Data Specification Manual

957 CMR 2.00:

Payer Reporting of Total Medical Expenses and Alternative Payment Methods

April 9, 2020

Table of Contents

1. Summary of Changes

2. Introduction

3. File Submission Instructions and Schedule

4. Data Submission Guidelines
   a. General Guidelines
   b. Health Status Adjustment Specifications
   c. Claims Run-Out Period Specifications

5. Data Dictionary
   a. Field Definitions

Appendix A: Physician Group OrgID List and Medical Group NPI Crosswalk

Appendix B: Massachusetts Zip Codes for Use with Zip Code TME&APM

Appendix C: Payment Method Allocation Logic

1. Summary of Changes

- Updated file submission schedule. Please note change in deadlines
- Due to updated submission schedule, required claims runout increased to 90 days
- Added a table to the front page regarding Telehealth expenditures
- Added a Group Insurance Commission (GIC) indicator to the Physician Group TME data tab
- Added questions to the front page regarding services included in Other Professional and Other Medical service categories, carved out benefits in global partial budget arrangements
- Updated Insurance Category codes
- Updated formulas on the summary tabs

2. Introduction

M.G.L. c. 12C, § 10 requires the Center for Health Information and Analysis (CHIA) to collect from private and public health care payers "health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010" and "data on changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies." M.G.L. c. 12C, § 16 further directs CHIA to collect "the proportion of health care expenditures reimbursed under fee-for-service (FFS) and alternative payment methodologies."

Regulation 957 CMR 2.00 governs the methodology and filing requirements for health care payers to calculate and report this data to CHIA. The Data Specification Manual provides additional technical details to assist payers in reporting and filing this data.

Payers are required to submit one Total Medical Expenses (TME) & Alternative Payment Methods (APM) file to CHIA annually: the file must include final data for calendar year 2018 and preliminary data for calendar year 2019. In the 2020 collection year, payers are required to submit final data for calendar year 2017 only if there are substantive changes to the data or model used for risk adjustment. Files will contain different tabs, including:

- Front page, including data confirmation and payer comments
- Total Medical Expenses (TME) & Alternative Payment Methods (APM) by member zip code
- Total Medical Expenses (TME) & Alternative Payment Methods (APM) by physician group and local practice group
- Summary tabs, which automatically calculates totals and trends with inputted data from the zip code and physician group tabs

3. File Submission Instructions and Schedule

Payers will access CHIA's online submission platform at https://chiasubmissions.chia.state.ma.us. Then log-in with a valid username and password. If system access is needed, please complete a User Agreement for Insurance Carriers and email the completed form to CHIA-DL-Data-Submitter-

HelpDesk@massmail.state.ma.us. For technical issues, please email CHIA-DL-Data-Submitter-HelpDesk@massmail.state.ma.us or Erin Bonney at erin.bonney@state.ma.us.

Payers will submit total medical expenses information in accordance with regulation 957 CMR 2.00 on the following schedule. CHIA recognizes the increased burden on data submitters in 2020, and have adjusted the filing schedule below to ease administrative burden. For additional concerns around timelines or data submission requirements, please reach out to Erin Bonney:

Total Medical Expenses Filing Schedule	
Date	**Files Due**
September 16, 2020	• CY 2018 Final TME&APM • CY 2019 Preliminary TME&APM (+ IBNR factors)

4. Data Submission Guidelines

4a. Overview
In accordance with 957 CMR 2.04, payers must report TME & APM at two levels: by member zip code and by physician group.

Reported TME&APM should be based on allowed amounts, i.e. provider payment and any patient cost sharing amounts. Payers should include only information pertaining to Massachusetts residents, members for which they are the primary payer, and exclude any paid claims for which it was the secondary or tertiary payer.

Allowed claims should not be capped or truncated and should represent claims prior to the impact of any reinsurance.

When reporting capitation arrangements, payers should use fee-for-service (FFS) equivalents rather than reporting the arrangements within the Non-Claims categories. Any balance can be included in the Non-Claims field.

For payment method assignment, payers will classify payment methods for physician groups and members based on the mutually exclusive payment method allocation hierarchy: (1A) global payments (full benefits); (1B) global payments (partial benefits); (2) limited budget; (3) bundled payments; (4) other, non-FFS based; and (5) FFS. APMs can be layered on a FFS structure, wherein a fee-for-service mechanism is used for claims processing and payment transaction purposes. The type of APM to which a provider organization and a member should be attributed is determined by the contractual arrangement between the payer and the provider organization. For example, for a member whose managing physician group is under a global payment contract, the dollar amount associated with this member should be classified as global payments even though the payer utilizes a

FFS payment mechanism to reimburse providers at the transactional level and then conducts a financial settlement against the spending target at the end of the year. The same logic applies to limited budget or bundled payment arrangements.

