Common Health Information Reporting Partnership (CHIRP) Policies and Procedures

Approved by MNCM Board of Directors
on February 15, 2023
Last Revised March 18, 2025

MN Community MEASUREMENT

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Common Health Information Reporting Partnership (CHIRP) Governance Committee Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Membership	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: October 22, 2024
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

1.1 **Program Definition and Scope**

The Common Health Information Reporting Partnership (CHIRP) is a program established to empower stakeholders with meaningful data to drive improvement in health care quality, equity, and affordability by facilitating data sharing among health care payers and health care providers for specified use cases.

2.1 **Governance Committee Established**

The Common Health Information Reporting Partnership (CHIRP) Governance Committee is established to provide ongoing guidance on data sharing programs offered by MNCM through the CHIRP program. The scope of work for the committee includes:

2.1 Providing advice to the MNCM Board of Directors on the strategic direction for the program to ensure ongoing alignment with stakeholder needs; specifically, this includes providing recommendations on:

2.1.1 Supported use cases for provider-to-payer data sharing and payer-to-provider data sharing.

2.1.2 Action necessary to ensure ongoing alignment with stakeholder needs. This includes but is not limited to: enhancements to current programs and services, expansions in the scope of programs and services, enhancements/investments needed in technical infrastructure/technologies.

2.2 Advising staff on ongoing program operations across five critical domains: governance, legal/policy, finance, technical infrastructure, and business operations.

2.3 Engaging Technical Advisory Groups as needed to inform the development of committee recommendations to the Board of Directors.

3.1 **CHIRP Governance Committee Leadership**

The CHIRP Governance Committee will be led by two co-chairs, appointed by the MNCM Board Chair and must include one health care payer representative and one health care provider representative.

3.1 Terms: Following the start-up period of the CHIRP program, Co-chair terms are two years in length, staggered to ensure continuity. After the initial term, co-chairs have the option to renew for two additional terms. At the end of the third term, co-chairs may reapply for appointment.

3.2 Board Liaison: If neither of the co-chairs is a member of the Board of Directors, the MNCM Board Chair will appoint a committee member who also serves on the Board to act as the committee liaison to the Board of Directors.

4.1 **CHIRP Governance Committee Members**

CHIRP Governance Committee members are recommended by the co-chairs and approved by the MNCM Board Chair, following an application process. Following the start-up period for the CHIRP Governance Committee, as advised by the Board of Directors, all committee members must be from health care payer organizations and health care provider organizations that are active participants in CHIRP.

4.1 Size: The Governance Committee shall include a minimum of 12 members, including the co-chairs. Additional members may be added at the discretion of the Board Chair up to a maximum of 16 members.

4.2 Terms: When the committee is formed, terms will be established for each position on the committee with all terms ending during month of December. Initial appointments will be staggered, with half of the representatives for each category with terms ending in the odd year, and half of the representatives for each category with terms ending in the even year. Following the initial appointments, committee member terms will be two years in length.

After an appointee has completed one term, the committee member will have the option to renew for two additional terms. At the end of the third term, committee members may reapply for appointment. If a position is vacated, and a new appointment is made outside of the normal cycle, the new appointee will complete the established term, and will have the option to renew for three additional terms.

4.3 Balance: The committee shall include an equal balance of health care payer and health care provider representatives.

Representation Type	**Minimum Number of Members**
Payer Organizations	6
Provider Organizations (e.g., health systems, hospitals, clinics)	6

4.4 Diversity: In the appointment of members, the committee co-chairs and MNCM Board Chair shall strive to ensure the committee includes diverse representation. Considerations within the overarching representation types include:

4.4.1 Health care providers including but not limited to: medical directors, physicians, physician assistants, nurses, and pharmacists

4.4.2 Professionals working in finance, data analysis, quality improvement and clinic administration

4.4.3 Experience in measurement/quality improvement

4.4.4 Race/ethnicity diversity

4.4.5 Size of medical group/clinic or payer

4.4.6 Geographic diversity - metro vs. non-metro medical group or payer location/populations served

4.4.7 Safety net medical groups and payers that serve disadvantaged populations

4.5 Members of the Board of Directors will be directly appointed to the CHIRP Governance Committee by the MNCM Board Chair as appropriate. These members will not be subject to the term limits and application processes of committee members. However, if the committee member has completed their service on the Board of Directors, they must reapply for their position on the CHIRP Governance Committee if they wish to continue serving on the committee.

5.1 **Committee Operations**

5.1 Quorum: 51% of membership present.

5.2 Frequency: Meetings will be held semi-annually at minimum, with the frequency adjusted by the co-chairs as needed depending on program needs.

5.3 Attendance: Committee members must attend/participate in 50% of the meetings each year. The co-chairs can recommend removal of a CHIRP Governance Committee member if attendance requirements are not met.

5.4 Application Process for New Members: Information on openings on the committee will be sent via email to the primary contacts for all CHIRP participating organizations as identified in their annual participant update. The communication will include a link to the online application.

5.5 End of Term Process: For community committee members approaching the end of a term, MNCM staff will send an email reminder to confirm continuation of position on the committee. Committee members wishing to resign at the end of their term should submit a written notice of their intent to resign to MNCM staff. MNCM staff will provide

the notice of resignation to CHIRP Governance Committee co-chairs. No further action is needed for committee members choosing to continue with their position.

5.6 End of Third Term Process: For committee members approaching the end of three terms, MNCM will send an email reminder with the option to reapply for their position. Committee members wishing to resign at the end of their three terms should submit a written notice of their intent to resign to MNCM staff. MNCM staff will provide the notice of resignation to CHIRP co-chairs. Committee members interested in continuing as a committee member on the CHIRP Governance Committee should reapply for the position. However, the position is not guaranteed to these committee members.

5.7 Committee Member Replacement: If a committee member decides to resign from the committee before the end of a term, the committee member cannot transfer their position to another employee within their organization. To fill the vacancy, the process is treated the same as if the committee member resigned at the end of their term – the suggested replacement will need to apply for the position.

5.8 Conflict of Interest (COI): At the beginning of each year, committee members will be asked to complete MNCM's COI form. CHIRP co-chairs will review these forms annually along with any applications for new committee members.

COMMON HEALTH INFORMATION REPORTING PARTNERSHIP (CHIRP) TECHNICAL ADVISORY GROUP

CHARTER

APPROVED BY MNCM BOARD FEBRUARY 15, 2023

Purpose: The Common Health Information Reporting Partnership (CHIRP) Technical Advisory Group (TAG) is established to provide technical guidance and input into the development of CHIRP programs focused on common standards and facilitated data transfers among payers and providers. The scope of its work includes addressing issues pertaining to uniform content, processes, and flow of person-level claims and clinical data shared between payers and providers.

Background and Value Proposition:

As payment systems are changing from traditional fee-for-service to value-based payment models, providers, health systems and payers are becoming more reliant on data than ever before to inform their strategies, achieve goals for value-based care, and earn financial incentives tied to performance. Existing mechanisms for sharing of health care data needed to improve cost and quality performance are fragmented and lack alignment. Variation exists related to timeliness, scope and content of data as well as frequency of and mechanisms for sharing data. This results in duplication of effort and inefficiencies for both payers and providers and poses a significant challenge for efficient care delivery, population health management, and quality measurement – all factors that are key to success in this new environment.

MNCM convened the Common Health Information Reporting Partnership (CHIRP) Workgroup to develop recommendations on how MNCM could assist the community in addressing these challenges. After substantial discussion, this multi-stakeholder group moved forward with development and voluntary adoption of standards to promote alignment on content, processes and flow of person-level claims and clinical data between payers and providers, and subsequently defined a role for MNCM in facilitating data transfers among payers and providers. This TAG is established to do the detailed work to ensure the CHIRP standards remain aligned with evolving stakeholder needs and implementing the facilitated data sharing services according to the common standards adopted by the CHIRP Governance Committee. MNCM will provide substantial staff support for the TAG's work.

Scope: The scope of the TAG's work includes providing technical guidance to advance consistency of content, process, and flow of data for facilitated data transfers among payers and providers. Potential work products may include one or more of the following:

- List of data elements and definitions to be included
- Agreement on uniform timing, frequency, and format for data delivery
- Agreement on uniform mechanisms for sending and receiving data and reports
- Other ideas brought forward by TAG members

Time Commitment and Meeting Schedule

The group is set to meet a minimum of two times a year annually to meet responsibility requirements for the CHIRP Governance Committee. Meetings will be scheduled as followed:

- Spring (after the Spring CHIRP Governance Committee meeting)
- Fall (after the Fall CHIRP Governance meeting)

Additional meetings may be held based on the discretion of the CHIRP Governance Committee needs. Each meeting will be a duration of 90-minutes, held virtually. Participants will also need some time for meeting preparation, information gathering between meetings, and internal vetting of proposals.

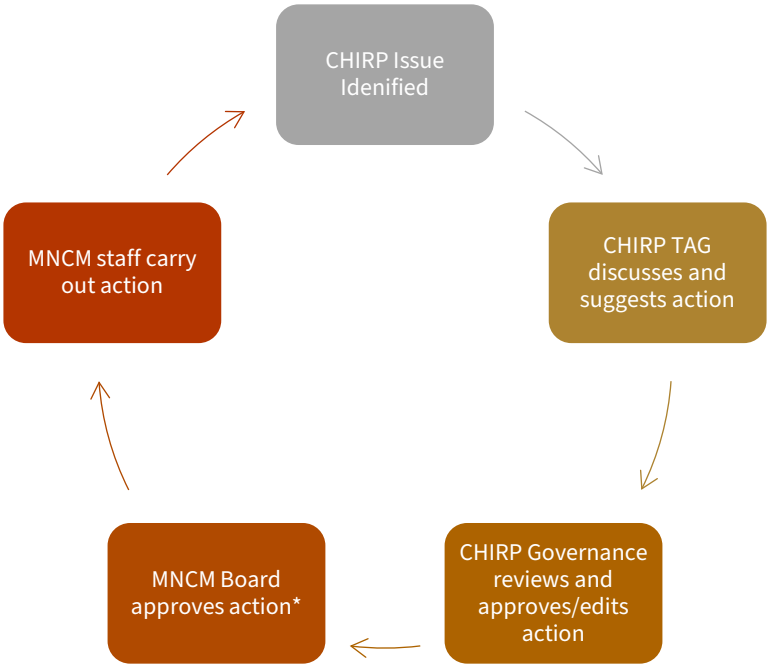
The following table is provided as a resource to understand the roles and separation of duties between the CHIRP Governance Committee and the CHIRP Technical Advisory Group.

Table 1: Separation of Duties for CHIRP Governance Committee and CHIRP TAG

	CHIRP Governance Committee	CHIRP TAG
Who directs their work?	- MNCM Board Adopts Governance Policy, considers recommendations from CHIRP Governance Committee, establishes annual budget	- CHIRP Governance Committee Identifies issues requiring deeper technical guidance and delegates to the CHIRP TAG as appropriate. Considers input from the TAG in formulating recommendations to MNCM Board.
Scope	- Annual review of CHIRP Data Standard - Provide ongoing guidance on data sharing programs offered by MNCM through the CHIRP program	- Data enhancements - List of data elements and definitions to be included - Agreement on uniform timing, frequency, and format for data delivery - Agreement on uniform mechanisms for sending and receiving data and reports
Responsibilities	- Providing advice to the MNCM Board of Directors on the strategic direction (Use Cases & necessary action related to CHIRP) - Advise MNCM staff on ongoing program operations - Engage CHIRP TAG to investigate recommendations	- Investigate CHIRP technical considerations, needs and best practices for CHIRP governance

Schedule	Meets minimum two times a year
	- Spring
	  o Review CHIRP Data Standards
	  o Recommend any enhancements to be made following year Q1
	- Fall
	  o Strategic Direction for CHIRP
	  o Program Operations
		Meets minimum two times a year
		- Spring
		  o Data Enhancement Development
		- Fall
		  o Investigates needs based on Governance Meeting
		- Ad Hoc meetings as necessary

The following diagram illustrates an example flow of work for the CHIRP TAG, CHIRP Governance Committee, MNCM Board, and MNCM Staff.



*Note: Not all actions will need to obtain MNCM Board approval

Common Health Information Reporting Partnership (CHIRP) Provider-to-Payer Use Cases Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Use Cases	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: February 15, 2023
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

#	Use Case Name	Description	Date Approved/ Updated
1	Health Care Provider Authorization to Send CHIRP Provider-to-Payer Clinical Data to Payers	Allow MNCM PIPE participants the option of having their clinical data shared via the MNCM CHIRP program to payer organizations. 1. Data would be shared with a payer or payers only if the participant agrees to permit such sharing, and only for uses mutually agreed-upon by the payer and participant as specified in the CHIRP Provider-to-Payer policies and procedures. 2. Patient data would be sent to the payer only if both the following criteria are met: (a) the patient appears on the current Member Enrollment file supplied to MNCM by the payer; and (b) the patient is identified in the PIPE medical group participant's Demographic File as being covered by the payer on the date of the submission.	February 15, 2023
2	Health Care Payer Use of CHIRP Provider-to-Payer Clinical Data	The Use Case allows Participants, which are health care payers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, for care management, collection of quality data and risk adjustment. No other access to, and use of, Health Data is permitted under this Use Case.	February 15, 2023

DATA SPECIFICATIONS

Common Health Information Reporting Partnership (CHIRP):

Provider to Payer Data Standard & Flat File Format for CHIRP Data

Version 1

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SUMMARY OF CHANGES

Changes as compared to the *CHIRP Provider to Payer Data Standard and Flat File Format v1.3 FINAL 7-11-2023* document:

- To conform to the HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA's Data Aggregator Validation (DAV) program, the following data elements approved for the CHIRP Data Standard by the CHIRP Governance Committee will **not be included in any CCDs**. These data elements **are included** in the CHIRP Data file formats specified in this document. The description and *Included Data Fields* list in the CHIRP Provider-to-Payer Data Standard section has been updated to reflect this change.
    - Patient Status (Demographic File)
    - Preferred Language Other (Demographic File)
    - Provider Specialty – Other (Encounter File)
    - Lab Type (Lab/Procedure File)
    - Procedure Type (Lab/Procedure File)
- The CHIRP Data files will only contain data that has **not** been certified by the DAV program; therefore, the DAV Status fields have been removed from all files. **No data** in these files have been certified as Standard Supplemental data by NCQA's DAV Program.
- Individual file descriptions and file names have been updated for consistency and clarity.

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CHIRP PROVIDER-TO-PAYER DATA STANDARD

The CHIRP Provider-to-Payer Data Standard encompasses the data elements currently approved by the CHIRP Governance Committee. The historical look back periods were defined as an accepted use case by the committee.

The HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA's Data Aggregator Validation (DAV) program does not allow for inclusion of all committee approved data elements. The fields marked with an asterisk in the table below, including Patient Status, Preferred Language Other, Lab Type, Procedure Type, and Provider Specialty – Other, **are not included** in the DAV Certified Standard Supplemental Data file formats or any outbound CCDs. They **are included** in the CHIRP Data file formats.

Matched patients/members from DAV Certified medical groups are included in the CHIRP Data files for the express purpose of sharing these five data elements. All other CHIRP specified data elements for these patients/members are present in the DAV Certified Standard Supplemental Data files and CCDs.

Included Data Fields	
Patient ID	Lab Service Date
Patient Full First Name	Lab Code
Patient Last Name	Lab Type*
Patient Date of Birth (DOB)	Lab Result
Patient Sex at Birth	Procedure Date
Patient Date of Death (DOD)	Procedure Code
Patient Status*	Procedure Type*
Race1	Date of Encounter
Race2	Encounter / CPT Service Code
Race3	Encounter Clinic Name
Race4	Provider NPI *(associated with encounter)*
Race5	Provider Specialty *(associated with encounter)*
Ethnicity	Provider Specialty – Other *(associated with encounter)**
Preferred Language	Height *(associated with encounter)*
Preferred Language Other*	Weight *(associated with encounter)*
Street Address	Tobacco Status *(associated with encounter)*
City	Diagnosis Coding System *(associated with encounter)*
State	Diagnosis Code(s) *(associated with encounter)*
ZIP Code	
Insurance	
Insurance Member ID	
Blood Pressure Date	
Blood Pressure Time	
Systolic Reading	
Diastolic Reading	

Included Clinical Data Types

Mammography
HbA1C Value
Cervical Cytology
HR-HPV Test
Chlamydia Test
Colonoscopy
CT Colonography
FIT-DNA
Flexible Sigmoidoscopy
FOBT
uACR Test
eGFR Test
Tobacco Use

Immunizations

- DTaP Immunization
- Inactivated Polio Immunization
- Measles Mumps Rubella Immunization
- Measles Rubella Immunization
- Measles Immunization
- Mumps Immunization
- Rubella Immunization
- Haemophilus Influenzae Immunization
- Hepatitis B Immunization
- Varicella Zoster Immunization
- Pneumococcal Conjugate Immunization
- Hepatitis A Immunization
- Rotavirus Immunization
- Influenza Immunization
- Human Papillomavirus Immunization
- Meningococcal Conjugate Immunization
- Tdap Immunization

Historical Look Back Periods

- Demographic File will contain most current information, no historical data will be provided
- Encounter File will include one year of historical data from last date of service in the cycle
- Blood Pressure file will be one year of data from last date of service in the cycle
- Lab/Procedure File will have measure specific look back periods
    - Within 10 years of last date of service in the cycle: Colonoscopy
    - Within five years of last date of service in the cycle: cervical cytology, high risk human papillomavirus (hrHPV), sigmoidoscopies, CT colonography
    - Within four years of last date of service in the cycle: immunizations
    - Within three years of last date of service in the cycle: mammography, and stool DNA (sDNA) with FIT tests
    - Within one year of last date of service in the cycle: FOBT, and lab tests (a1c, uACR, eGFR)

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CHIRP DATA FLAT FILE FORMATS

These flat file formats contain all data elements specified in the CHIRP data standard. The flat files are offered as a complement to the corresponding NCQA specified CCD file(s) for use by payers unable to ingest CCDs. **None of the data** in these files have been certified as Standard Supplemental data by NCQA's DAV Program.

CHIRP_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Patient Full First Name	Full first name of the patient.	String
6	Patient Last Name	Last name of the patient.	String
7	Patient Date of Birth (DOB)		yyyy-mm-dd
8	Patient Sex at Birth	F = Female M = Male U = Unknown/Undefined	Text; 1 character
9	Patient Date of Death (DOD)		yyyy-mm-dd
10	Patient Status	0 = Deceased 1 = Alive	Number, 1 digit
11	Race1	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
12	Race2	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String

CHIRP_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
13	Race3	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
14	Race4	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
15	Race5	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
16	Ethnicity	Patient reported Ethnicity. If the patient was not asked for their ethnicity or if ethnicity was left blank by patient, the field is blank. See Table B for code map.	String
17	Preferred Language	Patient reported preferred language. If the patient was not asked for their preferred language or if preferred language was left blank by patient, the field is blank. See Table C for code map.	Text
18	Preferred Language Other	May contain text description of preferred language.	String; up to 50 characters
19	Street Address	Patient primary residence	String; up to 50 characters
20	City	Patient primary residence	String; up to 50 characters
21	State	Patient primary residence, Standard two-character state abbreviation.	Text; 2 characters
22	ZIP Code	Patient primary residence, Minimum of five digits	Number

CHIRP_Encounter/CPT File

This encounter level information includes 1) value set defined services including those from the *Included Clinical Data Types* list and 2) clinical data that typically occurs once per encounter (e.g., weight, tobacco status, diagnoses). The file contains one row per service code related to an encounter. Data elements only present if available and included in the CHIRP provider-to-payer data standard. If the Encounter Service Code is a lab or procedure, the data may also be present in the Lab/Procedure File.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Date of Encounter		yyyy-mm-dd
6	Encounter / CPT Service Code		String; up to 50 characters
7	Encounter Clinic Name	Clinic where encounter occurred	Text
8	Provider NPI	▪ National Provider Identifier for provider associated with the encounter. ▪ 10 digits	Number; 10 digits
9	Provider Specialty	Provider's board-certified specialty. If the provider is not a physician, this is the board-certified specialty of the supervising physician. See Table D for code map.	Text
10	Provider Specialty - Other	May be populated with text description of provider's specialty	String; up to 50 characters
11	Height	▪ Height collected by clinical staff during encounter ▪ Value in inches, including decimals if applicable	Number
12	Weight	▪ Weight collected by clinical staff during encounter ▪ Value in pounds, including decimals if applicable	Number
13	Tobacco Status	Tobacco status within two years of the encounter 0 = Tobacco Free; patient does not currently use tobacco 1 = Current tobacco user	Number; 1 digit
14	Diagnosis Coding System	HL7 Object Identifier; made up of a series of numbers and dots, specifying type of code: ICD-10, ICD-9, SNOMED; See Table E for code map.	Text

CHIRP_Encounter/CPT File

This encounter level information includes 1) value set defined services including those from the *Included Clinical Data Types* list and 2) clinical data that typically occurs once per encounter (e.g., weight, tobacco status, diagnoses). The file contains one row per service code related to an encounter. Data elements only present if available and included in the CHIRP provider-to-payer data standard. If the Encounter Service Code is a lab or procedure, the data may also be present in the Lab/Procedure File.

Element Order	Field Name	Details	Format/Field Length
15 to 64	Diagnosis Code(s)	▪ Diagnosis associated with the encounter ▪ Up to 50 diagnoses per encounter may be present	String; up to 50 characters

CHIRP_Blood Pressure File

The file contains one row per ambulatory blood pressure that was not associated with a diagnostic test or surgical procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Blood Pressure Date		yyyy-mm-dd
6	Blood Pressure Time		Military time: hh:mm:ss
7	Systolic Reading		Number
8	Diastolic Reading		Number

CHIRP_Lab/Procedure File

Contains value set defined labs and procedures from the *Included Clinical Data Types* list. The file contains one row per lab or procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters

CHIRP_Lab/Procedure File

Contains value set defined labs and procedures from the *Included Clinical Data Types* list. The file contains one row per lab or procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
5	Lab Service Date		yyyy-mm-dd
6	Lab Code	Value set specified code for lab performed by submitting medical group.	String; up to 50 characters
7	Lab Type	Value set specified labs contained in patient record performed outside submitting medical group, text description of lab type	String; up to 50 characters
8	Lab Result	Result for value set specified labs	String; up to 50 characters
9	Procedure Date	Date that the procedure was performed.	yyyy-mm-dd
10	Procedure Code	Value set specified procedure code performed by submitting medical group. Codes may include CPT, CVX, SNOMED, HCPCS, ICD10-PCS, etc.	String; up to 50 characters
11	Procedure Type	Value set specified procedures contained in patient record performed outside submitting medical group, text description of procedure type	String; up to 50 characters

DATA MAPPING TABLES

Table A: Race Code Mapping

Race	HL7 Compliant Code
Asian	2028-9
Black	2054-5
Indigenous	1002-5
Native Hawaiian/Other Pacific Islander	2076-8
Other	Unknown
White	2106-3
Chose not to disclose or patient-reported as Unknown	Unknown

Table B: Ethnicity Code Mapping

Ethnicity	HL7 Compliant Code
Hispanic/Latinx	2135-2
Not Hispanic/Latinx	2186-5
Chose not to disclose or patient-reported as Unknown	UNK

Table C: Preferred Language Code Mapping

Language	HL7 Compliant Code
Amharic	am
Arabic	ar
Bosnian	bs
Burmese	my
Cambodian	Cambodian
Cantonese	Cantonese
Chinese	zh
English	en
French	fr
German	de
Hearing Impaired	Hearing Impaired
Hindi	hi
Hmong	hmn
Japanese	ja
Karen	kar
Korean	ko
Laotian	Laotian
Mandarin	Mandarin
Oromo	om
Polish	pl
Romanian	ro
Russian	ru
Sign Language	sgn
Somali	so
Spanish	es
Swahili	sw
Tagalog	tl
Thai	th
Tibetan	bo

Language	HL7 Compliant Code
Tigrinya	ti
Urdu	ur
Vietnamese	vi
Yoruba	yo

Table D: Provider Specialty Code Mapping

Provider Specialty	HL7 Compliant Code
Family Medicine Physician	207Q00000X
Internal Medicine Physician	207R00000X
Geriatric Medicine (Internal Medicine) Physician	207RG0300X
Cardiovascular Disease Physician	207RC0000X
Endocrinology	207RE0101X
Psychiatry Physician	2084P0800X
Obstetrics & Gynecology Physician	207V00000X
Allergy & Immunology Physician	207K00000X
Thoracic Surgery (Cardiothoracic Vascular Surgery) Physician	208G00000X
Colon & Rectal Surgery Physician	208C00000X
Dermatology Physician	207N00000X
Emergency Medicine Physician	207P00000X
Gastroenterology Physician	207RG0100X
Nephrology Physician	207RN0300X
Neurology Physician	2084N0400X
Neurological Surgery Physician	207T00000X
Occupational Medicine Physician	2083X0100X
Hematology & Oncology Physician	207RH0003X
Ophthalmology Physician	207W00000X
Orthopaedic Surgery Physician	207X00000X
Otolaryngology Physician	207Y00000X
Pediatrics Physician	208000000X
Physical Therapist	208100000X
Pulmonary Disease Physician	207RP1001X
Diagnostic Radiology Physician	2085R0202X
Rheumatology Physician	207RR0500X
Surgery Physician	208600000X
Urology Physician	208800000X
Neonatal-Perinatal Medicine Physician	2080N0001X
Radiation Oncology Physician	2085R0001X
Anesthesiology Physician	207L00000X
Chiropractor	111N00000X

Table E: Diagnosis Coding System Code Mapping

Diagnosis Coding System	HL7 Compliant Code
ICD-10	2.16.840.1.113883.6.90
ICD-9	2.16.840.1.113883.6.103
SNOMED	2.16.840.1.113883.6.96

DATA SPECIFICATIONS

Common Health Information Reporting Partnership (CHIRP):

Provider to Payer Data Standard & Flat File Format for DAV Certified Standard Supplemental Data

Version 1

MN Community MEASUREMENT

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SUMMARY OF CHANGES

Changes as compared to the *CHIRP Provider to Payer Data Standard and Flat File Format v1.3 FINAL 7-11-2023* document:

- To conform to the HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA's Data Aggregator Validation (DAV) program, the following data elements approved for the CHIRP Data Standard by the CHIRP Governance Committee have been removed from the flat file formats for DAV Certified Standard Supplemental Data. The description and *Included Data Fields* list in the CHIRP Provider-to-Payer Data Standard section has been updated to reflect this change.
    - Patient Status (Demographic File)
    - Preferred Language Other (Demographic File)
    - Provider Specialty – Other (Encounter File)
    - Lab Type (Lab/Procedure File)
    - Procedure Type (Lab/Procedure File)
- To align with the requirements of the DAV program, this flat file set will only contain those medical groups that have successfully completed DAV certification. Therefore, the DAV Status fields have been removed from all files.
- Individual file descriptions and file names have been updated for consistency and clarity.

CHIRP PROVIDER-TO-PAYER DATA STANDARD

The CHIRP Provider-to-Payer Data Standard encompasses the data elements currently approved by the CHIRP Governance Committee. The historical look back periods were defined as an accepted use case by the committee.

Included Data Fields	
Patient ID	Lab Service Date
Patient Full First Name	Lab Code
Patient Last Name	Lab Result
Patient Date of Birth (DOB)	Procedure Date
Patient Sex at Birth	Procedure Code
Patient Date of Death (DOD)	Date of Encounter
Race1	Encounter / CPT Service Code
Race2	Encounter Clinic Name
Race3	Provider NPI *(associated with encounter)*
Race4	Provider Specialty *(associated with encounter)*
Race5	Height *(associated with encounter)*
Ethnicity	Weight *(associated with encounter)*
Preferred Language	Tobacco Status *(associated with encounter)*
Street Address	Diagnosis Coding System *(associated with encounter)*
City	Diagnosis Code(s) *(associated with encounter)*
State	
ZIP Code	
Insurance	
Insurance Member ID	
Blood Pressure Date	
Blood Pressure Time	
Systolic Reading	
Diastolic Reading	

The HL7 C-CDA R2.1 Continuity of Care Document (CCD) format specified by NCQA's Data Aggregator Validation (DAV) program does not allow for inclusion of all committee approved data elements. The fields approved by the Committee but **not included** in the DAV-certified standard supplemental data file include Patient Status, Preferred Language Other, Lab Type, Procedure Type, and Provider Specialty – Other.

Included Clinical Data Types

Mammography
HbA1C Value
Cervical Cytology
HR-HPV Test
Chlamydia Test
Colonoscopy
CT Colonography
FIT-DNA
Flexible Sigmoidoscopy
FOBT
uACR Test
eGFR Test
Tobacco Use

Immunizations

- DTaP Immunization
- Inactivated Polio Immunization
- Measles Mumps Rubella Immunization
- Measles Rubella Immunization
- Measles Immunization
- Mumps Immunization
- Rubella Immunization
- Haemophilus Influenzae Immunization
- Hepatitis B Immunization
- Varicella Zoster Immunization
- Pneumococcal Conjugate Immunization
- Hepatitis A Immunization
- Rotavirus Immunization
- Influenza Immunization
- Human Papillomavirus Immunization
- Meningococcal Conjugate Immunization
- Tdap Immunization

Historical Look Back Periods

- Demographic File will contain most current information, no historical data will be provided
- Encounter File will include one year of historical data from last date of service in the cycle
- Blood Pressure file will be one year of data from last date of service in the cycle
- Lab/Procedure File will have measure specific look back periods
    - Within 10 years of last date of service in the cycle: Colonoscopy
    - Within five years of last date of service in the cycle: cervical cytology, high risk human papillomavirus (hrHPV), sigmoidoscopies, CT colonography
    - Within four years of last date of service in the cycle: immunizations
    - Within three years of last date of service in the cycle: mammography, and stool DNA (sDNA) with FIT tests
    - Within one year of last date of service in the cycle: FOBT, and lab tests (a1c, uACR, eGFR)

DAV CERTIFIED STANDARD SUPPLEMENTAL DATA FLAT FILE FORMATS

These flat files are offered as a complement to the corresponding NCQA specified CCD file(s) for the DAV program for use by payers unable to ingest CCDs.

DAV_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Patient Full First Name	Full first name of the patient.	String
6	Patient Last Name	Last name of the patient.	String
7	Patient Date of Birth (DOB)		yyyy-mm-dd
8	Patient Sex at Birth	F = Female M = Male U = Unknown/Undefined	Text; 1 character
9	Patient Date of Death (DOD)		yyyy-mm-dd
10	Race1	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
11	Race2	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
12	Race3	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String

DAV_Demographic File

Contains one row for each patient contained in any of the other files. Data only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
13	Race4	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
14	Race5	Patient reported race. If the patient was not asked for their race or if race was left blank by patient, fields are blank. See Table A for code map.	String
15	Ethnicity	Patient reported Ethnicity. If the patient was not asked for their ethnicity or if ethnicity was left blank by patient, the field is blank. See Table B for code map.	String
16	Preferred Language	Patient reported preferred language. If the patient was not asked for their preferred language or if preferred language was left blank by patient, the field is blank. See Table C for code map.	Text
17	Street Address	Patient primary residence	String; up to 50 characters
18	City	Patient primary residence	String; up to 50 characters
19	State	Patient primary residence, Standard two-character state abbreviation.	Text; 2 characters
20	ZIP Code	Patient primary residence, Minimum of five digits	Number

DAV_Encounter/CPT File

This encounter level information includes 1) value set defined services including those from the *Included Clinical Data Types* list and 2) clinical data that typically occurs once per encounter (e.g., weight, tobacco status, diagnoses). The file contains one row per service code related to an encounter. Data elements only present if available and included in the CHIRP provider-to-payer data standard. If the Encounter Service Code is a lab or procedure, the data may also be present in the Lab/Procedure File.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Date of Encounter		yyyy-mm-dd
6	Encounter / CPT Service Code		String; up to 50 characters
7	Encounter Clinic Name	Clinic where encounter occurred	Text
8	Provider NPI	▪ National Provider Identifier for provider associated with the encounter. ▪ 10 digits	Number; 10 digits
9	Provider Specialty	Provider's board-certified specialty. If the provider is not a physician, this is the board-certified specialty of the supervising physician. See Table D for code map.	Text
10	Height	▪ Height collected by clinical staff during encounter ▪ Value in inches, including decimals if applicable	Number
11	Weight	▪ Weight collected by clinical staff during encounter ▪ Value in pounds, including decimals if applicable	Number
12	Tobacco Status	Tobacco status within two years of the encounter 0 = Tobacco Free; patient does not currently use tobacco 1 = Current tobacco user	Number; 1 digit
13	Diagnosis Coding System	HL7 Object Identifier; made up of a series of numbers and dots, specifying type of code: ICD-10, ICD-9, SNOMED; See Table E for code map.	Text
14 to 63	Diagnosis Code(s)	▪ Diagnosis associated with the encounter ▪ Up to 50 diagnoses per encounter may be present	String; up to 50 characters

DAV_Blood Pressure File

The file contains one row per ambulatory blood pressure that was not associated with a diagnostic test or surgical procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Blood Pressure Date		yyyy-mm-dd
6	Blood Pressure Time		Military time: hh:mm:ss
7	Systolic Reading		Number
8	Diastolic Reading		Number

DAV_Lab/Procedure File

Contains value set defined labs and procedures from the *Included Clinical Data Types* list. The file contains one row per lab or procedure. Data elements only present if available and included in the CHIRP provider-to-payer data standard.

Element Order	Field Name	Details	Format/Field Length
1	Insurance	Code of Primary or Secondary Insurance of member. Please refer to a separate document entitled *Insurance Coverage Data Elements, Field Specifications &Codes* for field specifications.	Number, up to two digits
2	Insurance Member ID	Member ID of member for payer listed in Insurance field.	String; up to 50 characters
3	Medical Group OID	Medical group's registered HL7 Object Identifier; made up of a series of numbers and dots.	Text
4	Patient ID	Unique provider-submitted patient identifier used consistently across all data files.	String; up to 50 characters
5	Lab Service Date		yyyy-mm-dd
6	Lab Code	Value set specified code for lab performed by submitting medical group.	String; up to 50 characters
7	Lab Result	Result for value set specified labs	String; up to 50 characters
8	Procedure Date	Date that the procedure was performed.	yyyy-mm-dd
9	Procedure Code	Value set specified procedure code performed by submitting medical group. Codes may include CPT, CVX, SNOMED, HCPCS, ICD10-PCS, etc.	String; up to 50 characters

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DATA MAPPING TABLES

Table A: Race Code Mapping

Race	HL7 Compliant Code
Asian	2028-9
Black	2054-5
Indigenous	1002-5
Native Hawaiian/Other Pacific Islander	2076-8
Other	Unknown
White	2106-3
Chose not to disclose or patient-reported as Unknown	Unknown

Table B: Ethnicity Code Mapping

Ethnicity	HL7 Compliant Code
Hispanic/Latinx	2135-2
Not Hispanic/Latinx	2186-5
Chose not to disclose or patient-reported as Unknown	UNK

Table C: Preferred Language Code Mapping

Language	HL7 Compliant Code
Amharic	am
Arabic	ar
Bosnian	bs
Burmese	my
Cambodian	Cambodian
Cantonese	Cantonese
Chinese	zh
English	en
French	fr
German	de
Hearing Impaired	Hearing Impaired
Hindi	hi
Hmong	hmn
Japanese	ja
Karen	kar
Korean	ko
Laotian	Laotian
Mandarin	Mandarin
Oromo	om
Polish	pl
Romanian	ro
Russian	ru
Sign Language	sgn
Somali	so
Spanish	es
Swahili	sw
Tagalog	tl
Thai	th
Tibetan	bo

Language	HL7 Compliant Code
Tigrinya	ti
Urdu	ur
Vietnamese	vi
Yoruba	yo

Table D: Provider Specialty Code Mapping

Provider Specialty	HL7 Compliant Code
Family Medicine Physician	207Q00000X
Internal Medicine Physician	207R00000X
Geriatric Medicine (Internal Medicine) Physician	207RG0300X
Cardiovascular Disease Physician	207RC0000X
Endocrinology	207RE0101X
Psychiatry Physician	2084P0800X
Obstetrics & Gynecology Physician	207V00000X
Allergy & Immunology Physician	207K00000X
Thoracic Surgery (Cardiothoracic Vascular Surgery) Physician	208G00000X
Colon & Rectal Surgery Physician	208C00000X
Dermatology Physician	207N00000X
Emergency Medicine Physician	207P00000X
Gastroenterology Physician	207RG0100X
Nephrology Physician	207RN0300X
Neurology Physician	2084N0400X
Neurological Surgery Physician	207T00000X
Occupational Medicine Physician	2083X0100X
Hematology & Oncology Physician	207RH0003X
Ophthalmology Physician	207W00000X
Orthopaedic Surgery Physician	207X00000X
Otolaryngology Physician	207Y00000X
Pediatrics Physician	208000000X
Physical Therapist	208100000X
Pulmonary Disease Physician	207RP1001X
Diagnostic Radiology Physician	2085R0202X
Rheumatology Physician	207RR0500X
Surgery Physician	208600000X
Urology Physician	208800000X
Neonatal-Perinatal Medicine Physician	2080N0001X
Radiation Oncology Physician	2085R0001X
Anesthesiology Physician	207L00000X
Chiropractor	111N00000X

