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**MCDB Data Request Application**

Please complete the application form below to request access to the Maryland Medical Claims Data Base (MCDB Standard Extract). Please use as much space as needed and respond completely to all items. The application may be returned if incomplete. Send the completed application to: mhcc.datarelease@maryland.gov

There is a non-refundable application fee of $200. Please remit a check of $200 addressed to Brian Banschbach, Maryland Health Care Commission, 4160 Patterson Avenue, Baltimore, MD 21215. Please contact Brian Banschbach (brian.banschbach@maryland.gov) if an invoice is needed.

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| --- | --- |
| **Project Title** |  |
| **Date of the Request** |  |
| **Organization Requesting the Data** |  |
| **Contact Person** |  |
| **Title** |  |
| **E-mail** |  |
| **Phone Number** |  |
| **Address** |  |
| **Project Period** |  |

**PROJECT SPECIFICATION**

*Please attach a project specification that includes:*

1. ***Project purpose****. Describe your study background, objectives, and significance. If appropriate, include a description of the hypothesis to be tested. In addition, please summarize how specifically your project will address the triple aim of better health, better care, and lower costs.*
2. ***Study protocol or project activities****. Summarize how the requested data will be used, including the analytic plan. Describe any other data that will be linked to or used in conjunction with the MCDB for this project.*
3. ***Distribution of the Report or Product.*** *Describe the intended product or report to be derived from the requested data. Describe how information derived from this data will be used and by whom. Do you intend to make the results of your analysis project publicly available and, if so, in what form(s)? Describe the level of data aggregation planned (e.g. person/member, provider, geography, etc.). Summarize how the project products will protect PHI and PII.*
4. ***Applicant qualifications****. Describe the applicant’s experience and expertise with projects of similar scale and scope, and justify how the applicant qualifies for the use of the requesting data.*
5. ***Funding source:*** *Describe the source of funding for this project.*
6. ***Timeframe:*** *Describe the timeframe for the project.*

**REQUESTED DATA**

Please specify the following in your request:

* years of data requested (Options: 2010, 2011, 2012, 2013, 2014):
* Data files (Medical Eligibility, Professional Services, Institutional Services, Pharmacy Services):

**DATA MANAGEMENT PLAN**

1. PHYSICAL POSSESSION AND STORAGE OF MHCC DATA FILES (see attached Data Management Plan)
	1. Who will have the main responsibility for organizing, storing, and archiving the data? Please provide name(s) and job title(s).
	2. Describe how your organization maintains a current inventory of sensitive data files.
	3. Describe how your organization binds all members (i.e., organizations, individual staff) of research teams to specific privacy and security rules in using sensitive data files.
	4. Provide details on how your organization will notify MHCC of any project staffing changes.
	5. Describe the physical & technical infrastructure (facilities, hardware, software, other) that will secure the MHCC data files. Include information regarding physical (local/network drive storage, etc.) and logical access (password protocols, etc.) to the files/file locations. Also, describe backup hardware (tape, disc, etc.) & procedures (medium & internal/external storage).
		1. Describe network user security protocols such as
2. DATA SHARING, ELECTRONIC TRANSMISSION, DISTRIBUTION
	1. Describe your organization’s policies and procedures regarding the sharing, transmission, and distribution of sensitive data files (including Data Use Agreements).
	2. If your organization employs a sensitive data tracking system, please describe.
	3. If applicable for this project, describe the policies and procedures your organization has developed for the physical removal, transport and transmission of PHI and PII.
	4. Are additional organizations involved in analyzing the data files provided by MHCC?
3. COMPLETION OF RESEARCH TASKS AND DATA DESTRUCTION
	1. Describe your organization’s process to complete the Certificate of Data Destruction form (attached) and policies and procedures to destroy data files upon completion of its research.
	2. Describe your organization’s policies and procedures used to protect sensitive data files when individual staff members of research teams (as well as collaborating organizations) terminate their participation in research projects (which may include staff exit interviews and immediate access termination).
	3. Address policies and procedures your organization has to ensure original data files are not used following the completion of the project.

**DATA SECURITY AND ETHICS**

Application for MCDB data requires approval through its designated Institutional Review Board (IRB), [Chesapeake IRB](https://www.chesapeakeirb.com/). In addition, if your study has been approved by another IRB or Privacy Board, please attach the approval document.

**PROJECT STAFF**

*All project staff, including any contractors and collaborators, who would potentially use, have custody of data, and/or develop or use products of the data should be named in this section. This section specifically identifies the organization and the role in this project. Copy information fields for each staff person for this project.*

**Name**:

**Title**:

**Email Address:**

**Phone Number:**

**Address:**

**Affiliation** (for the purposes of this project, if not member of primary organization):

**Role in this project**:

**Will this individual have access to raw data, analytic files, or output with cell sizes less than 11?**YES    NO

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**CERTIFICATE OF DATA DESTRUCTION**

The undersigned hereby certifies that all copies of the following data files provided to by the Maryland Health Care Commission on have been destroyed.

Description of files destroyed (file names provided by MHCC):

Method of destruction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Shredding, Overwriting, etc.)

Date of destruction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Data destroyed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_