CHIA Data User Workgroup

Donald Kirkwood, Manager of Data Release and Procurement
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April 28, 2026

Agenda

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- CHIA Annual Data Release Status
- Requesting Data Using CHIA's New Online Application Process
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Questions?

Announcements

CHIA ANNUAL DATA RELEASE STATUS (CASE MIX)

All FY2024 case mix databases are now available for application.

The FY2025 hospital inpatient discharge data is targeted for release in June 2026, emergency department data in August 2026, and outpatient observation stay data in September 2026, see: https://www.chiamass.gov/case-mix-data

Case Mix Releases

Product	Target	Actual	Status
Case Mix FY 2025 (October 1, 2024 - September 30, 2025)			
Hospital Inpatient Discharge Data (HIDD)	June 2026	-	In Progress
Emergency Department Data (EDD)	August 2026	-	In Progress
Outpatient Observation Stay Data (OOD)	September 2026	-	In Progress

CHIA ANNUAL DATA RELEASE STATUS (MA APCD)

Right on schedule with the promised targeted release date, all years of Massachusetts APCD data are now available for application, see: https://chiamass.gov/ma-apcd

MA APCD Overview

MA APCD Overview
(Updated – December 2025)

Request MA APCD Data

See step-by-step instructions
to apply for MA APCD data

MA APCD Calendar Year 2024 Documentation

- MA APCD CY 2024 Documentation Guide
- MA APCD CY 2024 Release Notes
- MA APCD CY 2024 Standardized Extract Data Specifications
- MA APCD Updated Master Patient Index and Data Exclusion
- MA APCD CY 2024 De-Identification Summary

Annual Release Status

This information was updated on: 03/13/2026

MA APCD Releases

Product	Target	Actual	Status
MA APCD CY 2024 (2020-2024 data with six-month run out from 2025)	Fall 2025	Fall 2025	Available
Release Status Notes • MA APCD CY 2024 is available for application.			
MA APCD CY 2023 (2019-2023 data with six-month run out from 2024)	Fall 2024	Fall 2024	Available
Release Status Notes • MA APCD CY 2023 is available for application.			

REMEMBER DATA USE STARTS WITH READING THE DOCUMENTATION

REQUESTING DATA USING CHIA'S NEW ONLINE APPLICATION PROCESS

Step-by-step instructions are on the MA APCD data at: https://www.chiamass.gov/request-ma-apcd-data and Case Mix data at: https://www.chiamass.gov/request-case-mix-data

The application process applies to all data requestors, with certain steps varying based on applicant type and the purpose behind the request. Where the process differs, those differences are noted below.

Prior to submitting an **MA APCD request**, all applicants should determine whether they are requesting:

- Identifiable Data, or
- Statistically De-identified Data

Prior to submitting a **Case Mix request**, all applicants should determine whether they are requesting:

- Identifiable Data, or
- HIPAA-Safe Harbor Compliant De-identified Data

Requests for Identifiable Data for Research must include:

- A detailed description of the following:
- Research methodology, objectives, and rationale
- The need for specific Identifiable Data elements
- How the results will be published or contribute to generalizable knowledge
- Authorization to receive Identifiable Data, either through individual patient authorization or waiver of authorization approved by an Institutional Review Board or Privacy Board.

ALERT: Impact of Place on Dental Use by Medicaid-Enrolled Adults in Massachusetts

Impact of Place on Dental Use by Medicaid–Enrolled Adults in Massachusetts

S Ticku [1], E Alpert [1 2], E Mo [3], J Barrow [4], H Wu [5]

Affiliations + expand

PMID: 41834389 DOI: 10.1177/23800844261425639

Abstract

Introduction: Place-level factors influence oral health disparities, yet research predominantly focuses on individual-level determinants. This study examines how neighborhood characteristics influence dental service utilization among Medicaid-enrolled adults in Massachusetts.