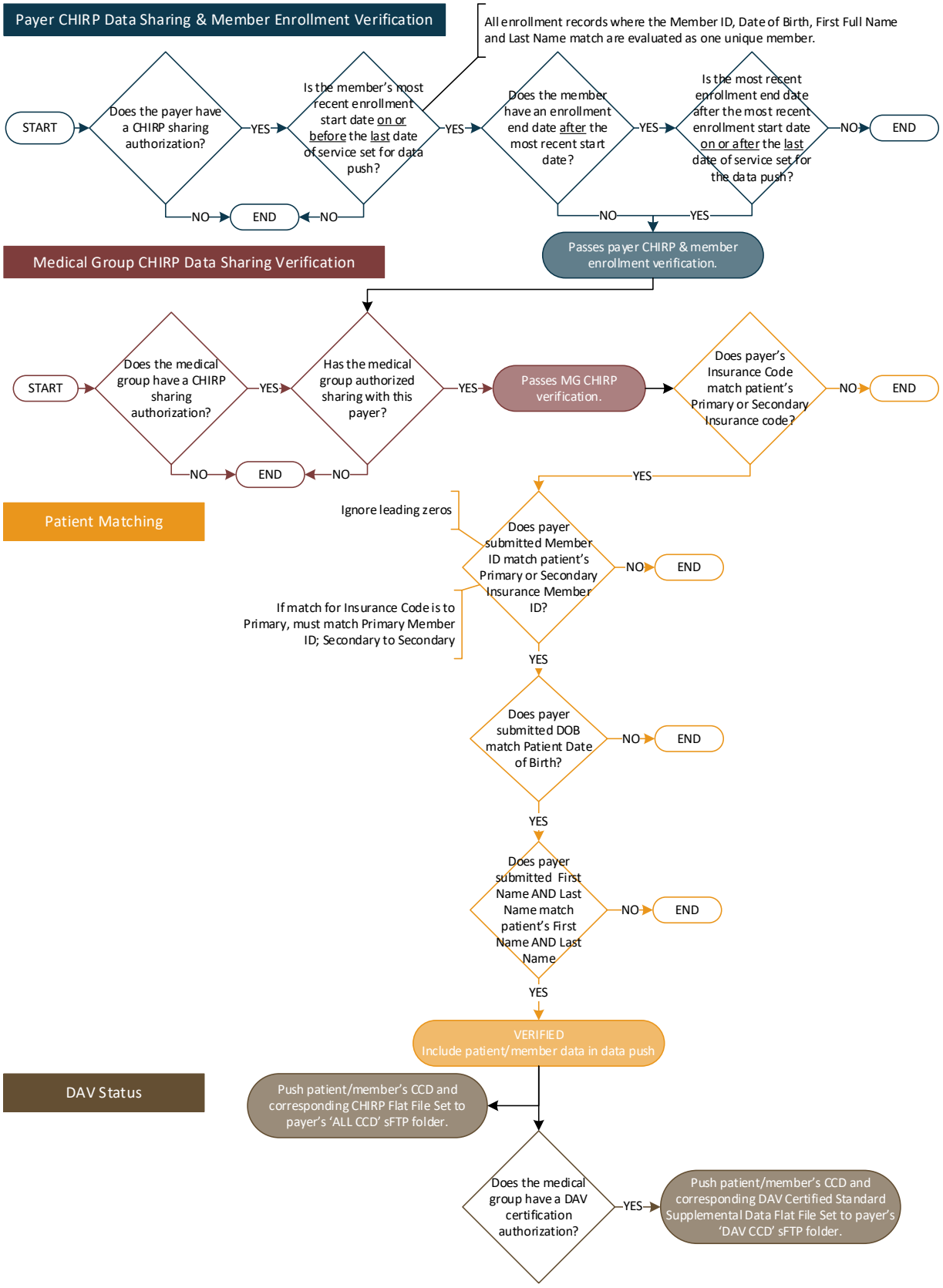
Table E: Diagnosis Coding System Code Mapping

Diagnosis Coding System	HL7 Compliant Code
ICD-10	2.16.840.1.113883.6.90
ICD-9	2.16.840.1.113883.6.103
SNOMED	2.16.840.1.113883.6.96

Common Health Information Reporting Partnership (CHIRP) Patient Matching Algorithm Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Patient Matching Algorithm	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: January 30, 2024
Category of Policy: MN Community Measurement – CHIRP Policy	

The following algorithm will be used to confirm matched patients for approved CHIRP use cases:


Payer CHIRP Data Sharing & Member Enrollment Verification
All enrollment records where the Member ID, Date of Birth, First Full Name and Last Name match are evaluated as one unique member.
START
Does the payer have a CHIRP sharing authorization?
YES
Is the member's most recent enrollment start date on or before the last date of service set for data push?
YES
Does the member have an enrollment end date after the most recent start date?
YES
Is the most recent enrollment end date after the most recent enrollment start date on or after the last date of service set for the data push?
NO
END
NO
END
NO
NO
YES
Passes payer CHIRP & member enrollment verification.
Medical Group CHIRP Data Sharing Verification
START
Does the medical group have a CHIRP sharing authorization?
YES
Has the medical group authorized sharing with this payer?
YES
Passes MG CHIRP verification.
Does payer's Insurance Code match patient's Primary or Secondary Insurance code?
NO
END
NO
END
NO
YES
Patient Matching
Ignore leading zeros
If match for Insurance Code is to Primary, must match Primary Member ID; Secondary to Secondary
Does payer submitted Member ID match patient's Primary or Secondary Insurance Member ID?
NO
END
YES
Does payer submitted DOB match Patient Date of Birth?
NO
END
YES
Does payer submitted First Name AND Last Name match patient's First Name AND Last Name
NO
END
YES
VERIFIED
Include patient/member data in data push
DAV Status
Push patient/member's CCD and corresponding CHIRP Flat File Set to payer's 'ALL CCD' sFTP folder.
Does the medical group have a DAV certification authorization?
YES
Push patient/member's CCD and corresponding DAV Certified Standard Supplemental Data Flat File Set to payer's 'DAV CCD' sFTP folder.

Common Health Information Reporting Partnership (CHIRP) Data Integrity Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Data Integrity Policy	Effective Date: Approved by MNCM Board, February 15, 2023
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: February 15, 2023
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

Medical Group Participation in the NCQA Data Aggregator Validation (DAV) Program

Medical groups taking part in the Common Health Information Reporting Partnership (CHIRP) must actively participate in the Primary Source Verification (PSV) portions of the DAV certification process. This process will occur at least annually. Active participation includes, but is not limited to:

- Notifying MNCM regarding all EHR and query changes that impact data prepared for submission to the Process Intelligence Performance Engine (PIPE) in a timely manner.
- Taking part in pre-PSV training as determined by MNCM.
    - Training to include expectations for the PSV process and specific timelines.
- Designating a primary contact that will be readily available to manage inquiries and requests from MNCM for the duration of the PSV process.
- Providing MNCM with screen prints or screen shots of patient records from the EHR as requested.
- Adhering to agreed upon turnaround times.

Payer Data Integrity

Payers that submit enrollment data for patient matching with provider submitted insurance data and product attachment will undergo a rigorous validation process to ensure data accuracy and reliability. Validation is conducted as part of onboarding into PIPE and prior to the regular transfer of clinical data to payers and use of insurance product for various analysis purposes. Ongoing validation is conducted as well.

- Prior to data submission, payers will complete training to review the *PIPE Data File Field Specifications for Health Plan Member Verification* and the file import process. MNCM also reviews an overview of the validation process and project plan with the payer data team.
- Upfront validation is conducted before data is imported into the PIPE system.
    - An audit is conducted of the payer's query/SQL code that will be used to extract enrollment data. MNCM verifies that the query is free from any limitations or parameters that may exclude the necessary data.
    - After the payer extracts the data, an audit of the data file is conducted to ensure that the data file is constructed correctly for ingestion into the PIPE system, data is in the correct format, and the requested data elements are included as expected.
- After the first data file is imported into the PIPE system for testing, import errors produced by the PIPE system are evaluated by the payer and MNCM.

- The number of patients submitted, and the number/percentage of patients matched are evaluated by the payer and MNCM.
- During onboarding, output files for the NCQA specified CCD file and CHIRP specified flat file for delivery to the payer will be produced. The payer and MNCM review the output files, and an audit of a random selection of verified patients is conducted to ensure appropriate matching of provider and payer data elements. Data format integrity is also checked.
- Ongoing validation is conducted to ensure the reliability and integrity of the patient enrollment data. Payers are requested to review this policy on an annual basis and provide any updates to MNCM about changes to their process, system, or expected results.

Any issues or errors identified during the validation process that require corrections are reviewed by and discussed between the payer and MNCM.

Additional details are available in the *PIPE Data Validation* tip sheet for payers.

Information Management Access Plan

MNCM is committed to ensuring the confidentiality, integrity, and availability of all protected health information (PHI/ePHI), confidential and sensitive data (hereafter referred to as covered information) it creates, receives, maintains, and/or transmits. This purpose the Information Management Access Plan defines how MNCM manages access to covered information and supporting information systems for CHIRP and related systems.

Scope & Goals - Information Management Plan

The goals of information access management are to ensure:

- Access to covered information and system resources is granted under the minimum necessary needed to perform assigned job responsibilities.
- Access is promptly granted, adjusted, suspended or terminated by the proper authority (e.g. system owner, supervisor, etc.)
- Users are being positively identified before granting access to covered information and system resources.
- Access is adjusted when appropriate (i.e. promotion/demotion, job change, new clinic etc.)
- Access is promptly removed when an individual's employment is ended.
- System/Application owners perform periodic audits to detect or prevent instances of excessive access.

Responsibilities – Information Management Plan

Information Security Officer

MNCM 's Information Security Officer (ISO) in partnership with the organization's Privacy Officer, are responsible for maintenance, interpretation and enforcement of this policy/procedure.

Privacy Officer

MNCM 's Privacy Officer in partnership with the organization's ISO, are responsible for maintenance, interpretation and enforcement of this policy/procedure.

System Administrators

Responsibilities include, but are not limited to the following:

- Add, remove, change or suspend access as defined by this policy.
- Perform account maintenance as defined by this policy.

System/Application Owners

Responsibilities include, but are not limited to the following:

- Approving all requests for access to their respective systems/applications.
- Ensuring access rights to the system/application are based on minimum necessary.
- Maintaining a list of all users (individuals, contractors, and business associates) with access to PHI and other covered information.
- Ensuring access rights to their respective systems/applications are accurate through the practice of periodic revalidation as described by this policy.
- Ensure User IDs that were previously used and removed must not be re-used for a completely different person.

<u>User Registration and Management</u>

Access to MNCM systems will not be allowed without proper verification of identity. Proper verification of identity is the completion of some of the following:

- PIPE User Request Portal
- PIPE Agreement Completion
- CHIRP Agreement
- Other agreements that are identified

To enforce minimum necessary requirements, MNCM will implement role-based security in addition to limiting access to application functions through the use of application security that controls access to menus/screens based on the role.

Application access control will be managed individually by the application and not as a group or system. This is especially crucial for applications that communicate with each other. It will not be assumed that if a user has access rights to one application, that they also have rights to the other application.

Account types shall be identified (individual, system, department, etc.). The use of group, shared or generic accounts and passwords is prohibited.

<u>Account Management</u>

Account Maintenance – System Administrators will be responsible for reviewing performing monthly maintenance associated with the clean-up of unnecessary and dormant accounts. System administrators will:

- Disable default and unnecessary system accounts. If accounts must be maintained, the password to the account will be changed and privileges reduced to the lowest level of access.
- Configure automated mechanisms to assist in system account management including provisioning and de-provisioning user accounts, notifying appropriate account managers of changes in access, disabling emergency accounts within 24 hours, and temporary accounts within a fixed duration not to exceed 365 days.

Common Health Information Reporting Partnership (CHIRP) Payer-to-Provider Use Cases Policy

Policy Name: Common Health Information Reporting Partnership (CHIRP) Use Cases	Effective Date: Approved by MNCM Board, May 15, 2024
Policy Owner: MNCM CHIRP Governance Committee	Review/Revision Date: March 2027
Category of Policy (select one of the following): MN Community Measurement – CHIRP Policy	

#	Use Case Name	Description	Date Approved / Updated
1	Health Care Payer Authorization to Send CHIRP Payer-to-Provider Data to Health Care Provider	Allow payer organizations the option of having their data shared via the MNCM CHIRP program to provider organizations enrolled in the CHIRP program. 1. Data would be shared with a provider or providers only if the payer organization agrees to permit such sharing, and only for uses mutually agreed-upon by the payer and provider as specified in this *CHIRP Payer-to-Provider Use Cases Policy*. 2. Payers are responsible for identifying the Provider organization to which the data will be shared for each enrolled member, as specified in the *CHIRP Payer to Provider Data Standard.*	May 15, 2024
2	Health Care Provider Use of CHIRP Payer-to-Provider Data in Care Delivery	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for quality improvement, care coordination and population health management. No other access to, and use of, Health Data is permitted under this Use Case.	May 15, 2024
3	Health Care Provider Use of CHIRP Payer-to-Provider Data in Research	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for research to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case.	March 18, 2025
4	Health Care Provider	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by	March 18, 2025

	Use of CHIRP Payer-to-Provider Data in Public Health Surveillance	a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for public health surveillance to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case.	

DATA SPECIFICATIONS

Common Health Information Reporting Partnership (CHIRP):

Payer to Provider *Inbound* Data Standard

Version 1.1

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SUMMARY OF CHANGES

Version 1 to 1.1

- Added 'Error Causes' column to all file specifications. This information is intended to be used to troubleshoot errors triggered during automated validation checks performed by PIPE at the time of file import.
- Added clarifying text and/or edits to Details column throughout all files.
- Added Payer ID field to all files.
- Changed Format/Field Length specifications as needed throughout all files.
- Field Key information expanded for all files.
- Member First Name, Member Last Name, and Member Date of Birth added to *Measure Event Tracking*, *Chronic Conditions*, and *Prescription Fill Files* to facilitate matching of data in those files to the member in the *Member Attribution File*.
- Changed references from 'Prescriber' to 'Provider' in the *Chronic Conditions File*.
- Removed all references to GPI or RxNorm codes from *Prescription Fill File*.

DATA FILE SPECIFICATIONS

Version File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
Tracks the version of the file set. Contains the date ranges of the look back period for that version of the file set, and the date the file set was submitted. **Field Key:** • **R = Required**: Data element required to be included in submission file. Blanks will cause upload errors.					
1	Payer ID	MNCM assigned Payer ID. If Payer ID is unknown to the organization, contact MNCM at support@mncm.org.	R	Numeric; 1-2 digits	Blank field; Values outside the allowable range
2	Version #	Code representing the version date and source organization of the files being sent. Version # is included in all files sent. Must be formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String up to 50 characters	Blank field; Data that does not follow specified format
3	Claims Processing Date	Enter the last date on which claims were fully adjudicated.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format

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Version File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
4	Creation Date	Enter the date that the file was created. Corresponds to date included in Version #.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
5	End of look back period	Last date of service of the records pulled.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
6	Start of look back period	First date of service of the records pulled.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format

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Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
The file must contain all individuals attributed or enrolled to the medical group and contained within any of the other claims-based data files provided. Contains one row for each enrolled member with most up to date information based on creation date. This file operates under the assumption that payers are currently sending gap reports to one provider for a single patient. **Field Key:** • **R = Required:** Data element required to be included in submission file. Blanks will cause upload errors. • **S = Situational:** Data element should be submitted if data is applicable and available in a discrete field that can be queried. Exceptions exist; review Details and Error Causes fields thoroughly. • **S+:** It is required that at least one of the S+ fields be provided. If all S+ fields are blank, upload errors will occur.					
1	Payer ID	MNCM assigned Payer ID. If Payer ID is unknown to the organization, contact MNCM at support@mncm.org.	R	Numeric; 1-2 digits	Blank field; Values outside allowable range
2	Payer Name	Name of the health plan or payer sending data to the provider.	R	String; up to 50 characters	Blank field; Data that does not follow specified format
3	Insurance Member ID	The unique and most up to date number that the payer uses to identify the member. Used to link data across files to member. Must match across all files.	R	String; up to 80 characters	Blank field; Data that does not follow specified format
4	Insurance Subscriber ID	If applicable, provide member's unique subscriber ID. If present, used to link data across files to member. Must match across all files.	S	String; up to 80 characters	Data that does not follow specified format

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
5	Medical Group TIN	Enter the medical group's nine-digit Taxpayer Identification Number (TIN). Must not include hyphens or other characters. ⚠ If there is more than one TIN associated with the medical group, enter the TIN most closely associated with the most recent entity NPI	S+	Numeric, nine digits	Blank field if other S+ fields are also blank; Data that does not follow specified format
6	Clinic TIN	Enter the clinic's nine-digit Taxpayer Identification Number (TIN). Must not include hyphens or other characters. ⚠ If there is more than one TIN associated with the clinic, enter the TIN most closely associated with the most recent entity NPI	S+	Numeric, nine digits	Blank field if other S+ fields are also blank; Data that does not follow specified format
7	Clinic NPI	Enter the most recent ten-digit entity level National Provider Identifier (NPI) number. ⚠ At the time the member attribution file is pulled, if there are encounters at more than one entity location in the medical group, select the most recent entity level NPI	S+	Numeric; ten digits	Blank field if other S+ fields are also blank; Data that does not follow specified format
8	Medical Group Patient ID	Enter the unique Patient ID that the medical group provided in the CHIRP Provider-to-Payer data. This ID is unique to and within that medical group only, not a universal patient identifier.	S	String; up to 50 characters	Data that does not follow specified format

MN Community MEASUREMENT

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
9	Member First Name	Enter the full first name of the member.  Used to link data across files to member. Must match across all files.	R	String; up to 35 characters	Blank field; Data that does not follow specified format
10	Member Middle Name or Initial	Enter the member's middle name or initial if it is recorded in the database record.	S	String; up to 10 characters	Data that does not follow specified format
11	Member Last Name	Enter the last name of the member.  Used to link data across files to member. Must match across all files.	R	String; up to 60 characters	Blank field; Data that does not follow specified format
12	Member Date of Birth	 Used to link data across files to member. Must match across all files.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
13	Member Sex	Member's sex at birth F = Female M = Male U = Unknown	R	Text; 1 character	Blank field; Data that does not follow specified format; Values outside the allowable range
14	Street Address		S	Text	
15	City		S	Text	

MN Community MEASUREMENT

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
16	State	Standard two-character state abbreviation	S	String, two characters	Data that does not follow specified format
17	Zip Code		S	String; up to 10 characters	Data that does not follow specified format
18	Attribution Type	Indicate if this member's health plan attribution type is enrolled or assigned. 1 = Enrolled 2 = Assigned	R	Numeric; 1 digit	Blank field; Data that does not follow specified format; Values outside the allowable range
19	Enrollment Date for Pharmacy	Enter the start date of the member's most recent enrollment period for pharmacy coverage	S	Date; mm/dd/yyyy or m/d/yyyy	Data that does not follow specified format
20	Enrollment Date for medical	Enter the start date of the member's most recent enrollment period for medical coverage	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
21	Enrollment Months	Enter the number of whole months that this member has been enrolled	S	Numeric	Data that does not follow specified format
22	Pharmacy Months	Enter the number of whole months for which this member has pharmacy claims through this payer (i.e., claims through third-party would not be available)	S	Numeric	Data that does not follow specified format

MN Community MEASUREMENT

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length	Error Causes
23	Previous Insurance Plan Member ID	Member's previous insurance plan member ID, if changed.	S	String; up to 80 characters	Data that does not follow specified format
24	Version #	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Must be formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String; up to 50 characters	Blank field; Data that does not follow specified format

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
One record per eligible, actively enrolled member per measure event unless multiple measures or other circumstances apply. If multiple components of a measure event are present or needed, additional records may be present for that measure. Do not include members who are not eligible for any selected event measures during the measurement period. Refer to Measure Events with Acronym Coding and Sub-Measure Description table in Appendix A. **Field Key:** • **R = Required:** Data element required to be included in submission file. Blanks will cause upload errors. • **S = Situational:** Data element should be submitted if data is applicable and available in a discrete field that can be queried. Exceptions exist; review Details and Error Causes fields thoroughly. • **S*:** It is required that if one of these fields is populated, all must be populated (e.g., if Measure Procedure Code field is populated, Measure Procedure DOS and Measure Procedure Description fields must also be populated). Failure to meet these requirements for these fields will produce an error for each impacted field.					
1	Payer ID	MNCM assigned Payer ID.  If Payer ID is unknown to the organization, contact MNCM at support@mncm.org.	R	Numeric; 1-2 digits	Blank field; Values outside allowable range
2	Insurance Member ID	This is the unique and most up to date number that the payer uses to identify the member.  Used to link data across files to member. Must match Insurance Member ID field in Member Attribution File for corresponding member.	R	String; up to 80 characters	Blank field; Data that does not follow specified format

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
3	Insurance Subscriber ID	If applicable, provide the member's unique subscriber ID. ⚠ If present, used to link data across files to member. Must match Insurance Subscriber ID field in Member Attribution File for corresponding member.	S	String; up to 80 characters	Data that does not follow specified format
4	Member First Name	Enter the full first name of the member. ⚠ Used to link data across files to member. Must match Member First Name field in Member Attribution File for corresponding member.	R	String; up to 35 characters	Blank field; Data that does not follow specified format
5	Member Last Name	Enter the last name of the member. ⚠ Used to link data across files to member. Must match Member Last Name field in Member Attribution File for corresponding member.	R	String; up to 60 characters	Blank field; Data that does not follow specified format
6	Member Date of Birth	⚠ Used to link data across files to member. Must match Member Date of Birth field in Member Attribution File for corresponding member.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
7	Measure Event Mapped Acronym	Indicate which measure the member is eligible for from the list of specified measures and sub-measures. Refer to Appendix A for details.	R	String; up to 5 characters	Blank field; Data that does not follow specified format

MN Community MEASUREMENT

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
8	Measure Event Mapped Description	Provide the description of the measure event indicated in the previous column	R	Text	Blank field; Data that does not follow specified format
9	Gap Status	Indicate if there is a gap for this measure event by the end of the current measurement period. 0 = No gap 1= Gap	R	Numeric; 1 digit	Blank field; Data that does not follow specified format; Values outside allowable range
10	Measure Procedure DOS	Most recent date of service (DOS) related to this eligible member's measure event procedure, if available. Procedure may or may not meet gap but is the most recent.	S*	Date; mm/dd/yyyy or m/d/yyyy	Blank field if any other S* field in this file is populated; Data that does not follow specified format
11	Measure Procedure Code	Enter the most recent procedure code available in claims data related to this measure event, if available. Can include any of the following: CPT, HCPCS, ICD10-PCS	S*	String; up to 50 characters	Blank field if any other S* field in this file is populated; Data that does not follow specified format

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
12	Measure Procedure Description	Text description of the Measure Procedure Code	S*	String; up to 50 characters	Blank field if any other S* field in this file is populated; Data that does not follow specified format
13	Measurement Period Start Date	The start of the measurement period for which this member is eligible for the denominator and measure is being calculated (typically 1/1/20xx).	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
14	Measurement Period End Date	The end of the measurement period for which this member is eligible for the denominator and measure is being calculated (typically 12/31/20xx)	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
15	Measure Steward	Indicate the measure steward for this measure event (source definition of the measure): 1 = NCQA / HEDIS 2 = CMS 3 = MNCM 4 = Other	R	Numeric; 1 digit	Blank field; Data that does not follow specified format; Values outside allowable range

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
16	Version #	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Must be formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String; up to 50 characters	Blank field; Data that does not follow specified format

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
Listing of active, currently enrolled members with specified conditions. Each member and condition are listed in a separate row. The most recent date of service is to indicate the most recent encounter in which this condition was documented for this member by any provider. If an active enrolled member has none of the selected chronic conditions, do not include the member in this file. For health plans utilizing value sets, diagnoses that are included on a UB-04 or HCFA 1500 claims form at least one or more times may be used (e.g., hospital, clinic, urgent care, emergency department, home health, skilled nursing facility, etc.). Diagnoses that are found only on radiology or laboratory claims cannot be used to populate the chronic condition file. The chronic conditions of interest are the chronic disease states highlighted in the measure event tracking file (diabetes, hypertension, and hyperlipidemia). For additional information look to Appendix B. **Field Key:** • **R = Required:** Data element required to be included in submission file. Blanks will cause upload errors. • **S = Situational:** Data element should be submitted if data is applicable and available in a discrete field that can be queried. Exceptions exist; review Details and Error Causes fields thoroughly.					
1	Payer ID	MNCM assigned Payer ID. If Payer ID is unknown to the organization, contact MNCM at support@mncm.org.	R	Numeric; 1-2 digits	Blank field; Values outside allowable range
2	Insurance Member ID	This is the unique and most up to date number that the payer uses to identify the member. Used to link data across files to member. Must match Insurance Member ID field in Member Attribution File for corresponding member.	R	String; up to 80 characters	Blank field; Data that does not follow specified format

