

Addendum I – Analyst Supplement Colorado All Payer Claims Database Application

Project Description and Data Objective

Project Title and number: 21.116 COVReD: COVID-19 Real World Data – Unraveling causes, inequities and risk for death and disability in the era of COVID-19

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

Check all that apply:

- ☒ 2012
- ☒ 2013
- ☒ 2014
- ☒ 2015
- ☒ 2016
- ☒ 2017
- ☒ 2018
- ☒ 2019
- ☒ 2020
- ☒ 2021*

*Please consult the Data Warehouse refresh schedule to learn what is currently available for 2021

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

Check all that apply:

- ☒ 2012
- ☒ 2013
- ☒ 2014
- ☒ 2015
- ☒ 2016
- ☒ 2017
- ☒ 2018
- ☒ 2019

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

Please check all that apply

- ☒ **Commercial Payer Claims** - Data available with appropriate levels of aggregation
Need to discuss appropriate level of aggregation for client request type; would need analyst input
- ☒ **Individual**
- ☒ **Small Group Plans**

- ☒ **Large Group Plans**
 - **Currently available:** Medical Claims AND Pharmacy Claims from 2012-2021
 - Claims
 - Eligibility
 - Servicing and Billing Provider information
- ☒ **Fully insured Employer Plans**
- ☒ **Self-Insured ERISA and non-ERISA based Employer Plans (note: ERISA-based plans are voluntary submitters and are not all represented in the CO APCD)**
 - **Currently available:** Medical Claims AND Pharmacy claims
 - Claims
 - Eligibility
 - Servicing and Billing Provider information
- ☒ **Medicare Advantage** - data is available with appropriate levels of aggregation
Need to discuss appropriate level of aggregation for client request type; would need analyst input
 - **Currently available:** Medical AND Pharmacy claims from 2012-2021
 - Claims
 - Eligibility
 - Servicing and Billing Provider information
- ☒ **Health First Colorado (Colorado's Medicaid Program)** - Data requests must be reviewed by the Colorado Department of Health Care Policy and Financing (HCPF) to ensure alignment with administration of the Medicaid program as required by federal law
 - **Currently available:** Medical Claims AND Pharmacy Claims from 2012-2021
 - Claims
 - Eligibility
 - Servicing and Billing Provider information

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

- ☒ **Medicare Fee For Service (FFS)** - Data requests are only available for research purposes and must be approved and financially supported by HCPF.
 - **Currently available:** Medical Claims AND Pharmacy Claims from 2012-2019
 - Claims
 - Eligibility
 - Servicing and Billing Provider information

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

- ☐ Yes
- ☒ No

- If YES, please indicate the specific information you would like to include:
 - **Payer Line of Business**
 - ☐ Commercial

- **Payer Name: Please note Anti-trust guidelines will be followed. (DRRC review maybe also be required)**
 - *Please provide listing of payer names and health plans*
- **Commercial Product Line(s):**
 - ☐ PPO
 - ☐ HMO
 - ☐ POS
 - ☐ Supplemental
 - ☐ Indemnity
 - ☐ Other- Please specify
 - *Please provide listing of other product lines*
- ☐ **Colorado's Exchange, Connect for Health Colorado, Product Lines:**
 - ☐ Gold
 - ☐ Silver
 - ☐ Bronze

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

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

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

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

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

- ☒ **Yes**
- ☐ **No**

- If **YES**, and you need pharmacy claims limited to specific drug types, ***please list the 11-digit NDC codes you would like to receive (DO NOT INCLUDE DASHES AND PROVIDE LEADING ZEROS):***
 - Please provide listing

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

- ☒ Yes
☐ No

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

- ☐ Yes
☒ No

- If **YES**, please indicate the specific information you would like to include:
 - ☐ Hospital
 - ☐ Ambulatory Surgery Centers
 - ☐ Outpatient Facilities
 - ☐ Physician offices
 - ☐ Specialty offices
 - ☐ Home Health
 - ☐ Urgent Care
 - ☐ Emergency Room (Note: cannot differentiate between majority of Free-Standing and hospital-based ERs)
 - ☐ Other (specify)
 - Please list other site of service details

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

- ☐ Yes
☒ No

- If **YES**, please indicate the specific provider types you would like to include or provide a list of providers:
 - ☐ Facilities (hospitals, ambulatory surgery centers, etc.)
 - Please provide listing
 - ☐ Professionals
 - Please provide listing
 - ☐ Provider Taxonomy - Specialty Designations
 - Please provide listing
 - ☐ National Provider Identifier
 - Please provide listing
 - ☐ Other
 - Please provide listing

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

☐ Yes

☒ No

- If YES, please indicate the geographic groupings you would like to include: **not limit but include*

☐ **Provider location address**

▪ Need full address of all providers in CO

☐ **Member location address**

▪ Please provide listing

☐ **Zip 3**

▪ Please provide listing

☐ **Health Statistic Region**

<http://www.cohid.dphe.state.co.us/brfssdata.html>

▪ Please provide listing

☐ **County (Potential PHI)**

▪ Please provide listing

☐ **Zip 5 (PHI)**

▪ Please provide listing

☐ **Other**

▪ Please provide listing

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

☐ Yes

☒ No

- If YES, please indicate the groupings you would like to include:

☐ **Age bands/range (in years) requested (i.e. 0-21, 22-39, 40-55, etc.)**

Please specify specific bands and/or ranges

Please specify how you would like age to be calculated (i.e. Patient age at the end of year, at the time of service, etc.)

☐ **Gender**

☐ **Male**

☐ **Female**

☐ **Unspecified**

Member-level Detail – Do you need claims filtered at the member level for your project purpose?

i.e., do you need claims limited to specific members for your project?

☐ Yes

☒ No

- If YES, please indicate the information you would like to include:
 - ☐ **De-identified member information**
 - ☐ Unique member and person ID
 - ☐ Gender
 - ☐ Age: (at time of service)
 - ☐ 3-digit zip
 - ☐ **Protected Health Information (PHI)** – Any of the below requires DRRC approval process
**not limit but include*
 - ☒ Names (first, last, middle) (PHI)
 - ☒ Street Address (PHI)
 - ☒ City (PHI)
 - ☒ 5 Digit Zip (PHI)
 - ☒ DOB-Dates of Birth (PHI)
 - ☒ DOS-Dates of Service (PHI)

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

- ☐ Yes
- ☒ No

- If YES, please indicate the specific diagnosis code(s) you would like to include (DO NOT USE DECIMAL POINTS AND DO NOT REMOVE LEADING AND TRAILING ZEROS):
 - Please provide listing

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

- ☐ Yes
- ☒ No

- If YES, please indicate the specific procedure/revenue code(s) you would like to include under each type requested:
 - ☐ **CPT4**
Please provide listing
 - ☐ **CDT**
Please provide listing
 - ☐ **Revenue code**
Please provide listing
 - ☐ **APR-DRG**
Please provide listing
 - ☐ **ICD9 or ICD10**
(Please indicate whether the codes you provide are ICD 9 or 10 codes)
Please provide listing

***not limit but include ICD's*

Acknowledgement of Review and Approval of the Data Elements Dictionary that Accompanies the Project-


Initials: MW

DED filename and/or version number: COAPCD Data Extract Element Request Form V10.4

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

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

SIGNATURES:

For the CO APCD: CIVHC	For Receiving Organization: Board of Trustees of the Leland Stanford Junior University
Signature: 	Signature:
Name: Pete Sheehan	Name: Michala Welch
Title: VP of Client Solutions & State Initiatives	Title: Senior Contract and Grant Officer