Colorado All Payer Claims Database (CO APCD) Research Showcase

June 26, 2025

CIVHC

CENTER FOR IMPROVING VALUE IN HEALTH CARE

Agenda

- CIVHC and CO APCD Overview
- Public Reports on the Horizon
- Introduction to the Denver Indian Center
- Addressing the Problem
- Outcomes and Insights
- Additional Resources
- Ways to Partner with Us

Housekeeping

- All lines are muted
- Please ask questions in the Chat box, Q&A after each presentation
- Webinar is being recorded
- Link to the recording will be posted on the Event Resources page at: **civhc.org**

Who We Are

CIVHC

CENTER FOR IMPROVING
VALUE IN HEALTH CARE

Our Mission

To equip partners and communities in Colorado and across the nation with the resources, services and unbiased data needed to improve health and health care.

Our Vision

Everyone has the opportunity to be healthy and has access to equitable, affordable, high-quality health care.

We Are

- Non-profit
- Independent and objective
- Service-oriented

Who We Serve

Change Agents

Individuals, communities, or organizations working to lower costs, improve care, and make Colorado healthier.

How We Serve

Administrator of the Colorado All Payer Claims Database

Public CO APCD Data

Identify opportunities for improvement in your community through interactive reports and publications

Non-Public CO APCD Data

License data from the most comprehensive claims database in CO to address your specific project needs

- Analytic Services
- Research & Evaluation Services
- Program Focus Areas: Advance Care Planning, Palliative Care
- Community Engagement

What's in the CO APCD

1.3+ Billion Claims (2013-2024)

70% of Covered Lives (medical only, 2023)

33 Commercial Payers* + Medicaid & Medicare (FFS and Advantage)

5.7+ Million Lives*, Including 1M (50%) of self-insured

Trend information (2013-Present)

**Reflects calendar year 2023 payers only*

What's not in the CO APCD

Federal Programs - VA, Tricare, Indian Health Services

Uninsured and self-pay claims

Majority of ERISA-based self-insured employers

Showcase Presenters

Kimi Landry, MPH, CIVHC
Evaluation and Research Analyst

Clare Leather, MPH, CIVHC
Public Reporting Program Manager

David Wright, MA, DICI,
Grants Manager & Relationship Guidance Specialist

Recent Public Reporting Releases

- Community Dashboard
- Chronic Conditions Analysis (will be live today!)

Community Dashboard Background and Purpose

Background: The enabling legislation for the CO APCD (HB 10-1330) requires the creation and release of population health information.

Purpose: The Community Dashboard is designed to provide insights into health care trends, costs, and utilization patterns across Colorado.

- The dashboard helps communities, policymakers, health care providers, and researchers identify disparities and opportunities for improvement.

CO APCD
Community Dashboard

Overview/Definitions | Regional/County Profiles | Trends | Rankings

County Profile

Select MEASURE GROUP: Cost of Care

Select GEOGRAPHY TYPE: (•) County ( ) DOI Region

Select GEOGRAPHY: Adams

Select YEAR: 2023

Select PAYER TYPE: (•) All Payers ( ) Commercial ( ) Medicaid ( ) CHP+ ( ) Medicare Advantage ( ) Medicare FFS

County: **Adams** | Urban

Cost of Care	County		Statewide	Urban	Rural
Total Spending	$2,306M		$30,513M	$25,954M	$4,559M
Inpatient	$531M		$6,267M	$5,353M	$914M
Outpatient	$545M		$8,148M	$6,408M	$1,739M
Professional	$785M		$10,196M	$8,996M	$1,199M
Pharmacy	$445M		$5,904M	$5,197M	$707M
Health Plan and Patient (Total)	$7,553	↓	$8,231	$8,043	$9,534
Inpatient	$1,789	↑	$1,720	$1,687	$1,948
Outpatient	$1,753	↓	$2,108	$1,918	$3,421
Professional	$2,636	↓	$2,876	$2,909	$2,652
Pharmacy	$1,461	↓	$1,689	$1,687	$1,706
Health Plan Only (Total)	$7,124	↓	$7,613	$7,455	$8,706
Inpatient	$1,750	↑	$1,674	$1,641	$1,902
Outpatient	$1,624	↓	$1,902	$1,740	$3,018
Professional	$2,442	↓	$2,598	$2,633	$2,358
Pharmacy	$1,389	↓	$1,593	$1,590	$1,610
Patient Only (Total)	$429	↓	$618	$588	$828
Inpatient	$39	↓	$46	$46	$46
Outpatient	$129	↓	$206	$178	$403
Professional	$193	↓	$278	$276	$294
Pharmacy	$72	↓	$97	$97	$95

Notes:
(1) "n/a" indicates that the value is unavailable due to one of the following: a) measure methodology, b) data unavailable at the time of the analysis, or c) data was suppressed due to low volume.
(2) Total cost Per Person Per Year (PPPY) values do not equal the sum of the PPPY values for service categories because not all members are eligible for both medical and pharmacy services.
For more information, please refer to the methodology document.

