CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Community Dashboard: Methodological Notes

Summer 2026

The Community Dashboard provides communities across Colorado with information on health care cost, utilization, access, and quality of care. The most recent report is based on 2013-2024 claims from the Colorado All Payer Claims Database (CO APCD) which represents most Colorado residents with health insurance. The CO APCD includes claims for Medicaid, Medicare Advantage, and Medicare Fee-for-Service, and commercial payers. The CO APCD does not include most of the ERISA-based self-insured employer claims, or federal insurance programs such as Veterans Affairs, Indian Health Services, and Tricare.

Below are methodological considerations applicable to both the interactive Community Dashboard and the associated data files. The data files include additional measures and demographic breakdowns (i.e. age and sex) for measures in the interactive dashboard. Both the interactive report and the data files are available publicly at www.civhc.org.

Description of Measures

Cost of Care Measures

Cost measures represent payments made by health insurance payers and insured individuals for medical services and prescription drugs, expressed on a per person per year (PPPY) basis for Colorado residents. The PPPY calculation excludes insurance premiums and reflects only payments for services received or prescriptions filled.

Key Caveats

- Prescription drug costs do not include provider-administered drugs or rebates received either by patients at the point of sale or by payers after purchase.
- Inpatient, outpatient, and professional service costs exclude payments made outside the standard claims process, except for certain Medicaid payments to hospitals.
- Non-claims-based payments are excluded from this report, except for Medicaid supplemental hospital payments.
- Medicaid coverage differences: Medicaid covers a broader range of services than many other payers, including long-term nursing home care, extended home health services, and home- and community-based services. Comparisons between Medicaid payments and those of other payers should be made with caution.

The PPPY measure is calculated by dividing total spending on medical and pharmacy services by the total number of insured years. Total spending is based on insurance claims submitted to the CO APCD by health insurance plans. Insured years are calculated by summing the months of insurance eligibility for

individuals with at least one month of coverage during the reporting period and dividing by 12. PPPY is reported as a dollar amount.

There are three cost breakdowns displayed in the report:

- Health Plan Only Cost PPPY: the amount of dollars paid solely by health insurance plans
- Patient Only Cost PPPY: the amount of dollars paid solely by the patient, also known as "out-of-pocket" cost, which includes copay, coinsurance and deductibles
- Total Cost (Health Plan and Patient) PPPY: the sum of Health Plan Cost and Patient Cost

Dollar amounts were calculated using two approaches: (1) without adjustment for population risk and (2) with risk adjustment applied. Both versions are available in the detailed data files; however, the interactive online dashboard displays only risk-adjusted measures.

Risk-adjusted amounts are calculated using the Johns Hopkins Adjusted Clinical Groups (ACG) System, which assigns weights to individuals based on diagnoses, disease patterns, age, and sex to account for differences in health status. These weights are applied to produce measures that allow for more comparable, or "apples-to-apples," cost comparisons across populations within a given year and payer type.

Neither approach, whether risk-adjusted or unadjusted, includes adjustments for inflation over time.

Service Categories

There are four major service categories displayed for cost measures in this report: **Inpatient, Outpatient, Professional, and Pharmacy.**

- **Inpatient** services refer to health care services received after being admitted to a hospital, skilled nursing facility, or another institution offering inpatient services. Inpatient services include payments for facility services only, and do not include any professional or ancillary payments such as labs that may get billed separately. It is important to note that Medicaid pays for services that are not covered by commercial payers (e.g., long-term care services and nursing facilities) and users should keep this in mind when comparing Medicaid inpatient costs with inpatient costs from other payers.
- **Outpatient** services are health care services that do not involve a hospital admission. Outpatient services can take place in a hospital or hospital owned facility and include home health services and services provided in ambulatory surgery centers, rural health clinics, Federally Qualified Health Centers (FQHCs), or other outpatient facilities. Outpatient services include payments for facility services only and do not include any professional or ancillary payments such as labs that may get billed separately.
- **Professional** services are those provided by physicians or other health care professionals, such as a nurse practitioner, chiropractor, psychiatrist, or oncologist, and refer to non-facility costs for evaluation and management services (e.g., office visits, specialist consultations, hospital and emergency room visits, home visits, nursing home visits) and procedures (e.g., major and minor surgical procedures, ambulatory procedures, anesthesia, endoscopies, imaging procedures).
    - These services may be delivered in conjunction with inpatient or outpatient care across a variety of settings but are reported separately in the dashboard.

