

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

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

Project Title and number:

22.53 Disaggregating Race/Ethnicity Data in Colorado's Data Systems to Understand Differences in Behavioral Health

**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 or with your Health Data Solutions Consultant 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
- ☐ 2020

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

Please check all that apply

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

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

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

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

- ☐ Yes  
☒ No

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

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

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

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

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

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

☒ Yes

☐ No

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

- ☐ **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
  - ☐ 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

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

Initials: \_\_\_\_\_

DED filename and/or version number: \_\_\_\_\_

**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:	For Receiving Organization:
Signature:	Signature:
Name: Pete Sheehan	Name:
Title: VP of Client Solutions & State Initiatives	Title: