All Payer All Claims Update Amendment

Use this form for approved APAC data requests when requesting changes to:

- additional years of data requested
- additional data elements requested
- any change in use of data including linking or additional research questions
- any change in research protocol regardless of whether approval by an Institutional Review Board is required

No change in data use or research protocol is authorized when using APAC data until this amendment is approved. OHA will determine the cost of the requested data years or data elements and provide an invoice after review. Payment is required before data is released.

Staffing changes are submitted on the Administrative Amendment form. The application number and Principal Investigator name must match the signed Data Use Agreement (DUA) for the project.

If you have any questions on the amendment process, including the application number or date of the original application, please contact apac.admin@state.or.us. Information on data elements, data dictionary and data years available can be found at https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/APAC-Data-Requests.aspx.

PROJECT INFORMATION

Project Title HIV_Surveillance_Utilization_Study

Application number (####-description) 4448_HIV_Surveillance_Utilization_Study

Applicant Jeffrey Capizzi

Principal Investigator Jeffrey Capizzi

Organization Oregon Health Authority, HIV/STD/TB Section

Email jeff.capizzi@dhsoha.state.or.us

Date of original application (month and year) July 6 2017

Section 1: Request category

This amendment includes (choose all that apply):

- [x] Request for additional data year(s); complete Sections 2 - 3
- [ ] Request for additional data elements; complete Sections 2 and 4
- [ ] Request to modify research questions; complete Sections 2 and 5
- [ ] Request to modify data linking activities; complete Sections 2 and 6
- [ ] Request to modify research protocol; complete Sections 2 and 7

Section 2: Institutional Review Board (IRB) approval

- [ ] This project did not require IRB approval.
- [■] The amendment is already approved within the scope of the original project. *If not, a new application for data must be submitted.*
- [ ] The modification(s) of data elements, research questions, linking or change in research protocol was within the scope of the original project and the changes have been approved by the IRB. *OHA reserves the right to independently assess if the modification is within the scope of the original project.*
  - [ ] Updated IRB approval attached

Section 3: Additional data year(s)

Years previously received under this Data Use Agreement:

[x] 2011	[x] 2012	[x] 2013	[x] 2014
[x] 2015	[x] 2016	[ ] 2017	

Additional years requested in this amendment:

[x] 2011	[x] 2012	[x] 2013	[x] 2014
[x] 2015	[x] 2016	[x] 2017	

Section 4: Additional data elements

4.1 Describe the reason additional data elements are required and how use of the additional elements falls within the original project.

The HIV/STD/TB Section requests most of the same data elements with the addition of data from 2017. The period spanning 2011–2017 is requested because we are trying to study the prescription of HIV medications longitudinally and therefore need a unique identifier which is consistent across years.

We have requested some additional data elements in the most current data file that were not available during our last request. Many of these new fields may be useful for data cleaning and de-duplication. In other instances, it is assumed that it would be more efficient to transfer the data without going to the effort of excluding specific fields. We recognize that some of the fields will have marginal benefit to our analysis.

We had previously not requested member names, addresses, dates of birth, and dates of death. We did not know these fields were available or we would have requested them earlier. These fields will be useful to estimate case reporting completeness and missed opportunities for an earlier HIV diagnosis. This work is one of the core functions of HIV Surveillance.

Parties have agree to delivery of existing data set which includes data elements not originally requested but which are allowed/supported by public health surveillance activities.

4.2 Complete and attach the Data Element Workbook to specify which data elements are requested. Justification is required for each data element in compliance with HIPAA's minimum necessary data requirement.

☑ Completed Data Element Workbook attached.

Section 5: Modification of research questions

Explain the requested change and how the change is within the original project approved for APAC data use.

The requested changes are consistent with HST original objectives, which were to assess the care of persons with HIV, including utilization of HIV medication (antiretroviral medications, hepatitis treatment, and HIV pre-exposure prophylaxis (PrEP). These issues are of ongoing importance in Oregon, and HST plans to continue to monitor care longitudinally.

Section 6: Data linking activities

Explain the requested change and how the change is within the original project approved for APAC data use.

Access to member names, addresses, dates of birth, and dates of death makes it possible to match APAC and HIV Surveillance data. This allows us to distinguish between patients with a diagnosis code consistent with HIV infection or AIDS who are really HIV negative. That is, when the patient was incorrectly coded as positive. This allows the HIV Surveillance program to better estimate completeness of reporting.

The addition of names, addresses, dates of birth, and dates of death, allows HIV Surveillance to have greater confidence in the analyses that we have conducted in previous years. The requested change does not change the original project or planned analyses, but it does improve the quality of the analyses.

Section 7: Change in research protocol

Explain the requested change and how the change is within the original project approved for APAC data use.

There is no change in protocol. Data will be managed in a way consistent with the original project approved. Security and confidentiality practices are the same. Access to the data is limited to HIV Surveillance staff. Data is stored in the HIV Surveillance Office, which has limited access. Because of the memory requirements of the data itself is kept on an encrypted external hard-drive. Only two people have the user-name and password to access the hard-drive. Health Analytics and the APAC manager will review any publications resultant of the analyses of these data. Previous APAC data files will be destroyed on a timeline consistent with the original project. A reduced and de-identified analytic file may be retained in accordance with archive rules and to respond to questions regarding the results or published work.

Section 8: Signatures

Other than the changes requested above and approved, all terms and conditions of the Data Use Agreement and any other previous amendments are still in full force and effect. Changes in research questions, data linking or research protocol are not approved until this amendment has been signed by all parties with the final signature that of OHA.

Applicant's signature

10/08/2019
Date

JEFFREY CAPIZZI
Printed name 10.10.19

EPIDEMIOLOGIST
Title

OHA authorized signature

Date

Karen Hampton
Printed name

Interim Research & Data Manager
Title

The completed form can be emailed or mailed to:

Office of Health Analytics – APAC
421 SW Oak Street, Suite 850
Portland OR 97204

apac.admin@state.or.us

The Oregon State Legislature authorized APAC in 2009 to measure and improve the quality, quantity, cost and value of health care services. Oregon Revised Statutes and Administrative Rules provide guidelines for APAC data collection, use and release and the Oregon Health Authority (OHA) is responsible for APAC oversight. APAC contains protected health information and data that identifies people. OHA is responsible for ensuring compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the protection of people's health information, identity and privacy. OHA ensures that data requests comply with HIPPA, protect the privacy of members and their health information, are justified and that OHA shares only the minimum necessary data.

