



# APCD Support of Colorado Out-of-Network Legislation

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**VALUE** IN HEALTH CARE

# Discussion Overview

- Colorado All Payer Claims Database (CO APCD)
- Colorado HB 19-1174 legislation for out-of-network health care services for implementation in 2020
- Key implementation facts
- Topics and highlights of methodology
  - Out-of-network provider services at in-network facilities (anesthesia addressed separately)
  - Out-of-network facility emergency services
- Gaps in delivering fee schedules
- Lessons learned

# Colorado APCD

- The state's most comprehensive source of health care insurance claims information
  - Eligibility; provider; medical, pharmacy and dental claims for commercially-insured, Medicare, Medicare Advantage, and Medicaid members
  - Over 900 million claims for almost 4.3 million insured lives in Colorado, from 2012 to the present
  - Includes claims data for roughly half of commercially-insured members in the state
- Center for Improving Value in Health Care (CIVHC)
  - CO APCD administrator; maintain and enhance APCD
  - Conduct analyses/publish results to advance Triple Aim

# HB 19-1174 Out-of-Network Bill

Provision	Colorado HB 19-1174
Settings	<p><u>Services of out-of-network providers in in-network facilities and emergency care (pre-stabilization) at out-of-network facilities.</u> Applies to fully-insured and self-funded (non-ERISA) plans. Includes ambulance services (ground).</p>
Hold Harmless	<p>Limits consumers to in-network cost-sharing, deductibles, and OOP maximum.</p>
Ban on Balance Billing	<p>Applies to providers.</p>
Payment Standard	<p><u>Out-of-network providers:</u> Greater of:</p> <ul style="list-style-type: none"><li>• 110% of median in-network rate for insurer</li><li>• 60<sup>th</sup> percentile reimbursement in same geographic region based on claims in APCD.</li></ul> <p><u>Emergency services:</u> Greater of:</p> <ul style="list-style-type: none"><li>• 105% of median in-network rate for insurer</li><li>• 50<sup>th</sup> percentile reimbursement in similar facility and region based on claims in APCD.</li></ul>
Dispute Resolution	<p>Independent mediated negotiation process if parties do not reach a voluntary agreement.</p>

# Key Implementation Facts

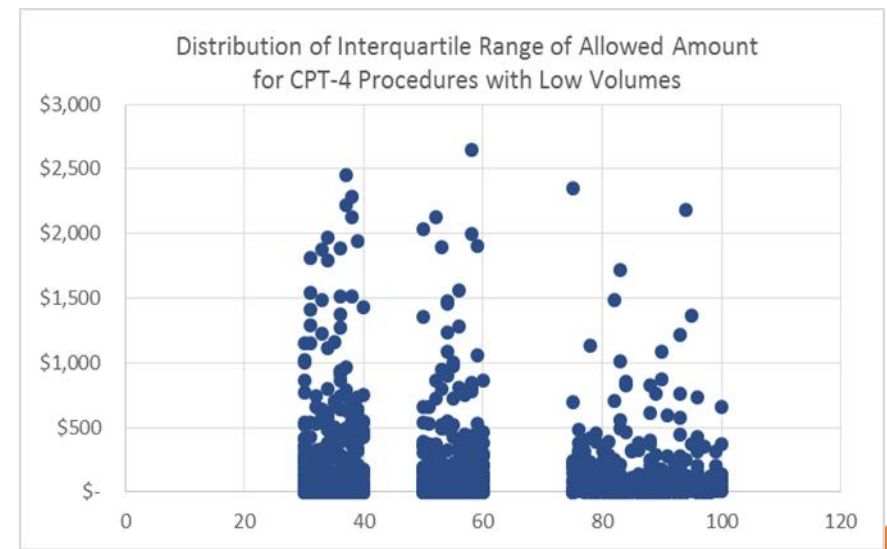
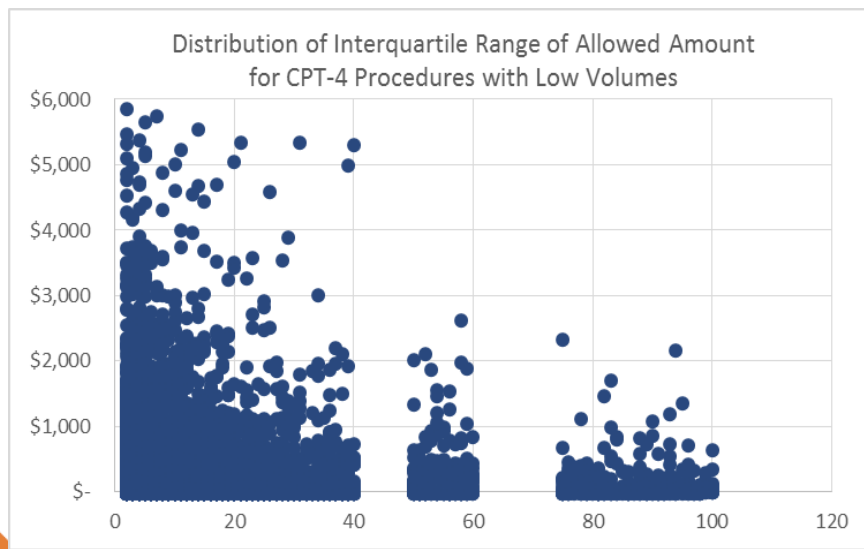
- APCD used to produce fee schedules from previous calendar year of commercial claims, based on allowed amounts (combination of payer and member expense)
- Produced fees for each of nine Colorado Division of Insurance (DOI) rating regions
- When volume of a service is low
  - If volume of claims is below threshold in DOI region, statewide in-network APCD allowed amount is used
  - If statewide volume is below threshold, fee based on the carrier median is only source
  - If carrier does not have an in-network rate, then goes to arbitration (Note: arbitration can be initiated for other reasons as well)

