CHIA USER WORKGROUP

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March 23, 2021

CHIA.

Agenda

- Announcements:
  - APCD Release 8.0 Updates
  - FY19 Case Mix Release Projections
  - Data Release and Application Update
- Website Updates
- Application Reminders
- User Support Questions
  - Admission Type
  - Carrier Specific Subscriber ID
  - Medical Coverage Codes
  - Medicare Code
  - Marketplace Category
  - Out of Pocket Costs
- Q&A

MA APCD Release 8.0

- Available **NOW**
- Applicants with *approved projects* that require updated APCD data (Release 8.0) should submit to CHIA a completed Exhibit B (*Certificate of Continued Need and Compliance*) of the Data Use Agreement. After submitting a completed Exhibit B you will receive an invoice (if applicable) for the requested data. Upon payment of the invoice the order for the data will be placed.
- **Release 8.0** includes data on services from January 2014 – December 2018 with six months of claim runout (includes paid claims through 6/30/19).
- Will be linkable to Release 7.0 via crosswalk
- Additional information on highlights and enhancements will be presented in future APCD User Workgroups.

Case Mix FY19 Release

CURRENT RELEASE TIMEFRAMES FOR EACH FILE:

- Inpatient (HIDD)

  Available for request and delivery

- Emergency Department (ED)

  Available for request and delivery

- Outpatient Observation (OOD)

  Available for request and delivery

- Applicants with *approved projects* that require newly available year(s) of Case Mix Data (e.g., FY 19) should submit to CHIA a completed Exhibit B (*Certificate of Continued Need and Compliance*) of the Data Use Agreement. After submitting a completed Exhibit B you will receive an invoice (if applicable) for the requested data. Upon payment of the invoice the order for the data will be placed.

Data Release and Application Updates

Due to Governor Baker's emergency actions to limit the spread of COVID-19 CHIA's workforce will be remote, for now. This arrangement will limit CHIA's ability to produce and deliver data extracts. At this time, CHIA is releasing data and providing extracts to requestors.

During this time, CHIA will continue to accept and review data applications for both Case Mix and All-Payer Claims Database (MA APCD) datasets. Review committees, DRC and DPC, will continue their meetings remotely as necessary.

Due to CHIA's physical office being closed, applications will be accepted without a fee. After receipt of the application, CHIA will issue an invoice which will allow applicants to remit payment online.

If you are a Data User that has a CHIA hard drive in your possession, please keep the hard drive at this time while CHIA's physical office is closed.

Website Release Updates

- Updates on the production of APCD and Case Mix databases and status of data requests are now posted to CHIA's website!
  - **Aim #1** is to provide weekly or bi-weekly status update on CHIA data products as they are in development.
  - **Aim #2** is to provide applicants with information about expected fulfillment status for individual data requests.
  - Request IDs will be communicated to Data Requestors via email.

- Please visit http://www.chiamass.gov/status-of-data-requests/ to see the current status of releases.

APPLICATION REMINDERS

Fee Waiver Request Reminders

1. If you're submitting a request for a fee waiver, remember to include the fee remittance form in your application package on IRBNet.
2. Remember to submit supporting documentation (if required).
3. If you're requesting a financial hardship waiver, remember to submit information detailing your project's financial situation (examples: project budget, grant funding, organizational / departmental funding). Also request to pay a specific price that you reasonably believe you're able to afford to contribute.
4. CHIA generally does not offer full financial hardship fee waivers. We expect all applicants to have made an attempt to find funding to cover the full cost of the data fees.
5. Fee waiver requests can take some time to process – especially financial hardship requests.

USER QUESTIONS

Question: Both the MA APCD and the case mix hospital inpatient discharge data have an 'admission type' field. I am confused by the definitions. The filing specifications for the MA APCD medical claims references the National Uniform Billing Committee's UB-04 data definitions for admission type. I am specifically confused about the distinction between *emergency versus urgent* admission type.

Answer: *It is important not to confuse MA APCD filing specifications with case mix filing specification definitions. The case mix filing specifications contain some legacy customized codes that are not used in the MA APCD. There is a nuanced difference in the admission type definitions in the two repositories. Like the MA APCD, CMS also uses the UB-04 Admission Type definitions and provides detail at the following link (see: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1775CP.pdf)*

Differences between MA APCD and Case Mix Admission Type Codes

MA APCD Admission Type	Case Mix Inpatient Type of Admission
1 = Emergency	1 = Emergency
2 = Urgent	2 = Urgent
3 = Elective	3 = Elective
4 = Newborn	4 = Newborn
5 = Trauma	5 = Information Not Available
9 = Information Not Available	

While both MA APCD and case mix use the same definitions for codes 1, 2, 3, 4, the definitions differ for code 5. Unlike the MA APCD, case mix does not classify an admission type for trauma separately as used in the MA APCD code 5. Also, the MA APCD and case mix use different codes to indicate information not available, MA APCD uses 9, case mix uses 5.

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Answer (continued): *Table 1 below lists detailed descriptions which CMS provides of the UB-04 admission type codes used on medical claims data. Emergency admission type code is a higher severity than an urgent admission. While both requires immediate medical attention, emergency type is for a medical condition that is life threatening or potentially disabling. This is evidenced by frequency of the admission type coding for patients who have expired in MA APCD Release 8 medical claims. In Figure 1 below, patients who have expired have the highest frequency of admission type code '1' for emergency.*

Emergency

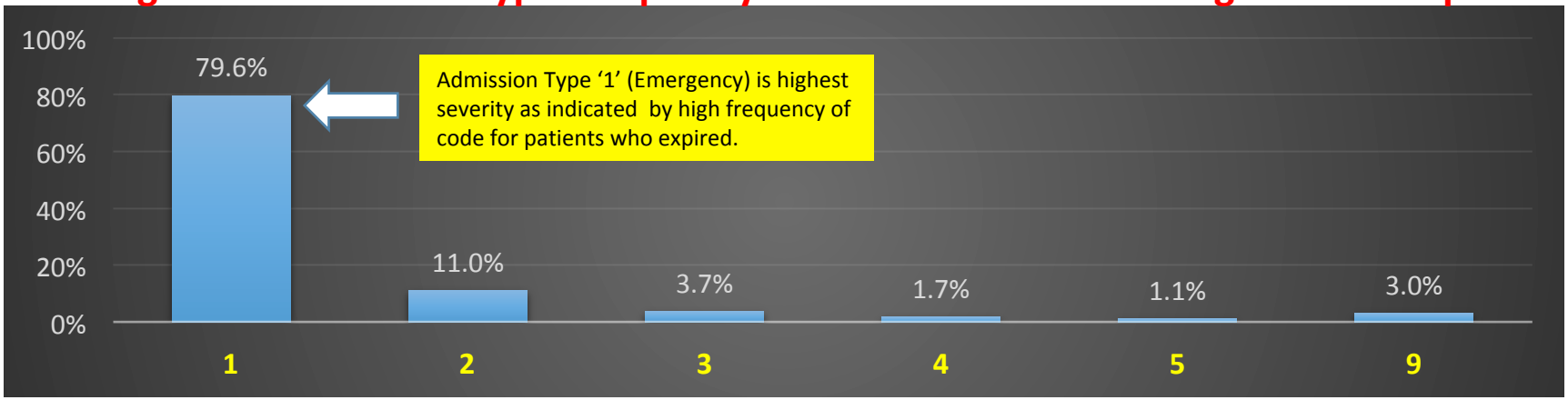
Urgent

Elective

Table 1. Admission Type Definitions

Value	Description
1	**Emergency** - The patient required immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient was admitted through the emergency room.
2	**Urgent** - The patient required immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient was admitted to the first available, suitable accommodation.
3	**Elective** - The patient's condition permitted adequate time to schedule the availability of a suitable accommodation.
4	**Newborn**
5	Trauma Center - Visits to a trauma center/hospital as licensed or designated by the State or local government authority authorized to do so, or as verified by the American College of surgeons and involving a trauma activation.
9	**Information Not Available**

Figure 1. Admission Type Frequency for Patients with Discharge Status 'Expired'



Question: Is there a Subscriber ID to determine individuals enrolled together in the same plan and a Person ID to distinguish when individuals leave a shared plan for another? Does a Person ID allow following individuals across coverage changes, for example, if an individual transitions from one carrier to another?

Answer: *Individuals on the same plan can be determined using the OrgID, Carrier Specific Unique Subscriber ID, and Carrier Specific Unique Member ID. If the individual (**determined by the Carrier Specific Unique Member ID and OrgID**) is on the same plan with another, they would **share the same OrgID and Carrier Specific Unique Subscriber ID**. CHIA generates a member link entity identifier (**MEID**) which enables analysis of individuals across payers. If an individual changes from a shared plan to a different plan, the MEID can be used to determine changes in any combinations and associations of OrgIDs and Carrier Specific Unique Member IDs and Carrier Specific Unique Subscriber IDs. The Member Eligibility file also has an Individual Relationship Code (**ME012**) where the carriers report the value that defines the member's relationship to the subscriber. For example, a relationship code of 20 (self/ employee) would indicate that the subscriber and the member are the same person.*

***The* MA APCD Release 8.0 Documentation has the following key definitions.**

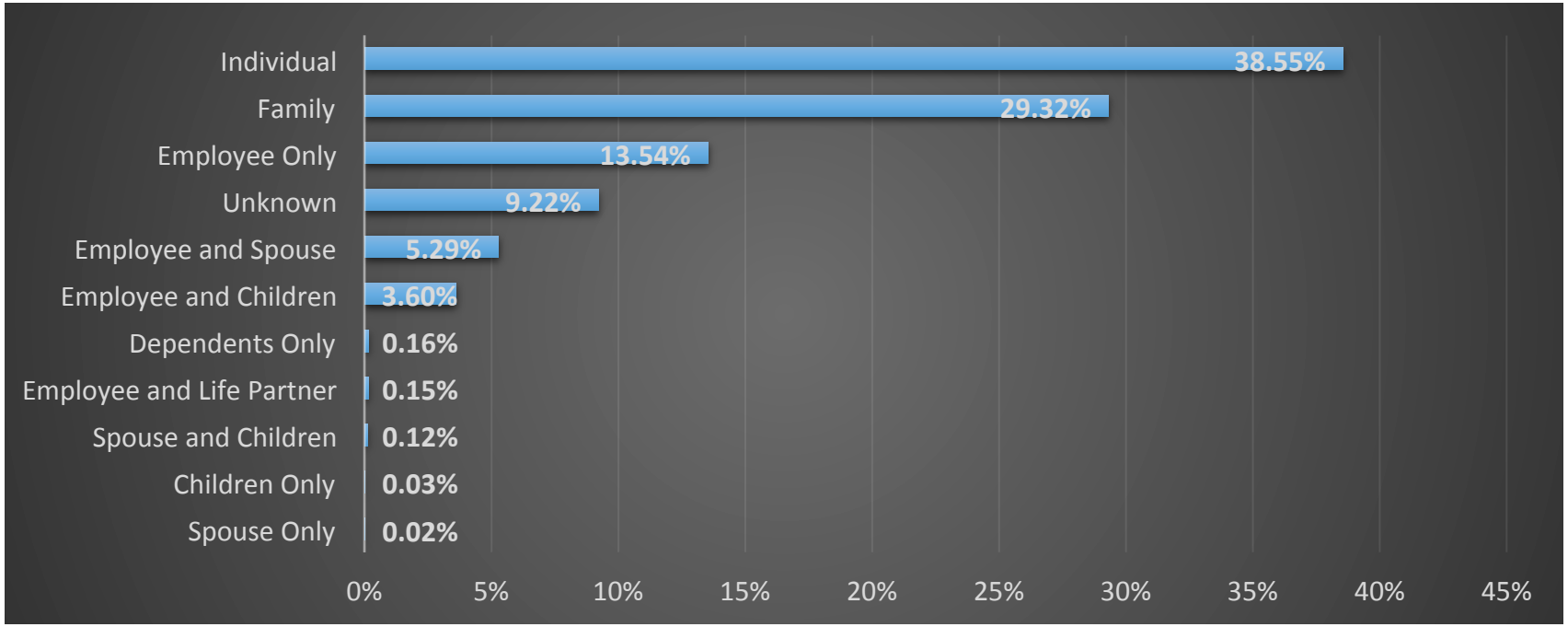
Term	Definition
Subscriber	The subscriber is the insurance policy holder. The individual that has opted into and pays a premium for health insurance benefits under a defined policy. In some instances, the subscriber can be the Employer, or a non-related individual in cases of personal injury.
Member	A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.
Individual Relationship Code	Indicator defining the Member/Patient's relationship to the Subscriber
Member Link EID	CHIA provides a derived element (Member Link EID) that represents a unique Enterprise ID (EID) of an individual member (person entity). This number can be used to link an individual across all filing types – Eligibility, Claims, and to analyze individuals across carriers.