The purpose of the data elements workbook is for data requesters to specify APAC data options and provide the justification for each APAC data element requested for their project described in their APAC3 application. OHA uses the data elements workbook and the APAC3 data request application to assess HIPPA compliance and risks and to determine if the projects meets the APAC data use and release guidelines. **Data requesters must complete the data request options worksheet and the data elements worksheet in the data elements workbook and submit the workbook with their APAC3 application.**

Please answer each of the following questions about APAC data request options and submit with your APAC data request:

Please indicate the year(s) of data requested	2011	2012	2013	2014	2015	2016	2017
	x	x	x	x	x	x	x

Do you want out-of-state people included in claims & elligibility data?	Yes	No
	x	

Do you want denied claims included?	Yes	No
	x	

Do you want orphan claims included?	Yes	No
	x	

Do you want self-insured eligibility and claims data included?	Yes	No
	x	

Do you want PEBB and OEBB eligibility and claims data included?	Yes	No
	x	

Do you want to limit claims by allowed amount?	No	Yes, limit to greater than zero	Yes, limit to greater than or equal to zero
	x		

What payer types do you want?	Commercial	Medicaid	Medicare (commercial only)	CMS Medicare (Restricted access. Available to OHA only)
	x	x	x	x

What medical claim types do you want?	All medical claims	Inpatient hospital	Emergency department	Outpatient	Ambulatory surgery	Ambulance	Transportation	Hospice	Skilled Nursing Facility
	x	x	x	x	x	x	x		x

Do you want professional services included with the medical claim types?	Yes	No

Do you want pharmacy claims?	Yes	No

Do you want monthly eligibility data?	Yes	No

Do you want member demographic data?	Yes	No

Do you want member demographic data?		

Do you want provider data?	Yes	No

Do you want billed premium data?	Yes	No

Do you want claims and eligibility data for selected age groups only?	All ages	Exclude people 65 yrs and older	Specify age exclusions:
	x		

Do you want to limit claims and eligibility data by gender?	Include all	Include only female	Include only male
	x		

Do you want to limit <u>medical claims</u> data to selected diagnoses?	No	Yes. List diagnosis codes
	x	

Do you want to limit <u>pharmacy data</u> to selected NDC codes or therapeutic classes?	No	Yes. List NDC codes or therapeutic classes codes
	x	

Are you requesting identifiable data?	No	Zip code	County	Address	Name	Month of birth	Month of death	Date of birth	Date of death
		x	x	x	x			x	

The APAC data elements workbook is organized by the APAC data structure described in the APAC User Guide and Data Dictionary: claims, member static demographics, monthly eligibility, provider data and billed premiums. Data elements available for both medical and pharmacy claims are listed first and followed by data elements available only for medical claims, only for pharmacy claims, monthly eligibility, demographics provider data and billed premiums. Description and values are listed for each data element. A check mark in the payer reported column indicates that the data element was reported directly by payers.The payer reported threshold column indicates the amount of missing or data error allowed in the quarterly data submission. A check mark in the public use data column indicates that the data element is in public use data sets. A check mark in the limited column indicates the data element is available for a limited data request. Data elements with no check mark in the limited column are only available by custom data request. Data elements with restricted or limited access are listed last and require more detailed information about the purpose and data security and may be subject to review by the Oregon Department of Justice.

Instructions: Mark each data element requested with an X in the first column. Delete all data elements not requested. Provide a justification for each data element requested in the last colum. Save the data elements workbook and attach to your APAC data request.

Mark requested data elements with an X in this column	Data Element	Description	Values	Payer Reported	Payer Reported Threshold	Vendor Created	Public Use Data	Limited data	Justification
	Data Elements Available for Both Medical and Pharmacy Claims:								
x	Year or incurred_year	Year of service or eligibility occurred	YYYY			x	x	x	
x	YearMonth or incurred_year_and_month	Year and month service or eligibility occurred	YYYYMM			x		x	
x	incurred_month_start_date	First day of the month the service or eligibility occurred	YYYY-MM-DD			x		x	
x	Incurred_cal_quarter	Quarter the service or eligibility occurred	Numeric			x			
x	Fromdate or fill date or from_date	Service begin date or pharmacy fill date	YYYY-MM-DD	x	0.0%			x	
x	Todate or to_date	Service end date	YYYY-MM-DD	x	0.0%			x	
x	Paydate or paid_date	Payment date	YYYY-MM-DD	x	0.0%			x	
x	Paid_Month_Start_Date	First day of the month the service was paid	YYYY-MM-DD			x		x	
x	Paid_Year_and_Month	claim paid year and month	YYMM			x			
x	Paid_Year	claim paid year	YYYY			x			
x	paid_cal_quarter	claim paid calendar quarter	Numeric			x			
x	paid_fiscal_year	claim paid fiscal year	YYYY			x			
x	paid_fiscal_quarter	claim paid fiscal quarter	Numeric			x			
x	MI_Post_date	End date of the vendor posting period	YYYY			x			
x	Claim_Entry_Date	Date claim entered into APAC	YYYY-MM-DD			x			
x	Claim_rec_Date	Date claim received by payer	YYYY-MM-DD	x	N/A	x			
x	Patid or member ID or member_key	Unique person identifier created from payer reported identifier for each plan. Not unique across payers and years	Numeric	x	0.0%			x	
x	Personkey or MI_Person_key	Unique identifier created for a person across payers and years	Numeric			x		x	
x	Relation	Member's relationship to the subscriber i.e., child and/or spouse	See Relationship Table	x	1.2%				
x	Services_key	Primary key for claims	Numeric			x			
x	Clmid or Claim_ID_Key	Payer specific claim identifier created from the payer reported claim identifier. Not unique across payers and years. Claims can have one or more service lines per identifier. There are some claims without an identier 2011-2013 (null identifier). The ID is Zero (0) when the claim row is incurred but not reported (IBNR) and not an actual claim	Numeric			x		x	
x	Claim line or SV_line	Claim service line number	Numeric	x	0.0%			x	