# High-Level Claims Data Selection

- **Commercial** fee-for-service claims
- Service dates in **2018** (8-month runout)
- Claims indicating payer is **primary**
- Provider network status equals **in-network**
- **Place of service** in a facility for professional services

# Provider Services (excl. Anesthesia)

- Defined by CPT-4 procedure code + 1 modifier
- Significant percentage of CPT-4 procedure + modifier combinations have low claim volumes, too low to produce a stable estimate
- Decided on a **30** volume threshold

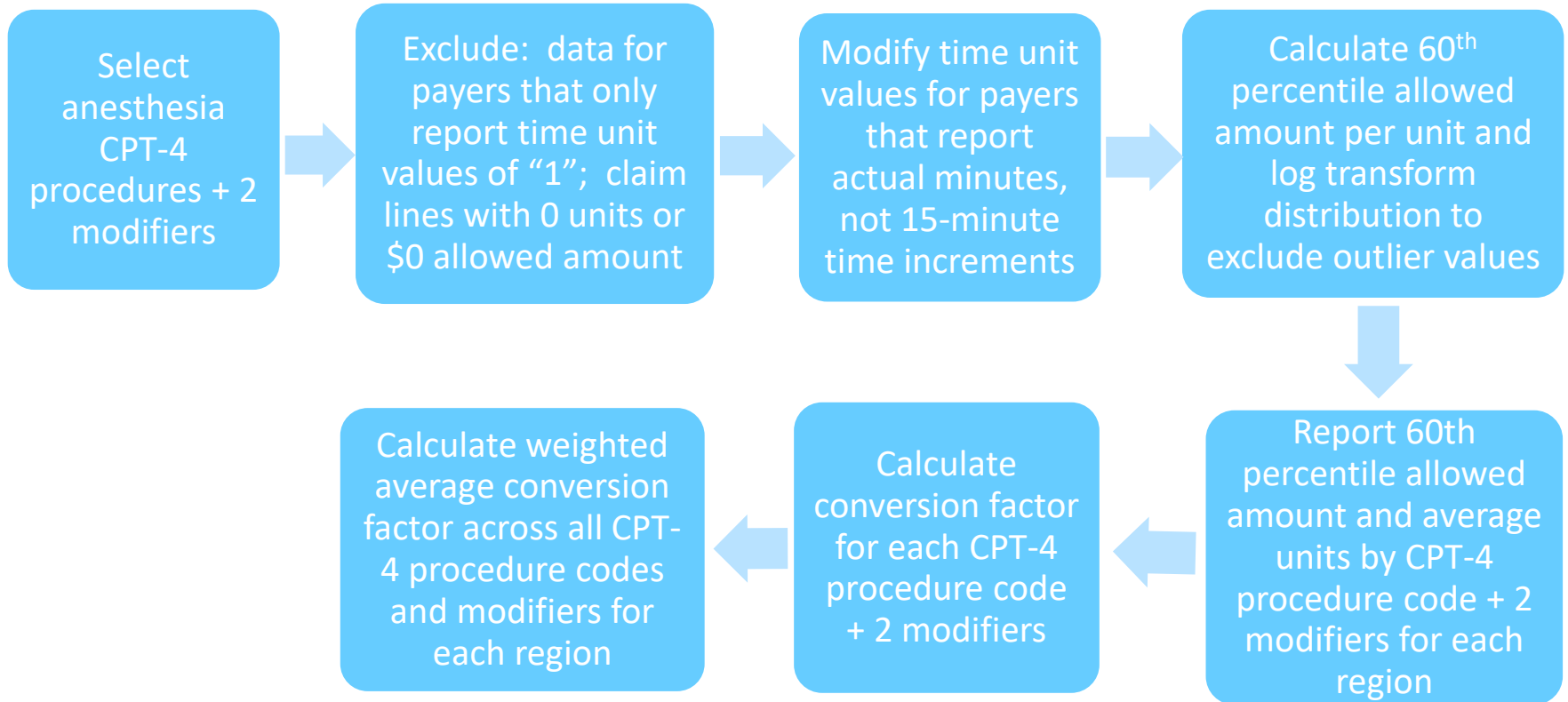


# Anesthesia Services

- Payment based many factors – CPT-4 procedure + modifiers, describing provider/provider role and patient physical status, and time units
- Anesthesia claims data present significant problems – low volume, inaccurate/inconsistently defined time units
- Adopted method used by state of Oregon, which is based on a calculated regional conversion factor
  - Conversion factor is a dollar value, which, when combined with CPT-4 base units, modifiers and time unit values, produces the payment amount
  - Establishes a mechanism for carriers to calculate CO APCD-based fee using aggregate of all available “clean” data



