



**DELAWARE HEALTH CARE CLAIMS DATABASE
DATA REQUEST APPLICATION**

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 describes the circumstances under which DHIN may release HCCD data to requesting parties (<http://dhin.org/wp-content/uploads/2017/11/2017-11-14-Delaware-Health-Care-Claims-Database-Data-Access-Regulation-rev.pdf>) :

§ 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. Applications for De-Identified Data may be eligible for expedited review.

§ 3.5. The Committee shall review, without exception, the following types of applications to confirm the intended use is consistent with the statutory purpose of the HCCD.

- Applications for Limited Data Sets
- Applications for Identified Data
- Applications from out-of-state commercial requestors who are not Reporting Entities and whose intended use will not directly benefit Delawareans.

§ 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 all data shared publicly or re-disclosed to anyone other than an approved user for compliance with cell suppression rules and omission of pricing information; and consistency with the purpose and methodology described in this application.

Successful applicants should allow a minimum of two months 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 (including any financial or competitive relationship that may be relevant to this request for data):

- 5) Project Lead (Principal Investigator, Project Director, etc.):
- 6) Project Lead Title:
- 7) Project Contact (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 provide information to effectively manage risk for the health needs of a population.

- 3) Please use the three options below to identify whether you are requesting any Protected Health Information (PHI) or Personally Identifiable Information (PII). Circle the one that applies below and provide a brief description of why this level of data is necessary to accomplish the project’s purpose.
- a. Do you need direct patient identifiers such as name, medical record number, or social security number? If so, this is a request for an **Identified Data Set**. These requests are subject to additional scrutiny by the committee and will be evaluated for adherence to the “minimum necessary” principle. Please describe below why this level of data is necessary to accomplish the project’s purpose.

 - b. Do you need indirect patient identifiers such as patient-specific dates (e.g. dates of service or DOB) or patient-specific geographic subdivisions smaller than a state (e.g. address, city, or 5-digit zip code)? If so, this is a request for a **Limited Data Set**. These requests are subject to additional scrutiny by the Committee and will be evaluated for adherence to the “minimum necessary” principle. Please describe below why this level of data is necessary to accomplish the project’s purpose.

 - c. If you do not require any PHI or PII (indirect or direct patient identifiers), 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.

- 1) Please describe if/how project findings will be disseminated publicly and to whom (e.g. peer-reviewed publication, organization newsletter, program evaluation report, etc.).

- 2) If project findings will be disseminated, please describe how you plan to comply with CMS cell suppression rules.

- 3) If project findings will be disseminated, please describe how you plan to comply with the Safety Zone requirements set forth in Statement 6 of the Dept. of Justice and Federal Trade Commission Enforcement Policy. If you are unable to satisfy the requirements of the Safety Zone, please include a detailed proposal of alternative safeguards for the dissemination of HCCD data or results that would afford protections equivalent to those set forth in Statement 6 regarding potentially anticompetitive behavior. A description of the Safety Zone requirements can be found here: <https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care>

- 4) If no findings will be made publicly available, briefly describe how the information derived from HCCD data will be used and by whom:

(D). Data Requested

Complete the information below to provide a high-level description of your data request.

- 1) Level of data that you are requesting (refer to your response in Part 1, Section B, question 3):

- De-Identified Data Set
- Limited Data Set*
- Identified Data Set *

* These data requests include PHI or PII. Under HIPAA, PHI or PII 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, State Employee/Retiree Plans, Medicare Advantage):
- 4) Subset of medical claims requested, if appropriate (e.g., “durable medical equipment only” or “inpatient services only.”)
- 5) Geographic groupings requested (e.g. all of Delaware, three or five-digit zip-code):
- 6) Age and/or Gender stratifications requested, if applicable:
- 7) Site of service detail requested, if applicable (e.g.: All, hospital, free-standing facilities, office, etc.):
- 8) Pharmacy claims requested (Yes/No):
- 9) Specific diagnoses of interest, if applicable (e.g. ICD10 codes). Please note, the data requestor must provide DHIN with the codes of interest.
- 10) Specific medical procedures codes of interest, if any. Please note, the data requester must provide DHIN with the codes of interest.
- 11) Are patient identifiers being requested (Yes/No):
- 12) 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.

