One Utah Health Collaborative

Transparency Dashboard Methodology

7/1/2026

About This Dashboard

What this shows: This dashboard displays negotiated rates between healthcare providers (hospitals, physicians, advanced practice providers, practices, and other licensed facilities) and insurance plans for the top 570 common medical services based on total negotiated rate, delivered in Utah based on the most utilized and above $2 million allowed amounts, such as office visits, emergency department visits, cataract removal, and dialysis. These rates come from insurers that are required to publish under the federal Transparency in Coverage (TiC) rule.

Background: Healthcare spending in the United States continues to rise, accounting for approximately 18% of the national GDP. This sustained growth highlights the urgent need for strategies to address cost drivers and improve affordability. Price transparency serves as a cornerstone of this effort; it empowers consumers to make informed care decisions, enables health systems to benchmark performance against peers, and provides policymakers with critical data on market efficiency. This dashboard supports these goals by translating complex, federally mandated Transparency in Coverage (TiC) disclosures into actionable insights, helping bridge the information gap between providers, payers, and the public.

Objective: To give Utah consumers visibility into procedure prices and quality before receiving care, support cohort comparisons of cost across providers to encourage best-practice care options, and give policymakers better visibility into cost drivers and market efficiency.

Audience: Utah consumers making care decisions, health system leadership benchmarking against peers, and state policymakers evaluating cost trends.

Why rates vary: The price a provider is paid for the same service can differ significantly depending on the insurance plan, the specific contract terms negotiated, and other factors such as location, provider type and credentials, and value-based incentives. This dashboard lets you compare a provider's negotiated rate to a group of similar providers.

Data Source

Rate data is primarily sourced from federal Transparency in Coverage (TiC) machine-readable files, which insurers are required to publish monthly. These files provide comprehensive negotiated rates between insurers and in-network providers for covered services. Additional details can be found at the CMS website: https://www.cms.gov/healthplan-price-transparency. Key variables extracted from TiC files include:

- **billing_code** and **billing_code_type**: The CPT/HCPCS code and coding system identifying the specific medical service.
- **negotiated_rate**: The specific dollar amount agreed upon between the insurer and provider.
- **negotiation_arrangement**: The fee structure (e.g., fee-for-service, bundled, or capitation).
- **negotiated_type**: The pricing method, such as negotiated, derived, or fee schedule.
- **service_code**: Identifying the place of service.
- **billing_class**: Whether the billing is professional or institutional.
- **npi**: The National Provider Identifier of the billing provider.
- **tin**: The Tax Identification Number of the contracted entity.

The second data source is the Utah All-Payer Claims Database (APCD), maintained by the Utah Department of Health and Human Services. It contains a repository of medical, pharmacy, and dental claims dating back to 2013, used here to validate TiC rates against actual paid amounts. More info: https://healthcarestats.utah.gov/about-the-data/apcd/. Key APCD variables used include:

- **paid_amount** and **allowed_amount**: The actual dollar amounts paid on a claim.
- **procedure_code**: The CPT/HCPCS code billed on the claim.
- **provider identifiers**: Used to match claims against TiC-file NPIs.
- **enrollment/eligibility fields**: Used to scope claims to the relevant time period and market.

Top Procedure Code Selection: This iteration of the dashboard includes the top 570 billing codes by total allowed amount.

Billing Code Categories

Billing codes are grouped into standardized CMS categories to allow users to browse by service type.

- **Clinical Laboratory Services:** Tests performed on clinical specimens (e.g., blood, tissue) to provide information about a patient's health.
- **Other Clinical Laboratory Services:** Specialized diagnostic laboratory procedures.
- **Physical Therapy, Occupational Therapy, and Outpatient Speech-Language Pathology Services:** Therapeutic services focused on rehabilitation, functional recovery, and speech/language restoration.
- **Preventive Screening Tests and Vaccines:** Services provided to prevent illness, including immunizations and routine health screenings.
- **Radiation Therapy Services and Supplies:** Treatments using ionizing radiation to shrink tumors and kill cancer cells.

- **Radiology and Certain Other Imaging Services:** Diagnostic imaging procedures such as X-rays, CT scans, and MRIs used to visualize internal structures of the body.

For more information on CMS classification standards, visit the [CMS Health Plan Price Transparency website](#).

Quality Metrics (Valenz Method)

The dashboard utilizes the Valenz® Outcomes Analytics methodology to provide objective quality insights. The Composite Quality Score (CQS) is calculated based on three primary outcome measures:

- **Mortality:** Tracks patient deaths while accounting for risk factors.
- **Complications:** Monitors medical, post-surgical, and post-obstetrical adverse events.
- **Readmissions:** Tracks hospital readmissions within 30 days of discharge.

For outpatient services, quality is measured by tracking Emergency Room visits and Inpatient Admissions within 30 days post-discharge. These measures are risk-adjusted using the Elixhauser Comorbidity Index to ensure fair comparisons across providers.

Method

This dashboard is built on 570 commonly used billing codes based on total allowed amount, covering services like office visits, emergency department visits, cataracts removal, and dialysis.

When you select a specific provider, the dashboard shows you:

- That provider's negotiated rate
- The median rate for its comparison group- For each service, we group together providers with similar characteristics (same county, payer, specialty, and location type) and calculate the median rate — the middle value when all rates are lined up from lowest to highest. We use the median rather than the average because a small number of unusually high or low rates can skew an average and make it less representative of what most providers are actually paid.
- Lowest, highest

Validation

Negotiated rates in this dashboard are being validated against the Utah APCD, a state claims database containing actual paid amounts for services rendered in Utah
(validation method)

Data code categories

Billing codes included in this dashboard are grouped into CMS categories, allowing users to browse by service type instead of just by code.

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Limitations

- Rates reflect what was published by insurers as of the file date above and may not reflect current contract rates.
- If there are only a few providers offering a service, the median price becomes less meaningful.
- This is not a bill estimate: These are negotiated rates, not what a patient will actually owe, which depends on deductibles, coinsurance, and plan design.

Data Updates

This dashboard is refreshed periodicaly.

References

https://healthcarestats.utah.gov/about-the-data/apcd/

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Negotiated_rate: the dollar amount agreed between the insurer and provider for that service
Negotiation_arrangement: how the rate was set (e.g., fee-for-service, bundled, capitation)
negotiated_type the pricing method (negotiated, derived, or fee schedule)
Service_code: the place of service
Billing_class: professional or institutional billing
Npi: the National Provider Identifier of the billing provider
Tin: the Tax Identification Number of the contracted entity
CPT: Current Procedural Terminology
HCPCS: Healthcare Common Procedure Coding System