continued ➡

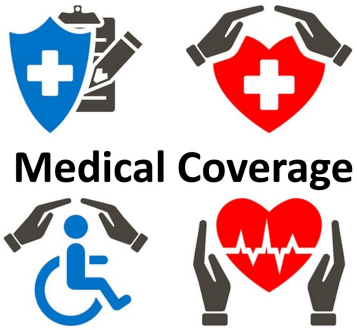
Answer (continued): *The Member Eligibility file also has a benefit Coverage Level Code field (ME007) where the carrier reports the code that defines the dependent coverage using benefit coverage code levels in the table to the right. The benefit coverage code levels have a high percent of completeness.* ***Only 9.2% of the member eligibility record coverage code levels are coded as unknown.***

Coverage Code Level	Description
CHD	Children Only
DEP	Dependents Only
ECH	Employee and Children
ELF	Employee and Life Partner
EMP	Employee Only
ESP	Employee and Spouse
FAM	Family
IND	Individual
SPC	Spouse and Children
SPO	Spouse Only
UNK	Unknown

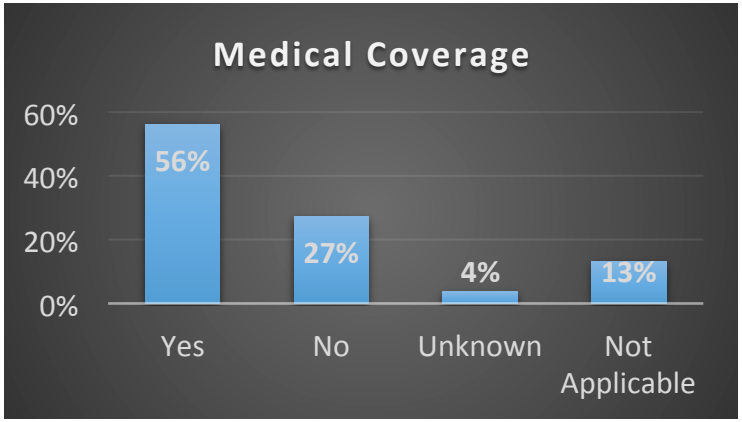
Frequency of Coverage Code Levels in Member Eligibility File

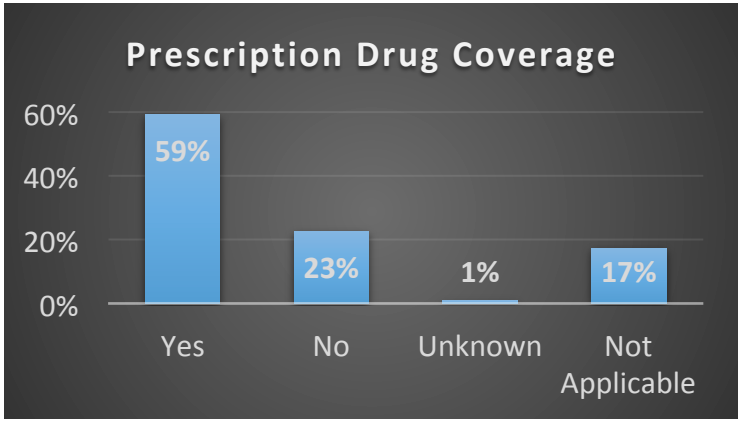


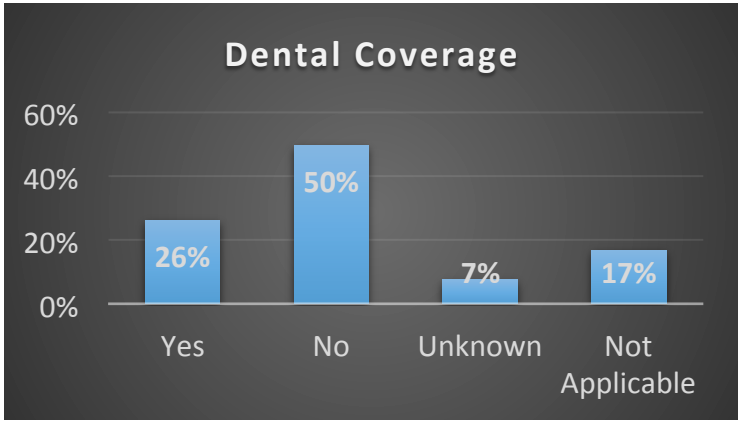
Question: What do each of the values for the medical coverage variable correspond to? From the documentation, I was able to figure out that '1' corresponds to "yes", '2' to "no", but I'm not sure about '3' and '5'.

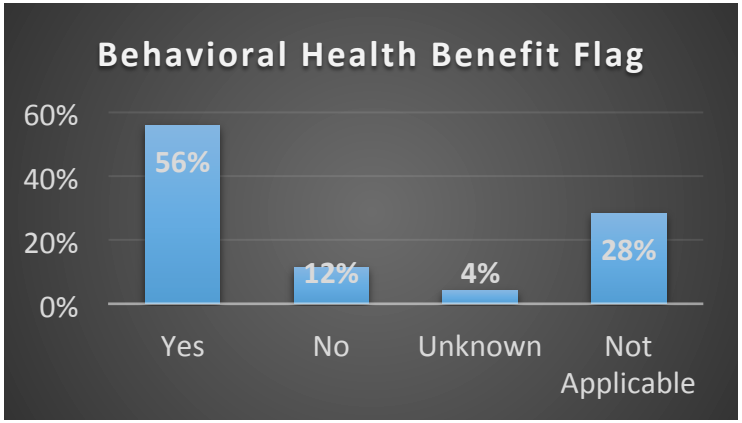


Answer: *In the Member Eligibility file, four different coverage fields (Medical Coverage (ME018), Prescription Drug Coverage (ME019), Dental Coverage (ME020) and the Behavioral Health Benefit Flag (ME051)) have the same coding options:* ***1 (Yes), 2(No), 3 (Unknown), 4 (Other),*** *and* ***5 (Not Applicable).*** *The frequency of coding for these four coverage fields (see charts below) indicates that the coding option for 'Other' has not been used and the percent of records coded as unknown is low.*









Question: What does the Medicare Code variable in the Member Eligibility file mean and what values do its codes correspond to?

Answer: *The **Medicare Code variable (ME081**) is used by the carrier to report the value that defines if and what type of Medicare coverage applies to the eligibility record using the codes shown in the table to the right.*

Part A is Inpatient/hospital coverage, Part B is outpatient/medical coverage, Part C is Medicare coverage by private companies approved Medicare, and Medicare Part D is prescription coverage.

ME081 Medicare Code

Value	Description
1	Part A Only
2	Part B Only
3	Part A and B
4	Part C Only
5	Advantage
6	Part D Only
9	Not Applicable
0	No Medicare Coverage

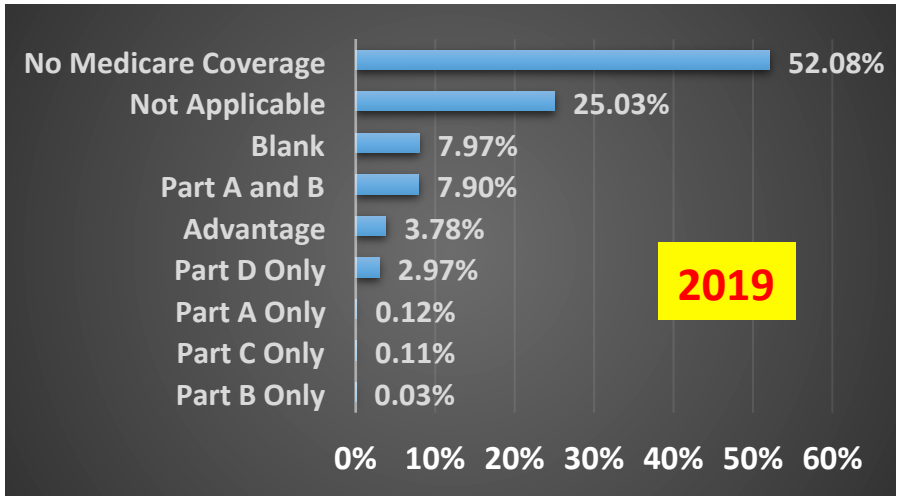
MA APCD Release 8.0 Documentation Explanation of Medicare codes

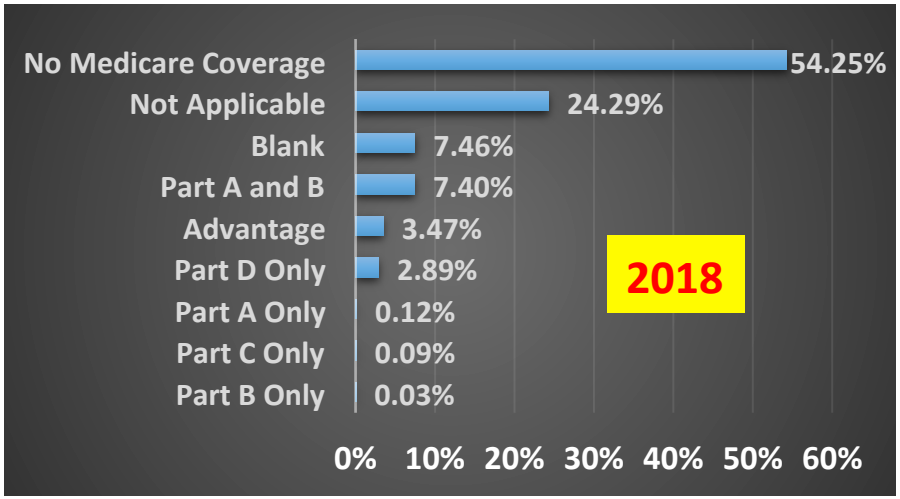
Term	Definition
Medicare Benefits (Part A & B)	Health insurance available under Medicare Part A and Part B through the traditional fee-for-service payment system. Part A is hospital insurance that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care. Part B helps cover medically-necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.
Medicare Advantage	A Medicare Advantage Plan (Part C) is a Medicare health plan choice offered by private companies approved by Medicare. The plan will provides all Part A (Hospital Insurance) and Part B (Medical Insurance) coverage and may offer extra coverage such as vision or dental coverage Medicare Benefits (Part A & B)

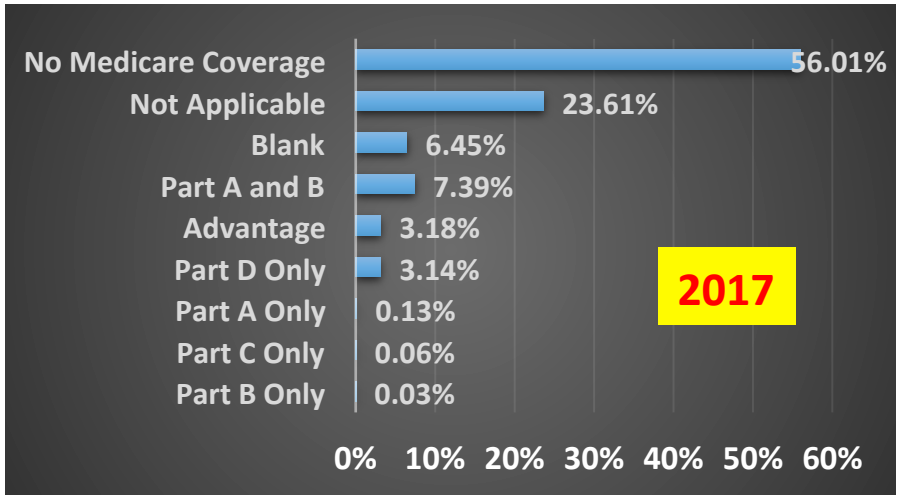
continued 

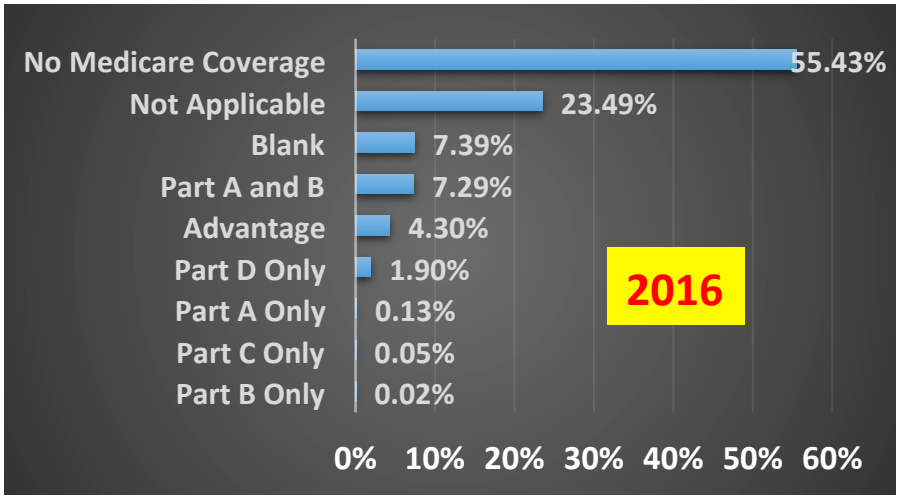
Answer (continued): *In looking at the frequency of Medicare Coding in MA APCD Release 8.0 by count of distinct MEIDs and by year for calendar years 2016 to 2019 for Massachusetts residents, while under 15% of records have a Medicare product, each year that percentage has been increasing as shown in the four charts below.*

Frequency of Medicare Code (MEO81) for Massachusetts Residents by Distinct MEID Count









Question: Is there a way to identify non-group vs employer sponsored plans? Market place vs off-marketplace non-group plans?

Answer: *Yes, the non-government limited data set Product file includes a field called Insurance Plan Market (PR005), see table to right. And the Member Eligibility file includes a field called Market Category Code (ME030), see table below.*

Market Category Code (ME030)

Code	*Description*
IND	Individuals (non-group)
ISCO	Individuals as a Senior Care Option
FCH	Individuals on a franchise basis
GCV	Individuals as group conversion Policies
GS1	Employers having exactly 1 employee
GS2	Employers having 2 thru 9 employees
GS3	Employers having 10 thru 25 employees
GS4	Employers having 26 thru 50 employees
GLG1	Employers having 51 thru 100 employees
GLG2	Employers having 101 thru 250 employees
GLG3	Employers having 251 thru 500 employees
GLG4	Employers having more than 500 employees
GSA	Small employers through a qualified association trust
OTH	Other types of entities. Insurers using this market code shall obtain prior approval.

Insurance Plan Market (PR005)

Code	Description
GPOS	Group - POS
GCOB	Group COBRA
GCCH	Group-Commonwealth Choice
GEMP	Group-Employer
GFED	Group-Federal
GGIC	Group-GIC
GMMK	Group-Merged Market
GMUN	Group-Municipality
GPRT	Group-Retiree
GSCO	Group-Senior Care Option
GUNN	Group-Union
HEXC	Health Exchange
ICCA	Individual - Commonwealth Care
ICCH	Individual - Commonwealth Choice
ICLO	Individual Closed
ICOB	Individual COBRA
ISCO	Individual Senior Care Option
IYGA	Individual Young Adult
MCRA	Medicare Part A
MCRB	Medicare Part B
MCRC	Medicare Part C
MCRD	Medicare Part D
MEDX	MediGap/Medicare Supplemental/Medex
ITHR	Other
OTMC	Other Medicare
STUD	Student
COBR	COBRA
GRUP	Group

Question: What out-of-pocket cost data is available? Are these data broken down by deductible, co-pay, and co-insurance amounts? *Answer: Yes, below are 14 currency fields included in the data release and their description. The ones related to out-of-pocket costs are highlighted in yellow.*

Element	Data Element Name	Description	Element Submission Guideline
MC062	Charge Amount	Amount of provider charges for the claim line	Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC063	Paid Amount	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC064	Prepaid Amount	Amount carrier has prepaid towards the claim line	Report the prepaid amount for this claim line. Report the Fee for Service equivalent amount for Capitated services. Report 0 when there is no Prepaid amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC065	Copay Amount	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC066	Coinsurance Amount	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC067	Deductible Amount	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC095	Coordination of Benefits/TPL Liability Amount	Amount due from a Secondary Carrier when known	Report the amount that another carrier / insurer is liable for after submitting payer has processed this claim line. Report 0 if there is no COB / TPL amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC096	Other Insurance Paid Amount	Amount paid by a Primary Carrier	Report the amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Do not include any Medicare Paid Amount - that should be reported in MC097. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC097	Medicare Paid Amount	Amount Medicare paid on claim	Report the amount Medicare paid towards this claim line. Only report 0 here if Medicare paid 0. If Medicare did not pay towards this claim line do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC098	Allowed amount	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC099	Non-Covered Amount	Amount of claim line charge not covered	Report the amount that was charged on a claim that is not reimbursable due to eligibility limitations or provider requirements. Report 0 if all charges are covered or fall into other categories. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC114	Excluded Expenses	Amount not covered at the claim line due to benefit/plan limitation	Report the amount that the patient has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at $50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by $250.00. Report 0 if there are no Excluded Expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070
MC116	Withhold Amount	Amount to be paid to the provider upon guarantee of performance	Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Report 0 if the provider has the agreement but did not satisfy the measure, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070
MC121	Patient Total Out of Pocket Amount	Total amount patient/member must pay	Report the total amount patient / member is responsible to pay to the provider as part of their costs for services. Report 0 if there are no Out of Pocket expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070