Public Data> Featured Focus Area > Community Dashboard

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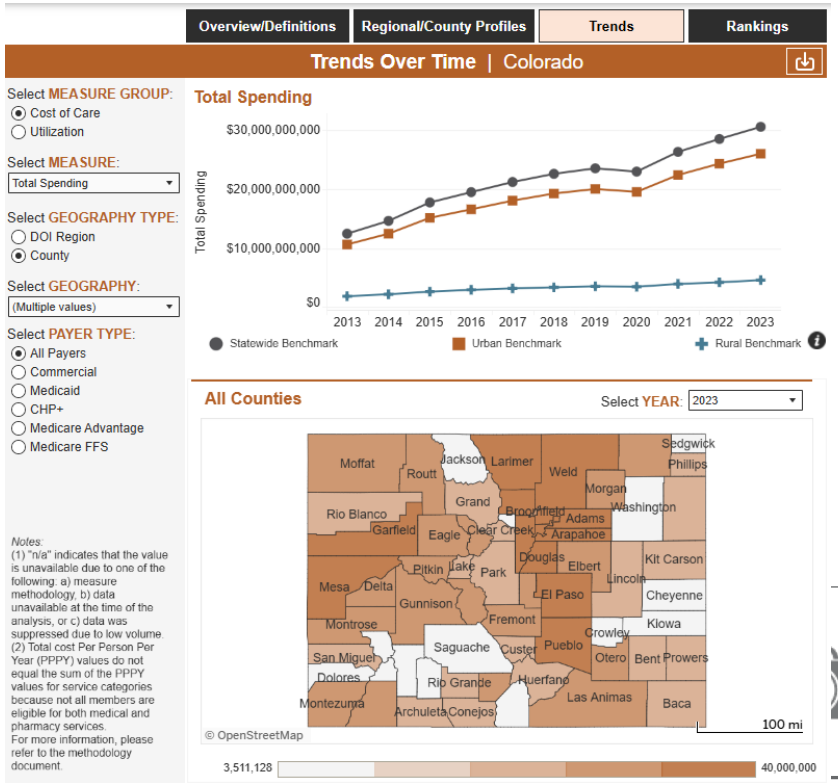

Chronic Conditions Report

Background: Chronic conditions are among the leading causes of death and disability in the United States. They reduce quality of life, drive up health care costs, and place a heavy burden on health systems nationwide.

Purpose: CIVHC's Chronic Conditions Analysis sheds light on 30 prevalent chronic diseases from 2017 to 2023 claims data in the CO APCD.

- Analysis includes trends in how common these conditions are, the average annual cost of care and total spending for individuals living with at least one chronic illness.

Chronic Conditions Report

Public Data> Featured Focus Area > Community Dashboard

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- Acute Myocardial Infarction
- Alzheimer's Disease
- Anemia
- Asthma
- Atrial Fibrillation and Flutter
- Benign Prostatic Hyperplasia
- Cancer, Breast
- Cancer, Colorectal
- Cancer, Endometrial
- Cancer, Lung
- Cancer, Prostate
- Cancer, Urologic (Kidney, Renal Pelvis, and Ureter)
- Cataract
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Depression, Bipolar, or Other Depressive Mood Disorders
- Glaucoma
- Heart Failure and Non-Ischemic Heart Disease
- Hip/Pelvic Fracture
- Hyperlipidemia
- Hypertension
- Hypothyroidism
- Ischemic Heart Disease
- Non-Alzheimer's Dementia
- Osteoporosis with or Without Pathological Fracture
- Parkinson's Disease and Secondary Parkinsonism
- Pneumonia, All-cause
- Rheumatoid Arthritis/Osteoarthritis
- Stroke/Transient Ischemic Attack
- Individuals with one or more chronic conditions
- Individuals with two or more chronic conditions

Chronic Conditions Use Cases

Researchers: Study trends in condition prevalence and spending, compare outcomes over time, and assess the impact of health interventions.

Policymakers and State Agencies: Use statewide data to inform chronic disease policy, guide funding decisions, and evaluate health program effectiveness.

Chronic Conditions Use Cases

Employers: Use condition and cost data to design benefits that address employee health needs, reduce avoidable spending, and support targeted wellness programs.

Public Health Entities: Identify where chronic diseases are most common, support prevention strategies, and prioritize areas for community outreach.

Understanding Health Disparities Among American Indian and Alaska Native Communities in Colorado, 2014-2024

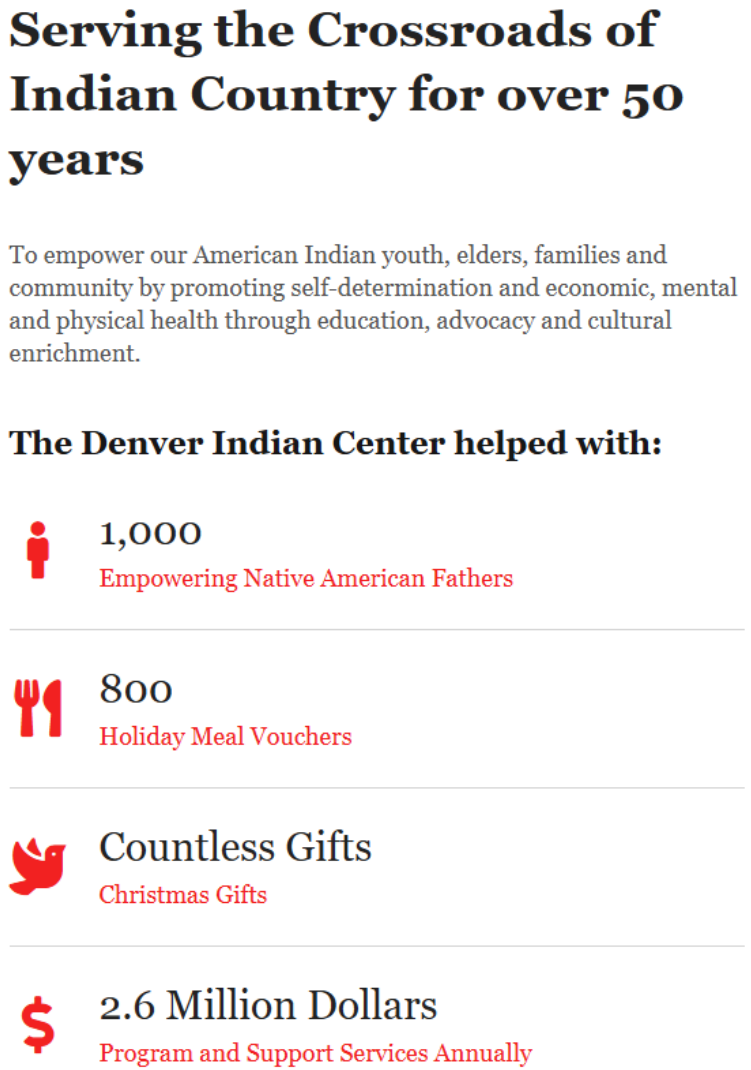
Insights from the Colorado All Payer Claims Database in partnership with the Denver Indian Center, Inc.

Kimi Landry (Research/Evaluation Analyst, CIVHC)

David Wright (Grants Manager/ Data Manager for the Honoring Fatherhood Program, DICI)

Building a Data Partnership with DICI to Support AI/AN Health Equity

- Project started through partnership discussions
- AI/AN communities need access to data
- CIVHC Equity Fund bridged data & evaluation gap
- First analysis of its kind for this population
- Goal: support culturally relevant provider training



Our Data Approach

- 10 years of CO APCD data (2014–2024)
- Social needs data from ACS + Z-codes
- Split into two timeframes to reflect changes in race reporting
  - 2014–2017 and 2018–2024
- AI/AN race prioritized when multiple races reported

https://www.census.gov/programs-surveys/acs/library/handbooks/aian.html

What We Asked

- Most common conditions by group
- Differences in care patterns
- Cost variation between groups
- Z-code use and ACS context
- Social risks by race

What We Measured: Diagnoses

- Condition that triggered the visit
- Top 5 principal diagnoses
- Stratified by race & year
- Focused on treated conditions
- Not just chronic prevalence

What We Measured: Utilization, Cost, and Location of Care

- ER visits and hospital stays
- Readmissions and follow-up care
- Per-member costs and PMPM trends
- Out-of-pocket spending
- Top facilities and care locations

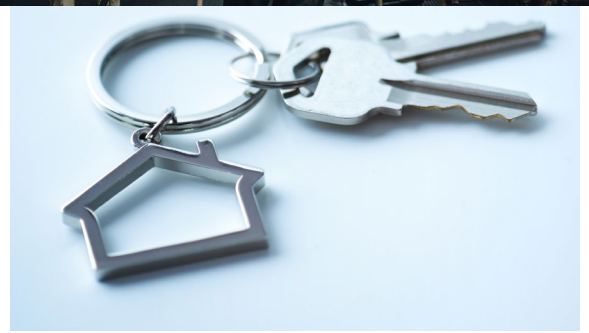
Understanding Cost Measures

Total cost = system pays all

Out-of-pocket = you pay directly

PMPM = average cost per month

What We Measured: Social Determinants of Health



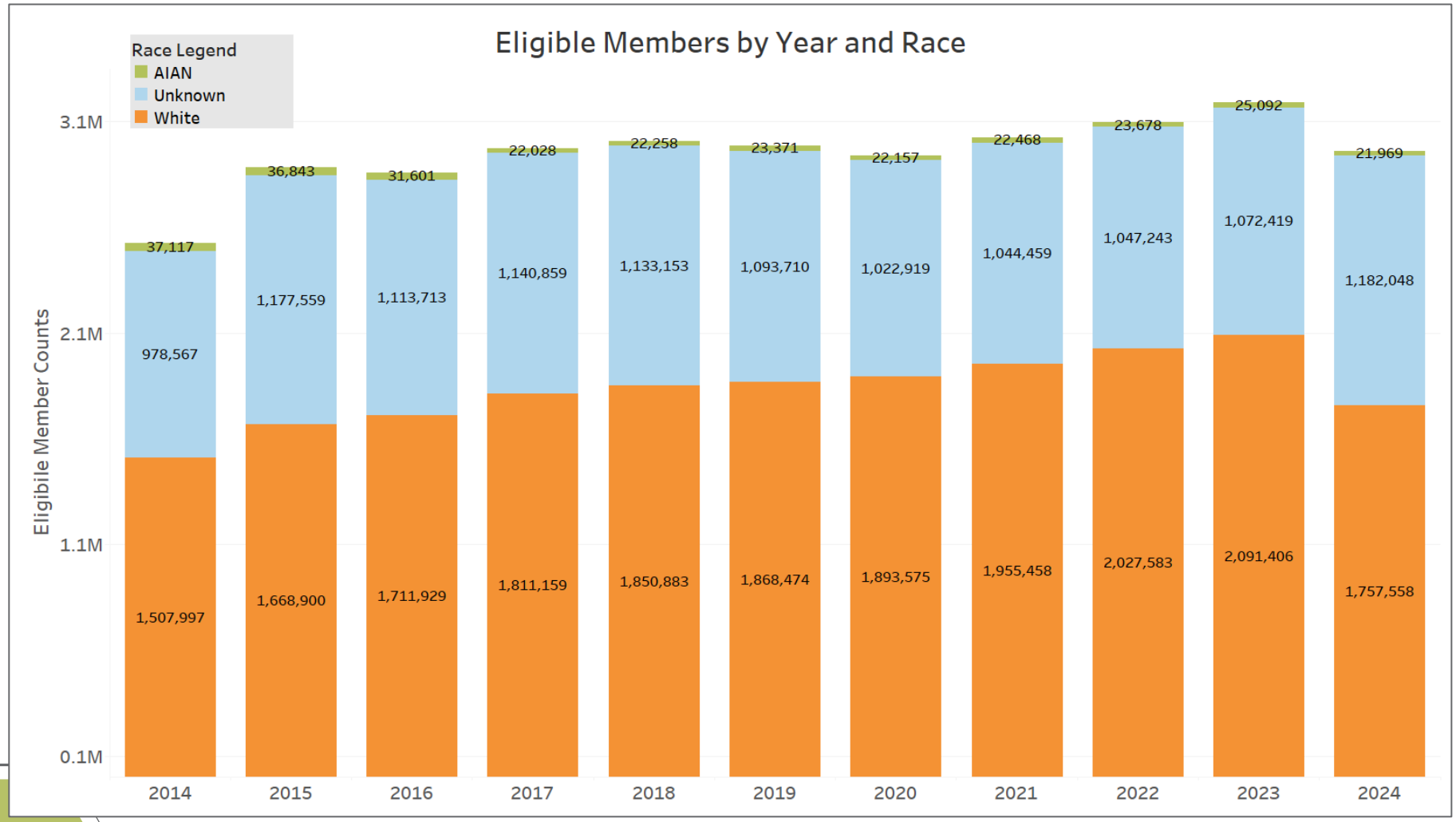
- Z codes for social risk
- Focused on housing, family structure, work
- ACS data for context
- Compared across race groups
- Trends in documentation gaps

Who We Analyzed

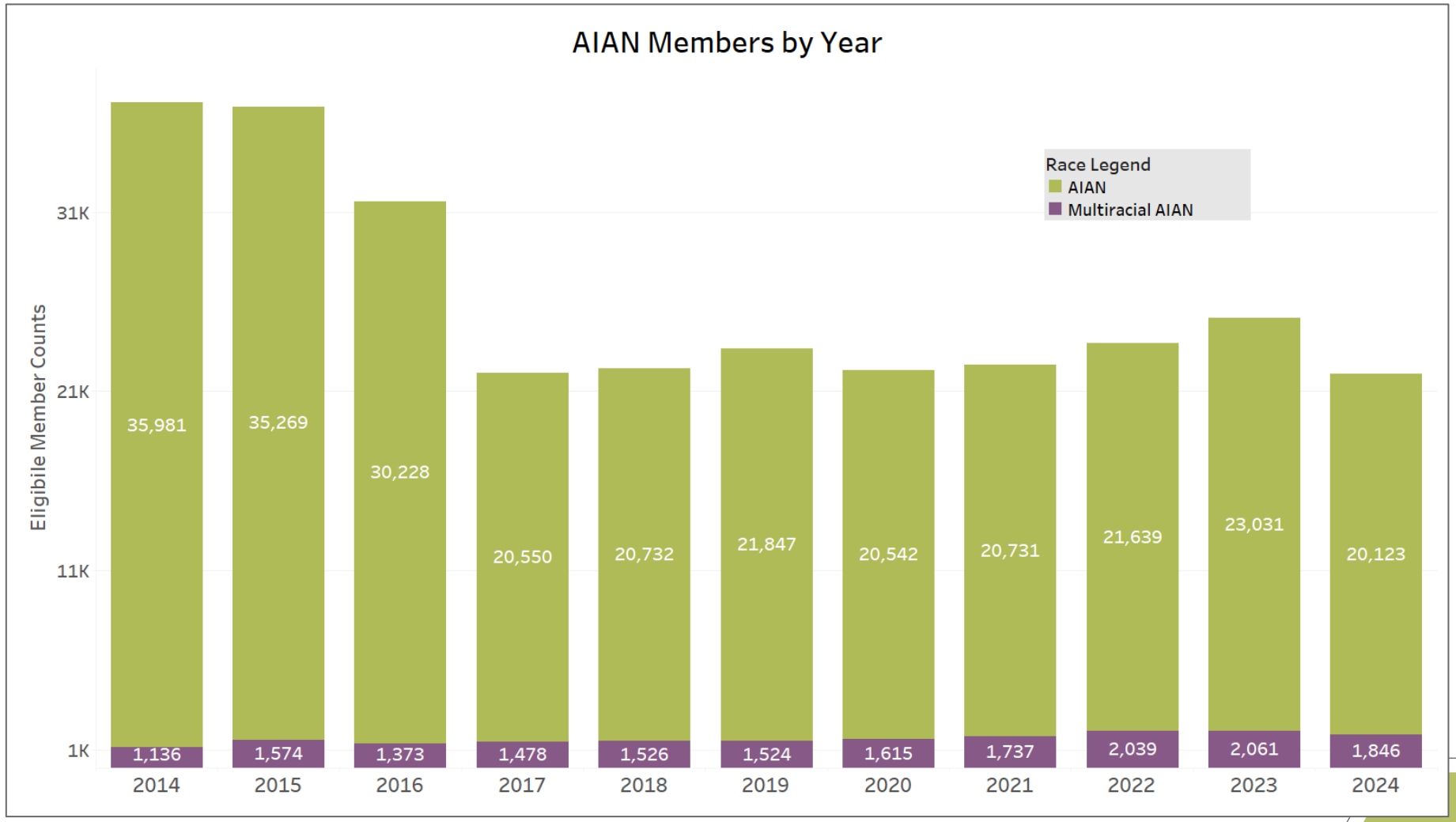
Ages 0+ | Commercial | Medicaid | Medicare FFS | Medicare Advantage | Non-Dual Eligible

- ✓ Included
  - AI/AN individuals: Single race or Multiracial
  - Non-Hispanic White: Alone or unknown ethnicity
  - Individuals with missing or unknown race/ethnicity
- ✕ Excluded
  - Black
  - Asian
  - Pacific Islander
  - Other races
  - Hispanic/Latino individuals, unless also AI/AN
- **Final Cohort Size = 5.6 Million Unique Individuals**

Eligible individuals by race and ethnicity (2014–2024)



AI/AN and Multiracial AI/AN Eligibility Trends (2014–2024)



