

## Addendum I – Analyst Supplement Colorado All Payer Claims Database Application

### **Project Description and Data Objective**

Project Title and number:

21.49 AspenPoint Gaps in Care and Services Market Analysis

**Date Range or Years Requested** – *What years of claims do you need to meet your project purpose? (If you want a range of data with specific month and day start and end dates, please supply the start and end dates next to the appropriate year.)*

Check all that apply:

- ☐ 2012
- ☐ 2013
- ☐ 2014
- ☐ 2015
- ☐ 2016
- ☐ 2017
- ☒ 2018
- ☒ 2019
- ☒ 2020\*

\*Please consult the Data Warehouse refresh schedule to learn what is currently available for 2020

**Medicare FFS data:** Data requests are only available for research purposes and must be approved and financially supported by HCPF.

Check all that apply:

- ☐ 2012
- ☐ 2013
- ☐ 2014
- ☐ 2015
- ☐ 2016
- ☐ 2017
- ☐ 2018

**Lines of Business:** *Which payers do you need for your project purpose?*

Please check all that apply

- ☒ **Commercial Payer Claims** - Data available with appropriate levels of aggregation  
Need to discuss appropriate level of aggregation for client request type; would need analyst input
  - ☒ **Individual**
  - ☒ **Small Group Plans**
  - ☒ **Large Group Plans**
    - **Currently available:** Medical Claims AND Pharmacy Claims from 2012-2020

- Claims
- Eligibility
- Servicing and Billing Provider information
- ☒ Fully insured Employer Plans
- ☒ Self-Insured ERISA and non-ERISA based Employer Plans (note: ERISA-based plans are voluntary submitters and are not all represented in the CO APCD)
  - **Currently available:** Medical Claims AND Pharmacy claims
    - Claims
    - Eligibility
    - Servicing and Billing Provider information
- ☒ Medicare Advantage - data is available with appropriate levels of aggregation  
Need to discuss appropriate level of aggregation for client request type; would need analyst input
  - **Currently available:** Medical AND Pharmacy claims from 2012-2020
    - Claims
    - Eligibility
    - Servicing and Billing Provider information
- ☒ Health First Colorado (Colorado's Medicaid Program) - Data requests must be reviewed by the Colorado Department of Health Care Policy and Financing (HCPF) to ensure alignment with administration of the Medicaid program as required by federal law
  - **Currently available:** Medical Claims AND Pharmacy Claims from 2012-2020
    - Claims
    - Eligibility
    - Servicing and Billing Provider information

The following lines of business, when requested, require CIVHC Data Release Review Committee review as well as HCPF review, approval, and financial support.

- ☐ Medicare Fee For Service (FFS) - Data requests are only available for research purposes and must be approved and financially supported by HCPF.
  - **Currently available:** Medical Claims AND Pharmacy Claims from **2012-2018**
    - Claims
    - Eligibility
    - Servicing and Billing Provider information

**Payer-Specific Details** – Do you need to limit claims to particular health insurance coverage types?

- ☐ Yes
- ☒ No

- If YES, please indicate the specific information you would like to include:
  - Payer Line of Business
    - ☐ Commercial
      - Payer Name: Please note Anti-trust guidelines will be followed. (DRRC review maybe also be required)

○ Please provide listing of payer names and health plans

• **Commercial Product Line(s):**

- ☐ PPO
- ☐ HMO
- ☐ POS
- ☐ Supplemental
- ☐ Indemnity
- ☐ Other- Please specify

○ Please provide listing of other product lines

☐ **Colorado's Exchange, Connect for Health Colorado, Product Lines:**

- ☐ Gold
- ☐ Silver
- ☐ Bronze

**Payment Type** – Which elements of total paid amount on each claim do you need to support your project purpose? (Check all that apply)

