

An Act

HOUSE BILL 18-1327

BY REPRESENTATIVE(S) Young, Hamner, Rankin, Buckner, Esgar, Exum, Ginal, Hansen, Herod, Jackson, Kennedy, Lee, Lontine, Melton, Michaelson Jenet, Rosenthal, Valdez, Duran;
also SENATOR(S) Moreno, Lambert, Lundberg, Court, Donovan, Fields, Kefalas, Merrifield.

CONCERNING THE ALL-PAYER HEALTH CLAIMS DATABASE, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, 25.5-1-204, **amend** (4) as follows:

25.5-1-204. Advisory committee to oversee the all-payer health claims database - creation - members - duties - legislative declaration - rules. (4) (a) The administrator shall seek funding for the creation of the all-payer health claims database and develop a plan for the financial stability of the database. If sufficient funding is received through gifts, grants, and donations on or before January 1, 2012, as determined by the executive director, the administrator shall, in consultation with the advisory committee, create the Colorado all-payer claims database. ~~The Colorado all-payer claims database shall be operational no later than January 1, 2013.~~

Capital letters or bold & italic numbers indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

(b) THE GENERAL ASSEMBLY MAY ANNUALLY APPROPRIATE GENERAL FUND MONEY TO THE STATE DEPARTMENT TO PAY FOR EXPENSES RELATED TO THE ALL-PAYER HEALTH CLAIMS DATABASE.

SECTION 2. In Colorado Revised Statutes, **add** 25.5-1-204.5 as follows:

25.5-1-204.5. All-payer health claims database scholarship grant program - creation - definitions. (1) AS USED IN THIS SECTION, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(a) "ADVISORY COMMITTEE" MEANS THE ADVISORY COMMITTEE TO OVERSEE THE ALL-PAYER HEALTH CLAIMS DATABASE CREATED PURSUANT TO SECTION 25.5-1-204.

(b) "GOVERNMENTAL ENTITY" MEANS A STATE OR LOCAL GOVERNMENTAL ENTITY, INCLUDING A STATE-SUPPORTED INSTITUTION OF HIGHER EDUCATION, BUT DOES NOT INCLUDE THE STATE DEPARTMENT.

(c) "PROGRAM" MEANS THE ALL-PAYER HEALTH CLAIMS DATABASE SCHOLARSHIP GRANT PROGRAM ESTABLISHED PURSUANT TO THIS SECTION.

(2) THERE IS CREATED IN THE STATE DEPARTMENT THE ALL-PAYER HEALTH CLAIMS DATABASE SCHOLARSHIP GRANT PROGRAM TO DEFRAY THE COSTS OF NONPROFIT AND GOVERNMENTAL ENTITIES IN ACCESSING THE ALL-PAYER HEALTH CLAIMS DATABASE TO CONDUCT RESEARCH.

(3) THE STATE DEPARTMENT SHALL:

(a) IN CONSULTATION WITH THE ADVISORY COMMITTEE, DEVELOP A GRANT APPLICATION UNDER THE PROGRAM CONSISTENT WITH THE RULES OF THE EXECUTIVE DIRECTOR;

(b) ACCEPT APPLICATIONS FOR SCHOLARSHIP GRANTS FROM ANY NONPROFIT OR GOVERNMENTAL ENTITY NEEDING ACCESS TO THE ALL-PAYER HEALTH CLAIMS DATABASE TO CONDUCT RESEARCH;

(c) AFTER CONSIDERING THE RECOMMENDATIONS OF THE ADVISORY COMMITTEE, DETERMINE WHICH GRANT APPLICATIONS TO APPROVE AND THE

AMOUNT OF EACH GRANT; AND

(d) DISTRIBUTE APPROVED SCHOLARSHIP GRANTS TO NONPROFIT OR GOVERNMENTAL ENTITIES.

(4) THE EXECUTIVE DIRECTOR SHALL, FOLLOWING RECOMMENDATIONS OF THE STATE DEPARTMENT AND THE ADVISORY COMMITTEE, ADOPT RULES PURSUANT TO SECTION 24-4-103 GOVERNING THE PROGRAM, INCLUDING PROCEDURES, CRITERIA, AND STANDARDS FOR AWARDING SCHOLARSHIP GRANTS.

(5) THE ADVISORY COMMITTEE SHALL:

(a) CONSULT WITH THE STATE DEPARTMENT ON THE DEVELOPMENT OF A GRANT APPLICATION FORM; AND

(b) REVIEW APPLICATIONS FOR SCHOLARSHIP GRANTS AND RECOMMEND WHICH SCHOLARSHIP GRANTS TO APPROVE AND THE AMOUNT OF EACH RECOMMENDED GRANT.

SECTION 3. Appropriation. (1) For the 2018-19 state fiscal year, \$1,570,395 is appropriated to the department of health care policy and financing for use by the executive director's office. This appropriation is from the general fund. To implement this act, the office may use this appropriation as follows:

(a) \$42,616 for personal services, which amount is based on an assumption that the office will require an additional 0.9 FTE;

(b) \$2,779 for operating expenses; and

(c) \$1,525,000 for the all-payer health claims database.

(2) For the 2018-19 state fiscal year, the general assembly anticipates that the department of health care policy and financing will receive \$1,070,395 in federal funds to implement this act, which amount is included for informational purposes only. The appropriation in subsection (1) of this section is based on the assumption that the department will receive this amount of federal funds to be used as follows:

- (a) \$42,616 for personal services;
- (b) \$2,779 for operating expenses; and
- (c) \$1,025,000 for the all-payer health claims database.

SECTION 4. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.



Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES



Kevin J. Grantham
PRESIDENT OF
THE SENATE



Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES



Effie Ameen
SECRETARY OF
THE SENATE

APPROVED 3:44 PM 4/23/15



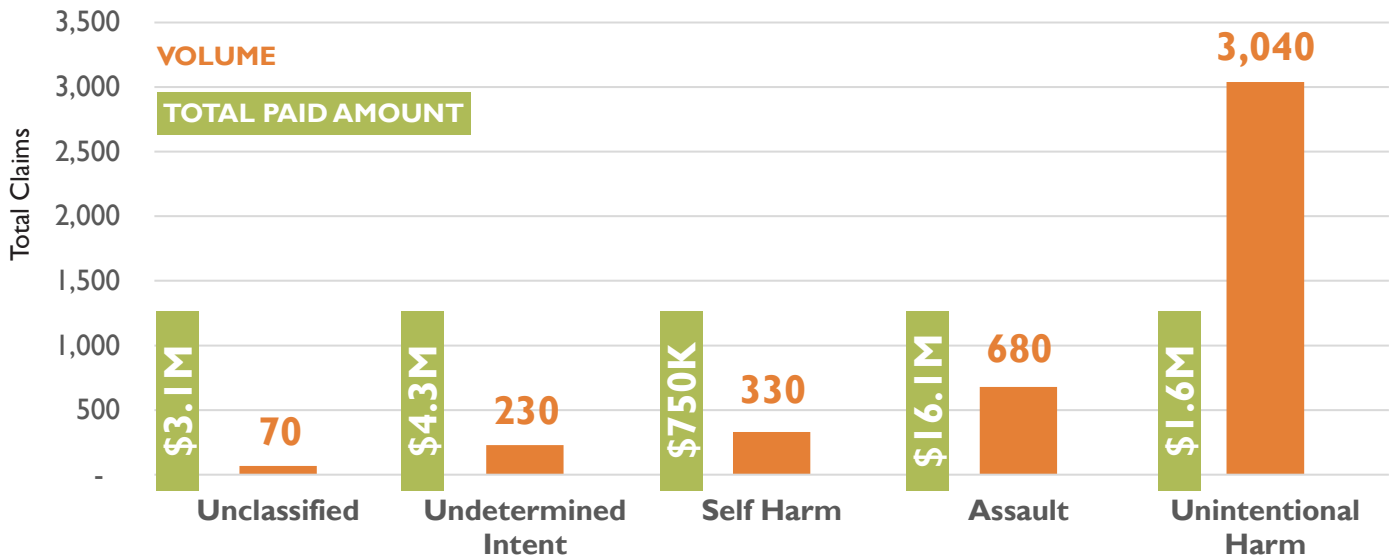
John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO



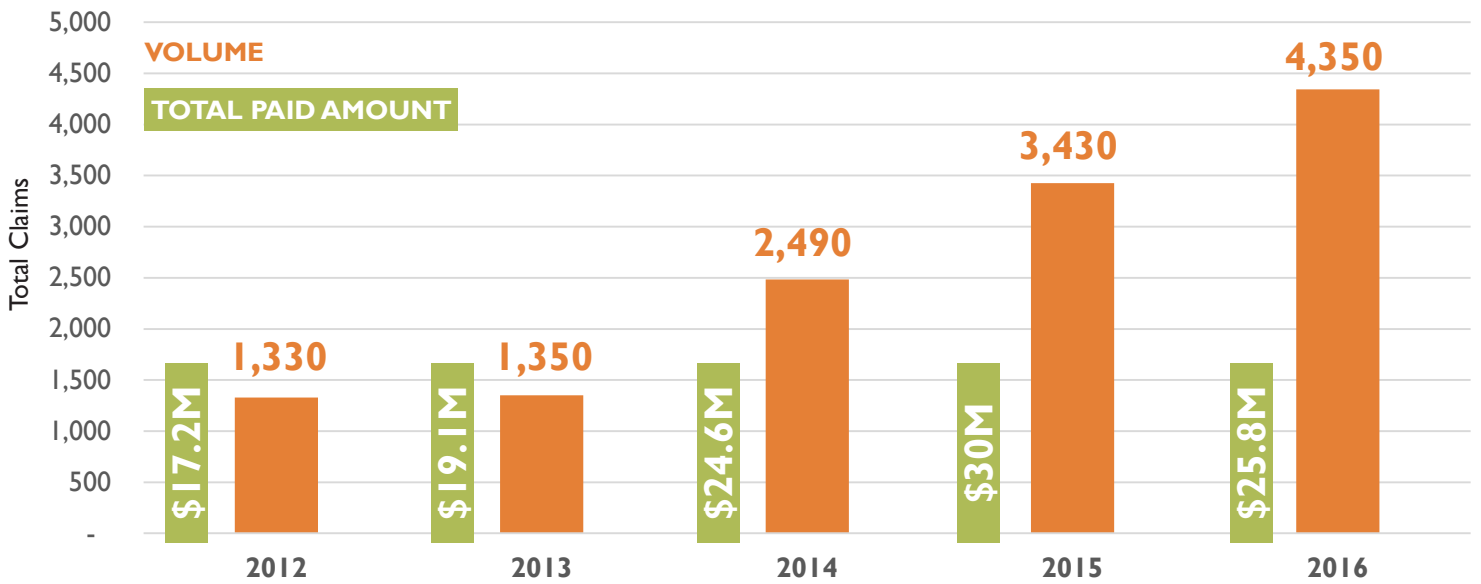
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CO APCD DATA BYTE: FIREARM INJURY TRENDS AND COSTS IN COLORADO

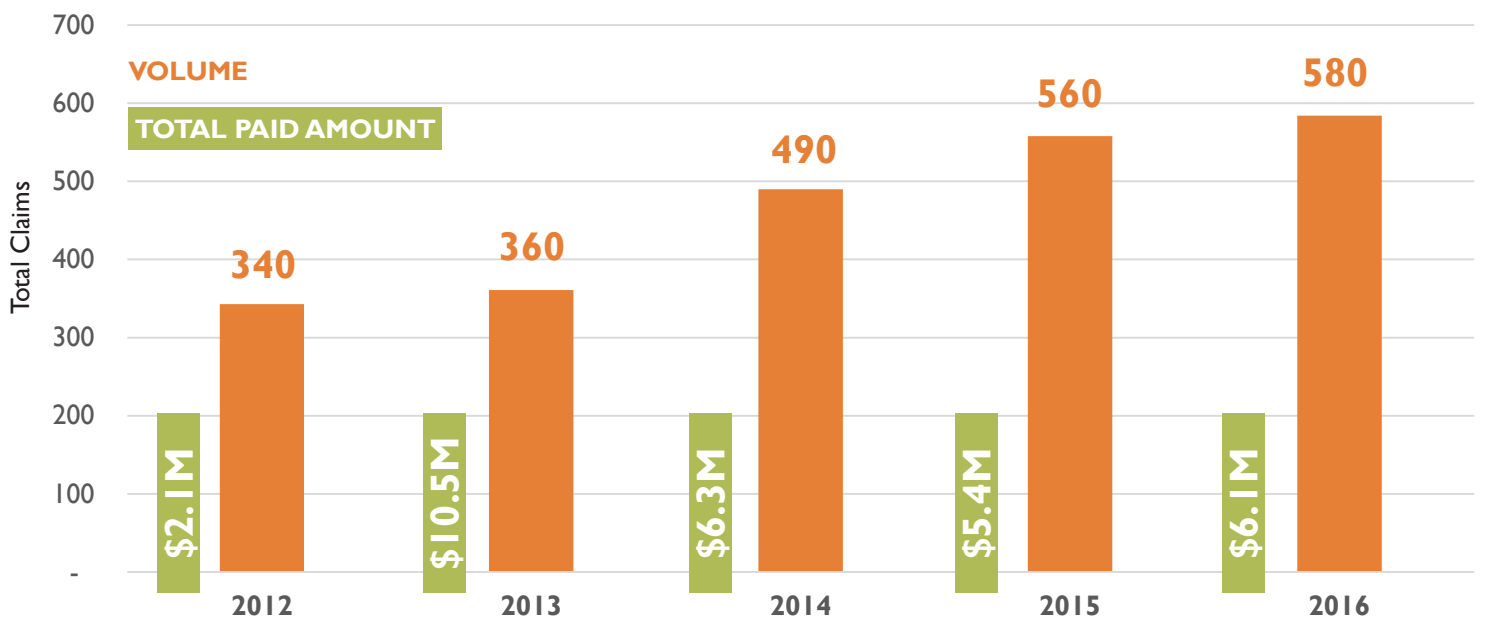
FIREARM CLAIMS BY INJURY TYPE, COMMERCIAL, MEDICAID, MEDICARE FFS, MEDICARE ADVANTAGE, CO APCD, 2016



