

**Commonwealth of Massachusetts
Center for Health Information & Analysis (CHIA)
Non-Government Agency Application for Data**

NOTE: This application is to be used by all applicants, except Government Agencies, as defined in 957 CMR 5.02.

I. GENERAL INFORMATION

| APPLICANT INFORMATION | |
|--|---|
| Applicant Name: | Amy Travers |
| Title: | Manager of Provider Financial Planning |
| Organization: | Boston Medical Center Healthnet Plan |
| Project Title: | Ongoing reporting of BMCHP case mix versus other Medicaid |
| Date of Application: | 10/29/13 |
| Project Objectives (240 character limit) | Review of hospital utilization for BMCHP populations (by hospital, by product) versus other Medicaid populations. |
| Project Research Questions | 1. How BMCHP case mix compares to MassHealth and other populations |
| | |

Please indicate if you are a Researcher, Payer, Provider or Provider Organization and you are seeking data pursuant to 957 CMR 5.04 (De-identified Data) or 957 CMR 5.05 (Direct Patient Identifiers for Treatment or Coordination of Care).

| | |
|--|---|
| <input type="checkbox"/> Researcher <input type="checkbox"/> Payer <input type="checkbox"/> Provider / Provider Organization | <input checked="" type="checkbox"/> 957 CMR 5.04 (De-identified Data) <input type="checkbox"/> 957 CMR 5.05 (Direct Patient Identifiers) |
|--|---|

All other requests are subject to 957 CMR 5.06.

II. PROJECT SUMMARY

Briefly describe the purpose of your project and how you will use the CHIA data?

The data will be used in support of analytics of hospital utilization. Our focus is review of hospital utilization for BMCHP populations (by hospital, by MassHealth, or Commonwealth Care program) versus other Medicaid populations. The data is critical in comparisons of our current or proposed contractual terms versus the MassHealth case rate since the population used to establish the SPAD differs from BMCHP's populations. We also plan to use the data to support hospitals engaged in medical cost savings efforts.

III. FILES REQUESTED

Please indicate the databases from which you seek data, the Level(s) and Year(s) of data sought.

| DATABASE | Level 1 ¹ or 2 ² | Single or Multiple Use | Year(s) Of Data Requested Current Yrs. Available 2009 - 2011 |
|---|---|------------------------|---|
| <input type="checkbox"/> Medical Claims | <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 | Select... | <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |
| <input type="checkbox"/> Pharmacy Claims | <input type="checkbox"/> Level 1 <input type="checkbox"/> Level 2 | Select... | <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |
| <input type="checkbox"/> Dental Claims | <input type="checkbox"/> Level 2 | Select... | <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |
| <input type="checkbox"/> Member Eligibility | <input type="checkbox"/> Level 2 | Select... | <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |
| <input type="checkbox"/> Provider | <input type="checkbox"/> Level 2 | Select... | <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |
| <input type="checkbox"/> Product | <input type="checkbox"/> Level 2 | Select... | <input type="checkbox"/> 2009 <input type="checkbox"/> 2010 <input type="checkbox"/> 2011 |
| CASEMIX | Level 1 - 6 | | Fiscal Years Requested |
| Inpatient Discharge | <input checked="" type="checkbox"/> Level 1 – No Identifiable Data Elements <input type="checkbox"/> Level 2 – Unique Physician Number (UPN) <input type="checkbox"/> Level 3 – Unique Health Information Number (UHIN) <input type="checkbox"/> Level 4 – UHIN and UPN <input type="checkbox"/> Level 5 – Date(s) of Admission; Discharge; Significant Procedures <input type="checkbox"/> Level 6 – Date of Birth; Medical Record Number; Billing Number | | <u>1998-2012 Available</u> (limited data available 1989-1997) 2012 |
| Outpatient Observation | <input type="checkbox"/> Level 1 – No Identifiable Data Elements <input type="checkbox"/> Level 2 – Unique Physician Number (UPN) <input type="checkbox"/> Level 3 – Unique Health Information Number (UHIN) <input type="checkbox"/> Level 4 – UHIN and UPN <input type="checkbox"/> Level 5 – Date(s) of Admission; Discharge; Significant Procedures <input type="checkbox"/> Level 6 – Date of Birth; Medical Record Number; Billing Number | | <u>2002-2011 Available</u> |

¹ Level 1 Data: De-identified data containing information that does not identify an individual patient and with respect to which there is no reasonable basis to believe the data can be used to identify an individual patient. This data is de-identified using standards and methods required by HIPAA.

² Level 2 (and above) Data: Includes those data elements that pose a risk of re-identification of an individual patient.

| | | |
|----------------------|--|----------------------------|
| Emergency Department | <input type="checkbox"/> Level 1 – No Identifiable Data Elements | <u>2000-2011 Available</u> |
| | <input type="checkbox"/> Level 2 – Unique Physician Number (UPN) | |
| | <input type="checkbox"/> Level 3 – Unique Health Information Number (UHIN) | |
| | <input type="checkbox"/> Level 4 – UHIN and UPN; Stated Reason for Visit | |
| | <input type="checkbox"/> Level 5 – Date(s) of Admission; Discharge; Significant Procedures | |
| | <input type="checkbox"/> Level 6 – Date of Birth; Medical Record Number; Billing Number | |

IV. REQUESTED DATA ELEMENTS [APCD]

State and federal privacy laws limit the use of individually identifiable data to the minimum amount of data needed to accomplish a specific project objective. Please use the [APCD Data Specification Workbook](#) to identify which data elements you would like to request and attach this document to your application.

