CENTER FOR HEALTH INFORMATION AND ANALYSIS

Massachusetts All-Payer Claims Database (MA APCD)

Annual Release 2024

2020-2024
Documentation Guide

CHIA.

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Introduction

The Center for Health Information and Analysis (CHIA), pursuant to **M.G.L. c. 12C**, is the agency of record serving 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/carriers, third-party administrators, and MassHealth, Massachusetts's Medicaid program.

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. These data include claims files (dental, medical, and pharmacy), enrollment files, insurance product information, and provider details. MA APCD collection and release are governed by **957 CMR 8.00 and 957 CMR 5.00**.[1] Detailed claims-level data is available to approved applicants to provide a deeper understanding of the Massachusetts health care delivery system—essential to improving quality, reducing costs, and promoting transparency.

The Massachusetts All-Payer Claims Database (MA APCD) Calendar Year (CY) 2024 includes data on health care activity in the Commonwealth or by Massachusetts-based insurance plans that occurred from January 1, 2020 through December 31, 2024. This release includes six months of run-out (paid claims through June 30, 2025).

This document provides data users with information on the CY 2024 release of the MA APCD. This includes high-level data collection notes, release details, file-specific notes, reference tables, user support recommendations, and other supporting documentation. For more general information on the MA APCD, please see CHIA's **MA APCD Overview**.

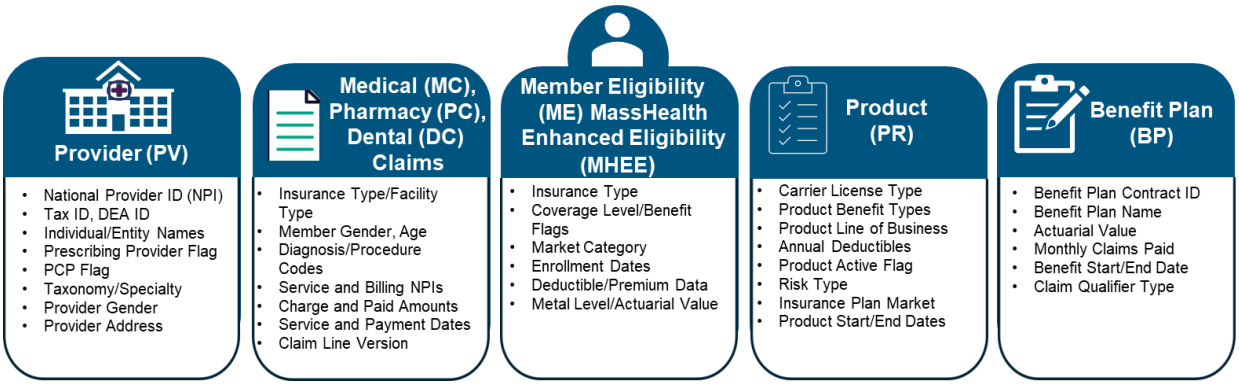
APCD Structure

Massachusetts all-payer claims data is composed of medical, pharmacy, and dental claims and information from the member eligibility, provider, product, and benefit plan files. These data are collected from health insurance payers (also known as carriers) licensed to operate in the Commonwealth, as well as from their third-party administrators (such as pharmacy benefit managers (PBMs) and other delegated entities) that submit data on behalf of payers. This information encompasses public and private payers, including MassHealth/Medicaid data, as well as fully insured and some self-insured plans. (As a result of the Supreme Court decision *Gobeille v. Liberty Mutual*, since 2016, many self-insured beneficiaries are no longer in the MA APCD.)

[1] **https://www.chiamass.gov/regulations/**

Separate chapters in this document contain notes specific to each MA APCD file type, listed below.

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



Each file contains an identifier (ID) element that, in combination with Submission Control ID (`submissioncontrolid`) and Submitter (`orgid`), can enumerate and uniquely identify rows of data in a particular submission:

- Medical Claim ID, `medicalclaimid`
- Dental Claim ID, `dentalclaimid`
- Pharmacy Claim ID, `pharmacyclaimid`
- Product ID, `productid`
- Provider ID, `providerid`
- Member Eligibility ID, `membereligibilityid`

These ID elements are administrative in nature and are not intended for relational linkage across tables. For information on linking, please see Linking Data Elements Between Files on p. 39.

Two additional files, the Geography (GEO) file and the Member Link EID (MEID) file, contain location-specific and relational (linking) information, respectively. The Geography (GEO) file contains Member Eligibility elements related to member, subscriber, and employer location. The Member Link EID (MEID) file contains unique person identifiers with corresponding Submitters and Carrier-

Specific Unique Member IDs. For more information on the GEO and MEID files, please see Standardization and Enhancements on p. 10 and Linking Data Elements Between Files on p. 39.

Documentation and Support

CHIA provides a wealth of **online resources** to help users work with the MA APCD, including release documentation (i.e. this guide and **Release Notes**), general information, Data Specification Workbooks, and user support presentations.

CHIA's MA APCD **Data Specification Workbook** contains the following information for each data element (also known as data field) in the release, separated by file:

- name
- source reference code, e.g., MC001 or PC003
- clarifying notes

For additional information on the source of each data element/field, consult CHIA's **APCD Data Submission Guides**, which provide guidance by file for payers submitting data. This includes the following specifications for each data element:

- name
- source reference code, e.g., MC001 or PC003
- data type
- length
- description

Please note that CHIA does not release all submitted data. For the purposes of de-identification and protecting individual privacy, CHIA cleans, derives, and/or excludes certain elements. Therefore, these submission guides do not provide complete information on released data elements. In addition, submission guides can change annually, so consult the submission guide that matches the release year of the data release you are using.

In CHIA's monthly **Data User Workgroup**, users receive guidance on data releases and enhancements, as well as detailed responses to user questions about specific data issues from CHIA's in-house data experts. Related presentations and tutorials are also available.

Before asking a specific question, or to determine a recommended approach, please consult available data user workgroup presentations.

For a sample of external peer-reviewed publications, doctoral dissertations, and white papers using the MA APCD, see **Resultant Research Using the MA APCD and CHIA's Case Mix Data**. To alert CHIA to a new publication using the MA APCD, please email **apcd.data@chiamass.gov**.

Historical Data

Users working with multiple releases of MA APCD data should not link data sets across releases without first consulting CHIA. Changes in membership, carrier IDs, file structures, and linking data elements make such efforts technically complex and prone to error without CHIA assistance. Users seeking clarification regarding new data elements or changes in coding from year to year should contact CHIA for assistance.

Contact Information

For specific questions about content or use of the MA APCD, email **apcd.data@chiamass.gov**. If applicable, include the related Application ID, name of Principal Investigator, and extract number. To help CHIA respond to your inquiry efficiently and accurately, please include your full contact information in your email. This should include your full name, organization, mailing address, and telephone number. Please keep questions brief to improve response time.

To contact CHIA by mail, use the following address:

The Center for Health Information and Analysis
501 Boylston Street, 5th Floor
Boston, MA 02116

Data Collection and Processing

Payers submit data to CHIA every month, except for product file data, which they submit quarterly. The `submissionyearmonth` element contains submission dates. For monthly submissions, expected values are `202401`, `202402`, `202403`, etc. and for quarterly submissions, expected values are `202403`, `202406`, `202409`, `202412`, etc.

Before leaving the data submitter's site, personal identifiers such as name and Social Security number are hashed (replaced with randomly generated 128-character references that do not contain identifying information). Submitted files are then encrypted and sent through a secure portal.

When payers initially submit their data to CHIA for the MA APCD, an automated data validation process is run on each file. This is an important data quality check, identifying whether the information is present, is in the expected format (for example, alpha vs. numeric), and contains valid values (for example, valid ICD-CM or Insurance Type codes). A Data Validation Report is generated and sent to each payer, and CHIA works with the payers to ensure completeness and accuracy.

Data elements are grouped into four categories (A, B, C, and Z). The **MA APCD Submission Guides** provide required conditions for each intake element:

- "A" elements must meet either the standard MA APCD threshold or the payer-specific threshold of variance, i.e. percentage of invalid values. Depending on the data element, there is an allowance of up to a 2 percent variance within the error margin percentage. If any submitted "A" element falls below this percentage, this results in a failed file submission for the payer and the payer's CHIA liaison will work with the payer to correct the submission.
- "B," "C," and "Z" elements are also monitored, but CHIA does not currently enforce thresholds on these elements.

Third Party Administrators (TPAs)

In instances where more than one entity administers a health plan, the health care payer and third-party administrators are both responsible for submitting data. In these cases, some records might be represented twice—once by the payer and once by the TPA.

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 standard MA APCD threshold. Payers can request a higher threshold for specific elements, but they must provide a business reason (rationale) and, in some cases, a remediation plan.

For example, a payer could request a variance not to submit values or to exceed the standard variance threshold for an element that it does not always collect. CHIA might accept the rationale but

also ask the payer to develop a remediation plan for submitting values within the threshold for that element in the future.

Payers also use this process to request certain file type variances (for example, a vision payer can request a variance in submitting pharmacy or dental claim files). CHIA staff review each request and follow up with payers appropriately.

Standardization and Enhancements

CHIA works with the payers to ensure completeness and accuracy of submitted data. In addition, CHIA standardizes and cleans key data elements to align with established specifications from industry and external agencies, such as the Centers for Medicare and Medicaid Services (CMS) and medical and dental professional organizations. For more information on external specification sources, see Appendix A: National Reference Tables.

MA APCD submissions occur as “claim lines”; typically, each time a payer adjudicates a claim, it creates a new line. As a result, each claim can have multiple lines. CHIA provides highest-version flags, based on payer-specific logic, to help users identify the latest status of a claim. Highest-version flags are available for many of the largest payers in medical, pharmacy, and dental claims. For more information, see Claims Files and Versioning on p. 12 and the chapters on each claims file.

CHIA also performs a Master Patient Index process that generates a Member Link EID (MEID), a unique enrollee number that does not contain personally identifying information. The MEID allows an individual person’s utilization to be tracked across multiple plans as that person’s insurance coverage changes over time. The MEID file contains each MEID with corresponding Submitters and Carrier-Specific Unique Member IDs. For information on using the Member Link EID, please see Linking Data Elements Between Files on p. 39. For information on the Master Patient Index process, please see **Updated Master Patient Index and Data Exclusion**.

Formatting

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** for each file type.
- Some data elements are hashed (replaced with randomly generated “surrogate keys” that do not contain identifying information) to provide confidentiality for payers, providers and individuals while allowing linking between claims, files, and lookup tables.

Limitations

The quality of submitted claims data depends on the data collection and processing policies and coding practices of the reporting payers/carriers, their subsidiaries, and third-party administrators. Information may not be entirely consistent from submitter to submitter due to differences in:

- variance process,
- submitter collection and verification of patient- and provider-supplied information,
- claims coding, consistency, and/or completeness,
- extent of submitter data processing capabilities,
- flexibility of submitter data processing systems,
- varying degrees of commitment to quality of merged data,
- differences in each submitter's line of business,
- capacity of financial processing systems to record late-occurring payments on CHIA's electronic submission, and
- non-comparability of data collection and reporting.

Non-Massachusetts Residents

CHIA requires data submission for employers that are based in Massachusetts or that have a site in Massachusetts. This requirement is for all payers that are licensed by the Massachusetts Division of Insurance or are required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents. Payers submitting claims and encounter data on behalf of a Massachusetts employer group must submit data for all members, including those who reside outside of Massachusetts.

A member may live outside Massachusetts for several reasons yet still be included in CHIA's data submissions because their coverage originates from a Massachusetts employer group. For example, a parent employed by a Massachusetts company may have a child attending college in another state who remains covered under the parent's insurance. Similarly, an employee who relocates to another state or works remotely for a Massachusetts-based employer continues to fall under the same reporting requirement. Dependents living with a divorced parent in another state, retirees who have moved out of Massachusetts but retain coverage through their former Massachusetts employer, and employees temporarily assigned to work in another state are all examples of members whose insurance coverage is tied to a Massachusetts employer or payer subject to CHIA data submission rules.

Claims Files and Versioning

Claims data include fully insured, self-insured, Medicaid, and Supplemental Policy data in three different files:

- Dental Claims file
- Medical Claims file
- Pharmacy Claims file

Claims data for the CY 2024 release cover services incurred from January 1, 2020 through December 31, 2024. Due to the manner in which payers 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, 2024 ("run-out"). CHIA includes six months of run-out data in this release, through June 30, 2025, making the submission year/month (`submissionyearmonth`) range from `202001` to `202506`.

Claim Lines

- Each row in a claims file represents one claim line. A single claim can have multiple lines: If there are multiple services performed and billed on a claim, each of these services is uniquely identified and reported on one line.
- A single encounter (visit) could result in multiple claims with the same service date.
- Each time a claim is adjudicated, a line is created.

CHIA requires line-level detail of all claims for analysis. Line-item data provide an understanding of how services are used and adjudicated by different payers.

Certain elements of claim-level data (e.g., CHIA Payer Claim Control Number, `chiapayerclaimcontrolnumber`) 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. The CHIA Payer Claim Control Number is a unique identifier that applies to the entire claim.

Versioning

The goal of claim versioning is to identify the latest status of a claim, reflecting all payment and adjustment activity through the run-out period. In its versioning process, CHIA applies cleaning logic to identify duplicates, voids/back-outs, replacements/amendments, and the "highest version," or latest status. Some payers provide custom logic for including/excluding claim lines in CHIA's versioning process. CHIA sets flags to explain the versioning results, detailed below.

The Highest Paid Version flag is populated for medical, pharmacy, and dental claims, but the other flags (Highest Version Denied, Highest Version, and Fully Denied Claim) are populated for medical claims only.

Highest Paid Version Flag

`versionindicator` (integer, 1)

0	Not highest version paid
1	Highest version paid
9	Versioning not applied

The Highest Paid Version flag (`versionindicator`) identifies the latest version of a claim line that was paid.