Where can I find past User Workgroup Presentations?

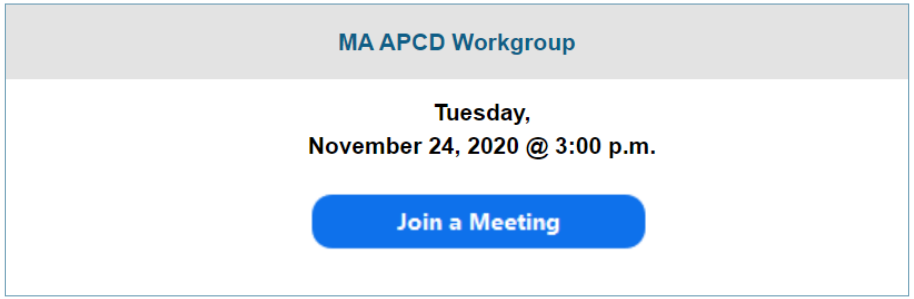
- http://www.chiamass.gov/ma-apcd-and-case-mix-user-workgroup-information/

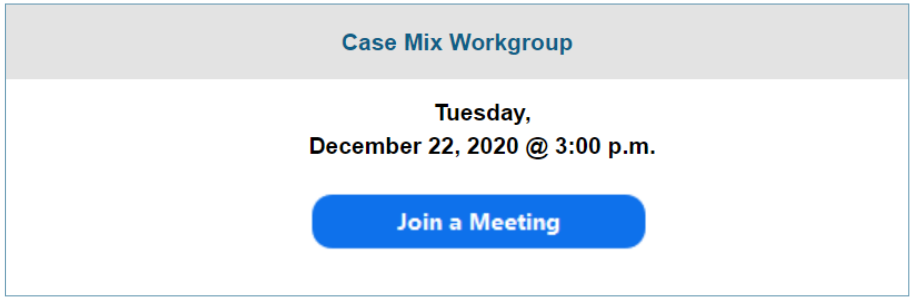
MA APCD / Case Mix Meeting Presentations

2019 Presentations	
2019 MA APCD Presentations	**2019 Casemix Presentations**
MA APCD Tuesday, November 26, 2019 • Presentation (PDF) | Word	Please Note: The Case Mix Workgroup Meeting for December 2019 was cancelled.
MA APCD Tuesday, September 24, 2019 • Presentation (PDF) | PPT	Case Mix Tuesday, October 22, 2019 • Presentation (PDF) | PPT
MA APCD Tuesday, July 23, 2019 • Presentation (PDF) | PPT	Case Mix Tuesday, August 27, 2019 • Presentation (PDF) | PPT

When is the next User Group meeting?

- The next User Group will meet Tuesday, April 27.





- http://www.chiamass.gov/ma-apcd-and-case-mix-user-workgroup-information/

Questions?

- Questions related to MA APCD:
  apcd.data@state.ma.us
- Questions related to Case Mix:
  casemix.data@state.ma.us

REMINDER: Please include your **IRBNet ID#**, if you currently have a project using CHIA data.

Call for Topics and Presenters

- If there is a **TOPIC** that you would like to see discussed at an MA APCD or Case Mix workgroup in 2020, contact Amy Wyeth [amy.wyeth@state.ma.us]
- If you are interested in **PRESENTING** at a MA APCD or Case Mix workgroup in 2020, contact Amy Wyeth [amy.wyeth@state.ma.us] You can present remotely, or in-person at CHIA
- We may be reaching out to some data users with invitations to present, and hope you will consider this!