CHIA Data User Workgroup

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September 23, 2025

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Agenda

➤ **Announcements:**

- All FY2024 Case Mix Data Products and Checking Data Availability
- Location of Application Documents
- Change in Process for Submitting Request for Data Documents
- Commenting on CHIA Data Release Applications
- Upcoming CDAO Fall 2025 Conference, Renaissance Boston Seaport District
- Upcoming 2025 AI in Healthcare & Pharma Summit, the Colonnade Hotel, Boston
- Alert: New Publication on Medications for Opioid Use Disorder in County Jails — Outcomes after Release

➤ **Data User Support Questions**
- Specialty and Retail Clinics
- Weekend Patterns
- Oral Cancer in Dental Claims vs. Medical Claims
- MemberMDMIDs IDs for Case Mix

➤ **Q&A**

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Announcements

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All FY2024 Case Mix Data Products Now Available

All case mix data products (HIDD, EDD, and OSD) for fiscal year 2024 (October 1, 2023 – September 30, 2024) are now available for application.

Product	Target	Actual	Status
Case Mix FY 2024 **(October 1, 2023 - September 30, 2024)**			
Hospital Inpatient Discharge Data (HIDD)	June 2025	May 2025	Available
Emergency Department Data (EDD)	August 2025	July 2025	Available
Outpatient Observation Stay Data (OOD)	September 2025	August 2025	Available

The CHIA website (https://chiamass.gov/status-of-data-requests) provides detailed information regarding the availability of current data releases as well as the projected timelines. As of the present update, the Massachusetts All-Payer Claims Database (MA APCD) for calendar year 2024 release (which includes 2020-2024 data with six-month run out from 2025) is currently in progress and targeted for release Fall 2025.

Location of Application Documents

- Application Documents
- Fee Schedule
- Regulatory Information
- Data Release Committee
- Applications Received and Commenting
- Check the Status of Your Request

The following webpage links provide the step-by-step instructions for non-government entities and government entities on how to apply for the case mix and MA APCD data.

Non-Government Application Documents

https://www.chiamass.gov/non-government-agency-apcd-requests
https://www.chiamass.gov/non-government-agency-case-mix-requests

Government Application Documents

https://www.chiamass.gov/government-agency-apcd-requests
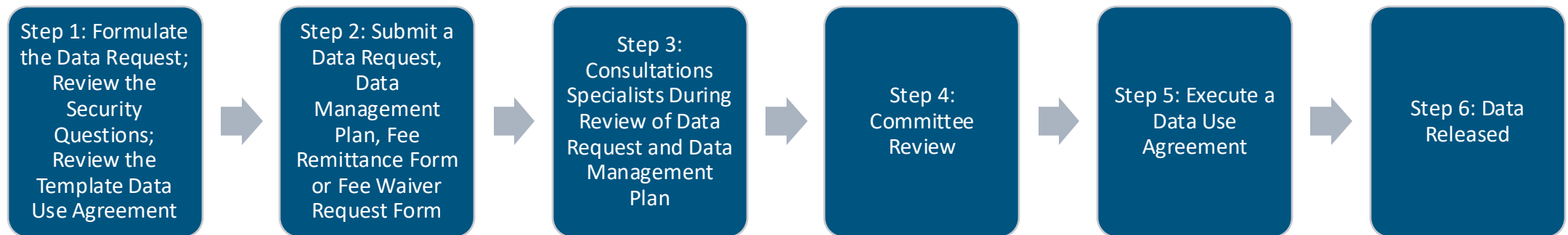https://www.chiamass.gov/government-agency-case-mix-requests

The webpage provides detailed instructions on the six steps below in the application process that have been designed to help applicants prepare applications and to allow for the release of data while protecting patient privacy.

| Step 1: Formulate the Data Request; Review the Security Questions; Review the Template Data Use Agreement | → | Step 2: Submit a Data Request, Data Management Plan, Fee Remittance Form or Fee Waiver Request Form | → | Step 3: Consultations Specialists During Review of Data Request and Data Management Plan | → | Step 4: Committee Review | → | Step 5: Execute a Data Use Agreement | → | Step 6: Data Released |