- ☒ **Charged Amount**
- ☒ **Plan Paid Amount\***
- ☐ **Member Liability, i.e., amount the member is responsible for (check all that apply)**
  - ☐ Coinsurance
  - ☐ Deductible
  - ☐ Copay
- ☐ **Total Allowed Amount** – (summation of plan paid and member liability)
- ☐ **Prepaid Amount** – (to be considered for capitated payment plans only)

**Medical Claims** – Which types of claims do you need for your project purpose?

- Check all that apply
  - ☒ **Inpatient (IP)** – Related to individuals who receive care in hospital settings
  - ☒ **Outpatient (OP)** – Related to an individual receiving medical treatment in any setting other than a hospital admission (i.e. ambulatory surgery center; doctor's office, imaging center, Emergency Room, home health, etc.)
  - ☒ **Professional (PROF)** – Related to medical procedures within professional settings (e.g. physician office, imaging center, etc.) and clinics

**Pharmacy Claims** – Do you need prescription drug-based claims for your project purpose?

- ☒ Yes  
☐ No
- If YES, and you need pharmacy claims limited to specific drug types, ***please list the 11-digit NDC codes you would like to receive (DO NOT INCLUDE DASHES AND PROVIDE LEADING ZEROS):***
  - Limitation methodology being finalized- interested only in those that would coincide with the requested medical claims

**Dental Claims** – Do you need dental claims for your project purpose?

- ☐ Yes  
☒ No

**Site of Service Detail** – Do you need to look at claims that occurred in specific care settings for your project purpose? i.e., do you need to limit services by site of service?

- ☒ Yes (in the 3 named counties) // client will limit specific site of service (CIVHC will be provide all mental health and substance abuse claims for the 3 counties) **claims limited to those patients residing within the county, regardless of where site of service performed**
- El Paso
  - Teller
  - Park
- ☐ No

If YES, please indicate the specific information you would like to include: (See above - client will limit specific site of service (CIVHC will be provide all mental health and substance abuse claims for the 3 counties)

- El Paso
  - Teller
  - Park
- ☐ Hospital
- ☐ Ambulatory Surgery Centers
- ☐ Outpatient Facilities
- ☐ Physician offices
- ☐ Specialty offices
- ☐ Home Health
- ☐ Urgent Care
- ☐ Emergency Room (Note: cannot differentiate between majority of Free-Standing and hospital-based ERs)
- ☐ Other (specify)
- Please list other site of service details

**Provider-level Detail** – Do you need claims limited to specific providers or provider type(s) ie. (Provider IDs, locations, hospitals, medical groups, etc.) for your project purpose?

- ☐ Yes
- ☐ No
- If YES, please indicate the specific provider types you would like to include or provide a list of providers:
  - ☐ **Facilities (hospitals, ambulatory surgery centers, etc.)**
    - Please provide listing
  - ☐ **Professionals**
    - Please provide listing
  - ☐ **Provider Taxonomy - Specialty Designations**
    - Please provide listing
  - ☐ **National Provider Identifier**
    - Please provide listing
  - ☐ **Other**
    - Please provide listing

**Geography** – Do you need claims data limited by geography or location for your project purpose?

- ☒ Yes
- ☐ No
- If YES, please indicate the geographic groupings you would like to include:
  - ☒ **Provider location address (all mental health claims for persons living in the 3 identified counties of El Paso, Teller & Park)**
  - ☒ **Member location address (all mental health claims for persons living in the 3 identified counties of El Paso, Teller & Park)**
  - ☐ **Zip 3**
    - Please provide listing
  - ☐ **Health Statistic Region**
    - <http://www.cohid.dphe.state.co.us/brfssdata.html>
    - Please provide listing
  - ☒ **County (Potential PHI)**
    - El Paso
    - Teller
    - Park
  - ☒ **Zip 5 (PHI)**
    - Please provide listing
  - ☐ **Other**
    - Please provide listing

**Age and/or Gender** – Do you need claims data limited by age or gender for your project purpose?

- ☐ Yes
- ☒ No

- If YES, please indicate the groupings you would like to include:
  - ☐ Age bands/range (in years) requested (i.e. 0-21, 22-39, 40-55, etc.)
  - ☐ Gender
    - ☐ Male
    - ☐ Female
    - ☐ Unspecified

**Member-level Detail** – Do you need claims filtered at the member level for your project purpose?  
i.e., do you need claims limited to specific members for your project?