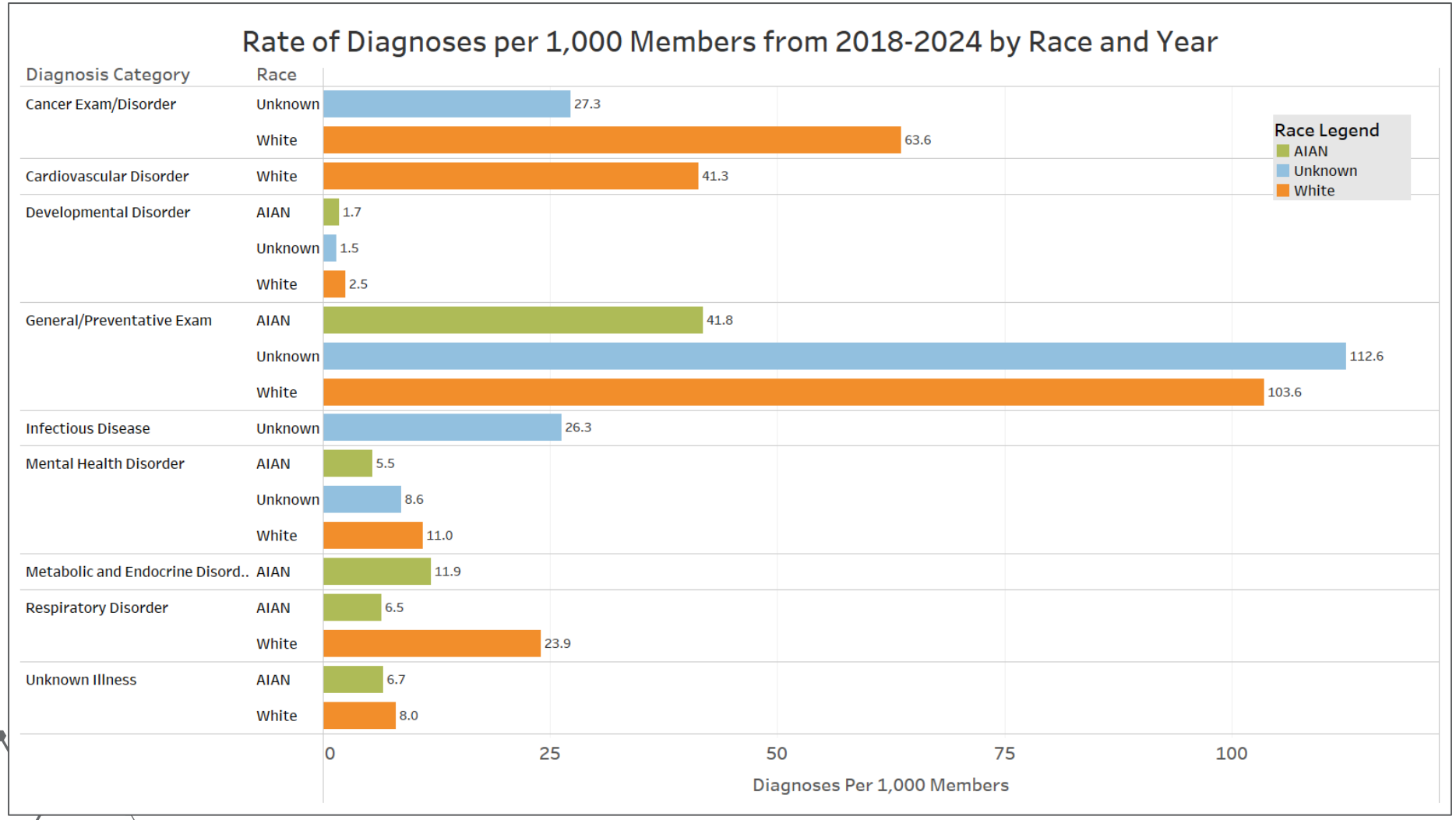
Age and Gender Distribution

- AI/AN: 60% under 36
- NHW: 52% are 36+
- Unknown: 47% are 36+
- Women = majority in all groups
- “Other” gender dropped over time

Health Insurance Eligibility Patterns

- AI/AN: Medicaid dropped; commercial rose from 12% to 18%
- Multiracial AI/AN: Commercial coverage jumped from 57% to 68%
- NHW: Commercial remained highest; Medicaid stable
- Unknown: Medicaid and commercial stable (~30% and ~55%, respectively)
- ACS vs Claims: 60% report private insurance, but 15% in claims

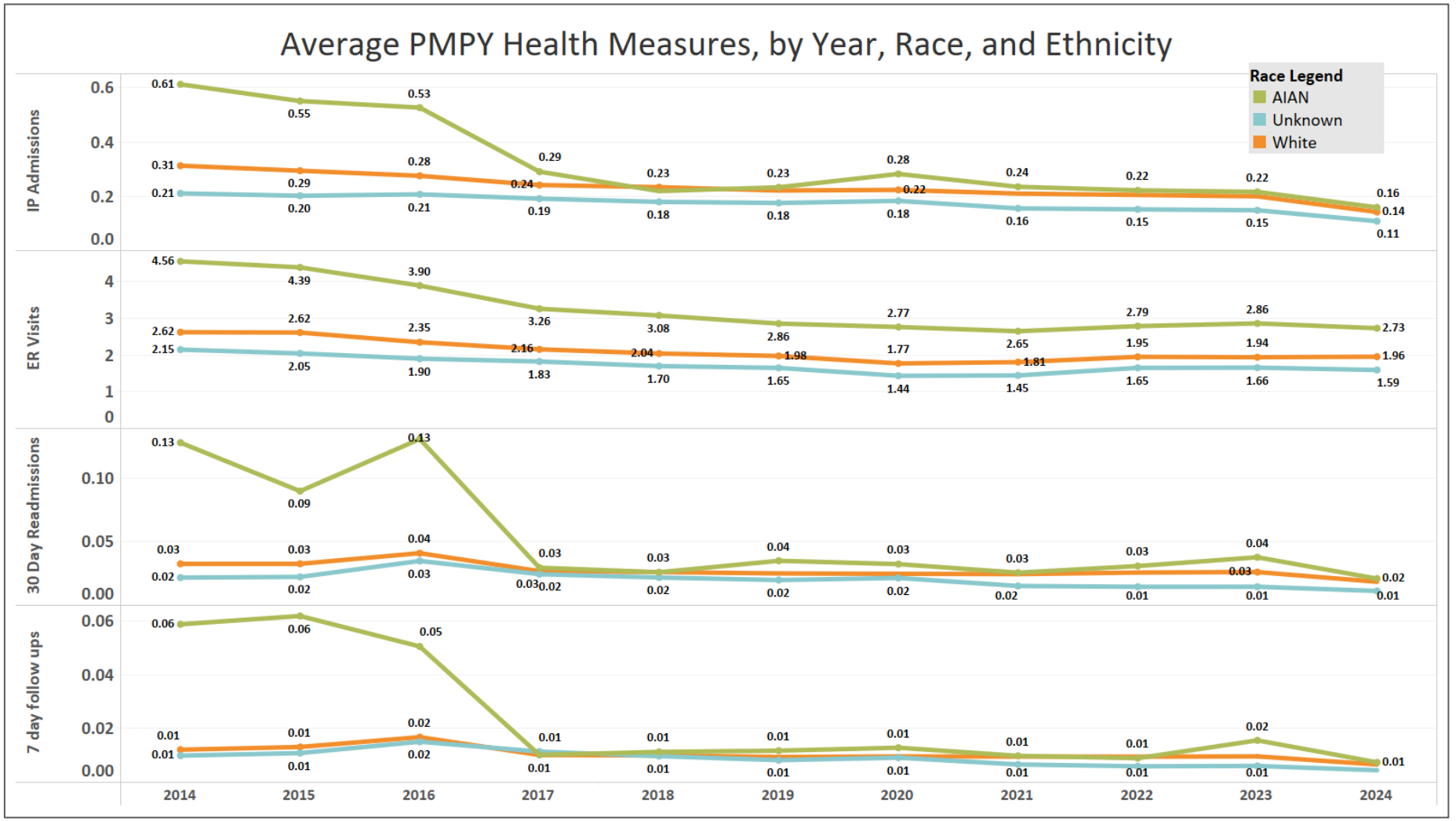
Top treated diagnoses among AI/AN and NHW populations (2018-2024)