Zip Code Guidelines

- Payers must calculate and report TME & APM by the five-digit zip code for all members who are residents of Massachusetts, including, to the extent possible, residents with policies issued (sitused) out-of-state. The zip code is determined based on the member's residence of record on the last day of the relevant reporting period, or the last day in the Payer's network. Payers shall only report data for Massachusetts residents.
- Payers must report all allowed amounts for members regardless of whether services are provided by providers located in Massachusetts.
- When reporting capitation arrangements, payers should use fee-for-service (FFS) equivalents rather than reporting the arrangements within the Non-Claims categories. Any balance can be included in the Non-Claims field.
- Allowed claims should not be capped or truncated and should represent claims prior to the impact of any reinsurance.

Physician Group Guidelines

- Payers shall report TME & APM by Physician Group, and Physician Local Practice Group according to the following categorization of Massachusetts resident members as of December 31st of the reporting year. Member months for members who were attributed to more than one PCP in a calendar year should be allocated based on the number of months associated with each PCP:
    1. Massachusetts members required to select a primary care provider (PCP) by plan design (as reported in all previous TME filings)
    2. Members not included in (1) who were attributed during the reporting year to a PCP, pursuant to a risk contract between the payer and provider.
    3. Members not included in (1) or (2), attributed to a PCP by the payer's own attribution methodology[1]
    4. Members not attributable to a PCP (aggregate line)
- Payers must calculate and report TME&APM by Physician Group and constituent Local Practice Group for any Local Practice Group for which the payer has 36,000 Massachusetts resident member months or more for the specified reporting period. The number of member months is determined by summing the total member months for a given product type and insurance category for the Local Practice Group. Payers must report the CHIA numeric

[1] Chapter 224 of the Acts of 2012 amended chapters 175 and 176 of the Massachusetts General Laws (M.G.L.) to stipulate that "to the maximum extent possible [carriers] shall attribute every member to a primary care provider." Please see M.G.L. C. 175 §108L, C. 176A §36, C. 176B §23, C. 176G §31 , and C. 176J §16.

identifier, the "OrgID," for all Physician Groups and Local Practice Groups that are listed on CHIA's website. Refer to Appendix A, Physician Group OrgID List, for this identifier.

- Data must be reported in aggregate for all practices in which the Local Practice Group's member months are below 36,000 and the practice has no parent Physicians' Group. This group is to be identified as "Groups below minimum threshold" with an OrgID of 999996.
- For Local Practice Groups below the 36,000 member month threshold that are part of a larger Physicians' Group, payers will report the data on a separate line within the parent group data section ("Other [name of physician group] Aggregate Data") using an OrgID of 999997, for the local practice group.
- Payers must report all allowed amounts for members regardless of whether services are provided by providers located in Massachusetts.

4b. Health Status Adjustment Specifications

Payers are permitted to use a health status adjustment method and software of their own choosing, but must disclose the method (e.g. ACGs, DxCG, etc.) and version in the health status adjustment tool(s) and version(s) fields on the Front Page of the submission template. A payer's Health Status Adjustment tool and version must be the same for all files submitted in a given reporting year (CY2018 Final and CY2019 Preliminary files in 2020). If the Health Status Adjustment tool or version is updated between submission years, payers must resubmit prior year final data such that all three submission years use a consistent health status adjustment tool, and note that a Final Resubmission of data is included on the Front Page of the submission template. For zip codes where a Health Status adjustment score is unable to be calculated due to a small number of member months, a risk score value of zero should be reported.

Where possible, payers shall apply the following parameters in completing the health status adjustment:

- The health status adjustment tool used should correspond to the insurance category reported, e.g. Medicare, Medicaid, commercial.
- Payers must use **concurrent** modeling.
- The health status adjustment tool must be all-encounter diagnosis-based (no cost inputs) and output total medical and pharmacy costs **with no truncation**

4c. Claims Run-Out Period Specifications

For preliminary TME & APM, payers shall allow for a claims run-out period of at least 90 days after December 31 of the prior Calendar Year. To request a variance on this specification, email Erin.Bonney@state.ma.us.

Payers should apply incurred but not reported (IBNR) factors to preliminary TME & APM data submitted for each type of TME & APM service category to estimate liabilities for claims or non-clams that, as of the date of data extractions, are anticipated but have not been reported to the Payer. These factors should be documented in a separate excel sheet and submitted to CHIA. If submitted 2019 data is considered by the data submitter to be final, IBNR factors of 0 should be

applied, and appropriate comments field on the Front tab should note that 2019 data is considered to be final with complete claims run out.

5. Data Dictionary

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Payer OrgID	Integer	########	This is the Payer's OrgID. This must match the Submitter's OrgID.
Front Page		Payer Name	Text	Text	Name of the Payer.
Front Page		Submission Year	Date	YYYY	Year in which the file is being submitted.
Front Page		Preliminary Data: Reporting Year	Date Period	YYYY	Year for which preliminary Total Medical Expenses/Alternative Payment Methods (TME&APM) data is being reported.
Front Page		Preliminary Data: Claims Paid Through Date	Date Period	MMDDYYYY	Date of preliminary TME&APM claims data runout. At least 60 days of claims runout is required.
Front Page		Final Data Reporting Year	Date Period	YYYY	Year for which final TME&APM data is being reported.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Final Data: Claims Paid Through Date	Date Period	MMDDYYYY	Date for which final TME&APM claims data are paid through. At least 15 months of claims runout is required.
Front Page		Final Resubmission included?	Text	Text	Responses must be 'yes' or 'no'.
Front Page		Final Resubmission Data: Reporting Year	Date Period	YYYY	Year for which final TME&APM data is being resubmitted (if applicable)
Front Page		Final Resubmission Data: Claims Paid Through Date	Date Period	MMDDYYYY	Date of final TME&APM resubmission claims data runout.
Front Page		Health Status Adjustment Tool	Text	Text	The health status adjustment tool, software, or product used to calculate the health status adjustment score required in TME&APM file.
Front Page		Health Status Adjustment Tool Version	Text	Text	The version number of the health status adjustment tool used to calculate the health status adjustment score required in the TME&APM file.
Front Page		Is the Risk Adjustment Tool concurrent?	Text	Text	Confirm that the risk adjustment tool uses concurrent modeling. Responses must be 'yes' or 'no'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Does the Risk Adjustment Tool use truncation?	Text	Text	Confirm that the risk adjustment tool does not use truncation. Responses must be 'yes' or 'no'.
Front Page		Is the Risk Adjustment Tool based on all-encounter diagnosis-based inputs?	Text	Text	Confirm that the risk adjustment tool is based on all-encounter diagnosis- based inputs. Responses must be 'yes' or 'no'.
Front Page		Is pharmacy data an input in your risk adjustment tool?	Text	Text	Confirm whether or not pharmacy data is an input in the risk adjustment tool. Responses must be 'yes' or 'no.'.
Front Page		IBNR Factors	Text	Text	Confirm that incurred-but-not-reported (IBNR) factors are applied to the data. Response must be 'yes' or 'no'.
Front Page		MA zip codes only?	Text	Text	Confirm that all reported zip codes are limited only to Massachusetts zip codes. Response must be 'yes' or 'no'.
Front Page		MA residents only?	Text	Text	Confirm that the reported members are limited only to Massachusetts residents. Response must be 'yes' or 'no'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Primary Payer only?	Text	Text	Confirm that the reported members are limited only to members for whom the payer is the primary payer. Response must be 'yes' or 'no'.
Front Page		Services included in 'Other Professional' service category	Text	Text	Provide a list of services included in the 'Other Professional' service category spending.
Front Page		Services included in 'Other Medical' service category	Text	Text	Provide a list of services included in the 'Other Medical' service category spending.
Front Page		Carved out services for global partial budget arrangements?	Text	Text	For payers reporting **global partial budget arrangements only**, provide a list of carved out benefit types.
Front Page		Is reported pharmacy data gross of prescription drug rebates? *	Text	Text	Confirm that reported pharmacy data is gross of prescription drug rebates. If unable to report gross expenditures (e.g. rebates are applied at the point of sale), please note in this field as well. Response should be 'gross of rebates' or 'net of rebates',
Front Page		Zip Code File Comments	Text	Free Text Comments	Zip Code TME&APM file comments.
Front Page		Physician Group File Comments	Text	Free Text Comments	Physician Group TME&APM file comments.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Front Page		Carved Out Benefits	Integer	#	For commercial partial business only, complete table with member months for which a given benefit is carved out. Carve out categories are mutually exclusive and total carved out member months should sum to total commercial partial member months reported in the Zip Code and Physician Group files. If member months are reported in the 'Other' carved out benefit type, please list what these services include at the bottom of the table.
Front Page		Telehealth Expenses	Integer	#	For telehealth expenditures only, complete table with an estimated spending for telehealth services. Please list the TME service category, or multiple service categories, in which telehealth expenditures are reported.
Zip Code	A	Submission Type	Text	Flag	P = Preliminary, F = Final
Zip Code	B	Reporting Year	Integer	####	Year for which data is being reported.
Zip Code	C	Zip Code	Integer	#####	Five digit Zip Code. Must be a valid Massachusetts zip-code.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Zip Code	D	Insurance Category	Integer	#	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid (e.g., MCO, ACO) 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5= SCO 6 = OneCare 7 = PACE 8 = Other Value must be an integer between '1' and '8'. For payers reporting in the "Other" category, payers should report in the zip code comments field on the front tab what is included in the "Other" category.
Zip Code	E	Product Type	Integer	#	Indicates the product type that is being reported: 1 = HMO 2 = PPO 3 = Indemnity 4 = Other 5 = POS Value must be an integer between '1' and '5'.
Zip Code	F	PCP Type Indicator	Integer	#	Indicates Primary Care Physician enrollment: 1 = Members required to select a PCP by plan design 2 = Members attributed to a PCP during reporting period pursuant to payer –provider risk contract 3 = Members attributed to PCP by payer's own attribution methodology 4 = Members not attributed to a PCP Value must be an integer between '1' and '4'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Zip Code	G	Payment Method	Text	Text	Indicates the payment method being reported: 1A = Global Budget/Payments (Full) 1B = Global Budget/Payments (Partial) 2 = Limited Budget 3 = Bundled Payments 4 = Other, non-FFS 5 = Fee for Service
Zip Code	H	Member Months	Integer	#########	The number of members participating in a plan over a specified period of time expressed in months of membership.
Zip Code	I	Health Status Adjustment Score	Number	##.##	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. No negative values. Number must be between ".2" and "10".
Zip Code	J	Allowed Claims: Hospital Inpatient	Integer	#######	Total allowed claims for hospital inpatient medical expenses No negative values. *See Service Category definitions for additional detail*
Zip Code	K	Allowed Claims: Hospital Outpatient	Integer	#######	Total allowed claims for hospital outpatient medical expenses No negative values. *See Service Category definitions for additional detail*
Zip Code	L	Allowed Claims: Professional Physician	Integer	#######	Total allowed claims for professional physician medical expenses No negative values. *See Service Category definitions for additional detail*

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Zip Code	M	Allowed Claims: Professional Other	Integer	#######	Total allowed claims for professional medical expenses No negative values. *See [Service Category definitions] for additional detail*
Zip Code	N	Allowed Claims: Pharmacy	Integer	#######	Total allowed claims for pharmacy medical expenses net of any coverage gap discount (for payers with Medicare business only). No negative values. *See [Service Category definitions] for additional detail*
Zip Code	O	Allowed Claims: Other	Integer	#######	Total allowed claims for all other medical expenses No negative values. *See [Service Category definitions] for additional detail*
Zip Code	P	Total Non-Claims Payments	Integer	#######	Total non-claims related payments *See [Service Category definitions] for additional detail*
Physician Group	A	Submission Type	Text	Flag	P = Preliminary, F = Final
Physician Group	B	Reporting Year	Integer	####	Year for which data is being reported.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Physician Group	C	Physician Group OrgID	Integer	######	Physician Group OrgID. Must be a CHIA-issued OrgID. For aggregation of sites that fall below threshold, but that are part of a larger contracting entity, use OrgID 999997. For aggregation of sites that fall below the threshold and that do not belong to a larger contracting entity, use OrgID 999996.
Physician Group	D	Local Practice Group OrgID	Integer	######	Local Practice Group OrgID. Must be a CHIA-issued OrgID. For aggregation of sites that fall below threshold, but that are part of a larger parent organization, use OrgID 999997. For aggregation of sites that fall below the threshold and that do not belong to a larger parent organization, use OrgID 999996.
Physician Group	E	Insurance Category	Integer	#	Indicates the insurance category that is being reported: 1 = Medicare & Medicare Advantage 2 = Medicaid (e.g., MCO, ACO) 3 = Commercial: Full-Claim 4 = Commercial: Partial-Claim 5= SCO 6 = OneCare 7 = PACE 8 = Other Value must be an integer between '1' and '8'. For payers reporting in the "Other" category, payers should report in the zip code comments field on the front tab what is included in the "Other" category.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Physician Group	F	Product Type	Integer	#	Indicates the product type that is being reported: 1= HMO 2= PPO 3= Indemnity 4= Other (e.g. EPO) 5 = POS Value must be an integer between '1' and '5'.
Physician Group	G	PCP Type Indicator	Integer	#	Indicates Primary Care Physician attribution: 1 = Members required to select a PCP by plan design 2 = Members attributed to a PCP during reporting period pursuant to payer – provider risk contract 3 = Members attributed to PCP by payer's own attribution methodology 4 = Members not attributed to a PCP Value must be an integer between '1' and '4'.
Physician Group	H	Payment Method	Text	Text	Indicates the payment method that is being reported: 1A = Global Budget/Payments (Full) 1B = Global Budget/Payments (Partial) 2=Limited Budget 3=Bundled Payments 4=Other, non-FFS based 5= Fee for Service
Physician Group	I	Risk Type	Integer	#	Indicates the risk type for contracts between the payer and provider 1 = No Risk 2 = Shared Savings Only 3 = Upside and Downside Risk Value must be an integer between '1' and '3'.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Physician Group	J	Pediatric Indicator	Integer	#	Indicates if the local practice group is a practice in which at least 75% of its patients are children up to the age of 18. 0 = No, 1 = Yes Value must be either a '0' or '1'.
Physician Group	K	MassHealth Accountable Care Organization (ACO) Indicator	Integer	#	Indicates provider is a MassHealth Accountable Care Organization (ACO). 0 = not an ACO or no Medicaid business, 1= ACO Value must be either a '0' or '1'.
Physician Group	L	Group Insurance Commission (GIC) Indicator	Integer	#	Indicates population in following columns reflects Group Insurance Commission (GIC) contract members. 0 = no GIC contract, 1= GIC contract Value must be either a '0' or '1'.
Physician Group	M	Member Months	Integer	#########	The number of members participating in a plan over a specified period of time expressed in months of membership. No negative values.
Physician Group	N	Health Status Adjustment Score	Number	##.##	A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. No negative values. Number must be between '.2' and '10'.
Physician Group	O	Allowed Claims: Hospital Inpatient	Integer	#######	Total allowed claims for hospital inpatient medical expenses No negative values.

