CO APCD Advisory Committee

August 10, 2021

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VALUE IN HEALTH CARE

Agenda

- Opening Announcements
- Operating Updates
- Public Reporting
- CO APCD Data Quality and Analytics
- Public Comment

Operational Updates

Kristin Paulson, JD, MPH

CIVHC Chief Operation Officer and General Council

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CO APCD Data to Support Legislation

- SB21-175 Prescription Drug Affordability Review Board (PDAB)
  - Names CO APCD as source of information, requested by payers and pharmacy benefit managers
    - Requires submission of new items incorporated into the FY21 CO APCD Executive Rule Change for Data Submission Guide 13
      - Top 15 drugs that caused increase in premiums
      - 15 most frequent drugs with rebates
      - 15 drugs with highest rebates by %
      - 15 drugs with the largest rebates by $
- HB21-1232 Colorado Option
  - Medicare reference-based pricing analytics from CO APCD to set rates

Federal APCD Funding No Surprises Act – Sct 115

- HHS Grant Program
  - $2.5 million over 3 years for state APCD efforts:
    - $1M each first 2 years
    - $500k in third year
  - The earliest funds could be available is Oct. 1, 2021.
- General Timeline
  - March ‘21 – Advisory Committee Members Appointed
  - August ‘21 – Advisory Committee recommendations ons voluntary & standard format expected
  - Oct ‘21 – Expected grant appropriations
  - Dec ‘21 – Regulations expected on data submission formatting

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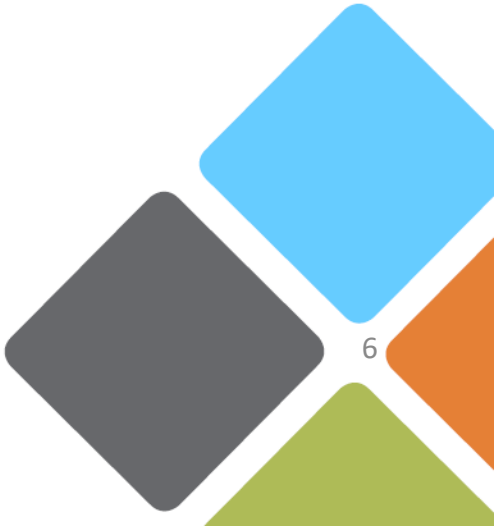

Public Reporting

Cari Frank, MBA

CIVHC VP of Communication and Marketing

Executive Director Kim Bimestefer

Colorado Department of Health Care Policy & Financing

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Public Reporting

- Recent Releases
  - Low Value Care
  - Alternative Payment Models
  - TCPA Case Study
  - Drug Rebate Report – in Review Period

What is “Low Value Care”?

- Care where the potential harm or cost is greater than the benefit to a patient
- Defined by Choosing Wisely guidelines, developed by American Board of Internal Medicine Foundation
- Contributing Factors
  - Fear of malpractice
  - Perception that patients want or expect tests or medications
  - Lack of information about the patient
  - Financial incentives of fee-for-service reimbursement

Statewide Results and Trends

The total spend for the 48 services measured was:

$1.3B

Of the total,

$140M

...was for **low value care**
(identified as likely wasteful or wasteful).