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
3	Insurance Subscriber ID	If applicable, provide the member's unique subscriber ID. ⚠ If present, used to link data across files to member. Must match Insurance Subscriber ID field in Member Attribution File for corresponding member.	S	String; up to 80 characters	Data that does not follow specified format
4	Member First Name	Enter the full first name of the member. ⚠ Used to link data across files to member. Must match Member First Name field in Member Attribution File for corresponding member.	R	String; up to 35 characters	Blank field; Data that does not follow specified format
5	Member Last Name	Enter the last name of the member. ⚠ Used to link data across files to member. Must match Member Last Name field in Member Attribution File for corresponding member.	R	String; up to 60 characters	Blank field; Data that does not follow specified format
6	Member Date of Birth	⚠ Used to link data across files to member. Must match Member Date of Birth field in Member Attribution File for corresponding member.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
7	Diagnosis Code	ICD-9 CM or ICD-10 CM code of the most recent diagnosis	R	String; up to 20 characters	Blank field; Data that does not follow specified format

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
8	Diagnosis Coding System	1 = ICD-10 2 = ICD-9	R	Numeric; one digit	Blank field; Values outside the allowable range; Data that does not follow specified format
9	Code Description	Full text description of diagnosis.	R	Text	Blank field
10	Index of Code	Submit the numeric indicator from the claim line indicating whether the diagnosis code was the primary diagnosis, secondary diagnosis, etc.	R	Numeric; up to three characters	Blank field; Data that does not follow specified format
11	Place of Service Code	CMS POS Code for the diagnosis.	S	String; up to two characters	Data that does not follow specified format
12	Most Recent DOS	Date of service for the diagnosis. If the member received this code more than once, enter the most recent date of service.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
13	Provider First Name	First name of provider who diagnosed the member. If member received this diagnosis more than once, enter the provider from the most recent date of service.	R	String; up to 50 characters	Blank field; Data that does not follow specified format

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
14	Provider Last Name	Last name of provider who diagnosed the member. If member received this diagnosis more than once, enter the provider from the most recent date of service.	R	String; up to 50 characters	Blank field; Data that does not follow specified format
15	Provider Taxonomy Code	Enter the CMS Healthcare Provider Taxonomy Code for the provider who diagnosed the member. If member received this diagnosis more than once, enter the provider from the most recent date of service.	S	String; up to 50 characters	Data that does not follow specified format
16	Provider NPI	Ten-digit National Provider Identifier (NPI) of the provider who diagnosed the member. If member received this diagnosis more than once, enter the provider from the most recent date of service.	S	Numeric; ten digits	Data that does not follow specified format
17	Condition Source	Indicate the claim type that was the source of the diagnosis: 1 = medical 2 = pharmacy 3 = medical and pharmacy	R	Numeric; 1 digit	Blank field; Data that does not follow specified format; Values outside allowable range
18	Version	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Must be formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String; up to 50 characters	Blank field; Data that does not follow specified format

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
Each member and prescription fill are listed in a separate row; Refer to Prescription Drug Classes List in Appendix C, for applicable prescriptions. Individuals should only appear in the prescription fill file if they were identified in the chronic condition file. **Field Key:** • **R = Required:** Data element required to be included in submission file. Blanks will cause upload errors. • **S = Situational:** Data element should be submitted if data is applicable and available in a discrete field that can be queried. Exceptions exist; review Details and Error Causes fields thoroughly.					
1	Payer ID	MNCM assigned Payer ID. If Payer ID is unknown to the organization, contact MNCM at support@mncm.org.	R	Numeric; 1-2 digits	Blank field; Values outside allowable range
2	Insurance Member ID	This is the unique and most up to date number that the payer uses to identify the member. Used to link data across files to member. Must match Insurance Member ID field in Member Attribution File for corresponding member.	R	String; up to 80 characters	Blank field; Data that does not follow specified format
3	Insurance Subscriber ID	If applicable, provide the member's unique subscriber ID. If present, used to link data across files to member. Must match Insurance Subscriber ID field in Member Attribution File for corresponding member.	S	String; up to 80 characters	Data that does not follow specified format

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
4	Member First Name	Enter the full first name of the member. Used to link data across files to member. Must match Member First Name field in Member Attribution File for corresponding member.	R	String; up to 35 characters	Blank field; Data that does not follow specified format
5	Member Last Name	Enter the last name of the member. Used to link data across files to member. Must match Member Last Name field in Member Attribution File for corresponding member.	R	String; up to 60 characters	Blank field; Data that does not follow specified format
6	Member Date of Birth	Used to link data across files to member. Must match Member Date of Birth field in Member Attribution File for corresponding member.	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
7	Pharmacy NPI	Ten-digit National Provider Identifier (NPI) of the pharmacy at which the prescription was dispensed.	R	Numeric; ten digits	Blank field; Data that does not follow specified format
8	Pharmacy Name	Name of dispensing pharmacy.	S	Text	
9	Pharmacy Zip Code	Zip code of dispensing pharmacy.	S	String; up to 10 characters	Data that does not follow specified format
10	Prescriber First Name	First name of provider who prescribed the medication for member.	R	String; up to 50 characters	Blank field; Data that does not follow specified format

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
11	Prescriber Last Name	Last name of provider who prescribed the medication for member.	R	String; up to 50 characters	Blank field; Data that does not follow specified format
12	Provider Taxonomy Code	Enter the CMS Healthcare Provider Taxonomy Code for the provider indicated in the Prescriber First Name and Prescriber Last Name fields in this file.	S	String; up to 50 characters	Data that does not follow specified format
13	Prescriber NPI	Ten-digit National Provider Identifier (NPI) of the provider who prescribed the medication for the member	R	Numeric; ten digits	Blank field; Data that does not follow specified format
14	Medication Fill Date	Date prescription was filled	R	Date; mm/dd/yyyy or m/d/yyyy	Blank field; Data that does not follow specified format
15	Medication Order Date	Date prescription was ordered	S	Date; mm/dd/yyyy or m/d/yyyy	Data that does not follow specified format
16	Generic Medication Name	Data must follow this format: generic medication name, strength(s) of medication, unit of measure of strength(s), dosage form, route of admin	R	Text	Blank field

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
17	Medication NDC	Eleven (11) character National Drug Code (NDC) for medication. • Do NOT include dashes/hyphens. • DO include leading and trailing zeros as appropriate	R	String; 11 characters	Blank field; Data that does not follow specified format
18	Medication Strength	Strength of medication.	R	String; up to 50 characters	Blank field; Data that does not follow specified format
19	Unit of measure of strength	Unit of measure of medication strength. • Standard abbreviations allowed.	R	String; up to 50 characters	Blank field; Data that does not follow specified format
20	Dosage Form	Dosage form of medication. • Do NOT use abbreviations.	R	String; up to 50 characters	Blank field; Data that does not follow specified format
21	Unit of measure of medication	Unit of measure of medication. • Only EA, GM, and ML abbreviations allowed.	S	String; 2 characters	Data that does not follow specified format
22	Route of Administration	Route of administration for medication. • Standard abbreviations required	S	String; 10 characters	Data that does not follow specified format
23	AHFS	The medication class of this medication as defined by the AHFS.	R	Text	Blank field

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length	Error Causes
24	Medication Quantity	Number of units of medication dispensed.	R	Numeric; up to 3 digits	Blank field; Data that does not follow specified format
25	Medication Days Supply	Number of days the dispensed quantity of the medication is intended to last.	R	Numeric; up to 3 digits	Blank field; Data that does not follow specified format
26	Refill Count	Number of refills prescribed for the medication.	S	Numeric; up to 3 digits	Data that does not follow specified format
27	Version #	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Must be formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated payername = name or acronym of payer organization	R	String; up to 50 characters	Blank field; Data that does not follow specified format

Appendices

Appendix A: Measure Events with Acronym Coding and Sub-Measure Description

Measure Event	Measure Acronym	Measure Description
Blood Pressure Control for DM	BPD	Blood Pressure Control for Patients with Diabetes
Breast Cancer Screening	BCS	Breast Cancer Screening
Controlling High Blood Pressure	CBP	Controlling High Blood Pressure
Cervical Cancer Screening	CCS	Cervical Cancer Screening
Chlamydia Screening in Women	CHL	Chlamydia Screening in Women
Childhood Immunizations	CIS10	Child Imm Status Combo 10
	CIS3	Child Imm Status Combo 3
	CIS7	Child Imm Status Combo 7
	CIS1	Child Imm Status DTaP
	CIS11	Child Imm Status Influenza
	CIS12	Child Imm Status Hepatitis A
	CIS13	Child Imm Status Hepatitis B
	CIS14	Child Imm Status HiB
	CIS15	Child Imm Status MMR
	CIS16	Child Imm Status Pneumococcal Conjugate
	CIS17	Child Imm Status IPV
	CIS18	Child Imm Status Rotavirus
	CIS19	Child Imm Status VZV
Colorectal Cancer Screening	COL	Colorectal Cancer Screening
Eye Exam for DM	EED	Eye Exam for Patients with Diabetes
Glycemic Status Assessment	GSD	Glycemic Status Assessment for Patients with Diabetes
Immunizations for Adolescents	IMA0	Immun Adol (no gap)
	IMA1	Immun Adol Combo 1
	IMA2	Immun Adol Combo 2
	IMA3	Immun Adol HPV
	IMA4	Immun Adol Meningococcal
	IMA5	Immun Adol Tdap
Kidney Health Evaluation for DM	KED	Kidney Health Evaluation for Patients with Diabetes
Prenatal and Postpartum Care	PPC0	Prenatal and Postpartum Care (no gap)
	PPC1	Prenatal care in first trimester
	PPC2	Postpartum care
Statin Therapy for DM	SPD	Statin Therapy for Patients with Diabetes

Measure Event	Measure Acronym	Measure Description
Other Measure 1	OTH1	Other Measure 1
Other Measure 2	OTH2	Other Measure 2
Other Measure 3	OTH3	Other Measure 3

Appendix B: Chronic Condition List

For the payer-to-provider format, we will concentrate on the chronic disease states highlighted in the gap report: diabetes, hypertension, and hyperlipidemia.

In the chronic condition table, our strategy involves integrating diagnosis codes essential for inclusion and exclusion criteria, with HEDIS serving as our guiding doctrine

The gap report measures capturing chronic conditions include:

- Blood Pressure Control for DM (BPD)
- Controlling High Blood Pressure (CBP)
- Eye Exam for Patients with Diabetes (EED)
- Glycemic Status Assessment (GSD)
- Kidney Health Evaluation for DM (KED)
- Statin Therapy for DM (SPD)

These measures have predefined values set by HEDIS which have exclusion and inclusion criteria. It we focus solely on ICD codes, excluding procedure codes, the following HEDIS value sets will be utilized:

- Diabetes
- IVD
- Frailty Diagnosis
- Advanced Illness
- Frailty Symptoms
- MI
- Macular Pain and Diseases
- ESRD Diagnosis
- Cirrhosis
- Pregnancy
- DM without complications
- History of Kidney Transplant
- Old MI
- Essential Hypertension

It’s important to note that certain measures in the gap report will not be included in the chronic condition and pharmacy tables. Notably, measures screening for cancer and those related to more acute conditions are currently excluded:

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL)
- Chlamydia Screening in Women
- Childhood Immunizations
- Immunizations for Adolescents

Appendix C: Therapeutic Drug Classes List

As noted above, for an individual to appear within the pharmacy table they must have been identified within the chronic condition table. Not all medications an individual is on should be sent, only medications that have the following mechanism of action.

For the therapeutic drug classes, two reputable sources were referenced to establish a comprehensive framework: the ADA 2023 Standards of Care in Diabetes and the AHA 2020 International Society of Hypertension Global Hypertension Practice Guidelines.