x	CS_Claim_ID_key	Vendor proprietary Health care grouper (HCG) determined continous stay claim identifier in an inpatient facility	Numeric			x		x	
x	Form_type	Type of claim. If revenue code (MC054) is not null and does not contain values like ('','0','00','000','0000') then 'U' is assigned otherwise 'H' is assigned. Rx claims are defaulted to 'D'	U=UB, H=CMS1500, D=Prescription drug			x			
x	clmstatus or sv_stat	Claim status	P, D, E, R	x	0.0%			x	
x	SV_Stat_and_Desc	Claim status description	paid, denied, encounter, reversed			x		x	
x	Member_month_defaulted	Flag indicates if the member month key connected to monthly eligibility was derived by the gap fill methodology	1 (defaulted), 0 (not defaulted)					x	
x	Member_month_defaulted_Product_level	Flag indicates if the member month key connected to monthly eligibility was derived by the gap fill methodology at the product level	1 (defaulted at product level), 0 (default did not occur at the product level)					x	
x	hcg or HCG_MR_line	HCG is the lowest level of the vendor health care grouping system	See HCG table			x	x	x	
x	hcg_Version	Version 2010 V 3.0.12	Text			x			
x	hcg_Year	Year associated with HCG version	YYYY			x			
x	HCG_MR_Line_Desc	Description of HCG MR_LINE	Text			x			
x	HCG_Setting	Highest level of the HCG system. One of five categories	1 (inpatient), 2 (outpatient), 3 (professional), 4 (prescription drug), 5 (ancillary) See HCG table			x			
x	HCG_MR_Line_Group	Second level of the HCG system	HIP (hospital inpatient), HOP (hospital outpatient), PHY (professional), RX			x			
x	HCG_MR_Line_Code_and_Desc	Over 100 HCG line group categories	Text			x			
x	HCG_MR_Line_Rollup	Third level of the HCG system	Text			x			
x	HCG_MR_Line_Rollup_Desc	61 HCG line group categories	Text			x			
x	MR_Line_Case_Key	Represents and HCG MR line case	Text			x			
x	Cases	HCG measure of unique services; number of inpatient admits	Numeric			x			
x	Case_source	HCG Source of case counts	Text			x			
x	Case_basis	HCG Type if case	Admit or case			x			
x	Util_Source	HCG Source of utlization counts	Text			x			
x	Util_Basis	HCG description of utilization type	Text			x			
x	MR_Admit_cases_raw	HCG source admit or cases	Text			x			
x	MR_Units_Days_Raw	HCG source units or days	Text			x			
x	PBP_Admits_cases_raw	HCG source Medicare Plan Benefit Package admits or cases	Text			x			
x	PBP_line_code_and_desc	Desciption HCG source Medicare Plan Benefit Package categories	See HCG PBP table			x			

x	qtydisp or quantity or qty or SV_Units	Quantity or count of services delivered; Revenue code count for inpatient hospitalization and CPT count for outpatient services; Quantity of pharmaceutical dispensed	Numeric	x	0.0%	x	x	x	
x	Medicareflag	Medicare coverage flag derived from HCG based on plan benefit package line (PBP). PBP is based on CPT/HCPCS, revenue and diagnosis codes.	Y (yes), N (no). See HCG PBP Table for more information		1.2%	x			
x	Payer_LOB	Payer line of business from derived from payer reported product code from eligibility data only and not claims data. Orphan claims assigned null.	Commercial, Medicaid, Medicare or null. See product code table for crosswalk			x			
x	Paytype or payer_type	Payer reported payer type codes from eligibility data only and not from claims data	C, D, G, P, T, U	x				x	
x	MC001_APAC _Payer_type	Payer reported payer type codes from claims data	C, D, G, P, T, U	x					
x	MC001_APAC _Payer_type_desc and claims payer type	Payer type description	(C) Carrier, (D) Medicaid, (G) Other government agency, (P) Pharmacy benefits manager, (T) Third-party administrator, (U) Unlicensed entity			x		x	
x	Prod	Payer reported product code from eligibility data only and not claims data	See product code table	x	0.0%		x	x	
x	APAC_Product_code	Payer reported product code from claims data	See product code table	x	0.0%		x		
x	APAC_Product_code_code_and_desc	Product code description	See product code table			x			
x	Claim_specific_LOB	Derived from payer reported product code from eligibility data only and defaulted to a specific LOB for some identifed payers	See claim specific LOB payer table			x			
x	medflag	Indicates medical coverage for the month when claim occurred	Numeric: 1 (yes), 0 (no)	x	0.0%				
x	rxflag	Indicates pharmacy coverage for the month when claim occurred	Numeric: 1 (yes), 0 (no)	x	0.0%				
x	HVMHflag	Required for members in OHLC high value medical home initiative	Y (yes), N (no)	x	N/A			x	
x	PEBB_OEBB	Public Employees Benefit Board or Oregon Educators Benefit Board covered members. Includes Oregonians and out-of-state residents	PEBB, OEBB, Null		0.0%	x			

x	PEBB_OEBB_Desc	Public Employees Benefit Board or Oregon Educators Benefit Board covered members. Includes Oregonians and out-of-state residents	PEBB, OEBB, Null			x			
x	PEBB Flag	Public Employees Benefit Board covered members. Includes Oregonians and out-of-state residents	0 (no), 1(yes)					x	
x	OEBB Flag	Oregon Educators Benefit Board covered members. Includes Oregonians and out-of-state residents	0 (no), 1(yes)					x	
x	Age_on_DOS	age on date of service	Numeric			x			
x	Attid or att_prov_key	Vendor created unique identifier for attending, rendering or pharmacy provider based on payer reported unique identifier. Identifier is payer specific and not unique across payers or years	Numeric		1.2%	x		x	
	Attid_encrypt or Att_Prov_ID_encrypted	encrypted ProviderID	Text			x			
x	ATT_PROV_CW_KEY	Vendor created unique attending provider identifier across payers and years				x			
x	BILL_PROV_CW_KEY	Vendor created unique billing provider identifier across payers and years				x			
x	Billid_taxonomy	National uniform claim committee (NUCC) provider taxonomy for the billing provider; NPI if not reported	Text			x			
x	Entity or bill_prov_name	Name of the entity that generated the bill for the service. Medical billing provider or pharmacy name. Name is payer specific and not unique across payers or years	Text	x				x	
x	COB or COB_stat	Coordination of benefit claim	Y (yes), N (no)	x	1.2%			x	
x	Network_indicator	Indicator of whether service received in or out of network	1 (in network), 2 (National network), 3 (out-of-network)	x	0.0%				
x	Copay or amt_copay	Expected Co-payment by the member	Two decimal places. 0 if amount equals zero. Blank if missing.	x	0.0%			x	
x	Coins or amt_coins	Expected Co-insurance by the member	Two decimal places. 0 if amount equals zero. Blank if missing.	x	0.0%			x	
x	Deduct or amt_deduct	Expected Deductible by the member	Two decimal places. 0 if amount equals zero. Blank if missing.	x	0.0%			x	