V. REQUESTED DATA ELEMENTS [CASE MIX]

Please use the CASE MIX DATA SPECIFICATION WORKBOOK to identify which deniable data elements (from Level 2 or above) you would like to request and attach this to your application.

VI. MEDICAID DATA

Federal law (42 USC 1396a(a)7) restricts the use of individually identifiable data of Medicaid recipients to uses that benefit the administration of the Medicaid program. If you are requesting Medicaid data from Level 2 or above, please describe in detail why your use of the data benefits the administration of the Medicaid program.

N/A

VII. MEDICARE DATA

Medicare data may be disseminated to state agencies and/or entities conducting research projects that are directed and partially funded by the state if such research projects would allow for a Privacy Board or an IRB to make the findings listed at 45 CFR 164.512(i)(2)(ii) if the anticipated data recipient were to apply for the data from CMS directly. If you are requesting Medicare data, please explain how your research project is directed and partially funded by the state and describe in detail why your proposed project meets the criteria set forth in 45 CFR 164.512(i)(2)(ii). Applicants must describe how they will use the data and inform CHIA where the data will be housed. CHIA must be informed if the data has been physically moved, transmitted, or disclosed.

N/A

VIII. DIRECT PATIENT IDENTIFIERS³

State and federal privacy laws may require the consent of Data Subjects prior to the release of any Direct Patient Identifiers. If you are requesting data that includes Direct Patient Identifiers, please provide documentation of patient consent or your basis for asserting that patient consent is not required.

³ Direct Patient Identifiers. Personal information, such as name, social security number, and date of birth, that uniquely identifies an individual or that can be combined with other readily available information to uniquely identify an individual.

IX. REQUESTS PURSUANT TO 957 CMR 5.04

Payers, providers, provider organizations and researchers seeking access to Level 1 (de-identified) data are required to describe how they will use such data for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis or other administrative research purposes. Please provide this information below.

We use inpatient case mix data to compare BMCHP population case mix to the population used to create the SPAD. These results are used to ensure we appropriately benchmark our contractual rates against the Mass Health fee schedule.

X. FILTERS

If you are requesting APCD elements from Level 2 or above, describe any filters you are requesting to use in order to limit your request to the minimum set of records necessary to complete your project. (For example, you may only need individuals whose age is less than 21, claims for hospital services only, or only claims from small group projects.

| APCD FILE | DATA ELEMENT(S) FOR WHICH FILTERS ARE REQUESTED | RANGE OF VALUES REQUESTED |
|------------------------|---|---------------------------|
| Medical Claims | NA | |
| Pharmacy Claims | | |
| Dental Claims | | |
| Membership Eligibility | | |
| Provider | | |
| Product | | |

XI. PURPOSE AND INTENDED USE

1. Please explain why completing your project is in the public interest.

Allows to benchmark case mix across payers and against the payment levels set by MH in calculating the MCO capitation rates. Provides information used to develop contracting strategy.

2. Attach a brief (1-2 pages) description of your research methodology. (This description will not be posted on the internet.) Methodology consistent with that used in prior years

3. Has your project received approval from your organization's Institutional Review Board (IRB)?

- Yes, and a copy of the approval letter is attached to this application.
- No, the IRB will review the project on _____.
- No, this project is not subject to IRB review.
- No, my organization does not have an IRB.

XII. APPLICANT QUALIFICATIONS

1. Describe your qualifications to perform the research described or accomplish the intended use of CHIA data.

I have several years experience working with the case mix data. We received level I data last year and are requesting the same level of information for FY12 to continue our analysis.

2. Attach résumés or curriculum vitae of the applicant/principal investigator, key contributors, and of all individuals who will have access to the data. (These attachments will not be posted on the internet.)

XIII. DATA LINKAGE AND FURTHER DATA ABSTRACTION

1. Does your project require linking the CHIA Data to another dataset? YES NO
2. If yes, will the CHIA Data be linked to other patient level data or with aggregate data (e.g. Census data)?
Patient Level Data Aggregate Data
3. If yes, please identify all linkages proposed and explain the reasons(s) that the linkage is necessary to accomplish the purpose of the project.

4. If yes, please identify the specific steps you will take to prevent the identification of individual patients in the linked dataset.

XIV. PUBLICATION / DISSEMINATION / RE-RELEASE

1. Describe your plans to publish or otherwise disclose CHIA Data, or any data derived or extracted from such data, in any paper, report, website, statistical tabulation, or similar document.

We do not plan to publish a report using the data. We intend to share information only with our business partners

2. Will the results of your analysis be publicly available to any interested party? Please describe how an interested party will obtain your analysis and, if applicable, the amount of the fee.

We do not plan to publish a report using the data. We intend to share information only with our business partners

3. Will you use the data for consulting purposes? YES NO
4. Will you be selling standard report products using the data? YES NO
5. Will you be selling a software product using the data? YES NO

6. If you have answered "yes" to questions 3, 4 or 5, please describe the types of products, services or studies.

XV. USE OF AGENTS AND/OR CONTRACTORS

Third-Party Vendors. Provide the following information for all agents and contractors who will work with the CHIA Data.

| | |
|-----------------------|--------------------------------|
| Company Name: | N/A will be used by BMCHP only |
| Contact Person: | |
| Title: | |
| Address: | |
| Telephone Number: | |
| E-mail Address: | |
| Organization Website: | |

1. Will the agent/contractor have access to the data at a location other than your location or in an off-site server and/or database? YES NO

2. Describe the tasks and products assigned to this agent or contractor for this project.

3. Describe the qualifications of this agent or contractor to perform such tasks or deliver such products.

4. Describe your oversight and monitoring of the activity and actions of this agent or subcontractor.