DELAWARE HEALTH CARE CLAIMS DATABASE

DATA REQUEST APPLICATION

Please use this application to request data or data access from the Delaware Health Care Claims Database (DE HCCD). For more information on the circumstances under which DHIN may release HCCD data to requesting parties, see Data access Regulation from the DHIN website.

Date of Application:	
Project title:	
HCCD Request # (DHIN to apply)	

Contents

PART 1 – Project and Data Set Overview (*for all requestors*)

A. Requestor Information

Organization name:	
Organization description:	
Project contact: Name	
Title:	
Phone number:	
Email address:	
Project lead: (if different from above, otherwise "N/A")	
Title:	
Phone number:	
Email address:	

B. Project Information

Project objective: *(Briefly describe the overall project objective)*

Project purpose: *(Briefly describe 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)*

C. Distribution of 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**. Review will ensure compliance with cell suppression rules, approved of pricing information and consistency with the purpose and methodology described in this application. Successful applicants should allow a minimum of 2 weeks to permit this review.

Will findings be made publicly available? (*e.g., peer-reviewed publication, organization newsletter, program evaluation report, etc.)*
☐ Yes – *Answer remaining questions in this section* ☐ No – *In the space below, describe how the information derived from HCCD data will be used and by whom*

If Yes is checked above, complete the following:

Public dissemination plan: *(Briefly describe if/how project findings will be disseminated and to whom, e.g., peer-reviewed publication, organization newsletter, program evaluation report, etc.)*

CMS cell suppression: *(Describe how you plan to comply with CMS cell suppression rules)*

Safety Zone compliance: *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. A description of the Safety Zone requirements can be found here: https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care)* ***Note:** If you are unable to satisfy the requirements of the Safety Zone, 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.)*

D. Data Set Overview

Use the three options below to identify whether you are requesting any **Protected Health Information** (PHI) or **Personally Identifiable Information** (PII):

Which type of data is needed for project: *(Check one)*	
☐ Identified Data Set*****	Contains **direct** patient identifiers such as name, medical record number, or social security number.
☐ Limited Data Set*****	Contains **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, 5-digit zip code)
☐ De-Identified Data Set	Contains **no** direct or indirect patient identifiers (i.e., no PHI or PII).
☐ Custom Report	Contains **no** direct or indirect patient identifiers (i.e., no PHI or PII); DHIN performs analytic services with aggregated output.

*Data sets 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. **PARTS 2 – 4 of this application are required.**

Data Set Rationale: *(If you checked **Identified** or **Limited Data Set** above, briefly describe why this level of detail is necessary to accomplish the project purpose. These requests are subject to additional scrutiny by the Committee and will be evaluated for adherence to the "minimum necessary" principle.)*

Data Request Details: *(Use the following to provide a high-level description of your data request)*	
Requesting Patient Identifiers?	☐ Yes ☐ No
Dates: *(Date range or years of data requested)*	

Data Request Details: *(Use the following to provide a high-level description of your data request)*	
Refresh frequency: *(How frequently will you need the data, e.g., one-time, quarterly refresh, annual refresh?)*	
Insurance Category: *(List out: Medicaid FFS, Medicaid Managed Care, Qualified Health Plans, State Employee/Retiree Plans, Medicare Advantage)*	
Medical claims subset: *(if appropriate, e.g., "durable medical equipment only" or "inpatient services only.")*	
Requesting pharmacy claims?	☐ Yes ☐ No
Geographic groupings: *(e.g., all of Delaware, three or five-digit zip-code)*	
Age and/or gender stratifications: *(if applicable)*	
Site of service detail: *(if applicable, e.g., All, hospital, free-standing facilities, office, etc.)*	
Specific diagnoses of interest: *(if applicable, e.g., ICD10 codes.)*	

E. Linkage to Other Data Sets

Will you link the HCCD data to other data (*e.g., peer-reviewed publication, organization newsletter, program evaluation report, etc.)*	
☐ Yes – *Answer remaining questions in this section* ☐ No – *Proceed to next section (Part 2)*	
HCCD data elements: *(Which HCCD data elements will be used to perform linkage?)*	
Non-HCCD data elements: *(Once the linkage is made, what non-HCCD data elements will appear in the new linked file?)*	
Necessary approvals: *(Have all necessary approvals been obtained to receive and link with the other data files, e.g., IRB or Privacy Board approval?)*	

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PART 2: Data Elements

DHIN will only release the minimum necessary data elements required to complete the project. Check the boxes of all specific data elements that you require for your project.

