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Commonwealth of Massachusetts
Center for Health Information & Analysis (CHIA)
Non-Government APCD Request for Data

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

<u>NOTE:</u> **In order for your application to be processed, you must submit the required application fee. Please consult the fee schedules for APCD data for the appropriate fee amount. A remittance form with instructions for submitting the application fee is available on the CHIA website.**

I. GENERAL INFORMATION

APPLICANT INFORMATION	
Applicant Name:	Bruce E. Landon, MD, MBA, MSc
Title:	Professor of Health Care Policy, Harvard Medical School; Professor of Medicine, Beth Israel Deaconess Medical Center (Landon)
Organization:	Harvard Medical School
Project Title:	The Changing Landscape of Health Care Delivery in Massachusetts: Insurance Coverage, Specialist Referrals and Payment Reform
Mailing Address:	Department of Health Care Policy Harvard Medical School 180A Longwood Ave. Boston, MA 02115
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Names of Co-Investigators:	Co-Investigators: Michael L. Barnett, MD Asaf Bitton, MD, MPH Sherri Rose, PhD Michael E. Chernew, PhD J. Michael McWilliams, MD, PhD Ateev Mehrotra, MD Zirui Song, PhD
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Original Data Request Submission Date:	March 13, 2015
Dates Data Request Revised:	April 18, 2015
Project Objectives (240 character limit)	(1) To describe the epidemiology of physician referral patterns

	and specialist volume for children and adults in Massachussetts. (2) To describe health insurance "churning" in Massachussetts, it consequences for utilization patterns and its association with care provided by organizations participating in global payment contracts. (3) To explore changes in referral patterns associated with participation in global payment contracts as well as spillover effects on fee-for-service spending and prices for non-Medicare enrollees.
Project Research Questions (if applicable)	**Aim 1A**: What is the basic epidemiology of physician referrals in Massachusetts among physicians and physician organizations in Massachusetts? **Aim 1B:** How is the volume of medical and surgical diagnoses/procedures distributed among specialists in Massachussetts and in organizations with global payment contracts? **Aim 2A:** What is basic epidemiology of health insurance switching in Massachusetts and what are the individual and insurance plan characteristics associated with insurance switching? **Aim 2B:** To what extent is health insurance switching associated with provider network disruption and changes in medical spending and utilization of medical services? **Aim 3A**. What is the association between changes in payment systems (moving from fee-for-service to global payment for physician organizations) and changes in referrals rates and types of referring/receiving physicians? **Aim 3B**. To what extent do the cost savings and other effects from alternate payment models such as the Pioneer ACO program and Alternative Quality Contract (AQC) spillover to enrollees insured under traditional fee-for-service models?

II. PROJECT SUMMARY
Briefly describe the purpose of your project and how you will use the requested CHIA data to accomplish your purpose.

> **INTRODUCTION**
>
> The health care landscape of Massachusetts is rapidly changing. Physicians and hospitals are increasingly forming accountable care organizations to enter contracts that specify a spending target or budget with financial risk. In addition, existing Massachusetts health reforms and changes from the Affordable Care Act create more opportunities for patients in the individual market to change insurance and provider

networks. In this environment, managing patient flows and specialty care will be increasingly important strategies to for health systems to manage the growth of health care spending. Specifically, three issues will be crucial for accountable care organizations to understand: 1) referral patterns of patients from one physician to another and to physicians within and outside of the ACO, 2) patterns of care and spending for organizations entering into ACO contracts and 3) insurance turnover and stability of patient loyalty to health systems over time. There is little research on these three issues in the context of payment reform in the level of depth provided by the Massachusetts All Payer Claims Dataset (APCD).

In this project, using the APCD we will first describe the basic epidemiology of referrals, examining the referral patterns and clinical volume of physicians across Massachusetts as well as their association with physician and organizational characteristics. We will then look at care patterns for ACO enrollees to examine how ACOs influence both referral patterns and the total costs of care, including variation in volume of diagnoses and procedures seen by specialists and how patients are distributed among these specialists. We will also examine the basic epidemiology of insurance switching among Massachusetts residents, its geographic distribution and associations with individual and insurance plan characteristics. We will also explore the extent to which referral behaviors, insurance switching and health care utilization changes under global payment contracts taking advantage of payments changes such as Medicare's Pioneer Accountable Care Organization program and the Alternative Quality Contract bundled payment model initiated in 2009 by Blue Cross Blue Shield of Massachusetts. We also will examine how changes in the payment models for these organizations influence referral patterns, costs of care, and insurance switching for fee-for-service patients cared for by these same organizations.