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Physician Group	P	Allowed Claims: Hospital Outpatient	Integer	#######	Total allowed claims for hospital outpatient medical expenses No negative values.
Physician Group	Q	Allowed Claims: Professional Physician	Integer	#######	Total allowed claims for professional physician medical expenses No negative values.
Physician Group	R	Allowed Claims: Professional Other	Integer	#######	Total allowed claims for professional medical expenses No negative values.
Physician Group	S	Allowed Claims: Pharmacy	Integer	#######	Total allowed claims for pharmacy medical expenses net of any coverage gap discount (for payers with Medicare business only). No negative values.
Physician Group	T	Allowed Claims: Other	Integer	#######	Total allowed claims for all other medical expenses No negative values.
Physician Group	U	Non-Claims: Incentive Programs	Integer	#######	Total payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development.
Physician Group	V	Non-Claims: Capitation	Integer	#######	Total payments made to providers not on the basis of claims (capitated amount).

Tab	Col	Data Element Name	Type	Format	Element Submission Guideline
Physician Group	W	Non-Claims: Risk Settlements	Integer	#######	Total payments made to providers as a reconciliation of payments made (risk settlements).
Physician Group	X	Non-Claims: Care Management	Integer	#######	Total payments made to providers for providing care management, utilization review, discharge planning, and other care management programs.
Physician Group	Y	Non-Claims: Other	Integer	#######	Total payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and cannot be classified elsewhere.
Summary	-	No payer data entry needed	-	-	The summary tabs will automatically populate with data from the zip code and physician group tabs. Please review these tabs prior to submitting data to CHIA to confirm that totals and trends are correct.

5a. Field Definitions

Tab A: Front Page

Table A.1

- Payer Name: The name of the reporting payer
- Payer Org ID: The CHIA-assigned organization ID for the payer or carrier submitting the file.
- Submission Year: Year in which the data is submitted (e.g., 2020)
- Preliminary Data: Reporting Year: Year for which preliminary TME & APM is being reported (e.g., 2019)
- Preliminary Data: Claims Paid Through Date: Date for which TME & APM claims data is paid through.
- Final Data: Reporting Year: Year for which final TME & APM is being reported (e.g., 2018)
- Final Data: Claims Paid Through Date: Date for which TME & APM claims data is paid through.
- Final Resubmission Included?: Responses must be a 'yes' or 'no'. If payers are submitting three calendar years of data, the response should be 'yes'.
- Final Resubmission Data: Reporting Year: Year for which the final TME & APM data is being resubmitted, if applicable.
- Final Resubmission Data: Claims Paid Through Date: Date of final TME & APM resubmission claims data runout.

Table A.2 Additional Data Confirmation

- Health Status Adjustment Tool: The health status adjustment tool, software or product used to calculate the Health Status Adjustment Score required in the TME&APM file.
- Health Status Adjustment Tool Version: The version number of the health status adjustment tool used to calculate the Health Status Adjustment Score required in the TME&APM file.
- Is the risk adjustment tool concurrent? Confirm that the risk adjustment tool is based on concurrent modeling.
- Does the risk adjustment tool use truncation? Confirm that the risk adjustment tool does not use truncation.
- Is the risk adjustment tool based on all-encounter diagnosis-based inputs? Confirm that the risk adjustment tool is based on all-encounter diagnosis-based inputs.
- Is pharmacy data an input in your risk adjustment tool? Confirm whether or not pharmacy data is an input in your current risk adjustment tool.