- Which HCCD data elements will be used to perform the linkage?
- Once the linkage is made, what non-HCCD data elements will appear in the new linked file?
- Have all necessary approvals been obtained to receive and link with the other data files (e.g., IRB or Privacy Board approval)?

PART TWO (Requested Data Elements and Data Security and Management Plan)

(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 identify 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.

Requested Data Elements

Eligibility File	Medical Claims File	Pharmacy Claims File	Provider File
Enterprise ID	Enterprise ID	Enterprise ID	
Data Submitter Name / Payer	Data Submitter Name / Payer	Data Submitter Name / Payer	Data Submitter Name / Payer
Insurance/Product Type	Insurance/Product Type	Insurance/Product Type	Provider ID
Medical Coverage Flag	Group or Policy Number	Group or Policy Number	Provider Tax ID
Prescription Drug Coverage Flag	Subscriber SSN	Subscriber SSN	Provider NPI
Dental Coverage Flag	Contract Number	Contract Number	Provider Entity Type
Behavioral Health Coverage Flag	Member Name	Member Name	Provider Name
Marketplace Offering?	Member Number	Member Number	Provider Specialty
Coverage Type	Subscriber Name	Subscriber Name	Provider Address
Risk Basis	Relationship to Insured	Relationship to Insured	Provider Office Address
Actuarial Value	Gender	Gender	Provider State License number
Eligibility Period	Date of Birth	Date of Birth	Provider Office Phone Number
Plan Effective Date	Member Address	Member Address	Provider DEA number
Group or Policy Number	Patient Account Number	Pharmacy Number	
Coverage Level	Service Provider Number	Pharmacy Tax ID	
Subscriber SSN	Service Provider Tax ID	Pharmacy Name	
Contract Number	Service Provider NPI	Pharmacy Address	
Member Name	Service Provider Entity Type	Prescribing Provider ID	
Member Number	Service Provider Name	Prescribing Physician NPI	
Subscriber Name	Service Provider Specialty	Prescribing Physician Name	
Relationship to Insured	Service Provider Address	Prescribing Provider DEA #	
Gender	Billing Provider Number	Claim Number	
Date of Birth	Billing Provider NPI	Claim Version Number	
Member Address	Billing Provider Name	Date Prescription Filled	
Type of Coverage	Claim Number	Prescription Written Date	
Race	Claim Version Number	Claim Status	
Hispanic Indicator	Date of Service	Drug Name	
Ethnicity	Admission Date	Drug Code	
Primary Insurance Indicator	Admission Time	Quantity Dispensed/Day Supply	
Market Category Code	Admission Type	Dispense as Written Code	
Employer Tax ID	Admission Source	New prescription or refill?	
Employer Group Name	Discharge Date and Time	Generic Drug Indicator	
PCP NPI	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		

(B). Justification for Requested Data Elements

- 1) If your request includes any PHI or PII, please provide detailed justification for the PHI/PII. Please specifically address why the research and/or project could not be accomplished without the use of identifiable information. Please include a description of the purpose and need for each data element requested. Be as detailed as possible.

- 2) If your request includes any price or cost information specific to an individual payer or any information that could be used to restrict competition, please provide detailed justification for why this information is necessary for the completion of your research or project.

(C). Data Management and Security Plan

Project Personnel:

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

- 2) List all project personnel who will have access to the HCCD data, including their title and project role.

- 3) List all project subcontractors, including third party agents or vendors, who will have access to the data. For each subcontractor include the following information: name, services to be provided, how the privacy/security practices of this subcontractor have been evaluated, the nature of agreements executed with this subcontractor to protect confidentiality and limit further disclosure of the data, and whether contracts allow termination in the event of violations of data protection provisions.
*** All subcontractors identified must complete the Data Management and Security Plan (Part II, Section C of this application).**

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? Describe authentication methods.

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 procedures 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 a confidentiality agreement and non-disclosure 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) Who will be responsible for ensuring that HCCD data is destroyed upon termination of the data use agreement? How will you inform DHIN of the destruction of the data?

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

PART THREE

(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.

