Executive Director Rulemaking meeting

Please stand by for realtime captions. [Captioner is on hold, waiting for event to begin.]
This is Kim Bimestefer Executive Director, here today we got rules for the computer. -- I want to remind everyone for those on the phone, you are welcome to participate with questions towards the end. Hopefully you can hear. If not I will speak up and try to adjust for that, thank you if you are on the phone -- Back there with the ladies to be.
Please sign up and we will have in order for you to testify limit your comments there that would be fabulous.
This is Chris Underwood dip Deputy of financing, who will administer, we are presenting rule number 01 ED 19-10-seven- A, we are making changes including to the file recommendation which has been made by recommendations submitters and data recipients and data elements that require all the updates and also towards the national standards by existing DFT data elements for consist with the elements and common layout or by adding useful data elements that are currently included in the data layout I will now handed over to Bonita who will walk us through the changes.
And Q.
Inc. you very much. Thank you for the opportunity to testify here. I am the vice president, at civic or improving healthcare. On behalf of Colorado as determined by the executive director in the policy financing department all payer claims database, the most comprehensive source and claim information in most robust and the information and majority of color bird -- Covered lives. -- Statutorily required to maintain and enhance database while providing reports and customer analysis, identifying ways in population health and quality care in lowering costs. Helping the insurance plan submitters in healthcare policy finance, help new requirements to the Colorado APC, through the guide. In order to provide more benefit to Colorado. Please note these regulatory changes apply only to the monthly submission to medical claims member eligibility and provider files any proposed changes to the annual model and drug rebate files will be addressed, these were only recently submitted any DST updates to financing rulemaking process will continue value of Colorado APCD, and the Colorado intent for the key changes to improve the quality, for example. The proposed changing field type for employer tax identification and the bar chart combination of variable and character to prevent payers entering in an employer name instead of a number in this field number two met, improve the completeness of the data by changing elements that are important in healthcare cost utilization and quality to being required. We propose adding for district status which is important or analyzing transitional care for patients discharged from the study. 3, move towards national standards to be consistent with the definitions in the APCD common layout, and adding these elements to the APCD currently included. We deny to help explain the claim line lot amounts are equal to zero dollars, information can contribute to accurate analysis and importing, reporting service costs and the layout data will put the Colorado APCD in better plans now I would like to I'm sorry -- I would like to summarize the payer engagement feedback we have received up to now, in preparation of this hearing, we have three payer connect calls to describe the changes and answer any questions. In addition we had inpatient public review meeting on December 4. I would like to discuss briefly some of the questions and comments we receive and some of the changes that we have made. These are in 2 parts. The first comments from several payers and they follow through to the categories and for concerns not having access to the information requested in this update. For example one payer expressed concerns that the a race data element field is required as opposed to optional and it's not always populated in their data warehouse. In addition other institutes where there is a proposed DST filled that may not be available to populate, and identify a solution to allow payers that are not available and default payers that indicate their value is unknown or unavailable. Second the repair concerns over lack of clarity for these specific changes and by dating and clarifying the intent in these fields. There were two incidences where the payer feedback was retracted the proposed update come from the first was a proposal to report what is called the fixed [Indiscernible - low volume] after discussing this with payers it was determined this was not a part of the players claim or eligibility files. Therefore payers would have to use and individually generate third-party software. They would result in [Indiscernible - low volume] reporting record status code. Due to concerns between it and another proposed data element, in both reasons, we should've determined to retract the proposal due to potential for error and complete confusion, and in addition to the comments from those several payers, we received additional comments yesterday. About specific comments I would like to address detailed comments. Parted and getting into these things. Thank you very much. Number one. Claim line type. That data element is questioned to the intent and much about a claim and lifecycle of the adjudication they will not fundamentally change the adjustment in the Colorado APCD it will help with deciphering the nuances and accurate reporting and cost to services a claim line is backed out and replaced, and should be in a future submission the element is to understand that kind of status

