CENTER FOR HEALTH INFORMATION AND ANALYSIS

Massachusetts All-Payer Claims Database (MA APCD)

Annual Release 2022

2018-2022
Documentation Guide

CHIA.

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Executive Summary

Each month, Massachusetts based insurers and national payers provide to the Center for Health Information and Analysis (CHIA) data collected from insurance billing for Massachusetts residents or the covered employees of Massachusetts companies. Their data includes claims files (dental, medical, and pharmacy), enrollment files, insurance product information, and provider data.

The Massachusetts All-Payers Claim Database Calendar Year (CY) 2022 holds data on health care activity in the Commonwealth or by Massachusetts based insurance plans that occurred from January 1, 2018 through December 31, 2022. MA APCD CY 2022 includes medical, pharmacy, and dental claims incurred between January 1, 2018 and December 31, 2022. This release includes six (6) months of run-out (paid claims through June 30, 2023).

This MA APCD CY 2022 Documentation Guide provides general information about CHIA's insurance, Medicaid, and Medicare Advantage holdings. This information includes high level data notes (data collection, release details, user support, file specific information, reference tables, and supporting data). A separate document, the **Data Specification Workbook**, has the full list of data elements.

Introduction

The Center for Health Information and Analysis (CHIA) pursuant to M.G.L. c. 12C, is the agency of record and serves as the Commonwealth's hub for health care data and analytics that support policy development and the systematic improvement of health care access and delivery in Massachusetts.
CHIA's enabling statute allows for the collection of data from commercial payers, third party administrators, and public programs (Medicare and MassHealth, Massachusetts' Medicaid program). To that end, CHIA collects Massachusetts All-Payer Claims Database (MA APCD). The MA APCD detailed claims level data is available to approved data users to provide a deeper understanding of the Massachusetts health care delivery system essential to improving quality, reducing costs, and promoting transparency. This document provides data users with information on the CY 2022 release of the MA APCD.

Overview

MA APCD data is comprised of medical, pharmacy, and dental claims and information from the member eligibility, provider, product, and benefit plan files, that are collected from health insurance payers licensed to operate in the Commonwealth of Massachusetts. This information encompasses public and private payers as well as fully-insured and self-insured plans. Note, due to the Supreme Court decision, *Gobeille v. Liberty Mutual*, the self-insured plans are severely reduced starting in 2016. This release also includes MassHealth Medicaid data in the MA APCD for the period of calendar years 2018-2022.
MA APCD data collection and data release are governed by 957 CMR 8.00 and 957 CMR 5.00. These regulations are available on the MA APCD website. (See **http://chiamass.gov/regulations/**.)
For ease of use, the CHIA has created separate chapters for MA APCD file types:

- Claims: (Dental (DC), Medical (MC), and Pharmacy Claims (PC))
- Member Eligibility (ME)
- Product File (PR)
- Benefits Plan Control (BP)
- Provider File (PV)
- MassHealth Enhanced Eligibility (MHEE)

MA APCD Files and Selected Databases

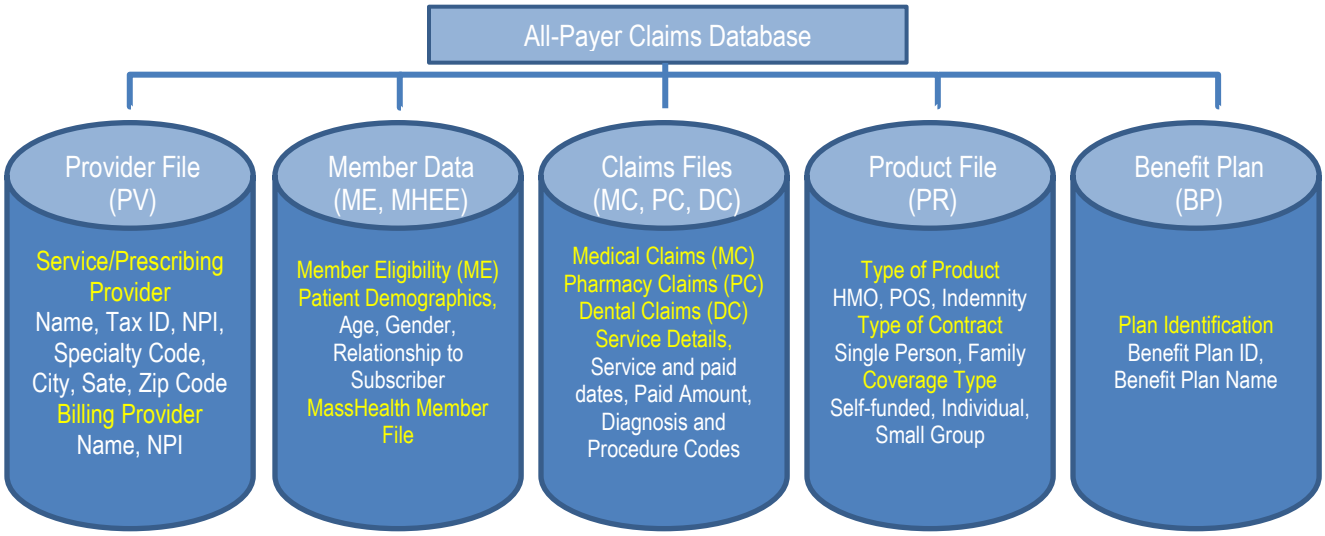

FIGURE 1 - MA APCD FILE TYPES

Data Collection

Massachusetts has been gathering information on the privately insured, Medicaid, and Medicare populations since 2006. The use and utility of data has changed over the years, but the Triple Aim (better quality, lower costs, and increased access to care) remains the central goal of the MA APCD.

CHIA collects data from payers due 30 days after the end of the previous month. CHIA works with the payers to ensure completeness and accuracy. CHIA standardizes and cleans key data elements to ensure practice alignment with accepted industry external source codes from outside government agencies including the Centers for Medicare and Medicaid Services (CMS), medical and dental professional associations, and other vendors to ensure data uniformity.

Establishment of the Massachusetts All-Payer Claims Database (MA APCD)

The first efforts to collect claim-level detail from payers in Massachusetts began in 2006 when the Massachusetts Health Care Quality and Cost Council (HCQCC) was established, pursuant to legislation in 2006, to monitor the Commonwealth's health care system and disseminate cost and quality information to consumers. Initially, data was collected by a third party on behalf of HCQCC under contract. On July 1, 2009, the Division of Health Care Finance and Policy (DHCFP) assumed responsibility for receiving secure file transmissions, creating, maintaining and applying edit criteria, storing the edited data, and creating analytical public use files. In July 2010, Regulations *114.5 CMR 21.00* and *114.5 CMR 22.00* became effective, establishing the MA APCD in Massachusetts.

Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency and Innovation," created CHIA. The new agency assumed many of the functions that were previously performed by the Division of Health Care Finance and Policy (DHCFP).

One of the purposes of the MA APCD is administrative simplification. CHIA collects, stores, and maintains data from payer and provider claims databases. CHIA serves as a central location for the information technology infrastructure (hardware, components, servers, and personnel) necessary to carry out its mission. All other agencies, authorities, councils, boards and commissions of the Commonwealth seeking health care data use CHIA-collected data rather than data directly from health care providers and payers. To ensure patient data confidentiality, CHIA may enter into an interagency services agreement for transfer and use of the data.

Previous Releases

A Preliminary Release (2.0) of the MA APCD covering dates of service CY 2008-2010 occurred in 2012 followed by subsequent Releases, 2.1 (2013), 3.0 (2014) and 4.0 (2015). MA APCD 5.0 covers dates of service CY 2011-2015 (with a minimum run-out of March 31, 2016). MA APCD 6.0 covers dates of service CY 2012-2016 (with a minimum run-out of June 30, 2017). MA APCD 7.0 covers dates of service CY 2013-2017 (with a minimum run-out of June 30, 2018). MA APCD 8.0 covers dates of service CY 2014-2018 (with a minimum run-out of June 30, 2019). MA APCD CY 2020 covers dates of service CY 2016-2020 (with a minimum run-out of June 30, 2021). MA APCD CY 2022 release covers dates of service CY 2018-2022 (with a minimum run-out of June 30, 2023).

Assembling the Data

CHIA receives data from payers through a secure online portal maintained by the Commonwealth. For MA APCD CY 2022, the data submitted to CHIA is a limited dataset with many personal identifiers masked/encrypted before, during, and after transmission.

When payers initially submit their data to CHIA for the MA APCD, an automated data validation process is run on each file to check for requirement conditions in accordance with filing thresholds in the MA APCD Submission Guides documentation [**http://www.chiamass.gov/apcd-data-submission-guides/**]. The automated validation edits perform an important data quality check on incoming submissions from payers. They identify whether the information is in the expected format (for example, alpha vs. numeric), contains invalid characters (for example, negative values, decimals, future dates), are valid values (for example, valid ICD-CM codes, valid Insurance Type codes) or is missing values. This process generates a Data Validation Report which is sent to the payer.
Data elements are grouped into four categories (A, B, C, and Z) MA APCD *Submission Guides* [http://chiamass.gov/apcd-data-submission-guides] provides the condition requirements and thresholds for each intake data element:

- 'A' level fields must meet the standard MA APCD threshold percentage or the payer-specific variance threshold in order for a file to pass. There is an allowance for up to a 2% variance within the error margin percentage (depending on the data element). If any 'A' level field falls below this percentage it results in a failed file submission for the payer and the payer's CHIA liaison will work with the payer to correct the submission.
- The other levels (B, C, and Z) are also monitored, but the thresholds are not presently enforced.

Variance Processing

Variance Processing is a collaborative effort between the payer and CHIA to reach a threshold percentage for any data element that does not meet the MA APCD threshold standard. Payers can request a lower threshold for specific fields, but they must provide a business reason (rationale) and, in some cases, a remediation plan for those elements. CHIA staff reviews each request and follows up with the payer for a variety of reasons; including addressing critical data quality issues, create plans to reach the threshold over time, and to seek a response to internal and external data user findings. Payers also use this process to request certain file type variances (for example: a vision payer requests a variance in submitting pharmacy or dental claim files).
When this process is complete, any submissions from the payer are held to the CHIA standard thresholds and approved variances. The payer receives a report after each submission is processed which compares their data against the required threshold percentages. CHIA holds reviews and discussions with the payer about the files that do not meet the required threshold percentage. The payer must then provide the corrected submission file.

Variance Example

Medical Claims file diagnosis fields (data elements MC042–MC053) are examples of fields for which variances have been approved. In requesting the variance, the carrier submitted a business rationale, explaining that to the pay claims, it was not necessary to retain more than the Primary or Admitting Diagnosis from claim forms. CHIA accepted the rationale and lower thresholds for these data elements. However, CHIA requested that the carrier should develop a remediation plan to start collecting this information going forward, thus eliminating the need for lower thresholds on these fields and improving the quality of the data.

Preparing Data for Release

All CHIA data goes through the same processing steps, including masking/encryption, intake, variance processing, Master Data Management (MDM), cleaning, and formatting. This data is then stored and maintained in a secure IBM Netezza system. Preliminary data is available to CHIA analysts for quality assurance, analysis, and public reporting. Release data goes through an additional process to be prepared for release to non-government and government data users.

Release files have the following characteristics:

- Each file type is written to a separate asterisk-delimited file. Each row in the release file represents one record of the file type. There is an asterisk-delimited field in each row for every data element.
- Empty or null data elements have no spaces or characters between the asterisks.
- With the exception of the MassHealth Enhanced Eligibility (MHEE) data elements, lookup tables are listed in the Submission Guides [**http://www.chiamass.gov/apcd-data-submission-guides/**] for each file type.
- Some data elements are encrypted to provide confidentiality for payers, providers and individuals, while allowing linking between claims, files, and lookup tables.

Data Protection/Privacy

The Commonwealth of Massachusetts has charged CHIA with protecting the confidentiality of individuals and organizations providing data to the MA APCD. This requirement extends to customers receiving MA APCD CY 2022 who are required through a data use agreement (DUA) to document their commitment to data privacy and security. The DUA outlines CHIA's restrictions on the disclosure and use of Data. Data Release regulations are available on CHIA's website [**http://www.chiamass.gov/regulations**].

MA APCD CY 2022 Release Overview

MA APCD CY 2022 release contains data elements collected from private and public payers of eligible health care claims for Massachusetts Residents. The data is collected in eight file types:

1. Dental Claims (DC),
2. Medical Claims (MC),
3. Pharmacy Claims (PC),
4. Member Eligibility (ME),
5. Product (PR),
6. Benefit Plan (BP),
7. Provider (PV), and
8. MassHealth Enhanced Eligibility (MHEE). – Available by special request for Government and MassHealth approved applicants only

Release Notes

Background

These release notes provide information for users of the Massachusetts All-Payer Claims Database (MA APCD) Annual Release for CY2022. This Annual Release includes medical, pharmacy and dental claims incurred between January 1, 2018 and December 31, 2022, and it includes six (6) months of run-out (paid claims through June 30, 2023). In addition to claims data, the release contains relevant reference files including member eligibility, providers, products, and benefit plans.

The Center for Health Information and Analysis (CHIA) has made minimal changes to this CY 2022 Annual Release. Users of the MA ACPD should consult the rest of Annual Release Documentation Guide for further details.

Annual Release Highlights

- Member Eligibility data for CY2022 Annual Release consists of December 2018, December 2019, December 2020, December 2021, December 2022 and June 2023 submissions.
- Also included in this Release is a subset of MassHealth Enhanced Eligibility (MHEE LDS) data available to all approved recipients of MassHealth data. The MHEE LDS data provides a view of a member on any given day.
- Updated master patient index.
    - A small percentage of records may not have a MEMBERLINKEID due to inconsistencies and inaccuracies in carrier reporting. Please see the MA APCD Annual Release Master Patient Index (MPI) Data Exclusion **document** for a complete list.
    - The MEMBERLINKEID used in this CY2022 Annual Release is based on the same logic and methodology as used in the CY2021 Annual Release. Other than the normal minor shifts one

would see as the underlying data improves, the MEMBERLINKEIDs would remain consistent between the two releases.

- This Release contains International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) procedure and diagnosis codes.
    - Diagnosis, Procedure, and E-code fields contain ICD-10 formatted codes.
    - ICD-10 codes are effective October 1, 2015.
- MassHealth Accountable Care Partnership Plans (Applies to OrgIDs 301, 296, 3505, 3735, 4962) started in 2018. These members and claims will be denoted as follows:
    - Insurance Type Code/Product (ME003, MC003, PC003, DC003) use the value of 30 to denote ACO.
- Updated MassHealth (Medicaid) filter logic
    - Members/Claims will be considered to be Medicaid if the carrier is a Medicaid related organization or they have a Medicaid Insurance Type Code/Product.
- Updated Substance Use Disorder (SUD) filter
    - Using the 2018 CMS filter as the model, new codes within the ranges in the 2018 CMS filter were identified and included in CHIA's SUD filter.
    - Ten new ICD-10-CM diagnosis codes, no new ICD-10-CM procedure codes, three CPT codes, no new APR-DRG codes, no new HCPCS codes, and no new ICD-9 codes were included.
    - Two MS-DRG codes were deleted.
    - Codes related to employer drug testing and tobacco are not included.

Carrier Highlights

- OrgID 8647
    - Issue with a subset of their member eligibility data (no other file types were affected). The issue is that one of their self-insured groups (about 5600 members) were assigned new member IDs and all of their members are currently in carrier's system twice going back to March 2019.
    - Did not populate the Medical Claims field MC100 - Delegated Benefit Administrator Organization ID for August 2017, June 2018 and August 2018 due to delays in getting the data from a Third Party Administrator for those time periods.
    - Uses two procedure codes, TF409 and TF410 in the MC055 – Procedure Code field in Medical Claims data which are dummy values to reflect OrgID-specific codes that are used internally to identify the COB/Recovery line on a claim. This OrgID does not report the COB/Recovery amounts in a separate field on the claim. Rather, they add a line onto a COB/Recovery claim so that when aggregated with the other lines on the claim, they net to the amount this OrgID paid as secondary payer. These lines should all have negative dollar values, unless the claim has been reversed: in those instances the rest of the lines are negative but the COB line is positive.
    - Beginning with their January 2020 submission, did a cleanup of their provider file data so that they no longer send any information on providers who do not have an NPI thus reducing the number of providers contained in their submissions. These records were generated because non-contracted providers in their system do not have term dates and so were still considered active. Any provider in their system who does not have an NPI on file has not actually submitted a claim since 2007 and can be considered to be inactive. That's when a having an NPI became a requirement for claims payment regardless of provider type.

- Carrier discovered they were submitting a small amount of fully-denied, secondary claims since the beginning of MA APCD collection. Using 1st qtr 2018 claims counts as a proxy, they estimated the number of incorrectly submitted claims as 6% of secondary claims. They also estimated secondary claims as 1.2% of total claims. Carrier agreed the denied claims related to this problem can be identified by counting distinct Payer Claim Control Numbers with at least one claim line with a Procedure Code beginning with 'TF.' In addition, ALL claim lines within the claim must be denied except the line with the procedure code beginning with 'TF'. This results in a small subset of denied secondary claims. Will be fixed going forward.
- Carrier has a large number of claim lines which are highest version and zero paid AND denied according to the Denied Flag. However, they're paid according to the Claim Line Paid flag. Carrier explained the services were provided and they were paid for under another line and should remain highest version because the services were provided and paid for. Carrier further explained the claim lines with a denial reason beginning with a 'D' are the ones paid under another line. There are a large number of zero-paid claim lines with a denial reason beginning with 'D', but there are also a large number of highest-version, zero-paid claim lines with a denial reason of 'NO' (ancillary to inpatient stay or a surgery) or 'NOPAY' (ancillary to inpatient stay or a surgery).
- Carrier switched to a new PBM in January 2023. Therefore, the CY2022 Release has six months of run out claims from the new PBM. The Version Indicator will be set to '9' for all pharmacy claims within the following submission periods: January 2023 through June 2023 (specifically incurred claims prior to 2023 that were paid in 2023 and any incurred in 2023). Changes in submission patterns for key fields related to claims versioning were identified and as a result, the current versioning logic does not align with the data from the new PBM. CHIA is working with the payer to update the logic.

- OrgID 3505
  - Noted in Release 7.0 that reversals were omitted for runout pharmacy claims submitted in April – June 2018. Carrier has stated this was corrected starting in Release 8.0.
  - Noted in Release 7.0 that starting with the February 2018 pharmacy claim file, the total Copay Amount in each submission for the QHP population drops to zero. Carrier has stated this was corrected starting in Release 8.0.
  - Populating Discharge Date year (MC069) with 1753 (a default date) on a number of claim lines in their Medical Claims submissions. The default value is the data as contained in their transactional system, which adds the default as the claim comes in. Going forward will provide a null value to APCD rather than this default date.
  - The total sum amount for PC037-IngredientCost/ListPrice for all submission periods looks much higher than PC036-Paid Amount. Carrier informed us they were populating PC037 with average wholesale price rather than ingredient cost. They will correct going forward.
- OrgID 302
  - Found a bug in their system that affects submissions going back to July 2016 through December 2018. This caused eligibility and claim volume to be overstated because some employer group members were being included in the submissions that should not have been. This has been corrected.
- OrgID 11364

- Noted the pharmacy claims allowed amount is under reported for January 2016 through June 2018. Revised Allowed Amounts will be provided in this Annual Release. Per carrier, correct figures are approximately $125M – $150M per month.
- Determined that their member eligibility, pharmacy claims and provider submissions were missing members, claims and providers from January 2014 through June 2019. Estimate that CHIA only received 50% of members and claims. This has been corrected.

- OrgID 11500
  - Noted deficiencies in Pharmacy Claims reporting, prior to June 2018, in which the deductible amount was reported as zero. Data corrected June 2018 forward.
  - Several clients terminated effective 12/31/2020 which represented more than 80% of the enrollment count therefore there is a large decline in membership and claims beginning in January 2021.
- OrgID 10926
  - Product Type code (MC003) in their Medical Claim files was not correctly reported beginning with the 201907 data through 201912 data. They were only reporting a value of '16' in MC003 and they should have either '16', '20' or 'HN'. This was corrected starting with 202001.
- OrgID 296
  - Noted that starting with July 2016 through September 2018 the Pre-Paid Amount field in medical claims was populated with "paid amount" resulting in inaccurate reporting. A correction was implemented by the payer (beginning with October 2018) to populate the pre-pay amount with the "approved amount" on claims from "vendor contracts for statistical arrangements for paying claims". All other claims Pre-Paid Amount will be zero.
  - Determined that a number of medical claims (5%-9%) were not included in the APCD files submitted from July 2017 through June 2019. Specifically, claims for dependents on their Commercial line of business were not reliably included in the files due to a mistake in the extract logic. Carrier has stated this will be corrected in this Annual Release.
  - Populating Admission Date (MC018) and Discharge Date (MC069) with 1900-01-01 (a default date) on a significant number of claim lines in their Medical Claims submissions. The default value is the data as contained in their transactional system, which adds the default as the claim comes in. Going forward will provide a null value to APCD rather than this default date.
  - Populating Member Gender (MC012) with 'N' on a small number of medical claims that are missing several Member data elements. Their logic is incorrectly assigning 'N' to the gender in these cases. They have updated the logic to populate the gender with 'U' for Unknown going forward for these instances.
- OrgID 291
  - Had a drop-off in Prepaid Amount in medical claims starting in July 2017 due to a decrease in their capitation business.
  - In 2019 CHIA started a data quality initiative to verify medical-claims versioning logic with all carriers. CHIA met with this carrier and the carrier confirmed the validity of the current caveated methods for versioning medical claims.
  - Product file sometimes uses the same Product ID for two separate products. Per the carrier, these duplicates are due to pediatric-dental benefits. Their pediatric-dental is tied in with medical benefits, so from a data perspective the Product ID is the same as the medical benefit.
- OrgID 8026

- Noted that starting with July 2016 through September 2018 Pre-Paid Amount field in medical claims was populated with "paid amount" resulting in inaccurate reporting. A correction was implemented by the payer (beginning with October 2018) to populate the pre-pay amount with the "approved amount" on claims from "vendor contracts for statistical arrangements for paying claims". All other claims Pre-Paid Amount will be zero.
- Determined that a number of medical claims (21%-45%) were not included in the APCD files submitted from July 2017 through June 2019. Specifically, claims for dependents on their Commercial line of business were not reliably included in the files due to a mistake in the extract logic. Carrier has stated this will be corrected in this Annual Release.
- Populating Admission Date (MC018) and Discharge Date (MC069) with 1900-01-01 (a default date) on a significant number of claim lines in their Medical Claims submissions. The default value is the data as contained in their transactional system, which adds the default as the claim comes in. Going forward will provide a null value to APCD rather than this default date.
- Exiting the Commercial Market in MA thus this OrgID is sunsetting. Will provide runout claims until the end of 2023.
- Populating Member Gender (MC012) with 'N' on a small number of medical claims that are missing several Member data elements. Their logic is incorrectly assigning 'N' to the gender in these cases. They have updated the logic to populate the gender with 'U' for Unknown going forward for these instances.

- OrgID 10441
  - Noted in Release 7.0 they were missing a small amount of business from their April – June 2018 member eligibility submissions. Carrier has stated this was corrected starting in Release 8.0.
  - Noted in Release 7.0 that due to a processing problem in the payer's system only MA residents were included. Carrier has stated that this was corrected starting in Release 8.0 to also include non-MA residents under a MA situs product.
  - Payer changed the format of the Payer Claim Control Number which disrupted the established pharmacy claims versioning logic. For Release CY2022, the pharmacy claims are without versioning results (the versioning indicators are set to '9') while CHIA works with the payer on updated versioning logic.
- OrgID 10632
  - Submitting separate records for members who have both medical and pharmacy coverage. The record indicating Medical coverage would populate ME018 – Medical Coverage = 1, ME019 – Prescription Drug Coverage = 2. The record indicating Pharmacy coverage would populate ME018 = 2, ME019 = 1. Those records are not merged due to ME055 – Business Type Code. For records indicating Pharmacy coverage, ME055 is populated with '4' indicating Pharmacy Benefit Manager. Records indicating Medical coverage would populate ME055 with a different value.
- OrgID 10353, 10441, 10929
  - The population of pharmacy claims and related providers submitted to CHIA were understated beginning with July 2017 through June 2019. Carrier has resubmitted with the missing data.
- OrgID 10929
  - This OrgID sunsetted in April 2022. Will continue to report run off claims for 6 months.
  - Payer changed the format of the Payer Claim Control Number which disrupted the established pharmacy claims versioning logic. For Release CY2022, the pharmacy claims are without

versioning results (the versioning indicators are set to '9') while CHIA works with the payer on updated versioning logic.

- OrgID 312, 10444
  - MC095 - Coordination of Benefits/TPL Liability Amount. Data from January 2016 through June 2019 was misstated. This field should have been reported as zero since they do not have a data source for this data element. Carrier has stated this will be corrected in this Annual Release.
  - MC099 – Non-Covered Amount. Data was understated and has been corrected in this Annual Release.
  - MC114 – Excluded Expenses. Data from August 2018 to June 2019 should have been reported as zero as they do not have a data source for this data element. This has been corrected in this Annual Release.
  - Changed Carrier Specific Unique Member ID (CSUMID) found in ME107, MC137, PC107 due to system enhancements beginning with August 2018 submissions. Carrier provided a crosswalk to map old CSUMIDs to new which CHIA applied to this Annual Release data.
  - System enhancements also impacted member eligibility and claims record counts beginning with August 2018 submissions.
  - There's a small number of claim lines which should have been amended and were not due to the limitations of the data format. Specifically, 22,000 or .6% of total claim lines for OrgID 312 and 6,000 or .4% of total claim lines for OrgID 10444 should have been amended and were not.
  - Carrier realigned membership between the two OrgIDs and, as a result, a subset of members were assigned new member ids. CHIA applied a crosswalk from the old member ids to the new member ids (supplied by carrier) to the data. However, as a result of the realignment, some claim lines were 'orphaned' within the data. They became orphaned when the first versions of the claim lines were submitted under one OrgID and the later versions of the claim lines were submitted under a different OrgID. If the later versions of the claim lines were amendments, they were not linked to the original versions.
  - MC123 – Denied Flag equal to '1' which means 'Yes' for all records in the Medical Claims files for January 2019 and February 2019. This has been corrected in this Annual Release.
  - ME029 – Coverage Type: some records were assigned a value of 'IND' in addition to the valid values from the lookup table for Jan 2021 – April 2021 for OrgID 312. It was corrected starting in May 2021. The 'IND' are all Fully Insured 'UND' members.
- OrgID 3735
  - In late 2018, the claim id (PCCN) for behavioral health claims increased from 8 to 9. Carrier did not update their systems to include the ninth digit until early 2019. Therefore, CHIA received claims with a truncated PCCN. It was determined the claims could be isolated as follows: all behavioral claims with a submission date greater than or equal to November 2018, a date of service less than or equal to December 31, 2018 and a PCCN length equal to eight (8). CHIA calculated the impact to medical claims as follows: about 100,000 claim lines which represents about 30,000 claims.
  - There was a big drop in their Masshealth membership in 2018 and forward. This caused a drop in pediatric claims since MassHealth is primarily women with children and they have a large pediatric population.
- OrgID 9891

- Incorrectly populated the Medical Claims field MC100 - Delegated Benefit Administrator Organization ID. In instances where the value in this field is OrgID = 269, it should actually be OrgID = 296. This has been corrected beginning with July 2019.
- MC003 – Insurance Type Code/Product field not populated. Must match to an eligibility record and use value in ME003 – Insurance Type Code/Product.

- OrgID 4962
  - Incorrectly labelled some products in their Product file as Medicaid in PR004 – Product Line of Business Model. Carrier has stated this will be corrected in this Annual Release.
  - For a majority of the records in every monthly Dental Claims submission, the value of DC040-Coinsurance Amount is equal to 9,999.99 which is the default value in their dental vendor's claims system. It is the equivalent of 0.00.
  - Beginning with Jan-2023, there is a pharmacy claims count increase due to how their new PBM handles adjusted and reversed claims differently than their previous PBM; The new PBM negates the old claim and issues a new claim instead of sending an adjustment to the old claim (maintaining the old claim number) so this will result in an increase in the number of paid claims because a new claim number is issued.
  - Carrier switched to a new PBM in January 2023. Therefore, the CY2022 Release has six months of run out claims from the new PBM. The Version Indicator will be set to '9' for all pharmacy claims within the following submission periods: January 2023 through June 2023 (specifically incurred claims prior to 2023 that were paid in 2023 and any incurred in 2023). Changes in submission patterns for key fields related to claims versioning were identified and as a result, the current versioning logic does not align with the data from the new PBM. CHIA is working with the payer to update the logic.
- OrgID 290
  - Incorrectly labelled some products in their Product file as Medicaid in PR004 – Product Line of Business Model.
- OrgID 10935
  - Incorrectly labelled some products in their Product file as Medicaid.
- OrgID 3156
  - In 2019 CHIA started a data quality initiative to verify medical-claims versioning logic with all carriers. CHIA met with this carrier and the carrier confirmed the validity of the current caveated methods for versioning medical claims.
- OrgID 12814
  - As much as 46% of the Medical Claims records have a missing value for MC063 (Paid Amount) for April 2019, May 2019 and June 2019. This has been corrected in this Annual Release.
  - There was a configuration issue with Inpatient Deductibles which started in January, 2017, as well as SNF coinsurances/copay. The issue was identified in January, 2018 and resolved. Carrier had all claims impacted adjusted. They reported copay, coinsurance, and deductible correctly at the time the files were originally submitted. After that point in time the claims were then adjusted in the following months leading to the large variations in the data. As such carrier has verified that the data was correct as submitted.
- OrgID 300
  - Reported ME028 – Primary Insurance indicator = '1' (yes) for approximately 30,000 Medi-Gap members when the indicator should have been '2' (no). These members can be identified where

ME003 = '15' or 'SP'. The group sold Medi-Gap claims (MC003 = '15') are included for a period of time (pre 2016) where they have no matching eligibility record.
    - Corrected ME028 Primary Insurance indicator so that this is marked as '2' (secondary) for their Medicare Supplement products. Also, corrected MC063 Paid Amount so that Withhold Amount is NOT included in MC063 derivation. These corrections were made beginning with January 2020 data.
    - For the submission period 201902, there is a Medical Claim record with a value over $60M in the Charge Amount (MC062) field. Carrier did not end up paying anything in the end on this and it ends up fully denied. This record should be excluded as an anomaly from any analysis.

    - The May 2023 medical claim file is smaller than normal, as claim processing systems were down in April and were not brought back until the end of May. There are no behavioral health claims in the May 2023 medical claim file. The June 2023 medical file contains the backlog of behavioral claims.

    - The May 2023 pharmacy claim file has no records, as they stopped receiving processed claims for members from their PBM in April and did not start receiving claim files again until mid-June.
- OrgID 10932
    - Incorrectly labeled all of their medical claim lines as MC138 – Claim Line Type = "R" (Replacement) in submission files from July 2015 through June 2019. There was a programmatic change in the carrier's system that caused this data element to identify all claims as replacements. Populating with the appropriate values going forward.
- OrgID 11726
    - HMO claim lines require a different versioning method from the other medical claim lines. Carrier reported the HMO claim lines represented 1-2% of their claim lines and they can be identified by a Payer Claim Control Number with a length of 15. Given the small volume,CHIA is not implementing a separate versioning method for the HMO claims.
    - Combined OrgID 11474 Medical and Pharmacy members/claims into OrgID 11726 beginning with December 2020 files.
- OrgID 11474
    - Submitted run-out Medical claims under this OrgID through December 2021.
- OrgID 10728
    - For data element MC246 – MassHealth Claim Type, carrier mistakenly populated "P" for pharmacy rather than "M" for physician claim. Will be corrected for March 2021 data and forward.
    - For data element MC112 – Referring Provider ID, all values are null for submission periods January 2016 through August 2018 and August 2019 through June 2021.
    - For data element PC059 – Recipient PCP ID, all values are null for the submission periods December 2020 through June 2021.
    - Submitted an incomplete Pharmacy Claims file for September 2019. Carrier has stated this has been corrected.
    - Submitted an incomplete Medical Claims file for November 2020. Carrier has stated this has been corrected.
    - NPI fields (MC026 & MC242) contain default values for non-emergency transportation services to their membership. Only 25% of those ride providers have NPIs as they are classical non-medical

transportation vendors. 1999999976 – default for institutional; 1999999984 – default for professional; 1999999992 – default for DME.

- OrgID 301
  -
- OrgID 13074
  - Discontinued their Medicare Advantage product in Massachusetts starting in January 2022. Sent runout claims through June 2022.
- OrgID 10187
  - There was a spike in the number of Medical claim voids during 2021 due to retro adjustments.
  - In 2022, their claims department did two massive retro rate provider increases. One was in February and the other in the spring/summer so there's some fluctuation in the number of records for those time frames.
- OrgID 9913
  - The Paid Amount (DC038) for the January 2022 Dental Claims submission is not populated. Carrier has stated this has been corrected.
- OrgID 13027
  - PC035-Charge Amount for submission periods from 202001 to 202012 is inflated by 2 decimal points. The amounts should be divided by 100 to get the proper amount.
- OrgID 20122
  - PV049-Accepting New Patients beginning with submission period 202101 through 202303, blanks in that field should have been coded as '3-Unknown'. This was corrected for the 202304 submission and forward.
  - Medical Claims are now versioned from 202101 to present.
- OrgID 10954
  - The PC040-CopayAmount is smaller for submission periods starting with 202104. Carrier has verified the copayment decrease and confirmed it to be correct.
- OrgID 11715
  - A small number of Medical Claim lines for MC018 - Admission Date show '17530101' as a placeholder admission date from their database. The reason is that they sometimes have incomplete data on out-of-state claims and their system defaults to that invalid date.
- Several carriers resubmitted data, improving data linkage between their file types.
- There are no new submitters included in this Annual Release.
- We have several small carriers that have stopped submitting due to 1) leaving the MA market altogether or 2) having a minimal presence in the MA market and a lack of specialized market sector in MA. You will continue to see their data for earlier years but CHIA does want to alert you that data will be sporadic for the year they exited the MA APCD (consult the Annual Release Documentation Guide for additional information). Below are the OrgIds for carriers that stopped submitting in this release or the prior releases:

ORG ID	LAST SUBMISSION PERIOD
295	Dec-2020
7041	Jun-2021
7249	Sep-2018

ORG ID	LAST SUBMISSION PERIOD
7397	Sep-2018
7422	Mar-2020
7431	Jun-2018
8026	Dec-2023
10435	Sep-2018
10440	Sep-2018
10920	Aug-2018
10924	Sep-2018
10928	Sep-2018
10929	Jun-2022
10936	Sep-2018
10943	Oct-2018
10949	Sep-2018
11237	Sep-2018
11274	Sep-2018
13074	Jun-2022
11377	Sep-2018
11446	Sep-2018
11869	Jun-2018
11934	Sep-2018
11936	Sep-2018
11939	Sep-2018
11943	Sep-2018
12226	Feb-2018
14284	Dec-2022
14285	Dec-2022

- As a result of the Supreme Court Gobeille ruling we have carriers that have removed self-insured data from their MA APCD data submissions and you will see a drop in members and claims in 2016 onward. Several carriers actively poll their employer groups for inclusion in MA APCD. At the end of 2018, we believe about 75% (or about 1.75 million members) of self-insured Member Eligibility data is missing from the MA APCD.

The Limited Data Set (LDS)

The pre-configured Limited Data Set (LDS) is designed to protect patient data confidentiality while ensuring analytic value. The "core" data elements are available to all users (non-government and government). Users wishing to add to the "core" elements must indicate this by selecting from the list of "buy-ups." The "buy-up" process allows a user to receive more granular data—for example, instead of a 3-digit patient zip code; the user can request a "buy-up" to a 5-digit patient zip code. Note that buy-ups will be reviewed for approval by CHIA based on research needs related to the project description.

ICD-10

The CY 2022 release contains International Classification of Diseases, Tenth Revision Clinical Modification (ICD-10-CM) procedure and diagnosis codes. Diagnosis, Procedure, and E-code fields contain both ICD-9 and ICD-10 formatted codes. ICD-10 codes are effective October 1, 2015. The ICD indicator flag indicates whether codes are reported in ICD-9 or ICD-10 format. The ICD indicator flag is as reported by carriers and is not 100% accurate. Users should interpret 2015Q4 incurred claims data cautiously, as some carriers may have mixed ICD-9 codes in with ICD-10 codes.

The ICD-9 procedure field has been renamed "ICD-CM Procedure Code" and is now 7 characters in length. The ICD indicator flag should indicate if a code is in ICD-9 or ICD-10 format. However, users have reported consistency issues with the ICD indicator flag. Users should interpret 2015Q4 incurred claims data cautiously, as payers may have mixed ICD-9 codes in with ICD-10 codes.

Third Party Administrators (TPAs)

CHIA seeks to create a comprehensive all-payer claims database that includes data from all health care payers and third-party administrators. In instances where more than one entity administers a health plan, the health care payer and third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides. In such instances some records may be represented twice—once by the payer, and once by the TPA.

Additional Privacy Protections

The Massachusetts APCD has maintained best-in-class data privacy controls and data security measures since its beginning. As the data has grown more detailed and complex, CHIA has made changes to improve security and privacy protections. To that end, CHIA has new security requirements which required the removal of some fields from the data and the masking of personal identifiers prior to submission to CHIA.

This includes the removal of much address information. In its place was an enhanced Master Data Management (MDM) process that generates a time-invariant, unique, de-identified enrollee number. This new ID is not compatible with prior MA APCD releases. However, it uses data from between 2010 through 2022 to allow for longitudinal analysis.

As the loss of certain identifiers may make connection between eligibility records and claims more difficult, CHIA introduced surrogate keys, designed to allow for easier cross-table linkages. Users should review the Release Template for details.

Historical Data Elements

Users of multiple releases of MA APCD data should not link releases to each other. Changes in membership, carrier IDs, file formats, and linking data elements make such efforts difficult and often wrong without CHIA assistance. Users with questions about new data elements or changes in coding from year to year should contact CHIA.

Data Limitations

MA APCD CY 2022 is derived from claims, product, provider, eligibility, and benefit information provided by reporting payers, their subsidiaries, and third-party processors. The quality of the submitted claims data is dependent upon the data collection and processing policies and coding practices of the reporting carrier. Information may not be entirely consistent from payer to payer due to differences in:

- Variance process
- Carrier collection and verification of patient and provider supplied information after services were provided,
- Claims coding, consistency, and/or completeness,
- Extent of carrier data processing capabilities,
- Flexibility of carrier data processing systems,
- Varying degrees of commitment to quality of merged data,
- Capacity of financial processing system to record late occurring payments on CHIA's electronic submission, and
- Non-comparability of data collection and reporting.

The Supreme Court decision, *Gobeille v. Liberty Mutual*, has had an impact on the completeness and robustness of the MA APCD. Although many payers are voluntarily submitting data from their self-insured plans, as allowed under law, some payers have removed that data from submission. You will, therefore, note that MA APCD CY 2022 may show limitations in the volumes previously seen for some Payers and/or data analyses. However, the MA APCD remains an important resource to support Massachusetts' efforts to lower costs and improve access and quality.

Help Using the Data

CHIA offers resources to data users to help them access and use the data. These resources include online methodologies and limited support through our Department of Data Operations and Technology.

Data Access

Potential users of the data should review the Data Access webpages for information on how to access the data. In addition, see Appendix A for general information.

Online Resources

The CHIA website includes resources used to create the MA APCD data. These include the data submission guides that payers use to generate the underlying data [**http://www.chiamass.gov/information-for-data-submitters/**]. The submission guides are a useful start for users, but they do not provide complete information as CHIA does not release all intake elements and may clean or derive release elements. Data submission guides can change annually, and therefore users doing longitudinal analysis may want to use these resources to determine year-by-year differences in specific, underlying data elements.

As part of CHIA's continuing MA APCD quality assurance work, a series of payer-specific technical data profiles (based on Release 5.0 data for the period between June 2014 and July 2015) are available as a resource for MA APCD data users [**http://www.chiamass.gov/apcd-technical-data-profiles/**]. These dashboards do not contain protected health information. CHIA publishes methodologies for public reporting about these profiles and other analysis. This includes methods for our Enrollment Trends reports [**http://www.chiamass.gov/enrollment-in-health-insurance/**], and our Release 4.0 Medical Expenditure Trends [**http://www.chiamass.gov/medical-expenditure-trends/**]. Users can also access code if they search the website for "programming code."

Users should be aware that some reports are generated from pre-release data and may use data elements not available due to privacy and/or security reasons. As well, current methodologies may be generated using a prior version of the MA APCD data, and therefore may not perfectly translate over for MA APCD CY 2022. As the code and methods are updated, users should be able to access that information on the same website pages.

User Support

Data documentation for MA APCD releases can be accessed at **http://www.chiamass.gov/ma-apcd/**. For more information about specific data elements, facility reporting thresholds, or other questions about the data, please contact CHIA by emailing **APCD.Data@chiamass.gov**.

Individuals emailing CHIA should reference their data user agreement, data version, and whether they, personally, access the data. Questions should be specific and brief to improve response time. Typical questions asked to user support include:

- How to read in the data
- Data element specific information
- How to link the data
- Recommended approaches

Additionally, users and the public are welcome to attend the CHIA APCD webinars, held monthly or semi-annually. These meeting bring together the MA APCD user community and provide a forum to discuss findings that might impact analysis. Users are highly recommended to attend and to review historical webinars [**http://www.chiamass.gov/ma-apcd-and-case-mix-user-workgroup-information/**].

General MA APCD questions should be sent to the MA APCD mailbox [**APCD.data@chiamass.gov**]. Direct questions regarding data requests/applications should be sent to the MA APCD data application mailbox [**APCD.data@chiamass.gov**].