Methods: This retrospective study analyzed data from adult Medicaid beneficiaries obtained from the 2015 Massachusetts All-Payer Claims Database, which includes dental, medical, and member eligibility information. ZIP Code Tabulation Area (ZCTA)-level Social Vulnerability Index (SVI) scores for 4 themes (socioeconomic status, household characteristics, minority status, housing/transportation) were calculated using American Community Survey 2015 data. Negative binomial regression analysis with multilevel modeling assessed the association between individual- and place-level factors on the utilization of preventive, restorative, and surgical dental care.

Results: The sample comprised 1,108,378 Medicaid beneficiaries across 511 ZCTAs and 13 counties in Massachusetts. ZCTA-level factors demonstrated several disparities. ZCTA with a low vulnerability for minority status SVI had up to 5-fold higher utilization across preventive (incidence rate ratio [RR]: 5.06, confidence interval [CI]: 3.67 to 6.97), restorative (RR: 5.28; CI: 3.88 to 7.17), and surgical (RR: 4.78; CI: 3.56 to 6.40) service types compared with high-vulnerability areas (predominantly minority ZCTAs). In addition, low-vulnerability neighborhoods for housing/transportation showed higher utilization for all preventive (RR: 2.67; CI: 1.98 to 3.59), restorative (RR: 2.44; CI: 1.84 to 3.24), and surgical (RR: 2.20; CI: 1.68 to 2.88) service types. Compared with ZCTA-level factors, individual factors such as age, gender, diabetes status, smoking status, and preventive medical care use contributed only marginally to explaining geographic variations in dental care use. Adding SVI themes reduced unexplained geographic variance by 38% for preventive services, 40% for restorative services, and 33% for surgical services.

See: Ticku S, Alpert E, Mo E, Barrow J, Wu H. Impact of Place on Dental Use by Medicaid-Enrolled Adults in Massachusetts. JDR Clin Trans Res. 2026 Mar 15. doi: 10.1177/23800844261425639. https://pubmed.ncbi.nlm.nih.gov/41834389/

New study using MA APCD shows that neighborhood-level social vulnerability, especially racial composition and housing/ transportation conditions, is a far stronger predictor of dental service use among Medicaid-enrolled adults than individual characteristics.

- Adults living in low–minority-vulnerability ZCTAs had ~5× higher use of preventive, restorative, and surgical dental services than those in high-vulnerability (predominantly minority) areas.
- Low housing/transportation vulnerability neighborhoods showed 2–3× higher utilization across all dental service types.
- Individual factors (age, sex, diabetes, smoking, preventive medical care use) explained only a small share of geographic variation in dental use.
- Incorporating SVI themes reduced unexplained geographic variance by 38% (preventive), 40% (restorative), and 33% (surgical).
- Geographic disparities persisted across 511 ZCTAs and 13 counties, underscoring structural, not behavioral, drivers of access.

ALERT: The All-Payer Claims Database After the Gobeille Supreme Court Decision: Assessing the Impact on Fatal Opioid-Related Overdose Research

The All-Payer Claims Database After the *Gobeille* Supreme Court Decision: Assessing the Impact on Fatal Opioid-Related Overdose Research

Jack Cordes[1] | Cici Bauer[2,3] | Dana Bernson[4] | Marc R. Larochelle[5] | Wenjun Li[6] | Jiahao Cao[2,3] | Olaf Dammann[1] | Thomas J. Stopka[1]

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Correspondence: Jack Cordes (jack.cordes@tufts.edu)

Received: 9 September 2025 | **Revised:** 26 December 2025 | **Accepted:** 11 February 2026

Keywords: APCD | controlled interrupted time-series | *Gobeille* | opioid-related overdose | representativeness

ABSTRACT

Objective: To determine the consequences of the *Gobeille v. Liberty Mutual* Supreme Court decision on the representativeness of the Massachusetts all-payer claims database (APCD). The loss of individuals captured in the APCD may vary demographically, geographically, and in the capture of fatal opioid-related overdose (OOD).

Data Sources and Study Setting: We used 2013–2021 data from the Massachusetts Public Health Data Warehouse (PHD), which links person-level APCD records to other datasets. The APCD includes commercially-insured health claims mandatorily reported pre-*Gobeille*. Post-*Gobeille*, reporting from self-insured plans, a subset of commercially-insured plans, became voluntary.

Study Design: In a repeated cross-sectional design, we compared the APCD population characteristics in 2015 to each subsequent year 2016–2021.

Data Collection/Extraction Methods: We compared pre-post *Gobeille* statewide APCD demographic distributions using standardized mean differences and assessed geographic distribution changes by ZIP Code. We identified fatal OOD using death certificates. We used annual and monthly interrupted time-series models with publicly-available state records as the control to quantify the pre- (2013–2015) and post- (2016–2021) *Gobeille* changes in the total APCD population and in fatal OOD when linked to the APCD within the PHD.

Principal Findings: Within APCD, the commercially-insured population decreased by 38% post-*Gobeille*. State-level age increased slightly and sex distributions remained stable, while proportions of White non-Hispanic individuals decreased. Suburban ZIP Codes had the highest losses of individuals. In 2021, under 80% of fatal OODs could be linked to the APCD, compared to 95% linkage pre-*Gobeille*. The change in monthly fatal OOD rates when linked to the APCD was 0.55 persons higher per 100,000 people post-*Gobeille* (95% CI: 0.05, 1.05) than the change observed in official statistics.

Conclusions: The *Gobeille* decision negatively impacted APCD geographic and racial representativeness in Massachusetts, which should be addressed to improve external validity in Massachusetts and other states using APCDs to assess health services.

See: Cordes J, Bauer C, Bernson D, Larochelle MR, Li W, Cao J, Dammann O, Stopka TJ. The All-Payer Claims Database After the Gobeille Supreme Court Decision: Assessing the Impact on Fatal Opioid-Related Overdose Research. Health Services Research. 2026 Apr;61(2):e70097. https://onlinelibrary.wiley.com/doi/pdf/10.1111/1475-6773.70097

New study evaluates how Gobeille v. Liberty Mutual decision, which made reporting from self-insured employer plans voluntary, affected the representativeness of the MA APCD and its use in fatal opioid-related overdose research. The authors find that Gobeille substantially reduced APCD population coverage and altered its racial and geographic composition, introducing important threats to external validity for APCD-based public health analyses.

- The commercially insured population captured in the APCD declined by ~38% after Gobeille, with especially large losses among White non-Hispanic individuals and residents of suburban ZIP Codes.
- By 2021, more than 20% of fatal opioid-related overdoses could not be linked to APCD records (versus ~95% linkage pre-Gobeille), substantially weakening the APCD's role as a linkage "spine."
- Although overall opioid overdose rate trends remained similar to official state statistics, disrupted linkage and population loss necessitate race-, geography-, and insurance-specific weighting to preserve generalizability in APCD-based research.

ALERT: Impact of Breast Cancer-Related Lymphedema on Cancer Care Costs: Longitudinal and Age-Based Analyses

Impact of Breast Cancer–Related Lymphedema on Cancer Care Costs: Longitudinal and Age–Based Analyses

Anne Marie Raymakers [1], Tari A King [2 3 4], Elizabeth A Mittendorf [2 3 4], Tanujit Dey [4 5], Mahima Jain [5], Electra D Paskett [6], Ann S McAlearney [7 8 9], Rachel A Greenup [10], Justin M Broyles [1 4], Sara P Myers [11 12 13 14]

Affiliations + expand

PMID: 41402689 DOI: 10.1245/s10434-025-18875-5

Abstract

Purpose: How breast cancer-related lymphedema (BCRL) costs evolve over time, especially for younger patients, is poorly understood. We sought to characterize BCRL-associated costs by age and treatment phase.

Methods: Using Massachusetts All-Payer Claims data, we compiled costs for patients aged ≤61 years who received surgery for stage I-III breast cancer between January 1, 2016, and December 31, 2016, then, postoperatively through December 31, 2020. Treatment costs were compared annually by BCRL status (two or more vs. no BCRL diagnosis codes within 2 years of surgery). BCRL and non-BCRL cohorts were propensity-matched, accounting for surgery types, chemotherapy, and radiation. Sensitivity analyses determined cost differences by age at diagnosis (18-44 vs. 45-61 years).

Results: Of 2141 patients, 244 (11.4%) had BCRL. BCRL incidence was similar across ages: 46 of 434 (10.6%) aged 18-44 years versus 198 of 1707 (11.6%) aged 45-61 years; p = 0.612. Before matching, patients with BCRL had higher copayment ($US1200 vs. $US610 non-BCRL; p < 0.001) and payer costs ($US140,000 vs. $US76,000 non-BCRL; p < 0.001). After matching, copayment differences persisted ($US1200 BCRL vs. $US850 non-BCRL; p < 0.001). Among those aged 18-44 years, BCRL conferred lower out-of-pocket costs ($US2900 vs. $US23,000 non-BCRL; p = 0.031) but no difference in copayment/payer costs in years 1-2 or costs thereafter. Among those aged 45-61 years, only copayment costs were significant in year 3 (p = 0.014). Heat map analysis revealed that costs concentrated around chemotherapy for all ages; among younger women, BCRL represented the

See: Raymakers AM, King TA, Mittendorf EA, Dey T, Jain M, Paskett ED, McAlearney AS, Greenup RA, Broyles JM, Myers SP. Impact of Breast Cancer-Related Lymphedema on Cancer Care Costs: Longitudinal and Age-Based Analyses. Ann Surg Oncol. 2026 Apr doi: 10.1245/s10434-025-18875-5. https://pubmed.ncbi.nlm.nih.gov/41402689/

New longitudinal study using MA APCD shows that breast cancer–related lymphedema (BCRL) is associated with higher cancer care costs, with cost differences often emerging during survivorship rather than initial treatment. Age-specific analyses reveal distinct patterns of financial burden, highlighting the need for ongoing strategies to mitigate financial toxicity after active cancer care ends.

- Patients with BCRL incurred significantly higher payer and copayment costs than matched non-BCRL patients, with copayment differences persisting after adjustment for treatment intensity.
- BCRL incidence was similar across younger (18–44) and older (45–61) women, but cost impacts varied by age and treatment phase, often appearing in later years.
- Among younger women, BCRL became a major source of out-of-pocket spending during survivorship, second only to chemotherapy and reconstruction, underscoring delayed financial effects.

ALERT: Provider networks for pulmonary hypertension in Massachusetts: implications for improving referrals to expert care

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Original Research | Adult Pulmonary

ATS American Thoracic Society
thoracic.org

Provider networks for pulmonary hypertension in Massachusetts: implications for improving referrals to expert care

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Abstract

Rationale: Despite clear guideline recommendations, few patients with pulmonary hypertension (PH) are referred to expert care, including high-risk patients with pulmonary arterial hypertension (PAH) and chronic thromboembolic pulmonary hypertension (CTEPH). Characterizing population-level care networks for patients with PH may inform understanding of referral patterns and help improve PH care quality.

Objectives: We leveraged social network analysis to characterize existing provider networks for patients with PH and to identify provider-level factors associated with connections to PH experts.

Methods: We linked patient-level data from the Massachusetts All-Payer Claims Database with provider-level data to identify all adults diagnosed with PH in 2014-2018 and all relevant providers who saw those patients for PH. We constructed provider networks among all patients with PH ("All-PH network") and subsets of patients with risk factors for PAH or CTEPH ("PAH network" and "CTEPH network," respectively). Our provider-level outcome was connection to PH experts, defined as sharing at least 1 patient with an expert. Within each network, we conducted multivariable regression models to determine the association between provider-level variables (specialty, practice location, PH panel volume) and our outcome.

Results: We identified 4766 providers and 8970 patients with PH, of whom 1768 (19.7%) had PAH risk factors and 2164 (24.1%) had CTEPH risk factors. Few providers shared patients with PH experts (31% All-PH network, 35% PAH network, 19% CTEPH network). Within the All-PH network, primary care providers had 59% decreased odds of PH expert connection compared to nonexpert pulmonologists (adjusted odds ratio, 0.41 [95% confidence interval, 0.32-0.51]). Providers practicing outside the greater Boston area and those with smaller PH panel volumes were also less likely to be connected to a PH expert. Findings were similar among the PAH and CTEPH networks.

Conclusions: We found significant gaps in connections to expert care, even among providers caring for patients at risk for PAH or CTEPH, which may be driven in part by limited provider experience, geographic barriers, and disconnected providers and care networks. Multifaceted strategies may be needed to improve referral rates for patients with PH.

Keywords pulmonary hypertension, health services accessibility, community networks, social network analysis

See: Gillmeyer KR, Rinne ST, Klings ES, Elwy AR, Wiener RS. Provider networks for pulmonary hypertension in Massachusetts: implications for improving referrals to expert care. Ann Am Thorac Soc. 2026 Mar 1. doi: 10.1093/annalsats/aaoaf039. https://pubmed.ncbi.nlm.nih.gov/41842741/

New study using MA APCD and social network analysis, mapped provider networks for adults with pulmonary hypertension (PH) to assess how often and under what conditions providers connect patients to PH experts. It found substantial gaps in expert connections, even for high-risk PH subgroups, driven by provider specialty, experience, and geography, suggesting systemic barriers to guideline-recommended referral.

- Only 31% of providers overall (35% in PAH networks and 19% in CTEPH networks) shared patients with a PH expert, and fewer than 10% of patients ever saw a PH expert.
- Primary care providers had markedly lower odds of PH expert connection than nonexpert pulmonologists (aOR 0.41 overall), with similar or worse patterns in PAH and CTEPH subnetworks.
- Providers outside the greater Boston area and those with small PH patient panels were significantly less likely to be connected to PH experts, highlighting geographic and experience-based barriers to referral.

FINAL REMINDER: ABSTRACT DEADLINE FOR WOMEN'S HEALTH CONFERENCE 2026 IN BOSTON

Deadline: May 15th, 2026, 11:59PM EST

Location
Simmons University, in the Main College Building's Linda K. Paresky Conference Center
300 Fenway
Boston, Massachusetts 02115
Time: 8:00 AM – 5:00 PM

See: https://hsph.harvard.edu/nutrition/events/womens-health-conference-2026/#registration

Register to join us in-person or on livestream (via Zoom)

Launched in 2023 by the Global Centre for Asian Women's Health (GloW) at the National University of Singapore Yong Loo Lin School of Medicine, in collaboration with Harvard T.H. Chan School of Public Health, the Global Women's Health Conference has been held in Singapore (2023, 2024) and Paris (2025).

The 2026 conference will take place in Boston from September 30 to October 2. Co-organized by Harvard T.H. Chan, GloW at NUS, Stanford University School of Medicine, and Université Paris Cité's iWISH, the meeting will showcase advances shaping women's health across the life course. Addressing persistent under-research and under-funding, the conference will convene global leaders to accelerate solutions in precision nutrition, reproductive and mental health, aging, AI and femtech, and health equity. The program concludes with a symposium marking the 50th anniversary of the Nurses' Health Study.

The scientific program will feature:

- Breakthroughs in precision nutrition and lifestyle medicine
- Advances in fertility, pregnancy, and reproductive health
- New approaches to mental health and brain health
- Healthy aging, cognition, and cardiometabolic health
- The expanding role of AI and femtech in diagnosis, treatment, and prevention
- Global women's health and health equity

REMINDER: 2026 AcademyHealth Annual Research Meeting

Date: May 30 to Jun 2, 2026, | Seattle, Washington

To Register: https://academyhealth.org/ARM2026

Hundreds of Researchers from Massachusetts

Examples of Some of the Many Studies from Massachusetts

University of Massachusetts Chan Medical School

- Estimated Impacts of Medically Tailored Meals on Healthcare Utilization and Costs In a Medicaid 1115 Demonstration
- 'Dynamic Diffusion Network': Supporting Implementation of Telehealth Program Targeting Veterans with Poor Diabetes Control
- Resolving EHR Functionality Questions at the Point of Care: Exploring How Peer Support Chat Can Facilitate EHR Learning
- Dose-Response Effects of Peer-Coaching on EHR Efficiency: Evidence from VA's EHR Transition
- "AI Has Many Potential Benefits but Many Potential Downsides:" Health Professions Trainees' Perspectives on AI In Clinical Training
- Exploring Real-Time Clinician Experiences with AI Ambient Scribe Solutions: Simulation Insights for Effective Integration

Massachusetts Health Policy Commission

- When the Closest Pharmacy Is Too Far: Mapping Pharmacy Deserts In Massachusetts
- Cost Sharing Incurred during Preventive Wellness Visits
- Exploring Racial Disparities In C-Section Rates In Massachusetts
- Preventable Oral Health Emergency Department Visits
- Behavioral Health Care Payment Variation Among Massachusetts Public and Commercial Payers: Insights and Policy Implications

University of Massachusetts Amherst

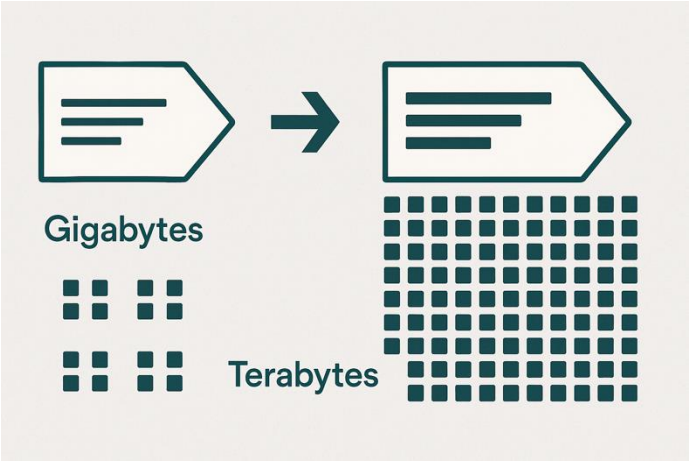
- Impact of Medicaid Accountable Care Organizations on Pediatric Asthma Care and Outcomes In Massachusetts: Provider Perspectives
- The Effects of Massachusetts Medicaid ACO Implementation on Pediatric Behavioral Healthcare Quality and Utilization for Medicaid-Insured Compared to Privately-Insured Children: A Mixed Methods Study
- Medicaid ACO Implementation and Behavioral Health Care for Children: Mixed Methods Exploring the Caregiver Experience
- Association of Insurance Type with Receipt of Pediatric Behavioral Health Specialty Care
- Postpartum Primary Care for Individuals with Hypertensive Disorders of Pregnancy: A Qualitative Study of Primary Care Providers' Perspectives

Questions?

Data User Support Questions

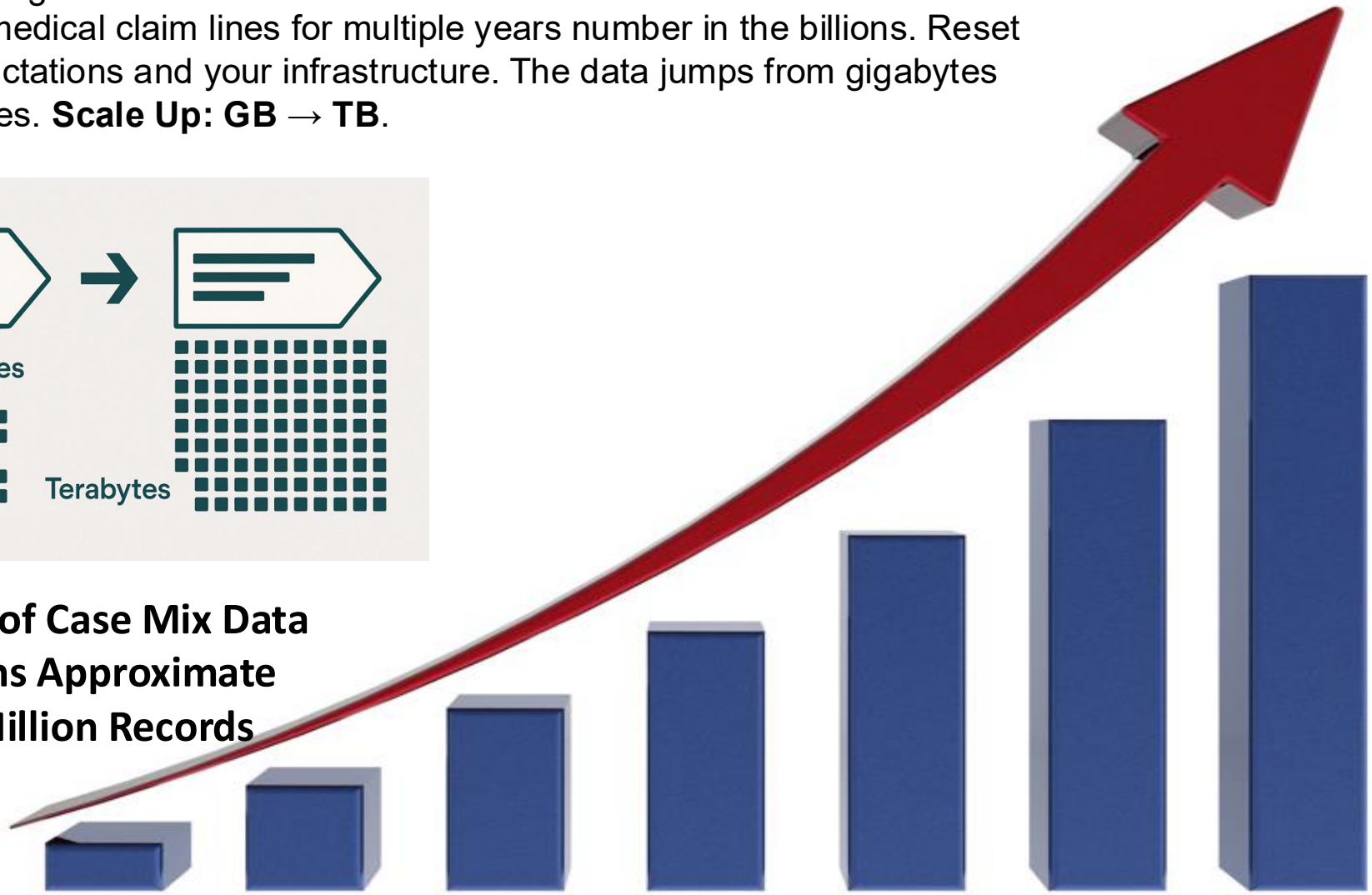
Data Size Revisited

Several data user who are used to importing case mix, apply for the MA APCD, and after receiving it, have problems loading the data. They are shocked by its size. Please keep in mind that the MA APCD is a different order of magnitude in size and volume. Case mix records number in the millions, medical claim lines for multiple years number in the billions. Reset your expectations and your infrastructure. The data jumps from gigabytes to terabytes. **Scale Up: GB → TB**.



24 Years of Case Mix Data Contains Approximate 275 Million Records

6 Years of APCD Contains Approximate 3.7 Billion Records



Question: I am interested in using the MA APCD to care settings among individuals with Alzheimer's disease (ICD-10-CM G30*). I wanted to know in advance to extend is health care setting is captured in the MA APCD for those with Alzheimer's . Are there known limitations or gaps in setting identification, particularly for residential or community-based care, that researchers should be aware of?

Answer: The MA APCD has comprehensive information on health care setting, making it well suited for studying the continuum of care associated with Alzheimer's disease. In MA APCD Release 2024, thirty-eight distinct places of service are explicitly captured through standardized coding, enabling precise differentiation of where care is delivered across clinical, institutional, residential, and virtual environments. Importantly, there are no material limitations or gaps in care-setting identification within the APCD for Alzheimer's research use cases. The database fully supports longitudinal analyses that trace patient movement across settings commonly involved in dementia care, including home-based services, ambulatory care, hospital-based care (both inpatient and outpatient), assisted living, nursing facilities, skilled nursing facilities, and telehealth

Health Care Setting	Description
Home	Location other than a hospital or other facility where the patient receives care in a private residence.
Office	Office location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides examinations, diagnosis, and treatment on an ambulatory basis.
Outpatient Hospital	Portion of a hospital that provides diagnostic, therapeutic (surgical and nonsurgical), and rehabilitation services to patients who do not require hospitalization or institutionalization.
Inpatient Hospital	Facility, other than psychiatric, that primarily provides diagnostic, therapeutic, and rehabilitation services under physician supervision to patients admitted for a range of medical conditions.
Assisted Living Facility	Congregate residential facility with self-contained living units that provides on-site support 24 hours a day, seven days a week, with the capacity to deliver or arrange health care and supportive services based on resident needs.
Nursing Facility	Facility that primarily provides skilled nursing care and related services for rehabilitation of injured, disabled, or sick persons, or regular health-related care above the level of custodial care.
Skilled Nursing Facility (SNF)	Facility that primarily provides inpatient skilled nursing and rehabilitative care to patients requiring medical or nursing services but not hospital-level care.

Question: I am preparing an application for CHIA data and need clarification on the difference in payer information in each dataset, hospital case mix data compared to the MA APCD. Are payer identification numbers the same? Where does the case mix payer data originate from?

Answer: Hospitals submitting case mix data obtain the patient's payer information directly from the patient's insurance card(s) presented by the patient during registration/admission.

Patient Insurance Card

Hospital Billing Data

The hospitals subsequently code that data according to the case mix filing specifications for the six payer fields: primary source of payment, secondary source of payment, primary payer type, secondary payer type, Medicaid ID number, and Health Plan Member ID. The payer data in the MA APCD is submitted directly from the payers. There is no overlap between case mix assigned payer codes and the MA APCD assigned payer organization identifiers. But there is an overlap of the payer names, see: https://www.chiamass.gov/assets/docs/p/case-mix/FY25-Case-Mix-Submission-Guides/Case-Mix-Payer-Source-Codes.xlsx

It is important to note that the case mix payer data contains all payers, including those which are not included in the MA APCD, such as Medicare-fee-for-service, all self-insured, federal employee health benefit plans, Workers' Compensation, Tricare and Veterans Health Administration, self-pay and free care.

Question: Are there differences in level of geographic detail available by state in case mix data and the MA APCD? Does one or the other contain more or fewer restrictions on geographic identifiers outside of certain regions represented in limited data sets for non-government users?

LDS Map of United States: Highlighted State Level Access to New England & New York

Answer: No, there is no difference. Both case mix and the MA APCD LDS file for non-government data users releases will only include patient/member state residency information for Massachusetts (MA), Connecticut (CT), Maine (ME), New Hampshire (NH), New York (NY), Vermont (VT) and Rhode Island (RI). All other states in the Unite States and outside of the country will be designated by XX.

WHEN IS THE NEXT DATA USER WORKGROUP MEETING?

NEXT CHIA DATA USER WORKGROUP MEETING
TUESDAY, MAY 26, 2026

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

Questions

- Questions related to MA APCD email:
  apcd.data@chiamass.gov
- Questions related to Case Mix email:
  casemix.data@chiamass.gov

chiamass.gov