



OFFICE OF HEALTH ANALYTICS
All Payer All Claims Data Reporting Program
Kate Brown, Governor

Oregon
Health
Authority

421 SW Oak Street, Suite 850
Portland, OR 97204
Website: www.oregon.gov/oha/analytics

APAC Data Use Agreement Amendment - Limited or Custom Data Set

Instructions

Use this form for amendments or renewals of Limited or Custom All Payer All Claims (APAC) data request applications that have been submitted, approved and have an executed Data Use Agreement. If you have not received an Application Number and wish to make changes to your submitted application, please contact apac.admin@state.or.us.

The Application Number and Applicant Name must match the information from the original application and Data Use Agreement. Please list changes in the appropriate section and provide sufficient details to allow staff to evaluate the request. All changes supersede the original application and Data Use Agreement.

Completed form should be sent to:

APAC.Admin@dhsaha.state.or.us

Or

Office of Health Analytics - APAC

421 SW Oak Street, Suite 850

Portland, OR 97204

If you have questions while completing this application, please follow these steps:

1. Visit the APAC website for more information about the APAC Reporting Program at <http://www.oregon.gov/oha/analytics/Pages/All-Payer-All-Claims.aspx>
2. Visit the APAC Data Request page for more information about the data request process at <http://www.oregon.gov/oha/analytics/Pages/APAC-Data-Requests.aspx>
3. Review the [APAC Frequently Asked Questions](#) to determine if your question has been answered there.
4. If you still have questions,
 - a. Direct questions about APAC or this application to: APAC.Admin@dhsaha.state.or.us
 - b. Direct data privacy questions to: dhsprivacy.help@state.or.us
 - c. Direct data security questions to: dhsinfo.security@state.or.us

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SECTION 1: PROJECT INFORMATION

1.1 Contact Information: Please provide the project contact information below.

Applicant name (must be the same applicant of original project): Sean Schafer

Application Number (example: APACYYYYXXXX or XXXX_description_of_project): APAC20150001-Schafer_PublicHealth

Organization: Oregon Health Authority, Public Health Division, Center for Public Health Practice, HST Section

Address: 800 NE Oregon St., Ste 1105

City: Portland State: OR Zip: 97232

Phone: 971-673-0181

Email: sean.schafer@state.or.us

Original Application Date: April 17, 2015

Is this an amendment (changes to the application—including revising project staff, request of additional data not specified in original application, etc.) or a renewal of an expiring Data Use Agreement or Institutional Review Board approval without any changes to the original application? Please choose only one. An amendment will also renew the Data Use Agreement.

Amendment Please continue to Section 2

Renewal Please continue to Section 3

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SECTION 2: AMENDMENT

(Skip this section and proceed to Section 3 if you are renewing an executed Data Use Agreement that is about to expire and not requesting further changes to the content of the original application. This amendment form may only be used to add or remove staff members working on the project or to request additional data.)

2.1 List any additional staff that will be working on the project.

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

Signature Date

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

Signature Date

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

Signature Date

Name: _____ Role: _____ Email: _____

The undersigned individual has read and is hereby bound by all terms and conditions of the original Data Use Agreement referenced in Section 1 of this amendment.

Signature Date

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2.2 List any staff that will no longer be working on the project:

Name: _____ Role: _____
Name: _____ Role: _____
Name: _____ Role: _____
Name: _____ Role: _____
Name: _____ Role: _____

2.3 What is the reason for the amendment?

We would like enrollment data so we can create rates for PID that take into account increase in health insurance coverage from the ACA.

2.4 Did the original application include an Institutional Review Board review and approval?

Yes No

(If no, proceed to question 2.7)

2.5 Is the amendment within the scope of the original IRB approval?

Yes No

If yes, please explain:

If no, requestor must submit new application, not an amendment.

2.6 Is an amended IRB approval attached? (An amended IRB approval is *required* for any amendments to the scope of the project.)

Yes No

Date amended IRB approval expires: _____

2.7 Are you requesting additional data files, data elements, or years of data?

Yes No

(If yes, proceed to question 2.8-11. If no, skip question 2.8-11.)

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2.8 Limited Data Sets: In the table below, indicate which additional data file(s) you are requesting. Refer to the [Data Element Workbook](#) for more information about the data elements included in each Limited data set. *Please note:* OHA will only provide the minimum necessary required data for the project at hand. In other words, you will only receive those data elements that you request and adequately justify.

- a. Are you requesting a Limited data set?

Yes No

If yes, please complete parts b and c below.

- b. In the table below, indicate which Limited data file(s) you are requesting (refer to Question 2.11 for the cost of each file).

		Payer					
		All Payers ¹	Medicaid	Medicare Advantage	Commercial Insurance	OEBB/PEBB	Medicare FFS ²
Data File	Episodes of Care ³	<input type="checkbox"/>					
	All Medical Claims ⁴	<input type="checkbox"/>					
	Hospital Inpatient Claims	<input type="checkbox"/>					
	Emergency Department Claims	<input type="checkbox"/>					
	Ambulatory Surgery Claims	<input type="checkbox"/>					
	Ambulatory Outpatient Claims	<input type="checkbox"/>					
	All Pharmacy Claims ⁵	<input type="checkbox"/>					

- c. Please indicate the year(s) requested for the data files selected above.

2011 2012 2013 2014 2015

¹ All Payers includes Medicaid, Medicare Advantage, and Commercial Insurance (including OEBB/PEBB).

² Medicare FFS data will only be given to projects in which OHA is funding and directing. Projects requesting Medicare FFS data will also need to be approved by requester's Institutional Review Board.

³ Episodes of Care file contains all medical claims, all pharmacy claims, and fields from the Medical Episode Grouper (MEG). MEG is a proprietary grouping algorithm that creates episodes that describe a patient's complete course of care for a single illness or condition. If requesting Episodes of Care file, no other data file is needed.

⁴ All Medical Claims file includes hospital inpatient, emergency department, ambulatory surgery and ambulatory outpatient claims, and other hospital treatment settings. If requesting all medical claims, you do not need to request these other data sets.

⁵ All Pharmacy Claims file contains only pharmacy claims.

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2.9 Custom Data Sets: Refer to the *Data Elements Collected by APAC* section of the Data User Guide for a list of data elements available. Please note: OHA will only provide the minimum necessary data for the project. In other words, you will only receive those data elements that you request and adequately justify.

a. Are you requesting a Custom data set?

Yes No

2.10 Data Element Workbook: For both Limited and Custom data set amendment requests, please complete the Data Element Workbook according to the instructions on the "Instructions" tab and attach it to this amendment.

Data Element Workbook completed and attached, including justifications for each element requested and payers tab completed.

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2.11 Cost of Data: If requesting additional data from the Limited data set, please calculate the cost below. (This table should match the files/years selected in Questions 2.8b and 2.8c.) **Please include payment with the application.** Checks should be made to Oregon Health Authority and will not be cashed until application is approved. If requesting a Custom data set, an invoice will be sent if/when OHA approves request.

		Payers					
		All Payers	Medicaid	Medicare Advantage	Commercial Insurance	OEBB/PEBB	Medicare FFS
Data File	Episodes of Care	<input type="checkbox"/> \$3,000	<input type="checkbox"/> \$1,000				
	All Medical Claims	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$500				
	Hospital Inpatient Claims	<input type="checkbox"/> \$375	<input type="checkbox"/> \$125				
	Emergency Department Claims	<input type="checkbox"/> \$375	<input type="checkbox"/> \$125				
	Ambulatory Surgery Claims	<input type="checkbox"/> \$375	<input type="checkbox"/> \$125				
	Ambulatory Outpatient Claims	<input type="checkbox"/> \$375	<input type="checkbox"/> \$125				
	All Pharmacy Claims	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$500				
	a. Total each column	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0
	b. Add column totals	\$ 0					
	c. Enter number of years of data requested (Q2.8.c)						
	d. Multiply rows b and c	\$ 0					
	e. OHA Production Cost	\$ 560					
	f. Add rows d and e for Total Payment	\$ 560					

Check box if payment is not included because Custom data set is requested.

Check box if payment is not included for another reason. Please explain.

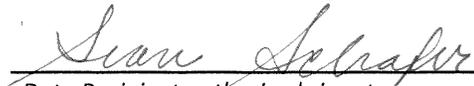
OHA entity

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Section 4: Signatures

Except as expressly amended above, all other terms and conditions of the Data Use Agreement and any previous amendments are still in full force and effect. Data Recipient certifies that any representations, warranties and certifications contained in the Data Use Agreement are true and correct as of the effective date of this amendment and with the same effect as though made at the time of this amendment. This amendment shall be effective as of the date signed by OHA. The ability of Data Recipient to use the Data under this amendment is valid for two years from the effective date.

SIGNATURES:



Data Recipient authorized signature

Sean Schafer

Printed name

10/09/2017

Date

Medical Epidemiologist

Title

OHA authorized signature

Printed name

Date

Title

Return completed form to apac.admin@state.or.us.

Completed form may also be printed and mailed to:
APAC Program Manager
Office of Health Analytics
421 SW Oak St., Suite 850 - APAC
Portland, OR 97204

Custom Data Set

You may request any of the data elements APAC collects, including any data elements in the limited data sets, and any listed in the *Data Elements Collected by APAC* section of the APAC Data User Guide. Complete columns A-E for all data elements requested. Provide any optional notes in column F. Direct identifiers such as patient name, address, or exact dates of service are only released under special circumstances that comply with HIPAA requirements, and may require specific approvals such as Institutional Review Board (IRB) approval and patient consent, and review by the Department of Justice.

OHA recommends certain data elements for all requests depending on claim type, as they are necessary to properly interpret duplicate claim lines. These elements are pre-populated in the table below. Requesters should still fill out columns C and D for these elements. If you do not wish to receive a pre-[See Instructions tab for further instructions and information about pre-populated elements.](#)

Please Note: Only complete this tab if you are requesting a custom data set instead of a limited data set.

[If requesting a custom data set, you must also complete the Payers tab.](#)

Indicate data elements requested. Use extract column name for elements from limited data sets. Use data element format AA## for elements from the <i>Data Elements Collected by APAC</i> section of the APAC Data User Guide.		Specify filters for each element		Provide any notes about the data elements requested, if applicable.	
Data Element	Name	Years Requested	Filters Applied	Justification	Notes
Enrollment data requesting					
enroll_primary	Primary insurer	2011-2015		Needed to obtain a denominator for PID rates	
Term_date	termination date	2011-2015		Needed to obtain a denominator for PID rates	
Eff_date	Effective date	2011-2015		Needed to obtain a denominator for PID rates	
personkey	Unique person identifier	2011-2015		Needed to obtain a denominator for PID rates	
memberkey	Unique member identifier	2011-2015		Needed to obtain a denominator for PID rates	
Incured year	incured year	2011-2015		Needed to obtain a denominator for PID rates	
incured month	incured month	2011-2015		Needed to obtain a denominator for PID rates	
mm_units	Medical member months	2011-2015		Needed to obtain a denominator for PID rates	
RX_units	Pharmacy member months	2011-2015		Needed to obtain a denominator for PID rates	
paytype	Insurance type	2011-2015		Needed to obtain a denominator for PID rates	
proccode	Product type	2011-2015		Needed to obtain a denominator for PID rates	
Line of business	Line of business	2011-2015		Needed to obtain a denominator for PID rates	
County	County	2011-2015		Needed to obtain a denominator for PID rates	

Appendix D—Staff review for DRC (standardized for all Health Analytics’ data requests)

Office of Health Analytics

Application Number: 20150001-05

Staff Review Checklist

Staff Name:

1. Data Source(s) Requested:

	APAC	

2. Application materials included:

- Application Y
- Payment N/A
- Data Elements Worksheet Y
- IRB Approval N/A

DUA

Has the requestor provided an overview of the project and adequately explained the need for the data?
N/A

Notes:

3. Has the requestor adequately justified the need for the specific data files and elements requested?
Y

Notes:

4. Has the requestor asked for the minimum necessary data to accomplish the stated purpose? Y

Notes:

Has the requestor adequately described safeguards in place to protect the data and comply with privacy and security requirements? N/A

Notes:

5. Recommendation for request: Approve

Notes:

Appendix G – Staff checklist and Minimum Necessary Review (MNR) for amendments or renewals

Staff Reviewer:

Agreement Number: 20150001-05

Purpose

The purpose of the staff checklist for amendment or renewals is to assess whether applicant completely and adequately filled out the amendment form.

Instructions

Complete all sections. If you check “no” on any question, please detail in the “notes” section of the same row why you checked “no” and what applicant must do in order to receive a “yes”.

1.

Task	Yes	No	N/A	Notes
Agreement number entered?	X			
Does agreement number and applicant listed in amendment/renewal match the agreement number and applicant in original application?	X			
Did applicant choose either “Amendment” or “Renewal”?	X			
Section 2 – Amendment (Must go to DRC for review)				
Have all additional staff signed stating they have read and are bound to the terms of the original DUA?	X			
If original application included IRB approval, does the amendment fall inside the scope of the original IRB approval?			X	
Does IRB approval have more than 3 months left? (Can be either the original IRB sent with original application is valid for more than 3 months or an amended IRB is attached and is valid for more than 3 months)			X	
If amended IRB approval is attached, does IRB application number on amendment match IRB application number on original IRB approval?			X	
If requesting new/more data, is Data Element Workbook attached?	X			

Do all requested elements have a year requested, filters applied and justification response in Data Element Workbook?	X			
If requesting a limited data set, does Data Element Workbook align with response in 2.8b-c?			X	
If requesting a custom data set, is it clear what elements are being requested?	X			
Is the Payers tab completed in the Data Element Workbook?	X			
If requesting Medicare FFS data, is the project at least partially funded and directed by OHA? (Per our DUA with CMS, Medicare FFS data may be shared outside of OHA for research only if OHA is partially funding and directing the project.)			X	
If requesting a limited data set, does Payers tab align with response in 2.8b?			X	
If requesting a custom data set, is it clear what payers are being requested?	X			
If Limited data is being requested, is payment included			X	
Do 2.8b and 2.8c correspond with the files selected and the number of year input in row c of the payment table?			X	
Is cost calculated correctly?			X	
Passes Minimum Necessary Review?	X			
Adequately justified each data element requested (provide rationale and list any data elements not adequately justified in notes)?	X			

Adequately described filters and algorithms for including and excluding claim lines (provide rationale and list strengths and weaknesses of algorithms in notes)?	X			
Consider the elements requested and whether additional elements can be excluded, redacted, or additionally filtered without unreasonably impairing the ability to accomplish the project purposes. Is data requested the minimum necessary? (If no, identify data elements that may be excluded, redacted or additionally filtered in notes.)	X			
Section 3 – Renewal (DUAs can be renewed without DRC approval)				
If applicant is renewing OHA agreement, does applicant include proper IRB documentation if necessary? (In notes, please state whether an amended IRB approval is attached, the original IRB is still valid, or original application did not include an IRB approval.)			X	
If applicant is renewing IRB approval, did applicant include renewed IRB approval?			X	
Does IRB application number on renewal memo match IRB application number on original IRB approval?			X	
Signatures				
Is amendment signed?	X			