Generally, a value of 1 means that the line was directly paid; depending on payer-specific logic, however, it is sometimes possible that payment for that specific line was actually denied. In this case, a value of 1 indicates that the service was covered and that the payment was included as part of another line in the same claim collection.

The Highest Paid Version flag is populated for medical, pharmacy, and dental claims.

Highest Version Denied Flag

`highestversiondenied` (integer, 1)

0	Not highest version denied
1	Highest version denied
9	Versioning not applied

The Highest Version Denied flag (`highestversiondenied`) identifies a claim line that is both the highest version of a claim and a denied payment. For example:

- If `highestversiondenied = 1` and `versionindicator = 1`, then this specific claim line was denied, but payment for this line was likely included with payment on another line (bundled payment).
- If `highestversiondenied = 1` and `versionindicator = 0`, then this claim line was denied, and this is the highest version of the claim.

The Highest Version Denied flag is populated for medical claims only.

Highest Version Flag

`highestversionindicator` (integer, 1)

0	Not highest version claim line
1	Highest version claim line
9	Versioning not applied

The Highest Version flag (`highestversionindicator`) identifies a claim line that is the highest version of that claim, whether or not it was paid.

The Highest Version flag is populated for medical claims only.

Fully Denied Claim Flag

`fullydeniedclaim` (integer, 1)

0	Not fully denied claim
1	Fully denied claim
9	Versioning not applied

The Fully Denied Claim flag (`fullydeniedclaim`) indicates that all individual claim lines in the claim are denied and therefore the entire claim is a fully denied claim. Users should expect to see only highest-version claims flagged as fully denied, i.e. `highestversionindicator = 1` and `fullydeniedclaim = 1`.

CHIA does not require payers to submit data from fully denied claims, but some do.

Claim Line Type Flag

`claimlinetype` (char, 1)

O	Original
V	Void
R	Replacement
B	Back-Out
A	Amendment

The Claim Line Type flag indicates the adjudication status of the associated claim line. CHIA uses this information in its versioning process.

Voids and back-outs refer to cancellations of a previous claim line. Replacements and amendments refer to updates of a previous claim line.

Dental Claims (DC)

The Dental Claims file consists of all paid claims from all reporting payers for derived CHIA Incurred Full Date (`incurredfulldate`) from `2020-01-01` through `2024-12-31`, as paid through June 2025. For the majority of claims, CHIA Incurred Full Date is Date of Service - Thru (DC036, `dateofservicethru`) for the claim line. In the rare case that Date of Service - Thru is missing or invalid, CHIA uses the first of the following elements that is valid:

- Date of Service - From (DC035, `dateofservicefrom`)
- Submission Year Month (derived, `submissionyearmonth`) value modified to day 15 of previous month

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 Identifiers

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

- Submitter (DC001, `orgid`)
- Payer Claim Control Number (DC004, `chiapayerclaimcontrolnumber`)

Payer-Assigned Identifiers

CHIA provides various payer/carrier-assigned identifiers (or surrogate keys) for linking to other files. Examples of these are:

- Dental Insurance Type Code/Product (DC003, `dentalinsurancetypecodeproduct`)
- Insured Group or Policy Number (DC006, `insuredgrouporpolicynumber`)
- Carrier-Specific Member ID (DC056, `chiacarrierspecificuniquememberid`)
- Carrier-Specific Subscriber ID (DC057, `chiacarrierspecificuniquesubscriberid`)

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:

- Date Service Approved (DC017, `dateserviceapprovedapdate`)
- Facility Type - Professional (DC030, `facilitytypeprofessional`)
- Claim Status (DC031, `claimstatuscleaned`)

- Charge Amount (DC037, `chargeamountcleaned`)
- Paid Amount (DC038, `paidamountcleaned`)
- Copay Amount (DC039, `copayamountcleaned`)
- Coinsurance Amount (DC040, `coinsuranceamount`)
- Deductible Amount (DC041, `deductibleamount`)
- Paid Date (DC045, `paiddate`)
- Allowed Amount (DC046, `allowedamountcleaned`)

These elements are variations of paper remittances or as defined by HIPAA 835 5010.

Linking Dental Provider Identifiers

In the Dental Claims file, Service Provider Number (DC018, `serviceprovidernumber_linkage_id`) links with the corresponding record in the Provider file (Plan Provider ID, PV002, `linkingproviderid` and Provider Delegate, derived, `linkingproviderdelegate`). Because they can contain sensitive information, CHIA uses surrogate keys for these elements.

In the Provider file, the Plan Provider ID (PV002, `linkingproviderid`) is the unique number for every service provider (person, facility, or other entity involved in a claim transaction) that a payer has in its system. This element helps to identify other claim data elements associated with a provider and to identify details of the provider's affiliation. It is important not to confuse Provider ID (`providerid`), an administrative row identifier not intended to link between tables, with Plan Provider ID (`linkingproviderid`), which can be used to link between tables.

The Dental Claims file also contains National Service Provider (NPI) ID (DC020, `nationalserviceprovideridcleaned`). This element can be used to link to the NPI elements in the provider file. Many data users opt instead to link this data to the Centers for Medicare and Medicaid Services (CMS) NPI Registry, which is the official federal database that provides public access to information about healthcare providers who have been assigned an NPI.

For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

Versioning

In the Highest Paid Version flag (`versionindicator`), a value of 0 (not highest paid version) or 1 (highest paid version) has been assigned to each dental claim line from the following Org IDs: 291, 3156, and 11541. Claim lines from all other payers should have a value of 9. Please see the **Release Notes** for additional information.

Medical Claims (MC)

The Medical Claims file consists of all paid claims from all reporting payers for derived CHIA Incurred Full Date (`incurredfulldate`) from `2020-01-01` through `2024-12-31`, as paid through June 2025. For the majority of claims, CHIA Incurred Full Date is Date of Service - To (MC060, `dateofserviceto`) for the claim line. In the rare case that Date of Service - To is missing or invalid, CHIA uses the first of the following elements that is valid:

- Discharge Date (MC069, `dischargedate`)
- Date of Service - From (MC059, `dateofservicefrom`)
- Submission Year Month (derived, `submissionyearmonth`) value modified to day 15 of previous 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.

Beginning in CY 2024, CHIA uses updated versioning algorithms, but the goal of the versioning process remains the same. Any difference between CY 2024 versioning results and versioning results in previous releases is minimal.

The data in the following elements is reported to payers through various standard healthcare billing and data exchange formats (UB04, HCFA 1500, HIPAA 837I, and 837P).

For De-Identified data, column names include “DE.”