Diabetes (ADA 2023)

- Insulin therapy (human and analogs)
- Biguanides
- Sulfonylureas (2nd generation)
- Thiazolidinediones
- α-Glucosidase inhibitors
- Meglitinides
- Dipeptidyl peptidase 4 inhibitors (DPP-4i)
- Sodium-glucose cotransporter 2 (SGLT2) inhibitors
- Glucagon-like peptide 1 receptor agonist (GLP-1 RA)
- Glucose-dependent insulinotropic polypeptide (GIP) & GLP1-RA
- Combination therapies of the classes above
- Bile acid sequestrant
- Dopamine-2 agonist
- Amylin mimetic

Hypertension (ADA 2023 & AHA 2020)

- Angiotensin converting enzyme (ACE) inhibitors
- Angiotensin receptor blockers (ARB)
- Dihydropyridine calcium channel blocker (CCB)
- Thiazide/thiazide-like diuretic
- Combination products of ACE, ARB or DP CCB
- Spironolactone
- Amiloride
- Doxazosin
- Eplerenone
- Clonidine
- β-Blockers

Hyperlipidemia (ADA 2023 & AHA 2020)

- Statin therapy (low, moderate, and high)
- Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor
- Statins and Ezetimibe combination therapy
- Statins and PCSK9 Inhibitors

Antiplatelet Agents (ADA 2023 & AHA 2020)

- Aspirin
- P2Y12 inhibitors
- Dual antiplatelet therapy (with low-dose aspirin and a P2Y12 inhibitor)
- Aspirin plus low-dose rivaroxaban

DATA SPECIFICATIONS

Common Health Information Reporting Partnership (CHIRP):

Payer to Provider *Outbound* Data Standard

Version 1

MN Community MEASUREMENT

MN Community MEASUREMENT

CONTENTS

MN Community MEASUREMENT

DATA FILE SPECIFICATIONS

Version File

Element Order	Field Name	Details	Field Key	Format/ Field Length
Contains data version information for all health plans sending data to the medical group. Contains the date ranges of the look back period for that version of the file set, and the date the file set was submitted. **Field Key:** **R = Required**: Data element required to be included in submission file and should be expected consistently in outbound file.				
1	Payer ID	MNCM assigned Payer ID. Refer to Payer ID reference documentation from MNCM. Contact MNCM at support@mncm.org with questions.	R	Numeric; 1-2 digits
2	Version #	Code representing the version date and source organization of the files being sent. Version # is included in all files sent. Formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String up to 50 characters
3	Claims Processing Date	Last date on which claims were fully adjudicated.	R	Date; mm/dd/yyyy or m/d/yyyy
4	Creation Date	Date that the file was created. Corresponds to date included in Version #	R	Date; mm/dd/yyyy or m/d/yyyy
5	End of look back period	Last date of service of the records pulled	R	Date; mm/dd/yyyy or m/d/yyyy
6	Start of look back period	First date of service of the records pulled	R	Date; mm/dd/yyyy or m/d/yyyy

Version File

Element Order	Field Name	Details	Field Key	Format/ Field Length
7	Use of Data in Research and Public Health Surveillance Allowed	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for research and public health surveillance to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case. The Health Care Payer has agreed to this Use Case for this data. FALSE = No TRUE = Yes	R	String; up to three characters

MN Community MEASUREMENT

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length
The file contains all individuals attributed or enrolled to the medical group and contained within any of the other claims-based data files provided. All health care payers sending data to the medical group are included in this file. There is one row for each matched and enrolled member with the most up to date information based on creation date. This file operates under the assumption that payers are currently sending gap reports to one provider for a single patient. **Field Key:** • **R = Required:** Data element required to be included in the submission file and should be expected consistently in outbound file. • **S = Situational:** Data element was included in the submission file if data was applicable and available in a discrete field that could be queried at the time of the data pull. Data will not be consistently available in outbound file. Exceptions exist, review Details field for more information. • **S+:** These fields are utilized for attribution of a patient to a medical group in the production of the outbound data. Health care payers are required to submit data in at least one of these fields.				
1	Payer ID	MNCM assigned Payer ID. Refer to Payer ID reference documentation from MNCM. Contact MNCM at support@mncm.org with questions.	R	Numeric; 1-2 digits
2	Payer Name	Name of the health plan or payer sending data to the provider.	R	String; up to 50 characters
3	Insurance Member ID	The unique and most up to date number that the payer uses to identify the member. Used to link data across files to member attributed to the medical group.	R	String; up to 80 characters

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length
4	Insurance Subscriber ID	If applicable, member's unique subscriber ID. If present, used to link data across files to member attributed to the medical group.	S	String; up to 80 characters
5	Medical Group TIN	The nine-digit Taxpayer Identification Number (TIN) of the medical group attributed to the patient by the health care payer. Does not include hyphens or other characters. If there was more than one TIN associated with the medical group, the TIN most closely associated with the most recent entity NPI was submitted.	S+	Numeric, nine digits
6	Clinic TIN	The nine-digit Taxpayer Identification Number (TIN) of the clinic attributed to the patient by the health care payer. Does not include hyphens or other characters. If there was more than one TIN associated with the clinic, the TIN most closely associated with the most recent entity NPI was submitted.	S+	Numeric, nine digits
7	Clinic NPI	The ten-digit entity level National Provider Identifier (NPI) number of the clinic at which the patient had their most recent encounter billed to the health care payer, as of the time of the data pull.	S+	Numeric; ten digits
8	Medical Group Patient ID	The unique Patient ID that the medical group provided in the CHIRP Provider-to-Payer data shared with the health care payer. This ID is the Patient ID submitted by the medical group to PIPE. This data will only be populated if the medical group shares CHIRP data with the health care payer.	S	String; up to 50 characters

MN Community MEASUREMENT

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length
9	Member First Name	The full first name of the member. Used to link data across files to member attributed to the medical group.	R	String; up to 35 characters
10	Member Middle Name or Initial	The member's middle name or initial if it is recorded in the database record.	S	String; up to 10 characters
11	Member Last Name	The last name of the member. Used to link data across files to member attributed to the medical group.	R	String; up to 60 characters
12	Member Date of Birth	Used to link data across files to member attributed to the medical group.	R	Date; mm/dd/yyyy or m/d/yyyy
13	Member Sex	Member's sex at birth F = Female M = Male U = Unknown	R	Text; 1 character
14	Street Address		S	Text
15	City		S	Text
16	State	Standard two-character state abbreviation	S	String, two characters
17	Zip Code		S	String; up to 10 characters

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length
18	Attribution Type	Indicator from health care payer as to whether this member's health plan attribution type is enrolled or assigned. 1 = Enrolled 2 = Assigned	R	Numeric; 1 digit
19	Enrollment Date for Pharmacy	The start date of the member's most recent enrollment period for pharmacy coverage	S	Date; mm/dd/yyyy or m/d/yyyy
20	Enrollment Date for medical	The start date of the member's most recent enrollment period for medical coverage	R	Date; mm/dd/yyyy or m/d/yyyy
21	Enrollment Months	The number of whole months that this member has been enrolled	S	Numeric
22	Pharmacy Months	The number of whole months for which this member has pharmacy claims through this health care payer (i.e., claims through third-party would not be available)	S	Numeric
23	Previous Insurance Plan Member ID	Member's previous insurance plan member ID with this health care payer, if changed.	S	String; up to 80 characters
24	Version #	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String; up to 50 characters

Member Attribution File

Element Order	Field Name	Details	Field Key	Format/ Field Length
25	Use of Data in Research and Public Health Surveillance Allowed	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for research and public health surveillance to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case. The Health Care Payer has agreed to this Use Case for this data. FALSE = No TRUE = Yes	R	String; up to three characters

MN Community MEASUREMENT

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length
The file contains one record per eligible, actively enrolled member per measure event unless multiple measures or other circumstances apply. If multiple components of a measure event were present or needed, additional records may be present for that measure. Members who are not eligible for any selected event measures during the measurement period are not included. Refer to Measure Events with Acronym Coding and Sub-Measure Description table in Appendix A. **Field Key:** • **R = Required:** Data element required to be included in the submission file and should be expected consistently in outbound file. • **S = Situational:** Data element was included in the submission file if data was applicable and available in a discrete field that could be queried at the time of the data pull. Data will not be consistently available in outbound file. Exceptions exist, review Details field for more information. • **S*:** It is required that if one of these fields is populated, all must be populated (e.g., if Measure Procedure Code field is populated, Measure Procedure DOS and Measure Procedure Description fields must also be populated).				
1	Payer ID	MNCM assigned Payer ID. Refer to Payer ID reference documentation from MNCM. Contact MNCM at support@mncm.org with questions.	R	Numeric; 1-2 digits
2	Insurance Member ID	The unique and most up to date number that the payer uses to identify the member. Used to link data across files to member attributed to the medical group.	R	String; up to 80 characters
3	Insurance Subscriber ID	If applicable, member's unique subscriber ID. If present, used to link data across files to member attributed to the medical group.	S	String; up to 80 characters

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length
4	Member First Name	The full first name of the member.  Used to link data across files to member attributed to the medical group.	R	String; up to 35 characters
5	Member Last Name	The last name of the member.  Used to link data across files to member attributed to the medical group.	R	String; up to 60 characters
6	Member Date of Birth	 Used to link data across files to member attributed to the medical group.	R	Date; mm/dd/yyyy or m/d/yyyy
7	Measure Event Mapped Acronym	The measure the member is eligible for from the list of specified measures and sub-measures. Refer to Appendix A for details.	R	String; up to 5 characters
8	Measure Event Mapped Description	The description of the measure event indicated in the previous column	R	Text
9	Gap Status	Indicator if there is a gap for this measure event by the end of the current measurement period. 0 = No gap 1= Gap	R	Numeric; 1 digit
10	Measure Procedure DOS	Most recent date of service (DOS) related to this eligible member's measure event procedure, if available. Procedure may or may not meet gap but is the most recent.	S*	Date; mm/dd/yyyy or m/d/yyyy

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length
11	Measure Procedure Code	The most recent procedure code available in claims data related to this measure event, if available. Can include any of the following: CPT, HCPCS, ICD10-PCS	S*	String; up to 50 characters
12	Measure Procedure Description	Text description of the Measure Procedure Code	S*	String; up to 50 characters
13	Measurement Period Start Date	The start of the measurement period for which this member is eligible for the denominator and measure is being calculated (typically 1/1/20xx).	R	Date; mm/dd/yyyy or m/d/yyyy
14	Measurement Period End Date	The end of the measurement period for which this member is eligible for the denominator and measure is being calculated (typically 12/31/20xx).	R	Date; mm/dd/yyyy or m/d/yyyy
15	Measure Steward	The measure steward for this measure event (source definition of the measure): 1 = NCQA / HEDIS 2 = CMS 3 = MNCM 4 = Other	R	Numeric; 1 digit
16	Version #	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String; up to 50 characters

Measure Event Tracking File

Element Order	Field Name	Details	Field Key	Format/Field Length
17	Use of Data in Research and Public Health Surveillance Allowed	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for research and public health surveillance to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case. The Health Care Payer has agreed to this Use Case for this data. FALSE = No TRUE = Yes	R	String; up to three characters

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length
This file contains the listing of active, currently enrolled members with specified conditions. Each member and condition are listed in a separate row. The most recent date of service indicates the most recent encounter in which this condition was documented for this member by any provider. If an active enrolled member has none of the selected chronic conditions, the member is not included in this file. For health plans utilizing value sets, diagnoses that are included on a UB-04 or HCFA 1500 claims form at least one or more times may have been submitted (e.g., hospital, clinic, urgent care, emergency department, home health, skilled nursing facility, etc.). Diagnoses that are found only on radiology or laboratory claims are not included. The chronic conditions of interest are the chronic disease states highlighted in the measure event tracking file (diabetes, hypertension, and hyperlipidemia). For additional information look to Appendix B. **Field Key:** • **R = Required:** Data element required to be included in the submission file and should be expected consistently in outbound file. • **S = Situational:** Data element was included in the submission file if data was applicable and available in a discrete field that could be queried at the time of the data pull. Data will not be consistently available in outbound file. Exceptions exist; review Details field for more information.				
1	Payer ID	MNCM assigned Payer ID. Refer to Payer ID reference documentation from MNCM. Contact MNCM at support@mncm.org with questions.	R	Numeric; 1-2 digits
2	Insurance Member ID	The unique and most up to date number that the payer uses to identify the member. Used to link data across files to member attributed to the medical group.	R	String; up to 80 characters

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length
3	Insurance Subscriber ID	If applicable, member's unique subscriber ID. If present, used to link data across files to member attributed to the medical group.	S	String; up to 80 characters
4	Member First Name	The full first name of the member. Used to link data across files to member attributed to the medical group.	R	String; up to 35 characters
5	Member Last Name	The last name of the member. Used to link data across files to member attributed to the medical group.	R	String; up to 60 characters
6	Member Date of Birth	Used to link data across files to member attributed to the medical group.	R	Date; mm/dd/yyyy or m/d/yyyy
7	Diagnosis Code	ICD-9 CM or ICD-10 CM code of the most recent diagnosis	R	String; up to 20 characters
8	Diagnosis Coding System	1 = ICD-10 2 = ICD-9	R	Numeric; one digit
9	Code Description	Full text description of diagnosis.	R	Text
10	Index of Code	The numeric indicator from the claim line indicating whether the diagnosis code was the primary diagnosis, secondary diagnosis, etc.	R	Numeric; up to three characters
11	Place of Service Code	CMS POS Code for the diagnosis.	S	String; up to two characters

