CIVHC
CENTER FOR IMPROVING
VALUE IN HEALTH CARE

CO APCD Provider Payment Tool

Frequently Asked Questions

Navigation

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About the Report

What is the Provider Payment Tool, and why was it developed?

The Provider Payment Tool is a unique health care transparency tool. It was first created in January 2023 by the Center for Improving Value in Health Care (CIVHC) in response to Senate Bill 22-068. The tool shows how payments to doctors and other health care providers vary across Colorado, offering a level of transparency not typically available in other states.

What is the purpose of Senate Bill 22-068 and what does it require?

Senate Bill 22-068 was passed to increase provider health care payment transparency in Colorado. It requires CIVHC, administrator of the Colorado All Payer Claims Database (CO APCD), to create a public report displaying payments made to health care providers. The bill requires the tool to include payments for CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes by region, payer type (commercial, Medicare FFS and Advantage, Medicaid), provider type, and service location. The tool must include data from 2018 to present and must be updated annually on or before January 1st of each year.

How can the Provider Payment Tool be used?

The tool increases transparency around health care costs and has the potential to lower costs by:

- Equipping payers and providers with information to benchmark their own payments and negotiate rates.
- Helping consumers and employers understand reasonable health care costs.
- Assisting legislators, state agencies, and researchers in identifying payment variations to make health care more affordable and equitable.

How is the Provider Payment Tool different from other transparency tools?

While many other tools show facility prices only (i.e. hospital payments), the Provider Payment Tool shows how much Colorado doctors and other providers get paid for specific services. It is also more robust than many tools with prices for thousands of health care services and multiple filters options available.

What insights does the Provider Payment Tool offer?

The tool offers insights into how payments vary based on several factors, including:

- Where the service took place in Colorado, and what setting (hospital or outpatient).
- Which insurance payer was involved.
- The type of doctor or provider who provided the service.
- How payments have changed over time.

For example, it shows how payments for a 45-minute therapy session vary depending on the insurance payer and provider type. It also shows how payments across all insurance payers have changed since 2018.

What filters are included in the analysis?

The following data elements are currently included in the Provider Payment Tool. Users can filter payment results based on the elements below.

- **Years:** 2018, 2019, 2020, 2021, and 2022.
- **Payers:** Commercial, Medicaid, Medicare Advantage, and Medicare Fee-for-Service.
- **Setting:** Hospital (inpatient) vs. non-hospital (outpatient).
- **Geography:** Statewide, County, or Division of Insurance (DOI) rate setting region.
- **Provider Type/Setting:** Specialists and General Practitioners, Home Health, and Nursing Home, etc.

Why use CPT and HCPCS codes?

Providers bill health insurance companies for their services using CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes. CPT codes represent medical procedures, and HCPCS codes cover a wider range of health care services and supplies. These codes help insurance companies know how much to pay providers based on the services that were offered.

What types of services and payments are covered by the tool?

The tool covers a wide range of health care services, identified by CPT and HCPCS codes. It provides total allowed amounts which are prices that include payments from payers and patients. The tool also includes payment information for anesthesia services, considering various influencing factors.

Why are anesthesia services provided on a separate tab?

Anesthesia services are more complicated in terms of calculating payments because they are paid for using a formula that includes the service or code, patient health status, type of anesthesia provider, and number of units or minutes were billed. The separate tab for anesthesia provides users with options to enter information into a calculator tool to estimate payments.

Why does the tool include all of the different payment options (averages, percentiles, etc.) and which one should I use?

Senate Bill 22-068 specifies that average payments, and 25th, 50th, 60th, and 75th percentile payments are included in the tool to show the range of payments. Averages are influenced by outliers in the upper and lower payment range, while the 50th percentile reflects the median or “middle” payment without being influenced by outliers. The 60th percentile is included because it is the upper payment threshold for most payments established in the Colorado Out of Network Billing legislation. Users can decide which payment(s) to use depending on their individual use case and needs.

How come sometimes the average payment is higher or lower than the 50th percentile or median payment?

Codes with average payments that are greater than or less than the percentile payments are driven by a small number of high or low payments to providers.

What's the difference between a Flat Fee and a Per Unit paid code?

Codes paid for on a flat fee have one payment regardless of any other factors, as opposed to payments that get calculated per unit (total time spent, drug doses, etc.).

How come I only get payments at the statewide or DOI level when I select a particular county?