    - This category also includes services and supplies billed by non-facility providers or suppliers, such as laboratory and cardiovascular testing, durable medical equipment (for example, prosthetics, oxygen, and related supplies), ambulance services, chemotherapy, vaccinations, and other related services.
- **Pharmacy** services refer to prescription drugs filled and paid for through health insurance for medications. Please note pharmacy costs do not include any rebates, discounts, or subsidies received by the payer or the patient. These costs also exclude physician-administered drugs that were received in an inpatient or outpatient setting.

PPPY values for inpatient, outpatient, and professional services are based on insured years for individuals with at least one month of medical eligibility during the reporting period. PPPY values for pharmacy services are based on insured years for individuals with at least one month of prescription drug eligibility.

Overall PPPY values are calculated using insured years for individuals with at least one month of either medical or prescription drug eligibility. Months in which an individual has both medical and prescription drug coverage are counted only once when calculating insured years.

Note: Not all people with insurance coverage are eligible for both medical and pharmacy services. As a result, the Total PPPY values do not equal the sum of the PPPY values for Inpatient, Outpatient, Professional, and Pharmacy services.

Total Spending

Total spending is calculated as a sum of all dollars spent on medical and pharmacy services by health insurance plans and patients combined, during the measurement year. This measure displays an overall sum and breakdowns by the service categories described in the Cost of Care section above: Inpatient, Outpatient, Professional, and Pharmacy.

Utilization Measures

General Health Care Use Measures

The Johns Hopkins ACG grouping system[1] developed Resource Use categories to group people who use similar levels of health care resources. The data provided in the Community Dashboard includes two categories of ACG classification that describe whether or not Coloradans with health care coverage are using their coverage and accessing the health care system as recommended. The values are calculated as a *rate per 1,000 insured people* and include everyone in the CO APCD that has at least one month of medical coverage eligibility in the reporting period.

- **Non-Users** – count of people with insurance coverage who have no CO APCD claims during the year (people who fall under ACG Resource Utilization Band level 0). This measure indicates people with insurance who are not using their insurance. This count also includes people who

[1] The Johns Hopkins University Bloomberg School of Public Health (2014). The Johns Hopkins ACG System Technical User Guide, Version 11.0. Retrieved from https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_035024.pdf on October 14, 2016.

do not have enough diagnostic information on their claims to be accurately classified into the appropriate resource use category.

- **Healthy Users** – count of people whose diagnostic information contains only data about preventive services and minor conditions during the year (people who fall under ACG Resource Utilization Band level 1). This measure indicates people who are "healthy" and use their health insurance for well-visits, preventive and minor acute care.

Primary Care Users

The primary care users per 1,000 people measure is calculated as the number of people who had at least one day in which primary care was received, or a primary care provider was visited during the measurement year of interest per 1,000 people. The definition for primary care used in this report is the same as the definition used in the CIVHC Primary Care Spending 2023 report. Specifics about the definition, including lists for the services and procedures that were considered primary care (Current Procedural Terminology (CPT) codes), and for the provider types (taxonomies) that were considered primary care providers can be found on pages 23-44 of the Primary Care Spending report, available here for download (Primary Care Spending - CIVHC.org).

Outpatient Visits

The outpatient visits per person is calculated for all people with at least one month of medical coverage eligibility during the reporting period. The count of outpatient visits is calculated by the Johns Hopkins ACG grouping system and refers to visits in outpatient settings where patients receive ambulatory care, such as in hospital outpatient settings, physician offices, ambulatory surgery centers, rural health clinics, FQHCs, community mental health centers, mass immunization centers, comprehensive outpatient rehabilitation facilities, and other outpatient facilities or telehealth visits provided in locations other than in patient's home.

Emergency Department Use Measures

The Community Dashboard includes a subset of measures referring to Emergency Department visits, calculated as the count of emergency department visits per 1,000 insured people. These measures were derived using the Patched New York University Emergency Department (ED) visit algorithm[2] (NYU algorithm). In addition to overall ED visits, the algorithm calculates the probability that an emergency department visit was preventable based on the primary diagnosis code of the visit. The interactive dashboard displays two categories: **Emergency Department Visits: All**[1], and **Emergency Department Visits: Potentially Preventable**. Breakouts of the potentially preventable Emergency Department visits categories, listed below, are available in separate data files. Each measure represents the count of emergency department visits of a specific type per 1,000 insured people aged 18 or older with medical insurance coverage at least 11 months out of the measurement year.