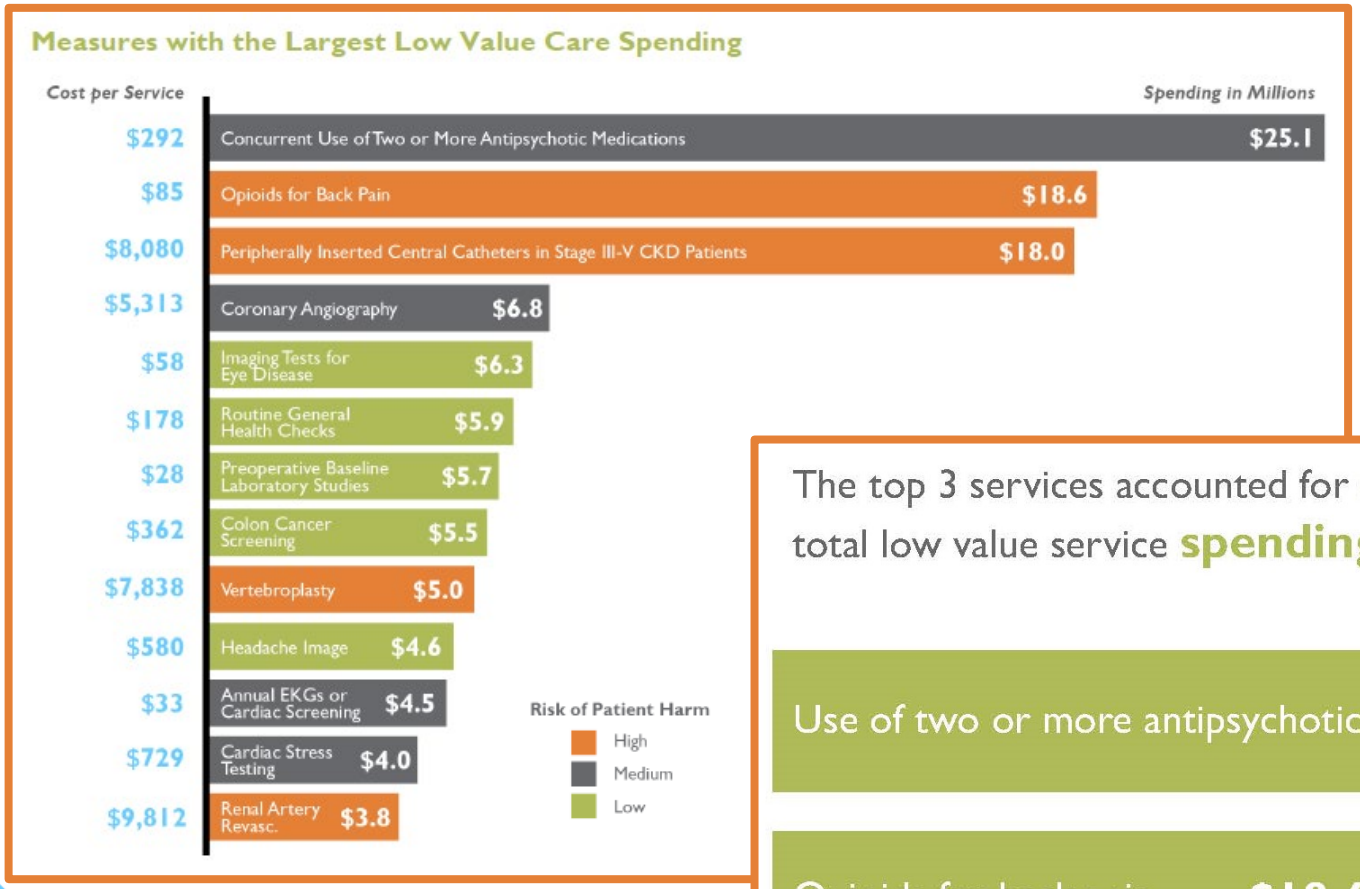
$17.4M were patient **out of pocket costs.**

- Necessary = Clinically appropriate.
- Likely Wasteful = The appropriateness of the services is questionable.
- Wasteful = The services were very likely unnecessary.

Between **2015-2017**....

- there was an **11%** increase for individuals who received at least one low value care service.
- there was a **9%** decrease in spending, ***but*** low value service utilization remained stable.
- there was an **18%** increase in the patient paid portion of the cost of low value care.

