

# ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE DATA RELEASE REQUEST

## CONTACT INFORMATION

Project Title: \_\_\_\_\_

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

Organization: \_\_\_\_\_

Organization Type: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## PROJECT INFORMATION

### Project Description (Use Additional Pages as Needed)

### Evaluation Criteria (Use Additional Pages as Needed)

Answer the following questions that will be asked during the data request review process. The APCD will work with you to answer any question if necessary.

1. Is the request consistent with the Transparency Initiative's goals and purpose?
2. Are there real or potential conflicts of interest or anti-competitive concerns?
3. If IRB approval is required, has the approval been granted?
4. Does the data request contain the minimum information required?
5. Does the request minimize the risk of re-identification of individuals?

Proposed Project Start Date: \_\_\_\_\_

Proposed Project End Date: \_\_\_\_\_

Is funding for the project dependent on approval of this request?  Yes  No



# ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE DATA RELEASE REQUEST

## DATA REQUEST

**Data Files**

- Enrollment Data   
  Medical Claims   
  Pharmacy Claims   
  Dental Claims   
  Provider Data

**Parameters**

	Date Range	Date Type	Other Parameters
Enrollment*			
Medical Claims			
Pharmacy Claims			
Dental Claims			

**Notes**

***Date Range** is the month and year. Historical data dates back from 2013.*

***Date Type** is how the date range should be defined for the project (e.g., date of service, date of claim submission, date of claim payment, or date of enrollment).*

*\*If requested member data should include all active members as of a specific date, e.g. 1/1/2013, the requested member date range should 'predate' that date to ensure that all active members are selected. For example, if all active members are required for 2013, the data request should indicate that member data should include records with date of first enrollment < 2013-01-01 and the date of disenrollment > 2013-01-01.*

**Payer-Level Detail** (e.g., Medicaid or private payer)

**Preferred Data File Type**

- Text File   
  SAS File   
  MS Excel Spreadsheet   
  SQL Server 2016 Table   
  Other

Other: \_\_\_\_\_

**Preferred Data Delimiter**

- Pipe   
  Tab   
  Comma   
  Other

Other: \_\_\_\_\_

**Preferred Text Qualifiers**

- Single Quote   
  Double Quotes   
  None   
  Other

Other: \_\_\_\_\_



# ARKANSAS HEALTHCARE TRANSPARENCY INITIATIVE DATA RELEASE REQUEST

## DATA USAGE

*Note: Ark. Code Ann. § 23-61-907 prohibits the use of data to reidentify or attempt to reidentify an individual without obtaining the individual's consent.*

Do you plan to merge or combine the Initiative data with other data files? Note, this does not include comparing Initiative data with other data files (e.g., Census data).

Yes     No

If yes, what is the purpose?

Which data elements will be used to merge or combine the Initiative data with other data files?

## PUBLICATION AND DISSEMINATION

Describe your plans to publish or disseminate the derived or extracted information:

Do you anticipate that the Initiative Data requested, or information published or disseminated based on Initiative Data, could be used for anticompetitive purposes, including but not limited to price-fixing, market or customer allocation, service or output restriction, price stabilization, or in any way that restricts or limits competition?

Yes     No

## QUALIFICATIONS AND EXPERIENCE

Attach a separate document that identifies all key personnel who would be assigned to the project and describe their qualifications.

For all key personnel, describe the experience, if any, with prior or current projects of comparable scope and complexity to this project.

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## OTHER PROJECT PARTICIPANTS

Provide the name, role, and organization of all the receiving organization's employees, contractors, and clients that will have access to the Initiative Data. Use a separate page if needed.

Name	Role	Organization
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Will a third-party or other organization have access to the Initiative Data?  Yes  No

Provide the following third-party information for all individuals or organizations who will have access to Initiative Data or who will be named as being affiliated with this project. Use a separate page if needed.

Company Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Title: \_\_\_\_\_

Email: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Will the data be housed at an off-site location?  Yes  No

If yes, submit their data management policies and procedures in your Data Management Plan. What is their role in the project?