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Change in <u>Step 2</u> Process for Submitting Data Request Documents

All application documents should be emailed to CHIA

① Prepare	② Submit	③ Review & Consult	④ Committee Review & Approval	⑤ Sign Agreement	⑥ Data Released
Review documents Ask questions Formulate request	Submit data request	Technical specialist review & consultation	DPC & DRC review Executive Director approves	Agreements signed prior to release of data extract	IT processes data extract Extract shipped

- ❑ To access **Massachusetts case mix data**, applicants must submit a written Data Request Form, a Fee Remittance/Fee Waiver Form, and, if the request is for Case Mix Levels 2 and above, a Data Management Plan to CHIA to casemix.data@chiamass.gov.

- ❑ To access **Massachusetts all payer claims data**, applicants must submit a written Data Request Form, a Data Management Plan, and a Fee Remittance/Fee Waiver Request Form to CHIA to apcd.data@chiamass.gov.

Data Leaders Speak on Shaping the Future with AI, Advanced Analytics, and Data-Driven Transformation Strategies

October 22-23, 2025, Renaissance Boston Seaport District, 606 Congress Street

CDAO Fall 2025 Conference

See: https://cdao-fall.coriniumintelligence.com/

Some of the over 100 confirmed speakers from the public and private sector include:

- Gene Voskov, Chief, Data Analytics & Resources Bureau, Division of Local Services, **Massachusetts Dept. of Revenue**
- Julia Cherashore, Deputy Superintendent, Data Governance and Management, **New York State Dept. of Financial Services**
- Rita Fuller, Corporate VP Center for Data Science and Artificial Intelligence, **New York Life Insurance Company**
- Ram Krishna Gautam, Head of Clinical Platform (EMR, Provider Services and AI Solutions), **Teladoc Health**
- Marina Printz, Lead Data Scientist, Center for Data Science and AI, **New York Life Insurance Company**
- Rahul Kashyap, Medical Director, Research, **Summit Health**
- Ferhat Yilmaz, Associate Director, **Novo Nordisk**
- Nick Smith, Senior Sales Engineer, **Alteryx**
- Rajesh Sura, Head of Data Engineering and Analytics, **Amazon**

Sample of Panel and Group Discussion Topics

- ❑ Turning Strategy into Action: Operationalizing Data, Analytics & Agentic AI for Maximum Impact
- ❑ Rethinking Data Lineage
- ❑ From Insight to Impact: How AI & ML in Pyramid Accelerate Analytics Adoption
- ❑ Transforming Data into Strategic Assets: The Critical Importance of Data Quality for Generative AI Applications
- ❑ Data Storytelling- What Stories are Worthwhile and What is Just Noise? How Can you Tell the Most Effective Story Using your Data?
- ❑ Mastering Data Governance: Frameworks, Policies, and Processes for Unwavering Quality and Compliance Roles and Responsibilities Within Data Governance Structure

Actionable AI Applications for Transforming Healthcare & Pharma

November 18-19, 2025, The Colonnade Hotel, 120 Huntington Ave, Boston

RE-Work 2025 AI in Healthcare & Pharma Summit

See: https://boston-ai-healthcare.re-work.co/

Some of the speakers and panelists include:

Carolyn Pfeiffer, Senior Director, Privacy, Ai & Ethics and DSSPE Operations, **Johnson & Johnsons**

Anemone Kasasbeh, Lead Data Scientist, **IPG Health**

Hao Zhang, Director, Digital Healthcare Innovation, Mitsubishi **Tanabe Pharma America**

Rahul Kashyap, Medical Director Research, **Wellspan Health**

Ellie Norris, Director, D&A Strategy and Technology Partnership/ MRL IT Clinical & Real-World Evidence Generation, **Merck**

Lance Bradshaw, Director of Workforce Transformation, **Intermountain Health**

Shuja Mohammed, Head of Strategic Planning & Operations for AI & Data Science, **Astrazeneca**