Descriptive Name	Source Reference Code	Release Column Name
Admitting Diagnosis	MC039	admittingdiagnosiscleaned admittingdiagnosisDE
E-Code	MC040	ecodecleaned ecodeDE
Principal Diagnosis	MC041	principaldiagnosiscleaned principaldiagnosisDE
Other Diagnosis - 1–24	MC042–MC053, MC142–MC153	otherdiagnosis1-24cleaned otherdiagnosis1-24DE
Revenue Code	MC054	revenuecodecleaned
Procedure Code	MC055	procedurecodecleaned
Procedure Modifier - 1–4	MC056–MC057, MC108–MC109	proceduremodifier1-4
ICD-CM Procedure Code	MC058	icdcmprocedurecodecleaned
Other ICD-CM Procedure Code - 1–6	MC083–MC088	othericdcmprocedurecode1-6cleaned
Accident Indicator	MC126	accidentindicator
Family Planning Indicator	MC127	familyplanningindicator
Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Indicator	MC129	epsdtindicator
Procedure Code Type	MC130	procedurecodetype
Date of Service - From	MC059	dateofservicefrom
Date of Service - To	MC060	dateofserviceto
Quantity of Service	MC061	quantity
Charge Amount	MC062	chargeamountcleaned
Paid Amount	MC063	paidamountcleaned
Prepaid Amount	MC064	prepaidamountcleaned
Copay Amount	MC065	copayamountcleaned
Drug Code	MC075	drugcodecleaned

Claim IDs

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

- Submitter (MC001, `orgid`)
- Payer Claim Control Number (MC004, `chiapayerclaimcontrolnumber`)

Payer-Assigned Identifiers

CHIA provides various payer/carrier-related identifiers (or surrogate keys) for linking to other files. Examples of these are:

- Insurance Type Code/Product (MC003, `insurancetypecodeproduct`)
- Insured Group or Policy Number (MC006, `insuredgrouporpolicynumber`)
- Carrier-Specific Unique Member ID (MC137, `chiacarrierspecificuniquememberid`)
- Carrier-Specific Unique Subscriber ID (MC141, `chiacarrierspecificuniquesubscriberid`)

Adjudication Data

CHIA requires adjudication-centric data in the file for analysis. The following elements are typically used in an adjudication process and are variations of paper remittances or as defined by HIPAA 835 5010.

Descriptive Name	Source Reference Code	Release Column Name
Date Service Approved (AP Date)	MC017	dateserviceapprovedapdate
Admission Date	MC018	admissiondate
Admission Type	MC020	admissiontype
Admission Source	MC021	admissionsource admissionsourceDE
Discharge Status	MC023	dischargestatuscleaned dischargestatusDE
Discharge Date	MC069	dischargedate
Type of Bill - on Facility Claims	MC036	typeofbillonfacilityclaims
Site of Service - on NSF/CMS 1500 Claims	MC037	siteofserviceonnsfcms1500claimscleaned
Claim Status	MC038	claimstatus
Paid Amount	MC063	paidamountcleaned
Prepaid Amount	MC064	prepaidamountcleaned
Copay Amount	MC065	copayamountcleaned
Coinsurance Amount	MC066	coinsuranceamount
Deductible Amount	MC067	deductibleamount
Coordination of Benefits / TPL Liability Amount	MC095	coordinationofbenefitstplliabilityamount
Other Paid Insurance Amount	MC096	otherinsurancepaidamountcleaned
Medicare Paid Amount	MC097	medicarepaidamountcleaned
Allowed Amount	MC098	allowedamountcleaned
Non-Covered Amount	MC099	noncoveredamountcleaned
Payment Arrangement Type	MC113	paymentarrangementtypecleaned
Excluded Expenses	MC114	excludedexpensescleaned
Withhold Amount	MC116	withholdamount
Reason for Adjustment	MC080	paymentreasoncleaned
Capitated Encounter Flag	MC081	capitatedencounterflag
Paid Date	MC089	paiddate
Coinsurance Days	MC091	coinsurancedays
Covered Days	MC092	covereddays
Non-Covered Days	MC093	noncovereddays
Referral Indicator	MC118	referralindicator

Descriptive Name	Source Reference Code	Release Column Name
PCP Indicator	MC119	pcpindicator
Global Payment Flag	MC122	globalpaymentflag
Denied Flag	MC123	deniedflag
Denied Reason	MC124	denialreasoncleaned
Employment-Related Indicator	MC128	employmentrelatedindicator
Claim Line Type	MC138	claimlinetype

Linking Medical Provider Identifiers

In the Medical Claims file, there are four elements that have National Provider ID (NPI) embedded in their names:

- National Service Provider ID (MC026, nationalserviceprovideridcleaned)
- National Billing Provider ID (MC077, nationalbillingprovidercleaned)
- Plan Rendering National Provider ID (MC242, nationalprovideridplanrenderingcleaned)

These elements can be linked to the following elements in the Provider file:

- National Provider ID (PV039, nationalprovideridcleaned)
- National Provider2 ID (PV040, nationalprovider2idcleaned)

Many users link these data to the Centers for Medicare and Medicaid Services (CMS) National Provider Identifier (NPI) Registry, which is the official federal database that provides public access to information about healthcare providers who have been assigned a National Provider Identifier (NPI).

In the Medical Claims file, other provider identifiers are payer/carrier-specific and include “linkage_id” in their column names:

- Service Provider Number (MC024, serviceprovidernumber_linkage_id)
- Billing Provider Number (MC076, billingprovidernumber_linkage_id)
- Referring Provider ID (MC112, referringproviderid_linkage_id)
- Attending Provider (MC125, attendingprovider_linkage_id)
- Plan Rendering Provider Identifier (MC134, planrenderingprovider_linkage_id)
- Provider Location (MC135, providerlocation_linkage_id)

These elements can be linked to the Provider file element Plan Provider ID (PV002, `linkingproviderid`) in combination with the Claims element Linking OrgID Provider (derived, `linkorgidpv`), which can be linked to the Provider element Submitter (PV001, orgid). Because they can contain sensitive information, CHIA uses surrogate keys for these elements. For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

In the Provider file, the Plan Provider ID (PV002, `linkingproviderid`) is the unique number for every service provider (person, facility, or other entity involved in a claim transaction) that a payer has in its system. This element helps to identify other claim data elements associated with a provider and to identify details of the provider's affiliation. It is important not to confuse Provider ID (`providerid`), an administrative row identifier not intended to link between tables, with Plan Provider ID (`linkingproviderid`), which can be used to link between tables.

Service Provider Number, Tax ID Number, National Service Provider ID, Entity Type Qualifier (MC024–27) and Service Provider Specialty, City Name, State, ZIP Code (MC032–MC035) relate to the servicing provider entity, e.g., physician's office, organization, or group. The intent is to collect entity-level rendering provider information at the most granular level achievable by the payer. By contrast, the individual physician or other person providing the service is expected in Service Provider First Name (MC28), Middle Name (MC29), and Plan Rendering Provider Identifier (MC134).

Plan Rendering Provider Identifier (MC134) and Provider Location (MC135) capture the servicing or rendering provider at the physician or other licensed person rendering level. These elements should describe precisely who and where the service was rendered. 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 element. For example, XYZ Orthopedic Group is acceptable if XYZ Orthopedic Group Westside is not available, but XYZ Orthopedic Group Westside is preferable.

