

Commonwealth of Massachusetts
Center for Health Information & Analysis (CHIA)
Acknowledgement of Conditions Upon Receipt of Medicaid Data

ACKNOWLEDGMENT OF CONDITIONS UPON RECEIPT OF MASSHEALTH DATA

This Acknowledgment supplements the Data Use Agreement (“DUA”) dated _____, between the Center for Health Information and Analysis (“CHIA”) _____, hereinafter referred to as “Recipient”.

This Acknowledgment pertains to the project entitled: _____ as described in the Recipient’s Data Application for data from the Massachusetts All Payer Claims Database (“APCD”).

This Acknowledgment is effective as of the date of execution below. To the extent that this Acknowledgment is inconsistent with any terms in the DUA, this Acknowledgment modifies and overrides the DUA, which shall otherwise remain in full force and effect.

The undersigned Recipient hereby acknowledges that:

- Pursuant to an interagency service agreement between CHIA and MassHealth, CHIA submitted the Recipient’s request for Medicaid data from the APCD to MassHealth for review to determine whether the request is “directly connected” to the administration of the MassHealth program;
- Federal regulation at 42 CFR 431.302 provides purposes directly related to plan administration which include (1) Establishing eligibility; (2) Determining the amount of medical assistance; (3) Providing services for beneficiaries; and (4) Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan.
- For all Recipients, EHS approves the request contingent upon the following requirements:
 - that the Recipient shall provide an advance draft of any publication to the MassHealth Chief of Staff (elizabeth.m.lamontagne@state.ma.us), and if the Recipient accessed identifiable data an additional draft must be provided to the EHS Privacy Office (privacy.officer@mass.gov), five (5) business days prior to publication; and
 - that the Recipient shall provide EHS with the results of its analysis of the MassHealth data.
 - The undersigned Recipient hereby agrees to comply with the above requirement(s), as a condition of receiving MassHealth data from CHIA.

The Recipient acknowledges that the above condition(s) are hereby incorporated into the Recipient’s DUA with CHIA as obligations of the Recipient and that, as such, failure to comply with any of the listed conditions could result in denial of future access to any CHIA Data, termination of current access to CHIA Data, and/or a demand for immediate return or destruction of all CHIA data.

On behalf of the Recipient the undersigned individual hereby attests that he or she is authorized to legally bind the Recipient to the terms of this Acknowledgment and agrees to all the terms specified herein.

Name of authorized signer:		Organization:	
Street Address:	City:	State:	ZIP Code:
Office Telephone <i>(Include Area Code)</i> :		E-Mail Address <i>(If applicable)</i> :	
Signature:	Title:	Date:	