Health Care Utilization (2014-2024)

- AI/AN inpatient use fell 15%
- ER visits stayed disproportionately high
- Follow-up rates stayed under 5%
- Readmissions peaked in 2019 (AI/AN)
- Signals gaps in recovery care

PMPY for IP Admissions, ER Visits, 30-day Readmissions, and 7-day Follow Up Visits (2014-2024)



Cost of Care (2014-2024) – Burden by Race

- AI/AN: ~$1,000 PMPM; higher ED use, fewer specialty visits
- NHW: Lower total cost overall, but higher out-of-pocket burden
- Unknown: Highest total and out-of-pocket cost; ~$809/month in Medicare

Cost of Care (2014-2024) – Medicaid

- AI/AN: Highest cost early; $1,600 PMPM in 2014, out-of-pocket ~$75/month
- NHW: Similar pattern but lower total costs; by 2020, < $0.25/month
- Unknown: Similar drop in costs post-2018; very low out-of-pocket

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Cost of Care (2014-2024) – Commercial

- AI/AN: Out-of-pocket stable at ~$72/month (2014 & 2023); lower than others
- NHW: Highest burden in 2014 ($160), still high in 2023 ($96)
- Unknown: Highest peak in 2023 ($194/month); large cost variability

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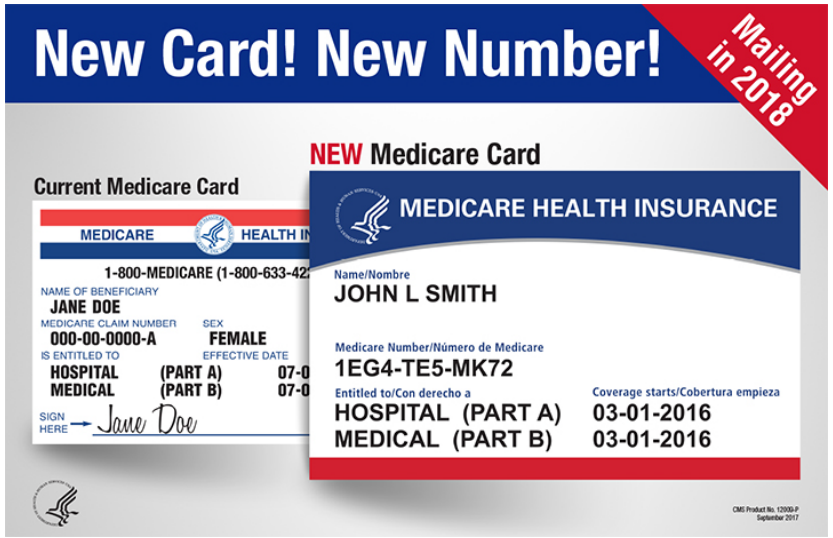
Cost of Care (2014-2024) – Medicare



- AI/AN: Paid less than others 2014–2017; gaps widened after 2018
- NHW: Consistently high at $180+ PMPM
- Unknown: Peaked at $809 in 2023; highest cost across all groups

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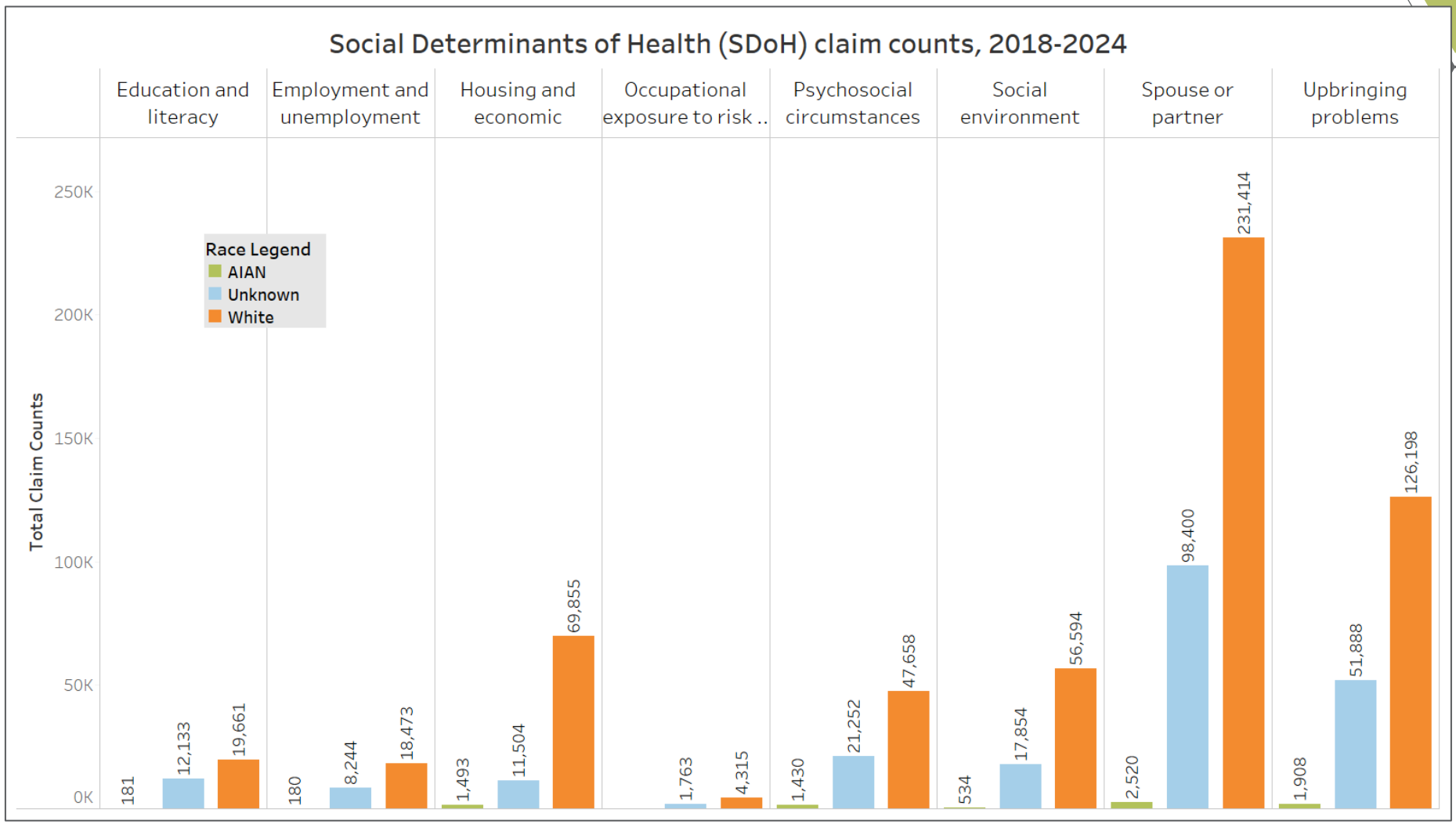
Utilization Analysis by City and Hospital (2018-2024)

- Denver Health had the highest AI/AN visit volume
- Volume concentrated in Denver and Aurora, across all racial groups
- Kaiser facilities saw a sharp rise in AI/AN visits
  - NHW and Unknown had 65%+ of visits at those facilities
- The data suggest a shift for AI/AN patients

Social Determinants of Health: Claims Data (2018-2024)



Social Determinants of Health: ACS vs Claims (2023)

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- ACS shows broader risk exposure
- Insurance rates don’t align
- Disability rates higher for AI/AN
- Claims undercount commercial coverage
- Data gaps limit true visibility

Conclusion and Future Considerations

- Claims show persistent care disparities
- Chronic illness, cost burden remain
- Data must inform real solutions
- Train providers in cultural care
- Combine data with lived experience

Limitations

- Race/ethnicity coding changed over time
- 2024 data incomplete across payers
- CO APCD excludes IHS, uninsured
- Z codes often underreported in claims
- Suppression policies limit subgroup detail

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Questions and Feedback

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