Capabilities of the Colorado All Payer Claims Database

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Type of Information	What You Can't Do With Claims Alone	What You Can't Do With the CO APCD *Currently**	What You CAN Do With the CO APCD Right Now
Claim Type and Specifics	• Denied claims • Un-adjudicated claims	• Substance abuse claims; dependent on Federal rule change (42 CFR, Part 2) and local payer participation • Worker's Compensation claims; does not require rule change, but dependent on payer participation	• Adjudicated medical, pharmacy, dental, provider-level, and member-level claims • Behavioral health claims (in process, not currently available)
Insurance Type	• Services provided to uninsured or self-pay	• Services provided through TriCare, the Veterans Administration, Indian Health Service, Federal Employee Health Benefits (FEHB) or other Federally sponsored programs (other than Medicare)	• Medicare Fee-for-Service (FFS) • Medicare Advantage • Health First Colorado (Colorado's Medicaid Program) • Commercial Payer • Dual Eligible (Medicare/Medicaid or two or more commercial health plans e.g. primary and supplemental)** • Non-ERISA based self-insured employer plans • Voluntarily submitted ERISA-based self-insured employer plans
Plan Details	• Plan benefit design information (high deductible, premium information, etc.)	• Plan benefit design information (high deductible, etc., premium information)	• Payer line of business (Commercial, Health First Colorado, Medicare FFS, Medicare Advantage) • Payer names for Commercial (Anthem, Humana, etc.) • Connect for Health Colorado product and metallic levels: Gold, Silver and Bronze • Commercial product line (PPO, HMO, etc.) • Benefits richness, e.g., ratio of plan paid to total allowed amount

Payments	• Costs for services paid for out of pocket or without submission of a claim
	• Premiums paid by an employer or member
	• Administrative fees
	• Back-end payment amounts (i.e. Medicaid receives rebates from pharmaceutical companies for use of certain drugs)
	• Retroactive payments from the provider to CMS or vice versa (i.e. CMS payments to Critical
		• Capitation fees and provider incentive payments	• Charged amount
			• Total Allowed Amount (amount paid by both the payer and the patient)
			• Plan paid amount
			• Member liability in total and specific breakouts of:
			  • Coinsurance
			  • Deductible
			  • Co-pay

Capabilities of the Colorado All Payer Claims Database

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Type of Information	What You Can't Do With Claims Alone	What You Can't Do With the CO APCD *Currently**	What You CAN Do With the CO APCD Right Now
	Access Hospitals after cost report submission)		
Providers	• Referrals between providers • Provider network analysis • Provider affiliation (i.e. hospital owned)		• Provider, organization, or facility name • Taxonomy (provider specialty) • National Provider Identifier (national standard identification number for providers) • Provider office address
Service Site		• Pharmacy chain name • Free-standing Emergency Department claims billed under parent hospital	• Place of service code (ER, Home Health, Hospice, Urgent Care, Hospital, Long-term Care, etc.)
Member details		• Identify claims by employer name – requestor must provide group policy number	De-identified member information: • Unique member and person ID • Gender • Age • 3-digit zip Protected Health Information (***PHI only available after detailed review by Data Release Review Committee for compliance with HIPAA/HITECH and CO APCD rules):*** • Names (first, last, middle) • Street Address • City • Zip • DOB
Medical History	• Personally reported medical history (i.e. had hysterectomy 15 years ago, or family history of breast cancer)		• Identify an individual's diagnoses, labs or tests performed, cost of care, pharmacy, provider, and history of accessing the health care system (facilities/providers/physician offices, etc.). Data available from 2009 forward for Medicaid/Medicare and some commercial payers; most complete from 2012 on for majority of commercial payers.
Diagnosis, Service and Preventive Services	• Results of lab tests – information not included in claims • Preventive services, screenings, etc. that are not paid for by an insurance payer (Health Fair	• Mental health/substance abuse diagnosis (see above, pending behavioral health organization submission through HCPF/Medicaid, commercial payer willingness and Federal rule change)	• Chronic disease prevalence, service utilization and cost to treat information (asthma, diabetes, etc.) • Evaluate effectiveness of programs not covered fully by insurance (i.e. palliative care, nutritional meals, care coordination, etc.)

Capabilities of the Colorado All Payer Claims Database

Type of Information	What You Can't Do With Claims Alone	What You Can't Do With the CO APCD *Currently**	What You CAN Do With the CO APCD Right Now
	screenings, out-of-pocket flu shots, etc.)		• Service-specific price information by region and provider group/facility (cost for knee replacement, imaging services, office visits, etc.) • Preventive care and screening rates and associated costs (breast cancer screening, colonoscopy, mammography, annual preventive services, etc.)
Pharmacy	• Prescriptions issued but not filled • Drugs received through discount program that does not have a claim associated • 100% self-pay medications	• Pharmacy chain identification (i.e. Walmart, Walgreens, etc.)	• Prescriptions reimbursed by insurance – allowed amount and utilization by patient residence, trends • Drug Trade Name, specific strength and dosage form based on NDC code on the pharmacy file (not on the claim) • Dosage information; days supply/number of pills or other units • Drugs administered during inpatient hospital stays*** • Medication adherence rates and trends
Diagnostic Testing & Labs	• Specific results of labs or other diagnostic tests.		• Cost and utilization for people receiving labs or diagnostic test that generate a claim.
Quality of Care	• Identify clinical outcomes of treatment or specific services provided		• Process quality measures (National Quality Forum, etc.) – i.e. standards of care such as appropriate testing for diabetes patients and other "proxy" measures • Readmissions, observation stays • Hospital-acquired infections/conditions • Potentially avoidable costs – based on episode analytics

* Possible with a change to the Data Submission Guide and/or legislative rule or partner collaboration
** Currently in development with new data warehouse vendor; available in 2018
*** Included in Data Submission Guide (v.9), goes into effect December 2017