The Claims Files and Claims Versioning

CHIA has created a consistent MA APCD with medical, pharmacy, and dental claims compiled from fully-insured, self-insured, Medicare, Medicaid, and Supplemental Policy data.
This section describes the claim file types. The claims files are:

- Dental Claims (DC) file
- Medical Claims (MC) file
- Pharmacy Claims (PC) file

Claims data for the CY 2022 release covers services incurred from January 1, 2018 through December 31, 2022. Due to the manner in which carriers submit data to CHIA, some services incurred within the release range are included in later submissions. Therefore, it is necessary to include data submissions beyond December 31, 2022. We call this "run-out." CHIA includes six months of run-out data in the release, making the submission year/month range from 201801 to202306.
MA APCD submissions are at the claim line level. Typically, each time a claim is adjudicated a line is created. As a result, each claim may have multiple lines. Identifying the highest version of the claim allows analysts to accurately determine total charges, discounts, payments, etc. Highest version flags, based on carrier-specific logic, are available for the largest payers for Medical (MC) Claims and Pharmacy Claims (PC).

Denied Claims

CHIA does not require payers to submit data from wholly denied claims. The provider *must* submit data for all claims paid partially or in whole. If a single procedure is denied within a paid claim, the provider must report the denied line. In the MA APCD, denied line items of adjudicated claims can assist in the analysis of covered benefits and/or patient eligibility.

Claims Versioning Overview

CHIA's standard versioning process includes applying cleaning logic, identifying duplicates, voids/back -outs, replacements/amendments, and setting the highest version flag. Versioning logic has been reviewed and approved by each carrier.
Claim versioning allows CHIA to identify specific attributes in claims that may have multiple versions over time and claim type. This section provides an overview of claim versioning. The Claim Line Type Codes, Highest Paid Version Flag, Highest Version Denied Flag, Highest Version Flag, and Fully Denied Claim Flag are most useful for claim versioning.
The Highest Paid Version Flag is populated for both medical and pharmacy claims, but the other flags (Highest Version Denied Flag, Highest Version Flag, and Fully Denied Claim Flag) are populated for medical claims only.

The Claim Line Type field is critical to claim line versioning. The Claim Line Type code along with other critical data elements determines the action to be taken by CHIA in order to version the claim **(Table 5: Claim Line Type Codes)*.**

Highest Paid Version Flag

The VERSIONINDICATOR flag helps data users determine the highest version of a claim line that was "paid," and is derived as part of the standard versioning production logic (**Table 6: VERSIONINDICATOR Flag**)*. This is the version indicator approved by payers per discussions with CHIA for MA APCD release and financial analysis purposes. Additionally, some payers provided custom logic for including/excluding claim lines.
Typically a value of one means that the line was directly paid; however, note that depending on carrier specific logic it is sometimes possible that payment for that specific line was actually denied. However in such a case, a value of one indicates that the service was covered and the payment was included as part of the payment on another line in the same claim collection.

Highest Version Denied Flag

The purpose of the HIGHESTVERSIONDENIED flag is to identify claim lines within a claim that have been denied (**Table 7: HIGHESTVERSIONDENIED Flag**)*. A value of 1 indicates that the claim line was both highest version and payment was denied. For example:

- If HIGHESTVERSIONDENIED =1 and the "VERSIONINDICATOR" = 1, then that means that while this specific claim line was denied, payment for this line was likely included with payment on another line (bundled payment).
- If HIGHESTVERSIONDENIED =1 and "VERSIONINDICATOR" = 0, then that means that this claim line was denied, and that this claim line is the highest version of the claim line.

Highest Version Flag

The HIGHESTVERSIONINDICATOR flag shows claim lines that are the highest version claim line, whether or not the claim line was paid (**Table 8: HIGHESTVERSIONINDICATOR Flag**)*.

Fully Denied Claim flag

The FULLYDENIEDCLAIM flag is a claim level attribute, applied at the claim line level (**Table 9: FULLYDENIEDCLAIM Flag**)*. If all the individual claim lines in the highest version of a claim are denied, then the entire claim is a fully denied claim. The same derived claim level value will be applied to each claim line in the collection.
The logic used in assigning these flags requires sorting the dataset and breaking on OrgID and PCCN (Payer Claim Control Number) where Highest Version indicator = 1. This ensures only a highest version claim will be considered a fully denied claim. Users should expect to see only highest version claims flagged as fully denied (that is: HIGHESTVERSIONINDICATOR = 1 and FULLYDENIEDCLAIM = 1).

> **Note:** Any claim that is not a highest version claim line related to the final version will not be flagged as a fully denied claim as these claim lines are considered a different claim view, separate from the final claims view. Be aware, however, that these types of claims often have the same Payer Claim Control Number (PCCN) as the highest paid version.

*These tables may be found in the Critical Reference Tables section later in this document.

Dental Claims (DC)

Payers are required to submit a Dental Claims (DC) File. The Dental Claims File consists of all paid claims from all reporting payers for Dates of Service years 2018 to 2022 as paid through June2023. (This represents a six month plus run-out period of 2023data.) CHIA releases the Dental Claims file for each requested year based on *Date of Service To* for the claim line. If *Date of Service To* is unavailable, CHIA utilizes the *Submission Month Period* to filter data.

Payers are instructed by CHIA to submit any dental claim that is considered paid. The paid amount should be reported as zero and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly for claims that are paid under a *global payment*, or *capitated payment*, and thus are zero paid.

Claim Lines

Each row in the DC file represents one claim line. If there are multiple services performed and billed on a claim, each of those services are uniquely identified and reported on a line. Line item data provides an understanding of how services are utilized and adjudicated by different payers.

Certain data elements of claim level data are repeated in every row in order to report unique line item processing and maintain a link between line item processing and claim level data. CHIA requires line-level detail of all Dental Claims for analysis. The line-level data aids with understanding utilization within products across Payers. Subscriber and Member (Patient) Payer unique identifiers (DC056 and DC057) are included to aid with the matching algorithm.

Claim IDs

Claims may be isolated by grouping claim lines by the following elements:

Payer Org ID (DC001) + Payer Claim Control Number (DC004)

Payer-Assigned Identifiers

CHIA requires various payer-assigned identifiers for matching logic to other files, including DC003, DC006, DC056 and DC057. These fields can be used to aid with the matching algorithm to other files. When paired against ME003 in the ME File, please be aware that a greater granularity exists in that element that allows for senior and supplemental coverage options beyond those that may appear in the DC003 element.

Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are DC017, DC030, DC031, DC037 through DC041, DC045, and DC046 and are variations of paper remittances or as defined by HIPAA 835 4010/5010.

Provider IDs

Element DC018 (Provider ID) is a critical element in the MA APCD. It links the Provider identified on the Dental Claims file with the corresponding record in the Provider File (PV002)/ Provider Delegate (Derived). The purpose of PV002/Provider Delegate is twofold: to help identify provider data elements associated with the provider, submitted in the claim line, and to identify the details of the Provider Affiliation(s). PV002 can contain sensitive personal information; therefore, CHIA has created surrogate keys for this field.

Versioning

The dental claims are not currently versioned.

Medical Claims (MC)

Payers are required to submit a Medical Claims (MC) File. The Medical Claims File consists of all paid claims from all reporting payers for Dates of Service years 2018 to 2022 as paid through June2023. (This represents a six month plus run-out period of 2023data.) CHIA releases the Medical Claims file for each requested year based on *Date of Service To* for the claim line. If *Date of Service To* is unavailable, CHIA utilizes the following data:

- Discharge Date
- Date of Service From or Admit Date; or
- Submission Month.

CHIA instructs Payers to submit any medical claim that is defined as paid. Paid amount should be reported as zero and the corresponding Allowed, Contractual, and Deductible Amounts should be calculated accordingly for claims that are paid under a *global payment*, or *capitated payment*, thus are zero paid.

Claim Lines

CHIA requires the line-level detail for analysis, which aids with identifying utilization within products across Payers. The specific medical data reported in MC039 through MC062, MC071, MC072, MC075, MC083 through MC088, MC090, MC108, MC109, MC111, MC126, MC 127, MC129, MC130, and MC136 are types of elements that are reported to a Payer on the UB04, HCFA 1500, the HIPAA 837I and 837P or a Payer specific direct data entry system. Subscriber and Member (Patient) unique identifiers are collected to aid with the matching algorithm, see MC137 and MC141.
Certain data elements of claim level data are repeated in every row in order to report unique line item processing. CHIA uses the claim-line level data to capture accurate details of claims and encounters.
The reporting of Voided Claims maintains logic integrity between services utilized and deductibles applied.

Claim IDs

Claims may be isolated by grouping claim lines by the following elements:
Payer Claim Control Number (MC004)/Payer Org ID (MC001)

Payer-Assigned Identifiers

CHIA requires various Payer-assigned identifiers for matching-logic to the other files. Examples of this type of field include MC003, MC006, MC137 and MC141. When paired against ME003 in ME File, please be aware that a greater granularity exists in that element that allows for senior and supplemental coverage options beyond those that may appear in the MC003 element.

Adjudication Data

CHIA requires adjudication-centric data on the file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010/5010.

Provider IDs

The set of fields MC024-MC035 relate to the provider who performs the service. The intent is to collect entity level rendering provider information, at the lowest level achievable by the payer. A physician's office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.
If the payer only knows the billing entity, and the billing entity is not a *service rendering* provider, the payer would need a variance request for the Servicing Provider fields.
If the payer only has the data for a main *service rendering* site but not the specific satellite information where services are rendered, then the main service site *is* used as the Servicing Provider field. For example, XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and, ultimately, the goal.
The fields MC134 (Plan Rendering Provider) and MC135 (Provider Location), capture servicing or rendering provider at the physician or other licensed person rendering level. These fields should describe precisely who and where the service was rendered. If the payer does not know who performed the service or the specific site where the service was actually performed, the payer will need a variance request for one or both of these fields. It is not appropriate to report facility or billing information here.
Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are critical fields in the MA APCD; they are used to link the Provider identified on the MC file with the corresponding Provider ID (PV002)/ Provider Delegate (Derived) in the Provider File.
The purpose of PV002/Provider Delegate is to help identify provider data elements associated with provider data submitted in the claim line detail, and to identify the details of the provider affiliation. However, due to the fact that PV002 can contain sensitive personal information; CHIA has created surrogate keys for this field.

Versioning

CHIA's standard versioning process includes applying cleaning logic, identifying duplicates, applying voids/back - outs, and replacements/amendments, and setting the highest version flag. Versioning logic and results have been reviewed with each carrier. A highest versioning flag (Derived) is used in the CY 2022 release. A value of 0 or 1 has been assigned to each medical claim line from the following ORG IDs: 291, 295, 296, 300, 301, 312, 3156, and 3505. 3735, 4962, 7041, 7422, 8026, 8647, 10187, 10353, 10441, 10444, 10926*, 10929, 11474, 11726, 12814*, partial on 10632. Claim lines from all other payers should have a value of 9. (See *The Claims Files and Claims Versioning* for more details.)

> *OrgIDs 10926 and 12814 were added as part of Release 6.0 and included in Release 7.0. Versioning logic was shared with the carriers and results have been beta tested internally

Pharmacy Claims (PC)

Payers must submit a Pharmacy Claims (PC) file. The PC file includes individual claim lines for each requested year. Claim lines are assigned a *Date of Service To*. CHIA releases the Pharmacy Claims file for each requested year based on *Date of Service To* for the claim line. If *Date of Service To* is unavailable, CHIA utilizes the following data:

- Date Prescription Filled;
- Paid Date;
- Date Prescription Written;
- Date Service Approved; or
- Submission Period (YYYYMM) less one day.

CHIA instructs payers to submit any pharmacy claim that is considered paid. Claims paid under a *global payment* or *capitated payment* are designated zero paid. For these claims, payers should report the Paid amount as zero and the corresponding *Allowed*, *Contractual*, and *Deductible Amounts* should be calculated accordingly.

Claim Lines

CHIA requires line-level detail for analysis. The line-level data aids with understanding utilization within products across payers. Subscriber and member (patient) payer unique identifiers included linked data using the matching algorithms; see the data elements PC107 and PC108.

Payer-Assigned Identifiers

CHIA collects various Payer assigned identifiers for matching-logic to the other files. Examples of these fields include PC003, PC006, PC107 and PC108. These fields can be linked using matching algorithm across other file types. When paired against ME003 in the ME File, please be aware that greater granularity exists in that element that allows for senior and supplemental coverage options beyond those that may appear in the PC003 element.

Adjudication Data

CHIA requires adjudication-centric data to comply with analytic requirements. The elements typically used in an adjudication process are PC017, PC025, PC036, PC040 through PC042, PC063, PC065 through PC070 and PC110 and are variations of paper remittances or HIPAA 835 4010/5010.

Provider Identifiers

CHIA collects numerous identifiers that may be associated with a provider. The identifiers will be used to help link providers across payers if the primary linking data elements are not a complete match. The additional identifying elements will improve the quality of the matching algorithms. Examples of these identifying elements include PC043-PC055 relating to the Prescribing Provider.

Elements PC043 (Prescribing Provider ID and PC048 (Prescribing Physician NPI) are critical fields that link the Prescribing Provider identified on the Pharmacy Claims file with the corresponding record in the Provider File (PV002)/Provider Delegate (Derived).

The purpose of PV002 and Provider Delegate are twofold; to help identify provider data elements associated with provider data, submitted in the claim line detail, and to identify the details of the provider affiliation. PV002 can contain sensitive personal information; therefore CHIA has created surrogate keys for this field.

Versioning

A highest paid version flag is provided in the CY 2022 release. A value of zero or one has been assigned to each pharmacy claim line from the following ORG IDs: 291, 295, 296, 300, 301, 302, 312, 3156, 3505, 3735, 4962, 7041, 7789, 8026, 8647, 10444, 10632, 10926, 11474, 11541, 11726. Claim lines from all other payers have a value of nine. (See *The Claims Files and Claims* Versioning for more details.) Also, see Table 2 below for a list of related caveat(s) by submitting ORG ID. Grouped ORG IDs illustrate single Carrier reporting.
For linkage purposes, the same re-identified integer values were substituted into the Pharmacy File.