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length
12	Most Recent DOS	Date of service for the diagnosis. If the member received this code more than once, this is the most recent date of service.	R	Date; mm/dd/yyyy or m/d/yyyy
13	Provider First Name	First name of provider who diagnosed the member. If member received this diagnosis more than once, this is the provider from the most recent date of service.	R	String; up to 50 characters
14	Provider Last Name	Last name of provider who diagnosed the member. If member received this diagnosis more than once, this is the provider from the most recent date of service.	R	String; up to 50 characters
15	Provider Taxonomy Code	The CMS Healthcare Provider Taxonomy Code for the provider who diagnosed the member. If member received this diagnosis more than once, this is the provider from the most recent date of service.	S	String; up to 50 characters
16	Provider NPI	Ten-digit National Provider Identifier (NPI) of the provider who diagnosed the member. If member received this diagnosis more than once, this is the provider from the most recent date of service.	S	Numeric; ten digits
17	Condition Source	The claim type that was the source of the diagnosis: 1 = medical 2 = pharmacy 3 = medical and pharmacy	R	Numeric; 1 digit
18	Version	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated • payername = name or acronym of payer organization	R	String; up to 50 characters

Chronic Conditions File

Element Order	Field Name	Details	Field Key	Format/Field Length
19	Use of Data in Research and Public Health Surveillance Allowed	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for research and public health surveillance to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case. The Health Care Payer has agreed to this Use Case for this data. FALSE = No TRUE = Yes	R	String; up to three characters

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length
Each member and prescription fill are listed in a separate row; Refer to Prescription Drug Classes List in Appendix C, for applicable prescriptions. Individuals only appear in the prescription fill file if they were identified in the chronic condition file. **Field Key:** • **R = Required:** Data element required to be included in the submission file and should be expected consistently in outbound file. • **S = Situational:** Data element was included in the submission file if data was applicable and available in a discrete field that could be queried at the time of the data pull. Data will not be consistently available in outbound file. Exceptions exist; review Details field for more information.				
1	Payer ID	MNCM assigned Payer ID.  Refer to Payer ID reference documentation from MNCM. Contact MNCM at support@mncm.org with questions.	R	Numeric; 1-2 digits
2	Insurance Member ID	The unique and most up to date number that the payer uses to identify the member.  Used to link data across files to member attributed to the medical group.	R	String; up to 80 characters
3	Insurance Subscriber ID	If applicable, member's unique subscriber ID.  If present, used to link data across files to member attributed to the medical group.	S	String; up to 80 characters
4	Member First Name	The full first name of the member.  Used to link data across files to member attributed to the medical group.	R	String; up to 35 characters

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length
5	Member Last Name	The last name of the member. Used to link data across files to member attributed to the medical group.	R	String; up to 60 characters
6	Member Date of Birth	Used to link data across files to member attributed to the medical group.	R	Date; mm/dd/yyyy or m/d/yyyy
7	Pharmacy NPI	Ten-digit National Provider Identifier (NPI) of the pharmacy at which the prescription was dispensed.	R	Numeric; ten digits
8	Pharmacy Name	Name of dispensing pharmacy.	S	Text
9	Pharmacy Zip Code	Zip code of dispensing pharmacy.	S	String; up to 10 characters
10	Prescriber First Name	First name of provider who prescribed the medication for member.	R	String; up to 50 characters
11	Prescriber Last Name	Last name of provider who prescribed the medication for member.	R	String; up to 50 characters
12	Provider Taxonomy Code	The CMS Healthcare Provider Taxonomy Code for the provider indicated in the Prescriber First Name and Prescriber Last Name fields in this file.	S	String; up to 50 characters
13	Prescriber NPI	Ten-digit National Provider Identifier (NPI) of the provider who prescribed the medication for the member	R	Numeric; ten digits
14	Medication Fill Date	Date prescription was filled	R	Date; mm/dd/yyyy or m/d/yyyy

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length
15	Medication Order Date	Date prescription was ordered	S	Date; mm/dd/yyyy or m/d/yyyy
16	Generic Medication Name	Data follows this format: generic medication name, strength(s) of medication, unit of measure of strength(s), dosage form, route of admin	R	Text
17	Medication NDC	Eleven (11) character National Drug Code (NDC) for medication. • Does NOT include dashes/hyphens. • Does include leading and trailing zeros as appropriate	R	String; 11 characters
18	Medication Strength	Strength of medication.	R	String; up to 50 characters
19	Unit of measure of strength	Unit of measure of medication strength. • Standard abbreviations allowed.	R	String; up to 50 characters
20	Dosage Form	Dosage form of medication.	R	String; up to 50 characters
21	Unit of measure of medication	Unit of measure of medication. • Only EA, GM, and ML abbreviations used.	S	String; 2 characters
22	Route of Administration	Route of administration for medication.	S	String; 10 characters
23	AHFS	The medication class of the medication as defined by the AHFS.	R	Text
24	Medication Quantity	Number of units of medication dispensed.	R	Numeric; up to 3 digits

Prescription Fill File

Element Order	Field Name	Details	Field Key	Format/Field Length
25	Medication Days Supply	Number of days the dispensed quantity of the medication was intended to last.	R	Numeric; up to 3 digits
26	Refill Count	Number of refills prescribed for the medication.	S	Numeric; up to 3 digits
27	Version #	Code from Version File from this file set. Code represents the version date and source organization of the files being sent. Formatted as yyyy_mm_dd_payername where: • yyyy_mm_dd = Date file set was generated payername = name or acronym of payer organization	R	String; up to 50 characters
28	Use of Data in Research and Public Health Surveillance Allowed	This Use Case allows Participants, which are health care providers, to access and use Health Data of individuals insured or covered by a health benefit plan administered by the Health Care Payer, and delivered through the CHIRP program, for research and public health surveillance to the extent allowable under state and federal laws. Providers are responsible for obtaining any necessary patient authorizations. No other access to, and use of, Health Data is permitted under this Use Case. The Health Care Payer has agreed to this Use Case for this data. FALSE = No TRUE = Yes	R	String; up to three characters

MN Community MEASUREMENT

Appendices

Appendix A: Measure Events with Acronym Coding and Sub-Measure Description

Measure Event	Measure Acronym	Measure Description
Blood Pressure Control for DM	BPD	Blood Pressure Control for Patients with Diabetes
Breast Cancer Screening	BCS	Breast Cancer Screening
Controlling High Blood Pressure	CBP	Controlling High Blood Pressure
Cervical Cancer Screening	CCS	Cervical Cancer Screening
Chlamydia Screening in Women	CHL	Chlamydia Screening in Women
Childhood Immunizations	CIS10	Child Imm Status Combo 10
	CIS3	Child Imm Status Combo 3
	CIS7	Child Imm Status Combo 7
	CIS1	Child Imm Status DTaP
	CIS11	Child Imm Status Influenza
	CIS12	Child Imm Status Hepatitis A
	CIS13	Child Imm Status Hepatitis B
	CIS14	Child Imm Status HiB
	CIS15	Child Imm Status MMR
	CIS16	Child Imm Status Pneumococcal Conjugate
	CIS17	Child Imm Status IPV
	CIS18	Child Imm Status Rotavirus
	CIS19	Child Imm Status VZV
Colorectal Cancer Screening	COL	Colorectal Cancer Screening
Eye Exam for DM	EED	Eye Exam for Patients with Diabetes
Glycemic Status Assessment	GSD	Glycemic Status Assessment for Patients with Diabetes
Immunizations for Adolescents	IMA0	Immun Adol (no gap)
	IMA1	Immun Adol Combo 1
	IMA2	Immun Adol Combo 2
	IMA3	Immun Adol HPV
	IMA4	Immun Adol Meningococcal
	IMA5	Immun Adol Tdap
Kidney Health Evaluation for DM	KED	Kidney Health Evaluation for Patients with Diabetes
Prenatal and Postpartum Care	PPC0	Prenatal and Postpartum Care (no gap)
	PPC1	Prenatal care in first trimester
	PPC2	Postpartum care
Statin Therapy for DM	SPD	Statin Therapy for Patients with Diabetes

Measure Event	Measure Acronym	Measure Description
Other Measure 1	OTH1	Other Measure 1
Other Measure 2	OTH2	Other Measure 2
Other Measure 3	OTH3	Other Measure 3

Appendix B: Chronic Condition List

For the payer-to-provider format, we will concentrate on the chronic disease states highlighted in the gap report: diabetes, hypertension, and hyperlipidemia.

In the chronic condition table, our strategy involves integrating diagnosis codes essential for inclusion and exclusion criteria, with HEDIS serving as our guiding doctrine

The gap report measures capturing chronic conditions include:

- Blood Pressure Control for DM (BPD)
- Controlling High Blood Pressure (CBP)
- Eye Exam for Patients with Diabetes (EED)
- Glycemic Status Assessment (GSD)
- Kidney Health Evaluation for DM (KED)
- Statin Therapy for DM (SPD)

These measures have predefined values set by HEDIS which have exclusion and inclusion criteria. It we focus solely on ICD codes, excluding procedure codes, the following HEDIS value sets will be utilized:

- Diabetes
- IVD
- Frailty Diagnosis
- Advanced Illness
- Frailty Symptoms
- MI
- Macular Pain and Diseases
- ESRD Diagnosis
- Cirrhosis
- Pregnancy
- DM without complications
- History of Kidney Transplant
- Old MI
- Essential Hypertension

It's important to note that certain measures in the gap report will not be included in the chronic condition and pharmacy tables. Notably, measures screening for cancer and those related to more acute conditions are currently excluded:

- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)
- Colorectal Cancer Screening (COL)
- Chlamydia Screening in Women
- Childhood Immunizations
- Immunizations for Adolescents

Appendix C: Therapeutic Drug Classes List

As noted above, for an individual to appear within the pharmacy table they must have been identified within the chronic condition table. Not all medications an individual is on should be sent, only medications that have the following mechanism of action.

For the therapeutic drug classes, two reputable sources were referenced to establish a comprehensive framework: the ADA 2023 Standards of Care in Diabetes and the AHA 2020 International Society of Hypertension Global Hypertension Practice Guidelines.

Diabetes (ADA 2023)

- Insulin therapy (human and analogs)
- Biguanides
- Sulfonylureas (2nd generation)
- Thiazolidinediones
- α-Glucosidase inhibitors
- Meglitinides
- Dipeptidyl peptidase 4 inhibitors (DPP-4i)
- Sodium-glucose cotransporter 2 (SGLT2) inhibitors
- Glucagon-like peptide 1 receptor agonist (GLP-1 RA)
- Glucose-dependent insulinotropic polypeptide (GIP) & GLP1-RA
- Combination therapies of the classes above
- Bile acid sequestrant
- Dopamine-2 agonist
- Amylin mimetic

Hypertension (ADA 2023 & AHA 2020)

- Angiotensin converting enzyme (ACE) inhibitors
- Angiotensin receptor blockers (ARB)
- Dihydropyridine calcium channel blocker (CCB)
- Thiazide/thiazide-like diuretic
- Combination products of ACE, ARB, or DP CCB
- Spironolactone
- Amiloride
- Doxazosin
- Eplerenone
- Clonidine
- β-Blockers

Hyperlipidemia (ADA 2023 & AHA 2020)

- Statin therapy (low, moderate, and high)
- Proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitor
- Statins and Ezetimibe combination therapy
- Statins and PCSK9 Inhibitors

Antiplatelet Agents (ADA 2023 & AHA 2020)

- Aspirin
- P2Y12 inhibitors
- Dual antiplatelet therapy (with low-dose aspirin and a P2Y12 inhibitor)
- Aspirin plus low-dose rivaroxaban

Common Health Information Reporting Partnership (CHIRP) Data Aggregation Policy

Policy Name: CHIRP Payer-to-Provider Data Aggregation Policy	Effective Date: Approved by MNCM Board, February 21, 2024
Policy Owner: MN Community Measurement	Review/Revision Date: October 2026
Category of Policy (select one of the following): MN Community Measurement – CHIRP Governance Committee Policy	

The following algorithm will be used to aggregate Payer data to be routed to participating Providers for approved Payer-to-Provider CHIRP use cases: