Agenda

• Opening Announcements
• Operating Updates
• Public Reporting
• CO APCD Data Quality and Analytics
• Public Comment
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 on voluntary & standard format expected
  • Oct ‘21 – Expected grant appropriations
  • Dec ‘21 – Regulations expected on data submission formatting
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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

$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.
### Measures with the Largest Low Value Care Spending

<table>
<thead>
<tr>
<th>Cost per Service</th>
<th>Spending in Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>$292</td>
<td>Concurrent Use of Two or More Antipsychotic Medications</td>
</tr>
<tr>
<td>$85</td>
<td>Opioids for Back Pain</td>
</tr>
<tr>
<td>$8,080</td>
<td>Peripherally Inserted Central Catheters in Stage III-V CKD Patients</td>
</tr>
<tr>
<td>$5,313</td>
<td>Coronary Angiography</td>
</tr>
<tr>
<td>$58</td>
<td>Imaging Tests for Eye Disease</td>
</tr>
<tr>
<td>$178</td>
<td>Routine General Health Checks</td>
</tr>
<tr>
<td>$28</td>
<td>Preoperative Baseline Laboratory Studies</td>
</tr>
<tr>
<td>$362</td>
<td>Colon Cancer Screening</td>
</tr>
<tr>
<td>$7,838</td>
<td>Vertebroplasty</td>
</tr>
<tr>
<td>$580</td>
<td>Headache Image</td>
</tr>
<tr>
<td>$33</td>
<td>Annual EKGs or Cardiac Screening</td>
</tr>
<tr>
<td>$729</td>
<td>Cardiac Stress Testing</td>
</tr>
<tr>
<td>$9,812</td>
<td>Renal Artery Revasc.</td>
</tr>
</tbody>
</table>

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

Available at: www.civhc.org/get-data/public-data/focus-areas/low-value-care/
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


- Repair/Reconstruction of the Femur and Knee: $-2,440
- Colonoscopy: $414
- Upper Endoscopy Procedures: $870
- Hernia Repair Procedures: $900
- Bladder Surgery: $1,280
- Arthroscopic Joint Procedures: $1,280
- Laparoscopy (Biliary Tract): $1,540
- Repair/Reconstruction of the Breast: $3,340
- Laparoscopy/Hysteroscopy (Uterus): $3,510
- Laparoscopy (Appendix): $3,550

44% Average savings moving from hospital to free-standing facility

10% Shift in Service Site
$1.1 Million

Potential 2-Year Cost Savings

50% Shift in Service Site
$5.7 Million
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.
Drug Rebates in Colorado

Spending Overview, 2019
- $4.7B Total Spending
- $3.5B Total Spending with Rebates
- 26.2% % Rebates of Total Spending

Total Spending
- $4.1B in 2017 (13.2% increase)
- $4.5B in 2018 (10.1% increase)
- $4.7B in 2019

Total Spending with Rebates
- $3.1B in 2017
- $3.3B in 2018
- $3.5B in 2019

Total Rebates
- $1193.68M in 2017
- $1298.10M in 2018
- $1348.29M in 2019

Average (2017-2019): $1,143,753,300

% Rebates of Total Spending
- 24.4% (2017-2019)
- 26.9% (+2.8%
- 26.2% (-0.7%)

Note: All spending displayed is pharmacy spending which only includes drugs dispensed at a pharmacy and does not include physician-administered drugs in hospitals or other medical settings.
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
Kristin Paulson, JD, MPH
CIVHC Chief Operation Officer and General Council
Goal: CO APCD Data Processing and Analytics

Quality
• Validity of underlying data (combination of submissions and processing)

Alignment
• Degree to which processed data match other sources after business rules have been applied

Accuracy
• Analytic output produces expected results based on data quality and methodology

*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
Future Meeting Schedule

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