- ☒ Yes \*Include but not limit by
- ☐ No
- If YES, please indicate the information you would like to include:
  - ☐ De-identified member information
    - ☐ Unique member and person ID
    - ☒ Gender
    - ☒ Age: (at time of service)
    - ☐ 3-digit zip
  - ☐ Protected Health Information (PHI) – Any of the below requires DRRC approval process
    - ☐ Names (first, last, middle) (PHI)
    - ☐ Street Address (PHI)
    - ☐ City (PHI)
    - ☒ 5 Digit Zip (PHI)
    - ☐ DOB-Dates of Birth (PHI)
    - ☒ DOS-Dates of Service (PHI)

**Diagnosis Detail** – Do you need claims limited to a specific diagnosis or multiple diagnoses for your project purpose?

- ☒ Yes
- ☐ No
- If YES, please indicate the specific diagnosis code(s) you would like to include (DO NOT USE DECIMAL POINTS AND DO NOT REMOVE LEADING AND TRAILING ZEROS):
  - Please provide listing

**Procedure/Revenue Code Detail** – Do you need claims limited to specific procedure or revenue code(s) for your project purpose?

- ☒ Yes -
- ☐ No

- **If YES**, please indicate the specific procedure/revenue code(s) you would like to include under each type requested:

☒ **CPT4 -**

90785  
90791  
90792  
90832  
90833  
90834  
90836  
90837  
90838  
90839  
90840  
90846  
90847  
90849  
90853  
90865  
90867  
90868  
90869  
90870  
90875  
90876  
90880  
90882  
90885  
90887  
90889  
90899  
90901  
90911  
93005  
96101  
96118  
96130  
96131  
96132  
96133  
96136  
96137

96372  
99201  
99202  
99203  
99204  
99205  
99211  
99212  
99213  
99214  
99215  
99221  
99222  
99223  
99231  
99232  
99233  
99238  
99239  
99241  
99242  
99243  
99244  
99245  
99281  
99282  
99283  
99284  
99285  
99308  
99309  
99310  
99354  
99355  
99358  
99359  
99366  
99368  
99441  
99442  
99443

H0001

H0002  
H0004  
H0005  
H0006  
H0015  
H0017  
H0018  
H0019  
H0020  
H0023  
H0025  
H0031  
H0032  
H0033  
H0034  
H0035  
H0036  
H0038  
H0045  
H2000  
H2011  
H2012  
H2014  
H2015  
H2016  
H2017  
H2021  
H2023  
H2027  
H2030  
H2031  
H2033  
S3005  
S5151  
S9445  
S9480  
T1007  
T1017  
T1019  
T1023

☐ CDT

*Please provide listing*

☒ **Revenue code**

0104

0114

0124

0450

0456

0529

0762

0901

☐ **APR-DRG**

*Please provide listing*

☐ **ICD9 or ICD10**

**(Please indicate whether the codes you provide are ICD 9 or 10 codes)**

*Please provide listing*

**Additional Requests/Info Not Included Above** – *Is there any additional information you would like for us to know to fulfill your request?*

By signing this Agreement, the Receiving Organization agrees to abide by all provisions set out in this Agreement.

**SIGNATURES:**

**For the CO APCD: CIVHC**

**For Receiving Organization: AspenPointe**

**Signature:**

**Signature:**

**Name: Pete Sheehan**

**Name: Kevin Porter**

**Title: VP of Client Solutions & State Initiatives    Title: VP Operations and MSO Services**