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 $2million allowed amounts, such as office visits, emergency department visits, cataract removal, and dialysis etc. These rates come from insurers that are required to publish under the federal Transparency in Coverage (TiC) rule (https://www.cms.gov/priorities/healthplan-price-transparency/health-plan-price-transparency).

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. This dashboard includes files for Aetna, Cigna, Regents Blue Cross Blue Shield, Select Health, United Healthcare, and University of Utah Health Plans with PEHP and Medicaid coming soon. 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/priorities/healthplan-price-transparency/health-plan-price-transparency

Key variables extracted from TiC files include:

- **Plan ID**: A unique identification code used to track a specific health insurance plan product.
- **Carrier Name:** The name of the health insurance company publishing the pricing data.
- **Carrier Plan Name**: The official name of the specific insurance plan and its sponsor/employer.
- **Billing Code**: The standard reference code (such as CPT or HCPCS) used to bill for a specific healthcare service or procedure.
- **Billing Code Type**: The category or system the billing code comes from (e.g., CPT for outpatient procedures, MS-DRG for hospital stays).
- **Billing Code Type Label**: A combined label joining the code type and the billing code together to make filtering and data analysis easier.
- **Code Description**: A plain-text summary explaining what healthcare service or treatment the billing code refers to.
- **Negotiated Rate Carrier**: The pre-agreed payment price for a service as listed by the insurance company.
- **Negotiated Rate Provider**: The pre-agreed payment price for a service as listed directly by the hospital or clinic.
- **Negotiated Rate Final**: The actual, verified price selected and cleaned for analysis after comparing insurer and hospital records.
- **Medicare IP Benchmark**: The standard rate Medicare pays for inpatient (overnight hospital stay) care, used as a baseline price comparison.
- **Medicare OP Benchmark**: The standard rate Medicare pays for outpatient (same-day) hospital care, used as a baseline price comparison.
- **Medicare Prof Benchmark**: The standard rate Medicare pays for individual doctor and specialist services, used as a baseline price comparison.
- **Billing Class**: Indicates whether the bill comes from a healthcare professional (doctor) or an institution (hospital/facility).
- **Billing Code Modifier**: Two-character codes added to a billing code to provide extra context (e.g., distinguishing between standard care and technical equipment use).
- **Service Code**: A two-digit code indicating the specific location where a medical service was delivered (e.g., doctor's office, telehealth, or emergency room).
- **Place Service Name**: The human-readable name for where the medical service took place (e.g., "Urgent Care Clinic" or "Inpatient Hospital").
- **Facility Rate Type**: Shows whether the charge applies to care received inside a dedicated facility or outside of one.

- **Setting Type**: Categorizes the care environment into broader groups like overnight hospital stays (inpatient), same-day visits (outpatient), or unassigned.
- **NPI**: National Provider Identifier — a unique 10-digit ID number assigned to individual doctors, specialists, or healthcare organizations.
- **TIN Type**: Indicates whether the tax identification number used is an employer identification number (EIN) or an NPI.
- **TIN Value**: The actual tax ID number (or NPI) used by the healthcare provider for billing and tax purposes.
- **Provider Name**: The official full name of the practicing doctor or healthcare provider group.
- **Provider Weight**: An estimated measure of how frequently a doctor or facility performs a given procedure, based on patient claim history.
- **NPI Include**: A simple yes/no (1 or 0) tag indicating if a doctor's pricing should be included in analysis based on their procedure volume.
- **Hospital Facility Location**: The official physical name or campus location of the hospital facility providing care.
- **Provider Taxonomy Code**: A standard classification code that identifies the primary medical specialty or field of practice for a provider.
- **Facility Provider Group**: The broad category describing the type of practice or care setting (e.g., Hospitals, Ambulatory Health Care).
- **Facility Provider Type**: The specific sub-specialty or type of facility (e.g., General Acute Care Hospital, Urgent Care).
- **NPI Practice City**: The city where the healthcare provider's practice or clinic is located.
- **NPI Practice State**: The state where the healthcare provider's practice or clinic is located.
- **NPI Provider Postal Code**: The ZIP code for the healthcare provider's practice location.
- **County Code**: The numerical FIPS code assigned by the U.S. Census Bureau to identify the county where care is provided.
- **County Name**: The official name of the county where the healthcare provider's practice is located.
- **MSA ID**: The five-digit geographic area code used by the U.S. government to define metropolitan regions.
- **MSA CBSA Name**: The full region name corresponding to the metropolitan area (e.g., "Chicago-Naperville-Elgin").

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 claims 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.
- **Plan names:** Used to identify plans
- **County/zip variables:** Used to identify service location

Top Procedure Code Selection: This iteration of the dashboard includes the top 570 billing codes by total allowed amount that has been identified from the APCD claims of 2024 that amounted to more than $2 million.

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 HERE.

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 for inpatient services:

- **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. 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 rates and the plan names under them that pays those rates

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.

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.

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Data Updates

This dashboard is refreshed periodically as new data is provided by the payers.

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References

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

CMS Code Categories:
https://www.cms.gov/cms-guide-medical-technology-companies-and-other-interested-parties/coding/overview-coding-classification-systems

CMS TiC reference:
https://www.cms.gov/priorities/healthplan-price-transparency/health-plan-price-transparency

billing_code and billing_code_type: the CPT/HCPCS code and coding system identifying the service
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