or the backed out status for example. We do not anticipate this reporting on the element number two met, there is a request for the Spanish indicator in the data element is optional rather than required I will not discuss this because it was not added to the proposed changes to DSG they provide default options to use limited data or unavailable. For example. Race and Hispanic indicator will be conducted in healthcare, each of these data elements include an unknown as a valid value. And the value of adding this. And we have an option for the submitters to use the data if it's not available. Number three. A request to make Medicare beneficiary identifier pharmacy number, and tax ID and script number optional, rather than required, because they are not included in the data layout. Civic is discussing the ID only required for Medicare patients for CMS, implemented the use the new identifier, to create a new composite ID. Used to identify patients over time and across payers. Pharmacy number and pharmacy tax ID are made required to include the validity of generated pharmacy composite ID. Facilitate analysis of pharmacy dispensing practice. This number was proposed at the request of a pair in order to produce more accurate information. Two more points I would like to cut and cover as a result of yesterday. Being requested the consumers in the question, there is a concern the data may not be available in the claim line level, and gathering this information could result in anti-composition. For those with rebate, they will have rebate at the claim level because the payer originally discussed the data element, to the Colorado APCD Toles . The pay related is from the common data layout defined at the claim line level. This issued, it should be a non-issue. Concern was also expressed with the payment arranger type to collect the same information as we have an alternative payment model data. The payment arrangement types light. It is intended to capture information about the arrangement in which each payment was made such as ERG, percent of charges, or global payment. This information is important for analysis the payment for healthcare services for example. Payments for two different providers for different procedures may be different. Some are based on the global payment which includes the procedure and any postsurgical follow-up care. And other payments may not be based on such a global payment. It's important to know that. And what is included in that global payment. The values to this data element described to the alternative payment models comparing the data with the new type here. In the alternative payment model files that we received. There is overlap in the areas of performance in the areas in these two. The payment arrangement type data arrangement and elements is not a substitute for that submission. From the disclosure perspective, which is also a concern raised. These reporting's, would not violate anti-privacy laws or information gathered from these fields. The recommendation is to report this information and intended to validate and enhance APM and drug [Indiscernible], it could validate some of the information we are getting. Lastly the concern was raised about the purchasing alliance indicator and organization, because you are not consistent with the common layout, purchasing alliance has not been defined. To make this an optional field, you will work with individual payers representing alliance to identify these ED submissions. To conduct the analysis due to cost and quality of care, for these alliances. Identifying them is critical in reporting information back to them. What I'd like to do is summarize the changes at this stage. Hopefully this will be at a high enough level, this will take a little bit of time please bear with me. In this testimony I will summarize the changes that we are requesting executive director to approve, and focusing on the value of these elements to reporting capabilities of the Colorado agency. In interest of time I will not read each in full, but by value types and the value that it will bring to the agency proposed changes eligibility. We are suggesting that race and Hispanic indicators become a required field for health disparities in healthcare quality. We also request that adding a value gender of X to be consistent with the designated gender issues to be in common, and also request for medical claims and pharmacy claims. We are proposing that the market category codes be added and providing details about employment size and enhance employer in hell& Come this is consistent with the common data layout. And as a means to reporting, and the change of the data type, the introducer I discussed earlier. This was entered in, and submitting the employer ZIP Code. This is consistent with accommodating the layout. And also the nickname and clarity, avoiding names of individual policy members for individual plans. Then number five, the proposed rendition of the plan turn date, for the number of calculations, this is also on the data layout. In figure of the common data layout category codes mentioned above. We propose removing the group size data element. In the effective placement here. And making it required as opposed to the optional field as CMS has fully implemented this identifier. For Medicare patients. Also a proposal for the medical claims and for the pharmacy claims files. We also include indicator of whether a plan is Risa, to the non-Medicaid members, to enhance Medicaid analysis, and potentially under medical claims files. And lastly under eligibility submissions be proposed including a purchasing alliance organization indicator conducting cost and analysis such as peak health alliance, I discussed this previous as well. Now I will move to the medical claims filing proposed changes.

In addition to those being requested in the eligibility files. Also in the medical claims files, we propose adding the data element for a cross reference identification letter. And in reversal this could improve the accuracy of the data and consistent with the layout. In applying adjustments to unoriginal claim. Number two

Mac, fully admission source indicator to added to script, a description required, this data element will help identify where patient is admitted from, to support analysis of patient inpatient, such as a person dismiss the emergency or patient transferred to another hospital. We propose making a discharge status a required field, when they leave the setting, and remove this as a default option to better understand the transitions of care. Number 4. The amount due from a secondary carrier which is the benefits announce. Another proposal will help us to understand cost of care, when there is coordination benefits assisting in the accommodating layout. Within the pharmacy claims. Also propose adding a denied claim line indicator, this is number five Mac. This will help help in zero dollar amount, and assist in the analysis of cost [Indiscernible] . The addition of a claim line type which has replacement back out, and to help understand the status of the claim, and help report accurate services. This is a carbon dating layout, and accommodating the layout, in regarding this code, these data elements where there was concern. Again it is only used by us to be able to track and understand the relationship. And the lifecycle of the claim line. If it's backed outcome you can expect to replacement claim to look for that. We will note that is the end of the claim line. And it cycle. So these values. They are important to understanding what is happening to the claim line and properly recording it picks

Number seven. Adding a unit of measure data element is important. Such as anesthesiology services, which can be calm, and become problematic I can explain that in detail.

We had anesthesiologists, report the time we looked at time associated with the services, in some cases, I can ever remember how many minutes but others it was 15 minute increments, and we set up the data, and we didn't have a unit of measure field in order to figure that out. Number 8, lastly. Who would like to add a field for arrangement type which I discussed earlier. Fee-for-service DRP. This will help us to understand payments to providers that may be different from typical fee-for-service, and accommodating in the layout, this is important to note this is not a substitute for the annual payment model, the purpose and the requirements are different. -- However this information can help validate a small portion of that file. In case there are values for that in the payment arrangement type. Next I will discuss pharmacy claims and propose changes. Number one Mac, in addition to the information, being requested in the eligibility file, and claims file applied to the pharmacy claims file, we propose a pharmacy number be required to assist in generating a Colorado APCD ID. This is important for conducting analysis and dispensing. And adding an indicator to identify new prescriptions or refills and the number of refills which will enable the drug analysis. And this is consistent with the drug layout. And specialty drug indicator. Yes or no. This is proposed to the system analysis, and the cost of these drugs, to validate expenditures associated in the drug we get, in the rebate file, and it could be forced of a rebate at least one element. Now should the indications be compound drug indicator? In the required field. And adding them for the names and the ingredients, 4 compound drugs, this is what is consistent with today's layout. Remembering the portion in total doddle, the total amount. And the impact on pharmacy cost, the data MLM in addition to the data submission guide. In order to provide accurately the rebate. On both the member liability portion, and the planning portion of payments. Number six Mac. In addition to the proposed, indicating a former indicating yes or no, versus non-formulary drug impact. This is also consistent with the common data layout. Lastly, we are requesting a number for the Scripps number, for payments and as previously stated at the request of a pair, in addition to the medical claims, changes no, if we have one miscellaneous change. Which is to make grandfather status, as opposed to the required fields. In the majority of plans indicate this at no in the current. In closing. As the administrator of APCD, continuing to deliver inherent data and information to support positive changes in the Colorado health system, this is changes to the monthly eligibility and claims files will take us to the next level and helping stakeholders make informed decisions that lower costs but improve care. Thank you I would like to be answering any questions.

I will throw you some questions. We have been talking a little bit about the importance of accuracy and certain information. We have a what an enormous database and meaningful analysis is it your belief that the changes you request will improve the accuracy and the validity to report to the state and others?

Yes.

Those objectives for these which deal with most popular requirements of Coloradans, which is affordability. It will help us more and be able to interpret identify areas of impact and for the affordability. We show the third barrier of clarity, going forward to the best that we can, in sure payers have self [Indiscernible], which is voluntary, and is insured and we are missing a significant amount of data, and the changes that you are making. It will make a easier for us to identify yes?

In the area that you said we can look at portability new and emerging areas, like prescription drugs, it's critical for us to get our arms around the fastest area to expand these changes will help us do a better job in getting our arms around, definitely. As we encourage employers to bond and work together, we are getting closer and the changes will help to assess.

In general it seems what you have done is to change to make those requirements that the state has asked you to, the affordability strategies and helping us to be a part of APCD. Given that. Thank you for the work that you've done. Now a couple of questions on who has had the last payer Executive Director which Ms. October of last year. We had a role to impact alternate pairs, just to compare and contrast in a way that laypeople can understand, the difference between what we are currently requesting on rebate to what you are adjusting. When I say that let me see that I'm more specific. We have a submission for June 2017, and then did that have rebates by script? Or was it more in the everyday aggregate?

The aggregate. The point of the cells, by contrast it is by script.

In his journal cross session came from the carrier? Or at least one carrier?

Correct.

Is that apart, are they requesting that we send the request?

I don't know for sure. I understand they have feedback from payers and summarized it in either letter. So I would appreciate a written response that includes the words that you used verbally. I don't necessarily know that it's responded to that specific item. And what is confidential information. What is proprietary is a better word, what is. Prior Terry to the contracts and the carriers and the catchers, getting down, did I understand the prescription, then the impacting members that the prescription all level. And the request then, is it twofold to adjust that we need the prescription level, and the member versus employer and impact is tighter.

I understand exactly why you didn't want it. I would be interested in the information and then we can track the impact of $160 billion and as it impacts Colorado, how it can impact those payers, how the money is employer. And the utilization.

What you're trying to do. Make information, privacy, etc. Proprietary. Okay and that regard, because we just got this yesterday, you need a little time just on that right, unfortunately I'm not the best person to address it.

There are some quick ones.

Why don't we hear additional testimony. We might invite you for further networks, -- They will stay at the table.

Sarah orange.

Good morning. Good morning Judge and members of the town I represent the top insurance plan representing health insurance industry. We submitted a letter yesterday in joint with the Colorado application for the health plan. I really appreciate the discussion thank you to the department and for the opportunity comment thank you, and quickly it's out of my area of understanding Kia there and the complexity, and thank you are answering any questions I have. Most I think we have here, highly technical. Highly technical comments were addressed. I really appreciate if we can, can we get to the letter, and what is responsive to the question and reiterate. I appreciate the optionally conditional indicator where people might not offer indication to the carrier, in respect to the Medicare payer, the script numbers, should we appreciate and move it towards the national standards? My understanding it's outside the standards and conversation is going on to include that, may be appropriate for those delayed until they are part of the national standard. I think it was a little bit outside of it gloomy. The other thing. -- Can I am going to interrupt you.

Can we take these one by one. Are the standard? The Medicare beneficiaries are moving to the standard. CMS is adopting it. Which is unusual for it to not be part of the standard. We have not engaged the counsel and the policy numbers in the tech IDs yet. These again are basic pieces of information that we can use to support the identification of the pharmacy throughout our database, and to do analysis of the dispensing. This is, fundamental to our analysis us. And the script number is offered by payer. They came to us to add it. They could accurately report.

Thank you.

Any questions?

Thank you. The next question in respect to the data amount come I think it would be helpful to have an understanding probably the crux of the concern, whether this is competitive, and will you disclose to the public and aggregated format, if this is specific that we seen at previous, how was it utilized in the public domain?

I will answer part two and I will turn it over to Anita. For the member decisions, there is a host of conversation going on. And we will hopefully.

That information we will release some of that on the description drug report, one of the areas we talk about in the report emphasize three-day utilization. Whether or not you push those three dates to check, or an option. For the sponsored care. And in the same way that Medicaid uses those three. And the cost that we play as a state, we often don't use it as co-pay. And it could be an influence rebate. And includes the intent of the design. And the brand, and the preferred brand in those who have worked here. And to have not actually encouraged members to miss line, and misaligned these and wave the co-pays for the members so actually we can take a high cost and we are tracking around the pick from the industry on affordability especially

drugs which are not driving the cost right now, and the ability to understand that influence is the bigger picture. Do you want to add anything to that?

You spoke to that extremely well thank you for that comprehensive response. That is the reason. That's why I poked out what this predatory -- Preparatory -- And nowhere close to these agreements and the manufacturers, we want to know the impact done on affordability, and other payers and clearly intended consequences on why those aligned and then the financial interest of the person and that behavior, we are getting at the right bench, but I don't know that we need more conversation about the importance of confidentiality agreements. We will see what is going on and we don't need to make that publicly available, do you want to correct anything I did say?

No I would like to invite and the English.

Thank you basically just to address specifically the concerns regarding anti-competitive information that may be released. Receiving currently levels on the detail right now, the information stated that the script level associated with the rebate information will be treated at the same level of privacy. This was high-tech as well. We want to make sure if it's very clear the information will receive the claim one level detail, and regarding these guidelines. In general. We want to make sure that there is the level of confidence that we will manage and ensure that we are following. Thank you very much.

And Q Anna, I think the last thing that remains. The bullet put in the data, this is a required field now, if this information is not available, they me have that information they may not, is there that optional I can't recall -- If you don't have that information available is there something for that where you can say I don't have that available?

Not very articulate question.

But we understand.

Thank you.

Currently there is not a default for unknown it appears we do need to add that.

Anything else?

That concludes my comment thank you very much. Thank you for the conversation today, and the conference.

Can I amend?

Of course.

I think you know more than I do.

The concerns about some of these elements not being put into common data layout. And would like to defer on them and say they are. Med affair Medicare official ID is not one of those elements that's the only one that's not a part of the common data layout, even script number is a part.

Is the comment before that it would be?

Clear.

We've had conversations with the counsel, that will be added when they add discussions on layout.

Do you have an idea on the timing?

Know. I imagine, probably fairly soon, these IDs have to be incorporated into these datasets. Okay. Thank you.

You are welcome to stay if you like.

Don Tuttle please.

That is it.

Thank you.

Inc. you very much for those who were in the attendance on the phone and in person, couple things I would like to think about to go back and forth a little bit on specific questions going to the rebate, I said I heard Anna on the proprietary part I do want to understand. I think we should all be interested at this level. That is an outstanding question. Let's say. In the rolling before Christmas. Hopefully for earlier, and then again before the end of the year. With that I think we are adjourned thank you very much again happy holidays everybody.

[Captioner Standing By]