Table 2: MA APCD Pharmacy Versioning Caveats by ORG IDs

ORG ID	CAVEAT(S)
10441, 10929	Due to changes in the submission patterns, the versioning logic for this submitter was adversely impacted. As a result, CHIA is reviewing the new data and the pharmacy claims are not versioned as of CY2022 Release.
291	Pharmacy claims submitted by ORG ID 291 contains anomalies related to Charge Amount (PC035) and Pharmacy Number (PC018) which have a minor impact on versioning, but the anomalies do not have a material impact on ORG ID 291's total pharmacy dollars within the Release. CHIA and ORG ID 291 reviewed the anomalies together and agreed the impact was less than 1% on Total Allowed Amount (PC068.) CHIA is currently working with ORG ID 291 to address the issues and refine the versioning logic for a future release of MA APCD.
11474, 11726, 295	CHIA versioned the claims as of January 2014, incurred period. This Carrier is not reporting back-out claim lines within their MA APCD Pharmacy submissions. As a result, the Carrier estimates there are 30 claims per month that may have been backed out by the pharmacy benefit manager but are marked as highest version because ORG ID is not sending back-outs. Again, this issue is present for all three submitting Org IDs (11726, 295, and 11474) across all submitting years. The Carrier is working with their PBM to obtain and report back outs to MA APCD in the future.
7041	ORG ID 7041 is reporting a small number of claims (less than 100 claims across all years) where the Pharmacy Number (PC018) changes in later versions of the claim from the true value of the pharmacy number to a value of '1111111'. According to the Carrier, these exception lines occur when a refund is issued to the member.
8026, 296, 12122	Based on the action plan approved by this Carrier's grouped ORG IDs (8026, 296, 12122), CHIA versioned the claims as of January 2014, incurred period. As of CY2022 Release, pharmacy claims for ORG ID 12122 are no longer present in the pharmacy claims file.
4962	CHIA versioned the claims as of January 2014, incurred period. Due to an anomaly within the submitted data, CHIA was unable to version 1.5% of each month's claims. All claim lines related to this issue are marked as not highest version. Further investigation is needed to determine if this anomaly will be corrected in a future release. As of CY2022 Release, the anomaly above impacts a larger percentage of pharmacy claims lines. The anomaly which increases the number of not-highest-version claim lines ranges from about 8.7% to 13.8% of pharmacy claim lines by submission year. he submission patterns for this submitter were adversely impacted by a change in the pharmacy benefit manager (PBM) as of January 2023. As a result, CHIA is reviewing the data from the new PBM and the pharmacy claims for the run-out period (January 2023 – June 2023) are not versioned as of the CY2022 Release.
8647 (Commercial , Medicare)	ORG ID 8647 reported that 17% to 19% of monthly claims from the Medicare Platform represent Single Transaction Coordination of Benefit (STCOB) encounters. These encounters contain more than one claim for the same prescription. According to the

	carrier, STCOB claims occur when enhanced coverage is provided in addition to the primary coverage. The submission patterns for this submitter were adversely impacted by a change in pharmacy benefit manager (PBM) as of January 2023. As a result, CHIA is reviewing the data from the new PBM and the pharmacy claims for the run-out period (January 2023 – June 2023) are not versioned as of the CY2022 Release.
10926, 7789, 10444, 312	ORG ID 7789 - CHIA versioned the claims as of October 2013 incurred period. ORG ID 10444 - CHIA versioned the claims as of January 2013 incurred period. ORG ID 312 - CHIA versioned the claims as of January 2013 incurred period. **Note:** 10926 was versioned for the entire 2012-16 incurred period

Member Eligibility (ME) File

As part of the MA APCD, payers are required to submit a Member Eligibility file. Annual eligibility files contain all eligibility records with at least one day of member eligibility within the prior 24 months. For the CY 2022 release, Member Eligibility data is from December 2018, December 2018, December 2019, December 2020, December 2022, and June 2022. Data from 2022 is included to provide a full 24 months of enrollment data for those payers that might experience a slight lag between reporting enrollment in 2022Q4 and submission of claims incurred in 2022.
There are a number of elements in the ME file (for example, race and ethnicity,) that are poorly reported. Individual elements each have a reporting threshold setting, which allows Payers to meet reporting requirements. The variance process allows for Payers to address any inability to meet threshold requirements. See *Variance Processing* earlier in this document for additional information.

Identifying Eligible Members

A number of data elements can be used to identify eligible members. Methods include, but are not limited to, the following approaches:

- Use the Member ID (MEID). CHIA has created a new MA APCD Master Patient Index (MPI) that assigns a single unique surrogate key to each person, regardless of how many different insurance carriers have submitted data about the person. For more information see '**Overview of New MA APCD Master Patient Index**' on CHIA's website.
- For individuals within a specific reporting period, several methods are provided on the CHIA website (see "Help Using the Data" for details). One common way is to use the Product Enrollment Start and Product Enrollment End dates to limit users to specific time. Please note that these dates should align to service dates to identify appropriate claims.
- Some eligibility files are submitted by different payers than those who submitted claims. Appendix B lists these exceptions and users should consult Appendix B before linking claims to individuals by organization ids.

Member Eligibility File Features

CHIA defines the ME File detail level as at least one record per member, per Product ID, per beginning and ending date of eligibility for that product. Each row represents a unique instance of a Member and their Product Eligibility and other attributes.

Multiple records for "Member and Product" may exist but begin and end eligibility dates within a product should not overlap. A product change, or break in eligibility, among other changes, triggers a requirement for a new eligibility record. If a member is eligible for more than one Product, then the member will be reported on multiple records in the same month. If a member has more than one Primary Care Physician (PCP) under the same Product, then the member and Product will be reported on multiple records in the same month. If a member has a break in eligibility, this results in multiple records.

For example, when medical and pharmacy benefits are delivered via two separate products rather than a bundled product (say, HMO Medical 1000 and RX Bronze) we expect two records, one for HMO Medical 1000 and one for RX Bronze. In this example, the Medical Coverage indicator (ME018) would have a value of one (1) for Yes and the Prescription Drug Coverage indicator (ME019) would have a value of two (2) for No in the HMO Medical 1000 eligibility record. These field values would be reversed in the RX Bronze eligibility record.

A break in eligibility allows for the opportunity to analyze information on Member Eligibility by Products and Member Eligibility by Claims, to better understand utilization. CHIA uses enrollment data to calculate member months by product and by provider.

Coverage attributes such as PCP should reflect the values most relevant to the end period for the Eligibility segment (if an inactive segment) or the Member Eligibility file end period (e.g., 12/31/2016).

Subscriber/Member Information

The file includes both member and subscriber information; however, information on eligibility relates strictly to the *member*, who may or may not be the subscriber. CHIA primarily uses payer-supplied data to link a member to a subscriber.

Coverage Indicators

CHIA collects coverage indicator flags indicating a member has medical, dental, pharmacy, behavioral health, vision, and/or lab coverage. These fields can be compared against the Product file and are helpful in understanding benefit design.

Dates

CHIA collects two sets of start and end dates:

- ME041 and ME042 are the dates associated with the member's enrollment with a specific product. ME041 captures the date the member enrolled in the product and ME042 captures the end date or is Null if they are still enrolled.
- ME047 and ME048 are the dates a member is enrolled with a specific PCP. For plans or products without PCPs, these fields will not be populated.

ME File Impact on Product File (PR) Entries

The multiple row convention, as described earlier, also impacts the Product File. Each product listed in the ME File also must be present in the Product File, with PR006 indicating that the product is a Pharmacy, Medical or other product. The Product Benefit Type should correlate to the flags in the Member Eligibility File. For example, for the Product File record for the HMO Medical 1000 we would expect PR006 Product Benefit Type to be one (1), which equals a description of 'Medical Only' and RX Bronze's Product File record would have a value of two (2) for 'Pharmacy Only' in PR006.

Redundancy in Claims Data Elements

Many of the segments in the file use semantics like claims data, and some fields are exact duplicates of fields in claims files. CHIA collects contents of the Payer's Member File regardless of the information contained in claims files. This extra or similar information across files is needed to support analysis of the variations of Member Eligibility. It is also a requirement of other states.

Product (PR) File

Payers are required to submit a Product (PR) File. MA APCD CY 2022 has one PR File that consists of aggregated and unduplicated records across multiple years.
A Product, often described by the business model that it conforms to, starts as a base offering, for example, HMO, PPO, Indemnity, etc. Product Line of Business Model (PR004) is collected by the MA APCD to define the type of business model. The data must be submitted using a CHIA-provided lookup table.
Each row represents a unique instance of a Product. However, some payers have reported products on separate rows that differ only in aspects that are not specified in the Product File. Therefore, for some payers there may appear to be duplicate rows when, in fact, they are distinct products.

Product Identifiers and File Linking

CHIA collects elementary identifiers associated with a Product. The data in fields PR002 through PR008 can be used when analyzing Product data across payers. The identifiers help to link Product data to ME File.

Product Dates

CHIA collects two date fields for each PR record. The Start and End Dates (PR009 and PR010) for each Product describes the dates the Product was active with the payer and usable by eligible members. For Products that were still active, the End Date should be Null. For Products that were not active, but may still have claims being adjudicated against them, the End Date should be the End Date reported to the Division of Insurance *or* the date the license was terminated.

Provider (PV) File

CHIA collects provider data, which can be used to analyze claims data when submitted in accordance with the release Submission Guide. Since claims data is collected monthly, the Provider file can be synced with the claims file and provides a snapshot of how the provider file looked at the end of the period for which claims are sent.
The PV file is a compilation of all payer provider files. It is expected that a unique provider record exists for *each instance* where the provider is found in a payer submission. However, a provider record may also repeat within a payer for each attribute change. Providers who have not been active since January 2010 do not need to be included in the collection process; however, some payers have elected to do so.
CHIA defines a Provider as an organization or person that is:

- Providing services to patients, and/or
- Submitting claims for services on behalf of a servicing provider, and/or
- Providing business services or contracting arrangements for a servicing provider.

A Provider may be a health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.

Provider File

Each row represents a unique instance of a provider entity within a payer, and may repeat rows for each attribute change, such as:

- Affiliation to another entity, or,
- Provider's affiliation to a specific location, or,
- Provider's begin and end date.

Provider ID

Provider IDs (found in all three claims files) are some of the most critical fields in the MA APCD process as they link the Provider identified on the claims file with the corresponding record in the Provider File (PV002). The definition of PV002, Provider ID, is: the unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a payer has in its system. This field is used to uniquely identify a provider and that provider's affiliation and a provider and that provider's practice location within this provider file.
PV002 and Product Delegate (Derived) help identify the provider data elements submitted in the claim line detail, and to identify the details of the Provider Affiliation. Since PV002 frequently contains sensitive personal information, CHIA applied a substitution element to this field for this release. This substituted element provides linkage to the Provider File.

Provider Linkage

CHIA collects numerous identifiers that may be associated with a provider. CHIA uses these identifiers to link providers across payers if the primary linking data elements are not a complete match. These extra identifying elements improve the quality of the matching algorithms.

Demographics

CHIA collects address information on each provider entity to meet reporting and analysis requirements. Additional demographic data elements such as Gender of the provider are collected for use in linking providers across payers. These fields can be used, when provided, to help increase the quality of the matching algorithms across payers. See Appendix D: Linking Data Elements for details.

Provider Specialty

The required fields are Taxonomy (PV022), Provider Type Code (PV029), and Provider Specialty (PV030, PV042, PV043, and PV044) and can be used to meet reporting and analysis requirements including clinical groupings and provider specific reports. Payers submit a combination of standard and payer-defined code sets (lookup tables) to CHIA for these fields.

Start and End Dates

CHIA collects *two sets of date fields* for each provider record. The sets of data are the Beginning and End Date for each provider and the Provider Affiliation Start and Provider Affiliation End Date. They are defined as follows:

- **The Begin and End date for each provider (PV037 and PV038)** describes the dates the provider is active with the payer and is eligible to provide services to members. For providers who are still active the End date should be Null**.**
- **The Provider Affiliation Start and Provider Affiliation End Date (PV062 and PV063)** describe the providers' affiliation/association with a parent entity, such as a billing entity, corporate entity, doctor's office, provider group, or integrated delivery system. Each unique instance of these start and end dates *must* be submitted as a separate record on this file. If a provider was active and termed in the past with the payer, and was added back as an active provider, each instance of those 'active' dates should be provided¸ one for each time span. Similarly, each instance of a provider affiliation, and those associated dates should be provided in a record. If a provider has always been active with a payer since 2010, but has changed affiliations once, there would be two records submitted as well, one for each affiliation and those respective dates. If a provider's affiliation is terminated, and is made active again at a later date, this would require two records also.

Some examples of how the provider information may be supplied:

1. Individual Provider practicing within one doctor's office or group and only one physical office location
   A provider fitting this description should have one record per active time span. The record would contain information about the provider (Dr. Jones) and the affiliation fields would indicate that Dr. Jones practices or contracts with (ABC Medical). ABC Medical, since it is a group, would have its own separate record as well in this file. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.
2. Individual Provider practicing within an office they own
   A provider fitting this description should have one record per active time span for their individual information (Dr. Jones) and a second record for their practice, Dr. Jones Family Care. A physician assistant or nurse working in the doctor's office should also be submitted, under their own unique record.
3. Individual Provider practicing within an office they own or for a practice they do not own across two physical locations
   A provider fitting this description should have two records per active time span. The office, affiliation or entity that the doctor does business under (ABC Medical, Dr. Jones family medicine) would have only one additional record.

4. Individual Provider practicing across two groups or different affiliations
   A provider fitting this description should have two records per active time span, one for each group/entity they are affiliated with. Each group/entity would have its own separate record as well.
5. Entity, Group or Office in one location
   An entity fitting this description should have one record per active time span. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records.
6. Entity, Group or Office in two locations
   An entity fitting this description should have two records per active time span, one for each location. All affiliated entities, or providers that could be linked or rolled up to these entities, groups or offices, would each have their own records. If these affiliated entities and providers are associated with just one of the locations, they would have one corresponding record. If they are affiliated with each of the parent entity's locations, they should have one record f or each location, as in Example 3.
7. Billing organizations
   An entity that shows up in the claims file in the Billing Provider field should also have a corresponding provider record. For example, Medical Billing Associates, Inc. should have one record for each location and identifier it bills under as determined by the claims file.
8. Integrated Delivery Systems
   Organizations such as Partners Healthcare or Atrius Health should have their own record if the payer has a contract with those entities. All entities, groups or providers affiliated with the Organization should have the Provider ID of this entity in the Provider Affiliation Field. Entities meeting a description similar to an Integrated Delivery System should show up one time in the provider file.