Gunasekaran (Guna) Singaravelu, Associate Director, **Daiichi Sankyo**

Wei-Ting Ling, Associate Director, **Gilead Sciences**

Matt Dixon, Cloud Architect, **Northwell Health**

AI in Healthcare & Pharma 2025 Key Themes

- ❑ AI in Clinical Practice: GenAI, decision support, mental health, remote monitoring, and documentation
- ❑ AI in Drug Development: Accelerating discovery, optimizing trials, and advancing precision medicine
- ❑ Responsible AI: Governance, privacy, patient consent, and regulatory readiness
- ❑ Adoption & ROI: How to scale AI solutions, prove value, and align internal stakeholders
- ❑ Equity & Access: Ensuring AI supports underserved communities and diverse populations
- ❑ Cross-Sector Collaboration: Linking payers, providers, and pharma through real-world data and shared strategy

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Alert: New Publication on Medications for Opioid Use Disorder in County Jails — Outcomes after Release

Available at: https://www.nejm.org/doi/full/10.1056/NEJMsa2415987

A new article entitled "Medications for Opioid Use Disorder in County Jails—Outcomes after Release" using linked state data, researchers examined outcomes for 6,400 incarcerated individuals with probable opioid use disorder between September 2019 and December 2020, Among this population, 42 percent received MOUD while in jail, most commonly buprenorphine (68 percent), followed by methadone (26 percent) and naltrexone (7 percent). The findings included that:

- Compared with those who did not receive treatment, MOUD recipients were more often White, more likely to be serving a sentence rather than awaiting trial, and more likely to have entered jail already on medication.
- Post release, individuals treated in jail were substantially more likely to continue care: 60 percent initiated MOUD within 30 days of release compared to only 18 percent of untreated peers. However, continuity remained a challenge, with only half maintaining treatment for most of the first 90 days and 58 percent still engaged at six months.
- Even so, receipt of MOUD in jail was strongly associated with better outcomes, including significantly reduced risks of fatal overdose, nonfatal overdose, death from any cause, and reincarceration. Rates of hospitalization did not differ meaningfully between groups.
- Overall, the study demonstrates that jail-based MOUD programs increase the likelihood of treatment engagement after release and are linked to major reductions in overdose, mortality, and reincarceration. These findings highlight the public health and public safety value of making evidence-based addiction medications available in correctional settings.

Data User Support Questions

CHIA Data User Workgroup | September 23, 2025

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Question: I am preparing an application to access the MA APCD to analyze staffing levels, the geographic distribution and the utilization patterns of pharmacy-based walk-in clinics, for example, those located in CVS or Walgreens. What specialty-based identifiers in the MA APCD can be used to identify such outpatient settings?

Answer: Pharmacy based walk-in clinics staffed by nurse practitioners or physician assistants in the MA APCD provider table most frequently use the following three taxonomy codes: '**261Q00000X**', '**193400000X', '261QP2300X**' which, according the National Uniform Claim Committee (NUCC) Provider taxonomy Version 25.1, are defined as follows:

Code: 261Q00000X **Grouping:** Ambulatory Health Care Facilities **Classification:** Clinic/Center **Specialization:** None (general classification)	**Code**: 193400000X **Grouping**: Group **Classification**: Single Specialty **Specialization**: None (general classification)	**Code**: 261QP2300X **Grouping**: Ambulatory Health Care Facilities **Classification**: Clinic/Center **Specialization**: Primary Care