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. A highest versioning flag (derived, `highestversionindicator`) is used in the CY 2024 release. A value of 0 or 1 has been assigned to each medical claim line from the following Org IDs: 291, 296, 300, 301, 312, 3156, and 3505, 3735, 4962, 7041, 8026, 8647, 10187, 10353, 10441, 10444, 10926*, 10929, 11474, 11726, 12814*, 16621, 20122 and partial on 10632. Claim lines from all other payers should have a value of 9.

For Org IDs 3735 and 16621, claim lines with the following characteristics have not been versioned and will have a `highestversionindicator` value of 9:

- Payer Claim Control Number (MC004, `chiapayerclaimcontrolnumber`) begins with "CB1"

- Length of Payer Claim Control Number is not 11

*For caveats, please see **Release Notes**.

Pharmacy Claims (PC)

The Pharmacy Claims file consists of all paid claims from all reporting payers for derived CHIA Incurred Full Date (`incurredfulldate`) from `2020-01-01` through `2024-12-31`, as paid through June 2025. For the majority of claims, CHIA Incurred Full Date is Date Prescription Filled (PC032, `dateprescriptionfilled`) for the claim line. In the rare case that Date Prescription Filled is missing or invalid, CHIA uses the first of the following elements that is valid:

- Paid Date (PC063, `paiddate`)
- Date Service Approved (AP Date) (PC017, `dateserviceapprovedapdate`)
- Date Prescription Written (PC064, `dateprescriptionwritten`)
- Submission Year Month (derived, `submissionyearmonth`) value modified to day 15 of previous month

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 Identifiers

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

- Submitter (PC001, `orgid`)
- Payer Claim Control Number (PC004, `chiapayerclaimcontrolnumber`)

Payer-Assigned Identifiers

CHIA provides various payer/carrier-assigned identifiers (or surrogate keys) for linking to other files. Examples of these are:

- Pharmacy Insurance Type Code/Product (PC003, `insurancetypecodeproduct`)
- Carrier-Specific Member ID (PC107, `chiacarrierspecificuniquememberid`)
- Carrier-Specific Subscriber ID (PC108, `chiacarrierspecificuniquesubscriberid`)

Adjudication Data

CHIA requires adjudication-centric data to comply with analytic requirements. The elements typically used in an adjudication process are:

- Date Service Approved (AP Date) (PC017, `dateserviceapprovedapdate`)
- Claim Status (PC025, `claimstatuscleaned`)

- Paid Amount (PC036, `paidamountcleaned`)
- Copay Amount (PC040, `copayamountcleaned`)
- Coinsurance Amount (PC041, `coinsuranceamount`)
- Deductible Amount (PC042, `deductibleamount`)
- Paid Date (PC063, `paiddate`)
- Date Prescription Written (PC064, `dateprescriptionwritten`)
- Other Insurance Paid Amount and related payment data (PC065–PC070, see Data Specification Workbooks)
- Claim Line Type (PC110, `claimlinetypecleaned`)

These are variations of paper remittances or as defined by HIPAA 835 5010.

Linking Pharmacy Provider Identifiers

In the Pharmacy Claims file, Prescribing Provider ID (PC043, `prescribingproviderid_linkage_id`) and Prescribing Physician NPI (PC048, `prescribingphysiciannpicleaned`) link to corresponding records in the Provider file (Plan Provider ID, PV002, `linkingproviderid` and Provider Delegate, derived, `linkingproviderdelegate`). Other identifying elements in the Pharmacy Claims file include PC044–PC055 (for Data Element Names and Release Column Names, see Data Specification Workbooks).

In the Provider file, the Plan Provider ID (PV002, `linkingproviderid`) is the unique number for every service provider (person, facility, or other entity involved in a claim transaction) that a payer has in its system. This element helps to identify other claim data elements associated with a provider and to identify details of the provider's affiliation. It is important not to confuse Provider ID (`providerid`), an administrative row identifier not intended to link between tables, with Plan Provider ID (`linkingproviderid`), which can be used to link between tables.

For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

Versioning

A highest paid version flag (`versionindicator`) is provided in the CY 2024 release. A value of 0 or 1 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, 8634, 8647, 10353, 10441, 10444, 10632, 10926, 11474*, 11541, 11726, 16621, and 20122. Claim lines from all other payers have a value of 9. (See Claims Files and Claims Versioning for more details.)

* See Table 2 below for a list of related caveat(s) by submitting Org ID. Grouped Org IDs illustrate single-carrier reporting.

Table 2: MA APCD Pharmacy Versioning Caveats by Org ID

Org ID	Caveat(s)
10942, 10953, 10954, 11069, 11239, 11264, 11364, 11371, 11500	For these pharmacy benefit manager (PBM) Org IDs, duplicate claims and eligibility data exist since it has been submitted by both the health insurer and the PBM. In addition, these PBM Org IDs are excluded from the Master Patient Index process and will not have associated `memberlinkeid` values.
10353 10441, 10929, 20122	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 CY 2022 Release. As of the CY 2023 Release: Org ID 10353 - CHIA versioned the claims as of July 2022 submission period. Org ID 10441 - CHIA versioned the claims as of July 2022 submission period. Org ID 20122 - CHIA versioned the claims as of July 2022 submission period. The pharmacy claims for org id 10929 are NOT versioned in the CY2023 Release. This submitter no longer submits to MA APCD with the last submission of June 2022.
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.

Org ID	Caveat(s)
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 CY 2022 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 CY 2022 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. The 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 CY 2022 Release. As of CY 2023 Release, CHIA is also versioning the pharmacy claims from the new pharmacy benefit manager (PBM) as of January 2023. For the CY 2023 Release, CHIA found the run-out for the versioning process extended beyond the June 2024 cut-off period. As a result, some backouts present in later submissions were applied to the release data resulting in a higher-than-expected number of not-highest-version claim lines. CHIA plans to remediate the process for this finding in the next 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

Org ID	Caveat(s)
	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. As of CY2023 Release, CHIA is also versioning the pharmacy claims from the new pharmacy benefit manager (PBM) as of January 2023. **As of CY 2024 Release, claim lines with a value of "EG" in the beginning of the Product ID Number (submission guide PC056) and an incurred date prior to January 2023 are not versioned.**
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 **As of CY 2024 Release, all claim lines for Org ID 312 with a value of "NAVITUS" in the beginning of the Payer Claim Control Number (submission guide PC004) are not versioned.**

Member Eligibility (ME) File

The ME file contains all eligibility records with at least one day of member eligibility submitted during the release time frame. For CY 2024, the Member Eligibility file contains records with Submission Year Month (derived, `submissionyearmonth`) from `202001` to `202506` (i.e., January 2020 through June 2025).

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 Master Patient Index, a surrogate key CHIA designed to represent unique individuals. For more information, please see **Updated Master Patient Index and Data Exclusion**.
- For individuals within a specific reporting period, several methods are provided in **CHIA Data User Workgroup** presentations. 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 that submitted claims. Appendix B lists these exceptions. Consult Appendix B before linking claims to individuals by Org 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, their Product Eligibility, and other attributes.

Multiple records for a member and a product may exist, but beginning and ending 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 also 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, `medicalcoverage`) would have a value of one (1) for Yes and the Prescription Drug Coverage indicator (ME019, `prescriptiondrugcoverage`) would have a value of two (2) for No

in the HMO Medical 1000 eligibility record. These element values would be reversed in the RX Bronze eligibility record.