Following privacy protection standards, data is suppressed for any codes with less than 30 claims statewide, and can only be displayed at the county level if there are 30 claims in the data for that county. If there is not enough data to show a county selection, the Division of Insurance (DOI) data that includes that county will be displayed, and if there are not enough claims for the DOI region, statewide values are provided.

How do price transparency tools like this one contribute to reducing health inequities?

Price transparency tools are crucial to help identify areas of opportunity to reduce health inequities. Prices for health care services can vary widely, and tools like this can help lower barriers to accessing affordable care by providing information to empower consumers, providers, and policymakers.

Are there other price transparency tools and reports available from CIVHC?

Yes, CIVHC offers other price transparency tools and reports, including:

- Shop for Care: This tool shows prices for certain "shoppable" health care services and provides quality information for named hospitals and facilities.
- Out-of-Network Report: Created to support Colorado's No Surprises Billing Act, this report provides allowed amounts for professional and emergency services based on in-network benchmarks, helping determine maximum payments for out-of-network provider services.
- Medicare Reference Based Price: Shows how hospitals and other facilities get paid by commercial payers using Medicare payments as a reference point.

About the Data & Analytics

Are all health insurance payers included in the analysis?

The analysis includes data from both public and private health insurance payers that submit data to the CO APCD. This represents approximately 70% of medically insured individuals in the state. However, it does not include uninsured and the majority of ERISA-based self-insured employer covered lives. It also does not include federal health insurance programs like Tricare, Indian Health Services, and the VA.

Do the payments include in-network and out-of-network provider payments?

The data only includes payments for in-network providers for commercial, Medicaid, and Medicare Advantage claims. Medicare Fee-for-Service data does not distinguish between in-network and out-of-network providers, and may include some out-of-network payments that cannot be identified. However, it is CIVHC's understanding that Medicare Fee-for-Service does not cover out-of-network claims, and therefore would not be included in Medicare FFS payments.

What types of providers and services are included in "professional claims"?

Professional claims refer to services provided by physicians or other health care professionals, including nurse practitioners, chiropractors, psychiatrists, and oncologists. These services cover non-facility costs for evaluation and management services, procedures, lab tests, and more.

How can I find out which providers are included in the "Provider Type and Settings" list?

Provider types and settings are based on categories defined in the National Plan & Provider Enumeration System (NPPES). The full list of provider types and settings under each category is available for download on the report page under Provider Tool Taxonomy Tree.

It is important to note that health care providers often bill under their organization name rather than their specialty. For example, a surgeon might bill under the name of the hospital where they provided services rather than their specialty of "surgery". In this case, the payment for the surgeon has been included in the "hospital provider" category displayed on the tool.

Why aren't specific specialty types (i.e. Cardiologists) available for selection?

Provider types and settings were categorized (see more above) at the lowest level possible while still being able to provide data at a granular level across year, regions, payer types, etc. Showing more detailed specialty types would have severely limited the functionality of the tool due to suppression that would occur with more specific provider types.

Does the analysis cover all types of health care payments?

No, the analysis is based on fee-for-service payments only. It does not include supplemental payments, capitated payments, or payments made through Alternative Payment Models (APMs).

How does the tool account for payment variation?

The tool provides average payments which are influenced by outlier high and low end payments. To account for variation, the tool also provides low, mid, and high-end payments (25th, 50th, 60th, and 75th percentiles).

How are payments calculated for anesthesia services?

Payments for anesthesia services are calculated using a formula. The formula requires base units, physical status units, time units, and price modifiers. Each anesthesia code has a base unit which is provided based on CO APCD data using anesthesia codes. Physical status units indicate the patient's health before surgery while time units depend on the procedure duration and price modifiers vary based on the type of anesthesia provider. The tool provides a calculator that produces average and percentile payments depending on the inputs noted above.

Are there any privacy protections in place for the data?

Yes. CIVHC follows Centers for Medicare & Medicaid Services (CMS) guidelines for data suppressions which requires 11 or more claims. However, for this report, CIVHC has taken a more conservative approach and only included payments for codes that had a volume of 30 claims minimum statewide. County and DOI level payment views are also only available if there are 30 claims per code in the selected region.

Where can I find more information about the CO APCD and the data it contains?

For more information about the contents of the CO APCD, explore CIVHC's interactive dashboard, or contact us at info@civhc.org.