[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5517669/

[1] Please note that in the 2020 Community Dashboard, the methodology used for calculating this measure was different, and it was based on output from the Johns Hopkins ACG grouping system. Due to the change in methodology, we advise against comparing measure output from the previous Community Dashboard iteration with the current output.

1. **Emergency Department Visits: All** – number of outpatient visits with an emergency department revenue code, procedure code, or place of service code, regardless of reason of the visits defined by primary diagnosis.
2. **Emergency Department Visits: Potentially Preventable** – number of outpatient visits with an emergency department revenue code, procedure code, or place of service code; and a primary diagnosis code for which the NYU algorithm indicated that there was at least a 50% combined probability that the ED care need fell into one of the two preventable categories below:
    a. **Emergency Department Visits: Potentially Preventable, Nonemergent** – number of outpatient visits with an emergency department revenue code, procedure code, or place of service code and a primary diagnosis code for which the NYU algorithm indicated at least a 50% probability that the need was nonemergent (did not require contact with the medical system within 12 hours). *Note that this measure is available only in the data files that accompany the interactive dashboard.*
    b. **Emergency Department Visits: Potentially Preventable, Emergent but Primary Care Treatable** – number of outpatient visits with an emergency department revenue code, procedure code, or place of service code; and a primary diagnosis code for which the NYU algorithm indicated at least a 50% probability that the need was emergent and could have safely been treated in a lower-severity setting. *Note that this measure is available only in the data files that accompany the interactive dashboard.*

    Important to note: The **Potentially Preventable ED Visits** numerator is based on visits categorized as *Nonemergent* and *Emergent but Primary Care Treatable* using the NYU ED algorithm, but it is not a simple count. Each visit is assigned probabilities (0–1) across categories. A visit is included if the combined probability for those two categories exceeds 0.5. As a result, the numerator reflects this probability threshold rather than a direct count of visits.

3. **Emergency Department Visits: Potentially Preventable, Emergent, ER Care Needed but Avoidable** – number of outpatient visits with an emergency department revenue code, procedure code or place of service code; and a primary diagnosis code for which the NYU algorithm indicated at least a 50% probability that the need was emergent and could not have been treated in a lower-severity setting, and where the need could have been avoided with earlier management. *Note that this measure is available only in the data files that accompany the interactive dashboard.*

Limitations:

- There may be reasons for a visit that are not captured in a claim and cannot be classified based on the algorithm.[3]

[3] Erickson, N. (n.d.). What you need to know about the NYU emergency department visit algorithm. *Inflight Health*. Retrieved July 23, 2024, from https://inflighthealth.com/healthcare/what-you-need-to-know-about-the-nyu-emergency-department-visit-algorithm/

- The NYU ED algorithm has not been updated since 2001, resulting in increasing percentages of ED visits that are unclassifiable by the algorithm.[4]

Hospital Use Measures

Lastly, the report includes five measures referring to hospitalizations. One of the hospitalization measures in this report is a claims-based adaptation of the Prevention Quality Indicators (PQIs). The PQIs "identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge." The PQIs consist of "admission rates for ambulatory care sensitive conditions," hospital admissions that evidence suggests could have been avoided through high-quality outpatient care or that reflect conditions that could be less severe if treated early and appropriately; these indicators can be a crucial tool for community health needs assessments.[5]

Hospital use measures in this report are:

- **Inpatient Hospitalizations Per 1,000 People**. This measure reflects all inpatient hospitalizations (planned and unplanned) and is an observed rate derived using the Johns Hopkins ACG grouping system.[6] The measure is calculated among people in the CO APCD with at least one month of medical coverage eligibility in the reporting period.