Our research team is well-situated to perform this research and the Massachusetts health care market provides a unique opportunity to inform this crucial topic as health reform is implemented nationally. Using the Massachusetts APCD, which includes administrative claims data on the majority of insured patients residing in Massachusetts, provides a rare opportunity to examine in great depth the scope and impact of referrals in the state. Currently, our team is addressing similar questions using version 2.1 of the APCD. We believe that updated data that includes improved identification of patients over time as well as other improvements will enhance our ability to address these questions.

RESEARCH AIMS

Aim 1: To describe the epidemiology of physician referral patterns and specialist volume for children and adults in Massachusetts.
Using statewide data from the Massachusetts all-payer claims database (APCD), we will create a master provider index and perform a comprehensive analysis of referrals from primary care and specialist physicians to other physicians across Massachusetts. Overall, we aim to understand the extent of variation in referral decision-making among physicians and the association of patient, physician and organizational factors with variations in referral rates. We also aim to understand the extent to which referrals for selected chronic conditions are distributed across the specialist population. We hypothesize that after controlling for patient and physician factors, there will be greater than 2-fold variation in physicians' overall referral rates as well as the referral rates for common, potentially high-cost and/or prevalent primary care diagnoses such as low back pain, headache and gastro-esophageal reflux disease. We will also aggregate volume of clinical encounters by diagnosis and procedure types at the specialist level. We hypothesize that referrals to specialists across a wide variety of diagnoses will have a highly skewed distribution. In other words, a small number of high volume specialists likely recieve a very large proportion of referrals while a large number of low volume specialists treat the remaining patients. We will examine the extent to which accountable care organizations with global payment contracts in Massachussets have a balanced proportion of high volume specialists for common conditions such as prostatectomy, joint replacements, and cardiac surgery. Answers to these hypotheses can help guide

future efforts to target referral interventions and understand the larger role of speciality care at the organizational level.

Aim 2: Describe health insurance "churning" and its association with health care costs, utilization and other care provided by organizations participating in global payment contracts.

Using a continuously enrolled population, we will characterize individuals' insurance changes over time into any other commercial or public coverage using the member eligibility file. We hypothesize that there will be significant turnover in the private and public insurance markets, and that this turnover will be associated with changes in provider networks and increased care fragmentation. We will examine the association of plan switching with changes in health care spending, usual source of primary and specialty care as well as the association with changes in emergency department and inpatient utilization as well as other high cost services. For health systems participating in global risk contracts, the stability of the insurance coverage of their patient population is of great interest. Therefore, we will also examine the prevalence of insurance turnover in patients whose primary care is based in a global risk contract organization. We hypothesize that patients whose care is based in a global risk contract organization will not have higher rates of insurance turnover than matched control populations.

Aim 3: To explore changes in referral patterns and total costs of care for non-risk patients being cared for by organizations participating in global payment contracts.

The implementation of health reform in Massachusetts, beginning in 2006, achieved near-universal health insurance coverage but accelerated concerns about cost growth in the state. As a consequence, Massachusetts began serving as a laboratory for payment reform in 2009, when Blue Cross Blue Shield of Massachusetts implemented the Alternative Quality Contract (AQC), a risk contract involving global payment for physician organizations across the state. Using a quasi-experimental design, we will assess the impact of payment reform on referral volume and referral patterns, including referrals to different specialties and across different organizations ("leakage"), by comparing referral volume and patterns in physician organizations that entered risk contracts with those that remained primarily in standard fee-for-service contracts. We will also examine these patterns over time as AQC organizations entered into similar arrangements for their Medicare patients under the Accountable Care Organization programs and with other payers. Massachussets is home to 18 Medicare ACOs alone. With fee-for-service (FFS) remaining a predominant basis of provider group reimbursement under most of these risk-based contracts, most ACOs will face mixed payment incentives due to a mix of FFS and risk-based contracts across payers. Prior research from our department found cost-reducing spillovers of Medicare Advantage and the AQC on care in traditional fee-for-service Medicare. Should ACO contracts have similar spillover effects into the commercial population, evaluations focused exclusively on Medicare beneficiaries would underestimate the social value of ACOs. We plan to use the APCD to measure spillover effects of ACO contracts (both Medicare and commercial) on fee-for-service care for patients in Medicare Advantage and commercial plans served by Medicare ACOs.

