
# DELAWARE HEALTH CARE CLAIMS DATABASE

# DATA REQUEST APPLICATION

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*Please use this application to submit information regarding your request for data or data access from the Delaware Health Care Claims Database (DE HCCD)*

## Information

16 Del.C. §10306 authorizes the Delaware Health Information Network (DHIN) to promulgate rules and regulations to carry out its objectives under 16 Del.C. Ch. 103, Subchapter II. The Delaware Health Care Claims Database Data Access Regulation (link: XXX ) describes how the DHIN may release HCCD data to requesting parties:

> § 3.1. HCCD data may be released to a person or organization for purposes of promoting and improving public health; advancing the "Triple Aim" of improving health, improving health care quality and experience, and improving affordability; and providing information to effectively manage risk for the health needs of a population.
>
> § 3.3 Except as otherwise specified in this Regulation, all requests for HCCD data or data access shall require a written application that describes the intended purpose and use of the data and the security and privacy measures that will be used to safeguard the data and prevent unauthorized access to or use of the data.
>
> § 3.4. Except as otherwise specified in this Regulation, all applications for HCCD data or data access shall be reviewed and considered by the Committee
>
> § 4.4 The Committee shall determine by majority vote whether an application should be approved. As part of their review, the Committee shall consider:
>
> - Whether the intended use is consistent with the statutory purpose of the HCCD;
> - Whether access to the requested data is necessary to achieve the intended goals, including but not limited to the need for identifiable data, if requested;
> - Whether access to the requested data may provide an unfair competitive advantage to the requestor;
> - Whether any comments regarding the data request were received from Reporting Entities whose Claims Data is being requested, if applicable;
> - Whether the request complies with all applicable state and federal laws relating to the privacy and security of PHI;
> - Whether the request complies, to the fullest extent practicable, with guidance found in Statement 6 of the Department of Justice and Federal Trade Commission Enforcement Policy regarding the exchange of price and cost information;
> - Whether the applicant is qualified to serve as a responsible steward of the requested data.

The Committee will review the report for compliance with cell suppression rules (i.e. number of observations > 10) and omission of pricing information; and consistency with the purpose and methodology described in this application.

Successful applicants should allow **XX** months in their project timeline to permit this review.

## PART ONE (For All Data Requests)

### (A). Project Information

1) Today's Date:

2) Project Title:

3) Requesting Organization Name:

4) Requesting Organization Description:

5) Project Lead (Principal Investigator, Project Director, etc.):

6) Project Lead Title:

7) Person Responsible for the Project (if different from name above):

8) Title:

9) Phone Number:

10) Email Address:

### (B). Project Details

1) Briefly describe the overall project objective

2) Provide a brief description of how this project will promote and improve public health; advance the "Triple Aim" of improving health, improving health care quality and experience, and improving affordability; or how this project will provide information to effectively manage risk for the health needs of a population.

3) Do you need Protected Health Information (PHI)?
    a. Do you need patient-specific dates (e.g., dates of service or DOB), city, or 5 digit zip code? If so, this is a request for a Limited Data Set.
    b. Do you need direct patient identifiers such as name, address, or social security number? If so, this is a request for an Identified Data Set.
    c. If you do not require any PHI, this is a request for De-Identified Data and you should only complete **PART ONE** of this application.

### (C). Distribution of the Report or Product:

If you are producing a report for publication in any medium (print, electronic, lecture, slides, etc.) the HCCD Committee must review the report prior to public release. The Committee will review the report for compliance with cell suppression rules and adherence to Statement 6 of the Department of Justice

and Federal Trade Commission Enforcement Policy regarding the exchange of price and cost information; and consistency with the purpose and methodology described in this application.

1) Please describe your audience and how you will make your project results or findings publicly available? Please include how you plan to comply with CMS cell suppression rules and Statement 6 of the Dept. of Justice and Federal Trade Commission Enforcement Policy, in your response.

2) If no findings will be made publicly available, then briefly describe how the information derived from HCCD data will be used and by whom.

## (D). Request Parameters

1) Please select the type of data that you are requesting:
   - ☐ De-Identified Data Set
   - ☐ Limited Data Set*
   - ☐ Identified Data Set *

   * These types of data include Protected Health Information (PHI). Under HIPAA, PHI may only be released in limited circumstances for public health, health care operations, and research purposes. These types of data sets require applicants to complete **PART TWO** and **PART THREE** of this application.

2) Date range or years of data requested:

3) Lines of Business requested (please list out: Medicaid FFS, Medicaid Managed Care, Qualified Health Plans, Medicare Advantage,):

4) Subset of medical claims requested, if applicable (e.g., “durable medical equipment only” or “inpatient services only.”

5) Geographic groupings requested, if applicable (e.g. county, health statistics region, three or five digit zip-code):

6) Age and/or gender stratifications requested, if applicable (NOTE: race and ethnicity data is not well-populated in the HCCD data and is therefore not available in a sufficient quantity):

7) Site of service detail requested, if applicable (examples include: All, hospital, free-standing facilities, office, etc.):

8) Pharmacy claims requested (Yes/No):

9) Please list specific diagnoses of interest, if any (e.g. ICD10 codes). Please note, if specific diagnoses are being requested, the data requestor must provide DHIN with the codes of interest.

10) Please list specific medical procedures codes of interest, if any. Please note, if specific medical procedure codes are being requested, the data requester must provide DHIN with the codes of interest.

11) How frequently will you need the data? (e.g. one-time, quarterly refresh, annual refresh)

## (E). Linkages to Other Data Sets

1) Will you link the HCCD data to another data source? If yes, please answer the following questions.
    a. Which HCCD data elements will be used to perform the linkage?
    b. Once the linkage is made, what non-HCCD data elements will appear in the new linked file?
    c. Have all necessary approvals been obtained to receive and link with the other data files (e.g., IRB or Privacy Board approval)?

# PART TWO (Requests for Limited Data Sets and Identified Data)

## (A). Requested Data Elements

DHIN will only release the minimum necessary data elements required to complete the project. Use the Data Elements Request Form on the next page to circle the specific data elements that you require for your project. Use the space following the Form to explain why the selected data elements are required for the project's purpose.

**Data Elements Request Form**

| Eligibility File | Medical Claims File | Pharmacy Claims File | Provider File |
|---|---|---|---|
| Data Submitter Name | Data Submitter Name | Data Submitter Name | Data Submitter Name |
| Insurance/Product Type | Insurance/Product Type | Insurance/Product Type | Provider ID |
| HIX Offering? | Group or Policy Number | Group or Policy Number | Provider Tax ID |
| Group Size | SSN | SSN | Provider NPI |
| Risk Basis | Contract Number | Contract Number | Provider Entity Type |
| High-Deductible/HSA? | Member Name | Member Name | Provider Name |
| Actuarial Value | Member Number | Member Number | Provider Specialty |
| Metallic Tier/Value | Subscriber Name | Subscriber Name | Provider Address |
| Eligibility Period | Relationship to Insured | Relationship to Insured | Provider Office Address |
| Plan Effective Date | Gender | Gender | Provider State License number |
| Group or Policy Number | Date of Birth | Date of Birth | Provider Office Phone Number |
| Coverage Level | Member Address | Member Address | Provider DEA number |
| SSN | Patient Account Number | Pharmacy Number | |
| Contract Number | Service Provider Number | Pharmacy Tax ID | |
| Member Name | Service Provider Tax ID | Pharmacy Name | |
| Member Number | Service Provider NPI | Pharmacy Address | |
| Subscriber Name | Service Provider Entity Type | Prescribing Provider ID | |
| Relationship to Insured | Service Provider Name | Prescribing Physician NPI | |
| Gender | Service Provider Specialty | Prescribing Physician Name | |
| Date of Birth | Service Provider Address | Prescribing Provider DEA number | |
| Member Address | Billing Provider Number | Claim Number | |
| Type of Coverage | Billing Provider NPI | Claim Version Number | |
| Race | Billing Provider Name | Date Prescription Filled | |
| Hispanic Indicator | Claim Number | Prescription Written Date | |
| Ethnicity | Claim Version Number | Claim Status | |
| Primary Insurance Indicator | Date of Service | Drug Name | |
| Market Category Code | Admission Date | Drug Code | |
| Employer Tax ID | Admission Time | Quantity Dispensed / Days Supply? | |
| PCP NPI | Admission Type | Dispense as Written Code | |
| | Admission Source | New prescription or refill? | |
| | Discharge Date and Time | Generic Drug Indicator | |
| | Discharge Status | Compound Drug Indicator | |
| | Type of Bill | Charge Amount | |
| | Claim Status | Paid Amount | |
| | Admitting Diagnosis | Ingredient Cost/List Price | |
| | ICD-9/ICD-10 code(s) | Co-Pay Amount | |
| | Revenue Code | Co-Insurance Amount | |
| | Outpatient Provider Code (HCPCS) | Deductible Amount | |
| | Procedure Modifier(s) | Postage Amount Claimed | |
| | Date(s) of Service | Dispensing Fee | |
| | Quantify of Services | | |
| | Patient Account Number | | |
| | DRG | | |
| | Ambulatory Payment Classification | | |
| | NDC Drug Code | | |
| | Present on Admission Diagnosis | | |
| | Capitated Service Indicator | | |
| | Provider-Network Indicator | | |
| | Self-Funded Claim Indicator | | |
| | Charge Amount | | |
| | Paid Amount | | |
| | Prepaid Amount | | |
| | Co-Pay Amount | | |
| | Co-Insurance Amount | | |
| | Deductible Amount | | |
| | Charge Amount | | |

**Justification for Requested Data Elements**

## (F). Data Management and Security

**Project Personnel:**

1) Who will serve as the data custodian (responsible for organizing, storing, and archiving the HCCD data):

2) Who will be responsible for ensuring that HCCD data is destroyed upon termination of the data use agreement:

3) List all project personnel who will have access to the HCCD data

**Data Transfer, Storage, Access:**

1) How would you like the HCCD data to be transferred to your organization?
   - ☐ SFTP
   - ☐ External hard drive with encrypted data

2) How will HCCD data be stored by your organization (check all that apply)?
   - ☐ Secure server
   - ☐ Cloud-based system
   - ☐ Secure hard drive
   - ☐ External device

3) Please describe the security procedures in place to ensure that HCCD data will be sufficiently protected via this storage method.

4) How will project personal access the data?

5) How will access to HCCD data be restricted to only the individuals who require access?

**Technical and Physical Safeguards:**

1) Describe the actions your organization will take to physically secure the HCCD data.

2) Describe your policies and procures for ensuring that HCCD data are protected when stored on your servers.

3) Describe how your organization prevents the copying or transfer of data to local workstations and other hard media devices.

**Personnel/Staffing Safeguards:**

1) Please describe the training on confidential and electronic health information that the project personnel who will have access to the HCCD data have received?

2) Has every individual who will access the HCCD data received this training in the last year?

3) Have all individuals who will have access to the HCCD data signed an internal, requesting organization-specific confidentiality agreement?

**Information Security**

1) Does your organization have security policies that are followed and accessible to all staff accessing the HCCD data? If yes, attach these policies to the application.

2) When were your organization's security policies last updated?

3) How do staff/users notify your organization of security problems?

4) Has your organization or any member of the project team (including third-party vendor personnel) ever been involved with a project that experienced a data security incident? If yes, describe the incident, the response procedures that were followed and any subsequent changes in protocols to mitigate the risk of future events.

**Data Destruction**

1) Describe the measures you will use to destroy the HCCD data upon termination of the Data Use Agreement, per the requirements of the Data Use Agreement.

2) Describe your procedures for terminating access to the HCCD data when staff/researchers terminate participation in the project.

## PART THREE (Requests for Limited Data Sets and Identified Data)

### (A). Applicant Qualifications

Describe the qualifications of your organization and key personnel to conduct the proposed research, implement the proposed data management plan with fidelity and to adhere to the Data Use Agreement.

### (B). Use of Third Party Agents or Vendors

1. Will you be contracting with any third-party vendors who will have access to HCCD data? If yes, list the name(s) of the third-party vendor(s) and the services to be provided by third-party vendor(s). If a third-party vendor will be used, they must complete **Part Two** of this application as well.