- **Hospital Admissions: Potentially Preventable, Per 100,000 People**. The Prevention Quality Overall Composite (PQI 90), also referred to as Hospital Admissions for Ambulatory Care Sensitive Conditions, was developed by the U.S. Department of Health and Human Service's Agency for Healthcare Research and Quality[7] (AHRQ) and is a composite measure of the following individual PQI measures:
    - PQI 1 Diabetes Short-Term Complications Admission Rate;
    - PQI 3 Diabetes Long-Term Complications Admission Rate;
    - PQI 5 Chronic Obstructive Pulmonary Disease or Asthma in Older Adults Admission Rate;
    - PQI 7 Hypertension Admission Rate;
    - PQI 8 Heart Failure Admission Rate;
    - PQI 11 Community Acquired Pneumonia Admission Rate;
    - PQI 12 Urinary Tract Infection Admission Rate;
    - PQI 14 Uncontrolled Diabetes Admission Rate;
    - PQI 15 Asthma in Younger Adults Admission Rate;
    - PQI 16 Lower-Extremity Amputation among Patients with Diabetes Rate.

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[4] Johnston, K. J., Allen, L., Melanson, T. A., & Pitts, S. R. (2017). A "Patch" to the NYU Emergency Department Visit Algorithm. Health services research, 52(4), 1264–1276. https://doi.org/10.1111/1475-6773.12638

[5] AHRQ PQI Resources, Version v2024, Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from https://qualityindicators.ahrq.gov/measures/pqi_resources on February 12, 2025.

[6] The Johns Hopkins University Bloomberg School of Public Health (2014). The Johns Hopkins ACG System Technical User Guide, Version 11.0. Retrieved from https://www.healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/cntrb_035024.pdf on October 14, 2016.

[7] AHRQ PQI Technical Documentation, Version v2024, Agency for Healthcare Research and Quality, Rockville, MD. Retrieved from https://qualityindicators.ahrq.gov/measures/PQI_TechSpec on February 12, 2025.

The overall composite is calculated by summing the number of hospital discharges among patients ages 18 years or older that meet the inclusion and exclusion rules for the numerator, based on ICD diagnosis and procedure data, in any of a composite's component measures and dividing by the population ages 18 years or older. Hospital discharges that meet the criteria for the numerator in more than one of the above PQIs are counted only once in the composite numerator. The denominator was adapted to the purposes of this report, and it is calculated as the number of people in the CO APCD ages 18 and older with medical insurance coverage for at least 11 months during the measurement year. This measure is displayed as an observed rate.

- **Hospital 30-Day Readmissions Per 1,000 People.** This measure reflects all inpatient hospitalizations (both planned and unplanned readmissions) within 30 days after discharge and is an observed rate derived with the Johns Hopkins ACG grouping system[6]. The measure includes people in the CO APCD with at least one month of medical coverage eligibility in the reporting period. Higher readmission rates are associated with increased mortality and higher health care costs. Readmission may be prevented through increased quality of care at the hospital in conjunction with appropriate post-discharge planning and care coordination, and through increased support for patient self-management.
  There are two subcomponent measures included in the report, in addition to the total readmission rate:
  - **Hospital 30-Day *Unplanned* Readmissions Per 1,000 People** – unplanned admissions within 30 days after discharge for all-cause (planned and unplanned) inpatient hospitalizations.
  - **Hospital 30-Day *Planned* Readmissions Per 1,000 People** –planned admissions within 30 days after discharge for all-cause (planned and unplanned) inpatient hospitalizations.

Additional Utilization Measures

Access to Dental Care: Children and Adolescents. This measure was developed by the Dental Quality Alliance[8] and is calculated as the percentage of patients 20 years and younger with dental insurance for at least 180 continuous days who had at least one dental service during the measurement year. A dental service is defined as a dental procedure performed by dentists, County Health Department dental clinics or dental hygienists.

The most common dental procedures performed for children under the age of 1 include Oral evaluation for a patient under three years of age and counseling with primary caregiver (Current Dental Terminology code D0145), Unspecified diagnostic procedure (CDT D0999), and Topical application for fluoride varnish (CDT D1206).

[8] Dental Quality Alliance (DQA). Technical Specifications for UTL-CH-A and DQA Measures User Guide retrieved at https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/dqa/dental-quality-measures/2024/2024_utilization_of_services_dental.pdf

Pharmacy 30-Day Equivalent Supply Per Person. This measure reflects the number of pharmacy prescriptions filled per person in the year, calculated as 30-day equivalent supplies. The 30-day equivalent supply for a prescription is defined as follows: if the days' supply reported is less than or equal to 34, the number of 30-day equivalent supplies equals one. If the days' supply reported is greater than 34, the number of 30-day equivalent supplies is equal to the number of days' supply divided by 30. The measure includes people in the CO APCD with at least one month of pharmacy coverage eligibility in the reporting period.