We will estimate the spillover effects of greater risk assumed by Medicare ACOs for Medicare and commercial enrollees on utilization and prices for for-for-service patients of ACOs. Fee-for-service patients of provider groups not participating in the Medicare ACO programs will serve as the control group. Because these providers, too, may enter risk contracts with Medicare Advantage and commercial plans during the study period, we will refine our control group by excluding provider organizations assuming substantially more risk.

III. FILES REQUESTED

Please indicate the databases from which you seek data, and the year(s) of data requested.

ALL PAYER CLAIMS DATABASE	Single or Multiple Use	Year(s) Of Data Requested Current Yrs. Available 2009 – 2013
☒Medical Claims	☐Single Use ☒Multiple Use	☒2009 ☒2010 ☒2011 ☒2012 ☒2013
☐Pharmacy Claims	☐Single Use ☐Multiple Use	☐2009 ☐2010 ☐2011 ☐2012 ☐2013
☐Dental Claims	☐Single Use ☐Multiple Use	☐2009 ☐2010 ☐2011 ☐2012 ☐2013
☒Member Eligibility	☐Single Use ☒Multiple Use	☒2009 ☒2010 ☒2011 ☒2012 ☒2013
☒Provider	☐Single Use ☒Multiple Use	☒2009 ☒2010 ☒2011 ☒2012 ☒2013
☒Product	☐Single Use ☒Multiple Use	☒2009 ☒2010 ☒2011 ☒2012 ☒2013

IV. REQUESTED DATA ELEMENTS [APCD Only]

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. FEE INFORMATION

Please consult the fee schedules for APCD data) and Case Mix data, available at http://chiamass.gov/regulations/#957_5, and select from the following options:

APCD Applicants Only

☒   Academic Researcher
☐   Others (Single Use)
☐   Others (Multiple Use)

Are you requesting a fee waiver?
☐   Yes
☒   No

If yes, please submit a letter stating the basis for your request. Please refer to the fee schedule for qualifications for receiving a fee waiver. If you are requesting a waiver based on the financial hardship provision, please provide documentation of your financial situation. Please note that non-profit status alone isn't sufficient to qualify for a fee waiver.

VI. MEDICAID DATA [APCD Only]

Please indicate here whether you are seeking Medicaid Data:

☒　　　　Yes

☐　　　　No

Federal law (42 USC 1396a(a)7) restricts the use of individually identifiable data of Medicaid recipients to uses that are directly connected with 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 meets this requirement. Applications requesting Medicaid data will be forwarded to MassHealth for a determination as to whether the proposed use of the data is directly connected to the administration of the Medicaid program. MassHealth may impose additional requirements on applicants for Medicaid data as necessary to ensure compliance with federal laws and regulations regarding Medicaid.

> Understanding referral patterns, specialist volume and insurance turnover and how they change under global payment models is fundamental to delivering efficient care for the Medicaid population. Specialist care is responsible for a large proportion of health care costs for Medicaid patients, yet little is known about the prevalence of overutilization or underutilization of referrals to specialists. The Medicaid program will benefit from a greater understanding of how primary care physicians use specialist resources in Massachussets, and how that behavior changes with different payment models. In addition, understanding insurance turnover among Medicaid patients could be of great value to the Medicaid program in understanding how to best accommodate the changing needs of their population as income shifts and enrollment shifts back and forth from traditional Medicaid to managed care Medicaid. The answers from this project can help guide future payment reform efforts as well as providing guidance to Medicaid in addressing specialist overuse.