x	OOP or amt_pat_paid	Expected Patient paid amount. Amount patient paid. Required if co-payment, co-insurance or deductible are missing	Two decimal places. 0 if amount equals zero. Blank if missing.	x	0.0%		x	x	
x	Billed or amt_billed	Payer reported charges or billed amount for the service	Two decimal places. 0 if amount equals zero. Blank if missing.	x	0.0%				
x	amt_COB	Coordination of benefit claim amount paid	Two decimal places. 0 if amount equals zero. Blank if missing.	x	1.2%			x	
x	Pay_to_Patient	Pay to patient	y (directly reimbursed), N (not directly reimbursed), N (if unknown)	x	0.0%				
x	Amt_Prepaid	Prepaid amount	Two decimal places. 0 if amount equals zero. Blank if missing.	x	0.0%				
x	sensitive_condition_Flag	Identifies if a claim is a sensitive condition. See logic in sensitive condition tab	Y , N			x			
x	sensitive_condition_Flag_desc	Sensitive condition description	Y (yes), N (no)			x			
x	Orphan_claim_Line_flag	Identifies if a claim is an orphan claim with no link to any monthly eligibility segment +/- 12 months from the date of service	Y (yes), N (no)			x			
	Data Elements Avaliable Only for Medical Claims:								
x	TOB or UB_bill_type	Type of bill on the uniform billing form (UB)	See type of bill table	x	1.2%			x	
x	UB_bill_factype_desc	Type of bill description	See type of bill table			x			
x	POS	Industry standard place of service code	See place of service table	x	1.2%		x	x	
x	Adm_date	Admission date required for inpatient hospitalizations	YYYY-MM-DD	x	1.2%				
x	Dis_date	Discharge date required for inpatient hospitalization	YYYY-MM-DD	x	1.2%				
x	admtype	Admission type is required for inpatient claims	1 (Emergency), 2 (Urgent), 3 (Elective), 4 (Newborn), 5 (Trauma Center), 9 (Information Not Available)	x	1.2%				

x	admsrc	Admission source is required for inpatient claims	See admission source table	x	1.2%				
x	admdiag	Admitting diagnosis required for inpatient claims. ICD-9 for dates of service before 10/01/2014 and ICD-10 on or after	Alphanumeric	x	1.2%				
x	ptstatus or dis_stat	Status for member discharged from the hospital	See discharge status table	x	1.2%		x	x	
x	los	length of inpatient hospital stay. Length of stay equals discharge date minus admission date	Equals 1 or more for inpatient hospitalizations			x	x	x	
x	ICD version or ICD_10_OR_HIGHER	Specifies the claim ICD version ICD9 or ICD10	9 or 10	x	0.0%		x	x	
x	dx1 or ICD_DIAG_01_Primary	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%		x	x	
x	dx1 description or ICD_DIAG_DESC_PRIMARY	Primary diagnosis description	Text			x			
x	dx2 or ICD_DIAG_02	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx3 or ICD_DIAG_03	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx4 or ICD_DIAG_04	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx5 or ICD_DIAG_05	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx6 or ICD_DIAG_06	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx7 or ICD_DIAG_07	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx8 or ICD_DIAG_08	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx9 or ICD_DIAG_09	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx10 or ICD_DIAG_10	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx11 or ICD_DIAG_11	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	dx12 or ICD_DIAG_12	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	

x	dx13 or ICD_DIAG_13	Principal diagnosis. ICD-9 for dates of service before 10/01/2014 and ICD-10 after	Alphanumeric	x	1.2%			x	
x	ICD_DX_AHRQ_CSS_L1	AHRQ highest level grouping for primary diagnosis	Text			x			
x	ICD_DX_AHRQ_CSS_L2	AHRQ second highest level grouping for primary diagnosis	Text			x			
x	ICD9_DX_AHRQ_CSS_L3	AHRQ third highest level grouping for primary diagnosis ICD9	Text			x			
x	ICD10_DX_AHRQ_CSS_L3	AHRQ third highest level grouping for primary diagnosis ICD10	Text			x			
x	px1 or ICD_Proc_01_Principle	The main or principal inpatient surgery ICD code	Alphanumeric	x	1.2%		x	x	
x	px2 or ICD_Proc_02	Inpatient surgery ICD code 2	Alphanumeric	x	1.2%			x	
x	px3 or ICD_Proc_03	Inpatient surgery ICD code 3	Alphanumeric	x	1.2%			x	
x	px4 or ICD_Proc_04	Inpatient surgery ICD code 4	Alphanumeric	x	1.2%			x	
x	px5 or ICD_Proc_05	Inpatient surgery ICD code 5	Alphanumeric	x	1.2%			x	
x	px6 or ICD_Proc_06	Inpatient surgery ICD code 6	Alphanumeric	x	1.2%			x	
x	px7 or ICD_Proc_07	Inpatient surgery ICD code 7	Alphanumeric	x	1.2%			x	
x	px8 or ICD_Proc_08	Inpatient surgery ICD code 8	Alphanumeric	x	1.2%			x	
x	px9 or ICD_Proc_09	Inpatient surgery ICD code 9	Alphanumeric	x	1.2%			x	
x	px10 or ICD_Proc_10	Inpatient surgery ICD code 10	Alphanumeric	x	1.2%			x	
x	px11 or ICD_Proc_11	Inpatient surgery ICD code 11	Alphanumeric	x	1.2%			x	
x	px12 or ICD_Proc_12	Inpatient surgery ICD code 12	Alphanumeric	x	1.2%			x	
x	px13 or ICD_Proc_13	Inpatient surgery ICD code 13	Alphanumeric	x	1.2%			x	
x	poa1	Inpatient present on admission flag for diagnosis 1. Required if diagnosis 1 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa2	Present on admission flag for diagnosis 2. Required if diagnosis 2 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	

x	poa3	Present on admission flag for diagnosis 3. Required if diagnosis 3 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa4	Present on admission flag for diagnosis 4. Required if diagnosis 4 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa5	Present on admission flag for diagnosis 5. Required if diagnosis 5 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa6	Present on admission flag for diagnosis 6. Required if diagnosis 6 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	

x	poa7	Present on admission flag for diagnosis 7. Required if diagnosis 7 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa8	Present on admission flag for diagnosis 8. Required if diagnosis 8 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa9	Present on admission flag for diagnosis 9. Required if diagnosis 9 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa10	Present on admission flag for diagnosis 10. Required if diagnosis 10 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	

x	poa11	Present on admission flag for diagnosis 11. Required if diagnosis 11 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa12	Present on admission flag for diagnosis 12. Required if diagnosis 12 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	poa13	Present on admission flag for diagnosis 13. Required if diagnosis 13 is populated	Y (Yes), N (no), W (clinically undetermined), U (information not in record), diagnosis exempt from POA reporting (1), Null if not reported	x	1.2%			x	
x	proccode or Proc_code	The Current Procedural Terminology (CPT) code or the Healthcare Common Procedure Coding System (HCPCS) code	Alphanumeric	x	1.2%		x	x	
x	proc_desc	CPT and HCPCS code descriptions	Text			x		x	
x	proc_code_ and_ desc	CPT and HCPCS code and description	Text			x			
x	proc_code_ family_ID	High level grouping procedure codes from HRT HCPCS code reference	Text			x			
x	proc_code_ family_level_1	Highest level procedure code groups from HRT HCPCS	Text			x			
x	proc_code_ family_level_2	Second Highest level procedure code groups from HRT HCPCS	Text			x			
x	proc_code_ family_level_3	Lowest level procedure code groups from HRT HCPCS	Text			x			
x	proc_code_ ahrq_ccs	Agency for Healthcare Research and Quality (AHRQ) clinical classification grouping of procedure codes (CPT or HCPCS)	Text			x			

