CHIA Data User Workgroup

Donald Kirkwood, Manager of Data Release and Procurement
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September 22, 2026

Agenda

Announcements:

- Data Release Availability
- Requesting Data Using CHIA's New Online Application Process
- Reminder: National Association of Health Data Organization's (NAHDO) 2026 Annual Virtual Meeting
- CHIA Staff presenting at NAHDO's 2026 Annual Virtual Meeting
- Alert: Centers for Disease Control and Prevention (CDC) Seeking Public Comments on Data Intermediaries

Data User Support Questions

- Do Not Resuscitate Codes
- Ambulance Mileage
- EMS Utilization by Payer
- Race Unknown

Q&A

Questions?

Announcements

Outpatient Observation Stay Data for Fiscal Year 2025 is Newly Available for Applications



The on-schedule release of fiscal year 2025 outpatient observation stay data now completes the full suite of all three case mix datasets (hospital inpatient discharge, outpatient emergency department visit, and outpatient observation stay data). Collectively, these three population-based datasets enable a robust analyses of healthcare utilization and patient transitions across the entire continuum of acute and hospital outpatient care.

Hospital Inpatient Discharge Data



768,028 Discharges

Outpatient Emergency Department Visit Data



2,254,665 Visits

Outpatient Observation Stay Data



236, 544 Stays

MA APCD CY 2025 Scheduled for Release Fall 2026

Includes data covering 2021-2025 with a six-month run out from 2026



Fall officially begins today (9/22/2026). The MA APCD CY 2025 Release is in progress and targeted for release before the end of the year.

MA APCD Releases

PRODUCT	TARGET	ACTUAL	STATUS
MA APCD CY 2025 (2021-2025 data with six-month run out from 2026)	Fall 2026	Fall 2026	In Progress

Release Status Notes

- MA APCD CY 2025 is in development.

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.

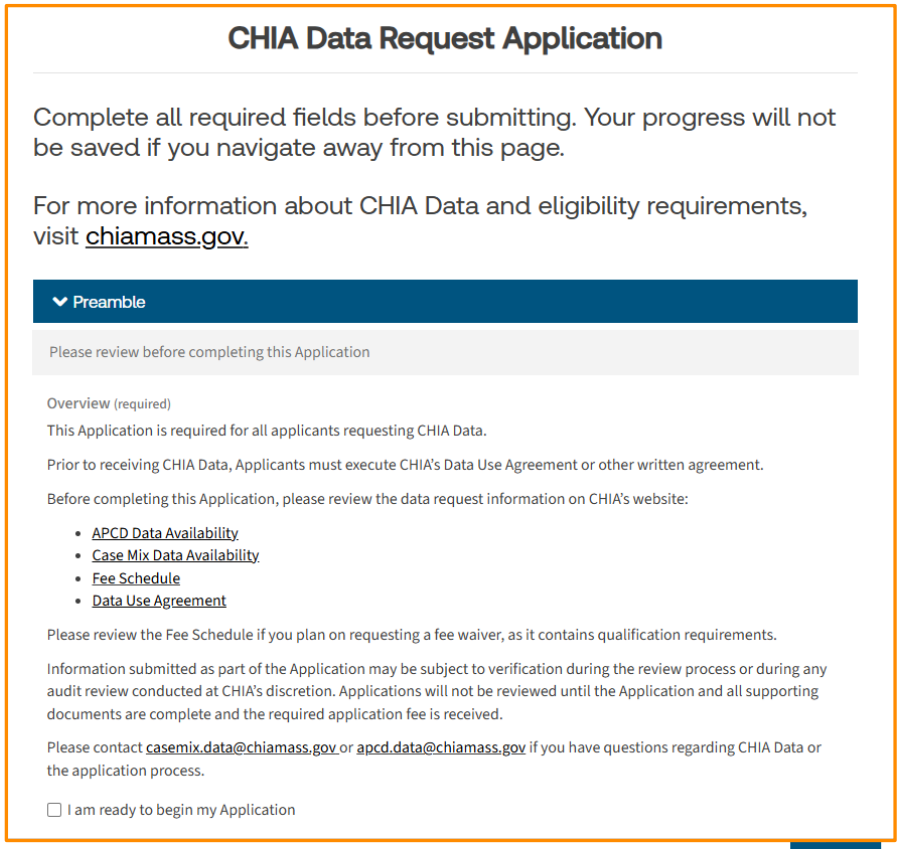
Reminder of CHIA's New Online Application Process for Requesting Case Mix data and MA APCD



Data users can now apply through a new smart online application form. There is now **one application form** for Case Mix or MA APCD data requests. The new process is designed to help users request appropriate data more efficiently.

Available at: https://masschia.highq.com/masschia/renderSmartForm.action?formId=aaff08f4-cc30-4638-8f30-a383df1717ec





CHIA Data Request Application

Complete all required fields before submitting. Your progress will not be saved if you navigate away from this page.

For more information about CHIA Data and eligibility requirements, visit chiamass.gov.

Preamble

Please review before completing this Application

Overview (required)

This Application is required for all applicants requesting CHIA Data.

Prior to receiving CHIA Data, Applicants must execute CHIA's Data Use Agreement or other written agreement.

Before completing this Application, please review the data request information on CHIA's website:

- APCD Data Availability
- Case Mix Data Availability
- Fee Schedule
- Data Use Agreement

Please review the Fee Schedule if you plan on requesting a fee waiver, as it contains qualification requirements.

Information submitted as part of the Application may be subject to verification during the review process or during any audit review conducted at CHIA's discretion. Applications will not be reviewed until the Application and all supporting documents are complete and the required application fee is received.

Please contact casemix.data@chiamass.gov or apcd.data@chiamass.gov if you have questions regarding CHIA Data or the application process.

☐ I am ready to begin my Application

REQUESTING DATA USING CHIA'S NEW ONLINE APPLICATION PROCESS

Data Application Submission Instructions

1 Prepare To Submit an Application

Review the data application questions and Data Use Agreement before submitting an application. CHIA staff can provide assistance by tailoring your request, discussing data privacy and security requirements, and calculating fees or supporting fee waiver requests. Any questions related to the application process can be directed to HighQ.Support@chiamass.gov.

2 Submit Online Application

CHIA uses a secure, cloud-based online platform for data request applications.

Submit a data request application

3 Review and Consultation

A CHIA Subject Matter Expert will review the application materials and, if needed, work with applicants to refine data requests. Review time depends on the complexity of the request and the sensitivity of the data requested.

4 Compliance Review and Approval

CHIA will confirm that the requested release is authorized under Massachusetts law. Note: Applicants seeking Medicaid data must establish that the proposed use is "directly connected" to the administration of the Medicaid program.

5 Execute Data Use Agreement

After approval, a Data Use Agreement (or equivalent agreement for government agencies) must be executed prior to data release. Note: Applicants seeking Medicare data must also sign the Medicare Addendum.

6 Data Release

Once the Data Use Agreement (or equivalent agreement for government agencies) is executed, CHIA processes the data extract, which is then transmitted to the recipient via secure delivery.

Check the status of your data request →

Detailed instructions for using CHIA's new online data request application are available at: https://www.chiamass.gov/requesting-submitting-data/requesting-data-records/request-ma-apcd-case-mix-data/



Reminder: Registration Open for National Association of Health Data Organizations (NAHDO) 2026 Virtual Annual Meeting

Data in Action: Turning Insight Into Impact

NAHDO's 41st Annual Conference

Virtual Sessions: November 17-19, 2026

For more information, see: https://www.nahdo.org/conference/2026

NAHDO is pleased to announce that their 2026 Annual Conference will include a full set of virtual sessions (November 17-19) as well as several exciting pre-conference events (October 28, November 4, and November 11). NAHDO has learned that there are many people who want to participate in our annual conference but due to various factors cannot attend in-person events. To maximize the number of participants, their main annual conference will be virtual as a companion to our in-person meetings and networking sessions. All paid conference registrants will be able to view and participate in live interactive sessions, and all sessions will be recorded and available for on-demand viewing by paid registrants. Our lineup of presenters, speakers and panelists includes innovators, deep thinkers, experts, thought-leading visionaries and sought-after industry leaders who will speak about cutting edge insights and ideas to improve on existing solutions and emerging technologies, new applications and opportunities.

CHIA Staff Presenting at National Association of Health Data Organizations (NAHDO) 2026 Virtual Annual Meeting*

Data in Action: Turning Insight Into Impact



November 12, 2026 2:00 PM - 2:30 PM

- Haley Farrar-Muir - Unifying Data for Equity: Building Agency-Wide Health Care Equity Dashboard
- Amy DeSantis - Understanding Regional and Demographic Disparities, 2019-2025

November 17, 2026 12:10 PM - 1:10 PM

- Sylvia Hobbs- Building a Secure, Citation-Anchored RAG Model for Health Data Organizations

November 18, 2026 12:10 PM - 1:10 PM

- Diego Burga - Health Care Spending Across Massachusetts Communities: Correlations to Community Sociodemographic Characteristics

November 19, 2026 12:10 PM - 1:10 PM

- Molly Bailey - Building a PBM Data Collection Program: Lessons Learned

November 19, 2026 1:20 PM - 2:20 PM

- Leah MacArthur, Donald Kirkwood - Modernizing Health Data Access: CHIA's Data Release Reform Initiative

** Note: Full Meeting Agenda available online at*:
https://www.nahdo.org/sites/default/files/2026-08/NAHDO%202026%20Agenda%20Master%20Database%20-%20Formatted%20Agenda.pdf

ALERT: The Centers for Disease Control and Prevention (CDC) Seeking Public Comments on Data Intermediaries



Comments must be submitted on or before November 20, 2026.

The Centers for Disease Control and Prevention (CDC) is seeking public comments on how data intermediaries can support secure, scalable, and standards-based public health data exchange. A data intermediary is a trusted organization, network, platform, or governed service that enables the secure exchange and stewardship of health-related data between data sources and public health authorities. The funding component of the RFI is hugely significant because it signals that the CDC is actively exploring who will pay for a potentially nationwide public health data exchange infrastructure and whether federal funding could help establish infrastructure sustainability. Comments matter because they not only allow you to have input on:

- Shaping the future of public health data exchange
- Establishing standards for secure, interoperable data sharing
- Influence funding and long-term infrastructure sustainability
- Strengthening privacy, governance, and accountability
- Ensuring real-world needs inform federal policy

Comments must be submitted by **November 20, 2026**, under **Docket No. CDC-2026-1519**.

For more information, see: https://www.govinfo.gov/content/pkg/FR-2026-09-21/pdf/2026-19271.pdf

New Publication Using MA APCD: Changes in documentation of social risk factor diagnosis codes: comparison of Medicaid Accountable Care Organization model types



Health Affairs Scholar, 2026, 4, 1–9
https://doi.org/10.1093/haschl/qxag220
Published: 25 August 2026
Research Article

Health Affairs Scholar OXFORD
EMERGING & GLOBAL HEALTH POLICY

Changes in documentation of social risk factor diagnosis codes: comparison of Medicaid Accountable Care Organization model types

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Abstract

Introduction Identifying social risk factors during the perinatal period may improve pregnancy-related outcomes. In 2018, the Massachusetts Medicaid program implemented an accountable care organization (ACO)—which required social risk factor screening—under 2 ACO model types: Model A (health system/Medicaid managed care plan partnership model) and Model B (primary care practice model).

Methods Using the 2016-2020 Massachusetts All Payer Claims Database and a difference-in-differences (DiD) design, we compared changes in any social risk factor documentation (ie, ICD-10 Z-codes) for Medicaid-enrolled deliveries in non-ACOs vs ACO Model A vs Model B, measured separately for the prenatal period, 60 days postpartum, 12 months postpartum, and the perinatal period. Secondary outcomes included documentation of specific Z-codes related to homelessness and food insecurity.

Results Both Model A (DiD = 1.03 percentage points [PP], $P < .001$) and Model B (DiD = 0.65 PP, $P < .001$) were associated with significant increases in Z-code documentation of food insecurity in the perinatal period. Model B was associated with a significant increase in Z-code documentation of homelessness in the perinatal period (DiD = 1.10 PP, $P < .001$) but not Model A.

Conclusion Massachusetts' Medicaid ACO was associated with modest increases in Z-code documentation during the perinatal period, with some variation by ACO model type.

Kevin H Nguyen, Kenneth Lim, Kathryn Thompson, Sarah H Gordon, Collette N Ncube, Lois McCloskey, Megan B Cole, *Changes in documentation of social risk factor diagnosis codes: comparison of Medicaid Accountable Care Organization model types*, *Health Affairs Scholar*, Volume 4, Issue 9, September 2026, qxag220, https://doi.org/10.1093/haschl/qxag220

New paper using the MA APCD identifies Medicaid-enrolled live deliveries occurring in Massachusetts between 2016 and 2020 and measures documentation of social risk factors using ICD-10 Z-codes in claims data, comparing changes in social risk factor documentation before and after implementation of the MassHealth Accountable Care Organization (ACO) program, including differences between ACO model types and non-ACO populations.

Implementation of the MassHealth Medicaid ACO program was associated with modest but statistically significant increases in documentation of social risk factors, particularly food insecurity, among Medicaid-covered pregnancies.

Questions?

Data User Support Questions

Question: I am analyzing whether 'Do Not Resuscitate' (DNR) coding patterns explain differences in observed-versus-expected mortality rates and first wanted to know the quality of DNR flags in CHIA HIDD and the extent to which the use of any dedicated DNR field flags align with also reporting ICD-10-CM code Z66 for DNR. Does the dedicated DNR field capture cases that lack Z66? Likewise, are there hospitals that report Z66 but fail to populate the DNR flag?



Answer: DNR Order Written (Flag Code 1) shows the strongest improved alignment with Z66 diagnosis code, steadily rising from 84.8% in FY2021 to 95.9% in FY2025. ***See right table below.*** Although there had been a high use of Z66 for Comfort Care Measures Only (Flag Code 2), this use dropped from 94.9% to 56.4% in FY2025. A patient can have both comfort care and DNR. The ICD-10-CM Official Guidelines for Coding and Reporting dictate that codes from category Z00-Z99 must accurately describe precise factors influencing a patient's health status. Code Z66 (Do Not Resuscitate status): This code is highly specific to signify a medical order stating that cardiopulmonary resuscitation (CPR) not be performed in the event of cardiac or respiratory arrest. There were also Flag Code 3 ("No DNR order or Comfort Care Ordered") with the Z66 DNR diagnosis code, increasing from 6.2% in FY2021 to 8.8% in FY2025, and blank DNR Flag codes with Z66, increasing from 7% in FY2021 to 10% in FY2025. ***See left table below.***

DNR Status Field Category	Fiscal Year	Total DNR Flag Volume	Volume Also Reporting DX Code Z66	Rate of Z66 Alignment
DNR Order Written (Code 1)	FY2021	24,176	20,511	84.8%
	FY2022	21,627	18,467	85.4%
	FY2023	19,989	18,048	90.3%
	FY2024	17,643	16,037	90.9%
	FY2025	16,745	16,062	95.9%
Comfort Care Measures Only (Code 2)	FY2021	6,106	5,769	94.5%
	FY2022	6,348	6,026	94.9%
	FY2023	6,726	5,925	88.1%
	FY2024	7,544	5,125	67.9%
	FY2025	10,690	4,659	43.6%

DNR Status Field Category	Fiscal Year	Total DNR Flag Volume	Volume Also Reporting DX Code Z66	Rate of Z66 Alignment
No DNR order or Comfort Care Ordered (Code 3)	FY2021	439,423	27,381	6.2%
	FY2022	417,517	28,979	6.9%
	FY2023	427,051	30,335	7.1%
	FY2024	478,267	34,556	7.2%
	FY2025	512,315	44,932	8.8%
Blank Field	FY2021	282,402	19,659	7.0%
	FY2022	283,827	22,506	7.9%
	FY2023	290,570	25,091	8.6%
	FY2024	263,231	26,037	9.9%
	FY2025	228,278	23,981	10.5%

Answer continued →

Answer *(continued):* When looking at confirmed DNR discharges by APR-DRG Risk of Mortality (ROM), the top 20 APR-DRGs by confirmed DNR volume show considerable variation in risk-of-mortality profiles. While ROM 3 (major) and ROM 4 (extreme) account for the largest share of DNR discharges in most diagnostic categories, the proportion of patients assigned to each ROM level differs meaningfully across DRGs. This pattern suggests that the relationship between documented DNR status and mortality risk is not uniform but varies according to the underlying clinical condition.



APR-DRG V. 40	TOP 20 DRGS FOR DNR (Code 1) Discharges	Total DNR (Code 1) Discharges	ROM 1	ROM 2	ROM 3	ROM 4
720	SEPTICEMIA & DISSEMINATED INFECTIONS	1897	1%	5%	27%	67%
194	HEART FAILURE	1233	1%	20%	54%	25%
137	MAJOR RESPIRATORY INFECTIONS & INFLAMMATIONS	756	*	*	50%	37%
466	MALFUNCTION, REACTION, COMPLIC OF GENITOURINARY DEVICE OR PROC	374	3%	17%	47%	32%
139	OTHER PNEUMONIA	395	1%	20%	51%	28%
710	INFECTIOUS & PARASITIC DISEASES INCLUDING HIV W O.R. PROCEDURE	162	*	*	25%	69%
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	306	5%	42%	34%	20%
136	RESPIRATORY MALIGNANCY	176	3%	11%	53%	32%
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	253	5%	26%	50%	19%
469	ACUTE KIDNEY INJURY	379	4%	33%	52%	10%
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	241	11%	30%	45%	14%
463	KIDNEY & URINARY TRACT INFECTIONS	545	8%	33%	53%	6%
308	HIP & FEMUR FRACTURE REPAIR	274	12%	35%	42%	11%
133	RESPIRATORY FAILURE	157	3%	25%	55%	17%
254	OTHER DIGESTIVE SYSTEM DIAGNOSES	242	12%	36%	41%	10%
249	OTHER GASTROENTERITIS, NAUSEA & VOMITING	216	11%	27%	52%	10%
42	DEGENERATIVE NERVOUS SYSTEM DISORDERS EXC MULT SCLEROSIS	334	10%	46%	39%	5%
426	NON-HYPOVOLEMIC SODIUM DISORDERS	180	12%	29%	52%	8%
342	FRACTURES & DISLOCATIONS EXCEPT FEMUR, PELVIS & BACK	167	32%	29%	31%	8%
383	CELLULITIS & OTHER SKIN INFECTIONS	200	16%	38%	41%	6%

Question: Is it possible to determine ambulance travel distance from the MA APCD medical claims? I am examining the relationship between care transitions and continuity of care and wanted to make sure I included an evaluation component looking at prehospital care.



Answer: Ambulances are a meaningful component of the continuum of care for both prehospital care and interfacility care during transfers. There are fields in the MA APCD to support the analyses of these relationships. For ambulance mileage analysis in the MA APCD, the two most important fields are typically:

1. **HCPCS procedure code**
   The key mileage HCPCS codes are:
   - A0425 – Ground mileage, per statute mile
   - A0435 – Fixed-wing air mileage, per statute mile
   - A0436 – Rotary-wing air mileage, per statute mile
2. **Quantity (units recorded in miles) field**

Table 1. MA APCD Example of Ambulance by Mileage Traveled

SERVICEPROVIDERLASTNAMEORORGANIZATIONNAME	PROCEDURECODE	QUANTITY
ACTON FIRE DEPT AMBULANCE	A0425	6
AMERICAN MEDICAL RESPONSE OF MASSACHUSETTS	A0425	8
ARMSTRONG AMBULANCE SERVICE INC	A0425	14
BOSTON MEDFLIGHT INC	A0436	7
CANTON FIRE DEPT	A0425	12
CATALDO AMBULANCE SERVICE	A0425	4
CHICOPEE FIRE DEPT	A0425	2
EAST LONGMEADOW FIRE DEPARTMENT	A0425	7
EVERETT FIRE DEPARTMENT	A0425	1
FALL RIVER EMERGENCY MEDICAL SERVICES	A0425	2
FITCHBURG EMERGENCY MEDICAL SERVICES	A0425	4
FOXBOROUGH FIRE DEPARTMENT	A0425	2
HYANNIS FIRE AND RESCUE DEPT	A0425	1
NORTHAMPTON FIRE DEPARTMENT	A0425	5
WILMINGTOWN FIRE DEPT	A0425	8

As you can see from the example in Table 1, it is important to keep in mind that even though the service provider name is listed as a fire department, many Massachusetts municipalities provide their own ambulance services, typically through local fire departments. Specifically, 55% provide their own ALS and BLS services*, 12% use a hybrid municipal-contracted model, and 33% outsource ambulance services to private providers.

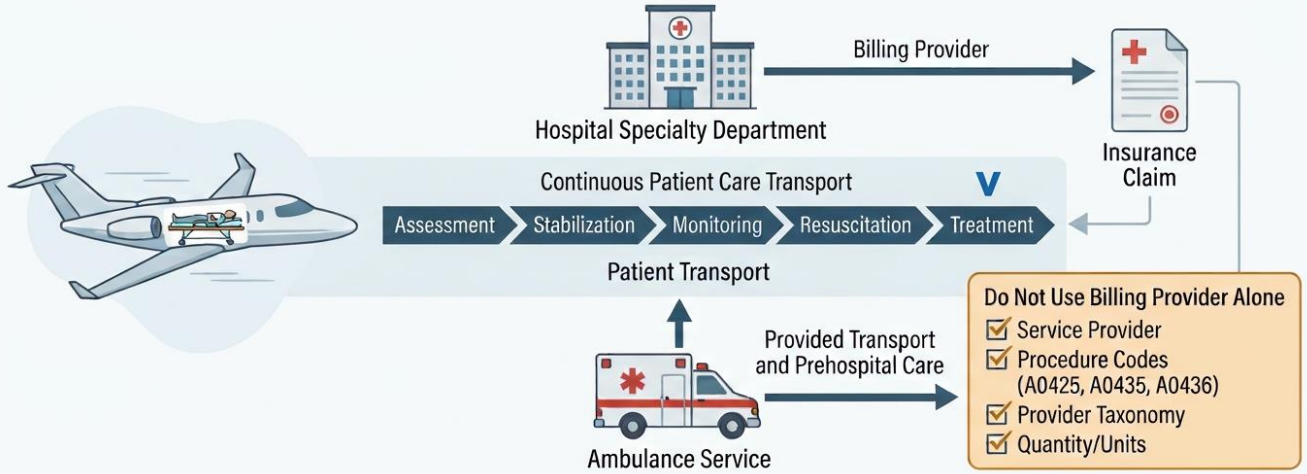
* Source: *https://www.mass.gov/files/documents/2023/11/07/HCD%20COST%20TRENDS%2011.7.2023.pdf*

Answer continued →



Answer *(continued):* It is also important to note that, for an ambulance transport, especially an air medical transport, a specific hospital specialty department may be identified as the billing provider organization while the ambulance service is identified as the service provider. This may reflect a contractual billing arrangement with the hospital or specialty group that allows the hospital-affiliated provider to submit the claim under its payer contract, while the air medical provider is identified as the entity that provided the medically necessary transport and accompanying pre-hospital medical care, including continuous clinical assessment, stabilization, monitoring, resuscitation, and treatment during the transport. Therefore, when identifying ambulance-related transports in medical claims, analysts should not rely solely on the billing provider. ***See Figure 1*** . They should also examine the service provider, procedure codes, provider taxonomy, and other available provider-role fields. Also, high ambulance mileage is the quantity field is not necessarily an outlier and may reflect air ambulance transports which transport longer distances. ***See Table 1.***

Figure 1. Keep in Mind Billing Contractual Arrangements



When identifying ambulance transports in medical claims, analyze multiple provider fields because the billing provider is not always the ambulance service but may be a hospital specialty department while the ambulance service performing the transport and delivering prehospital care is the service provider.

Table 1. Examples of High Mileage per Transport Air Medical Ambulances in the MA APCD

New England Life Flight doing business as Boston Medflight
Aviation West Charters doing business as Angel Medflight
Medical Logistics doing business as Airevac International
AAC-Air Ambulance Caribbean doing business as Aero MD
Worldwide Aircraft Services doing business as Jet ICU
Airmedical International
Medway Air Ambulance
Trinity Air Ambulance International
Reva Air Ambulance
Lifeflight of Maine
Grace on Wings
Lifeflight Network

Question: Which payers in the MA APCD medical claims account for the largest shares of reported mileage for fixed-wing, rotor-wing, and ground ambulance services, and how do those payer shares differ across service types?



Answer: The distribution of ambulance mileage varies substantially by service type: Blue Cross Blue Shield of Massachusetts accounts for the largest share of fixed-wing mileage at 53.2%, while Health Plans, Inc. has the largest shares of both rotor-wing mileage at 38.1% and ground ambulance mileage at 45.1%. Six payers appear among the top 10 for all three ambulance types: Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, Tufts Health Plan, Fallon Community Health Plan, Network Health, and WellPoint, Inc. The rankings also show payer-specific differences across service types, with some payers holding a substantial share of mileage for one ambulance type but a smaller share, or no top-10 position, for another. **See Table 1 below.**

Top 10 Payers by Fixed Wing Ambulance Percent Mileage in MA APCD Medical Claims

Rank	Payer Name	Fixed Wing
1	Blue Cross Blue Shield of MA	53.18%
2	Harvard Pilgrim Health Care	16.89%
3	WellPoint, Inc.	7.29%
4	Tufts Health Plan	6.62%
5	United Healthcare - Medicare	4.40%
6	United Healthcare	2.88%
7	Fallon Community Health Plan	2.29%
8	UnitedHealthcare Senior Care Options	2.25%
9	Health New England, Inc.	1.28%
10	Network Health	1.02%

Top 10 Payers by Rotor Wing Ambulance Percent Mileage in MA APCD Medical Claims

Rank	Payer Name	Rotor Wing
1	Health Plans, Inc.	38.08%
2	Blue Cross Blue Shield of MA	20.78%
3	MassHealth	8.15%
4	United Healthcare	7.79%
5	Harvard Pilgrim Health Care	5.04%
6	Tufts Health Plan	3.31%
7	Neighborhood Health Plan	3.31%
8	Network Health	2.71%
9	Fallon Community Health Plan	2.60%
10	WellPoint	2.43%

Top 10 Payers by Ground Ambulance Percent Mileage in MA APCD Medical Claims

Rank	Payer Name	Ground
1	Health Plans, Inc.	45.09%
2	MassHealth	21.40%
3	Blue Cross Blue Shield of MA	9.82%
4	Tufts Health Plan	3.70%
5	Harvard Pilgrim Health Care	3.08%
6	Boston Medical Center HealthNet Plan	2.53%
7	United Healthcare - Medicare	2.09%
8	WellPoint	1.94%
9	Fallon Community Health Plan	1.80%
10	Network Health	1.64%

Question: Did the introduction of three new race-reporting categories in FY2025 ("Patient chose not to answer"; "Don't Know"; "Unable to collect due to lack of patient clinical capacity to respond") lead to a reduction in use of the "Unknown" race category?

Decrease In Unknowns

Answer: Yes, while the number of records in the "Unknown" category increased each year from FY2021 through FY2024, rising from 7,321 to 11,037 over that period, in the new FY2025 outpatient observation stay data, after the introduction of three new categories, the number of records with an "Unknown" designation was 5,330, a decrease of 5,707 records (51.7%) compared with FY2024. **See Table 1** below for detailed figures on race reporting values by fiscal year in outpatient observation stay data.

Table 1. Patient Race1 Data (FY2021 - FY2025 Outpatient Observation Stay)

Race / Reporting Category	FY2021	FY2022	FY2023	FY2024	FY2025
White	140,612	140,664	161,334	153,138	163,289
Black/African American	19,143	19,061	24,331	27,286	32,284
Other Race	12,217	12,002	18,665	19,260	22,242
Asian	7,035	7,045	6,644	6,535	7,533
American Indian/Alaska Native	288	331	516	561	537
Native Hawaiian or Other Pacific Islander	141	146	197	217	234
Unknown	7,321	7,850	9,530	11,037	5,330
Don't know (New)	–	–	–	–	590
Choose not to answer (New)	–	–	–	–	2,643
Unable to collect (Lack of clinical capacity) (New)	–	–	–	–	1,862
Total Observations	186,757	187,099	221,217	218,034	236,544

Answer continued

Answer *(continued):* Outpatient observation stay had the largest percent decrease in unknowns from FY2024 to FY2025 (51.7%), followed by hospital inpatient discharges (48.8%, **see Table 2** below), and the outpatient Emergency department visits had the lowest percent decrease (27.2%, **see Table 3** below).

Decrease In Unknowns

Table 2. Patient Race1 Data (FY2021 - FY2025 Hospital Inpatient Discharges)					
Race / Reporting Category	FY2021	FY2022	FY2023	FY2024	FY2025
White	564,464	542,666	550,425	562,135	568,863
Black/African American	63,124	62,200	64,533	70,856	72,412
Other Race	49,442	48,918	49,821	52,474	56,606
Asian	23,056	22,863	24,123	24,965	26,081
American Indian/Alaska Native	1,229	1,187	1,440	1,598	1,601
Native Hawaiian or Other Pacific Islander	363	392	502	674	694
Unknown	50,429	51,093	53,492	53,983	27,620
Don't know (New)	-	-	-	-	2,584
Choose not to answer (New)	-	-	-	-	6,812
Unable to collect (Lack of clinical capacity) (New)	-	-	-	-	4,755
Total Discharges	752,107	729,319	744,336	766,685	768,028

Table 3. Patient Race1 Data (FY2021 - FY2025 Outpatient Emergency Department Visits)					
Race / Reporting Category	FY2021	FY2022	FY2023	FY2024	FY2025
White	1,316,386	1,420,834	1,429,390	1,442,427	1,415,639
Black/African American	263,245	292,916	306,026	325,028	332,108
Other Race	275,928	325,029	340,474	320,957	323,106
Asian	49,489	61,888	65,667	67,856	69,389
American Indian/Alaska Native	4,093	4,521	5,716	6,620	6,729
Native Hawaiian or Other Pacific Islander	1,203	1,490	2,814	3,613	3,431
Unknown	70,049	82,599	83,285	87,689	63,875
Don't know (New)	-	-	-	-	3,973
Choose not to answer (New)	-	-	-	-	26,136
Unable to collect (Lack of clinical capacity) (New)	-	-	-	-	10,279
Total Visits	1,980,393	2,189,277	2,233,372	2,254,190	2,254,665

WHEN IS THE NEXT DATA USER WORKGROUP MEETING?

NEXT CHIA DATA USER WORKGROUP MEETING
TUESDAY, OCTOBER 27, 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