- Are IBNR factors applied to preliminary data? Confirm that incurred-but-not-reported (IBNR) factors are applied to the preliminary data.
- Massachusetts zip codes only? Confirm that the zip code TME&APM tab includes Massachusetts zip codes only.
- Massachusetts residents only? Confirm that the zip code and physician group TME&APM tabs include Massachusetts residents only.
- Primary payer only? Confirm that the zip code and physician group TME&APM tabs include only claims data for which the payer was the primary payer, exclude any paid claims for which they were the secondary or tertiary payer.
- Services included in 'Other Professional' service category? Provide a list of services included in the 'Other Professional' service category spending.
- Services included in 'Other Medical' service category? Provide a list of services included in the 'Other Medical' service category spending.
- Carved out services for global partial budget arrangements? List or describe what types of services are carved out or excluded for **global partial budget arrangements only.**
- Is reported pharmacy data is gross of prescription drug rebates? Please confirm that reported pharmacy data is gross of prescription drug rebates. If unable to report gross expenditures (e.g. rebates are applied at the point of sale), please note in this field as well.
- Comments: Payers may use this field to provide any additional information or describe any data caveats for the TME&APM file.
    - Zip Code File Comments
    - Physician Group Comments

Table A.3 Carved Out Benefits – Commercial Partial Insurance Category only

- Carved out member months table below should be completed only by payers with commercial partial business. For each mutually exclusive benefit type, report the total commercial partial member months for the given year. **The sum of commercial partial member months in each column should equal the total commercial partial member months reported in the Zip Code and Physician Group tabs.**

Benefit	Commercial Partial MM CY 2017	Commercial Partial MM CY 2018	Commercial Partial MM CY 2019
Pharmacy Only			
Behavioral Health Only			
Pharmacy and Behavioral Health			
Other Services (not pharmacy and behavioral health)			
Pharmacy and Other			
Behavioral Health and Other			
Pharmacy, Behavioral Health, and Other			

If 'Other' Carved-Out Benefit MMs were reported, please specify what these services include	

Table A.4 Telehealth Expenses

- Telehealth Expenses table below should be completed only by payers with telehealth services. For each Calendar Year, complete table with an estimated spending for telehealth services. Please list the TME service category, or multiple service categories, in which telehealth expenditures are reported.

TME Service Category in which Telehealth Expenses are Reported (if reported in multiple service categories, please list all)	Telehealth Expenses CY 2017	Telehealth Expenses CY 2018	Telehealth Expenses CY 2019

Tab B. Zip Code Tab

- Data Type: Indicates whether file contains data for preliminary or final TME&APM reporting period.
- Reporting Year: Indicates the year for which the data is being reported. File should include at least two years of data.
- Zip Code: The five-digit zip code, based on the member's residence. Payers should report only Massachusetts zip codes.
- Insurance Category: A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for physicians' groups or zip codes for which the payer is able to collect information on all direct medical claims and subcarrier claims should be reported in the "Full Claims" category. Commercial data that does not include all medical and subcarrier claims should be reported in the "Partial Claims" category. For payers reporting in the "Other" category, payers should report in the comments field on Tab A what is included in the "Other" category".

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid (e.g., MCO, ACO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO
6	OneCare

7	PACE
8	Other

- Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	HMO
2	PPO
3	Indemnity
4	Other
5	POS

- PCP Type Indicator: Indicates whether members are required to select a Primary Care Provider (PCP) or are able to be attributed to a PCP.

PCP Indicator	Definition
1	Data for members who select a PCP as part of plan design
2	Data for members who are attributed to a PCP during reporting period pursuant to payer-provider risk contract
3	Data for members who are attributed to a PCP by payer's own attribution methodology
4	Data for members who are not attributed to a PCP

- Payment Method: Payments will be reported by payment method, as defined below.

  - *Global Budget/Payment:* Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a comprehensive set of services for a broadly defined population. Contract must include at a minimum: physician services and inpatient and outpatient hospital services.

    - Examples include shared savings and full/partial risk arrangements. The global budget/payment method should be separated into two categories: Global Budget/Payment Full Benefits (1A) and Global Budget/Payment Partial Benefits (1B). Global Budget/Payment Full Benefits contains the budget and payment data for a comprehensive set of services. Global Budget/Payment Partial Benefits contains the budget and payment data for a defined set of services, where certain benefits such as behavioral health services or prescription drugs are carved out and

not part of the budget. If you are reporting a physician group contract that has a carve-out service, then you would report that line's associated payments and members months as payment method 1B (Global Partial). All other global payments and members months for that physician group should be reported as 1A (Global Full).

- *Limited Budget:* Payment arrangements where budgets for health care spending are set either prospectively or retrospectively for a non-comprehensive set of services to be delivered by a single provider organization (such as capitated primary care and oncology services).

- *Bundled Payments:* Payment arrangements where budgets for health care spending are set for a defined episode of care for a specific condition (e.g. knee replacement) delivered by providers across multiple provider types.

- *Other, non-FFS based:* All other payment arrangements not based on a fee-for-service model, including supplemental payments for the Patient-Centered Medical Home (PCMH) arrangements. PCMH member months and total payments should be reported uniquely in the "Other, non-FFS based" payment method and not as a subset of another payment method.

- *Fee for Service (FFS):* A payment mechanism in which all reimbursable health care activity is described and categorized into discrete and separate units of service and each provider is separately reimbursed for each discrete service rendered to a patient. Fee for service payment includes: Diagnosis Related Groups (DRGs), per-diem payments, fixed procedure code-based fee schedule (e.g. Medicare's Ambulatory Payment Classifications (APCs)), claims-based payments adjusted by performance measures, and discounted charges-based payments. This category also includes Pay for Performance incentives that accompany FFS payment

Payment Method Code	**Definition**
1A	Global Budget/Payment (Full Benefits: budget includes comprehensive services)
1B	Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)
2	Limited Budget
3	Bundled Payments
4	Other, non-FFS based
5	Fee for Service

- Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.
- Health Status Adjustment Score: A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must

disclose the Health Status Adjustment tool and version number and calibration settings in the Header record. Please see section 4.b "Health Status Adjustment Specifications."

Allowed Claims: All reported claims amounts must reflect both payer-paid amounts and member cost-sharing.

- Allowed Claims: Hospital Inpatient: All payments made by the payer to hospitals for inpatient services generated from claims. Includes all room and board and ancillary payments. Includes all hospital types. Includes payments for emergency room services when the member is admitted to the hospital, in accordance with the specific payer's payment rules. Does not include payments made for observation services. Does not include payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician. Does not include inpatient services at non-hospital facilities.
- Allowed Claims: Hospital Outpatient: All payments to hospitals for outpatient services generated from claims. Includes all hospital types and includes payments made for hospital-licensed satellite clinics. Includes emergency room services not resulting in admittance. Includes observation services. Does not include payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician.
- Allowed Claims: Professional Physician: All payments to physicians or physician group practices generated from claims. Includes services provided by a doctor of medicine or osteopathy.
- Allowed Claims: Professional Other: All payments generated from claims to health care providers for services provided by a licensed practitioner other than a physician. This includes, but is not limited to, community health center services, freestanding ambulatory surgical center services, licensed podiatrists, nurse practitioners, physician assistants, physical therapists, occupational therapists, speech therapists, psychologists, licensed clinical social workers, counselors, dieticians, dentists, and chiropractors.
- Allowed Claims: Pharmacy: All payments generated from claims to health care providers for prescription drugs, biological products, or vaccines as defined by the payer's prescription drug benefit net of any coverage gap discount (for payers with Medicare business only)
- Allowed Claims: Other: All payments generated from claims to health care providers for medical services not otherwise included in other categories. Includes, but is not limited to, skilled nursing facility services, home health services, durable medical equipment, freestanding diagnostic facility services, hearing aid services and optical services. Payments made to members for direct reimbursement of medical services may be reported in "Claims: other" if the payer is unable to classify the service. However, payments to members for non-medical services, such as fitness club reimbursements, are not allowable medical expenses and should not be reported in any category.
- Total Non-Claims Payments: The sum of all associated non-claims payments for each insurance category, product type, and payment method combination.

Tab C: Provider Group Tab

- Data Type: Indicates whether file contains data for preliminary or final TME&APM reporting period.
- Submission Year: Indicates the year for which the data is being reported. File should include at least two years of data.
- Physician Group OrgID: The CHIA-assigned OrgID of the Physician Group. This may be the parent organization of one or more Local Practice Groups. For Local Practice Groups with no parent or larger affiliation, the Physician Group OrgID is the same as the Local Practice Group OrgID.
- Local Practice Group OrgID: The CHIA-assigned OrgID of the Local Practice Group. If the Local Practice Group is the complete Physician Group, report the Physician Group OrgID. For Local "Groups below minimum threshold" that are part of a larger physicians' group, data should be reported using aggregate OrgID 999997.

- Insurance Category: A number that indicates the insurance category that is being reported. Commercial claims should be separated into two categories, as shown below. Commercial self-insured or fully insured data for physicians' groups or zip codes for which the payer is able to collect information on all direct medical claims and subcarrier claims should be reported in the "Full Claims" category. Commercial data that does not include all medical and subcarrier claims should be reported in the "Partial Claims" category. Payers shall report for all insurance categories for which they have business, even if those categories do not meet the member month threshold. *Stand-alone Medicare Part D Prescription Drug Plan members and payments should not be reported in the data*. For payers reporting in the "Other" category, payers should report in the comments field on the Front Tab what is included in the "Other" category.

Insurance Category Code	Definition
1	Medicare & Medicare Advantage
2	Medicaid (e.g., MCO, ACO)
3	Commercial – Full Claims
4	Commercial – Partial Claims
5	SCO
6	OneCare
7	PACE
8	Other

- Product Type: The product type under the insurance category reported.