x	mod1	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html	See modifiers table	x	1.2%			x	
x	mod2	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html	See modifiers table	x	1.2%			x	
x	mod3	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html	See modifiers table	x	1.2%			x	
x	mod4	CPT or HCPCS modifier with all digits and numeric codes https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/Alpha-Numeric-HCPCS.html	See modifiers table	x	1.2%			x	
x	revcode or rev_code	Revenue code	Numeric	x	1.2%			x	
x	MI_MS_DRG_Code	Vendor derived DRG code version 25+	Text			x			
x	MI_MS_DRG_desc	Vendor derived DRG code description version 25+	Text			x			
x	MI_MS_DRG_Code_and_desc	Vendor derived DRG code and description version	Text			x			
x	msdrg	MS DRG is a Medicare grouping system that classifies inpatient hospital services into one of approximately 750 groups.	Text			x	x	x	
x	ms_drg_desc	MS DRG code description	Text			x			
x	ms_drg_code_and_desc	MS DRG code and description	Text			x			
x	MR_procs_raw	HCG source number of procedures	Text			x			
x	PPACA_Preven	HCG source indicates service is preventable	Text			x			
x	MR_exclusion_code	Indicates service may be excluded because it is zero allowed or not covered under typical benefits	Text			x			
x	PBP_line_code_and_desc	Medicare Plan Benefit Package defined benefit service category	Text			x			
x	MA_line_Det_code_and_desc	Medicare Advantage codes and descriptions	Text			x			
x	MA_line_code_and_desc	Medicare Advantage code descriptions	Text			x			
x	cchg	Chronic condition hierarchical group (CCHG) is a proprietary grouping algorith.	Alphanumeric			x			
x	cchg_desc	CCHG descriptions	Text			x			
x	cchg_cat_code_and_desc	CCHG and CCHG_des	Text			x			
x	megcode	Medical episode group (MEG) is a vendor proprietary grouping algorithm that creates episodes of care that describe a patient's complete course of care for a single illness or condition	Alphanumeric			x	x	x	
x	megdesc	MEG episode description	Alphanumeric			x	x	x	

x	megbodysys	MEG body system uses a proprietary grouping algorithm and groups episodes of care into body systems	Alphanumeric			x	x	x	
x	MEG_rollup	MEG rollup	Text			x			
x	megstage	MEG stage of the given episode	Alphanumeric			x	x	x	
x	MEG_high_stage	MEG disease stage within episode	Text						
x	megtype	MEG Type of care episode	Alphanumeric			x	x	x	
x	megcomplete	MEG indicator that episode is complete.	1 (yes), 0 (no)			x	x	x	
x	megnum	MEG unique identifier for a single episode	Numeric			x	x	x	
x	megdays	MEG duration of episode in days	Numeric			x	x	x	
x	MEG_Episode_Months_duration	Total number of months	Numeric						
x	megprorate	MEG prorated episode allowed amount allocation for the given service line. This field allows a user to sum detail lines for an overall episode count. Summing this field over all related service lines for a given episode will yield a result of 1.	Numeric			x	x	x	
x	MEG_EPISODE_count_paid_prorate	Prorated episode paid amount allocation for service line	Numeric			x		x	
x	megoutlier	MEG indicator for an outlier episode	1 (yes), 0 (no)			x	x	x	
x	meglow	MEG indicator for low outlier episode	1 (yes), 0 (no)			x	x	x	
x	meghigh	MEG indicator for high outlier episode	1 (yes), 0 (no)			x	x	x	
x	MEG_Min_Incurred_Month_start_date	MEG start month for episode	Text			x			
x	MEG_Max_Incurred_Month_start_date	MEG end month for episode	Text			x			
x	MEG_Episode_primary_prov_ID	MEG vendor defined primary provider	Text			x			
x	MEG_Episode_managing_prov_ID	MEG vendor defined managing provider	Text			x			
x	MEG_Episode_Top_facility_Prov_ID	MEG vendor defined facility	Text			x			
x	MEG_Episode_Top_facility_prov_name	MEG vendor defined name	Text			x			
	Data Elements Available Only for Pharmacy Claims:								
x	NDC	National Drug Code	Text	x	1.2%		x	x	
x	NDC_Prod_Name	Name of the drug associated with NDC	Text			x			
x	NDC_Code_and_ Prod_Name	NDC code and NDC_Prod_Name	Text			x			
x	rxclass or Ther_class	NDC therapeutic class. Medi-Span defined grouping of drugs with the same therapeutic properties	The first 10 characters of Medi-Span's Generic Product Identifier (GPI)			x	x	x	
x	Main	NDC therapeutic class. Medi-Span defined grouping of drugs with the same therapeutic properties. Name of class	Text			x			
x	Manufacturer_Name	Name of the company that manufactured the drug	Text			x			
x	Product_description	Drug name, dose, strength	Text			x			
x	GPIgenericName	Medi-Span generic product indicator	Text			x			

x	brand	Indicates if the drug is available as a generic, brand or over the counter	Multiple source brand (MSB), single source brand (SSB), over the counter (OTC)	x			x	x	
x	brand_status_rollup	Roll up indicates if brand or generic	Text			x			
x	Dosage_form	Medium of drug delivery i.e., foam, gel, tablet	Text	x					
x	Strength	Amount or potency of the drug	Text	x					
x	qtydisp	Quantity dispensed	Numeric	x	1.2%		x	x	
x	rxdays	Number of days that the drug will last if taken at the prescribed dose	Numeric	x	1.2%		x	x	
x	RX_Refills	Count of times prescription refilled	Numeric	x	1.2%				
x	rxcompound	Indicates if it is a compound drug	1 (no), 2 (yes) , Null, [0 and 9 are not valid values]	x	1.2%			x	
x	subcat1	Medi-Span second level rollup of therapeutic drugs	Text			x			
x	subcat2	Medi-Span third level rollup of therapeutic drugs	Text			x			
x	daw	Dispense as written. Indicates if the provider authorized a drug substitution	See dispense as written table	x	1.2%		x	x	
x	Alternate_refil_num	alternate refill number	Text	x					
x	Substitution_type	One of seven substitution methods used	Generic bioequivalence, drug bioequivalence, Generic no bioequivalence, drug no bioequivalence, TCS no bioequivalence, Therapeutic no bioequivalence, and drug class no bioequivalence			x			
x	NDC_sub	Unique idenfier for for substituted drug	Text			x			
x	NDC_product_name_sub	Name of substituted drug	Text			x			
x	NDC_code_and_prod_name_sub	NDC_sub and NCD_Product_name_sub	Text			x			
x	Brand-status_sub	Indicates if substituted drug is available	generic, multiple source, single source or over the counter			x			
x	Dosage_form_sub	Medium substituted drug delivered	foam, gel, tablet			x			