A break in eligibility allows 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., 12/31/2024).

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 whether a member has medical, dental, pharmacy, behavioral health, vision, and/or lab coverage. These elements can be compared with the Product file and are helpful in understanding benefit design.

Dates

CHIA collects two sets of start and end dates:

- Product Enrollment Start Date (ME041, `productenrollmentstartdate`) and Product Enrollment End Date (ME042, `productenrollmentenddate`) are the dates associated with the member's enrollment in a specific product. Product Enrollment Start Date captures the date the member enrolled in the product. Product Enrollment End Date captures the last date the member was enrolled or, if they are still enrolled, is null.
- Member PCP Effective Date (ME047, `memberpcpeffectivedate`) and Member PCP Termination Date (ME048, `memberpcpterminationdate`) are the dates a member is enrolled with a specific PCP. For plans or products without PCPs, these elements will not be populated.

ME File Impact on Product File (PR) Entries

The multiple row convention (see **Member Eligibility File Features** above) also impacts the Product file. Each product listed in the ME file also must be present in the Product file, with Product Benefit Type (PR006, `productbenefittype`) indicating whether the product is a Pharmacy, Medical or other product. Product Benefit Type should correlate to the flags in the Member Eligibility file. For

example, in the Product File record for HMO Medical 1000, `productbenefittype = 1` (indicating "Medical Only") and for RX Bronze, `productbenefittype = 2` (indicating "Pharmacy Only").

Linking Member Eligibility Provider Identifiers

In the Member Eligibility file, the following elements can link to the Plan Provider ID (PV002, `linkingproviderid`) in the Provider file:

- Health Care Home Number (ME036, `healthcarehomenumber_linkage_id`)
- Member PCP ID (ME046, `memberpcpid_linkage_id`)
- Attributed PCP Provider ID (ME124, `attributedpcpproviderid_linkage_id`)
- Health Care Home National Provider ID (ME038, `healthcarehomenationalprovideridcleaned`)

In the Provider file, the Plan Provider ID (PV002, `linkingproviderid`) is the unique number for every service provider (person, facility, or other entity involved in a claim transaction) that a payer has in its system. This element helps to identify other claim data elements associated with a provider and to identify details of the provider's affiliation. It is important not to confuse Provider ID (`providerid`), an administrative row identifier not intended to link between tables, with Plan Provider ID (`linkingproviderid`), which can be used to link between tables.

The above Member Eligibility elements can be linked to the Provider file element Plan Provider ID (PV002, `linkingproviderid`) in combination with the Member Eligibility file element Linking OrgID Provider (derived, `linkorgidpv`), which can be linked to the Provider element Submitter (PV001, `orgid`). Because they can contain sensitive information, CHIA uses surrogate keys for these elements.

For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

Redundancy in Claims Data Elements

Many of the segments in the file use semantics like claims data, and some elements are exact duplicates of elements in claims files. CHIA collects contents of the payers' Member Files 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.

For some health insurers with pharmacy benefit managers (PBMs), both the health insurer and the PBM submit claims and eligibility data. For these Org IDs, duplicate claims and eligibility data exist: 10942, 10953, 10954, 11069, 11239, 11264, 11364, 11371, and 11500. In addition, these Org IDs are excluded from the Master Patient Index process and will not have associated `memberlinkeid` values.

Product (PR) File

For the CY 2024 release, the Product (PR) file consists of aggregated and unduplicated records across the years 2020–2024.

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, `productlineofbusinessmodel`) 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 might appear to be duplicate rows when, in fact, they are for distinct products.

Product Identifiers and File Linking

CHIA collects the following elementary identifiers associated with a product, which can be used to analyze product data across payers or help link product data to the ME file:

- Product Name (PR002, `productname`)
- Carrier License Type (PR003, `carrierlicensetype`)
- Product Line of Business Model (PR004, `productlineofbusinessmodel`)
- Insurance Plan Market (PR005, `insuranceplanmarketcleaned`)
- Product Benefit Type (PR006, `productbenefittype`)
- Other Product Benefit Description (PR007, `otherproductbenefitdescriptioncleaned`)
- Risk Type (PR008, `risktype`)

For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

Product Dates

CHIA collects two date elements for each PR record. Product Start Date (PR009, `productstartdate`) and Product End Date (PR010, `productenddate`) describe the time frame that the product was active with the payer and usable by eligible members. 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,
- provider's affiliation to a specific location, or
- provider's begin and end date.

Linking Provider Identifiers

In the Provider file, the Plan Provider ID (PV002, `linkingproviderid`) is the unique number for every service provider (person, facility, or other entity involved in a claim transaction) that a payer has in its system. The Plan Provider ID and Provider Delegate (derived, `linkingproviderdelegate`) can be used to uniquely identify a provider and that provider's affiliation within the Provider file. Because they can contain sensitive information, CHIA uses surrogate keys for these elements.

It is important not to confuse Provider ID (`providerid`), an administrative row identifier not intended to link between tables, with Plan Provider ID (`linkingproviderid`), which can be used to link between tables.

For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

Provider Specialty

The following required elements 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 elements.

Descriptive Name	Source Reference Code	Release Column Name
Taxonomy	PV022	`taxonomycleaned`
Provider Type Code	PV029	`providertypecodecleaned`
Primary Specialty Code	PV030	`primaryspecialtycode`
Secondary Specialty2 Code	PV042	`secondaryspecialty2cleaned`
Secondary Specialty3 Code	PV043	`secondaryspecialty3cleaned`

Start and End Dates

CHIA collects two sets of date elements 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:

- **Begin Date** (PV037, `begindate`) and **End Date** (PV038, `enddate`) describe the dates the provider is active with the payer and is eligible to provide services to members. For providers who are still active, End Date should be null.
- **Provider Affiliation Start Date** (PV062, `provideraffiliationstartdate`) and **Provider Affiliation End Date** (PV063, `provideraffiliationenddate`) 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, one for each affiliation with respective dates. If a provider's affiliation is terminated and made active again at a later date, this would require two records also.

Some examples of how 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 elements 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 for each location, as in Example 3.
7. *Billing organization*
   An entity that shows up in the claims file in the Billing Provider element 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 Element. 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

A subset of major medical payers is required to submit a Benefit Plan Control Total File (BP) 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 with the detailed 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

The CY 2024 release 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 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, types, and names). CHIA receives this data from the EHS DW team as a single enhanced eligibility data file submission.

MHEE data requires approval from MassHealth. The full MHEE data set is only available to government agency requestors. Starting in Release 7.0, however, 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 through 2024 (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 is identified by the unique carrier specific data element (`chiacarrierspecificuniquememberid`). This element 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 2023, select records where `dte_effective_month` is between `20230101` and `20231231`.

