

**DATA USE AGREEMENT BETWEEN [Health Plan] and THE HEALTH CARE
INCENTIVES IMPROVEMENT INSTITUTE, INC. (HCI3)**

This DATA USE AGREEMENT made and entered into as of the _____ day of _____, 2010 by and between [Health Plan] located at _____ and The Health Care Incentives Improvement Institute, Inc. ("HCI3") located at _____:

WHEREAS, HCI3 is a collaborative effort among a consortium of purchasers and health plans to improve the quality of health care; and

WHEREAS, HCI3 and [Health Plan] wish to support quality measurement performance that would facilitate the performance assessment under the Prometheus Payment Model for health care payments centered on Evidence Informed Case Rates® ("ECR"); and

WHEREAS, HCI3, [Health Plan] and [HCI3 data partner] have entered into a Business Associate Agreement as required under the Federal Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009, and related regulations promulgated by the Secretary (collectively "HIPAA"); and

WHEREAS, HCI3 directly and through [HCI3 data partner] wishes to receive certain medical record data and other confidential information that [Plan] has received from participating plans (collectively, "Plan", or "Plans") that is protected health information ("PHI") or electronic protected health information ("E PHI") (collectively, "PHI") as defined under HIPAA.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein the parties hereto agree as follows:

1. HIPPA COMPLIANCE AND AGENTS.

HCI3 agrees to fully comply with the requirements under HIPAA, as set forth in the Business Associate Agreement.

2. USE AND DISCLOSURE; RIGHTS.

HCI3 agrees that it shall not use or disclose PHI, except as permitted under this Agreement. HCI3 may use or disclose the Data Set Information received, created by it, solely for the purpose of analyzing the data pursuant to the Prometheus Payment Model®, a copy of which is attached hereto and made a part hereof as Exhibit A, to further HCI3 and [Health Plan] research and possibly pilot an episode of care payment model.

An ECR® is a global payment for an entire episode of medical care for a particular payer-provider-patient triad, as informed by clinical practice guidelines and/or expert opinion. ECRs®, are patient-specific, severity-adjusted for a defined time period for the treatment of specific conditions. ECR® methodology was developed by the Prometheus Payment design team and is the property of the Health Care Incentives Improvement Institute, Inc (www.hci3.org) a nonprofit organization devoted to improving healthcare quality by creating and implementing programs that deliver positive financial incentives for providers that deliver high value care.

Constructing the ECR reports for [Health Plan] will be accomplished using data supplied by [Health Plan]. The data specifications are attached to this Data Use Agreement.

To construct the entire ECR, separate payments models for three components:

- 1) Inpatient facility,
- 2) Outpatient facility, and
- 3) Professional & others

The results can be brought together to model a global ECR budget for various components.

[PROMETHEUS Data Partner], one of the leading performance improvement organizations in the United States, dedicated to advancing healthcare quality and an experienced HCI3 Prometheus vendor will run all 21 of the Prometheus Payment Evidence informed Case Rate (ECR) analytics for [Health Plan]. [PROMETHEUS Data Partner] will provide to HCI3 and [Health Plan] an aggregate report of the results. [PROMETHEUS Data Partner] will not release the results of the analysis to other parties other than HCI3 without the express consent of [Health Plan]. HCI3 and [Health Plan] agree that as part of HCI3's grant with the [Name of Organization, if applicable] a report of the general findings from the measurement process may be released to the [Name of Organization, if applicable] if reviewed in advance with [Health Plan] for comments before a presentation of the conclusions to other parties. HCI3 may include [Health Plan] blinded summarized analysis in benchmark data sets but will not release plan specific analysis to any other parties without the express consent of [Health Plan].

All of the reports that [Health Plan] will receive are detailed in the Prometheus ECR Manual Version 3.5.2 provided to [Health Plan] and also attached to this Data Use Agreement. In addition to the reports, HCI3 will construct a summary report that will compare [Health Plan] results against national, regional, and/or similar health plans/populations. HCI3, along with [Health Plan] will work with [Name of Organization, if applicable] to define additional patient demographic and socioeconomic variables for analysis, analyze the results, and determine trends and potential opportunities for further research or pilot implementation.

3. SAFEGUARDS, LOCATIONS.

HCI3 agrees to develop, document, use and keep current appropriate procedural, physical and electronic safeguards sufficient to comply with the requirements of HIPAA to prevent any use or disclosure of Limited Data Set Information other than as permitted or acquired by this Agreement and to require [PROMETHEUS Data Partner] to do the same. HCI3

agrees to notify Covered Entity of the location of any Limited Data Set Information disclosed by Covered Entity or created by HCI3 on behalf of Covered Entity and held by or under the control of HCI3 or those to whom HCI3 has disclosed such Limited Data Set Information.