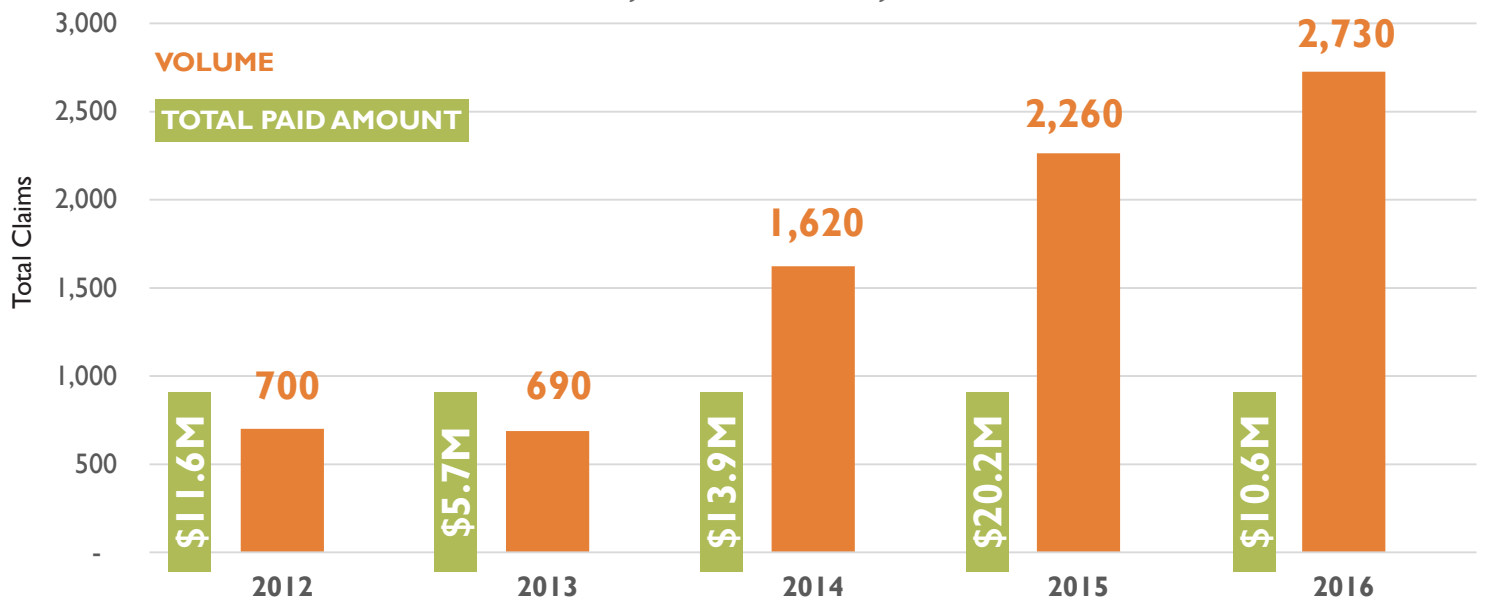
FIREARM INJURY TRENDS AND TOTAL COSTS, COMMERCIAL, MEDICAID, MEDICARE FFS, MEDICARE ADVANTAGE, CO APCD, 2012- 2016



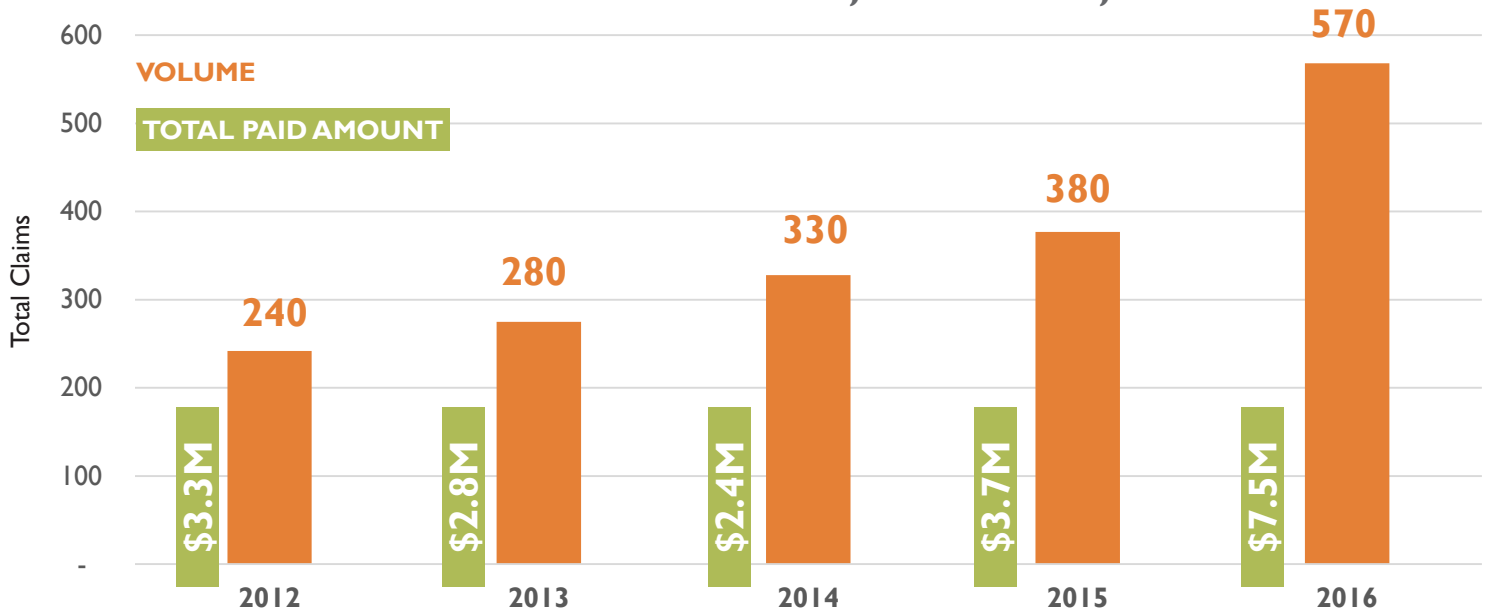
FIREARM INJURY TRENDS AND TOTAL COSTS COMMERCIAL, CO APCD, 2012-2016



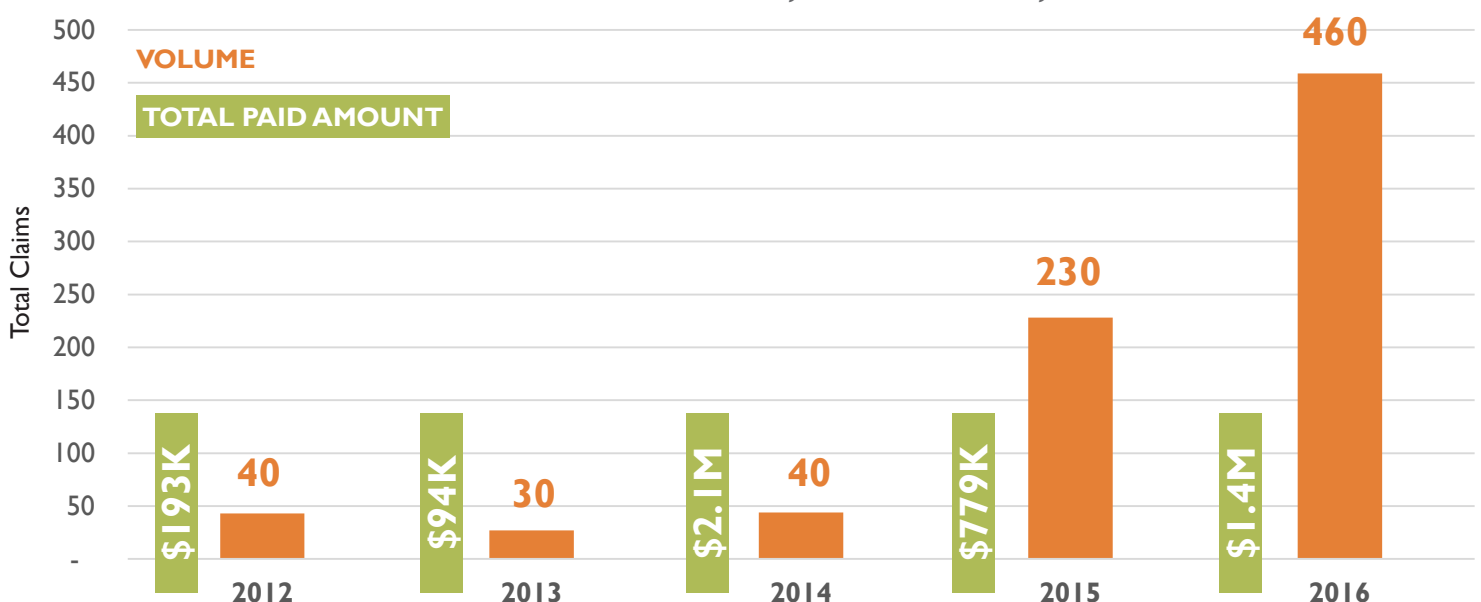
FIREARM INJURY TRENDS AND TOTAL COSTS MEDICAID, CO APCD, 2012-2016



FIREARM INJURY TRENDS AND TOTAL COSTS MEDICARE FEE-FOR-SERVICE, CO APCD, 2012-2016



FIREARM INJURY TRENDS AND TOTAL COSTS MEDICARE ADVANTAGE, CO APCD, 2012-2016



2012-2016 results for this analysis based on ICD9/10 codes X93xx, X94xx, X95xx, E96xx, X72xx, X73xx, X74xx, E95xx, W32xx, W33xx, W34xx, Y22xx, Y23xx, Y24xx, E97xx, E98xx, and E92xx contained in the Colorado All Payer Claims Database (CO APCD). Exclusions include diagnosis codes with the words "air," "paint," "nail," and "virus." The transition from ICD 9 to ICD 10 billing took effect in October 2015 and may contribute to the increase in volume related to firearms in 2015 and 2016. Data was not adjusted to account for the number of people in the CO APCD which has increased since 2012. Additionally, total claims volume includes any instance where billing included a firearm code, regardless of the person receiving it, therefore numbers may represent multiple instances where one person received ongoing care for an injury.

Small Intervention, Big Impact:

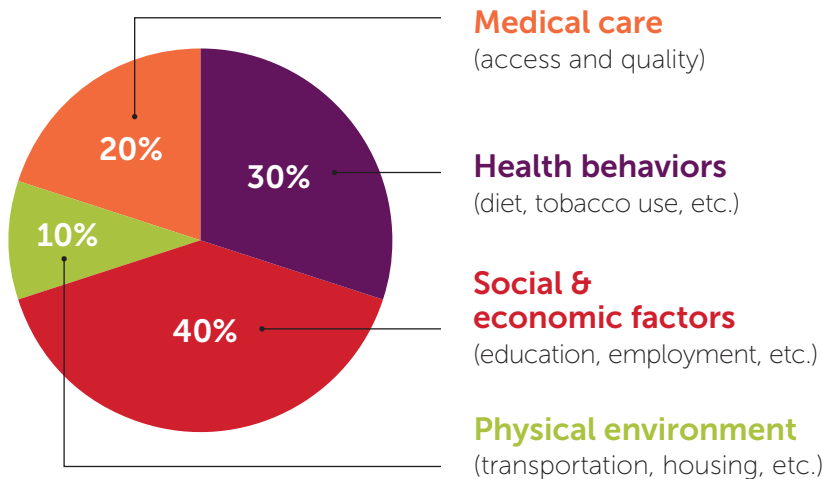
Health Care Cost Reductions Related to Medically Tailored Nutrition

Food is a critical aspect of health care for people living with illnesses like congestive heart failure, chronic obstructive pulmonary disease, and diabetes. Unfortunately, lack of disease-specific nutrition knowledge, low energy, and financial constraints due to hospital bills, co-pays, emergency department visits, and medications can make eating right especially challenging for people managing illness. Many end up being hospitalized due to malnutrition or other nutrition-related complications.

What happens when people living with chronic illness have access to home-delivered, medically tailored meals? Research shows this approach has the potential to reduce total health care costs for patients, insurance companies, and communities alike.

What impacts health the most?

When it comes to health, the quality of your health care matters. But research shows that medical care accounts for only a small fraction of overall health. Other factors, like where you live and what you eat, can have far greater impact.



What is a medically tailored meal?



Medically tailored meals are meals approved by a registered dietitian nutritionist that use evidence-based guidelines to ensure positive health outcomes.

At Project Angel Heart, we offer a variety of diets, including: standard healthy diet, renal-friendly, heart-healthy, vegetarian, allergy-friendly, and naked/blind. When you add in texture modifications and additional accommodations for allergies, side effects, and religious beliefs, we create an average of 18-20 different meal variations each day to make sure every client receives food that meets their unique needs.