Benefit Plan Control Total (BP) File

In connection with the Massachusetts Risk Adjustment program, a Benefit Plan Control Total File (BP) has been added to the MA APCD. All submitters participating in the Risk Adjustment program are required to submit a Benefit Plan Control Total File for their Risk Adjustment Covered Plans (RACPs). The Benefit Plan Control Total File requires

data for all RACPs offered in Massachusetts. Submitters are not required to submit Benefit Plan Control Total File data for their Non-RACP plans.

Control Total Data

The claim counts, member counts and dollar amounts should align to the detail claims submitted to the MA APCD, for the same reporting month for the RACP plans.

- Each row, or Detail Record, contains the information for a unique Benefit Plan Contract ID and Claim Type (Medical or Pharmacy) within the submission period.
- Each row also contains a Benefit Plan's begin and end date.

MassHealth Enhanced Eligibility (MHEE) File

(Available only to government agency requestors; a subset file, MHEE LDS, is available to other MassHealth approved requestors)
MA APCD CY 2022 includes MassHealth Enhanced Eligibility (MHEE) data. Because MassHealth eligibility data is constructed differently than that of commercial health plans, the standard MA APCD eligibility file poses analytic challenges to determining population segments, provider information, coverage segments, etc.
Unlike commercial health plans, MassHealth eligibility plans and coverage categories fluctuate regularly. As a result, CHIA requires a monthly eligibility submission (MHEE) from the MassHealth Data Warehouse. CHIA uses these monthly submissions to accurately analyze and report on MassHealth membership.
The MassHealth Enhanced Eligibility data is an extensive data source derived by and stored in the Executive Office of Health and Human Services Data Warehouse (EHS DW). It combines Medicaid Management Information System (MMIS) eligibility, managed care enrollment, Long Term Care (LTC) residency, Medicare eligibility and other member information into a single analytic resource, with non-overlapping effective dates. As a result, it provides a comprehensive view of a member on any given day. Because dates do not overlap, this data readily lends itself to member month summary reporting.
MassHealth Enhanced Eligibility is a critical data source for essentially all of the member month and Per Member Per Month (PMPM) cost reporting. The information primarily exists in a single data table in the EHS DW named NW_STATE_ELIGIBILITY. However, links to provider and member data are necessary to capture member demographics and provider details (e.g., Managed Care Entity (MCE) and Primary Care Clinician (PCC) provider IDs, type and names). CHIA receives this data from the EHS Data Warehouse team as a single enhanced eligibility data file submission.
MHEE data requires approval from MassHealth. The full MHEE dataset is only available to government agency requestors; however, starting in Release 7.0, a subset of the MHEE data (MHEE LDS) is available to all recipients of the MassHealth data. The purpose of this data is to supplement the standard Member Eligibility (ME) filing data with data submitted by MassHealth only. The MHEE data file consists of MassHealth data only. EHS DW submitted Data for the years 2014 thru 2022 (January-December) to CHIA; the data was then compiled into a format specifically intended to simplify usage by analysts in tandem with CHIA's other MA APCD Release data.

MHEE File

Each record or row represents an active time span or segment of relevant eligibility and enrollment for a member. A member s identified by the unique carrier specific data element (CHIACARRIERSPECIFICUNIQUEMEMBERID). This field can be used to link to the MA APCD ME file to gain additional member attributes not included in the MHEE file.
Date intervals (or spans) reflect a period for which the eligibility and enrollment status reflected in the record applies. These dates do not necessarily reflect the actual beginning or ending of eligibility or enrollment, rather they allow for the determination of eligibility and enrollment status of a member on any given day.
Date intervals on any segment do not cross over a monthly boundary. CHIA created monthly bounded eligibility spans, so that each month can stand on its own as a record of eligibility time intervals. This design allows reconstruction of any desired interval of eligibility by using date parameters to select a collection of monthly segments.

- Effective dates of enrollment are Monthly bounded values:
- DTE_EFFECTIVE and DTE_EFFECTIVE_Month (segment beginning YYYYMMDD)

- DTE_END and DTE_END_Month (segment end YYYYMMDD)

Example: To select all the eligibility segments for calendar year 2016, select records where **DTE_EFFECTIVE_MONTH** between "20160101" and "20161231"
While each eligibility segment spans no more than one month, there are as many segments within a month as there are discrete combinations of eligible time spans and aid categories. It is theoretically possible for a member to have as many segments as there are days in the month. Each time a new aid category is assigned, or other eligibility or enrollment changes, there is a new segment.
There is no overlap of any segments for a member. In cases where a member was eligible for more than one aid category (CDE_AID_CATEGORY) on the same day – the richest aid category has been assigned to the segment.

MassHealth MHEE File and the MA APCD ME File

The MHEE data doesn't replace the ME data. In the event a member is eligible under multiple coverage types, MHEE reflects the richest aid category whereas ME captures multiple coverage types/products in different, overlapping records/segments. The ME file also contains additional data elements not found on the MHEE file.

Additional Information

Member ID

MassHealth provides the member ID to CHIA. It is consistent with the MassHealth member ID included in MassHealth claims and ME data.

Provider Data

There are four provider ID fields included in the MHEE data which link to the MA APCD Provider (PV) data. To avoid duplication, the Provider Delegate field in the PV data (Derived - LINKINGPROVIDERDELEGATE) should be restricted to "Y" when joining to the PV data to obtain entity names and other provider attributes.
The provider ID fields in the following table link to the LINKINGPROVIDERID on the Provider file (PV reference: Plan Provider ID, PV002 and Provider Delegate, Derived) where the ORGID equals (MassHealth PV submissions).

Table 3: The Four Provider ID Fields

PROVIDER ID TYPE	DEFINITION	PROVIDER ID
MCO	Identifies the MCE for members enrolled in managed care – MCO, SCO, PACE, and One Care plans	ID_PROVIDER_LOCATION_MCO_LINKAGE_ID
PCC	Identifies a member's PCC, for members in the PCC Plan.	ID_PROVIDER_LOCATION_PCC_LINKAGE_ID
BH	Identifies the behavioral health – currently always MBHP.	ID_PROVIDER_LOCATION_BH_LINKAGE_ID MCE provider
LTC	Identifies members nursing or other long-term care facilities.	ID_PROVIDER_LOCATION_LTC_LINKAGE_ID

Active Record

Data analysis should be restricted to active records (IND_ACTIVE=Y). Inactive records reflect data for member IDs that are no longer active, typically due to a member ID change.

Product

This data does not link to the MA APCD PR data, but the field CDE_PGM_HEALTH identifies the product/coverage type. Note that CDE_PGM_HEALTH_BH and CDE_PGM_HEALTH_MC do not reflect products included in the MA APCD PR data. These two fields are specific to managed care enrollment rather than eligibility for particular products captured in the product data.

Richest Eligibility

As MassHealth members may be eligible for care under multiple categories of assistance, the MHEE file captures the richest eligibility (or all records in all categories of assistance available on a particular day) in the CDE_AID_CATEGORY and CDE_PGM_HEALTH fields. By definition, there are no overlapping intervals of time in this file view. Also note that there are three aid category references on the MHEE file. They are shown in the following table:

Table 4: Coverage Types

CATEGORY TYPE	DEFINITION
DE_AID_CATEGORY	Richest aid category
CDE_AID_CATEGORY_BH	Where applicable, the aid category the member was in that qualified them for MBHP enrollment.
CDE_AID_CATEGORY_MC	Where applicable, the aid category the member was in that qualified them for MC plan enrollment.

Non-Massachusetts Residents

Under *Administrative Bulletin 13-02*, CHIA restated the requirement that payers submitting claims and encounter data on behalf of a Massachusetts employer group submit claims and encounter data for employees who reside outside of Massachusetts.
CHIA requires data submission for employees that are based in Massachusetts whether the employer is based in MA or the employer has a site in Massachusetts that employs individuals. This requirement is for all payers that are licensed by the MA Division of Insurance or are required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Critical Reference Tables

The MA APCD has standardized the submission of many data elements into categories. The references tables listed in this Section reflect information that is also available through the MA APCD submission guides. Please note that payers may not use all categories or may submit their own categories for some data elements. Due to the length of these reference tables, only the most commonly used tables are referenced here. For details on specific reference tables associated with specific tables, please review the MA APCD *6.0 Submission Guides* [**http://www.chiamass.gov/apcd-data-submission-guides/**].

CHIA Reference Tables

The set of reference tables below are the most common tables used in multiple files in the MA APCD.

Versioning Tables

Table 5: Claim Line Type Codes

CLAIM TYPE CODE	CLAIM LINE TYPE DESCRIPTION	ACTION/SOURCE
O	Original	
V	Void	Delete Line Referenced/Provider
R	Replacement	Replace line Referenced Provider
B	Back Out	Delete Line Referenced/Payer
A	Amendment	Replace Line Referenced/Payer

The following table defines the Version values for the VERSIONINDICATOR.

Table 6: VERSIONINDICATOR Flag

VALUE	MEANING
1	Highest Version Paid
0	Not Highest Version Paid
9	Versioning Not Applied

Table 7: HIGHESTVERSIONDENIED Flag

VALUE	MEANING
1	Is Highest Version Denied
0	Is not Highest Version Denied
9	Highest Version Denied Flag Not Applied

Table 8: HIGHESTVERSIONINDICATOR Flag

VALUE	MEANING
1	Highest Version claim line
0	Not Highest Version claim line
9	Versioning Not Applied

Table 9: FULLYDENIEDCLAIM Flag

VALUE	MEANING
1	Fully Denied Claim.
0	Not Fully Denied Claim
9	Versioning Not Applied

Reference tables for flags and other indicators

Table 10: Flag Indicators

CODE	DESCRIPTION
1	Yes
2	No
3	Unknown
4	Other
5	Not Applicable

National Reference Tables

The external codes sources are codes developed and used by other agencies and organizations. They are essential to CHIA's efforts in collecting and maintaining MA APCD data. These sources provide guidance through lookup tables and codes, enabling CHIA to properly collect, standardize, and clean the data collected from the payers and providers. In the lookup tables featured in each MA APCD file type's layout, the data element delineates whether an external code source was used to populate a lookup table.

External Code Sources

TYPE	ORGANIZATION	URL
Countries	American National Standards Institute 25 West 43rd Street, 4th Floor New York, NY 10036	http://www.ansi.org/
States and Other Areas of the US	U.S. Postal Service National Information Data Center P.O. Box 2977 Washington, DC 20013	https://www.usps.com/
National Provider Identifiers National Plan & Provider Enumeration System	Department of Health and Human Services 200 Independence Avenue, S.W. Washington, D.C. 20201 Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	https://nppes.cms.hhs.gov/NPPES/
Provider Specialties Center for Medicare and Medicaid Services (CMS)	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	https://www.cms.gov/
Health Care Provider Taxonomy Washington Publishing Company	The National Uniform Claim Committee c/o American Medical Association 515 North State Street Chicago, IL 60610	http://www.wpc-edi.com/reference/
North American Industry Classification System (NAICS) United States Census Bureau	U.S. Census Bureau 4600 Silver Hill Road Washington, DC 20233	http://www.census.gov/eos/www/naics/
Language Preference United States Census Bureau	U.S. Census Bureau 4600 Silver Hill Road Washington, DC 20233	http://www.census.gov
International Classification of Diseases 9 & 10 American Medical Association	American Medical Association AMA Plaza 330 N. Wabash Ave. Chicago, IL 60611-5885	http://www.ama-assn.org/
HCPCS, CPTs and Modifiers American Medical Association	American Medical Association AMA Plaza 330 N. Wabash Ave. Chicago, IL 60611-5885	http://www.ama-assn.org/
Dental Procedure Codes and Identifiers American Dental Association	American Dental Association 211 East Chicago Avenue Chicago, IL 60611-2678	http://www.ada.org/
Logical Observation Identifiers Names and Codes Regenstrief Institute	Regenstrief Institute, Inc. 410 West 10th Street, Suite 2000 Indianapolis, IN 46202-3012	http://loinc.org/

National Drug Codes and Names U.S. Food and Drug Administration	U.S. Food and Drug Administration 10903 New Hampshire Avenue Silver Spring, MD 20993	http://www.fda.gov
Standard Professional Billing Elements Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	https://www.cms.gov/
Standard Facility Billing Elements National Uniform Billing Committee (NUBC)	National Uniform Billing Committee American Hospital Association One North Franklin Chicago, IL 60606	http://www.nubc.org/
DRGs, APCs and POA Codes Centers for Medicare and Medicaid Services	Centers for Medicare and Medicaid Services 7500 Security Boulevard Baltimore, MD 21244	http://www.cms.gov/
Claim Adjustment Reason Codes Washington Publishing Company	Blue Cross / Blue Shield Association Interplan Teleprocessing Services Division 676 N. St. Clair Street Chicago, IL 60611	http://www.wpc-edi.com/reference/
Race and Ethnicity Codes Centers for Disease Control	Centers for Disease Control and Prevention 1600 Clifton Rd. Atlanta, GA 30333, USA	http://www.cdc.gov

Appendix A: Data Access

The CHIA website provides instructions for requesting MA APCD data.

- Government Agencies: **http://www.chiamass.gov/government-agency-apcd-requests**
- Non-government users: **http://www.chiamass.gov/non-government-agency-apcd-requests/**

Step 1: Formulate the Data Request; Review Security Questions and Template Data Use Agreement

Prior to submitting a MA APCD request to CHIA, users are strongly encouraged to review the Data Request Form and the template Data Use Agreement and to identify any questions they may have about legal requirements. For information about how to maximize the appropriate use of CHIA data please email **apcd.data@chiamass.gov**. CHIA staff will work to resolve any initial questions and will:

- Help users identify the best ways to tailor their Data Requests to maximize the appropriate use of CHIA data;
- Provide guidance regarding data privacy and security requirements;
- Provide general information about the potential uses – and limitations on uses – of CHIA's data products; and
- Assist with IRBNet, which is used for submitting applications.