A. Data Elements

DHIN Calculated Fields

Field Name	Descripton
☐ Age (*Not* DOB)	Age at time of service, or age at year of observation
☐ Care Setting	Examples: ambulance, home, hospital ED, office, rehab facility etc
☐ Claim Type	Professional, facility, other

Field Name	Descripton
☐ Service Line	Inpatient, outpatient, emergency
☐ Drug Classification	As per the RedBook
☐ Dual-Eligible Flag	Identifies members who receive both Medicaid and Medicare
☐ Length of Stay	Two choices: please discuss. Mathematical LOS and CMS LOS
☐ Patient Paid Amount	Includes sum of co-pay, co-insurance and deductible
☐ Insurer Paid Amount	Includes insurer's payment to provider only
☐ Total Paid Amount	Includes sum of both patient and insurer's payments
☐ DRG for Inpatient claims	Based on 3M MS DRG software coded inpatient records
☐ Johns Hopkins ACG Risk score	Risk index value (0 – 2.0) as compared to other persons in the claims database
☐ Other needs?	

Payer Submitted Fields

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

PHI and PII: *(Provide detailed justification for all PHI/PII requested. Specifically address why the research and/or project could not be accomplished without the use of identifiable information. Include a description of the purpose and need for **each** data element requested. Be as detailed as possible.)*
Price and cost: *(Provide detailed justification for any price or cost information specific to an individual payer OR any information that could be used to restrict competition. Why is this information necessary for the completion of your research or project?)*

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PART 3: Personnel and Qualifications (*identified or limited data sets only*)

A. Key Personnel

Data Custodian: *(Who is responsible for organizing, storing, and archiving the HCCD data?)*	
Name	**Title**

Project Personnel: *(List all project personnel who will have access to the HCCD data)* **[Insert more lines if needed]**			
Name	**Title**	**Degree**	**Role**

Project Contractors: *(List all project subcontractors, including third party agents or vendors, who will have access to the data. **Note:** All subcontractors identified must complete **Part 4: Data Management and Security Plan** below.)* **[Insert more tables as needed]**

Subcontractor #1	
Name:	
Services to be provided:	
How have privacy/ security practices been evaluated?	
Nature of agreements executed to protect confidentiality/limit disclosure of data:	
Contract allows termination if data protection provisions are violated?	

Subcontractor #2	
Name:	
Services to be provided:	
How have privacy/ security practices been evaluated?	
Nature of agreements executed to protect confidentiality/limit disclosure of data:	
Contract allows termination if data protection provisions are violated?	

B. Qualifications

Research: (*Describe the qualifications of you organization and key personnel to conduct the proper research.)*
Data management plan: *(Describe the qualifications of your organization and key personnel to adhere to the Data Use Agreement and implement, with fidelity, the data management plan proposed in PART 4 below.)*

PART 4: Data Management & Security Plan (*identified or limited data sets only – MUST be completed by requestor AND subcontractors*)

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A. Data Transfer, Storage, Access

Transfer: *(What method should HCCD data be transferred to your organization?)*	☐ SFTP ☐ Secure Mail (small datasets only) ☐
Storage: *(Where will HCCD data be stored by your organization? **Note:** Check all that apply)*	☐ Secure server ☐ Cloud-based system ☐ Secure hard drive ☐ External device

Security Procedures (*Describe the security procedures in place to ensure that HCCD data will be sufficiently protected via the storage method(s) above.)*
Personnel access and authentication: (*How will project personnel access the data? Describe authentication methods.)*
Authorized users: (*How will access to HCCD data be restricted to only the individuals who require access?)*

B. Technical and Physical Safeguards

Physical security: (*Describe the actions your organization will take to physically secure the HCCD data)*
Policies and procedures: (*Describe your policies and procedures for ensuring that HCCD data are protected when stored on your servers)*
Prevention of unauthorized transfers: (*How does your organization prevent the copying or transfer of data to local workstations and other hard media devices?)*

Confidentiality training: (*Describe the training on confidential and electronic health information received by the project personnel who will access HCCD data.)*
Training current: *(Has every individual who will access HCCD data received this training in the last year?)*
☐ Yes ☐ No – *If no, explain below:*
Signed agreements: *(Has every individual who will have access to the HCCD data signed a confidentiality agreement and non-disclosure agreement?)*
☐ Yes ☐ No – *If no, explain:*

C. Information Security

Organization policies: (*Does your organization have security policies that are followed by and accessible to all staff accessing the HCCD data?)*
☐ Yes – *If yes, include with application* ☐ No – *If no, explain:*
Policy last updated: (*When were your organization's security policies last updated?)*
Notification process: (*How do staff/users notify your organization of security problems?)*

Past incidents: (*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?)*
☐ Yes – *If yes, describe the incident, the response procedures that were followed, and any subsequent changes in protocols to mitigate the risk of future events.* ☐ No

D. Data Destruction

Destruction plan: (*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.)*
Responsible party: (*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?)*
Access termination: (*Describe your procedures for terminating access to the HCCD data when staff/researchers terminate participation in the project)*

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Regulatory 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.

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Application Process

1. Submit your completed Application to DHIN's ServiceDesk@dhin.org
2. DHIN submits Applications to Payers for a 10 day Data Use Notification and Comment Period
3. On the First Monday of each month, the HCCD Committee determines approval status for the application.
4. DHIN will Invoice your organization for the Application Fee
5. Should you have any questions or need assistance with this application, please contact the DHIN ServiceDesk@dhin.org. An Analyst will respond.