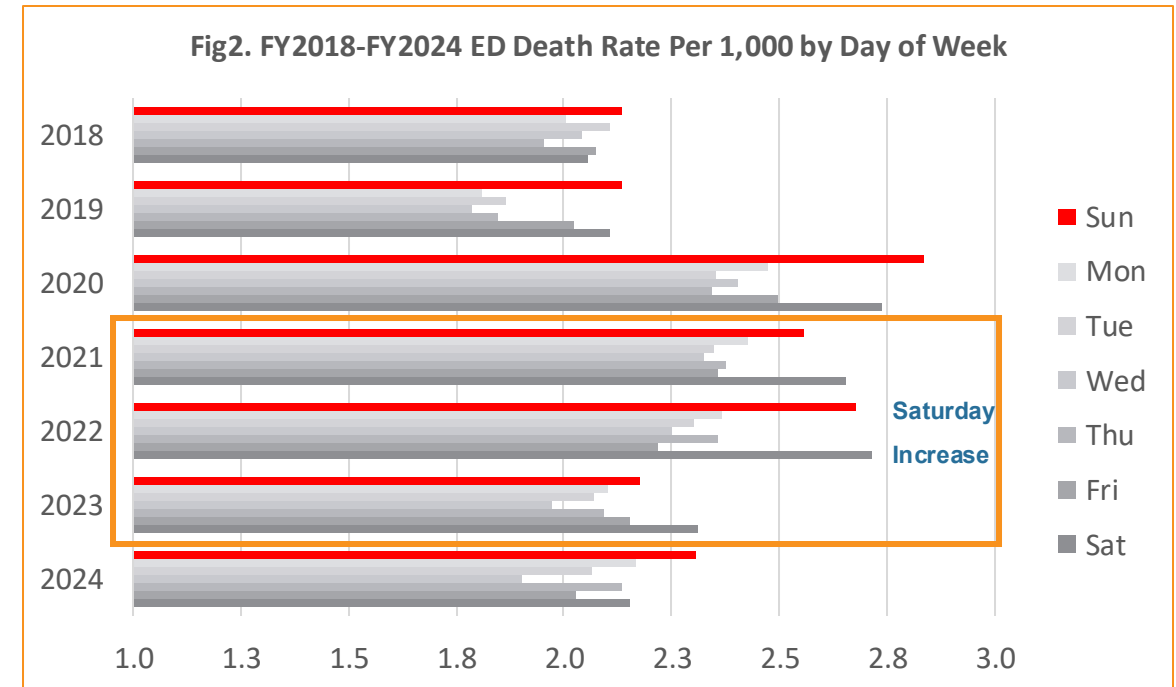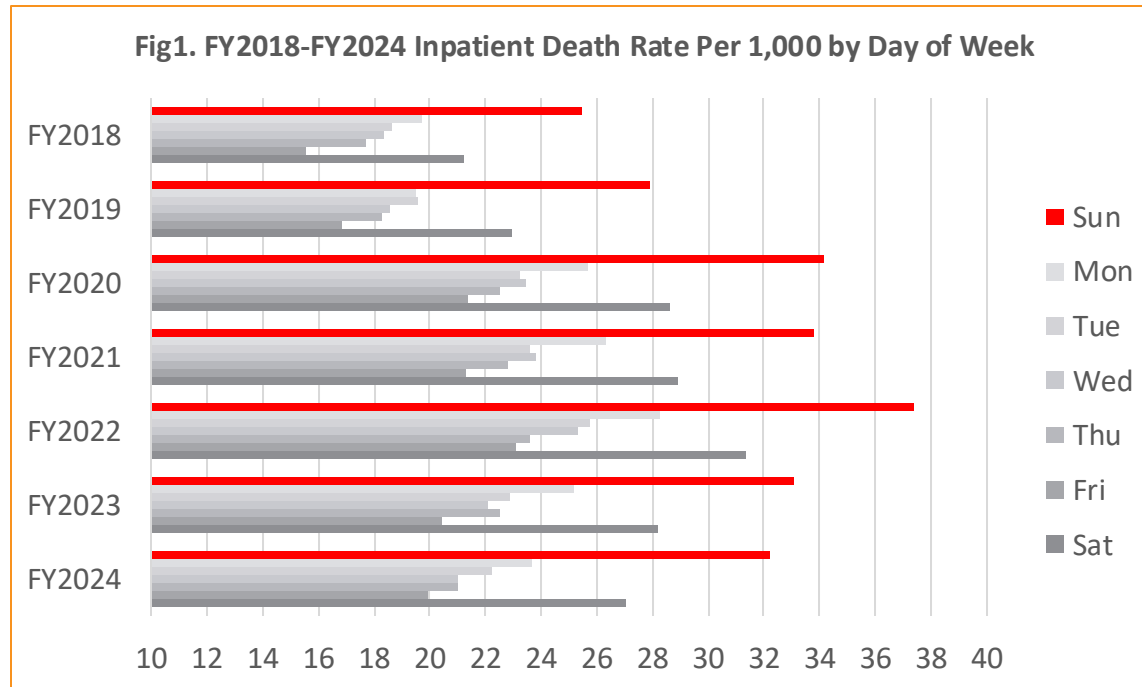### Distinctions Between Pharmacy Walk-In Clinics and Hospital Specialty Clinics