x	Strength_sub	Amount or potency of the substituted drug	Text			x			
x	Brands_status_rollup_sub	Indicates if drug substitutes is brand or generic	Text			x			
x	Manufacturer_Name_sub	Name of the substituted drug company	Text			x			
x	Product_descrption_sub	Substituted drug name, dose, strength	Text			x			
x	GPIgenericName_sub	Medi-Span substituted generic product indicator	Text			x			
x	Pharmacy name	Pharmacy name	Text	x	1.2%				
x	Pharmacy city	Pharmacy city	Text	x	1.2%				
x	Pharmacy state	Pharmacy state	Text	x	1.2%				
x	Pharmacy zip	Pharmacy zip	Text	x	1.2%				
x	ingredient cost/list price	ingredient cost/list price	Numeric	x	0.0%				
x	dispensing fee paid	dispensing fee paid	Numeric	x	0.0%				
	Data Elements Available for Member Demographic Data (static except for age related data elements):								
x	patid or member ID or member_key	Payer specific unique person identifier created from payer reported identifier. Not unique across payers and plans	Numeric	x	0.0%			x	
x	personkey or MI_Person_key	Unique identifier created for a person across payers and data years	Numeric			x		x	
x	gender or Mem_gender	Member Gender	M (male), F (female), and U (unknown)	x	1.2%		x	x	
x	Age	Age of the member calculated based on month of eligibility	Numeric			x			
x	race or mem_race	Member race reported by payer. Static from latest quarterly data submitted. Race data for 59% of unique people is missing or unknown.	4 (Asian), 2 (Black or African American), 3 (American Indian or Alaskan Native), 5 (Native Hawaiian or Pacific Islander), 1 (White), 6 (other or multiple races), 9 (unknown) and 0 (not defined)	x			x	x	
x	ethn or mem_ethnicity	Member ethnicity reported by payer. Static from latest quarterly data submitted. Ethnicity data for 72% of unique people is missing or unknown.	1 (Hispanic), 2 (Not Hispanic), 3 (unknown), Null	x			x	x	
x	lang or Mem_language	Primary spoken language; Static from latest quarterly data submitted. Payers report three-character string from ANSI/NISO https://www.loc.gov/standards/iso639-2/php/code_list.php Vendor recodes ANSI/NISO to numeric codes. Language data for 50% of unique persons is missing	Numeric. See language table	x			x	x	

x	MSA or Mem_MSA	Member metropolitan statistical area defined by US Census. Static from latest quarterly data submitted	Text			x	x	x	
x	Member_MSA_Name	Name of metropolitan statistical area. Static from latest quarterly data submitted	Text			x			
x	STATE or Mem_state	Member State. Static from latest quarterly data submitted	Two letter abreviation	x	1.2%			x	
x	urban	Zip codes grouped into urban and rural identified by OHA. Static from latest quarterly data submitted	1 (Urban), 2 (not Urban)			x	x		
	Data Elements Available for Monthly Member Eligibility Data:								
x	YEAR and incurred_year	Year of service or eligibility occurred	YYYY			x			
x	YEARMONTH and incurred_year_and_month	Year and month service or eligibility occurred	YYYYMM			x			
x	incurred_month_start_date	First day of the month the service or membership occurred	YYYY-MM-DD			x			
	incurred_cal_quarter	Quarter month the service or eligibility occurred	Numeric			x			
x	patid and member ID and member_key	Payer specific unique person identifier created from payer reported identifier. Not unique across payers and years	Numeric	x	0.0%				
x	personkey or MI_Person_key	Vendor created unique identifier for a person across payers and years	Numeric			x			
	MEMBER_ID_ENCRYPTED	Encrypted unique person identifier created from payer reported identifier. Not unique across payers and plans	Text			x			
x	SUBSCRIBER_KEY	Payer specific unique identifier for the person with employer paid insurance, Medicaid coverage or the person who purchased insurance	Numeric	x	1.2%				
x	Relation	Member's relationship to the subscriber i.e., spouse, child, dependent	See relationship table	x	1.2%				
x	Medicare_coverage_ flag	Medicare coverage reported by payer. X (other), C (Medicare part C only), D (Medicare part D only), CD (Medicare parts C and D), B (Medicare Part B), AB (Medicare parts A and B), Z (none), Null and blank	X , C , D , CD , B , AB , Z , Null and blank	x	1.2%				
x	PAYER_LOB	Payer line of business derived from payer reported product code from eligibility data only and not claims data. Orphan claims assigned null.	Commercial, Medicaid, Medicare or null. See product code table for crosswalk			x			
x	paytype or MC001_APAC _Payer_type	Payer type codes reported by payer for eligibility data only and not from claims data	C, D, G, P, T, U	x					

x	MC001_APAC _Payer_type_desc	Payer type description	(C) Carrier, (D) Medicaid, (G) Other government agency, (P) Pharmacy benefits manager, (T) Third-party administrator, (U) Unlicensed entity			x			
x	prod or APAC_Product_code	Payer reported product code from eligibility data only and not claims data. No null values	See product code table	x	0.0%				
x	APAC_Product_code_code_and_desc	Product code description	See product code table			x			
x	EFF_DATE	First day of the month member enrolled	YYYY-MM-DD	x	0.0%				
x	TERM_DATE	Last day of the month member enrolled	YYYY-MM-DD	x	0.0%				
x	MI_Post_date	End of the posting period for membership load	YYYY-MM-DD			x			
x	primary or primary_insurance	Primary Insurance Indicator	Y (primary insurance), N (secondary or tertiary insurance). If unknown, default to Y	x	0.0%				
x	Prod_type	Derived type of membership. If member eligible for medical and payer is not behavioral health and is not pharmacy plan and is not Medicare part D then equals medical. If member eligible for pharmacy and payer is not behavioral health then equals pharmacy. Behavioral health if payer is behavioral health. The behavioral health type was created to mark duplicate medical member months. Medical Coverage is assigned if Medical_coverage_flag (ME018) =1 and payer is not behavioral health and payer type (ME001) is not pharmacy and product_code (ME003) is not pharmacy or Medicare part D. Rx Coverage is assigned if Prescription Drug Coverage Flag (ME019) =1 and payer is not behavioral health and submitter_abbr column does not equal 'OMIP'. Behavioral Health is assigned if Medical_coverage_flag (ME018) =1 and payer is behavioral health. Prod_type or prod_type_Key necessary for analysis of member months	Text: medical, rx, dental, behavioral, vision [No dental or vision in APAC]			x			