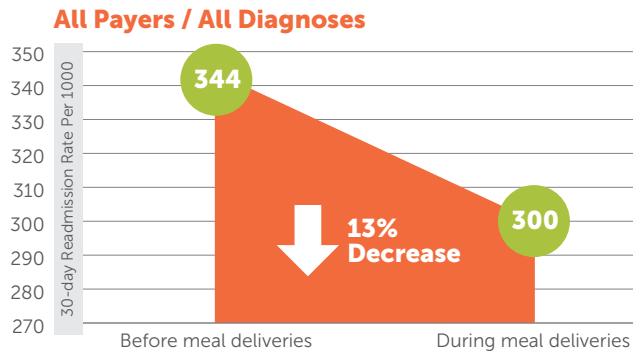
f t i #foodismedicine



Impact of medically tailored, home-delivered meals on health care costs

Using medical claims data from the Colorado All Payer Claims Database, we examined the health care costs of Project Angel Heart clients before, during, and after they received meal deliveries. Here's what we learned:

Medically tailored meals lead to a decrease in hospital readmissions



When Project Angel Heart clients received meals, they saw a 13% reduction in hospital readmissions.

The average cost of a hospital readmission is \$13,430.



Based on what we've learned, we recommend:

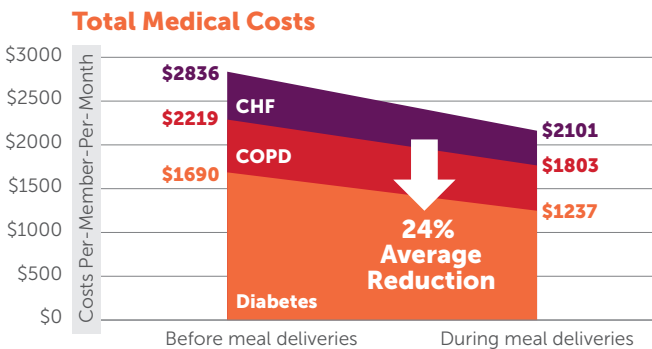
Integrate medically tailored, home-delivered meals into health care delivery and payment models

Research shows that the right food and nutrition—especially medically tailored meals—lead to improved health outcomes for people with chronic illness, so they should be considered a standard part of treatment by health care providers and insurance providers alike.

Continue to study how medically tailored meals impact the health outcomes and costs of chronically ill individuals

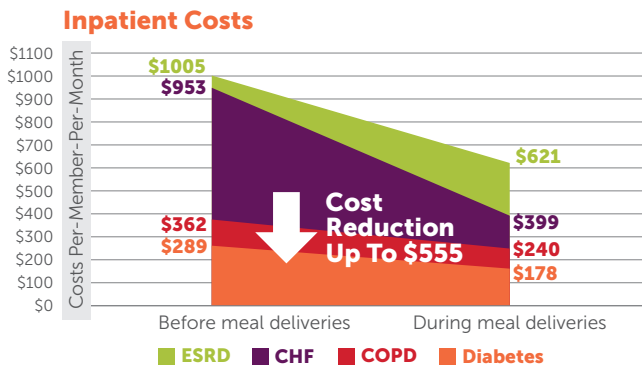
There's still a lot to learn about how medically tailored meals impact health outcomes and health care costs. Additional research is needed to build upon what we already know and to help providers of medically tailored meals continue demonstrating a strong return on investment when meals are integrated into care.

Total medical costs for people with CHF, COPD, and diabetes decreased



When clients living with chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), and diabetes received meal deliveries, their total monthly medical costs went down an average of 24 percent.

Clients spent less on hospital stays while receiving meals



Clients with CHF, COPD, end-stage renal disease (ESRD), and diabetes spent from \$111/month to \$555/month less on inpatient (hospital) medical expenses than they did prior to receiving meals.

Sources:

"Explore Health Rankings | What And Why We Rank". 2017. *County Health Rankings & Roadmaps*. <http://www.countyhealthrankings.org/explore-health-rankings/what-and-why-we-rank>. [Accessed 18 July 2017].

Barrett, M.L., Jiang, H.J., Steiner, C.A., Wier, L.M. (2015, December). *Statistical Brief #199: All-Cause Readmissions by Payer and Age, 2009–2013*. Available at: <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb199-Readmissions-Payer-Age.pdf> [Accessed 1 May 2018].

Project Angel Heart (2018). *Small Intervention, Big Impact: Cost Savings Related to Medically Tailored Nutrition*. [online] Denver. Available at: <http://www.ProjectAngelHeart.org/impact> [Accessed 1 Jun. 2018].



303.830.0202 | info@projectangelheart.org
ProjectAngelHeart.org





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Data Byte: Colorado Payer and Provider Payment Variation

June 2018

Statewide Results: Percent of Medicare Fee Schedule Comparison/Trend, Commercial Payers

| Service Type | 2012 Avg % Medicare* | 2016 Avg % Medicare* | Percentage Point Increase 2012-2016 |
|--|--------------------------------------|--------------------------------------|---|
| Inpatient Services (Top 12 By Volume/Price) | 250% (Range 210%-300%**) | 290% (Range 260%-330%**) | ↑ 40 |
| Outpatient Services (Top 10 By Volume/Price) | 440% (Range 210%-1,160%**) | 520% (Range 250%-1,150%**) | ↑ 80 |

* Average % Medicare reflects an average of the individual service category averages analyzed for IP and OP.

** **Range** reflects lowest average % Medicare rate and highest average % Medicare rate across the individual services analyzed.

In 2016, Commercial Payers paid 290% - 520% Medicare rates (IP/OP), and OP rates have increased nearly 80 percentage points





Reducing CO Statewide Price Variation: IP/OP Annual Potential Savings Scenarios, Commercial Payers, 2016

| Service Type | Total Current Spend | Median Price (Potential Savings*) | 200% Medicare (Potential Savings**) | 150% Medicare (Potential Savings**) |
|--|----------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| Inpatient Services (Top 12 By Volume/Price) | \$284 Million | \$36 Million | \$86 Million | \$136 Million |
| Outpatient Services (Top 10 By Volume/Price) | \$59 Million | \$13 Million | \$36 Million | \$42 Million |
| Total (IP/OP) (rounded to nearest million) | \$343 Million | \$49 Million | \$122 Million | \$178 Million |

***Median Price Potential Savings** reflects potential annual statewide savings if all IP/OP payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

****150% and 200% Medicare Potential Savings** reflects potential annual statewide savings if all IP/OP payments analyzed were normalized to either 150% or 200% Medicare payments.

Potential Annual Statewide Cost Savings: \$49-\$178 Million

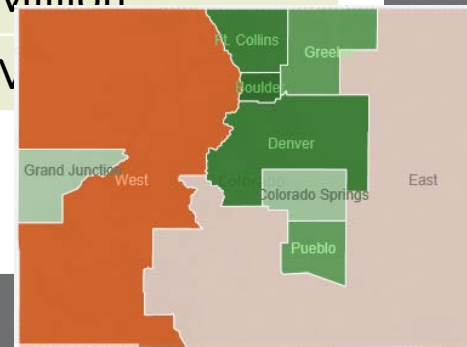
Regional Inpatient Results: Price Comparison, High to Low as % Medicare, 2016

| Division of Insurance Region | Median Inpatient Price as % of Medicare | Inpatient Current Spend (Top 12 by Volume/Price) |
|------------------------------|---|--|
| West | 386% | \$26.7 Million |
| East | 374% | \$4.9 Million |
| Ft. Collins | 354% | \$17.8 Million |
| Grand Junction | 347% | \$11.6 Million |
| Greeley | 326% | \$5.6 Million |
| Denver | 280% | \$156.2 Million |
| Pueblo | 278% | \$5.8 Million |
| CO Springs | 251% | \$21.0 Million |
| Boulder | 242% | \$34.7 Million |

1.6 x Difference



Note: Map included for demonstration of CO Division of Insurance (DOI) Regions only and do not reflect color ranking order per table above.



Regional Cost Savings Analysis, Inpatient: West DOI Region Annual Potential Savings, Commercial Payers, 2016

| Service Type | Total West DOI Current Spend | Median Price Potential Savings* | 200% Medicare Potential Savings** | 150% Medicare Potential Savings** |
|---|------------------------------|---------------------------------|-----------------------------------|-----------------------------------|
| Inpatient Services (Top 12 By Volume/Price) | \$26.7 Million | \$8.9 Million | \$12.8 Million | \$16.3 Million |

***Median Price Potential Savings** reflects potential annual savings for the West DOI region if all Inpatient payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

****150% and 200% Medicare Potential Savings** reflects potential annual savings for the West DOI region if all Inpatient payments analyzed were normalized to either 150% or 200% Medicare payments.

**Potential Annual Inpatient Cost Savings,
West DOI Region: \$9-\$16 Million**



Regional Outpatient Results: Price Comparison, High to Low as % Medicare, 2016

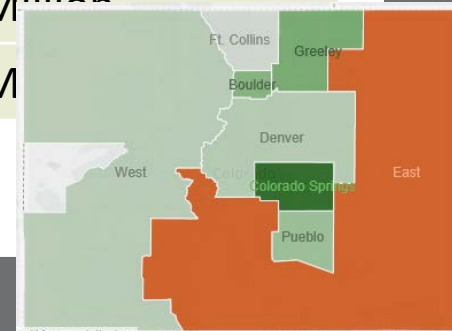


| Division of Insurance Region | Median Outpatient Price as % of Medicare | Outpatient Current Spend (Top 12 by Volume/Price) |
|------------------------------|--|--|
| East | 694% | \$2.4 Million |
| West | 648% | \$6.4 Million |
| Pueblo | 564% | \$2.0 Million |
| Denver | 563% | \$28.6 Million |
| Greeley | 534% | \$1.8 Million |
| Boulder | 495% | \$6.8 Million |
| Ft. Collins | 453% | \$5.3 Million |
| Grand Junction | 410% | \$1.6 Million |
| Colorado Springs | 324% | \$4.0 Million |

2.1 x
Difference



Note: Map included for demonstration of CO Division of Insurance (DOI) Regions only and do not reflect color ranking order per table above.



Regional Cost Savings Analysis, Outpatient: East DOI Region Annual Potential Savings Scenarios, Commercial Payers, 2016

| Service Type | Total East DOI Current Spend | Median Price Potential Savings* | 200% Medicare Potential Savings** | 150% Medicare Potential Savings** |
|--|------------------------------|---------------------------------|-----------------------------------|-----------------------------------|
| Outpatient Services (Top 10 By Volume/Price) | \$2.4 Million | \$990K | \$1.7 Million | \$1.9 Million |

***Median Price Potential Savings** reflects potential annual savings for the East DOI region if all Outpatient payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

****150% and 200% Medicare Potential Savings** reflects potential annual savings for the East DOI region if all Outpatient payments analyzed were normalized to either 150% or 200% Medicare payments.

**Potential Annual Outpatient Cost Savings,
East DOI Region: \$990K-\$1.9 Million**





Regional Cost Savings Analysis, IP/OP: Denver DOI Region Annual Potential Savings Scenarios, Commercial Payers, 2016

| Service Type | Total Denver DOI Current Spend | Median Price (Potential Savings*) | 200% Medicare (Potential Savings**) | 150% Medicare (Potential Savings**) |
|--|--------------------------------|-----------------------------------|-------------------------------------|-------------------------------------|
| Inpatient Services (Top 12 By Volume/Price) | \$156 Million | \$16 Million | \$45 Million | \$72 Million |
| Outpatient Services (Top 10 By Volume/Price) | \$29 Million | \$8 Million | \$18 Million | \$21 Million |
| Total (IP/OP) (rounded to nearest million) | \$185 Million | \$24 Million | \$63 Million | \$93 Million |

***Median Price Potential Savings** reflects potential annual Denver Division of Insurance Region (DOI) savings if all IP/OP payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

****150% and 200% Medicare Potential Savings** reflects potential annual Denver Division of Insurance Region (DOI) savings if all IP/OP payments analyzed were normalized to either 150% or 200% Medicare payments.

Potential Annual Denver DOI Savings: \$24-\$93 Million

Employer Case Study: Inpatient Annual Potential Savings Scenarios, Commercial Payers, 2016

| Service Type | Total Current Spend | Median Price Potential Savings* | 200% Medicare Potential Savings** | 150% Medicare Potential Savings** | 100% Medicare Potential Savings** |
|--|---------------------|---------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| Inpatient Services (Top 12 by Volume/Price) | \$5.1 Million | \$530K | \$1.5 Million | \$2.4 Million | \$3.3 Million |

***Median Price Potential Savings** reflects potential annual savings for a Colorado Employer if all Inpatient payments analyzed that were above the statewide median were paid at the statewide median price. Assumes prices below statewide median remain the same.

****100%, 150% and 200% Medicare Potential Savings** reflects potential annual savings for a Colorado Employer if all Inpatient payments analyzed were normalized to either 100%, 150% or 200% Medicare payments.