VII. 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	None	
Pharmacy Claims		
Dental Claims		
Membership Eligibility	None	
Provider	None	
Product	None	

IX. PURPOSE AND INTENDED USE

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

> Specialist care is a fundamental and ubiquitous in health care, yet we have little high quality research describing how referrals vary across a population, their association with different payments models or how often patients see high volume specialists across a wide variety of

conditions. Our project will being to lay the foundation to understand how specialist care happens in Massachussets, opening the field for further study in other national and state databases.

In addition, we will create the most detailed portrait in the literature so far of insurance turnover in a large commercially and publicly insured population. The public will benefit through the ability of health systems and providers to use our findings to create specialty care systems that better reflect patient and population needs. In addition, they will benefit from the insights we gain on insurance turnover that can inform policy efforts to help cushion the shock of insurance turnover the the fragmentation of care that likely follows.

2. **Attach** a brief (1-2 pages) description of your research methodology. (This description will not be posted on the internet.)

3. Has your project received approval from your organization's Institutional Review Board (IRB)? Please note that CHIA will not review your application until IRB documentation has been received (if applicable).
☐ Yes, and a copy of the approval letter is attached to this application.
☒ No, the IRB will review the project on _***modification of original application covering v2.1 analysis that encompasses all changes in the application currently under review as of 4/18/2015____***.
☐ No, this project is not subject to IRB review.
☐ No, my organization does not have an IRB.

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

Bruce Landon, M.D., M.B.A., M.Sc. is Professor of Health Care Policy and Medicine at Harvard Medical School and a practicing general internist at Beth Israel Deaconess Medical Center and will serve as overall Principal Investigator. Landon's primary research interest has been assessing the impact of different characteristics of physicians and health care organizations, ranging from health plans to physician group practices, on the provision of health care services. Dr. Landon has extensive experience analyzing claims data from both the Medicare program and commercial databases. Along with Dr. Barnett and Dr. Song, he recently studied national patterns in referral rates for office visits. They found that referrals rates doubled over the last ten years. Along with Drs. Song and Chernew, he also was an integral member of the evaluation team for the Alternative Quality Contract (led by Dr. Chernew), and thus has ample experience studying physician organizations in Massachusetts.
Asaf Bitton, M.D., M.P.H. is Instructor in Medicine at the Division of General Medicine at Brigham and Women's Hospital and Instructor in Health Care Policy at the Department of Health Care Policy at Harvard Medical School. He is also a faculty member of the Harvard Medical School Center for Primary Care, where he serves as Core Faculty Lead for Transformation Strategy and Design. He leads the Academic Innovations Collaborative, a collaborative of 19 Harvard-affiliated clinics transforming Boston primary care teaching practices serving nearly 300,000 patients and developing new models of academic and community-based primary care. He is currently serving as a Senior Advisor to the Comprehensive Primary Care initiative at the Center for Medicare and Medicaid Innovation. His main academic interests are in primary care delivery, policy, and innovation. To that end, he both implements and evaluates the patient centered medical home model, a revamped mode of primary care delivery that is being rapidly disseminated across the US. Specifically, he is evaluating the scope and quality improvement possibilities of various regional and national patient-centered medical home demonstration pilots, with a particular focus on devising quality metrics for the medical home. He chairs the Clinical Quality work group for the Commonwealth Fund PCMH evaluators' collaborative, and serves as an executive council member of the

Association of Chiefs and Leaders of General Internal Medicine.

Michael E. Chernew, PhD is the Leonard D. Schaeffer Professor of Health Care Policy at Harvard Medical School. Dr. Chernew's research examines several areas related to controlling health care spending growth while maintaining or improving quality of care. His work on consumer incentives focuses on Value-Based Insurance Design (VBID), which aligns patient cost sharing with clinical value. Several large companies have adopted these approaches and Dr. Chernew's ongoing work includes evaluations and design of such programs. His work on payment reform involves the evaluation of bundled payment initiatives, including global payment models that include pay-for-performance components. Related research examines the effects of changes in Medicare Advantage payment rates. Additional research explores the causes and consequences of rising health care spending, and geographic variation in spending, spending growth and quality. Dr. Chernew is the PI of a study that has analyzed the AQC working along with Dr. Song and Dr. Landon.