Breast Cancer Screening

This breast cancer screening measure is a preventive care measure endorsed by the National Quality Forum (NQF) and based on HEDIS® methodology: Breast Cancer Screening (NQF 2372). The measure is calculated as the percentage of women 50 to 74 years old who had one or more mammograms to screen for breast cancer during the measurement year and two years prior to the measurement year. To be included, patients must have medical insurance coverage for at least 11 months during the measurement year, during the prior year, as well as October through December two years prior to the measurement year.

Demographic Characteristics

The dashboard presents measure values by geographical location (by county and Division of Insurance Region) of the insured person's residence. Additional demographic breakdowns by age group and sex are available separately in the downloadable data files. However, some measures have consistently low cell sizes, and these demographic breakdowns have not been produced (e.g., Hospital Admissions: Potentially Preventable, Per 100,000 People). Individuals for whom age or gender information is not available or unknown are excluded from all analyses.

Demographic characteristics are determined at the person level as follows:

- Age is calculated as of December 31st of the reporting year. Typical age groups used in this report are: 0 to 17 ("Child"), 18 to 34 ("Young Adult"), 35 to 64 ("Mature Adult"), 65 or older ("Senior Adult").
- Quality of care and access to care measures have specific age ranges and, in some cases, age subgroup requirements.
- For the Access to Dental Care: Children and Adolescents measure, age groups used in this report are: < 1 (newborns), 1-6 (presence of deciduous teeth), 7-13 (arrival of permanent teeth), 14-20 (teenagers and young adults).

Only residents of Colorado are reflected in the data. State resident status is determined based on the most recent insurance eligibility record available in a given year, which indicates whether the person resides in a ZIP code within Colorado. All calculations are based on where Colorado residents live, not where they received care. For example, cost of care for people living in Eagle County may not reflect cost to receive care in Eagle County if residents in that area travel to other counties to receive care. For specific information regarding prices for services at particular facilities in Colorado, visit our reports at civhc.org.

Geographic Groupings

Geographic breakdowns available in the report include Colorado counties and Division of Insurance (DOI) commercial insurance geographic rate setting areas.[9] The following is a list of counties in each DOI region, along with the label displayed for each region in this report:

- Rating Area 1 – **Boulder**: Boulder
- Rating Area 2 – **Colorado Springs**: El Paso, Teller
- Rating Area 3 – **Denver**: Adams, Arapahoe, Broomfield, Clear Creek, Denver, Douglas, Elbert, Gilpin, Jefferson, Park
- Rating Area 4 – **Ft. Collins:** Larimer
- Rating Area 5 – **Grand Junction:** Mesa
- Rating Area 6 – **Greeley:** Weld
- Rating Area 7 – **Pueblo:** Pueblo
- Rating Area 8 – **East:** Alamosa, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Kit Carson, Las Animas, Lincoln, Logan, Mineral, Morgan, Otero, Phillips, Prowers, Rio Grande, Saguache, Sedgwick, Washington, Yuma
- Rating Area 9 – **West:** Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Lake, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit

Payer Types

This report includes the following payer groupings:

- All Payers
- CHP+
- Commercial
- Medicaid
- Medicare Advantage
- Medicare Fee-For-Service (Medicare FFS)

CHP+ (Child Health Plan Plus) is a public, low-cost health insurance program for certain children and pregnant women whose incomes are too high to qualify for Medicaid but too low to afford private coverage.

How Payer Type Is Assigned (Most Measures)

For cost and selected health care use measures such as rates of non-users, healthy users, and for the Hospital 30-Day Readmissions Per 1,000 People (Overall, Planned, and Unplanned), payer type is assigned based on eligibility months with primary medical insurance information for the respective payer type during a reporting year, counting the number of months with the respective payer type

[9] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/co-gra

regardless of whether the person had insurance for just a single month, the full year, or any number of months in-between.

Pharmacy eligibility information is considered when assigning a payer type for calculating pharmacy costs, even if the medical eligibility information is not present . Once a person is assigned a payer type, all medical and pharmacy claim records for that person are associated with that assignment, regardless of the insurance type information on the claim record. Secondary insurance information is not considered when assigning a payer type.

Breast Cancer Screening and Emergency Department Measures

For breast cancer screening and ED-related measures, payer type is determined at the person-month level using primary insurance information. These measures also require continuous enrollment:

- **Breast cancer screening:** At least 11 months of continuous enrollment with the same payer type during the year.
- **ED-related measures:** Six or seven months of continuous coverage, depending on the measure.