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

MHEE data does not replace ME data. In the event that 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 elements included in the MHEE data that link to the MA APCD Provider (PV) data. To avoid duplication, the Provider Delegate element in the PV data (derived,

`linkingproviderdelegate`) should be set to `1` when joining to PV data to obtain entity names and other provider attributes. The elements in the following table link to Plan Provider ID (PV002, `linkingproviderid`) in the Provider file `where linkingproviderdelegate = 1` and Provider Organization ID (PV031, `providerorganizationid`) equals (MassHealth PV submissions).

Provider ID Type	Definition	Release Column Name
MCO	Identifies the MCE for members enrolled in managed care—MCO, SCO, PACE, and One Care plans	id_provider_location_mco_linkage_id
PCC	For members in the PCC plan, identifies a member's PCC.	id_provider_location_pcc_linkage_id
BH	Identifies behavioral health provider (currently always MBHP)	id_provider_location_bh_linkage_id
LTC	Identifies members' nursing or other long-term care facilities	id_provider_location_ltc_linkage_id

For more information on linking between files, see Linking Data Elements Between Files on p. 39 of this guide and **Between-File Linkages in the MA APCD** on CHIA's website.

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

These data do not link to the MA APCD PR data, but the element `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 elements 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` elements. 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.

Category Type	Definition
cde_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

Linking Data Elements Between Files

In all between-file linkages, the original linkage identifier values submitted by carriers have been replaced with a surrogate key. This protects certain identifying information while still allowing linking between files. For a visual representation of linkage identifiers, see **Between-File Linkages in the MA APCD** on CHIA's website.

Claims and Provider File Linking

To link data in the Provider file to data in Claims files, join `linkingproviderid` in the Provider file to the corresponding provider linking element of interest in the Claims file (`serviceprovidernumber_linkage_id`, `billingprovidernumber_linkage_id`, `referringproviderid_linkage_id`, `attendingprovider_linkage_id`, `planrenderingprovideridentifier_linkage_id`, `prescribingproviderid_linkage_id`, or `providerlocation_linkage_id`) **and** join `orgid` in the Provider file to `linkorgidpv` in the Claims file, as in the table below.

Provider (PV) File Element	Links to Claims File Elements
`linkingproviderid`	`serviceprovidernumber_linkage_id`
	`billingprovidernumber_linkage_id`
	`referringproviderid_linkage_id`
	`attendingprovider_linkage_id`
	`planrenderingprovideridentifier_linkage_id`
	`prescribingproviderid_linkage_id`
	`providerlocation_linkage_id`
AND	AND
`orgid`	`linkorgidpv`

The Provider file also contains the element `linkingproviderdelegate`, which is meant to consolidate a one-to-many join.

Linking Plan Provider ID (`planproviderid`) + Provider Delegate (`linkingproviderdelegate`)

Incorporating the condition

```
where linkingproviderdelegate = 1
```

resolves intra-entity duplication of Provider ID values (selecting the most recent iteration). This constraint effectively enforces a one-to-one correspondence between claims-level provider references and their corresponding entries in the Provider file. Consequently, it allows the Provider file to function as a master file for the unique identifier `linkingproviderid`, which operates as a normalized surrogate key for the `planproviderid` originally reported by the individual carriers. This `where` constraint enhances referential integrity, reduces join ambiguity, and improves the linkage reproducibility of cross-file linkages.

Claims and Product File Linking

To link data in the Product file to data in Claims files, join `linkingproductid` in the Product file to `productidnumber_linkage_id` in the Claims files **and** `orgid` in the Product file to `linkorgidpr` in the Claims files, as in the table below.

Product (PR) File Element	Links to Claims File Elements
`linkingproductid`	`productidnumber_linkage_id`
AND	AND
`orgid`	`linkorgidpr`

The product file also contains the element `linkingproductdelegate`, which (as with the Provider file) is meant to consolidate a one-to-many join.

Linking Product ID (`linkingproductid`) + Product Delegate (`linkingproductdelegate`)

Member Eligibility Medical Home

In the Member Eligibility file, payers/carriers may report whether the member has been assigned a patient-centered medical home through which a continuum of services are coordinated. When Health Care Home Assigned Flag (MC035, `healthcarehomeassignedflag`) is set to `1`, the Health Care Home Number (MC036, `healthcarehomenumber_linkage_id`) should be populated with a value. The below tables show linking values that can be used with `healthcarehomenumber_linkage_id`, in combination with the following condition:

```
where healthcarehomeassignedflag = 1
```

Provider (PV) File Element	Links to Member Eligibility (ME) File Element
`linkingproviderid`	`healthcarehomenumber_linkage_id`

AND

PV File Element	Links to Claims Files Element
`orgid`	`linkingorgme`

Member Link EID

CHIA provides a derived data element called Member Link EID (`memberlinkeid`), which represents a unique Enterprise Identifier (EID) assigned to an individual person. Member Link EID enables linkage of the same person across file types and across different submitting payers/carriers.

Member Link EID is now independent of the Claims files, in a separate MEID file. Using `memberlinkeid`, you can find all Submitter (`orgid`) and Carrier-Specific Unique Member ID (`chiacarrierspecificuniquememberid`) records associated with the same person. When doing within-payer/carrier analysis, linkage can be done using `chiacarrierspecificuniquememberid` and `orgid`, as shown below.

Within-Carrier Linkage Using Carrier-Specific Unique Member ID and `orgid`

Member Eligibility	MassHealth Enhanced Eligibility	Medical Claims	Pharmacy Claims	Dental Claims
`chiacarrierspecificuniquememberid`	`chiacarrierspecificuniquememberid`	`chiacarrierspecificuniquememberid`	`chiacarrierspecificuniquememberid`	`chiacarrierspecificuniquememberid`
AND	AND	AND	AND	AND
`orgid`	`orgid`	`orgid` or, when linking to ME file, `linkorgidme`	`orgid` or, when linking to ME file, `linkorgidme`	`orgid` or, when linking to ME file, `linkorgidme`

However, it is important to note that because the MA APCD includes data submitted both by payers and by third-party administrators (TPAs), duplicate records for the same person can occur. CHIA's Master Person Index (MPI) process, which determines Member Link EIDs, excludes data that introduces excessive duplication or is of insufficient quality. Records were excluded from the MPI in three specific circumstances:

1. The entire eligibility submission from a given submitter was excluded.
2. One or more years of a submitter's data were excluded.
3. Selected individual records within a submission were excluded.

For more information on population of the Member Link EID element, please see Updated **Master Patient Index and Data Exclusion**.

Benefit Plan Control (BP) File Linking to Member Eligibility (ME) Data

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 linking elements have not been re-identified. Linking elements are Benefit Plan Contract ID (BP001, `benefitplancontractid`) and Member Eligibility Benefit Plan Contract ID (ME128, `benefitplancontractid`) in combination with `orgid`, as shown below.

Member Eligibility	Benefit Control Plan
benefitplancontractid	benefitplancontractid
AND	AND
orgid	orgid

Linking Claims Data to Member Eligibility Zip Code Data

The Geography (GEO) file contains Member Eligibility elements related to member, subscriber, and employer location. The tables below show elements in the Medical Claims (MC), Dental Claims (DC), and Pharmacy Claims (PC) files that link to elements in the GEO file using the sample code provided. Codes (zip and state) outside New England and New York geographic boundaries are represented by XX or 99999 in memberstateorprovince, subscriberstateorprovince, memberzipcode, and subscriberzipcode.