Step 2: Submit a Data Request

Prospective users are asked to submit a written Data Request Form and Data Specifications Workbook using IRBNet. An IRBNet account can be created through **https://www.irbnet.org/release/public/register.jsp** and affiliated with the Massachusetts Center for Health Information and Analysis once logged in.
After an initial screening to ensure the Data Request is complete, and that the requester is seeking to use the appropriate dataset(s) for the proposed project, the request will be forwarded to CHIA's Legal Unit to review for compliance with legal requirements.

Step 3: Consult with Technical Specialists, as Needed, During Review of Data Request

CHIA Legal will assign a Technical Specialist with expertise in data privacy to review the application materials. If needed, the Technical Specialist will work with applicants to refine data requests to ensure they meet legal requirements. The length of this review period will depend on the complexity of the request and the sensitivity of the data sought.

Step 4: Compliance Review by CHIA

A compliance review will be conducted within CHIA Legal to confirm that the requested release of data is consistent with regulations. A Data Request will be referred to CHIA's Data Privacy Committee when the Technical Specialist has sufficient information to make a recommendation as to whether the data requested are the minimum necessary to achieve the proposed objectives, as required by *M.G.L. c. 12C*. The information may include, among other things, a description of the specific uses of the MA APCD data, the proposed research methodology, specific justifications for the data elements requested, and information regarding proposed linkages.

Potential users seeking direct patient identifiers and other highly sensitive data also may be required to submit a letter from their General Counsel attesting to the agency's statutory authority to obtain and use such data for the purposes described in the agency's Data Request.
Potential users seeking Medicaid data also will be required to establish, to MassHealth's satisfaction, that the proposed use of the data is directly connected to the administration of the Medicaid program. CHIA works with MassHealth to coordinate MassHealth review of requests for Medicaid data.
The Executive Director grants final approval for release as appropriate.

Step 5: Execute a Data Use Agreement

After a request is approved by the Executive Director, a Data Use Agreement must be executed prior to the release of MA APCD data.
Government Agencies approved to receive Medicaid data must also sign a Medicaid Acknowledgement of Conditions Form and a Medicaid Addendum to the Data Use Agreement. Government Agencies approved to receive Medicare data must also execute a Medicare Addendum to the Data Use Agreement.

Step 6: Data Released

CHIA IT processes the data extract. Once the extract is completed, CHIA ships the data extract with the final approval letter signed by the Executive Director to the data recipient.

Appendix B: Associated OrgID Submitters

Table 1: Associated OrgID Submitters

ORG ID	FILE TYPE	NOTE
11745	Provider	Provider data included in Org Id 290 and/or 10441
10647	Provider	Provider data included in Org Id 10441
10353	Provider	Provider data included in Org Id 10441
10929	Provider	Provider data included in Org Id 290
10442	Eligibility	Eligibility data included in Org Id 290
10442	Provider	Provider data included in Org Id 290
10187	Eligibility	Eligibility data included in Org Id 3156

Appendix C: Recent Publications using the MA APCD

Users interested in seeing how the MA APCD has been used in academic and professional publications should review the CHIA website for current articles and reports.

Appendix D: Linking Data Elements

Data Encryption and File Linking

The claims files link to Provider and Product files using these data elements:

- Linking Plan Provider ID (PV002) + Provider Delegate (Derived) and/or
- Linking Product ID (PR001) + Product Delegate (Derived), respectively

When Values have been masked using *integer* values linkages can still be performed.

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.

Benefit Plan Control (BP) File Linking

The Benefit Plan Control File links only to the Member Eligibility (ME) file. The data elements in the BP file are restricted release elements. As a result, the linkage elements have not been re-identified. These elements are linkage elements: BP001 Benefit Plan Contract ID to ME128 Benefit Plan Contract ID.

Some data elements can be used to link across files. A brief table is provided below.

Table 2: BP File Linking Elements

FILE	ELEMENT CODE	DATA ELEMENT NAME
BP	BP001	Benefit Plan Control ID
DC	DC018	Service Provider Number
DC	DC042	Product ID Number
DC	DC056	Carrier Specific Unique Member ID
DC	DC057	Carrier Specific Unique Subscriber ID
DC	Derived DC11	Member Link EID
MC	MC024	Service Provider Number
MC	MC076	Billing Provider Number
MC	MC079	Product ID Number
MC	MC112	Referring Provider ID
MC	MC125	Attending Provider
MC	MC134	Plan Rendering Provider Identifier
MC	MC135	Provider Location
MC	MC137	Carrier Specific Unique Member ID
MC	MC141	Carrier Specific Unique Subscriber ID
MC	Derived MC16	Member Link EID
ME	ME036	Health Care Home (PCMH) Number
ME	ME040	Product ID Number
ME	ME046	Member PCP ID
ME	ME107	Carrier Specific Unique Member ID
ME	ME117	Carrier Specific Unique Subscriber ID
ME	ME124	Attributed PCP Provider ID
ME	Derived ME13	Member Link EID
PC	PC043	Prescribing Provider ID
PC	PC056	Product ID Number
PC	PC059	Recipient PCP ID
PC	PC107	Carrier Specific Unique Member ID
PC	PC108	Carrier Specific Unique Subscriber ID
PC	Derived PC12	Member Link EID
PR	PR001	Product ID
PR	Derived PR3	Product Delegate
PV	PV002	Provider ID

FILE	ELEMENT CODE	DATA ELEMENT NAME
PV	PV054	Medical / Healthcare Home ID
PV	PV056	Provider Affiliation
PV	Derived PV9	Provider Delegate
*MHEE		HashCarrierSpecificUniqueMemberID

Appendix E: Glossary

Users may be unfamiliar with some terms used in this document. They may also be seeking definitions to some of CHIA's data elements. A brief set of definitions listed below. Please note that the definitions for data elements are in general, and specific data element of interest should be investigated using the MA APCD Submission Guides [http://www.chiamass.gov/apcd-data-submission-guides/].

Table 1: Glossary

TERM	DEFINITION
Accident Indicator	A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Adjudication Data	Any data that describes how a claim was processed for payment. Typically information that would go back to the provider of services is used, but could include contract level information as well.
Admitting Diagnosis	This is the diagnosis (of a unique set of diagnoses) that supports a physician's order to admit a patient into an inpatient setting at a facility.
All-Payer Claims Database (APCD)	The All-Payer Claims Data Base (APCD) is a dataset of members, providers, products and claims from payers that allow for a broad understanding of cost and utilization across institutions and populations.
Ambulatory Payment Classification (APC)	A payment methodology applied to outpatient claims in a facility; defined by Federal Balanced Budget Act for Medicare claims originally.
Ancillary Services	Any service that supports the primary reason for the medical visit. This can be laboratory, X-ray or other services within or outside of the same facility.
APC	See Ambulatory Payment Classification.
APCD	See All-Payer Claims Database.
APCD Field Threshold	The percentage of correct data that needs to be submitted for a particular field to ensure that it "passes". See Variance Request.
Applicant	An individual or organization that requests health care data and information in accordance with 957 CMR 5
Attending Provider	A provider that has direct care oversight of the patient. Typically an individual reported on Facility Inpatient Claims.
Billing Provider	A provider entity that sends claims and requests for adjudication to a carrier for payment.
Capitated Encounter Flag	A MA APCD Flag Indicator that reports a line-item as being covered under a capitation arrangement.
Capitated Payment	Capitation is a contractual payment arrangement between provider and payer. It is the 'per member per month' methodology that does not take 'per service' into account during the contract timeframe.
Carrier-Specific Unique Member ID	The number a carrier uses internally to uniquely identify the member.
Carrier-Specific Unique Subscriber ID	This is the number the carrier uses internally to uniquely identify the subscriber.
Center For Health Information and Analysis	An agency of the Commonwealth of Massachusetts responsible for providing reliable information and meaningful analysis for those seeking to improve health care quality, affordability, access, and outcomes. Formerly the Division of Health Care Finance and Policy until November 5, 2012.

TERM	DEFINITION
Center	See Center for Health Information and Analysis.
CDT Code	See Common Dental Terminology Code.
CHIA	See Center for Health Information and Analysis.
Claim	A request for payment on rendered services to likely members. Claims can be in many formats: see UB04, HIPAA 837, Reimbursement Form, and Direct Data Entry.
Claim Line	An individual service reporting of a claim. See Line Counter.
Claim Line Type	A MA APCD value that reports a claim line status that moderately relates to the final digit (Frequency Code) of the Type of Bill or Place of Service code on a claim. Options are Original, Void, Replacement, Back Out and Amendment.
Claim Status	A MA APCD value that reports how a claim was processed by the reporting carrier. Relates to reimbursement order on claims.
Claims Adjudication	An evaluation process employed by insurance companies and/or their designees to process claims data for payment to providers.
Claims Data	Information consisting of, or derived directly from, member eligibility information, medical claims, pharmacy claims, dental claims, and all other data submitted by health care payers to CHIA.
CMS	See Centers for Medicare & Medicaid Services.
COB	See Coordination of Benefits.
COBRA	See Consolidated Omnibus Budget Reconciliation Act.
Coinsurance Amount	Usually defined as a percentage of the claim that the subscriber pays on covered services to the provider after deductibles have been met, per the plan contract.
Common Dental Terminology Code (CDT Code)	A code set developed for dental procedure reporting by the American Dental Association.
Compound Drug Indicator	A MA APCD Flag Indicator that reports if a pharmacy line had to be compounded for the patient due to patient-specific needs (weight, allergies, administration route) or unavailability of the drug in certain measures.
Consolidated Omnibus Budget Reconciliation Act (COBRA)	Refers to the COBRA legislation that requires offering continued health care coverage when a qualifying event occurs with the employed family member. Usually only required of large group employers (20 employees) under a modified payment schedule for same level of coverage.
Coordination of Benefits (COB)	A process that occurs between provider, subscriber(s) of same household, and two or more payers to eliminate multiple primary payments.
Coordination of Benefits/TPL Liability Amount	The amount calculated by a primary payer on a claim as the amount due from a secondary or other payer on the same claim when the primary payer is aware of other payers.
Copayment Amount	Usually defined as a set amount paid by the subscriber to the provider for a given outpatient service, per the plan contract.
Coverage Level Code	A MA APCD value submitted by the carrier that refines a line of eligibility to report the definition and size of covered lives.
Covered Days	The number of inpatient days covered by the plan under the member's eligibility. See Non-covered Days.

TERM	DEFINITION
Data Element Name	The Submission Guide element name reference if applicable or the description of derived element if created by CHIA.
Date Service Approved (AP Date)	This is the date that the claim line was approved for payment. It can be several days (or weeks) prior to the Paid Date or on the Paid Date, but cannot fall after the Paid Date.
DC File	See Dental Claim File
DDE	See Direct Data Entry
Deductible	Usually defined as an annual set amount paid by the subscriber to the provider prior to the plan applying benefits. Deductibles can be inpatient and/or outpatient as they are payer/plan specific.
Delegated Benefit Administrator	CHIA assigned Org ID for Benefit Administrator. A Delegated Benefit Administrator is an entity that performs a combination of activities related to benefit enrollment, management and premium collection on behalf of a payer.
Denied Claims	Claims and/or Claim Lines that a payer will not process for payment due to non-eligibility or contractual conflicts.
Dental Claim File (DC File)	A MA APCD File Type for reporting all Paid Dental Claim Lines of a given time period. File accommodates Replacement and Void lines.
Diagnostic Related Group (DRG)	Diagnostic Related Group: A system to classify hospital inpatient admits into a defined set of cases by numeric representation. Payment categories that are used to classify patients for the purpose of reimbursing providers for each case in a given category with a fixed fee regardless of the actual costs incurred.
Disability Indicator Flag	Indicator that a member has a disability. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Disease Management Enrollee Flag	A MA APCD Flag Indicator that reports if a member's chronic illness is managed by plan or vendor of plan.
Dispense as Written Code	Prescription Dispensing Activity Code
DRG	See Diagnostic Related Group
DRG Level	A reporting refinement from the Diagnostic Related Group coding that reports a level of severity of the case.
DRG Version	The version of the Diagnostic Related Group, a numbering system within the application used to allocate claims into the appropriate grouping date. This is mostly an annual process, although other updates are received.
E-Code	See External Injury Code
EFT	See Electronic Funds Transfer
EHS	Executive Office of Health and Human Services
EHS DW	Executive Office of Health and Human Services Data Warehouse
Employer EIN	Employer Identification Number (Federal Tax Identification Number) of the member's employer.
Employment Related Indicator	Service related to Employment Injury. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.

TERM	DEFINITION
Encounter Data	Detailed data about individual services provided by a capitated managed care entity.
EOB	See Explanation of Benefits.
EPO	See Exclusive Provider Organization.
EPSDT Indicator	Indicates that Early Periodic Screening, Diagnosis and Treatment (EPSDT) were utilized. A yes/no indicator that originates from the Professional Claims format to assess insurance liability, financial responsibility and aid with clinical assessments.
Excluded Expenses	Amount that the plan has determined to be above and beyond plan/benefit limitations for a given patient. Related to non-covered services.
Exclusive Provider Organization (EPO)	A managed care product type that requires each member to have a PCP assignment within a limited network but offers affordable coverage.
Executive Office of Health and Human	EHS
Executive Office of Health and Human	EHS DW
External Code Source	External code sources are lists of values generally accepted as a standard set of values for a given element. Example: Revenue Codes as defined by the National Uniform Billing Committee.
External Injury Code (E-Code)	ICD Diagnostic External Injury Code for patients with trauma or accidents. A subsection of the International Classification of Diseases Diagnosis Codes that specifically enumerate various types of accidents and traumas before diagnoses are applied.
Fee for Service	A payment methodology where each service rendered is considered for individual reimbursement.
Former Claim Number	This is a prior claim number originally assigned to the claim by the provider of service. Its use in the MA APCD dataset is usually to aid with versioning of a claim where versioning cannot be applied due to system limitations.
Formulary Code	A MA APCD Flag Indicator that reports a line-item as being listed on a payers list of covered drugs. This reporting helps to understand patient-out-of-pocket expenses.
Fully-Insured	In a fully insured plan, the employer pays a per-employee premium to an insurance company, and the insurance company assumes the risk of providing health coverage for insured events.
GIC	See Group Insurance Commission.
Global Payment	Payments received of a fixed-value for predefined services on members within a predefined time frame.
Global Payment Flag	A MA APCD Flag Indicator that reports a line-item as being paid under a Global Payment arrangement. See Global Payment.
Group Insurance Commission	The Group Insurance Commission (GIC) is an entity charged with overseeing health and tangent benefits of state employees, retirees and dependents.
Grouper	A tool/application that evaluates each claim and determines where the claim falls clinically across a broad spectrum of values (cases). This can be applied to inpatient and outpatient claims based on the grouper used.
Health Care Home	See Patient Centered Medical Home.