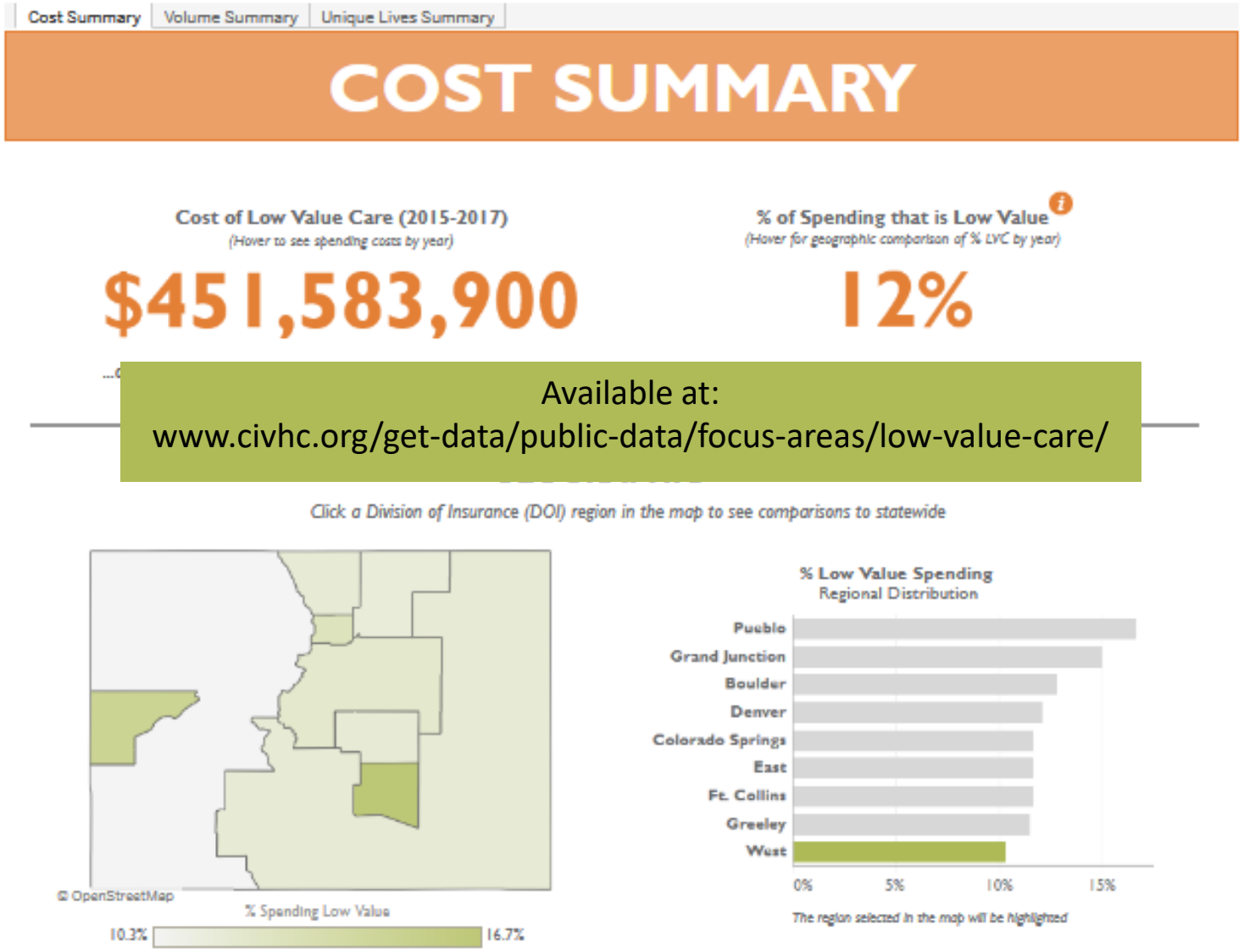
Highest Spend Low Value Services



The top 3 services accounted for **44%** of total low value service **spending.**

Use of two or more antipsychotics	**$25.1M**
Opioids for back pain	**$18.6M**
Cen. catheters in stage III-V CKD patients	**$18M**