When linking GEO file data to Claims file data, please note that GEO file data reflects a member's last known address at the date of monthly eligibility enrollment. Member location in GEO file data does not necessarily coincide with dates of service in Claims files. If a member's address changes between the date of monthly eligibility enrollment and the date on which they receive care, GEO file data will not accurately reflect their location at the time of care.

Medical Claims (MC) Linkage to Geography (GEO)

MC	GEO
linkorgidme	orgid
AND	AND
chiacarrierspecificuniquemember id	chiacarrierspecificuniquemember id
AND	AND
dateofservicefromyear	submissionyearmonth

Dental Claims (DC) Linkage to GEO

DC	GEO
linkorgidme	orgid
AND	
chiacarrierspecificuniquememberid	chiacarrierspecificuniquememberid
AND	
dateofservicefromyear	submissionyearmonth

Pharmacy Claims (PC) Linkage to GEO

Pharmacy Claims	GEO
linkorgidme	orgid
AND	
chiacarrierspecificuniquememberid	chiacarrierspecificuniquememberid
AND	
dateprescriptionfilledyear	submissionyearmonth

Appendix A: National Reference Tables

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	http://www.ansi.org/
States, Zip Codes, and Other Areas of the US	U.S. Postal Service	https://www.usps.com/
National Provider Identifiers	National Plan and Provider Enumeration System Department of Health and Human Services Centers for Medicare and Medicaid Services	https://nppes.cms.hhs.gov/
Provider Specialties	Centers for Medicare and Medicaid Services	https://www.cms.gov/
Health Care Provider Taxonomy	Washington Publishing Company	http://www.wpc-edi.com/reference/
North American Industry Classification System (NAICS)	U.S. Census Bureau	http://www.census.gov/eos/www/naics/
International Classification of Diseases 9 and 10	American Medical Association	http://www.ama-assn.org/
HCPCS, CPTs, and Modifiers	American Medical Association	http://www.ama-assn.org/
Dental Procedure Codes and Identifiers	American Dental Association	http://www.ada.org/
Logical Observation Identifiers, Names, and Codes	Regenstrief Institute, Inc.	http://loinc.org/
National Drug Codes and Names	U.S. Food and Drug Administration	http://www.fda.gov

Type	Organization	URL
Standard Professional Billing Elements	Centers for Medicare and Medicaid Services	https://www.cms.gov/
Standard Facility Billing Elements	National Uniform Billing Committee American Hospital Association	http://www.nubc.org/
DRGs, APCs, and POA Codes	Centers for Medicare and Medicaid Services	http://www.cms.gov/
Claim Adjustment Reason Codes	Washington Publishing Company	http://www.wpc-edi.com/reference/
Race and Ethnicity Codes	Centers for Disease Control and Prevention	http://www.cdc.gov

Appendix B: Associated Org ID Submitters

Table 1: Associated Org ID Submitters

Org ID	File Type	Note
11745	Provider	Provider data included in Org ID 290 and/or 10441
10353	Provider	Provider data included in Org ID 10441
10929	Provider	Provider data included in Org ID 290
10187	Eligibility	Eligibility data included in Org ID 3156

Appendix C: Glossary

This glossary presents definitions of many terms related to the MA APCD. Please note that the definitions for data elements are general; specific data elements are defined in the **MA APCD Submission Guides**.

Term	Definition
Accident Indicator	A yes/no indicator that originates from the Professional Claims format to assess insurance liability and financial responsibility and aid with clinical assessments.
Adjudication Data	Any data that describe 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 Database (APCD) is a data set 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; originally defined by Federal Balanced Budget Act for Medicare claims.
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/element 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 reported on Facility Inpatient Claims.
Billing Provider	A provider entity that sends claims and requests for adjudication to a payer/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 time frame.
Carrier	Also known as Payer. See Health Care Payer.
Carrier-Specific Unique Member ID	The number a payer/carrier uses internally to uniquely identify a member.

Term	Definition
Carrier-Specific Unique Subscriber ID	The number a payer/carrier uses internally to uniquely identify a 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.
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 and 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)	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.

Term	Definition
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.
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 and 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.
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.

Term	Definition
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.
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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 and financial responsibility and aid with clinical assessments.
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 and financial responsibility and aid with clinical assessments.

Term	Definition
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 Services	EHS
Executive Office of Health and Human Services Data Warehouse	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.
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 and financial responsibility and aid with clinical assessments.
Encounter Data	Detailed data about individual services provided by a capitated managed care entity.
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Executive Office of Health and Human Services Data Warehouse	EHS DW

Term	Definition
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 method 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 data set 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 (GIC)	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.
Hash	To replace with a randomly generated (often 128-character) reference, called a “surrogate key,” that does not contain identifying information. Some data elements are hashed to maintain confidentiality for payers, providers and individuals while allowing linking between claims, files, and lookup tables.
Health Care Home	See Patient Centered Medical Home.
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 can be an insurance carrier, a health maintenance organization, a nonprofit hospital services corporation, a medical service corporation, a Third Party Administrator, or a self-insured plan.
Health Plan Information	Information submitted by Health Care Payers in accordance with 957 CMR 8.
HIPAA 835 5010	Refers to a specific electronic transaction standard used in healthcare billing and payments. Version 5010 replaced the earlier 4010 version to improve data reporting and accommodate ICD 10-CM/PCS codes.

Term	Definition
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/PCS	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 element 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.
International Classification of Diseases, 10th Edition, Clinical Modification	Refers to the International Classification of Diseases, 9th Revision Codes, and Clinical Modification (ICD-9-CM) Procedure Coding System.
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	Managed Care Entity
MCO	See Managed Care Organization.
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.

Term	Definition
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 provide 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 and B).
Medicare Benefits (Part A and 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.
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 (HIPAA) for Administrative Simplification.
National Service Provider ID	National Provider Identification (NPI) of the Servicing Provider.
NCPDP	See National Council for Prescription Drug Programs

Term	Definition
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.
Org ID	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. Also known as Carrier.
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.
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	Payer/carrier’s unique code that identifies which individual provider cared for the patient for the claim line in question.

Term	Definition
Plan Specific Contract Number	Plan-assigned contract number. This should be the contract or certificate number for the subscriber and all of their 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 and PPO but is also synonymous with processing services, network leasing, and 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.
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.

Term	Definition
Provider	A health care practitioner, health care facility, health care group, medical product vendor, or pharmacy. 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 Providing business services or contracting arrangements for a servicing provider.
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 payer/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.
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.

Term	Definition
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.
Surrogate Key	A randomly generated reference (often 128 characters) that does not contain identifying information. Some data elements are “hashed,” i.e. replaced with surrogate keys, to maintain confidentiality for payers, providers and individuals while allowing linking between claims, files, and lookup tables.
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-, or 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 ensure that A-Level Thresholds are met.
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 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 element (or elements), 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 ensure 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).