x	Prod_type_key	Generated number that represents the type of membership Prod_type. This key is used to join claims with monthly member data for efficiency. Necessary for analysis of member months	Integer: 0 (combined), 1(medical member month), 2 (pharmacy member month), 4 (vision member month), 6 (behavioral health member month)			x			
x	MM_UNITS	Flag that indicates medical coverage for the month for the member	Numeric: 1 (yes), 0 (no)			x			
x	RX_UNITS	Flag that indicates prescription drug coverage for the month for the member	Numeric: 1 (yes), 0 (no)			x			
x	Sub_MM_UNITS	Flag that indicates medical coverage for the month for the subscriber	Numeric: 1 (yes), 0 (no)			x			
x	Sub_RX_UNITS	Flag that indicates prescription drug coverage for the month for the subscriber	Numeric: 1 (yes), 0 (no)			x			
x	TPA_OR_PBM_DUPLICATE_MM	Identifies duplicate member months reported by third party administrator or pharmacy benefit manager for the month	1 , 2 , 0			x			
x	TPA_OR_PBM_DUPLICATE_MM_Desc	Description of duplicate member months reported by third party administrator or pharmacy benefit manager	1 (medical member month duplication), 2 (pharmacy member month duplication, 0 (no duplication)			x			
x	PEBB_OEBB	Public Employees Benefit Board or Oregon Educators Benefit Board covered members Oregon and out-of-state residents	PEBB, OEBB, Null		0.0%	x			
x	PEBB_OEBB_Desc	Public Employees Benefit Board or Oregon Educators Benefit Board covered members Oregon and out-of-state residents descrption	PEBB, OEBB, Null			x			
x	market	Market Segment	See market table	x	0.0%				

x	metal	Health benefit plan metal tier for qualified health plans (QHPs) and catastrophic plans as defined in the ACA	0 (Not a QHP or catastrophic plan), 1 (catastrophic0, 2 (bronze), 3 (silver), 4 (gold), 5 (platinum)	x	0.0%				
x	HDHP	High Deductible Health Plan Flag	Y (Yes), N (No)	x	1.2%				
x	OMIPflag	Oregon Medical Insurance High risk Pool flag	Y (yes), N (no)	x	1.2%				
x	HKCflag	Oregon Healthy Kids flag	Y (yes), N (no)	x	1.2%				
x	Medicareflag	Medicare coverage flag derived from HCG. Not reported by payer	Y (yes), N (no)		1.2%	x			
x	HVMHflag	Required for members in OHLC high value medical home initiative	Y (yes), N (no)	x					
x	Med_home_flag	Flag indicates medical home	1 , 0	x	0.0%				
x	Enrollment_key	Vendor generated number that represents an enrollment record. Key can be used to join claims and enrollment				x			
	Data Elements Available for Provider Data:								
x	Prov_CW_Key	Vendor created unique provider identifier across payers	Integer			x			
x	ATT_PROV_CW_KEY	Vendor created unique attending provider identifier across payers	Integer			x			
x	prov_key or ATTID or att_prov_key	Payer specific identifier number for the attending, servicing, or rendering medical or pharmacy provider. Identifier is not unique across payers	Integer		1.2%	x		x	
x	Prov_Tin or Bill_Prov_TIN	Attending or billing provider Tax identifier	Text	x	1.2%				
x	Prov_taxonomy or billid_taxonomy	NUCC provider taxonomy for the billing provider; NPI if not reported	See Health care provider taxonomy codes www.nucc.org	x					
x	spec or Attending_MI_Specialty	Vendor derived provider specialty for attending, servicing or rendering provider	See Health care provider taxonomy codes www.nucc.org			x		x	
x	ATT_HCG_Primary_Care	HCG derived primary care provider	Text			x			
x	Provider street address	Provider street address	Text	x	1.2%				
x	Provider street address2	Provider street address	Text	x	1.2%				
x	Provider city	Provider city	Text	x	1.2%				
x	ATT_PROV_ZIP	Provider location zip	Numeric	x	1.2%				
x	ATT_PROV_State	Provider location state	Text	x	1.2%				
x	billid	APAC assigned billing provider ID	Text	x	1.2%				
x	Bill_Prov_Key	Unique identifier generated for billing provider	Numeric			x			
x	Bill_Prov_ID_FAC_CW	Billing provider unique identifier across payers	Numeric			x			

x	BILL_PROV_ZIP	Billing provider zip	Five or nine digit zip code	x					
x	BILL_PROV_COUNTY	County location of billing provider derived from zip code	Text			x			
x	BILL_PROV_state	Location of pharmacy or provider	Text	x					
x	BILL_PROV_MSA_Code	Billing provider Metropolitan statistical area name derived from zip code	Text			x			
x	BILL_PROV_MSA_Name	Metropolitan statistical area name	Text			x			
x	BILL_PROV_LNAME_FAC_CW	Oregon Hospital and Oregon Ambulatory Surgical Center Names. All other null	Text			x			
	Data Elements Available for Billied Premium Data:								
x	Patid or member ID or member_key	Unique person ID created from payer reported identifier for each plan. Not unique across payers and years	Numeric			x		x	
x	Personkey or MI_Person_key	Unique identifier created for a person across payers and years	Numeric			x		x	
x	Subscriber_Key	Payer specific unique identifier for the person with employer paid insurance, Medicaid coverage or the person who purchased insurance. Not unique across payers and plans	Numeric	x	1.2%			x	
x	MC001_APAC _Payer_type_key	Payer reported payer type codes from eligibility data only and not from claims data	C, D, G, P, T, U	x					
x	APAC_Product_code_key	Payer reported product code from eligibility data only and not claims data. No null values	See product code table	x			x		
x	PEBB_OEBB	Public Employees Benefit Board or Oregon Educators Benefit Board covered members Oregon and out-of-state residents	PEBB, OEBB, Null		0.0%	x			
x	Premium_employer_paid	Monthly premium paid by employer or subscriber	Numeric	x	0.0%				
x	Premium_bill_date	Date premium billed	YYYY-MM-DD	x	0.0%				
x	Premium_Exp_date	Date premium expired	YYYY-MM-DD	x	0.0%				
x	PREM_DEP_Count	Number of dependents	Numeric	x	0.0%				
	Restricted Access Data Elements that Require Strong Justification and Detailed Data Security and Release Plan:								
x	MEMBER_COUNTY	Member county of residency derived from zip code. Static from latest quarterly data submitted	Text			x			
x	ZIP or member_zip	Static from latest quarterly data submitted	Numeric	x	1.2%				
x	cco_id_desc	Name of Medicaid coordinated care organizations	Text	x					
x	CDE_PERC	Medicaid program eligibility codes	See PERC table	x					
x	OHA_Medicaid_cde_pgm_health	Medicaid health plan type for Medicaid recipients only	See cde pgm health table	x					
x	OHA_Medicaid_cde_enroll_recip_status	Medicaid enrollment status for Medicaid recipients only	See cde enroll status table	x					
x	OHA_Medicaid_cde_del_type	Medicaid healthcare delivery system type for Medicaid recipients only: Physical Health, Mental, or Dental	See cde delivery type table	x					

