

Application for Massachusetts All-Payer Claims Data (Government) [Exhibit A – Data Application]

I. INSTRUCTIONS

This form is required for all Applicants, Agencies, Departments, Organizations, or Authorities of the Commonwealth of Massachusetts, as well as federal agencies and departments of the United States of America, hereinafter referred to as “Organization” requesting protected health information. All organizations must also complete the [Data Management Plan](#), and attach it to this Application. The Application and the Data Management Plan must be signed by an authorized signatory. This Application and the Data Management Plan will be used by CHIA to determine whether the request meets the criteria for data release, pursuant to 957 CMR 5.00. Please complete the Application documents fully and accurately. Prior to receiving CHIA Data, the Organization must execute CHIA’s [Data Use Agreement](#). Requestors may wish to review that document prior to submitting this Application.

Government Agencies as defined in [957 CMR 5.02](#), requesting protected health information are not required to submit a fee for the data.

Before completing this Application, please review the data request information on CHIA’s website:

- [Data Availability](#)
- [Data Request Process](#)

After reviewing the information on the website and this Application, please contact CHIA at apcd.data@chiamass.gov if you have additional questions about how to complete this form.

The Application and all attachments must be uploaded to [IRBNet](#). All Application documents can be found on the [CHIA website](#).

Information submitted as part of the Application may be subject to verification during the review process or during any audit review conducted at CHIA’s discretion.

Applications will not be reviewed until the Application and all supporting documents are complete.

II. ORGANIZATION & INVESTIGATOR INFORMATION

| | |
|--------------------------------------------------|---------------------------|
| Project Title: | Click here to enter text. |
| IRBNet Number: | Click here to enter text. |
| Organization Requesting Data (Recipient): | Click here to enter text. |
| Organization Website: | Click here to enter text. |
| Authorized Signatory for Organization: | Click here to enter text. |
| Title: | Click here to enter text. |
| E-Mail Address: | Click here to enter text. |
| Telephone Number: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Data Custodian: | Click here to enter text. |

| | |
|------------------------------------------------------------------------------------------------------------|---------------------------|
| (individual responsible for organizing, storing, and archiving Data) | |
| Title: | Click here to enter text. |
| E-Mail Address: | Click here to enter text. |
| Telephone Number: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Primary Investigator (Applicant): (individual responsible for the research team using the Data) | Click here to enter text. |
| Title: | Click here to enter text. |
| E-Mail Address: | Click here to enter text. |
| Telephone Number: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Names of Co-Investigators: | Click here to enter text. |
| E-Mail Addresses of Co-Investigators: | Click here to enter text. |

III. PROJECT INFORMATION

IMPORTANT NOTE: Organization represents that the statements made below as well as in any study or research protocol or project plan, or other documents submitted to CHIA in support of the Data Application are complete and accurate and represent the total use of the CHIA Data requested. Any and all CHIA Data released to the Organization under an approved application may ONLY be used for the express purposes identified in this section by the Organization, and for no other purposes. Use of CHIA Data for other purposes requires a separate Data Application to CHIA or written request to CHIA, with approval being subject to CHIA's regulatory restrictions and approval process. Unauthorized use is a material violation of your organization's Data Use Agreement with CHIA.

1. What will be the use of the CHIA Data requested? [Check all that apply]

- | | | |
|-------------------------------------------------|--------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> Epidemiological | <input type="checkbox"/> Health planning/resource allocation | <input type="checkbox"/> Cost trends |
| <input type="checkbox"/> Longitudinal Research | <input type="checkbox"/> Quality of care assessment | <input type="checkbox"/> Rate setting |
| <input type="checkbox"/> Reference tool | <input type="checkbox"/> Research studies | <input type="checkbox"/> Severity index tool (or other derived input) |
| <input type="checkbox"/> Surveillance | <input type="checkbox"/> Student research | <input type="checkbox"/> Utilization review of resources |
| <input type="checkbox"/> Inclusion in a product | <input type="checkbox"/> Other (describe in box below) | |

Click here to enter text.

