## Capabilities of the Colorado All Payer Claims Database

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>What You CAN Do With the CO APCD Right Now</th>
<th>What You Can’t Do With Claims Alone</th>
<th>What You Can’t Do With the CO APCD Currently*</th>
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</table>
| **Claim Type and Specifics** | • Adjudicated medical, pharmacy, dental, provider-level, and member-level claims  
• Behavioral health claims (in process, not currently available) | • 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 |
| **Insurance Type** | • 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 | • 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) |
| **Plan Details** | • 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 | • Plan benefit design information (high deductible, premium information, etc.) | • Plan benefit design information (high deductible, etc., premium information) |
| **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 | • 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 Access) | • Capitation fees and provider incentive payments |
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| **Providers**       | • Provider, organization, or facility name  
                      • Taxonomy (provider specialty)  
                      • National Provider Identifier (national standard identification number for providers)  
                      • Provider office address | • Referrals between providers  
                      • Provider network analysis  
                      • Provider affiliation (i.e. hospital owned) | |
| **Service Site**    | • Place of service code (ER, Home Health, Hospice, Urgent Care, Hospital, Long-term Care, etc.) | | • Pharmacy chain name  
                      • Free-standing Emergency Department claims billed under parent hospital |
| **Member details**  | De-identified member information:  
                      • Unique member and person ID  
                      • Gender  
                      • Age  
                      • 3-digit zip | | • Identify claims by employer name – requestor must provide group policy number |
|                     | 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** | • 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. | • Personally reported medical history (i.e. had hysterectomy 15 years ago, or family history of breast cancer) | |
| **Diagnosis, Service and Preventive Services** | • Chronic disease prevalence, service utilization and cost to treat information (asthma, diabetes, etc.) | • Results of lab tests – information not included in claims  
                      • Preventive services, screenings, etc. that are not paid for by an insurance | • Mental health/substance abuse diagnosis (see above, pending behavioral health organization submission through HCPF/Medicaid, |
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<td><strong>Pharmacy</strong></td>
<td>• Prescriptions reimbursed by insurance – allowed amount and utilization by patient residence, trends</td>
<td>• Prescriptions issued but not filled</td>
<td>• Pharmacy chain identification (i.e. Walmart, Walgreens, etc.)</td>
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<tr>
<td></td>
<td>• Drug Trade Name, specific strength and dosage form based on NDC code on the pharmacy file (not on the claim)</td>
<td>• Drugs received through discount program that does not have a claim associated</td>
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<tr>
<td></td>
<td>• Dosage information; days supply/number of pills or other units</td>
<td>• 100% self-pay medications</td>
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<tr>
<td></td>
<td>• Drugs administered during inpatient hospital stays (only available for limited years)</td>
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</tr>
<tr>
<td></td>
<td>• Medication adherence rates and trends</td>
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<tr>
<td><strong>Diagnostic Testing &amp; Labs</strong></td>
<td>• Cost and utilization for people receiving labs or diagnostic test that generate a claim.</td>
<td>• Specific results of labs or other diagnostic tests.</td>
<td></td>
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<tr>
<td><strong>Quality of Care</strong></td>
<td>• Process quality measures (National Quality Forum, etc.) – i.e. standards of care such as appropriate testing for diabetes patients and other “proxy” measures</td>
<td>• Identify clinical outcomes of treatment or specific services provided</td>
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<tr>
<td></td>
<td>• Readmissions, observation stays</td>
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<td>• Hospital-acquired infections/conditions</td>
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<td>• Potentially avoidable costs – based on episode analytics</td>
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</table>

* These elements could potentially be added, but would require a change to the Data Submission Guide and/or legislative rule or partner collaboration