**Application for**

**Requesting Health Care Claims Research Data Sets**

Office of Health Strategy All Payer Claims Database (“APCD”) requires data requestors to complete this application to request access to APCD data. This application is only for de-identified data sets, which conform to the HIPAA Privacy Rule 45 CFR 164.514 (a)-(b) with members de-identified to protect privacy.

Please note that some parts of your completed application will be publicly posted on the APCD’s website. Research Methodology and Data Security details will not be posted publicly.

Please complete the application form below to request access to the APCD data. The APCD Data Review Committee (DRC) will evaluate all requests. Please submit your data request application, additional documents and/or spreadsheets and any questions through the OHS/CT GovQA website.

**Data Request Application:**

[**https://ohsct.govqa.us/WEBAPP/\_rs/**](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fohsct.govqa.us%2FWEBAPP%2F_rs%2F&data=05%7C01%7CAmy.Tibor%40ct.gov%7C351616ab374c497fcbba08db9383d4ca%7C118b7cfaa3dd48b9b02631ff69bb738b%7C0%7C0%7C638265966637459058%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=dvFsVUEUF5aSsyb8xA2EKCx%2BpCKyS9JFvbyqj9az7J8%3D&reserved=0)

1. **GENERAL INFORMATION**

|  |  |
| --- | --- |
| **Applicant Information** | **Details** |
| Principal Investigator’s Name and Title: | Click or tap here to enter text. |
| Organization Name: | Click or tap here to enter text. |
| Street Address, City/Town, State, Zip Code: | Click or tap here to enter text. |
| E-mail: | Click or tap here to enter text. |
| Phone Number: | Click or tap here to enter text. |
| Date of Application: | Click or tap to enter a date. |
| Project / Research Title: | Click or tap here to enter text. |
| Project / Research Objective(s) (100 words or less): | Click or tap here to enter text. |
| Project / Research Question(s) to be addressed via proposed research (if applicable, briefly) | 1. Click or tap here to enter text.    2. Click or tap here to enter text.  3. Click or tap here to enter text. |
| Contact Name: | Click or tap here to enter text. |
| Contact Phone Number: | Click or tap here to enter text. |
| Contact E-Mail: | Click or tap here to enter text. |
| Others Accessing Data: | 1. Click or tap here to enter text.  2. Click or tap here to enter text.  3. Click or tap here to enter text.  4. Click or tap here to enter text. |

1. **PROJECT SUMMARY**

Briefly describe the purpose of this project and how the requested data from Connecticut’s APCD will accomplish your purpose.

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| Brief overview of research project (in 200 words or less):  Click or tap here to enter text. |

1. **RESEARCH PROTOCOL**

Please complete the following information.

|  |
| --- |
| 1. Summary of background, purposes and origin of the research (in 200 words or less):   Click or tap here to enter text. |
| 1. How does the research address health-related questions, particularly in the context of improving health and health equity? (in 100 words or less):   Click or tap here to enter text. |
| 1. Please describe research design and methodology (in 200 words or less):   Click or tap here to enter text. |
| 1. Expected begin and end dates of the research:   Click or tap here to enter text. |
| 1. **Organizational qualifications:**   Briefly describe your organization’s experience with projects of similar scale and scope:  Click or tap here to enter text. |
| 1. **Funding Source:**   (1) What is the funding source of this project?  Click or tap here to enter text.  (2) What is the duration of this funding?  Click or tap here to enter text.  (3) Do you intend to charge a fee for your reports or the results of your analyses?  Click or tap here to enter text.  (4) If yes, to whom?  Click or tap here to enter text. |
| 1. **Prior Review:**   You are required to allow APCD’s administrator to review your report or output (spreadsheet, data table, etc.) prior to any publication to ensure that the report is in compliance with the requirements for attributes, including cell suppression rules, risk of inferential reidentification, and consistency to methodology of the project. Please describe how you intend to comply with this requirement.  Click or tap here to enter text.  On what date do you expect to release/publish this report?  Click or tap here to enter text.  By what date do you intend to file it with APCD’s administrator? (at least 4-week review period needed)  Click or tap here to enter text. |

1. **DATA SELECTION(S)**
2. **Data sets –** each type of data set will have one standard format unless the requestor wants to customize it further (at additional cost). The data sets are:
3. Eligibility
4. Medical Claims
5. Pharmacy Claims
6. Inpatient Discharge Data
7. ED Data
8. Outpatient Facility Data
9. Professional Data
10. **Filters**

Applicants can request filters on the data for limited extraction, if necessary for their research project. A list of common filters is given below.

|  |  |  |
| --- | --- | --- |
| **Common Filters** | **Data Set** | **Requested Filter** |
| Eligibility Dates | Elig | Click or tap here to enter text. |
| Zip Codes | Elig | Click or tap here to enter text. |
| Members’ Age | Elig | Click or tap here to enter text. |
| Service Dates | Med | Click or tap here to enter text. |
| Diagnoses | Med | Click or tap here to enter text. |
| Procedures | Med | Click or tap here to enter text. |
| Inpatient Admissions | Med | Click or tap here to enter text. |
| Medications (NDCs) | Pharm | Click or tap here to enter text. |
| Add rows for others |  | Click or tap here to enter text. |

1. **Aggregated Data**

Applicants can request that data is aggregated into summary tables. Doing so will provide an applicant with total counts, average, standard deviation, rates, and other meaningful statistical measures. Applicants will have to provide information on the following tables.

|  |  |  |  |
| --- | --- | --- | --- |
| **Data Set or Field**  **Names** | **Count, Sum, Average, Dev, Range, Rate** | **Description**  **of**  **Summary** | **Group**  **by**  **Variable(s)** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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1. **DATA SECURITY AND INTEGRITY**

(Information from this section will be posted on the APCD’s public website.)

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| --- |
| 1. Where will the data be located physically? (Provide the delivery address for the data including building and floor.)   Click or tap here to enter text. |

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| 1. Please provide name and information of the organization that will host and manage APCD data, including the name of the custodian.   Click or tap here to enter text. |

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| 1. Describe how you will maintain an inventory of APCD data, derived analytic files and scratch files, and how you will manage physical access to such data during the duration of the project. (Please describe and attach documents supporting your policies and procedures.)   Click or tap here to enter text. |

|  |
| --- |
| 1. Do you have confidentiality agreements with the principal investigator, the data custodian or other research individuals or technical (IT) team members, particularly those with access to the APCD data? (Please describe and attach documents supporting your policies and procedures.)   Click or tap here to enter text. |

|  |
| --- |
| 1. Technical Safeguards: 2. Describe the steps you take to physically secure data, such as site or office access controls, secured file cabinets, and locked offices?   Click or tap here to enter text.   1. What safeguards are in place to restrict data access among the research team? Describe your password-protected access system?   Click or tap here to enter text.   1. Describe your policies and procedures for ensuring APCD data is protected while stored on server(s). Describe how your organization ensures that APCD data on servers cannot be copied to local workstations, laptops, smartphones, and other media (CDs, DVDs, hard drives, thumb drives, etc.).   Click or tap here to enter text.   1. Provide your organization’s written information security program (WISP) or its policies and procedures regarding security provisions, particularly security or privacy safeguards against unauthorized access to or use of health data.   Click or tap here to enter text. |

1. **SIGNATURES**

By signing the application, you certify that the information enclosed herein is true and correct and if this Application is approved you agree to the terms and conditions of the Data Use Agreement (DUA) for the use of the APCD data.

**For the Applicant:**

**Signature**:

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name:** Click or tap here to enter text.

**Title:** Click or tap here to enter text.

**Date:** Click or tap to enter a date.

**Organization:** Click or tap here to enter text.

**APPENDIX 1: SPECIFICATIONS FOR DATA RELEASE APPLICATION**

**General Information & Instructions**

1. OHS may deliver APCD data via the following options:
2. Secured File Transfer: An approved applicant will be allowed to access data at approved levels for an established time period.
3. Disk drives: An approved applicant will be allowed to access data encrypted on a device – DVD drives, CD drives or Disk / USB Flash drive.
4. Email: For summary data, only.
5. For de-identified claim level data filters, use Table 4(B) to select filters for Eligibility, Medical, and Pharmacy claims. Also, as part of your request, indicate the data tables and fields you are selecting in the ***Request Sheet*** of the following Excel workbook below. Submit the completed workbook with your application.



1. For summary data, specify Table 4(C) of the application and/or work closely with APCD’s staff to ensure accuracy of the methodology. Use the data dictionary in #2 above.
2. OHS will contact you to set you up with an account to enable you to pay the $50 application fee, electronically.
3. Your application will be subject to administrative completeness review, APCD Data Release Committee (DRC) public review and approval process and OHS final approval.
4. You will be invited to the DRC monthly public review to respond to questions on the application, including, but not limited to, the research objective, methodology, data and computation infrastructure, data security provisions and release.
5. The DRC may approve the application or request more information at the review. A special meeting may be set for reviewing the additional information.
6. Upon DRC recommended approval, and OHS review and acceptance, you will be required to execute a DUA with OHS.
7. Data extract payment is due upon OHS receipt of a fully executed DUA. See Appendix 3 for the data fee schedule for data extracts. OHS will provide a cost estimate which will include the cost of any customized analytics, if any.
8. OHS must receive full payments ($50 application, analytics and/or extract fees) before it will issue the Applicant access to the data summary or extract.

**APPENDIX 2: Certification of Project Completion, Destruction, or Retention of Data**

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| --- | --- | --- | --- |
| Name: | Click or tap here to enter text. | | |
| Title: | Click or tap here to enter text. | | |
| Organization: | Click or tap here to enter text. | | |
| Address: | Click or tap here to enter text. | | |
| Telephone: | Click or tap here to enter text. | | |
| Project Title: | Click or tap here to enter text. | | |
| Data Sets: | Click or tap here to enter text. | | |
| Years: | Click or tap here to enter text. | | |
| Certification of Data Destruction | | | Date when data destroyed: Click or tap to enter a date. |
| Request to Retain Data | | Date until data will be retained: Click or tap to enter a date. | |

I hereby certify that the project described in the application is complete as of Click or tap to enter a date..

Please select one or more of the following options:

I/We certify that we have destroyed all data received from the APCD in connection with this project in any media, form, or format. This includes but is not limited to: data maintained on hard or USB flash drive(s), DVDs/CDs, or any other printed materials.

I/We certify that we have retained all data received from the APCD’s administrator in connection with this project, pursuant to the following health or research justification. (Provide detail on why it is necessary to retain data and for how long):

Click or tap here to enter text.

I/We certify that we have retained all data received from the APCD’s administrator in connection with this project, as required by the DUA.

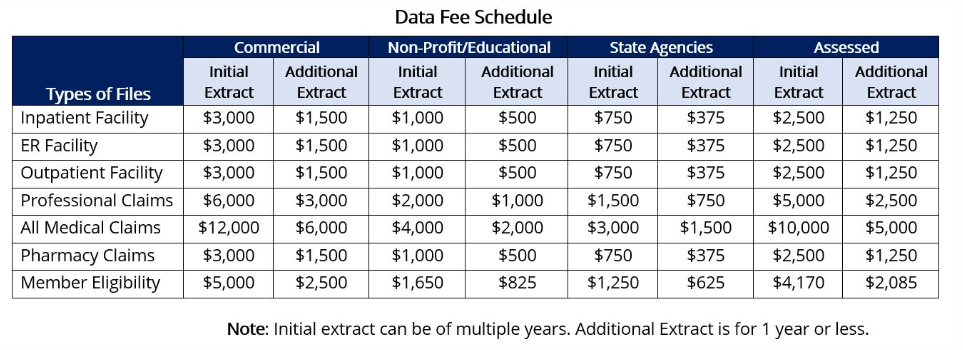
**SIGNATURE:**

**For the Receiving Organization:**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPENDIX 3: Data Fee Schedule**



Fees may include cost for analytic services if any analytics or aggregation is requested.

**APPPENDIX 4: Data Sources, Claim Types and Years in CT APCD**

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| --- | --- | --- | --- | --- |
| Payer | Population | Claim Type | Years Available  From | Years Available  To |
| Commercial\*\* | Fully Insured (individual, small and large group plans) | Eligibility/Enrollment  Medical Claims  Pharmacy Claims | 1/1/2012 | 6/30/2024 |
| Commercial\*\* | Self-insured (individual, small and large group plans) including State Employees/Retirees Plan & Municipalities in State Partnership Plan, and some employer sponsored Plans | Eligibility/Enrollment  Medical Claims  Pharmacy Claims | 1/1/2012 | 6/30/2024 |
| Medicaid (HUSKY Health) | All Ages\*\*\* | Eligibility/Enrollment  Medical Claims  Pharmacy Claims | 1/1/2015 | 6/30/2024 |
| Medicare (Fee for Service) | Ages 65 and older, and  under age 65 with certain disabilities/conditions | Eligibility/Enrollment  Medical Claims | 1/1/2012 | 12/31/2019 |
| Medicare  (Part D) | Drug Plan (Fee for service/Medicare Advantage) | Pharmacy Claims | 1/1/2012 | 12/31/2018 |
| Medicare (Medicare Advantage) | Health plans provided by a private companies contracted by Medicare. Most plans include Part D | Eligibility/Enrollment  Medical Claims  Pharmacy Claims | 1/1/2012 | 6/30/2024 |

\*\*Anthem (Elevance Health), Aetna, Cigna East, Cigna West, ConnectiCare, UnitedHealthcare, HealthyCT, Harvard Pilgrim, Optum Health, Oxford, WellCare Health, eviCORE Healthcare, Express Scripts, Caremark. Dental carriers: UnitedHealthcare, Ameritas, Elevance Health, Aetna, Cigna, Unum ***(Reporting threshold – 3,000 members)***

\*\*\*HUSKY A – children, teens, parent, pregnant women, & relative caregivers. HUSKY B or Children’s health insurance program (CHIP) for children and teens up to age 19. HUSKY C for adults 65 and older, and adults with disabilities. HUSKY D for low-income adults without dependent children.

**For entities outside the State of CT government, OHS releases a de-identified data extract containing commercial non-Medicare Advantage data only.**