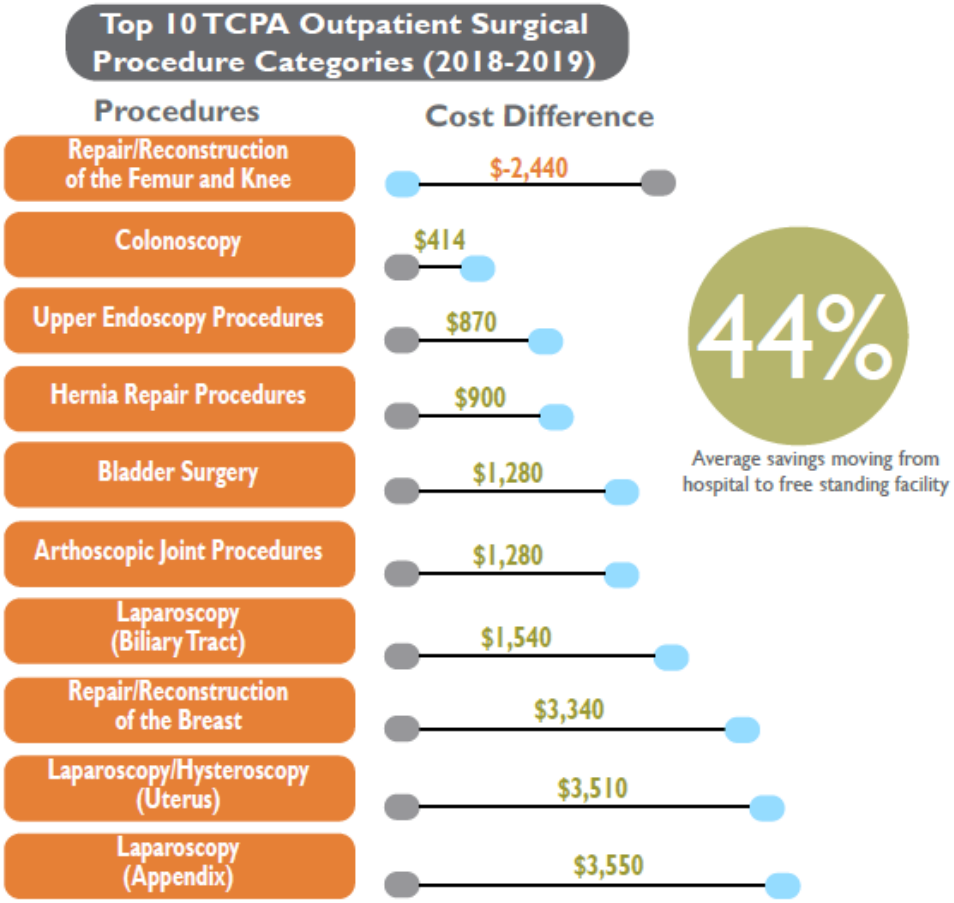
Interactive Report Now Available



The Colorado Purchasing Alliance (TCPA) Case Study

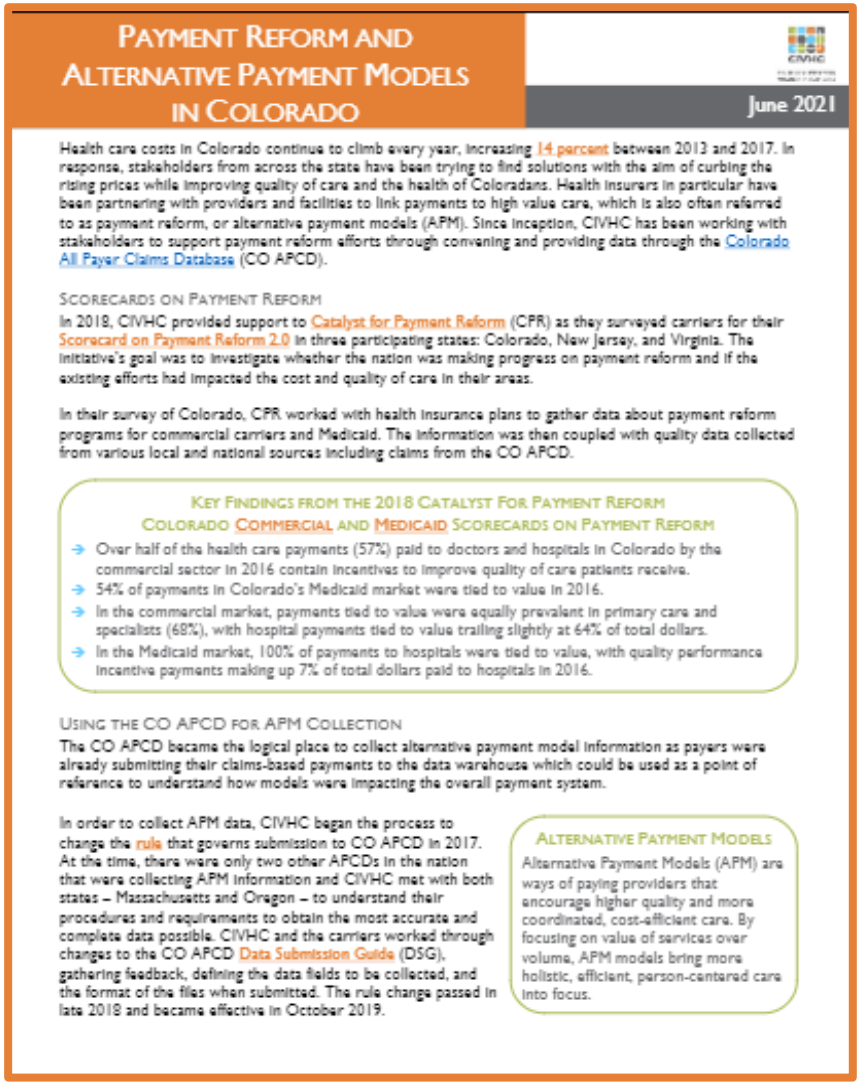
Purpose:

- investigate potential cost savings available for outpatient procedures
- compare costs for services performed at hospitals to those performed at independent, free-standing centers not owned by a health system or hospital



Alternative Payment Models

- CIVHC shares the journey to support stakeholders advancing new payment models and efforts to measure their implementation and impact
- A new webpage also features a timeline of projects and efforts over the last decade to advance new payment models



Payment Reform and Alternative Payment Models in Colorado

June 2021

Health care costs in Colorado continue to climb every year, increasing 14 percent between 2013 and 2017. In response, stakeholders from across the state have been trying to find solutions with the aim of curbing the rising prices while improving quality of care and the health of Coloradans. Health insurers in particular have been partnering with providers and facilities to link payments to high value care, which is also often referred to as payment reform, or alternative payment models (APM). Since inception, CIVHC has been working with stakeholders to support payment reform efforts through convening and providing data through the Colorado All Payer Claims Database (CO APCD).

Scorecards on Payment Reform

In 2018, CIVHC provided support to Catalyst for Payment Reform (CPR) as they surveyed carriers for their Scorecard on Payment Reform 2.0 in three participating states: Colorado, New Jersey, and Virginia. The initiative's goal was to investigate whether the nation was making progress on payment reform and if the existing efforts had impacted the cost and quality of care in their areas.

In their survey of Colorado, CPR worked with health insurance plans to gather data about payment reform programs for commercial carriers and Medicaid. The information was then coupled with quality data collected from various local and national sources including claims from the CO APCD.

Key Findings from the 2018 Catalyst For Payment Reform Colorado Commercial and Medicaid Scorecards on Payment Reform

- Over half of the health care payments (57%) paid to doctors and hospitals in Colorado by the commercial sector in 2016 contain incentives to improve quality of care patients receive.
- 54% of payments in Colorado's Medicaid market were tied to value in 2016.
- In the commercial market, payments tied to value were equally prevalent in primary care and specialists (68%), with hospital payments tied to value trailing slightly at 64% of total dollars.
- In the Medicaid market, 100% of payments to hospitals were tied to value, with quality performance incentive payments making up 7% of total dollars paid to hospitals in 2016.