# Anesthesia Fee Calculation



# Facility Emergency Services

- Emergency services
  - Paid as bundled services; included services differ by payer
  - Can encompass a variety of hospital services
- Fee schedules established for
  - Emergency room services case rate by evaluation & management (E&M) code, excluding carve-outs
  - Carve-outs for high-cost emergency services (e.g., implants, advanced imaging)
  - Observation case rates by E&M code, excluding carve-outs
  - Outpatient OR case rates by CPT-4 procedure, ex. carve-outs
  - Admissions from the ED by MS-DRG

# Admission from Out-of-Network ED

- Allowed amount for admissions following a visit to an out-of-network ED, defined by MS-DRG
- Challenges
  - HB 19-1174 addresses only services before stabilization
  - No mechanism to separate ED services from inpatient services acceptable to providers and payers when patient is stabilized and transferred to in-network facility
  - Low volumes for many MS-DRGs
- Potential solution – attempt to split bills for ED and for inpatient services before transfer to in-network hospital

# Gaps in Delivering Fee Schedules

- Low volume of services
- Invalid data; exclusion of these data adds to problem of low volume
- Empirical data sometimes produces unusual results, particularly if fees are largely influenced by small number of payers
- No standard method of defining services for establishing fee schedules
- Limitations of legislation; admissions from ED

# Lessons Learned

- Engage with regulators, payers and providers early
- Establish mechanism to communicate and resolve methodological challenges with all parties
- Work with payers to fix invalid data (e.g., unit values for anesthesia services)
- Desired changes for the future:
  - Utilize more than one year of APCD claims data, or provide an additional fee schedule reference when APCD volumes are too low
  - Solution to problem of payment for post-stabilization for patients admitted from the ED

# Published Results

<https://www.colorado.gov/pacific/dora/out-network-health-care-provider-reimbursement>



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## Out-of-Network APCD Reimbursement Datasets

- CIVHC/CO APCD Out-of-Network Reimbursement Datasets
  - [HB 19-1174 Re-issued CO APCD Reimbursement Dataset - 60th Percentile Allowed Amounts for Out-of-Network Professionals - Includes Anesthesiology](#)
  - [HB 19-1174 Re-issued CO APCD Reimbursement Dataset - 50th Percentile Allowed Amounts for Out-of-Network Emergency Services](#)
- [Summary of Impact of Corrections to Out-of-Network Fees Schedules for Re-issued CO APCD Reimbursement Dataset](#) - From CIVHC/APCD
- [Overview and Methods used for Re-issued CO APCD Reimbursement Dataset](#) - From CIVHC/APCD
- [FAQ from Center for Improving Value in Health Care \(CIVHC\)](#) - CIVHC's Colorado All Payer Claims Database (CO APCD) is specifically identified in the bill as a data source for the implementation of HB19-1174.

# Published Results - Example



HB 19-1174 A. RE-ISSUED CO APCD 60th Percentile Allowed Amounts for Professionals 01.02.20

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	A	B	C	D	E	F
1	DOI_REGION NU	CPT4_CD	MODII	60th PER	STATEWIDE USEI	
2	1	10022		\$ 124.00	1	
3	1	10022	59	\$ 107.62	1	
4	1	10030		\$ 285.14	1	
5	1	10035		\$ 165.31	1	
6	1	10035	59	\$ 94.82	1	
7	1	10060		\$ 157.43	0	
8	1	10061		\$ 355.62	1	
9	1	10120		\$ 201.76	1	
10	1	10140		\$ 168.51	1	
11	1	10160		\$ 175.36	1	
12	1	10180	78	\$ 181.22	1	
13	1	11012		\$ 455.36	1	
14	1	11042		\$ 96.10	0	
15	1	11042	59	\$ 48.35	1	
16	1	11043		\$ 236.09	1	
17	1	11044		\$ 325.15	1	
18	1	11045		\$ 63.10	1	
19	1	11046		\$ 138.42	1	
20	1	11100		\$ 128.76	1	
21	1	11101		\$ 74.20	1	
22	1	11200		\$ 114.13	1	
23	1	11402		\$ 135.31	1	
24	1	11403		\$ 184.88	1	



# The CIVHC Team, from Colorado

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