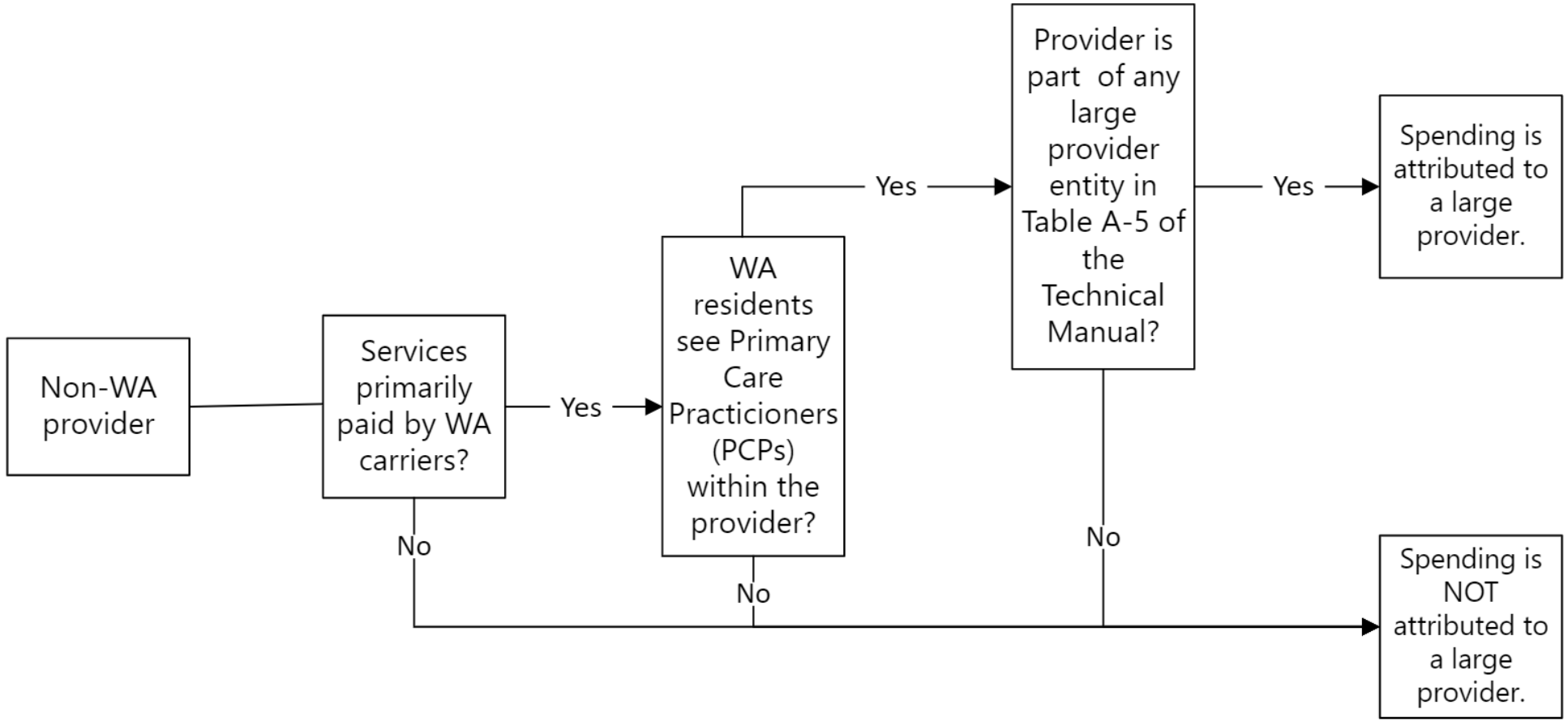
Data inclusion criteria

- Report for Washington residents
- Report allowed amounts (i.e., amounts paid by the insurer and member cost sharing) for claims based on date incurred
- Report only 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
- 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 180-day period

New

Data submission template | Tab 2: TME

Out of state provider specification



Washington State Health Care Authority

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 Member months	TME08–15 non-negative number Claims-based spending	TME16–21 non-negative number Non-claims-based spending	TME22 non-negative number Truncated claims spending	TME23 non-negative integer 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

- 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

- 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

UPDATED

Data submission template | Tab 2: TME

Claims: professional, primary care providers

- 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).

*Notes: *Please refer to the committee's website for more information:*
https://www.hca.wa.gov/about-hca/who-we-are/health-care-cost-transparency/advisory-committee-primary-care

Data submission template | Tab 2: TME

Claims: professional, specialty care providers

- 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

- 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

- 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

- 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.

Claims: other

- 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

- 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

- 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

- 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

- 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
7	Federal Employee Health Benefits: Full Claims*	$200,000
8	Federal Employee Health Benefits: Partial Claims	$200,000

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

Data submission template | Tab 2: TME

Truncated claims calculation

- **Common mistake**: Carriers submit the amount above the truncation threshold when it should be the amount **below or at** most 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)

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

Data submission template | Tab 3: SD

Standard deviation (SD), cont.

- 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

Updated

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 codes 7 and 8)*

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

Data submission template | Tab 3: SD

Calculating standard deviation

- 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

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

Data submission template

Tab 4: Line of business (LOB) enroll

LOB01 code Carrier code	LOB02 Line of business category	LOB03 non-negative integer Year 2020 member months	LOB04 non-negative integer Year 2021 member months	LOB05 non-negative integer Year 2022 member months

- LOB02 is prefilled in for each line of business

Data submission template

Updated

Tab 5: Prescription (Rx) rebates

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

- Rx Rebates should be reported as a negative
- RXR06 is there if medical and retail Rx cannot be separated out
  - Otherwise RXR06 should be RXR04 + RXR05

Washington State Health Care Authority

Data submission template

Tab 6: Reference Tables

- 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

- 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.

NEW

Suggested trend checks

- 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

NEW

Suggested trend checks, cont.

- By large provider entity, market code, and service category:
  - Check for year-over-year absolute (in dollars) and percent changes of PMPM in standard deviation in the SD tab
    - Impacts confidence interval of overall spending growth rate (which will be compared to benchmark)

Submission reminders

When and how to submit

- Data submission deadline: **April 18, 2025**
- We'll send reminders 2 weeks and 1 week before deadline
- Submit populated data submission template to HCACostBoardData@hca.wa.gov
  - **Do not** submit to HCAHCCTBoard@hca.wa.gov

Using the data submission template

- 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

- 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
- Iterative process continues until we fully validate and accept data

Need help?

- Carriers are welcome to ask questions anytime via email.
  - For data-related questions, please email HCACostBoardData@hca.wa.gov.
- Carriers may set up a separate time to privately consult with Board staff using office hours. Office hours will be held 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 beforehand to set up an appointment. Appointments accepted on a first come, first served basis.

Q&A