Using the CO APCD for APM Collection

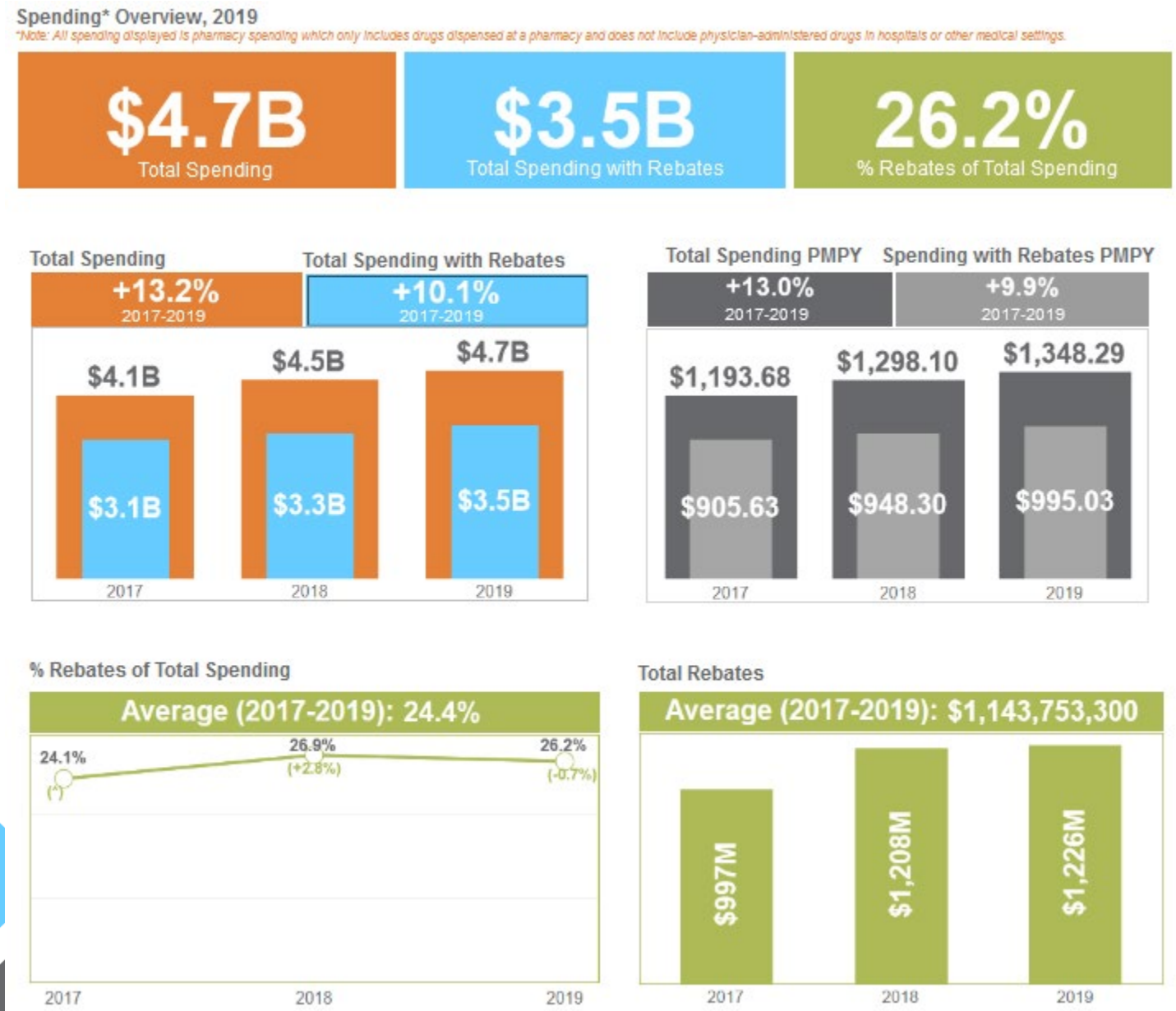
The CO APCD became the logical place to collect alternative payment model information as payers were already submitting their claims-based payments to the data warehouse which could be used as a point of reference to understand how models were impacting the overall payment system.

In order to collect APM data, CIVHC began the process to change the rule that governs submission to CO APCD in 2017. At the time, there were only two other APCDs in the nation that were collecting APM information and CIVHC met with both states – Massachusetts and Oregon – to understand their procedures and requirements to obtain the most accurate and complete data possible. CIVHC and the carriers worked through changes to the CO APCD Data Submission Guide (DSG), gathering feedback, defining the data fields to be collected, and the format of the files when submitted. The rule change passed in late 2018 and became effective in October 2019.

Alternative Payment Models

Alternative Payment Models (APM) are ways of paying providers that encourage higher quality and more coordinated, cost-efficient care. By focusing on value of services over volume, APM models bring more holistic, efficient, person-centered care into focus.