**Potential Annual Inpatient Savings,
Employer Case Study: \$530K-\$3.3 Million
\$45-\$275 per person**



Data Byte: Top 25 CPTs by Volume in CO



Top 25 Average and Median Allowed (Paid) and Charged Amounts by Professional CPT Payments, 2016 Commercial Claims, CO All Payer Claims Database

| CPT | Average Charge/Service | Average Paid Amount/Service | Average Paid Amount as % of Charge | Median Charge/Service | Median Paid Amount/Service | Median Paid Amount as % of Charge |
|--|------------------------|-----------------------------|------------------------------------|-----------------------|----------------------------|-----------------------------------|
| 99214 Office/Outpatient Visit Est | \$189 | \$120 | 63% | \$184 | \$126 | 68% |
| 99213 Office/Outpatient Visit Est | \$122 | \$82 | 67% | \$119 | \$86 | 72% |
| 99396 Prev Visit Est Age 40-64 | \$215 | \$159 | 74% | \$206 | \$158 | 77% |
| 99285 Emergency Dept Visit | \$716 | \$361 | 50% | \$685 | \$306 | 45% |
| 01967 Anesth/Analg Vag Delivery | \$1,573 | \$895 | 57% | \$403 | \$228 | 57% |
| 99203 Office/Outpatient Visit New | \$198 | \$129 | 65% | \$191 | \$132 | 69% |
| 99215 Office/Outpatient Visit Est | \$299 | \$182 | 61% | \$280 | \$182 | 65% |
| 88305 Tissue Exam by Pathologist | \$174 | \$85 | 49% | \$145 | \$61 | 42% |
| 99395 Prev Visit Est Age 18-39 | \$199 | \$144 | 72% | \$192 | \$143 | 74% |
| 00840 Anesth Surg Lower Abdomen | \$1,038 | \$589 | 57% | \$325 | \$180 | 55% |
| 00810 Anesth Low Intestine Scope | \$602 | \$342 | 57% | \$463 | \$266 | 57% |
| 90460 IM Admin 1 st /Only Component | \$55 | \$40 | 73% | \$41 | \$31 | 76% |
| 90471 Immunization Admin | \$39 | \$28 | 72% | \$39 | \$29 | 74% |
| 00670 Anesth Spine Cord Surgery | \$2,151 | \$1,132 | 53% | \$200 | \$105 | 53% |
| 00790 Anesth Surg Upper Abdomen | \$1,235 | \$681 | 55% | \$389 | \$210 | 54% |
| 97110 Therapeutic Exercises | \$60 | \$28 | 47% | \$56 | \$27 | 48% |
| 01402 Anesth Knee Arthroplasty | \$1,178 | \$623 | 53% | \$56 | \$48 | 86% |
| 95165 Antigen Therapy Services | \$207 | \$139 | 67% | \$24 | \$16 | 67% |
| 90461 IM Admin Each Addl Component | \$42 | \$25 | 60% | \$27 | \$17 | 63% |
| 97140 Manual Therapy 1/> Regions | \$59 | \$24 | 41% | \$53 | \$23 | 43% |
| 95004 Percut Allergy Skin Tests | \$112 | \$81 | 72% | \$11 | \$8 | 73% |
| 77052 Comp Screen Mammogram Add-On | \$17 | \$9 | 53% | \$11 | \$6 | 55% |
| 36415 Routine Venipuncture | \$15 | \$5 | 33% | \$15 | \$3 | 20% |
| 85025 Complete CBC w/Auto Diff WBC | \$24 | \$10 | 42% | \$20 | \$9 | 45% |
| 81002 Urinalysis Nonauto w/o Scope | \$11 | \$3 | 27% | \$10 | \$2 | 20% |

Data reflects paid amounts and charges for the top 25 Professional Current Procedural Terminology (CPT) codes by volume in 2016, submitted through claims from 33 commercial payers to the Colorado All Payer Claims Database (CO APCD). This analysis includes both in and out-of-network payments (approximately 95% of payments are in-network in Colorado), and includes CPTs with and without modifiers.

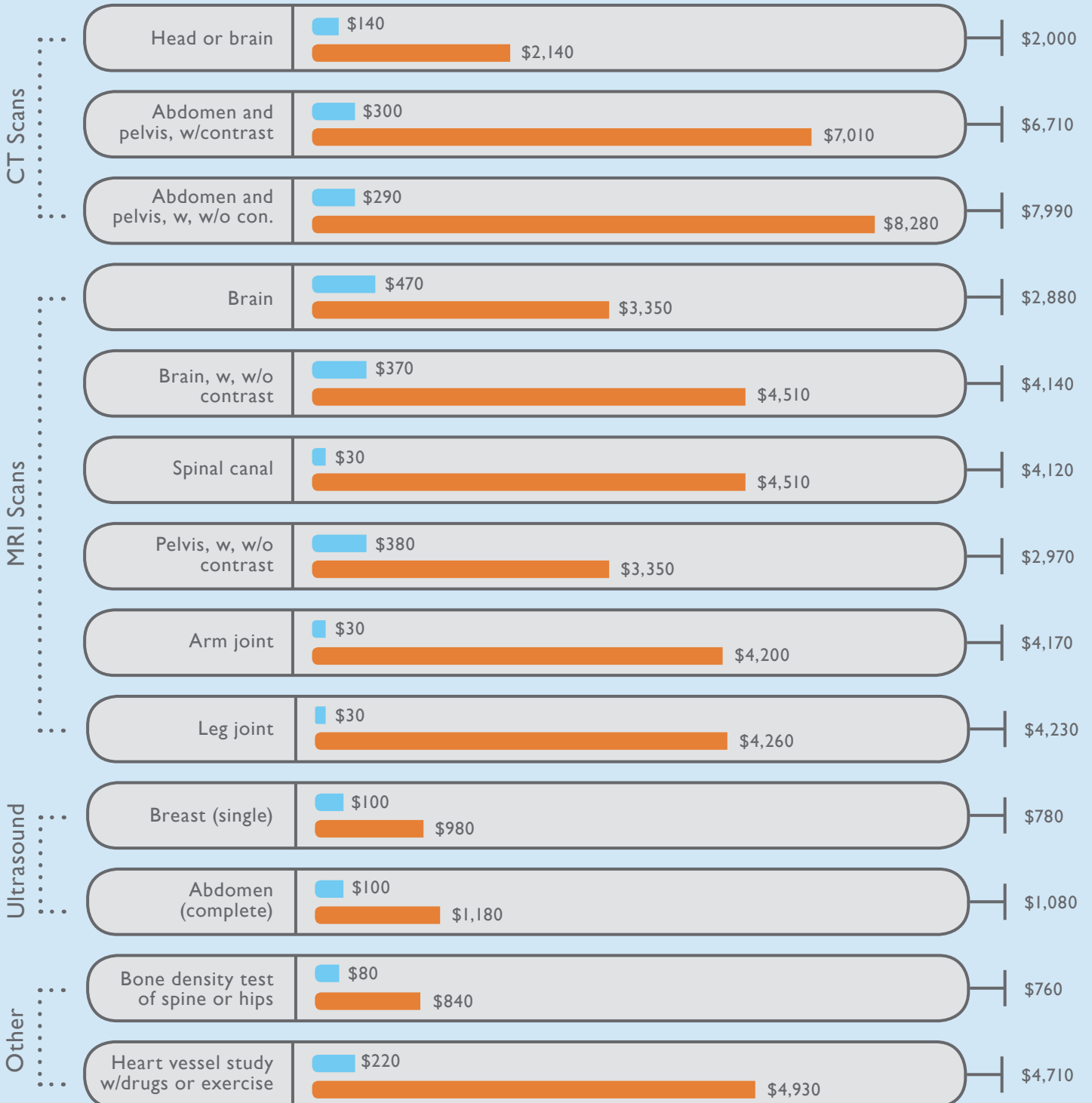


Cost of Imaging Procedures

Facility Cost and Quality Data Release
www.civhc.org/shop-for-care

MINIMUM / MAXIMUM

PRICE DIFFERENCE





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Colorado APCD Custom Data Scholarship Fund FY 2019 Application Information

Background

The Colorado General Assembly has appropriated \$500,000 to be used by the Department of Health Care Policy and Financing (HCPF) to offset the cost of licensing custom data and reports from the Colorado All Payer Claims Database (CO APCD) for eligible organizations. Pending state fund availability and continued use of scholarship dollars, it is anticipated that the fund will be renewed in succeeding fiscal years.

Note: The Colorado Department of Health Care Policy and Financing and the CO APCD Advisory Committee reserves the right to revise the following information at any time to ensure scholarships are maximized to benefit the citizens of Colorado.

Eligibility

- Non-profit organizations with annual revenues of \$10 million or less
- Governmental entities including state or local governmental entities and state-supported institutions of higher education

Application Deadlines

- **Scholarships are awarded on a first-come, first-served basis, so it is recommended to submit an application as early as possible.**
- **Note:** Scholarship eligible organizations can make more than one CO APCD data request in the same year

Eligible Projects:

Custom data sets and reports that inform and support projects to improve the Triple Aim are eligible. Examples include (but are not limited to):

- Evaluating benefit design and opportunities to reduce price variation
- Analyzing outcomes and cost benefit/ROI of programs such as palliative care and community-based care transitions work
- Developing alternative payment options such as bundled payments or population based per member/month payments for ACOs or medical home models

CO APCD data licensing fees vary by project type and are determined by the scope of work and resources needed for each project. See the tables on the following page for more details on approximate pricing, funding and matching fund requirements.



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Licensing Fees and Applicant Responsibility

Estimated Pricing by Product Type:

| | Range of Price* |
|-----------------------------------|-------------------|
| Standard Reports | \$500-\$7000 |
| Standard De-Identified Data Sets | \$15,000-\$25,000 |
| Custom De-Identified Data Sets | \$15,000-\$30,000 |
| Custom Limited Data Sets | \$20,000-\$40,000 |
| Custom Fully Identified Data Sets | \$30,000-\$50,000 |

*These are estimates. Actual cost of project will be determined by scope of each request.

Estimated Scholarship Responsibility by Requesting Organization Type:

| | Requestor Responsibility |
|---|-----------------------------|
| Federal and Out-of-State Governmental Entities | Up to 75% |
| Colorado-Based Governmental Entities | Up to 20% |
| Non-Profit Entities with Revenues less than \$10M | Up to 30% |
| Non-Profit Entities with Revenues between \$5M- \$10M | Up to 20% |
| Non-Profit Entities with Revenues less than \$5M | Up to 15% |
| State-Supported Institutions of Higher Education | Up to 15% |
| Colorado-Based Researchers | Up to 15% |
| Out of State Researchers | Up to 50% |



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How to Apply

To apply for the CO APCD scholarship fund, applicants must follow the existing APCD data request process administered by CIVHC. For detailed information about the data release application process, visit: <http://www.civhc.org/get-data/custom-data/>

For more information email ColoradoAPCD@civhc.org or call CIVHC directly at 720-583-2095.

¹ A Custom Report means any report generated based on the APCD that is not provided as a Public Facing Report available through <http://www.civhc.org/change-agents/>. Custom Reports contain a summary or analysis of data derived from the Colorado APCD database. A Custom Report will never display claims line or member level detail.

² De-Identification of Protected Health Information (PHI): Health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information (45 CFR § 164.514(a)).

³ Limited Data Set: A limited data set contains some protected health information data elements but must exclude the following direct identifiers of the individual or of relatives, employers, or household members of the individual (45 C.F.R. 164.514(e)(2))

⁴ Dataset refers to an excel file containing all requested data elements. Datasets contain only raw data without analytics.

DRAFT

HCPF/CO APCD Scholarship Application

Request Date
Date Submitted to HCPF
Project #

Approved by HCPF _____
Disapproved by HCPF _____
Reason for Disapproval: _____

| Project Information | |
|--|--|
| Project Title: | |
| Date: | |
| Organization Requesting Data: | |
| Contact Person: | |
| Title: | |
| E-mail: | |
| Phone Number: | |
| Person Responsible for the Project (if different than above): | |
| Title: | |
| E-mail: | |
| Phone Number: | |

Scholarship Eligibility:

- Non-profit, less than \$5M (include recent 990),**
- Research organization, less than \$5M (include budget document)**
- State agency**

Data Release Review Committee: [list date approved]

Project Purpose: [from application]

Research Questions to be addressed [from Application]

Type of Data Requested: [custom, limited data set, etc.]

Total: \$

Scholarship Request: \$

Data Requestor Portion: \$

Attachments Included:

- Application
- Supplemental Application
- Financial Document (i.e. 990, Budget, etc.)
- Data Release Fee (DRF)



CO APCD Advisory Committee Scholarship Proposal

Proposed CO APCD Advisory Committee Sub-Committee Structure (1 representative from each category):

- Consumer Advocate
- Academia with experience in health care data/research
- Non-profit health care representative (not a provider or payer)
- Commercial Payer/Employer representative
- Provider representative
- CO Dept. of Health Care Policy and Financing (HCPF)
- Non-HCPF State Agency

Proposed Process

- The Scholarship Grant Application (including the full project application and Data Release Fee) is provided to the Scholarship Subcommittee
 - The subcommittee will be emailed proposed application on a bi-weekly basis
 - The request will be 'tracked to ensure that emails are opened'
 - The subcommittee will have 5 business days to review the request
 - The subcommittee will be asked to voice an approval or disapproval by email response within the 5 business day window.
 - No-response will be taken as 'approval'.
 - If there are requests for additional details from the requestor the request will be given additional time to be reviewed and responded to.
 - A simple majority vote will be conducted on any project where there is varying opinion of whether to approve. This will be done after the group has been given all details to try and satisfy any concern about disapproval
 - CIVHC's Account Manager or designee will provide the summary of funds on a quarterly basis to the sub committee
 - If a grant application is approved, the Scholarship Subcommittee also has the responsibility of recommending a grant amount. CIVHC and HCPF have created a framework on the grant amounts for the Subcommittee's consideration.
- Once the project is approved by the CO APCD Advisory Committee's sub-committee, the project will be sent to HCPF for final approval.



CENTER FOR IMPROVING
VALUE IN HEALTH CARE

2018 Proposed Changes to the CO APCD Rule

The Colorado All Payer Claims Database (CO APCD) grows in scope and value each year, and as the Administrator, CIVHC continually looks for ways to evolve the database and realize the full potential of this powerful asset to help stakeholders advance the Triple Aim (better health, better care, lower costs). To this end, CIVHC suggests the following ways to continue to enhance the value of the CO APCD.

Collection of Alternative Payment Model Reimbursement Information

Why Collect Alternative Payment Model (APM) Data in the CO APCD?

- APMs represent an important and growing category of payments/reimbursement to providers as the Centers for Medicare & Medicaid (CMS) and other payers are signaling a shift toward Accountable Care models, MACRA and other episode-based payment initiatives
- Understanding APMs is important to track progress and understand the impact during the transition from the current Fee-for-Service (FFS) model to value-based purchasing (VBP)
- APMs are paid separately from fee-for-service claims and require a different type of data submission to the CO APCD

Benefit to Colorado

Information on APMs will contribute to a more complete understanding of the total amount spent on health care for Coloradans, both in total and for primary care services, and will allow the state to set goals, formulate strategies and track progress toward providing high value care.

How the Data Can Be Used

There are a growing number and variety of APMs being tested and we currently lack the ability to track spending and the number of patients receiving care under these models. Including data on APMs in the CO APCD would enable researchers, policy makers, health plans, providers and other stakeholders to establish baseline information regarding current spending levels and the number of patients receiving treatment under APMs (vs. traditional FFS) and track changes over time. Information on APMs will also contribute to a more comprehensive understanding of the total amount spent each year on health care. This information may also help identify the types of APMs that are most effective in reducing overall costs and inform development of policy solutions to address rising costs.

What APM Data and How Often Would CO Health Plans Submit?

The CIVHC APM data collection process will require submission of an annual supplemental file similar to the model currently used by the Oregon All Payer All Claims database (APAC). APMs types that have been identified for submission include: Global Budget; Limited Budget; Capitation – unspecified; Bundles/Episode Based Payment; Integrated Delivery System; Pay for Performance/Payment Penalty; and Shared Savings/Shared Risk. The submitted data allows analysis of spending through APMs compared to fee for service, stratified by geography, provider specialty and service type both overall/in total and for primary care services.

CO APCD submitters that provide comprehensive medical benefits will be required to submit an annual file reporting on all payments made on behalf of members. APM data fields include information that identifies providers, the payment amount, the number of member months attributable to each arrangement and the payment amounts for primary care through APMs and fee for service. Examples of the types of reports that may be based on this data include:

- Proportion of total medical spending under APMs both overall and for primary care
- Variation in spending and number of members covered by type of APM
- Types of APMs employed by provider specialty
- Spending and member volume trends by APM category and provider specialty

Collection of Prescription Drug Rebate Information

Why Collect Prescription Drug Rebate Information in the CO APCD?

In 2016, the Massachusetts Center for Health Information and Analysis (CHIA) CHIA researched and developed reporting requirements to collect drug rebate and other manufacturer price concession information in accordance with Federal laws. CIVHC proposes to use these specifications to implement a requirement for submission of prescription drug rebate information to the CO APCD.

Benefit to Colorado

Frequently, payers and pharmacy benefit managers receive discounts on prescription drugs in the form of rebates, discounts or other price concessions following reimbursement. While the CO APCD currently contains pharmacy claims, which includes how much was paid for the drug initially; it does not provide a complete picture of the total spent on prescriptions in Colorado. Aggregate information regarding prescription drug rebates will help Colorado better understand how much is actually being paid for prescription drugs by payer type, track trends, and identify opportunities to reduce spending.

How the Data Can Be Used

This data will allow stakeholders to investigate the effect of prescription drug rebates and other pharmaceutical manufacturer price concessions on aggregate cost growth trends. The data can be used in public reporting on pharmacy cost (see Cost of Care interactive reports at civhc.org), and in custom analyses and multi-state projects such as Total Cost of Care, and by local advocacy organizations, policy-makers and other stakeholders looking for ways to reduce pharmacy spending.

What Prescription Drug Rebate Information and How Often Would CO Health Plans Submit?

CIVHC will model the submission of prescription drug data on the requirements developed by Massachusetts. Aggregated prescription drug rebate data would be submitted once a year with information regarding the total amount of any prescription drug rebates and other pharmaceutical manufacturer price concessions paid by pharmaceutical manufacturers to a payer or their pharmacy benefit manager(s). Proposed data elements include:

- Total Pharmacy Expenditure Amount
- Pharmacy Expenditure Amount: Specialty Drugs
- Pharmacy Expenditure Amount: Non-Specialty Brand Drugs
- Pharmacy Expenditure Amount: Non-Specialty Generic Drugs
- Total Prescription Drug Rebate Amount
- Prescription Drug Rebate Amount: Specialty Drugs
- Prescription Drug Rebate Amount: Non-Specialty Brand Drugs
- Prescription Drug Rebate Amount: Non-Specialty Generic Drugs
- Per Member Per Month Pharmacy Expenditure Amount
- Per Member Per Month Prescription Drug Rebate Amount
- Combined Rebate Identifier
- Submitter/Payer Comments

Collection of Medicare Beneficiary Identifier

Why Collect Medicare Beneficiary Identifiers in the CO APCD?

Beginning in 2018, Centers for Medicare & Medicaid (CMS) transitioned to a new patient identifier called a Medicare Beneficiary Identifier (MBI). Submission of the new MBI number will enable CIVHC to update the CO APCD data warehouse and continue to report meaningful information for the Medicare population.

What is the timeline for CMS transition?

- The CMS transition period begins no earlier than April 1, 2018 and runs through December 31, 2019. During this window, business partners can use either the Health Insurance Claim Number (HICN) or the MBI to exchange data.
- After the transition period ends on January 1, 2020, MBIs should be used on claims with few exceptions.

CO APCD Plan During Transition Period (April 2018-Dec 2019)

- Expand the Subscriber Social Security Number fields (ME008, MC007, PC007) from a length of 9 to 11 to allow for the voluntary submission of MBI during the transition period beginning in April 2018.
- Modify the data intake validation process to accommodate Insurance Type/Product Code fields to allow both a 9 digit SSN or 11 character MBI.

CO APCD Plan Following Transition Period

- Add a new dedicated field to the CO APCD DSG to collect this new identifier.

June 25, 2018

Kim Bimestefer
Executive Director, Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Dear Executive Director Bimestefer,

Members of the Colorado All Payer Claims Database (CO APCD) Advisory Committee are providing this letter of support to the Center for Improving Value in Health Care (CIVHC) regarding the upcoming CO APCD rule change regarding modifying the Data Submission Guide (DSG). On an annual basis, CIVHC, in collaboration with the health insurance plan submitters and the Department of Health Care Policy and Finance (HCPF), propose new data elements for submission to the CO APCD to enhance the usability and comprehensiveness of the data set in order to provide more benefit to Colorado.

The CO APCD is the state's most comprehensive source of health care insurance claims information, and one of the most robust in the nation, representing the majority of covered lives in the state across commercial health insurance plans, Medicare, and Medicaid. As the non-profit administrator of the CO APCD, CIVHC is statutorily required to maintain and enhance the database while providing public and custom data analysis aimed at identifying ways to improve health and quality of care while lowering costs.

Annual DSG updates through the HCPF rule-making process enable CIVHC to continue to increase the value of the CO APCD by ensuring the data is as robust and useful as possible. This year's rule changes will help CIVHC continue to achieve the legislative intent of the CO APCD by adding these key elements to the database:

- **Alternative Payment Models (APM)**
 - Information on APMs being employed outside of the traditional fee-for-service model will contribute to a more complete understanding of the total amount spent on health care for Coloradans and will allow the state to set goals, understand best practices, formulate strategies and track progress toward providing high value care.
- **Prescription Drug Rebate Information**
 - Aggregate information regarding prescription drug rebates (collected in accordance with Federal laws) will help Colorado better understand how much is being paid for prescriptions drugs, track trends, and identify opportunities to reduce spending.
- **Medicare Beneficiary Identifier**
 - Beginning in 2018, Centers for Medicare & Medicaid (CMS) transitioned to a new patient identifier called a Medicare Beneficiary Identifier (MBI). Submission of the new MBI number will enable CIVHC to update the CO APCD data warehouse and continue to report meaningful information for the Medicare population.

We are committed to helping ensure that CIVHC and the CO APCD can continue to deliver independent, transparent data to support positive policy, thus insuring Colorado's position as a thought-leader and making us the healthiest state in the nation.

Sincerely,



Colorado State Representative Ginal

CO APCD Advisory Committee Chair on behalf of the following Committee Members and their organizations

Colorado All Payer Claims Database Advisory Committee Members 2018

Michelle Anderson - Director of Pharmacy Services Managed Care, Denver Health Medical Plan, Inc

Justin Aubert - Chief Financial Officer, Quality Health Network

Donna Baros - Chief Benefits Officer, CO PERA

Mitchell Bronson - Actuarial Statistician, Colorado Department of Regulatory Agencies

Matt Cassady - Compliance Director, Delta Dental of Colorado

Markie Davis - Manager, Employee Benefits and Risk Management, State of Colorado

Richard Doucet - CEO, Community Reach Center

Susan Euser - Vice President / Administration, Young Americans Center for Financial Education

Jack Feingold - VP, Account Development at WellDyne Rx

Joann Ginal - Colorado State Representative

Kristi Gjellum - Account Executive & Practice Lead, Employee Benefits, IMA, Inc.

Jon Gottsegen - Chief Data Officer, Governor's Office of Information Technology

Morgan Honea - CEO, CORHIO

Debra Judy - Policy Director, Colorado Consumer Health Initiative

David Keller - Professor and first Vice Chair, University of Colorado School of Medicine and Children's Hospital Colorado

Todd Lessley - VP for Population Health, Salud Family Health Centers

Philip Lyons - Director of Regulatory Affairs, United Healthcare

Janet McIntyre - Vice President, Professional Services, Colorado Hospital Association

Bert Miucco - CEO, HealthTeamWorks

David Ornelas – VP, Colorado Ambulatory Surgery Center Association (CASCA)

Bethany Pray - Healthcare Attorney, Colorado Center on Law and Policy

Wes Skiles - Director of Government Relations, Kaiser Permanente

Jim Smallwood – Colorado State Senator

Robert Smith – Executive Director, Colorado Business Group on Health

Jeanne Thrower Aguilar – Director of Benefits, Boulder Valley School District

Chris Underwood - Director, Health Information Office, HCPF Special Projects Coordinator, HCPF

Nathan Wilkes - Owner/Principal Consultant, Headstorms, Inc.

June 25, 2018

Kim Bimestefer
Executive Director, Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Dear Executive Director Bimestefer,

On behalf of the undersigned organizations, we are providing this letter of support to the Center for Improving Value in Health Care (CIVHC) regarding the upcoming CO APCD rule change regarding modifying the Data Submission Guide (DSG). On an annual basis, CIVHC, in collaboration with the health insurance plan submitters and the Department of Health Care Policy and Financing (HCPF), propose new data elements for submission to the CO APCD to enhance the usability and comprehensiveness of the data set in order to provide more benefit to Colorado.

The CO APCD is the state's most comprehensive source of health care insurance claims information, and one of the most robust in the nation, representing the majority of covered lives in the state across commercial health insurance plans, Medicare, and Medicaid. As the non-profit administrator of the CO APCD, CIVHC is statutorily required to maintain and enhance the database while providing public and custom data analysis aimed at identifying ways to improve health and quality of care while lowering costs.

Annual DSG updates through the HCPF rule-making process enable CIVHC to continue to increase the value of the CO APCD by ensuring the data is as robust and useful as possible. This year's rule changes will help CIVHC continue to achieve the legislative intent of the CO APCD by adding these key elements to the database:

- **Alternative Payment Models (APM)**
 - Information on APMs being employed outside of the traditional fee-for-service model will contribute to a more complete understanding of the total amount spent on health care for Coloradans and will allow the state to set goals, understand best practices, formulate strategies and track progress toward providing high value care.
- **Prescription Drug Rebate Information**
 - Aggregate information regarding prescription drug rebates (collected in accordance with Federal laws) will help Colorado better understand how much is being paid for prescriptions drugs, track trends, and identify opportunities to reduce spending.
- **Medicare Beneficiary Identifier**
 - Beginning in 2018, Centers for Medicare & Medicaid (CMS) transitioned to a new patient identifier called a Medicare Beneficiary Identifier (MBI). Submission of the new MBI number will enable CIVHC to update the CO APCD data warehouse and continue to report meaningful information for the Medicare population.

We are committed to helping ensure that CIVHC and the CO APCD can continue to deliver independent, transparent data to support positive policy, thus ensuring Colorado's position as a thought-leader and making us the healthiest state in the nation.

Sincerely,

Zach Wachtl, MD, FAAFP
President
Colorado Academy of Family Physicians

Steve Perry, MD, FAAP
President
American Academy of Pediatrics – Colorado Chapter

Annette Kowal
CEO
Colorado Community Health Network

Andy Fine, MD, FACP
Governor
American College of Physicians – Colorado Chapter

July 12, 2018

Via Email

Kim Bimestefer
Executive Director, Department of Health Care Policy and Financing
1570 Grant Street
Denver, Colorado 80203

Re: Support for All Payer Claim Database Rule Change

Dear Executive Director Bimestefer,

The undersigned organizations are providing this letter of support on the upcoming rule change to modify the Data Submission Guide (DSG) for the Colorado All Payer Claim Database (APCD). Annual DSG updates increase the APCD's value by ensuring the data is as robust, useful, and comprehensive as possible. This year's proposed rule changes will help us and other stakeholders enhance the Triple Aim by adding the following elements to the database:

- **Alternative Payment Models (APM)**
 - As APMs are a growing category of payments to providers, collecting data on them will contribute to a more complete understanding of the total amount spent on health care in Colorado. Currently, APMs are paid separately from fee for service claims and require a different type of submission. Including APM data in the APCD will allow Colorado to establish base information on usage, track changes over time, understand best practices, and inform development of policies to address rising health care costs.
- **Prescription Drug Rebate Information**
 - Aggregate information regarding prescription drug rebates, collected in accordance with federal laws, will help Colorado better understand how much is being paid for prescriptions drugs, track trends, and identify opportunities to reduce pharmacy spending.
- **Medicare Beneficiary Identifier**
 - Beginning in 2018, the Centers for Medicare & Medicaid transitioned to a new patient identifier called a Medicare Beneficiary Identifier (MBI). Submission of the new MBI number will enable the Center for Improving Value in Health Care to update the APCD data warehouse and continue to report meaningful information for the Medicare population.

In summary, we believe the APCD is a critical source of data to support health care policy in the state and we support efforts to enhance the comprehensiveness of the APCD. We urge HCPF to modify the DSG to add the elements described above to the APCD.

Sincerely,

Colorado Consumer Health Initiative
Colorado Center on Law and Policy
Mental Health Colorado

Chronic Care Collaborative
Colorado Organization for Latina Opportunity and Reproductive Rights
Colorado Chapter National Hemophilia Foundation
Stahlman Disability Consulting, LLC
Vertical Strategies
The Arc of Colorado
The Arc Arapahoe and Douglas Counties
Colorado Cross-Disability Coalition
Disability Law Colorado
Yondorf & Associates

Alzheimer's Association, Colorado Chapter



American Cancer Society Cancer Action Network

American Council of the Blind of Colorado

American Diabetes Association

American Heart Association

American Liver Foundation, Rocky Mountain Division

American Lung Association of Colorado

Arthritis Foundation Rocky Mountain Chapter

Brain Injury Alliance of Colorado

Colorado Coalition for the Medically Underserved

Colorado Gerontological Society

Colorado Health Network

Colorado Ovarian Cancer Alliance

Crohn's and Colitis Foundation of America, Rocky Mountain Chapter

easterseals Colorado

National Eczema Association

Epilepsy Foundation of Colorado

Huntington's Disease Society of America, Rocky Mountain Chapter

Komen Colorado

Leukemia and Lymphoma Society, Rocky Mountain Chapter

Liver Health Connection

Lupus Foundation of Colorado

Mental Health America of Colorado

Muscular Dystrophy Association

NAMI (National Alliance on Mental Illness) Colorado

National Hemophilia Foundation, Colorado Chapter

National Kidney Foundation of Colorado, Montana and Wyoming

National MS Society Colorado

June 25, 2018

Kim Bimestefer
Executive Director
Department of Health Care Policy and Financing

Via email

Dear Director Bimestefer,

The members of the Chronic Care Collaborative fully support the Center for Improving Value in Health Care (CIVHC) request for upcoming rule change the Data Submission Guidelines.

Our members have benefited from the data and analysis that CIVHC has provided regarding costs of prescription drugs. We support the entire request for updates to the Data Submission Guidelines. Of particular interest to our member voluntary health organizations is the information on prescription drug rebates. The costs of drugs impact our constituents/members directly and the enhanced information and transparency of data will assist us in both our direct work with constituents and through informing our policy work.

We urge rule making to encompass the elements related to Alternative Payment Models, Prescription Drug Rebates, and Medicare Beneficiary Identifier.

Sincerely,

Sharon O'Hara
Director

America's Health
Insurance Plans

601 Pennsylvania Avenue, NW
South Building
Suite Five Hundred
Washington, DC 20004

202.778.3200
www.ahip.org



Colorado Association of Health Plans
1370 Grant Street, second floor
Denver, CO 80203

February 20, 2018

Ms. Ana English
President and Chief Executive Officer
Center for Improving Value in Health Care
950 S. Cherry St. Ste. 208
Denver, CO 80246

Re: Proposed Revision of the Data Submission Guide for Colorado's All-Payer Claims Database - CORRECTED

Dear Ms. English:

We write today on behalf of America's Health Insurance Plans (AHIP) and the Colorado Association of Health Plans (CAHP) to convey our concerns regarding the new data element in the Data Submission Guide for Colorado's All-Payer Claims Database (APCD) that would require insurers to report monthly premiums paid by an enrollee or their employers for insurance coverage.

AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Our members are committed to providing consumers with affordable products that offer a broad range of robust provider networks of quality, cost-efficient providers.

CAHP is a state association of health insurers that are offering coverage to Coloradans. CAHP's membership includes Colorado specific carriers as well as national carriers. CAHP's mission is promoting high quality, affordable, evidence-based health care in Colorado.

We support efforts to provide greater transparency for health care costs, and the use of data to improve the quality of care. We believe that the APCD is one tool that can be helpful for this purpose. However, we have concerns regarding the utility and appropriateness of proposed revisions requiring the submission of premium data for these purposes.

Premium Data Offers Very Little Value as an APCD Data Element

Premium data is not reflective of the quality of care, nor is it reflective of specific data with respect to the cost of health care. Other data collected by APCDs is a much better barometer for

assessing quality (e.g., facility outcomes data) than premium data. Premiums are also not a driver of health care costs, but rather the rise in premiums is attributable, in part, to increases in the cost of care. There are also many factors that are unrelated to the cost of care, such as the implementation of new regulations and mandates, that can affect premiums.

Furthermore, consumers already have access to information about premium rates in the individual and small group market. Large group premiums are often the result of negotiations that consider factors that are unique to each employer

AHIP and CAHP have consistently objected to the inclusion of this information in informal and advisory stakeholder meetings. Premiums reflect the cost of health coverage and not the cost of care. The data within the APCD is not realtime data. Therefore, adding premium information that is not current would only serve confuse consumers.

Last, the inclusion of premium information does not seem to fit the requirements of 25.5.1.204 (5), C.R.S., and therefore AHIP and CAHP seek clarification of the statutory authority to make this proposed revision.

The Inclusion of Large Group Premium Data in the APCD has the Potential to Expose Sensitive Information Regarding Insurer's Business Operations

As mentioned above, large group premiums are often the result of negotiations that consider factors that are unique to each employer. This information offers insight into the proprietary information insurers may use in their contractual negotiations that are typically confidential. The release of this information will have a detrimental impact on Colorado's insurers. Moreover, there is no public benefit to be gained by the release of this information.

If this proposal is implemented, it will make Colorado an outlier and at odds with other APCDs in terms of required data elements with no consumer benefit. This information will not give the public greater insight into health care costs and only expose proprietary information.

We appreciate this opportunity to provide comments on this proposal. If you have any questions, please do not hesitate to contact Sara Orrange at sorange@ahip.org or (703-587-7873); or Julie Mowry at jahoerner@comcast.net or (303-985-2349).

Sincerely,



Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans

Julie Hoerner Mowry
Retained Counsel
Colorado Association of
Health Plans

Cc. Kim Bimestefer, Executive Director
Health Care Policy & Financing



March 26, 2018

Julie Hoerner Mowry
Retained Counsel
Colorado Association of Health Plans

Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans

Dear Ms. Mowry and Ms. Orrange:

Thank you for your response to the proposed changes to the 2018 Colorado All Payer Claims Database (CO APCD) Data Submission Guide (DSG). As Administrator of the CO APCD, the Center for Improving Value in Health Care (CIVHC) welcomes the opportunity to discuss concerns regarding proposed rule changes and modifications to the DSG. I am today writing to notify you that, based on input from a variety of stakeholders and after consultation with the Executive Director of the Colorado Department of Health Care Policy and Financing, CIVHC has decided not to pursue collection of premium information for the 2018 CO APCD DSG.

In relaying CIVHC's decision not to include premium information this year, we want to be clear that it remains CIVHC's position that the planned collection, use, and dissemination of health insurance premium data from payers is permissible under Colorado law, is consistent with national trends, does not violate any trade secret laws, and is lawful under the antitrust laws for the same reasons and to the same extent that CIVHC's current data practices are lawful. Colorado Revised Statutes (C.R.S. 25.5-1-204 (2015)) describes the CO APCD's established mission as "facilitating the reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs." Monthly insurance premiums make up a large portion of annual health care expenditures for consumers and employers alike; inclusion of this data element will ultimately provide stakeholders the opportunity to determine the full cost of care in Colorado to a closer degree than ever before.

Moreover, there is national precedent for inclusion of premium information in the CO APCD. Several APCDs already collect insurance premium amounts from health plans in their states, including New Hampshire, Massachusetts, Connecticut, and Oregon. Additionally, the US Department of Labor proposed development of a Common Data Layout (CDL) in order to standardize data collection and formatting. A number of large national payers participated in the development of the CDL alongside APCDs from across the nation, including Colorado. Insurance premium data are included in the CDL, and CIVHC's proposal to include such information in the 2018 DSG merely aligns the CO APCD with these

national standardization efforts. Alignment of the data elements has been an ongoing request of the health plan data submitters who submit to multiple state APCDs.

Changes to the 2018 CO APCD DSG

The remaining proposed modifications to the 2018 CO APCD DSG include collection of reimbursement information for Alternate Payment Methods (APMs) in the following categories: Global Budget; Limited Budget; Capitation – Unspecified; Bundled/Episode Based Payment; Integrated Delivery System; Pay for Performance Payment/Penalty and; Shared Savings/Shared Risk. After further discussion with the Executive Director, we have also decided to include the collection of gross prescription drug claim information as well as net (after rebate) prescription drug claim information in the 2018 DSG. Similar to the APMs, payers will be required to submit this data annually for a three-year look back period by June 30th of each year. Other 2018 CO APCD DSG changes, as previously reviewed, include the collection of the Medicare Beneficiary Identifier (MBI) and minor DSG clarification items.

CIVHC is committed to providing timely, actionable, and credible data that supports change agents working to advance the Triple Aim of lower costs, improved care, and healthy Coloradans. Should further discussion be necessary, we are happy to meet at your convenience.

Sincerely,

Ana English
President and CEO

Cc: Kim Bimestefer, Executive Director, Healthcare Policy & Financing





June 15, 2018

Ms. Ana English
President and Chief Executive Officer
Center for Improving Value in Health Care
950 S. Cherry St. Ste. 208
Denver, CO 80246

Re: Proposed Revision of the Data Submission Guide for Colorado's All-Payer Claims Database – Alternative payment model and Prescription drug rebate information

Dear Ms. English:

We write today on behalf of America's Health Insurance Plans (AHIP) and the Colorado Association of Health Plans (CAHP) to convey our concerns regarding the new data element in the Data Submission Guide for Colorado's All-Payer Claims Database (APCD).

AHIP is the national association whose members provide coverage for health care and related services. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers. Our members are committed to providing consumers with affordable products that offer a broad range of robust provider networks of quality, cost-efficient providers.

CAHP is a state association of health insurers that are offering coverage to Coloradans. CAHP's membership includes Colorado specific carriers as well as national carriers. CAHP's mission is promoting high quality, affordable, evidence-based health care in Colorado.

We support efforts to provide greater transparency for health care costs, and the use of data to improve the quality of care. We believe that the APCD is one tool that can be helpful for this purpose. However, the new data elements are significant and will not further these goals. Further, the collection of this data appears to exceed the legislative and regulatory scope of Colorado's APCD.

Drug Rebate Information:

As a threshold matter, the cost and affordability challenges stemming from the persistently increasing costs of prescription drugs are primarily and substantially a function of prescription drug list prices and sub-optimum utilization of readily available, yet substantially cheaper generic prescription drugs. While health insurers utilize a number of cost-containment strategies, including in-house or contractual partnerships with pharmacy benefit managers (PBMs) to negotiate and control the costs of prescription drugs on behalf of their members, drug list prices – set only by the drug manufacturers – represent the most determinative factor regarding any specific prescription drug's price and affordability, or lack thereof, for consumers. We question the value that prescription drug rebate information, reported by plans to Colorado's APCD and the Center for Improving Value in Health Care (CIVHC), will add to Colorado's health care cost transparency landscape.

Oregon and Massachusetts are cited as models for the collection of both the drug rebate data and alternative payment model (APM) data. However, with respect to the drug rebate data, what CIVHC is proposing goes beyond what is collected in Massachusetts. Massachusetts payers are not required to report commercial full-claim and commercial-partial claim members separately. Massachusetts payers are also not required to report separate commercial fully and self-insured observations.

CAHP's and AHIP's memberships also hold significant concerns regarding the sensitive and proprietary nature of this data and are concerned that sufficient safeguards have not been put in place to maintain the confidentiality of this competitively sensitive information. The reporting of even aggregated data can expose health insurers to the risk that confidential, proprietary, and or trade secret information could be disclosed and utilized in ways that result in anti-competitive impacts that drive less competition and higher prices for consumers. The Federal Trade Commission (FTC) has repeatedly expressed concern that the disclosure of sensitive business data of this kind will harm competition because the disclosure of this type of information runs the risk of restricting the ability of plans to effectively negotiate money-saving contracts with pharmacies.¹ The FTC has further stated that a decrease in competition in drug pricing and a weakening of payers' ability to negotiate will cause drug prices to increase, thus harming consumers and advancing the opposite result of APCD's intended purpose in considering these changes.² Moreover, in some cases, drug discount or rebate information may be subject to confidentiality provisions in contracts with manufacturers.

Finally, there is a lack of clarity regarding the goals and expectations for how this data will be used. Given the sensitive nature of this data, there should be a more robust public process in policy decisions about the collection of rebate data. This would be best achieved through the

¹ "FTC Staff Letter Concerning Mississippi Senate Bill 2445." Letter to The Honorable Mark Formby, Mississippi House of Representatives. March 22, 2011.

² https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.terry-g.kilgoreconcerning-virginia-house-bill-no.945-regulate-contractual-relationshipbetween-pharmacy-benefit-managers-andboth-health-benefit/v060018.pdf

legislative process. For example, Massachusetts' legislature specifically provided statutory authority to the APCD to "consider the effect of drug rebates and other price concessions in the aggregate without disclosure of any product or manufacturer-specific rebate or price concession information, and **without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price.**"³

The enacting legislation for Colorado's APCD does grant CIVHC some latitude in determining what data may be collected to facilitate the reporting and analysis of information that improves Coloradans' health and care experience and that helps control costs. However, CAHP and AHIP are respectfully seeking clarification on the specific statutory authority to require the submission of rebate information. Further, we would welcome a more deliberative process, such as that seen in Massachusetts, before drug rebate data is mandated to be reported.

Alternative Payment Model Data:

Colorado should work to simplify the collection and submission of APM data. It is important to note that the collection of this data in Oregon has not been without significant challenges.

With respect to APM data, Oregon's Health Authority noted⁴ the following issues:

- Not all payers have the same definition of APM categories;
- APM contracts have different performance periods; and
- Identifying claims-based payments captured in typical APCD files as being part of APM is challenging.

Oregon worked to simplify its submission process for this information. Payers in Oregon are required to submit separate APM files annually, and APM file data is never combined with claims based APCD data.⁵

Additional Comments & Concerns:

For the foregoing reasons, CAHP and AHIP oppose these data submission changes. However, if these changes are approved, we suggest the following technical corrections:

- The DSG should clarify what identifier will be used in fields MC008, ME009, PC008.
- The DSG should define "non-claim payment amount" and "claim payment amount."
- The data element numbers for the "Medicare Beneficiary Identifier" field included in the Pharmacy Claims file Appears to contain a typo. While the other data elements in the Pharmacy Claims files as numbered as PCXXX with a three-digit number following the PC, the Medicare Beneficiary Identifier field is numbered as PC0050.

³ M.G.L.A. 12C § 16, MA ST 12C § 16

⁴ Bernstein, Tanya, and Stacey Schubert. "Collecting Data on Alternative Payments Models as Part of an APCD - Oregon's Process and Lessons Learned Along the Way." October 4, 2017. Accessed May 25, 2018. https://www.nahdo.org/sites/nahdo.org/files/Tayna%20-%20Oregon%20NAHDO%20presentation_final.pdf

⁵ Id.

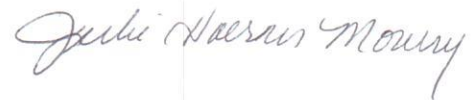
- The Medicare Beneficiary Identifier (MBI) will likely not be available until late 2018 or early 2019. Some of our members do not have the ability to collect and submit both Health Insurance Claim Number and the MBI. Once the MBIs are made available by CMS, carriers will need to make changes to their data warehousing systems to enable the collection and reporting of this information. Therefore, in order to grant carriers enough time to comply with the new reporting requirement, we would suggest that the effective date for the required submission of the MBI be delayed until January 1, 2020.
- If APM and drug rebate data are required to be submitted,
 - This data should be submitted as an Excel spreadsheet. This would lessen the administrative burden on carriers and is consistent with how other APCDs are collecting this information.
 - The APCD should clarify that rebate reporting will be considered proprietary and confidential; and therefore, such data should be limited to Colorado's state agency use and such data shall be exempted from submission to the APCD data release regulations permitted for private entities under 10 CCR 2505-5.1.200.5.A; or
 - Additional protections or specifications in the APCD Rule/Regulation should be developed to clarify which specific elements are subject to disclosure from the Rebate Report fields provided in the DSG with discretion by the DRRC Privacy Board and may only be disclosed by APCD at an aggregate level and may not be subject to disclosure under the Colorado Public (Open) Records Act.

We appreciate this opportunity to provide comments on this proposal. If you have any questions, please do not hesitate to contact Sara Orrange at sorange@ahip.org or (703-887-5285); or Julie Mowry at jahoerner@comcast.net or (303-985-2349).

Sincerely,



Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans



Julie Hoerner Mowry
Retained Counsel
Colorado Association of
Health Plans

Cc. Kim Bimestefer, Executive Director
Health Care Policy & Financing



July 9, 2018

Julie Hoerner Mowry
Retained Counsel
Colorado Association of Health Plans

Sara Orrange
Regional Director, State Affairs
America's Health Insurance Plans

Dear Ms. Mowry and Ms. Orrange:

Thank you for your response to the proposed changes to the 2018 Colorado All Payer Claims Database (CO APCD) Data Submission Guide (DSG). As Administrator of the CO APCD, the Center for Improving Value in Health Care (CIVHC) welcomes the opportunity to discuss concerns regarding proposed rule changes and modifications to the DSG. Your letter touches on a number of discussion-worthy topics; in order to provide the most thorough responses possible, we address each in turn below.

CO APCD: Scope of Authority

The Colorado General Assembly created the CO APCD in 2010 to enhance and promote quality and cost transparency in Colorado's health care market. The CO APCD is authorized and governed by C.R.S. § 25.5-1-204 (the "Statute") and its implementing regulations, including 10 CCR 2505-5, § 1.200.

The Statute directs CIVHC, in its role as CO APCD Administrator, to take actions in support of the CO APCD mission to facilitate the reporting of health care and health quality data that results in "transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs."

It is our position that the broad statutory mandate of the CO APCD clearly authorizes CIVHC to collect drug rebate and alternative payment model ("APM") information, since both data elements are part of and related to health care cost and health care spending in Colorado.

CIVHC's Stakeholder Engagement

It is also suggested that CIVHC engage in a more "deliberative process" before conducting a public rulemaking to propose the addition of new mandatory data elements to CIVHC's Data Submission Guide. CIVHC solicits feedback on proposed regulatory changes in a number of ways, as described in more detail below, via CIVHC's regular payer connect calls and via engagement of the multi-stakeholder CO APCD Advisory Committee. The Committee's express purpose is to advise CIVHC on data collection and dissemination practices to ensure consistency with the CO APCD's statutory mandate. Moreover, CIVHC regularly consults with its regulators at the Colorado Department of Health Care Policy and Financing ("HCPF") and the Colorado Attorney General's office to ensure that its data collection, storage and dissemination practices are permissible under applicable law and are consistent with the Department's goals for the CO APCD.

For the reasons described herein, collection of APM and pharmacy rebate data is supported by the CO APCD Advisory Committee. The Committee signed a letter stating that the proposed new elements are essential and necessary to understand the true costs of pharmaceuticals in Colorado and the impact of the APMs being implemented in Colorado. The Committee also advises CIVHC regarding public reporting of CO APCD data in accordance with the Committee's legislative mandate.

Anti-Trust / Trade Secret Concerns

CIVHC disagrees with the suggestion that the reporting of aggregated data about drug rebate information would expose health insurers to the risk that confidential, propriety, or trade secret information could be disclosed with an anti-competitive impact or that CO APCD data releases could result in higher prices for consumers.

There are careful limitations on the data that organizations (and the general public) can receive from the CO APCD. CIVHC releases data in two ways – via highly aggregated public reports and via non-public data releases. All CO APCD data releases are subject to HIPAA restrictions and state legal and regulatory restrictions to protect privacy. Non-public data releases are extensively vetted by the Data Release and Review Committee (“DRRC”) and legal counsel to ensure consistency with the CO APCD statute and applicable state and federal law, including, but not limited to, the following considerations:

1. In keeping with the “minimum necessary” standard established under HIPAA, applicants for a non-public data release must demonstrate need and provide justification for each data element requested. The DRRC will recommend and the CO APCD Administrator will release only those data elements that are specifically necessary to accomplish the applicant's intended use.
2. Protected Health Information (PHI) may only be released in limited circumstances for public health, health care operations and pre-approved research purposes in accordance with HIPAA and applicable law, and can never be shared publicly as a result of a research project or program.
3. For research-related requests, applicants may be required to show written approval from an Institutional Review Board or a Privacy Board as part of the Application.
4. Data recipients are required to enter into a Data Use Agreement with CIVHC in which data recipients agree:
 - To treat CO APCD Data confidentially and not to use, or enable any other parties to use, the CO APCD Data for anticompetitive or other unlawful purposes, including but not limited to price-fixing, market or customer allocation, service or output restriction, price stabilization, or any other agreement or coordination among parties that in any way restricts or limits competition.
 - Data will be used only for the purpose stated in the Application.
 - No attempt will be made to use any data supplied to ascertain the identity of specific insured individuals or patients, or to report data at a level of detail that could permit a reader to ascertain the identify of specific insured individuals or patients, nor will downstream linkages to outside data sources occur without specific authorization from the CO APCD Administrator.
 - Restricted data elements such as PHI will not be released except as specifically approved in the original Application and Data Use Agreement.

Higher Quality. Lower Cost. A Healthier Colorado.



- The Applicant will obtain these assurances in writing from any recipient of data or agent that processes data on behalf of the Applicant.
- The data will not be re-released in any format to anyone except personnel identified and approved in the original Application and Data Use Agreement

Given the stringent application and review process for public and non-public data releases, CIVHC disagrees that the collection, use, and dissemination of drug rebate or APM information would have any anti-competitive effect or pose any harm to health insurance companies' true trade secrets.

Value of Collecting Drug Rebate Information

Little is known about the amount of drug rebates paid by pharmaceutical manufacturers and pharmacy benefit managers (PBMs) to health care payers in Colorado. Currently, there is aggregated cost of care information publicly available¹; however, without the inclusion of pharmacy rebate and APM data, the information is limited in its use. For example, public cost of care information is broken down by pharmaceutical, inpatient, outpatient and professional costs and without the aggregate pharmacy rebate information, pharmaceutical costs are inflated. Across the four service categories, pharmacy costs in Colorado have risen the most since 2012 (27%), yet we are not certain how costs are being offset by rebates, if at all. Thus, at present, there is not an understanding of the true impact of pharmacy costs on our state.

HCPF has expressed concern that pharmaceutical spending calculated based on claims data in the CO APCD does not accurately reflect actual payments because of the lack of information on drug rebates. Additionally, pharmaceutical spending estimates, calculated based on drug list prices, may result in inaccurate estimates of actual payments for prescription drugs and render comparisons across payer types of limited value. Accounting for pharmacy rebates will enable Colorado to more fully understand cost drivers to address areas of concern. National projects like the Network for Regional Healthcare Improvement (NRHI) Total Cost of Care project² will also benefit from this data collection, as Colorado will be able to report true aggregate pharmacy costs for comparison to other states.

Clearly, the proposed collection of highly aggregated drug rebate data will allow a better understanding of the total annual spend on prescription drugs, facilitate more meaningful comparisons across payer types, allow the tracking of changes and trends over time, and provide a baseline against which future performance of the health care system can be compared and better understood.

Each payer would submit this information in the aggregate for three very broad product categories: specialty drugs, and non-specialty branded and generic drugs. No drug manufacturer will be identified in this data and no individual drug, therapeutic class or other level of product detail is requested. Because the data requested is so highly aggregated, there are no anti-trust or trade secret related concerns and such limits would not be appropriate or necessary.

Furthermore, with such highly aggregated data, there is no possibility of reverse engineering the price or rebate paid by any drug company to a specific payer for individual drugs or categories thereof. These proposed requirements were designed based on similar requirements established in Massachusetts. Because CIVHC is an independent non-profit organization administering the CO APCD on behalf of the State of Colorado, we are not subject to the Colorado Public (Open) Records Act.

In future revisions to the DSG, CIVHC will clarify that the proposed drug rebate data submission requirement applies to those health plans providing primary coverage and emphasize that our intention

¹ See <http://www.civhc.org/get-data/public-data/interactive-data/cost-of-care/>.

² See <http://www.civhc.org/programs-and-services/national-initiatives/total-cost-of-care/>.



is not to require submission of this information from partial-claim or supplemental health insurance plans. While both fully-insured and non-ERISA self-funded health plans will be required to submit aggregated drug rebate information, there is no requirement that payers report separately for these types of commercial insurance products.

Alternative Payment Models

CIVHC relied heavily on the Oregon model for collecting APM information because the commercial health insurance plans operating in Oregon are similar to those operating in Colorado. After significant research and communication with various stakeholders, we feel that the APM categories established in Oregon will be appropriate for purposes of collecting this same information in Colorado.

We are proposing to collect this information once per year in a supplemental Excel file 9-months after the end of the most recent calendar year. This follows submission schedules and timelines established in Oregon and will allow adequate time for payers to generate this information and submit to the CO APCD consistent with the proposed timeline, performance period and other requirements.

CIVHC is not requiring that payers report APM information in the same format as claims data. Claims data is submitted by payers monthly whereas the supplemental Excel APM file will be submitted annually. The proposed APM submission format follows the Oregon example, is much simpler than that required for claims data and can be generated and submitted by payers in the form of an Excel spreadsheet. Similar to Oregon, Colorado will not attempt to combine the APM data with claims data.