2. Provide an abstract or brief summary of the specific purpose and objectives of your Project. This description should include the research questions and/or hypotheses the project will attempt to address, or describe the intended product or report that will be derived from the requested data and how this product will be used. Include a brief summary of the pertinent literature with citations, if applicable.

Click here to enter text.

3. Has an Institutional Review Board (IRB) reviewed your Project?

- ☐ Yes [If yes, a copy of the approval letter and protocol must be included with the Application package on IRBNet.]
- ☐ No, this Project is not human subject research and does not require IRB review.

4. **Research Methodology:** Applications must include either the IRB protocol or a written description of the Project methodology (typically 1-2 pages), which should state the Project objectives and/or identify relevant research questions. This document must be included with the Application package on IRBNet and must provide sufficient detail to allow CHIA to understand how the Data will be used to meet objectives or address research questions.

IV. PUBLIC PURPOSE

1. Briefly identify the public purpose(s), ***including citing all applicable statutory authority***, for which CHIA Data is being sought and explain how the requested Data will be used to accomplish the purpose(s). Use quantitative indicators of public health importance where possible, for example, numbers of deaths or incident cases; age-adjusted, age-specific, or crude rates; or years of potential life lost. *Uses that serve the public interest under CHIA regulations include, but are not limited to: health cost and utilization analysis to formulate public policy; studies that promote improvement in population health, health care quality or access; and health planning tied to evaluation or improvement of Massachusetts state government initiatives.*

Click here to enter text.

V. DATASETS REQUESTED

The Massachusetts All-Payer Claims Database (“APCD”) is comprised of medical, pharmacy, and dental claims and information from the member eligibility, provider, and product files that are collected from health insurance payers licensed to operate in the Commonwealth of Massachusetts. This information encompasses public and private payers as well as data from fully-insured and self-insured plans. APCD data are refreshed and updated annually and made available to approved data users. For more information about APCD Data, including available years of data and a full list of elements in the database please refer to layouts, data dictionaries and similar documentation included on [CHIA’s website](#).

Data requests are typically fulfilled on a one time basis, however; certain Projects may require future years of data that will become available in a subsequent release. Projects that anticipate a need for future years of data may request to be considered for a subscription. Approved subscriptions will receive, upon request, the same data files and data elements included in the initial Release annually or as available. Please note that approved subscription requests are subject to the Data Use Agreement, and subject to the limitation that the Data can be used only in support of the approved Project.

1. Please indicate below whether this is a one-time request, or if the described Project will require a subscription.
☐ One-Time Request **OR** ☐ Subscription
2. CHIA is currently filling requests for claims data from 2018 to 2023. Requests made outside of these years may not be fulfilled by CHIA and will be considered on a case-by-case basis. Please specify the years of data that are being requested: _____.

3. Specify below the data files requested for this Project, and provide your justification for requesting *each* file.

| |
|------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Medical Claims |
| Describe how your research objectives require Medical Claims data: Click here to enter text. |
| <input type="checkbox"/> Pharmacy Claims |
| Describe how your research objectives require Pharmacy Claims data: Click here to enter text. |
| <input type="checkbox"/> Dental Claims |
| Describe how your research objectives require Dental Claims data: Click here to enter text. |
| <input type="checkbox"/> Member Eligibility |
| Describe how your research objectives require Member Eligibility data: Click here to enter text. |
| <input type="checkbox"/> Provider |
| Describe how your research objectives require Provider data: Click here to enter text. |
| <input type="checkbox"/> Product |
| Describe how your research objectives require Product data: Click here to enter text. |
| <input type="checkbox"/> Benefit Plan |
| Describe how your research objectives require Benefit Plan data: Click here to enter text. |
| <input type="checkbox"/> MassHealth Enhanced Eligibility |
| Describe how your research objectives require MassHealth Enhanced Eligibility data: Click here to enter text. |

VII. DATA ELEMENTS REQUESTED

State and federal privacy laws limit the release and use of Data to the minimum amount of data needed to accomplish a specific Project objective. CHIA requires Applicants to justify individually identifiable elements in order to conform to these privacy laws.

Requests for individually identifiable elements will be reviewed by CHIA to determine whether each represents the minimum data necessary to complete the specific Project objective.

For a full list of elements in the release, please refer to [release layouts, data dictionaries](#) and similar documentation included on CHIA's website.

Use the most recent [APCD Data Specification Workbook \(Excel\)](#) to identify which data elements you are requesting (Column D), and provide justifications (Column F) for any individually identifiable elements where it is required (Column E), as indicated in the APCD Data Specification Workbook. **Upload** the completed APCD Data Specification Workbook to IRBNet.

ZIP code and state geographic subdivisions are available for Massachusetts residents and providers only. Small population ZIP codes are combined with larger population ZIP codes. One ZIP Code per person (MEID) per year has been assigned based on the ZIP code/state reported in the member eligibility record's earliest submission year month. If the record does not have an MEID, assignment is based on distinct OrgID/Carrier Specific Unique Member ID.

Non-Massachusetts ZIP codes and state codes except for CT, MA, ME, NH, NY, RI, and VT are suppressed.

VIII. SUBSTANCE USE RECORDS

The receipt and re-release of substance use records is governed by federal law, 42 CFR Part II. As a result the All-Payer Claims Data is not complete as it relates to substance use records and CHIA's ability to re-release such records is constrained.

1. Indicate whether you are seeking substance use records for this Project:

☐ Yes ☐ No

2. If yes, please have the Agency's legal counsel contact CHIA's General Counsel's office.

IX. MEDICARE DATA

1. Indicate whether you are seeking Medicare Data:

☐ Yes ☐ No

2. Use the most recent [Medicare Request Form \(Excel\)](#) to identify which data elements you are requesting.

Upload the completed Medicare Request Form to IRBNet. *Note that Medicare data cannot be linked to CHIA's APCD Data.*

3. Applicants approved to receive Medicare Data will be required to execute a [Medicare Addendum](#) to CHIA's Data Use Agreement, containing terms and conditions required by CHIA's Data Use Agreement with CMS.

4. Medicare Data may only 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) ("Waiver Requirements") if the anticipated data recipient were to apply for the data from CMS directly. Please **attach** the IRB or Privacy Board waiver letter. If the Applicant does not have a waiver letter, CHIA may be able to determine that the research Project meets the Waiver Requirements. Please answer the following questions and provide any additional information that may be helpful in making this determination:

The Organization has a plan, and will abide by the plan, to protect all Protected Health Information (PHI) (as defined under HIPAA) from use or disclosure not expressly permitted under this Application:

☐ Yes ☐ No

The Organization will destroy all PHI at the earliest opportunity, consistent with the executed Data Use Agreement with CHIA:

☐ Yes ☐ No

The Organization will not disclose any PHI to any individual not authorized or legally required to use the PHI:

☐ Yes ☐ No

The Organization cannot conduct the research without access to the PHI requested:

☐ Yes ☐ No

Briefly describe how you will use the Medicare Data in the space below:

Click here to enter text.

5. The organization must inform CHIA of the location where the Data will be stored and may not move the Data to any other location without first informing CHIA. *List below **all** addresses where Medicare Data will be stored.*

| | | | |
|-----------------------------------------------------------------|---------------------------------|----------------------------------|-------------------------------------|
| Agency or Organization: Click here to enter text. | | | |
| Street Address: Click here to enter text. | City: Click here to enter text. | State: Click here to enter text. | ZIP Code: Click here to enter text. |
| Office Telephone (Include Area Code): Click here to enter text. | | | |

| | | | |
|-----------------------------------------------------------------|---------------------------------|----------------------------------|-------------------------------------|
| Agency or Organization: Click here to enter text. | | | |
| Street Address: Click here to enter text. | City: Click here to enter text. | State: Click here to enter text. | ZIP Code: Click here to enter text. |
| Office Telephone (Include Area Code): Click here to enter text. | | | |

X. MEDICAID (MASSHEALTH) DATA

1. Please indicate whether you are seeking Medicaid Data:

☐ Yes
☐ No

2. Federal law (42 USC 1396a(a)7) restricts the use of individually identifiable data of Medicaid recipients to uses that are **directly connected to the administration of the Medicaid program**. If you are requesting identifiable MassHealth Data, please describe, in the space below, why your use of the Data meets this requirement. *Your description should focus on how the results of your project could be used by the Executive Office of Health and Human Services in connection with the administering the MassHealth program.* Requests for MassHealth 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 MassHealth program. CHIA cannot release MassHealth Data without approval from MassHealth. This may introduce significant delays in the receipt of MassHealth Data.

Researchers must provide the following information for MassHealth to determine how the disclosure of identifiable MassHealth claims data is directly related to the administration of the MassHealth program:

- How does the project relate directly to the administration of the Medicaid program?

- What specific Medicaid program, policy, rule or law will be affected or changed based on the outcome of this project?
- How will MassHealth's objectives be helped or impaired by approving this project?
- Will the results of the research have the potential for:
 - reducing cost of the Medicaid program,
 - improving access for recipients, and/or
 - increasing quality of care to recipients?
- Please describe the project deliverables the researchers will provide to MassHealth
- Please describe how MassHealth can use the project deliverables in administration of the MassHealth program

3. Organizations approved to receive Medicaid Data will be required to execute a [Medicaid Acknowledgment of Conditions](#). MassHealth may impose additional requirements on applicants for Medicaid Data as necessary to ensure compliance with federal laws and regulations regarding Medicaid.

XI. DATA LINKAGE

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

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

- ☐ Yes
- ☐ No linkage or merger with any other data will occur

2. If yes, please indicate below the types of data to which CHIA Data will be linked. [Check all that apply]

- ☐ Individual Patient Level Data (e.g. disease registries, death data)
- ☐ Individual Provider Level Data (e.g., American Medical Association Physician Masterfile)
- ☐ Individual Facility Level Data (e.g., American Hospital Association data)
- ☐ Aggregate Data (e.g., Census data)
- ☐ Other (please describe):

3. If yes, describe the dataset(s) to which the CHIA Data will be linked, indicate which CHIA Data elements will be linked and the purpose for each linkage.

Click here to enter text.

4. 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.

Click here to enter text.

5. If yes, attach or provide below a complete listing of the variables from all sources to be included in the final linked analytic file.

Click here to enter text.

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

Click here to enter text.

XII. PUBLICATION / DISSEMINATION / RE-RELEASE

1. Do you anticipate that the results of your analysis will be published or made publicly available? If so, how do you intend to disseminate the results of the study (e.g.: publication in professional journal, poster presentation, newsletter, web page, seminar, conference, statistical tabulation)? Any and all publication of CHIA Data must comply with CHIA's cell size suppression policy, as set forth in the Data Use Agreement. Please explain how you will ensure that any publications ***will not disclose a cell less than 11***, and percentages or other mathematical formulas that result in the display of a cell less than 11.

Click here to enter text.

2. Describe your plans to use or otherwise disclose CHIA Data, or any Data derived or extracted from such Data, in any paper, report, website, statistical tabulation, seminar, or other setting that is not disseminated to the public.

Click here to enter text.

3. What will be the lowest geographical level of analysis of data you expect to present for publication or presentation (e.g., state level, city/town level, zip code level, etc.)? Will maps be presented? If so, what methods will be used to ensure that individuals cannot be identified?

Click here to enter text.

4. Will you be using CHIA Data for consulting purposes?

- ☐ Yes
☐ No

5. Will you be selling standard report products using CHIA Data?

- ☐ Yes
☐ No

6. Will you be selling a software product using CHIA Data?

- ☐ Yes
☐ No

7. Will you be using CHIA Data as in input to develop a product (i.e., severity index tool, risk adjustment tool, reference tool, etc.)

☐ Yes

☐ No

8. Will you be reselling CHIA Data in any format not noted above?

☐ Yes

☐ No

If yes, in what format will you be reselling CHIA Data?

Click here to enter text.

9. If you have answered “yes” to questions 5, 6, 7 or 8, please provide the name and a description of the products, software, services, or tools.

Click here to enter text.

10. If you have answered “yes” to questions 5, 6, 7 or 8, what is the fee you will charge for such products, software, services or tools?

Click here to enter text.

XIII. APPLICANT QUALIFICATIONS

1. Describe your previous experience using claims data. This question should be answered by the primary investigator and any co-investigators who will be using the Data.

Click here to enter text.

2. **Resumes/CVs:** When submitting your Application package on IRBNet, include résumés or curricula vitae of the principal investigator and co-investigators. (These attachments will not be posted on the internet.)

XIV. USE OF AGENTS AND/OR CONTRACTORS

By signing this Application, the Organization assumes all responsibility for the use, security and maintenance of the CHIA Data by its agents, including but not limited to contractors. The Organization must have a written agreement with the agent of contractor limiting the use of CHIA Data to the use approved under this Application as well as the privacy and security standards set forth in the Data Use Agreement. CHIA Data may not be shared with any third party without prior written consent from CHIA, or an amendment to this Application. CHIA may audit any entity with access to CHIA Data.

Provide the following information for **all** agents and contractors who will have access to the CHIA Data. [*Add agents or contractors as needed.*]

| AGENT/CONTRACTOR #1 INFORMATION | |
|--------------------------------------|---------------------------|
| Company Name: | Click here to enter text. |
| Company Website | Click here to enter text. |
| Contact Person: | Click here to enter text. |
| Title: | Click here to enter text. |
| E-mail Address: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Telephone Number: | Click here to enter text. |
| Term of Contract: | Click here to enter text. |

1. Describe the tasks and products assigned to the agent or contractor for this Project and their qualifications for completing the tasks.

Click here to enter text.

2. Describe the Organization's oversight and monitoring of the activities and actions of the agent or contractor for this Project, including how the Organization will ensure the security of the CHIA Data to which the agent or contractor has access.

Click here to enter text.

3. Will the agent or contractor have access to and store the CHIA Data at a location other than the Organization's location, off-site server and/or database?

☐ Yes

☐ No

4. If yes, a separate Data Management Plan **must** be completed by the agent or contractor.

| AGENT/CONTRACTOR #1 INFORMATION | |
|--------------------------------------|---------------------------|
| Company Name: | Click here to enter text. |
| Company Website | Click here to enter text. |
| Contact Person: | Click here to enter text. |
| Title: | Click here to enter text. |
| E-mail Address: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Telephone Number: | Click here to enter text. |
| Term of Contract: | Click here to enter text. |

1. Describe the tasks and products assigned to the agent or contractor for this Project and their qualifications for completing the tasks.

Click here to enter text.

2. Describe the Organization's oversight and monitoring of the activities and actions of the agent or contractor for this Project, including how the Organization will ensure the security of the CHIA Data to which the agent or contractor has access.

[Click here to enter text.](#)

3. Will the agent or contractor have access to or store the CHIA Data at a location other than the Organization's location, off-site server and/or database?

☐ Yes

☐ No

4. If yes, a separate Data Management Plan **must** be completed by the agent or contractor.

[INSERT A NEW SECTION FOR ADDITIONAL AGENTS/CONTRACTORS AS NEEDED]

XV. ATTESTATION

By submitting this Application, the Organization attests that it is aware of its data use, privacy and security obligations imposed by state and federal law *and* confirms that it is compliant with such use, privacy and security standards. The Organization further agrees and understands that it is solely responsible for any breaches or unauthorized access, disclosure or use of CHIA Data, including, but not limited to, any breach or unauthorized access, disclosure or use by any third party to which it grants access.

Organizations approved to receive CHIA Data will be provided with Data following the payment of applicable fees and upon the execution of a Data Use Agreement requiring the Organization to adhere to processes and procedures designed to prevent unauthorized access, disclosure or use of data.

By my signature below, I attest: (1) to the accuracy of the information provided herein; (2) this research is not funded by a source requiring the release of raw data to that source; (3) that the requested Data is the minimum necessary to accomplish the purposes described herein; (4) that that use of identifiable claims data is reasonably related to the agency's legal authority; (5) that the Organization will meet the data privacy and security requirements described in this Application and supporting documents, and will ensure that any third party with access to the Data meets the data use, privacy and security requirements; and (5) to my authority to bind the Organization.

| | |
|-------------------------------------------------------|-------------------------------------------------------------------------|
| Signature: (Authorized Signatory for Organization) | Drag signature image here or delete and physically sign |
| Printed Name: | Click here to enter text. |
| Title: | Click here to enter text. |
| Date: | Click here to enter text. |

Attachments:

A completed Application must have the following documents attached to the Application or uploaded separately to IRBNet:

- ☐ 1. IRB approval letter and protocol (if applicable), or research methodology (if protocol is not attached)
- ☐ 2. Data Management Plan (including one for each agent or contractor that will have access to or store the CHIA Data at a location other than the Organization's location, off-site server and/or database);
- ☐ 3. CVs of Investigators (upload to IRBNet)
- ☐ 4. APCD Data Specification Workbook with all requested individually identifiable elements justified (upload to IRBNet)
- ☐ 5. Medicare data IRB or privacy board waiver letter (if applicable)
- ☐ 6. [Medicare Request Form](#) (upload to IRBNet)

APPLICATIONS WILL NOT BE REVIEWED UNTIL THEY ARE COMPLETE, INCLUDING ALL ATTACHMENTS.

Data Management Plan for Use of CHIA Data [Attach to Data Application]

I. INSTRUCTIONS

Any Recipients, contractors, or agents receiving CHIA Data (“Data”) must complete and execute this [Data Management Plan](#). Certain CHIA Data includes Protected Health Information (“PHI”) as defined under the Health Insurance Portability and Accountability Act [HIPAA] and its implementing regulations) and all CHIA Data contains elements that may be used to identify an individual. The Data Management Plan(s) will be incorporated within the Data Use Agreement that must be executed prior to receipt of the Data. You may wish to refer to the Data Use Agreement as you complete this Data Management Plan. This Data Management Plan should be completed by the Chief Information Security Officer, Chief Privacy Officer, legal counsel or another officer with sufficient knowledge of the Agency or Organization’s data privacy and security practices and who has authority to bind the Agency or Organization.

NOTE: This Data Management Plan is confidential and will not become a part of the public record.

II. GENERAL INFORMATION

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| Project Title: (as it appears on Data Application) | Click here to enter text. |
| Primary Investigator: (as it appears on Data Application) | Click here to enter text. |
| Organization Requesting CHIA Data (Recipient): (as it appears on Data Application) | Click here to enter text. |
| Organization Holding CHIA Data under this Data Management Plan: (this entity must be either the Recipient or listed as an Agent/Contractor for the Recipient on the Data Application) | Click here to enter text. |

III. CERTIFICATIONS

The undersigned certifies and agrees as follows:

- The Data will be **encrypted at rest on storage media (backup tapes, local hard drives, network storage, et al) with at least AES-256 standard or stronger.**
- The Data will be **encrypted in transit consistent with the approved method(s) described in this Data Management plan at section V.3-b.**
- Anti-malware software or service is active on any server or endpoint containing or accessing the Data or other controls mitigating malware infection and propagation are in place
- If a Covered Entity or Business Associate under HIPAA, the Agency or Organization is in full compliance with the privacy and security requirements of HIPAA; trains all staff who access PHI on the requirements of HIPAA; and has Business Associate Agreements with all non-employees who access PHI.
- The Agency or Organization has policies and procedures in place to address:
 - The sharing, transmission and distribution of PHI

- The physical removal, transport and transmission of PHI
- The physical possession and storage of PHI
- The destruction of PHI upon the completion of its use
- Confidentiality agreements with all individuals, including contractors, who will access PHI
- Agreements governing the use and disclosure of PHI with all non-employees who will access PHI

IV. RESPONSIBLE PARTIES

Please identify the following individuals within your Agency or Organization:

1. The individual responsible for organizing, storing and archiving the Data. This individual is the Custodian of the CHIA Data required under Article XI of the Data Use Agreement.

| | |
|--------------------------------------|-------------------------------------------|
| Name: | Click here to enter text. |
| Agency/Organization: | Click here to enter text. |
| Title: | Click here to enter text. |
| Phone: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Email: | Click here to enter text. |
| Reports to (name and title): | Click here to enter text. |

2. The individual(s) responsible for the research team using the Data, including ensuring each individual (i) has a signed confidentiality agreement, (ii) accesses and uses only the minimal Data necessary to achieve the research purpose, (iii) accesses the Data only on a secured server according to Applicant's policies. This individual is also responsible for maintaining the access log required under Article II, Section 5 of the Data Use Agreement.

| | |
|--------------------------------------|-------------------------------------------|
| Name: | Click here to enter text. |
| Agency/Organization | Click here to enter text. |
| Title: | Click here to enter text. |
| Phone: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Email: | Click here to enter text. |
| Reports to (name and title): | Click here to enter text. |

3. The individual responsible for notifying CHIA of any breach of the Data Use Agreement or this Data Management Plan.

| | |
|--------------------------------------|-------------------------------------------|
| Name: | Click here to enter text. |
| Organization: | Click here to enter text. |
| Title: | Click here to enter text. |
| Phone: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Email: | Click here to enter text. |
| Reports to (name and title): | Click here to enter text. |

4. The individual responsible for ensuring the Data is destroyed upon termination of the Data Use Agreement, completing the Data Destruction Form and providing that Form to CHIA.

| | |
|--------------------------------------|---------------------------|
| Name: | Click here to enter text. |
| Organization: | Click here to enter text. |
| Title: | Click here to enter text. |
| Phone: | Click here to enter text. |
| Address, City/Town, State, Zip Code: | Click here to enter text. |
| Email: | Click here to enter text. |
| Reports to (name and title): | Click here to enter text. |

V. DATA SECURITY AND INTEGRITY

Agents or contractors that will have access to or store the CHIA Data at a location other than the Recipient's location, or in an off-site server and/or database, must complete a separate [Data Management Plan](#).

1. *Physical Location of the Data:*

- a. Please provide the delivery address for the Data, as well as the full address, including building and floor, of each location where Data will be delivered and stored.

Delivery:

| | | | |
|--------------------------------------------------------------------------|---------------------------------|----------------------------------|-------------------------------------|
| Organization: Click here to enter text. | | | |
| Street Address: Click here to enter text. | City: Click here to enter text. | State: Click here to enter text. | ZIP Code: Click here to enter text. |
| Office Telephone (<i>Include Area Code</i>): Click here to enter text. | | | |

Storage:

| | | | |
|--------------------------------------------------------------------------|---------------------------------|----------------------------------|-------------------------------------|
| Organization: Click here to enter text. | | | |
| Street Address: Click here to enter text. | City: Click here to enter text. | State: Click here to enter text. | ZIP Code: Click here to enter text. |
| Office Telephone (<i>Include Area Code</i>): Click here to enter text. | | | |

- b. Will the Data be stored by the third party on a system in the cloud (reachable via the Internet)?

☐ Yes
 ☐ No

 - i. If you answered yes to (b): Has this Cloud Service Provider passed a FedRAMP 3PAO assessment *for the specific cloud system* which will host the data?

☐ Yes
 ☐ No

- ii. If you answered yes to (b): What is the name of the provider *and* the FedRAMP level the specific cloud system hosting the data is operating at?

Click here to enter text.

2. Data Privacy Training and Awareness:

- a. Has every individual who will access the Data received training on the proper handling of protected health information and/or personal data within the last year?
- ☐ Yes ☐ No

3. Encryption of Data:

- a. Will all CHIA Data at rest be encrypted on storage media (backup tapes, local hard drives, network storage, et al) with **encryption at least AES-256 or stronger**. *All holders of CHIA Data must encrypt data at rest a Data Management Plan indicating otherwise will not be approved and returned for revisions.*
- ☐ Yes ☐ No
- b. Will CHIA Data be transmitted by your Agency or Organization over the Internet?
- ☐ Yes ☐ No

If you answered yes to (b): which of the following if any are used when transmitting data over the internet? If selecting *other* please describe the method in space provided below.

- ☐ SSL (meets or exceeds TLS 1.1 or TLS 1.2) ☐ SFTP ☐ other

Click here to enter text.

4. Information Security:

- a. Does your Agency or Organization have published information security policies which are followed and accessible to all staff accessing or handling CHIA Data?
- ☐ Yes ☐ No
- b. Has every individual who will access the CHIA Data received cyber security awareness training in the last year?
- ☐ Yes ☐ No
- c. Has your Agency or Organization experienced a breach of PHI or Personally Identifiable Information in the last seven (7) years?
- ☐ Yes ☐ No
- i. *If you answered yes to (c): how was the breach resolved and what steps were taken to prevent a recurrence?*

Click here to enter text.

5. Technical and Physical Controls:

- a. Are all the user accounts that log on to any machine (server or endpoint) that accesses the Data uniquely assigned to individual users (i.e., the user accounts are not shared)?
☐ Yes ☐ No
- b. Is an audit log maintained of all user log-on attempts to the system hosting the CHIA Data?
☐ Yes ☐ No
- c. What is the minimum password length and character complexity (uppercase, lowercase, numeric, and special characters) required for new passwords on the user accounts logging on to the system accessing the CHIA Data?

Click here to enter text.

- d. Describe any additional authentication technical security controls you employ to defend the system against unauthorized logon, e.g. maximum failed login attempts, lockout period, etc.:

Click here to enter text.

- e. Do you run a current version of a commercial off-the-shelf anti-virus or anti-malware product on the systems that will host or access the CHIA Data?
☐ Yes ☐ No

If you answered no to (e), please provide details within your response in question (g) regarding additional controls implemented to prevent malware infection and propagation.

- f. If the CHIA Data will be on a server or network accessible storage drive, then check all the security features present in the room containing CHIA Data:
- i. ☐ Recorded video
 - ii. ☐ Access log of all individuals entering the room
 - iii. ☐ Secure server rack
 - iv. ☐ Access control limiting access only to authorized individuals
- g. What additional specific physical or technical safeguards (not mentioned in prior answers) will be used to *mitigate* the risk of unauthorized access to CHIA Data?

Click here to enter text.

- h. When was the last information security risk assessment performed in your Agency or Organization? Who conducted it?

Click here to enter text.

- i. When was the last IT audit performed in your Agency or Organization? Who conducted it?

Click here to enter text.

VI. DATA DESTRUCTION

The Recipient attests that the CHIA Data and all copies of the CHIA Data used by the Applicant or its employees, contractors, or agents will be destroyed upon Project Completion or termination of the Data Use Agreement. All data destruction must conform to the requirements of [M.G.L. c. 93I](#) and to the Data Use Agreement. Please specify below the technical measures you will use to meet these requirements.

Click here to enter text.

VII. ATTESTATION

By submitting this Data Management Plan, the Agency or Organization attests that it is aware of its data use, privacy and security obligations imposed by state and federal law *and* confirms that it is compliant with such use, privacy and security standards. The Agency or Organization further agrees and understands that it is solely responsible for any breaches or unauthorized access, disclosure or use of CHIA Data, including, but not limited to, any breach or unauthorized access, disclosure or use by its agents.

By signature below, I attest: (1) to the accuracy of the information provided herein (2) that the Agency or Organization agrees to hold and/or access CHIA Data at all times in compliance with all provisions of this Data Management Plan and the Data Use Agreement; and (3) to my authority to bind the Agency or Organization undersigned as an authorized signatory of the Agency or Organization.

| | |
|-----------------------------------------------------------------------------------|---------------------------------------------------------|
| Signature: (Authorized Signatory for Agency or Organization holding CHIA Data) | Drag signature image here or delete and physically sign |
| Printed Name: | Click here to enter text. |
| Title: | Click here to enter text. |
| Agency or Organization Holding CHIA Data: | Click here to enter text. |
| Date: | Click here to enter text. |