Medicaid and CHP+ Distinction

Medicaid and CHP+ are mutually exclusive payer categories for measures that apply to children, or to both children and adults. Medicaid includes only individuals enrolled in Medicaid, and CHP+ includes only children and pregnant women enrolled in CHP+. For most measures in this report, individuals with CHP+ coverage are excluded from the Medicaid category.

Some measures apply only to adults. In those cases, CHP+ is generally not applicable. However, a small number of individuals with CHP+ coverage, such as pregnant women, may appear in Medicaid results for these adult-focused measures:

- Emergency Department Visits: All, Per 1,000 People
- Emergency Department Visits: Potentially Preventable, Per 1,000 People
- Emergency Department Visits: Potentially Preventable, Nonemergent, Per 1,000 People
- Emergency Department Visits: Potentially Preventable, Emergent but Primary Care Treatable, Per 1,000 People
- Emergency Department Visits: Potentially Preventable, Emergent, ER Care Needed but Avoidable, Per 1,000 People
- Hospital Admissions: Potentially Preventable, Per 100,000 People (Observed)

Exception:
For the Access to Dental Care: Children and Adolescents measure, only Medicaid is reported. CHP+ data was excluded due to data quality concerns related to one or more CHP+ dental providers.

For more information about the payer data in the CO APCD used for this analysis, click here.

Comparison to Statewide and Urban/Rural Benchmarks

For each county or DOI region value, the dashboard displays three data points for comparison purposes: measure values at the state level, and overall for all urban counties and rural counties. The rural and

urban county classification is based on the U.S. Office of Management and Budget county-level designation: counties that are part of a Metropolitan Statistical Area are considered "urban", and all other counties are considered "rural".[10] The following is a list of rural and urban Colorado counties:

- **Urban counties (17):** Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Larimer, Mesa, Park, Pueblo, Teller, and Weld;
- **Rural counties (47):** Alamosa, Archuleta, Baca, Bent, Chaffee, Cheyenne, Conejos, Costilla, Crowley, Custer, Delta, Dolores, Eagle, Fremont, Garfield, Grand, Gunnison, Hinsdale, Huerfano, Jackson, Kiowa, Kit Carson, La Plata, Lake, Las Animas, Lincoln, Logan, Mineral, Moffat, Montezuma, Montrose, Morgan, Otero, Ouray, Phillips, Pitkin, Prowers, Rio Blanco, Rio Grande, Routt, Saguache, San Juan, San Miguel, Sedgwick, Summit, Washington, Yuma.

Data Suppression

Following privacy protection standards used by the Centers for Medicare & Medicaid Services (CMS), data are suppressed for values based on fewer than 11 units. For example, cost PPPY values based on fewer than 11 insured-years or emergency department rates based on fewer than 11 visits. Throughout the dashboard and the data files, data points impacted by low volume are replaced with an "n/a" on the dashboard and left as blank cells in the data files.

Data Limitations

Data presented in this report are the result of a process that strives to ensure high quality, reliable, and accurate information. Potential areas of concern are investigated and addressed accordingly, on a regular basis, and while every effort is made to address all known areas of concern for this report, some may remain. Additionally, when comparing costs across different payer types, keep in mind that not all payers cover the same services (i.e. the Medicaid program covers long term care and home health services that are not usually covered by other payers).

Data for small population breakdowns or for rare events should be interpreted with caution, since they are prone to significant fluctuations. Colorado counties with small populations (fewer than 5,000 people overall) at one point during the reporting time frame include: Baca, Cheyenne, Costilla, Custer, Dolores, Gilpin, Hinsdale, Jackson, Kiowa, Lincoln, Mineral, Ouray, Phillips, San Juan, Sedgwick, Saguache, and Washington.

Data Vintage

This report is based on claims data in the CO APCD data warehouse as of the March 2025 release. For more information about number of claims in the CO APCD during a particular reporting year and data discovery information regarding payer submissions, please visit our website at civhc.org.

For more information or additional questions, contact us at info@civhc.org

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[10] Colorado Rural Health Center (2016). *Colorado: County Designations, 2016.* Retrieved from http://coruralhealth.wpengine.netdna-cdn.com/wp-content/uploads/2016/03/2016.CountyDesignations.pdf on July 13, 2017.