x	OHA_Medicaid_cde_mc_region or CDE_MC_Region	Medicaid member managed care region location: different geographical zip codes, counties, or the entire state for Medicaid recipients only	Region values available by request	x					
x	OHA_Medicaid_cde_medicare_status	Medicare Third Party Resource (TPR) health insurance coverage for Medicaid recipients only: MA, MB, or MAB. Blank if the Mediciad recipient does not have Medicare coverage	See cde Medicare status table	x					
x	OHA_Medicaid_dosbeg	Begin date of service for Medicaid recipients only	date	x					
x	OHA_Medicaid_dosend	End date of service for Medicaid recipients only	date	x					
x	OHA_Medicaid_ind_tp	Third party payer for Medicaid members only	Y(yes), N (no)	x					
x	BR_Payer_Lob	Combines Payer_LOB and OEBB_PEBB from payer reported member eligibility. PEBB and OEBB members are removed from commercial and assigned PEBB or OEBB	Commercial, Medicaid, Medicare, PEBB, OEBB, Null	x					
x	BR_YEARMONTH	Minimum from date for the entire claim (MC059). This may be different than the from date on each service line	YYYYMM	x					
x	Product_code	OHA medicaid supplemental eligibility data file	C or M for Medicaid. All else null	x					
	Restricted Access Data Elements that Are Never Shared or Rarely Shared, require Strong Justification, Detailed Data Security and Release Plan, and Subject to DOJ review:								
x	Mem_DOB	member date of birth	YYYYMM	x	1.2%				
x	Member last name	Member last name	Text	x	1.2%				
x	Member first name	Member first name	Text	x	1.2%				
x	Member middle name	Member middle name	Text	x					
x	street address	street address	Text	x	1.2%				
x	city	city	Text	x	1.2%				

Appendix G – Staff checklist and Minimum Necessary Review (MNR) for amendments or renewals

Staff Reviewer: Mary Ann Evans

Agreement Number: 4448

Purpose
The purpose of the staff checklist for amendment or renewals is to assess whether applicant completely and adequately filled out the amendment form.

Instructions
Complete all sections. If you check "no" on any question, please detail in the "notes" section of the same row why you checked "no" and what applicant must do in order to receive a "yes".

1.

Task	Yes	No	N/A	Notes
Agreement number entered?	x			
Does agreement number and applicant listed in amendment/renewal match the agreement number and applicant in original application?	x			
Did applicant choose either "Amendment" or "Renewal"?	x			
Section 2 – Amendment (Must go to DRC for review)				
Have all additional staff signed stating they have read and are bound to the terms of the original DUA?	x			
If original application included IRB approval, does the amendment fall inside the scope of the original IRB approval?			x	
Does IRB approval have more than 3 months left? (Can be either the original IRB sent with original application is valid for more than 3 months or an amended IRB is attached and is valid for more than 3 months)			x	

If amended IRB approval is attached, does IRB application number on amendment match IRB application number on original IRB approval?			x	
If requesting new/more data, is Data Element Workbook attached?	x			
Do all requested elements have a year requested, filters applied and justification response in Data Element Workbook?	x			
If requesting a limited data set, does Data Element Workbook align with response in 2.8b-c?				
If requesting a custom data set, is it clear what elements are being requested?	x			
Is the Payers tab completed in the Data Element Workbook?	x			
If requesting Medicare FFS data, is the project at least partially funded and directed by OHA? (Per our DUA with CMS, Medicare FFS data may be shared outside of OHA for research **only if** OHA is partially funding and directing the project.)			x	
If requesting a limited data set, does Payers tab align with response in 2.8b?				
If requesting a custom data set, is it clear what	x			

payers are being requested?				
If Limited data is being requested, is payment included			x	
Do 2.8b and 2.8c correspond with the files selected and the number of year input in row c of the payment table?			x	
Is cost calculated correctly?			x	
Passes Minimum Necessary Review?	x			
Adequately justified each data element requested (provide rationale and list any data elements not adequately justified in notes)?	x			
Adequately described filters and algorithms for including and excluding claim lines (provide rationale and list strengths and weaknesses of algorithms in notes)?	x			
Consider the elements requested and whether additional elements can be excluded, redacted, or additionally filtered without unreasonably impairing the ability to accomplish the project purposes. Is data requested the minimum necessary? (If no, identify data elements that may be excluded, redacted or additionally filtered in notes.)	x			
Section 3 – Renewal (DUAs can be renewed without DRC approval)				
If applicant is renewing OHA agreement, does applicant include proper IRB documentation if necessary? (In notes, please state whether an amended IRB			x	

approval is attached, the original IRB is still valid, or original application did not include an IRB approval.)				
If applicant is renewing IRB approval, did applicant include renewed IRB approval?			x	
Does IRB application number on renewal memo match IRB application number on original IRB approval?			x	
Signatures				
Is amendment signed?	x			

Appendix D—Staff review for DRC (standardized for all Health Analytics' data requests)

Office of Health Analytics Application Number:4448_____

Staff Review Checklist

Staff Name: Mary Ann Evans

1. Data Source(s) Requested:

	APAC	

2. Application materials included:

Application Y

Payment N/A

Data Elements Worksheet Y

IRB Approval N/A

DUA

3. Has the requestor provided an overview of the project and adequately explained the need for the data? Y

   Notes:

4. Has the requestor adequately justified the need for the specific data files and elements requested? Y

   Notes:

5. Has the requestor asked for the minimum necessary data to accomplish the stated purpose? Y

   Notes:

6. Has the requestor adequately described safeguards in place to protect the data and comply with privacy and security requirements? Y

   Notes:

7. Recommendation for request: Approve

Notes: Requests identified data for surveillance