Additional Comments and Concerns

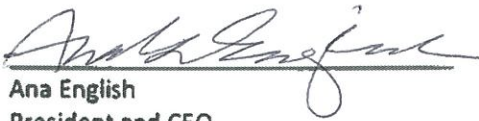
- CIVHC proposes that both the APM and drug rebate data be submitted once per year in the form of a supplemental Excel spreadsheet consistent with similar requirements in other states to lessen carrier administrative burden.
- The fields MC008, ME009 and PC008 have been part of the CO APCD claims data submission requirements since 2012. Per the CO APCD Data Submission Guide, these fields are to be populated with “the (health) plan assigned contract number.” These fields are not part of either the proposal to collect APM or drug rebate information.
- Both non-claim payment amount and claim payment amount are defined on pages 68 and 69 of the DRAFT Data Submission Guide (DSG), version DSG V10, dated 6.21.2018. Non-claims payment amounts are to be reported in the categories of Alternative Payment Models as defined in look-up Table B.1.J on pages 92 and 93 of DSG V10.
- Thank you, the typo in the Medicare Beneficiary Identified (MBI) field has been corrected.
- The MBI requirement will be changed to optional at this time. As the CMS established phase in period comes to a close, this will become a required field.

In addition to the broad statutory mandate of the CO APCD to collect drug rebate and APM information, the Division of Insurance is willing to request the information as well if necessary.



CIVHC is committed to providing timely, actionable, and credible data that supports change agents working to advance the Triple Aim of lower costs, improved care, and healthy Coloradans. Should further discussion be necessary, we are happy to meet at your convenience.

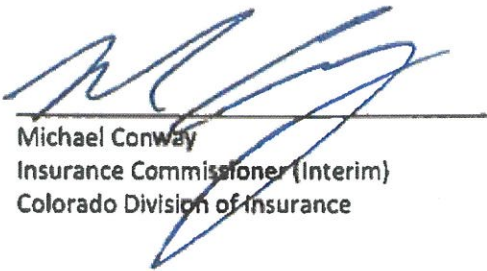
Sincerely,



Ana English
President and CEO
Center for Improving Value in Health Care



Kim Bimestefer
Executive Director
CO Department of Health Care Policy and Financing



Michael Conway
Insurance Commissioner (Interim)
Colorado Division of Insurance





June 15, 2018

Ms. Ana English
President and Chief Executive Officer
Center for Improving Value in Health Care
950 S. Cherry St. Ste. 208
Denver, CO 80246

Re: Proposed Revision of the Data Submission Guide for Colorado's All-Payer Claims Database
– Alternative payment model and Prescription drug rebate information

Dear Ms. English:

On behalf of the Pharmaceutical Care Management Association (PCMA) we would like to express our concerns over the recent proposed changes in the data submission requirements for Colorado's All-Payer Claims Database (APCD). PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 266 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

PBMs exist to make drug coverage more affordable, by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help health care consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though unions, large employers, and public programs are not *required* to use PBMs, most *choose* to because PBMs help lower the costs of prescription drug coverage.

We agree that the rising cost of pharmaceuticals in this country is a serious problem, but we believe that CIVHC's new proposed rebate data collection is counterproductive and could actually *raise* drug prices without proper safeguards.

The CIVHC required reporting of pharmaceutical rebate data by Colorado's health plans is most likely based on the mistaken belief that this type of information would lower drug prices. We believe that it is important that there be a competitive marketplace among drug manufacturers in order to drive down the cost of prescription medications. Any public disclosure of rebate information would allow manufacturers to learn what type of price concessions other manufacturers are giving, thus establishing a disincentive from offering deeper discounts. The Congressional Budget Office (CBO) has noted that disclosure requirements could allow firms to



“observe the prices charged by their rivals, which could lead to reduced competition.”¹ According to CBO, the “disclosure of rebate data would probably cause the variation in rebates among purchasers to decline” leading to a “compression in rebates.”² Additionally, The Federal Trade Commission (FTC) has stated that, “[i]f pharmaceutical manufacturers learn the exact amount of rebates offered by their competitors, then tacit collusion among them is more feasible” and “[w]henver competitors know the actual prices charged by other firms, tacit collusion — and thus higher prices — may be more likely.”³ The FTC has also warned that legislation requiring disclosure of negotiated terms could increase costs and “undermine the ability of some consumers to obtain the pharmaceuticals and health insurance they need at a price they can afford.”⁴

Finally, PCMA questions the appropriateness of collecting rebate information for inclusion in a claims database. Rebates are not paid claims and are part of private contracts between two business entities, and therefore, should not be included in the submission guidelines.

PCMA respectfully expresses concerns over CIVHC’s new All-Payer Database requirements on collecting proprietary rebate information. Please contact me at 270-454-1773 if you would like to discuss our concerns. Thank you.

Sincerely,

A handwritten signature in black ink, appearing to read "Melodie Shrader". The signature is fluid and cursive, written in a professional style.

Melodie Shrader
Regional Director, State Affairs

¹“Increasing transparency in the pricing of health care services and pharmaceuticals,” Congressional Budget Office, Jun. 5, 2008.

² Letter to Rep. Joe Barton and Rep. Jim McCrery, U.S. House of Representatives, Congressional Budget Office, Mar. 12, 2007.

³ Letter from FTC to Rep. Patrick T McHenry, U.S. Congress, (July 15, 2005); Letter from FTC to Assemblyman Greg Aghazarian, California State Assembly, (September 3, 2004).

⁴ US Federal Trade Commission & US Department of Justice Antitrust Division, “Improving Health Care: A Dose of Competition,” July 2004.



CENTER FOR IMPROVING
VALUE IN HEALTH CARE

950 S. CHERRY ST., SUITE 208 | DENVER, COLORADO 80246
PHONE 720.583.2095 | FAX 720.549.9189 | WWW.CIVHC.ORG

July 11, 2018

Melodie Shrader
Regional Director, State Affairs
Pharmaceutical Care Management Association
325 7th Street, NW, 9th Floor
Washington, DC, 20004

Dear Ms. Shrader:

Thank you for your response to the proposed changes to the 2018 Colorado All Payer Claims Database (CO APCD) Data Submission Guide (DSG). As Administrator of the CO APCD, the Center for Improving Value in Health Care (CIVHC) welcomes the opportunity to discuss concerns regarding proposed rule changes and modifications to the DSG. Your letter touches on a number of discussion-worthy topics; in order to provide the most thorough responses possible, we address each in turn below.

Appropriateness of Collecting Drug Rebate Information in a Claims Database

The Colorado General Assembly created the CO APCD in 2010 to enhance and promote quality and cost transparency in Colorado's health care market. The CO APCD is authorized and governed by C.R.S. § 25.5-1-204 (the "Statute") and its implementing regulations, including 10 CCR 2505-5, § 1.200.

The Statute directs CIVHC, in its role as CO APCD Administrator, to take actions in support of the CO APCD mission to facilitate the reporting of health care and health quality data that results in "transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs."

It is our position that the broad statutory mandate of the CO APCD clearly authorizes CIVHC to collect drug rebate and alternative payment model ("APM") information, since both data elements are part of and related to health care cost and health care spending in Colorado.

Anti-Trust / Trade Secret Concerns

CIVHC disagrees with the suggestion that the reporting of aggregated data about drug rebate information would expose health insurers to the risk that confidential, propriety, or trade secret information could be disclosed with an anti-competitive impact or that CO APCD data releases could result in higher prices for consumers.

There are careful limitations on the data that organizations (and the general public) can receive from the CO APCD. CIVHC releases data in two ways – via highly aggregated public reports and via non-public data releases. All CO APCD data releases are subject to HIPAA restrictions and state legal and regulatory restrictions to protect privacy. Non-public data releases are extensively vetted by the Data Release and Review Committee ("DRRC") and legal counsel to ensure consistency with the CO

APCD statute and applicable state and federal law, including, but not limited to, the following considerations:

1. In keeping with the “minimum necessary” standard established under HIPAA, applicants for a non-public data release must demonstrate need and provide justification for each data element requested. The DRRC will recommend and the CO APCD Administrator will release only those data elements that are specifically necessary to accomplish the applicant's intended use.
2. Protected Health Information (PHI) may only be released in limited circumstances for public health, health care operations and pre-approved research purposes in accordance with HIPAA and applicable law, and can never be shared publicly as a result of a research project or program.
3. For research-related requests, applicants may be required to show written approval from an Institutional Review Board or a Privacy Board as part of the Application.
4. Data recipients are required to enter into a Data Use Agreement with CIVHC in which data recipients agree:
 - To treat CO APCD Data confidentially and not to use, or enable any other parties to use, the CO APCD Data for anticompetitive or other unlawful purposes, including but not limited to price-fixing, market or customer allocation, service or output restriction, price stabilization, or any other agreement or coordination among parties that in any way restricts or limits competition.
 - Data will be used only for the purpose stated in the Application.
 - No attempt will be made to use any data supplied to ascertain the identity of specific insured individuals or patients, or to report data at a level of detail that could permit a reader to ascertain the identify of specific insured individuals or patients, nor will downstream linkages to outside data sources occur without specific authorization from the CO APCD Administrator.
 - Restricted data elements such as PHI will not be released except as specifically approved in the original Application and Data Use Agreement.
 - The Applicant will obtain these assurances in writing from any recipient of data or agent that processes data on behalf of the Applicant.
 - The data will not be re-released in any format to anyone except personnel identified and approved in the original Application and Data Use Agreement

Given the stringent application and review process for public and non-public data releases, CIVHC disagrees that the collection, use, and dissemination of drug rebate or APM information would have any anti-competitive effect or pose any harm to health insurance companies’ true trade secrets.

Rationale Behind Collecting Drug Rebate Information

As stated in the CO APCD enabling statute referenced earlier, one of the charges given to CIVHC as the Administrator of the database, is to fulfill the mission of the CO APCD through *reporting and analysis of health care spending in Colorado*. It is for this reason that we propose to collect drug rebate information. Little is known about the amount of drug rebates paid by pharmaceutical manufacturers and pharmacy



benefit managers (PBMs) to health care payers in Colorado. Currently, there is aggregated cost of care information publicly available¹; however, without the inclusion of pharmacy rebate and APM data, the information is limited in its use. For example, public cost of care information is broken down by pharmaceutical, inpatient, outpatient and professional costs and without the aggregate pharmacy rebate information, pharmaceutical costs are inflated. Across the four service categories, pharmacy costs in Colorado have risen the most since 2012 (27%), yet we are not certain how costs are being offset by rebates, if at all. Thus, at present, there is not an understanding of the true impact of pharmacy costs on our state.

The Colorado Department of Health Care Policy and Financing (HCPF) has expressed concern that pharmaceutical spending calculated based on claims data in the CO APCD does not accurately reflect actual payments because of the lack of information on drug rebates. Additionally, pharmaceutical spending estimates, calculated based on drug list prices, may result in inaccurate estimates of actual payments for prescription drugs and render comparisons across payer types of limited value. Accounting for pharmacy rebates will enable Colorado to more fully understand cost drivers to address areas of concern. National projects like the Network for Regional Healthcare Improvement (NRHI) Total Cost of Care project² will also benefit from this data collection, as Colorado will be able to report true aggregate pharmacy costs for comparison to other states.

Clearly, the proposed collection of highly aggregated drug rebate data will allow a better understanding of the total annual spend on prescription drugs, facilitate more meaningful comparisons across payer types, allow the tracking of changes and trends over time, and provide a baseline against which future performance of the health care system can be compared and better understood.

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Furthermore, with such highly aggregated data, there is no possibility of reverse engineering the price or rebate paid by any drug company to a specific payer for individual drugs or categories thereof. These proposed requirements were designed based on similar requirements established in Massachusetts. Because CIVHC is an independent non-profit organization administering the CO APCD on behalf of the State of Colorado, we are not subject to the Colorado Public (Open) Records Act.

In future revisions to the DSG, CIVHC will clarify that the proposed drug rebate data submission requirement applies to those health plans providing primary coverage and emphasize that our intention is not to require submission of this information from partial-claim or supplemental health insurance plans. While both fully-insured and non-ERISA self-funded health plans will be required to submit aggregated drug rebate information, there is no requirement that payers report separately for these types of commercial insurance products.

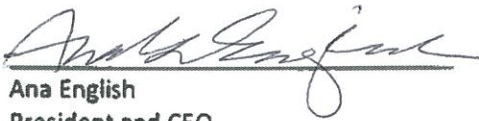
¹ See <http://www.civhc.org/get-data/public-data/interactive-data/cost-of-care/>.

² See <http://www.civhc.org/programs-and-services/national-initiatives/total-cost-of-care/>.



CIVHC is committed to providing timely, actionable, and credible data that supports change agents working to advance the Triple Aim of lower costs, improved care, and healthy Coloradans. Should further discussion be necessary, we are happy to meet at your convenience.

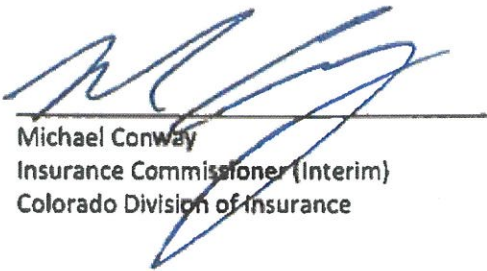
Sincerely,



Ana English
President and CEO
Center for Improving Value in Health Care



Kim Bimestefer
Executive Director
CO Department of Health Care Policy and Financing



Michael Conway
Insurance Commissioner (Interim)
Colorado Division of Insurance