Drug Rebates in Colorado



Public Reporting

- Upcoming Public Releases
  - August / Sept
    - Drug Rebate Analysis
    - COVID Test Price Variation Data Byte
    - Impact of COVID-19 on Overall Utilization
    - Telehealth Services Analysis v 4.0
    - Impact of COVID on Elective Procedure Use*
  - Late Fall 2021
    - Community Dashboard
    - Insights Dashboard Update
  - Late 2021/early 2022
    - Shop for Care update
  - Spring 2022
    - New Affordability Dashboard

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CO APCD Data Quality and Analytics

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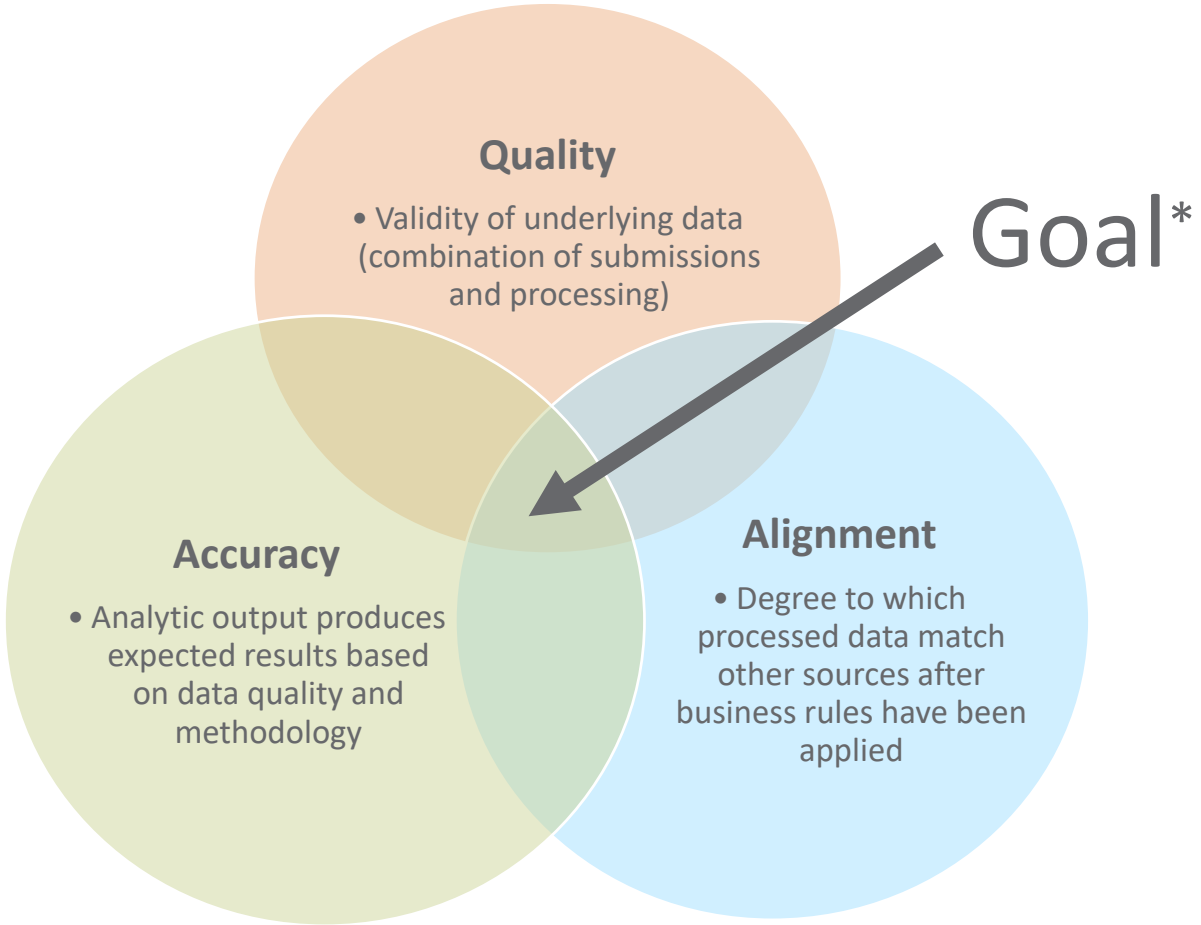
Goal: CO APCD Data Processing and Analytics



**Not always attainable when different methodologies and data sources are being compared*

What We Mean When We Say

Data Quality

- Submission
  - Missing fields
  - Incorrectly populated fields
  - Mis-submitted files
- Processing
  - Business rules

Accuracy

- Analysis
  - External vendor or internal analysis code or output errors

Alignment

- Alignment with Other Data Sets and Using Custom Methodology
  - No claim-line match with HCPF data, business rules
  - Comparison with clinical data or other external sources using survey data/data from uninsured or other populations not in the CO APCD, etc.
  - Methodology discrepancies