Feature	Pharmacy Walk-In Clinic	Hospital Affiliated Specialty Clinic
Appointment Needed	No (walk-in)	Usually required
Complexity of Care	Routine, preventive, and acute minor issues	Diagnostic evaluations, complex treatments and procedures
Cost Structure	Generally lower, often covered by insurance or out-of-pocket	Higher, often requiring referrals and insurance network approval dependent on specialty
Equipment & Testing	Limited point-of-care testing	Advanced diagnostic equipment (imaging, endoscopy, infusion centers, surgical suites)
Location	Inside retail stores (for example, CVS, Walgreens)	Standalone or hospital-affiliated medical offices
Patient Access	Walk-in, no appointment typically required	Appointment-based, often requires referral from a primary care provider
Providers	Nurse practitioners or physician assistants	Board-certified physicians and specialists with advanced residency/fellowship training
Scope of Care	Low-acuity services (minor illnesses, immunizations, wellness checks)	Higher acuity complex medical conditions (in cardiology, orthopedics, birth centers)
Services Offered	Minor illnesses, vaccinations, screenings	Advanced diagnostics, disease-specific treatments
Setting	Located inside retail stores or pharmacies	Standalone medical offices, hospital outpatient centers, or specialty institutes
Visit Duration	Short (< 30 minutes)	Longer (depending on medical complexity and onsite radiology tests)

Question: In my current analyses of hospital inpatient discharge data for FY2021 and FY2022, I observed an elevated mortality rate among discharges occurring on Sundays. As I am re-applying for access to all three repositories (hospital inpatient, emergency department visit, and observation stay), I wish to investigate the continuum of care but wanted to know in advance whether this day-of-week mortality pattern occurs in the emergency department care setting when stratified by day of week?

Answer: Over the seven-year period from FY2018 through FY2024, hospital inpatient discharges revealed that mortality rates per 1,000 consistently peaked on Sundays (Figure 1). A parallel review of ED visits revealed a similar Sunday concentration of elevated mortality in four years (2018, 2019, 2020, & 2024). However, in three consecutive years (2021, 2022, & 2023), the ED mortality shifted to Saturdays (Fig 2). In both care settings, there is a pronounced increase in weekend inpatient hospital and ED mortality rates.

Fig1. FY2018-FY2024 Inpatient Death Rate Per 1,000 by Day of Week

Fig2. FY2018-FY2024 ED Death Rate Per 1,000 by Day of Week

Question: I am analyzing medical claims to study cancer incidence and screening. When looking at the dental claims filing specifications online, I noticed that the dental claims had a diagnosis code field and wondered would if it would make sense to also include dental claims in my analysis. Specifically, over and above dental caries, do the diagnosis codes in the dental claims contain any reporting relevant to cancer, such as oral cancers or neoplasms that might could contribute meaningfully information to my analysis?