Sherri Rose, Ph.D. is an Assistant Professor of Biostatistics in the Department of Health Care Policy at Harvard Medical School. Her work is centered around developing and integrating innovative statistical approaches to advance public health and health care research. Broadly, Dr. Rose's methodological research focuses on semiparametric estimation in causal inference and machine learning for prediction. Her health services projects include risk adjustment and health care program impact evaluation. Dr. Rose received her Ph.D. in Biostatistics from the University of California, Berkeley, where she coauthored the book "Targeted Learning: Causal Inference for Observational and Experimental Data."

Ateev Mehrotra, M.D., M.P.H. is an Associate Professor in the Department of Health Care Policy at Harvard Medical School. Dr. Mehrotra's research focuses on quality and cost measurement in the health care system. Dr. Mehrotra receives his medical degree from the University of California, San Francisco and completed his residency in internal medicine and pediatrics at the Massachusetts General Hospital and Children's Hospital of Boston. In 2013, he received the Alice S. Hersh New Investigator Award from AcademyHealth for health services researchers early in their careers who show exceptional promise.

J. Michael McWilliams, MD, PhD is an Associate Professor of Health Care Policy and Medicine at Harvard Medical School and a practicing general internist at Brigham and Women's Hospital.
 Dr. McWilliams's research focuses on health care spending, quality, access, and disparities in aging populations with chronic conditions. He is currently leading research funded by the NIH, Robert Wood Johnson Foundation, Office of the Assistant Secretary for Planning and Evaluation, and Laura and John Arnold Foundation on a range of topics. He received his MD degree magna cum laude from Harvard Medical School, and his PhD degree in Health Policy from Harvard University. Dr. McWilliams has received the Mack Lipkin, Sr. Associate Award, Milton W. Hamolsky Junior Faculty Award, Best Published Research Paper of the Year Award, and Outstanding Junior Investigator of the Year Award from the Society of General Internal Medicine.

Michael L. Barnett, M.D. received his M.D. at Harvard Medical School (HMS) and received training in health services research through a Doris Duke Charitable Foundation research fellowship during medical school working with Bruce Landon and others in the HMS Department of Health Care Policy. His published work explores physician referrals as well as the relationship between physician social networks and health care costs. He is currently a fellow in general internal medicine at Brigham and Women's Hospital.

Zirui Song, Ph.D. received his Ph.D. in Health Policy (Economics) from the PhD Program in Health Policy at Harvard University and M.D. from Harvard Medical School. He has collaborated with the other investigators on analyses of the Massachusetts Alternative Quality Contract and related research. He is currently an internal medicine resident at Massachussets General Hospital.

2. Attach résumés or curricula 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.)

XI. DATA LINKAGE AND FURTHER DATA ABSTRACTION

Note: Data linkage involves combining CHIA data with other databases to create one extensive database for analysis. Data linkage is typically used to link multiple events or characteristics that refer to a single person in CHIA data within one database.

1. Do you intend to link or merge CHIA Data to other datasets?

    ☒ Yes

    ☐ No linkage or merger with any other database will occur

2. If yes, will the CHIA Data be linked or merged to other individual patient level data (e.g. disease registries, death data), individual provider level data (e.g., American Medical Association Physician Masterfile) , facility level (e.g., American Hospital Association data) or with aggregate data (e.g., Census data)? [check all that apply]

    ☐ Individual Patient Level Data

    What is the purpose of the linkage:

    What databases are involved, who owns the data and which specific data elements will be used for linkage:

    ☒ Individual Provider Level Data

    What is the purpose of the linkage:

The APCD has no master provider index that would enable easy linkage of providers across different health plans. In addition, it is difficult to separate out MA based physicians from many other types of providers, including institutions. Another crucial part of our analysis is grouping providers at the practice and network level. All of these will be made much easier with another dataset provider by Massachusetts Health Quality Partners (MHQP), which curates its own database of annually updated MA physicians with accurate linkage to networks and practices. This data is very difficult, if not impossible to dervice form the APCD itself.

    What databases are involved, who owns the data and which specific data elements will be used for linkage:

We plan to use the MHQP provider database, which would be purchased and housed within the HMS Health Care Policy department under the DUA provided by MHQP and subject to our uniform standard of tight security and privacy precautions. We will use provider NPI and health plan ID to link providers from the MHQP database to the APCD.

    ☒ Individual Facility Level Data

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What is the purpose of the linkage:

> Create better aggregation of NPIs to identify facilities and physician groups more accurately.

What databases are involved, who owns the data and which specific data elements will be used for linkage:

> 1) Unifom Provider OrgID List, available from the CHIA Website. We will use facility/group NPI for linkage.

☒   Aggregate Data

What is the purpose of the linkage:

> To add more sociodemographic detail to the APCD data at the geographic level.

What databases are involved, who owns the data and which specific data elements will be used for linkage:

> 1) Area Resource File, available from the US Census website and publicly available. 5-digit zipcode will be used for linkage.
> 2) Area Deprivation Index, available from the Health Innovation Program HIPxChange website from the University of Wisconsin. 5-digit zipcode will be used for linkage.

3. If yes, for each proposed linkage above, please describe your method or selected algorithm (e.g., deterministic or probabilistic) for linking each dataset. If you intend to develop a unique algorithm, please describe how it will link each dataset .

> We will link facilities and physician groups to the Uniform OrgID dataset and MHQP datasets using NPI as present in the provider file. Since not all provider entries have an associated NPI, an additional crosswalk will be made using the medical claims file between every exisiting payer specific provider ID and NPI present in the claims file. The zip-code level data will simply be merged by zipcode on to the member eligibility file.

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

> There is no additional risk of patient identification with the linkages we propose since we are only using facility/group level NPIs and zipcode level Census data which provides no additional identifying information beyond the 5-digit zip code, which is already present in the data.

5. If yes, and the data mentioned above is not in the public domain, please attach a letter of agreement or other appropriate documentation on restrictions of use from the data owner corroborating that they agree to have you initiate linkage of their data with CHIA data and include the data owner's website.

All of the proposed data linkages are in the public domain.

XII. 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, seminar, conference, or other setting.

> We anticipate producing several manuscripts for peer-reviewed journals, at least one from each of the major aims. We will submit to clinical, health policy, and economics outlets such as the New England Journal of Medicine, Journal of the American Medical Association, Health Affairs, Annals of Internal Medicine, Healthcare, JAMA Internal Medicine, and the Journal of Health Economics. We will also disseminate our findings with policy leaders, payers, provider networks, and academic leaders within Massachusetts and at professional meetings such as AcademyHealth and the Society of General Internal Medicine.

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 anticipate disseminating our findings in the peer-review literature. We also anticipate presenting our findings at national research conferences such as the Society of General Internal Medicine (SGIM) meeting and the AcademyHealth Annual Research Meeting. These are the primary avenues for public dissemination of the research.

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. Will you be reselling the data?
☐ Yes
☒ No

If yes, in what format will you be reselling the data (e.g., as a standalone product, incorporated with a software product, with a subscription, etc.)?

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

XIII.   USE OF AGENTS AND/OR CONTRACTORS

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

Company Name:	
Contact Person:	
Title:	
Address:	
Telephone Number:	
E-mail Address:	
Organization Website:	

8. Will the agent/contractor have access to the data at a location other than your location, your off-site server and/or your database?

☐   Yes
☐   No

If yes, please provide information about the agent/contractor's data management practices, policies and procedures in your Data Management Plan.

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

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

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

XIV. ASSURANCES

Applicants requesting and receiving data from CHIA pursuant to 957 CMR 5.00 ("Data Recipients") will be provided with data following the execution of a data use agreement that requires the Data Recipient to adhere to processes and procedures aimed at preventing unauthorized access, disclosure or use of data, as detailed in the DUA and the applicant's CHIA-approved Data Management Plan.

Data Recipients are further subject to the requirements and restrictions contained in applicable state and federal laws protecting privacy and data security, and will be required to adopt and implement policies and procedures designed to protect CHIA data in a manner consistent with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA).

By my signature below, I attest to: (1) the accuracy of the information provided herein; (2) my organization's ability to meet CHIA's minimum data security requirements; and (3) my authority to bind the organization seeking CHIA data for the purposes described herein.

Signature:	
Printed Name:	Bruce E. Landon
Title	Professor of Health Care Policy, Harvard Medical School; Professor of Medicine, Beth Israel Deaconess Medical Center
Original Data Request Submission Date:	
Dates Data Request Revised:	