Product Type Code	Definition
1	HMO
2	PPO
3	Indemnity

4	Other
5	POS

- PCP Type Indicator: The method used to attribute members to a specific physician group.

PCP Indicator	Definition
1	Data for members who select a PCP as part of plan design
2	Data for members who are attributed to a PCP during reporting period pursuant to payer-provider risk contract
3	Data for members who are attributed to a PCP by payer's own attribution methodology
4	Data for members who are not attributed to a PCP

- Payment Method: Payments will be reported by payment method, as defined in the Zip Code field definitions above.

Payment Method Code	Definition
1A	Global Budget/Payment (Full Benefits: budget includes comprehensive services)
1B	Global Budget/Payment (Partial Benefits: certain services carved-out and not part of the budget)
2	Limited Budget
3	Bundled Payments
4	Other, non-FFS based
5	Fee for Service

- **Risk Type:**
  - *No Risk:* A payment arrangement with no risk associated (e.g., Fee for Service).
  - *Shared Savings Only:* A payment arrangement in which providers share in cost savings at a pre-negotiated rate if they stay below a target budget for their population's care, but face no financial risk if their costs exceed it.
  - *Upside and Downside Risk:* In a two-sided risk model, providers share in cost savings if they stay below a target budget for their population's care and share in the losses at a pre-negotiated rate if their costs exceed the target budget. Providers are often eligible to keep a larger proportion of savings if they agree to share in any costs above the benchmark.

Risk Type Code	Definition
1	No Risk

2	Shared Savings Only
3	Upside and Downside Risk

- Pediatric Indicator: Indicates if the Local Practice Group is a practice in which at least 75% of its patients are children up to the age of 18. The pediatric indicator should be used to separately report pediatric *practices*, not the subset of pediatric patients within a non-pediatric practice

Pediatric Indicator	**Definition**
0	Not a pediatric practice
1	Pediatric practice

- MassHealth ACO Indicator: Indicates if the Local Practice Group is part of the MassHealth Accountable Care Organization (ACO) program. The ACO indicator should be used to report these groups. Medicaid payers should identify ACOs for the entirety of 2018, do not split data before and after the start of the program on 3/1/2018. Payers with no Medicaid business should report a "0" for all providers.

ACO Indicator	**Definition**
0	Not an ACO or no Medicaid business
1	ACO

- Group Insurance Commission (GIC) Indicator: Indicates the member population covered under a contract with the Group Insurance Commission. Payers with no GIC membership should report a "0" for all providers.

GIC Indicator	**Definition**
0	Non-GIC population
1	GIC population

- Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.
- Health Status Adjustment Score: A value that measures a patient's illness burden and predicted resource use based on differences in patient characteristics or other risk factors. Payers must disclose the Health Status Adjustment tool and version number and calibration settings in the Header record. Please see section 4.b "Health Status Adjustment Specifications".

Allowed Claims: All reported claims amounts must reflect both payer-paid amounts and member cost-sharing.

- Allowed Claims: Hospital Inpatient: Same definition as Zip Code Record above.
- Allowed Claims: Hospital Outpatient: Same definition as Zip Code Record above.
- Allowed Claims: Professional Physician: Same definition as Zip Code Record above.
- Allowed Claims: Professional Other: Same definition as Zip Code Record above.
- Allowed Claims: Pharmacy: Same definition as Zip Code Record above.
- Allowed Claims: Other: Same definition as Zip Code Record above.
- Non-Claims: Incentive Programs: All payments made to providers for achievement in specific pre-defined goals for quality, cost reduction, or infrastructure development. Examples include, but are not limited to, pay-for-performance payments, performance bonuses, and EMR/HIT adoption incentive payments.
- Non-Claims: Capitation: All payments made to providers *not* on the basis of claims. Amounts reported as capitation should not include any incentives or performance bonuses.
- Non-Claims: Risk Settlements: All payments made to providers as a reconciliation of payments made. Amounts reported as Risk Settlement should not include any incentive or performance bonuses.
- Non-Claims: Care Management: All payments made to providers for providing care management, utilization review, discharge planning, and other care management programs.
- Non-Claims: Other: All other payments made pursuant to the payer's contract with a provider that were not made on the basis of a claim for medical services and that cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments. Only payments made to providers are to be reported. Payments to government entities, such as the Health Safety Net Surcharge, may not be included in any category

Appendix A: Physician Group OrgIDs

Please visit: http://chiamass.gov/reference-materials

Please note that CHIA's mapping of parent and local physician group relationships is meant to serve as a guide only. Payers should report physician group data based on their individual contracting structures with providers.

Appendix B: Massachusetts Zip Codes for Use with Zip Code TME

Please see the database of Massachusetts Zip Codes posted on CHIA's website at

http://chiamass.gov/reference-materials

Appendix C: Payment Method Allocation