Answer: Keep in mind that the dental claims filing specifications only require that the diagnosis code field be populated when DC032 (dental procedure code) within the ranges of D7000- D7999 (codes for oral and maxillofacial surgery or D9220 or D9221 (codes for deep sedation). Nevertheless, the following diagnosis codes are reported in the dental claims related to cancer:
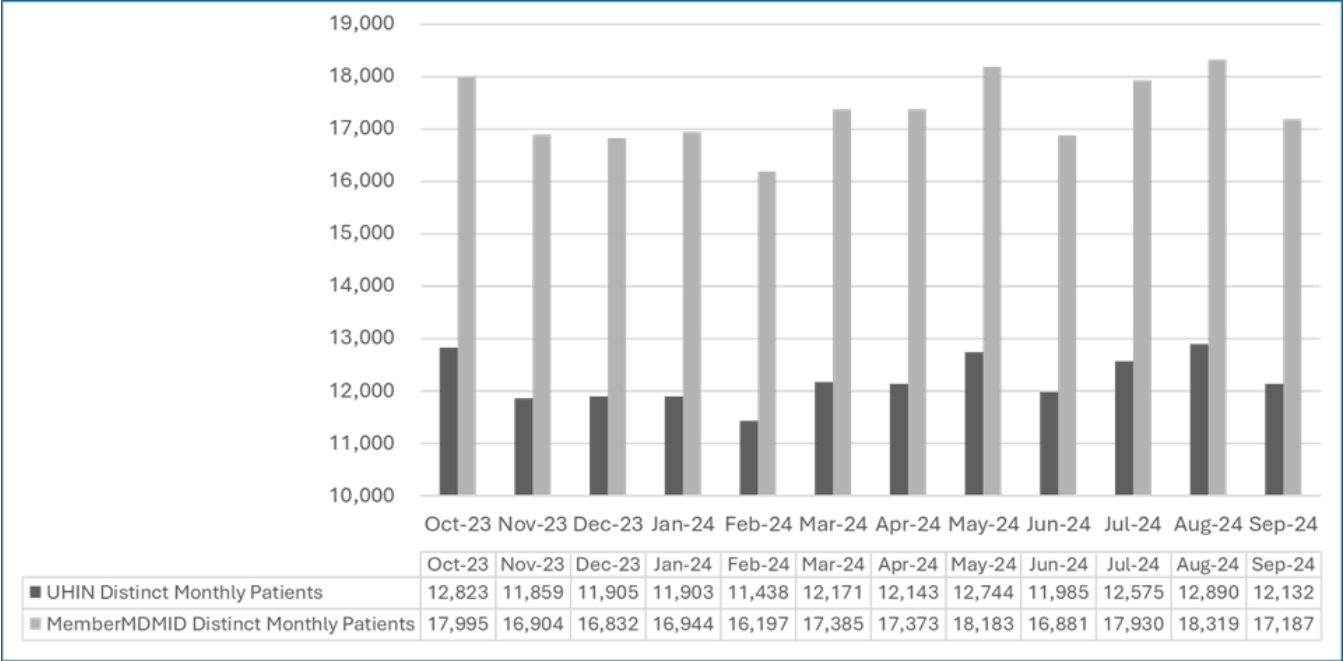
Diagnosis Codes Related to Cancer found in Dental Claims

DX Code	Description
Z1281	Encounter for screening for malignant neoplasm of oral cavity
D1030	Benign neoplasm of unspecified part of mouth
D490	Neoplasm of unspecified behavior of digestive system
D1039	Benign neoplasm of other parts of mouth
C069	Malignant neoplasm of mouth, unspecified
C031	Malignant neoplasm of lower gum

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Question: In the case mix data, what is the difference between using the UHIN for distinct monthly patient counts versus the MemberMDMID?

Answer: In looking at the newly released FY2024 observation stay data, for example, you will see a consistent gap between patient counts derived from distinct UHINs and those from distinct MemberMDMIDs. Across the fiscal year, UHIN-based counts averaged about 12,214 distinct patients per month, while MemberMDMID-based counts averaged 17,344 distinct patients per month, with an average monthly percent difference of 29.6%. See Figure 1 below. This trend highlights a steady undercount by UHINs relative to MemberMDMIDs, suggesting that reliance on legacy UHINs alone may lead to an approximate 30% underestimation of the true distinct monthly patient volume.

Figure 1. FY2024 Comparison of Distinct Monthly Patient Volume with UHINs and MemberMDMIDs

	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
■ UHIN Distinct Monthly Patients	12,823	11,859	11,905	11,903	11,438	12,171	12,143	12,744	11,985	12,575	12,890	12,132
■ MemberMDMID Distinct Monthly Patients	17,995	16,904	16,832	16,944	16,197	17,385	17,373	18,183	16,881	17,930	18,319	17,187

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When is the next Data User Group meeting?

- The next User Group will meet Tuesday, October 28, 2025.

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

Questions?

- Questions related to MA APCD email:

    apcd.data@chiamass.gov

- Questions related to Case Mix email:

    casemix.data@chiamass.gov