TERM	DEFINITION
Health Care Payer	A Private or Public Health Care Payer that contracts or offers to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. A Health Care Payer includes an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, Third Party Administrators, and self-insured plans.
Health Plan Information	Information submitted by Health Care Payers in accordance with 957 CMR 8.
HCQCC	(Massachusetts) Health Care Quality and Cost Council (HCQCC) Established in 2006, HCQCC collected claim-level detail from third party payers. By 2009, HCQCC's responsibilities were transferred to the Division of Health Care Finance and Policy (DHCFP) and then, in 2012, CHIA was created as an independent agency for the collection and analysis of heath care data.
ICD-9-CM	See International Classification of Diseases, 9th edition, Clinical Modification.
ICD-10-CM	See International Classification of Diseases, 10th edition, Clinical Modification
Individual Relationship Code	Indicator defining the Member/Patient's relationship to the Subscriber.
Insurance Type Code/Product	This field indicates the type of product the member has, such as HMO, PPO, POS, Auto Medical, Indemnity, and Workers Compensation.
International Classification of Diseases, 9th Edition, Clinical Modification	Refers to the International Classification of Diseases, 9th Revision Codes, and Clinical Modification (ICD-9-CM) procedure codes.
Last Activity Date	This is the date that a subscriber's or member's eligibility for any given product was last edited.
Line Counter	An enumeration process to define each service on a claim with a unique number. Process follows standard enumeration from other billing forms and formats.
Logical Observation Identifiers, Names and Codes (LOINC)	Lab Codes for Logical Observation Identifiers, Names and Codes. A method for reporting laboratory findings of specimens back to a health care provider / system.
LOINC	See Logical Observation Identifiers, Names and Codes.
LTC	Long Term Care
Major Diagnostic Category (MDC)	The Major Diagnostic Categories (MDC) is a classification system that parses all principal diagnoses into one of 25 categories primarily for use with DRGs and reimbursement activity. Each Category relates to a physical system, disease, or contributing health factor.
Managed Care Organization	A product developed to control costs of care management through various methods such as limited networks, PCP assignment, and case management.
Market Category Code	A MA APCD ME File refinement code that explains what market segment the policy that the subscriber/member has selected falls under.
MassHealth	The Massachusetts Medicaid program.
MC File	See Medical Claim File.
MCE	Manage Care Entity
MCO	See Managed Care Organization.

TERM	DEFINITION
MDC	See Major Diagnostic Categories.
Medicaid MCO	A Medicaid Managed Care Organizations is a private health insurance that has contracted with the state to supply Managed Care products to a select population.
Medical Claim File (MC File)	A MA APCD File Type for reporting all Paid Medical Claim Lines of a given time period. File accommodates Facility, Professional, Reimbursement Forms and Replacement and Void lines.
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)
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.
Member	A person who holds an individual contract or a certificate under a group arrangement contracted with a Health Care Payer.
Member Deductible	Annual maximum out of pocket Member Deductible across all benefit types. See Deductible.
Member Deductible Used	Member deductible amount incurred.
Member Eligibility File	A file that includes data about a person who receives health care coverage from a payer, including but not limited to subscriber and member identifiers; member demographics; race, ethnicity and language information; plan type; benefit codes; enrollment start and end dates; and behavioral and mental health, substance abuse and chemical dependency and prescription drug benefit indicators.
Member PCP Effective Date	Begin date for member enrollment with Primary Care Provider (PCP).
Member PCP ID	The member's Primary Care Physician's ID.
Member PCP Termination Date	Member termination date from that Primary Care Provider (PCP).
Member Rating Category	Utilized for Medicaid MCO members only, it defines the Member Medicaid MCO category.
Member Self Pay Amount	The amount that a Patient pays towards the claim/service prior to submission to the carrier or its designee.
Member Suffix / Sequence Number	Numeric suffix appended to the health insurance contract number that identifies the type of family member covered under the contract.
Members SIC Code	A code describing the line of work the enrollee is in. Carriers will use Standard Industrial Classification (SIC) code values.
MMIS	Medicaid Management Information System
NAICS	See North American Industry Classification System.
National Billing Provider ID	National Provider Identification (NPI) of the Billing Provider.
National Council for Prescription Drug Programs (NCPDP)	The Standards Organization for the pharmacy industry.
National Plan ID	Unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans.

TERM	DEFINITION
National Provider Identification (NPI)	A unique identification number for covered health care providers and health plans required under the Health Insurance Portability and Accountability Act (HIPPA) for Administrative Simplification.
National Service Provider ID	National Provider Identification (NPI) of the Servicing Provider.
NCPDP	See National Council for Prescription Drug Programs
Non Covered Days	The number of inpatient days not covered by the plan under the member's eligibility. See Covered Days.
Non-Covered Amount	An amount that refers to services that were not considered covered under the member's eligibility.
North American Industry Classification	A standard classification system used to define businesses System (NAICS) and the tasks within a business for statistical analysis, used by Federal statistical agencies for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy
NPI	See National Provider Identification
Organization Identification (Org ID)	A CHIA contact management unique enumeration assigned to any entity to allow for identification of that entity. This internally generated ID is used by CHIA to identify everything from carriers to hospitals in addition to other sites of service.
OrgID	See Organization Identification
P4P	See Pay for Performance
Paid Date	The date that a claim line is actually paid. Date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment. This can be the same date as Processed Date.
Patient	An individual that is receiving direct clinical care or oversight of self-care.
Patient Centered Medical Home (PCMH)	An approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family
Patient Control Number	This is a unique identifier assigned by the provider for individual encounters of care or claims.
Payer	See Health Care Payer
Payer Claim Control Number (PCCN)	A unique identifier within the payer's system that applies to the entire claim for the life of that claim. Not to be confused with Patient Control Number that originates at the provider site.
Payment	Financial transfer from payer to provider for services rendered to patients, quality maintenance, performance measures or training initiatives.
PBM	See Pharmacy Benefit Manager.
PC File	See Pharmacy Claim File.
PCMH	See Patient Centered Medical Home.
PCP	See Primary Care Physician.
PCP Indicator	A MA APCD Flag Indicator that reports a claim line-item as being performed by the patient's Primary Care Physician. See Primary Care Physician.

TERM	DEFINITION
Pharmacy Benefit Manager (PBM)	A Pharmacy benefit manager (PBM) is a company that administers all or some portion of a drug benefit program of an employer group or health plan.
Pharmacy Claim File (PC File)	A MA APCD File Type for reporting all Paid Pharmacy Claim Lines of a given time period. File accommodates Replacement and Void lines.
Plan Rendering Provider Identifier	Carrier's unique code which identifies for the carrier who or which individual provider cared for the patient for the claim line in question.
Plan Specific Contract Number	Plan assigned contract number. This should be the contract or certificate number for the subscriber and all of his/her dependents.
PMPM	Per Member Per Month
Point of Service (POS)	A point-of-service (POS) plan is a health maintenance organization (HMO) and a preferred provider organization (PPO) hybrid. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner similar to conventional indemnity plans.
POS	See Point of Service
PR File	See Product File
Preferred Provider Organization (PPO)	A plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network, but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
PCC	Primary Care Clinician
Primary Care Physician (PCP)	A physician who serves as a member's primary contact for health care. The primary care physician provides basic medical services, coordinates and, if required, authorizes referrals to specialists and hospitals.
Primary Insurance Indicator	A MA APCD Flag Indicator that reports if the payer adjudicated a Claim Line as the Primary Payer.
Private Health Care Payer	A carrier authorized to transact accident and health insurance under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a nonprofit medical service corporation licensed under chapter 176B, a dental service corporation organized under chapter 176E, an optometric service corporation organized under chapter 176F, a self-insured plan to the extent allowable under federal law governing health care provided by employers to employees, or a health maintenance organization licensed under chapter 176G.
Product	Any offering for sale by a health plan or vendor. It typically describes carrier-based business models such as HMO, PPO but is also synonymous with processing services, network leasing, re-pricing vendors.
Product Enrollment End Date	The date the member dis-enrolled in the product.
Product Enrollment Start Date	The date the member enrolled in the product.
Product File (PR File)	A MA APCD file that reports all products that a carrier maintains as a saleable service. Typically these products are listed with the Division of Insurance.

TERM	DEFINITION
Product Identifier	A unique identifier created by the submitter to each Product offered. It is used to link eligibilities to products and to validate claim adjudication per the product.
Provider	A health care practitioner, health care facility, health care group, medical product vendor, or pharmacy. Provider, as defined by CHIA - A Provider is an entity or person associated with either: 1. Providing services to patients, and/or 2. Submitting claims for services on behalf of a servicing provider, and/or 3. Providing business services or contracting arrangements for a servicing provider. A Provider may be a health care practitioner, health care facility, health care group, medical product vendor, or pharmacy.
Provider File (PV File)	A MA APCD file containing information on all types of health care provider entities. Typically these are active, contracted providers.
Provider ID	A unique identifier assigned by the carrier or designee and reported in the MA APCD files.
Public Health Care Payer	The Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid or the Commonwealth Health Insurance Connector to pay for or arrange for the purchase of health care services on behalf of individuals enrolled in health coverage programs under Titles XIX or XXI, or under the Commonwealth Care Health Insurance program, including prepaid health plans subject to the provisions of section 28 of chapter 47 of the acts of 1997; the Group Insurance Commission established under chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B. Also includes Medicare.
PUF	Public Use File
PV File	See Provider File
QA	See Quality Assurance
Quality Assurance (QA)	The process of verifying the reliability and accuracy of data within the thresholds set and rationales reported.
Rebate Indicator	A MA APCD Flag Indicator that reports if a pharmacy line was open for any rebate activity.
Referral Indicator	A MA APCD Flag Indicator that reports if a claim line required a referral regardless of its final adjudication.
Reimbursement Form	A form created by a carrier for subscribers/members to submit incurred costs to the carrier that are reimbursable under the benefit plan.
Risk Type	Refers to whether a product was fully-insured or self-insured.
Route of Administration	Indicates how drug is administered. Orally, injection, etc.
Script number	The unique enumerated identifier that appears on a prescription form from a provider.
Self-Insured	A plan offered by employers who directly assume the major/full cost of health insurance for their employees. They may bear the entire risk, or insure against large claims by purchasing stop-loss coverage. The self-insured employers may contract with insurance carriers or third party administrators for claims processing and other administrative services; others are self-administered.

TERM	DEFINITION
Service Provider Entity Type Qualifier	A MA APCD identifier used to refine a provider reporting into one of two categories, a person, or one of several non- person entity types.
Service Provider Specialty	The specialty of the servicing provider with whom a patient sought care.
Service Rendering Provider	The health care professional that performed the procedure or provided direct patient oversight.
Severity Level	See DRG Level
Single/Multiple Source Indicator	Drug Source Indicator. An identifier used to report pharmacy product streams.
Site of Service - on NSF/CMS 1500 Claims	Place of Service Code as used on Professional Claims. This is a two-digit code that reports where services were rendered by a health care professional.
Special Coverage	A MA APCD identifier used to refine eligibility with non- traditional coverage models to explain covered services and networks for this population. Valid choices are Commonwealth Care, Health Safety Net or N/A if not applicable.
Submission Guide	The document that defines the required data file format, record specifications, data elements, definitions, code tables and edit specifications.
Submitter	Any entity that has been registered with CHIA as a data submitter. This can be health plans, TPAs, PBMs, DBAs, or any entity approved to submit data on behalf of another entity; requires registration with CHIA. See Organization ID, above.
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.
Third Party Administrator (TPA)	Any person or entity that receives or collects charges, contributions, or premiums for, or adjusts or settles claims for, Massachusetts residents on behalf of a plan sponsor, health care services plan, nonprofit hospital or medical service organization, health maintenance organization, or insurer.
Third-Party Liability (TPL)	Refers to the coverage provided by a specific carrier for certain risks; typically work, auto, personal injury related.
Threshold Reduction	A process of the MA APCD Variance Request that a submitter performs to reduce the percentage of quality data that they must submit. This is performed prior to submitting a file to insure that A-Level Thresholds are met tMo pass the file into Quality Assurance.
TPA	See Third Party Administrator.
TPL	See Third-Party Liability.
Type of Bill - on Facility Claims	This is a two-digit code that reports the type of facility in which services were rendered.
UB04	See Universal Billing Form 04.
Unemployed	An individual that does not hold a paying position with a company.
Universal Billing Form 04	A standard billing form created by the National Universal Billing Committee for Facility Claims. The 04 refers to the last updated version of the claim format. It is typically a paper form but electronic versions of it exist.

TERM	DEFINITION
Variance	See Variance Request
Variance Request (VR)	A request to CHIA that explains why an organization cannot submit a field (or fields), meet a threshold (or thresholds), or submit a file (or files). This is a form, developed by the MA APCD, which defines base reporting percentages for all data elements on all filing types, where the submitter may disclose reasons for not meeting base-percentage reporting, and request a threshold reduction to percentages that can be met.
Version Number	Version number of this claim service line. An enumeration process required by the MA APCD Claims Files to insure that the most recent line(s) of any given claim are used in that claims analysis at time of reporting.
Voided Claims	Claim lines filed that will be excluded from analysis (i.e. Claims that were deemed not eligible for submittal).

Contact Information

Please contact CHIA with questions regarding the content and use of the data.

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Questions regarding data requests/applications should be emailed to:
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