What We Mean When We Say

- **Completeness**
  - More self-funded employer representation
  - More information about demographics to support health equity
  - APMs and drug rebate file submissions
- **Timeliness**
  - Difference between the paid through dates in the data warehouse available for non-public release and what CIVHC uses for public reporting
    - CIVHC prefers to use full calendar years of data in public analyses (6 months of runout for complete calendar year)
- **Documentation/Communication**
  - User-facing materials for each release
    - Methodology, data vintage
  - General user-facing materials
    - Data user guides, CO APCD capabilities documentation, known data limitations and discoveries, and table scripts for data recipients

Data Quality Workplan

- Continuous Quality Improvement (CQI)
  - Data Discovery Log Redesign
    - Guidance specific to data use needs
  - DQ Team Data Warehouse Refresh
    - Activities for after each refresh
  - Submitter Profiles / Submitter Quality Index
    - Submitter data quality profiles, including an index to assess overall submitter performance across all standard measures of quality.

Data Quality Workplan

- Enhanced Quality Metrics
  - Substance Use Disorder (SUD) Claims Collection
    - A new indicator will be created in the CO APCD to quickly identify these to omit from analyses.
    - Using a combination of sources to identify SUD claims
  - Employer Composite ID
    - Create a unique identifier for each employer. Need to be able to tie together over time for any name changes, EIN changes, etc.
    - Supports ongoing reporting to employer groups and purchasing alliances.

Data Quality Workplan

- Parity
  - Medicaid Supplemental Payments
    - Payments beyond the reflected paid amounts on the claims made by Medicaid are not represented in the CO APCD. CIVHC is expanding the methodology it uses to distribute supplemental hospital payments to include programs impacting SNF reimbursement.
- Data Intake
  - Resubmissions

SUD Claims Collection

- Uses of SUD data expanded in CARES Act
  - Allows for increased research use of SUD data, not as broad as allowed under HIPAA.
  - New rule is currently on hold at the federal level.
- Working on structure to begin collecting SUD data once final rule is released.
  - Defining SUD data for purposes of data release requirements.
  - Creating business rules for Iding, partitioning SUD data.
  - Requesting Medicare SUD file from ResDAC.
  - Incorporating Medicaid SUD definitions in CIVHC approach.

APM and Drug Rebate File Submissions

- Alternative Payment Model and Drug Rebate Test files were due July 15
  - Drug Rebate: all but one file received
  - APM: all but one file received
  - Validation check and payer feedback sent August 3
  - Quality and timeliness of submission much improved
  - Engaged Catalyst for Payment Reform (CPR), and Centers for Medicare & Medicaid Services, and Division of Insurance (DOI) to assist payers with proper classification of payments to APMs

Data Submission Guide 13

- Final Packet due to HCPF 11/25/21
- Additional demographic information
  - Adding ‘other’ option
    - Collaborating with HCPF for future changes
  - Disability Flag (HCPF only for now)
  - Language Preference
- Financial and DOI changes
  - Separating drug rebates and other compensation (Drug Rebate)
  - Separating up-side and down-side payments in APM file
  - Expanding market options (municipal, church, hospital, student, STLD, expatriate, etc.). Collaborating with DOI

Data Submission Guide 13

- Prescription Drug Affordability fields
- Value Based Purchasing Contracts
  - Collaborating with payers to develop definitions and reporting structure for accurate collection and analysis.
- Rule language changes
  - Clarifying required reporting for non-ERISA self-funded and Medicare Supplemental plans.
  - Increasing fines from $1000/wk with a max of $50,000 to $2,500/wk with a max of $100,000 per incident.
  - Calling out requirement to follow HIPAA, anti-trust law.
  - Adding language prohibiting release of Drug Rebate, APM, and Value Based Purchasing files.

Preview DSG 14

- Race and Ethnicity reporting in line with state and federal standards
- Vision claims
- Worker's compensation
- Ongoing discussions with the VA.

Committee Open Discussion

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Future Meeting Schedule

- November 9th
- 2022 – shift to 1st Tuesday
  - February 1st
  - May 3rd
  - August 2nd
  - November 1st
- 9am-11am
- Virtual until otherwise noted