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

<table>
<thead>
<tr>
<th>Provision</th>
<th>Colorado HB 19-1174</th>
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<tbody>
<tr>
<td><strong>Settings</strong></td>
<td>Services of out-of-network providers in in-network facilities and emergency care (pre-stabilization) at out-of-network facilities. Applies to fully-insured and self-funded (non-ERISA) plans. Includes ambulance services (ground).</td>
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<td><strong>Hold Harmless</strong></td>
<td>Limits consumers to in-network cost-sharing, deductibles, and OOP maximum.</td>
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<td><strong>Ban on Balance Billing</strong></td>
<td>Applies to providers.</td>
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<td><strong>Payment Standard</strong></td>
<td>Out-of-network providers: Greater of:</td>
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<tr>
<td></td>
<td>• 110% of median in-network rate for insurer</td>
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<td>• 60th percentile reimbursement in same geographic region based on claims in APCD.</td>
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<td>Emergency services: Greater of:</td>
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<td></td>
<td>• 105% of median in-network rate for insurer</td>
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<td></td>
<td>• 50th percentile reimbursement in similar facility and region based on claims in APCD.</td>
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<td><strong>Dispute Resolution</strong></td>
<td>Independent mediated negotiation process if parties do not reach a voluntary agreement.</td>
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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

1. Select anesthesia CPT-4 procedures + 2 modifiers
2. Exclude: data for payers that only report time unit values of “1”; claim lines with 0 units or $0 allowed amount
3. Modify time unit values for payers that report actual minutes, not 15-minute time increments
4. Calculate 60th percentile allowed amount per unit and log transform distribution to exclude outlier values
5. Calculate weighted average conversion factor across all CPT-4 procedure codes and modifiers for each region
6. Calculate conversion factor for each CPT-4 procedure code + 2 modifiers
7. Report 60th percentile allowed amount and average units by CPT-4 procedure code + 2 modifiers for each region
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


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

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The CIVHC Team, from Colorado

Julia Tremaroli, Katie Oberg and Vinita Bahl
(www.civhc.org)