4. **REPORT OF IMPROPER USE OR DISCLOSURE.**

HCI3 shall immediately report to Covered Entity any information of which it becomes aware concerning any use or disclosure of PHI or Limited Data Set Information that is not permitted by this Agreement or under HIPAA. This report shall identify the nature of the violating use or disclosure, the PHI or Limited Data Set Information used or disclosed who made the violating use or received disclosure, what corrective action HCI3 has or will take to prevent further violations, including any mitigation, and provide any other information as Covered Entity may request.

5. **TERMINATION RIGHTS, MITIGATION.**

HCI3 acknowledges and agrees that [Health Plan] shall have the right to terminate this Agreement in accordance with paragraphs 5 and 6 hereof, (a) at any time in its sole discretion, or (b) in the event HCI3 breaches or fails to comply with the requirements set forth in this Agreement. In addition, [Health Plan] may immediately terminate the Agreement, if [Health Plan] determines, in its reasonable discretion that HCI3 has failed to comply with the material term of the Agreement required by HIPAA or substantially not in compliance with the requirements of HIPAA. In addition to its obligations under this Agreement, HCI3 shall take any other reasonable actions available to it to mitigate any detrimental effects of such violation or failure to comply.

7. **BREACH OF KNOWLEDGE.**

If [Health Plan] knows of a pattern of activity or practice of HCI3 that constitutes a breach or violation of HCI3's obligations under this Agreement, HCI3 shall take any steps reasonably necessary to cure such breach and make HCI3 comply, and, if such steps are unsuccessful, [Health Plan] shall either (a) terminate this Agreement, if feasible, or (b) if cure and termination are not feasible, discontinue disclosure of Limited Data Set Information to HCI3 and report the breach or violation to DHHS. If HCI3, as a Covered Entity as defined by HIPAA, violates the terms and conditions of this Agreement or any other Agreement in its capacity as a HCI3 of Limited Data Set Information or business associate of another Covered Entity, HCI3 will be, for purposes of paragraph 5 of this Agreement, substantially not in compliance with HIPAA.

8. **RETURN OF PHI AND LIMITED DATA SET INFORMATION.**

HCI3 agrees that, upon termination of this Agreement, and if feasible, HCI3 shall, at its expense, (a) return or destroy all PHI and Limited Data Set Information received from, or created or received by HCI3 or any of HCI3's subcontractors or agents on behalf of Covered Entity that HCI3 or subcontractors or agents maintain or control in any form or matter and retain

no copies of such information or, (b) if such return or destruction is not feasible, immediately notify [Health Plan] of the reasons return or destruction are not feasible, and extend indefinitely the protection of this Agreement to such PHI and Limited Data Set Information and limit further uses and disclosures for those purposes that make the return or destruction of the PHI and Limited Data Set Information not feasible.

9. **TERM OF AGREEMENT.**

This Agreement shall be effective on _____, or upon that date that the final signature is obtained by the parties of this Agreement, whichever occurs later.

10. **CANCELLATION.**

Either party may cancel this Agreement, at any time, with or without cause, upon 30 days written notice to the other party.

11. **ASSIGNMENT.**

Neither [Health Plan] nor HCI3 shall assign or transfer any rights or obligations under this Agreement.

12. **AMENDMENTS.**

Any amendment to this Agreement must be in writing and shall be executed and approved by the same parties who executed the original Agreement or their successors in office.

13. **LIABILITY.**

[Health Plan] and HCI3 agree that each party will be responsible for its own acts and the results thereof to the extent authorized by law and shall not be responsible for the acts of the other and the results thereof.

14. **GOVERNING LAW** This Agreement shall be governed and interpreted according to the laws of the State of [Insert State] without regard to conflict of laws principles. The parties hereby submit to the exclusive jurisdiction of the [Insert State] Supreme Court for [Insert County] County or the United States District Court for the Southern District of [Insert District Name] for the purpose of any actions or proceedings that may be required to enforce any of the provisions of this Agreement

IN WITNESS WHEREOF, the parties have caused this Agreement to be fully executed intending to be bound hereby.

[Health Plan]

By: _____

Name:

Its:

Date:

HEALTH CARE INCENTIVES
IMPROVEMENT INSTITUTE, INC.

By: _____

Name: Francois de Brantes

Its: Executive Director

Date:

Document4

SAMPLE

Reports from ECR® Construction Programs

Table 9: ECR® Reports	
Name of Report File	Contents
Common report (one set for all data)	
GENERAL_DATA_SUMMARY	This report shows the summary information for all original data submitted by the users and the valid data included in the study period for ECRs®. This includes the number of patients and their associated stay records, professional records, and pharmacy records as well as their associated costs.
CORE_PRICE_INFO	This report shows the average unit cost for core services, calculated using outpatient/professional claims. These services and their costs are used to determine the gaps in care and the care coordination (underuse) amount at the patient level for each chronic medical ECR®.
ECR®-specific report (one set Per ECR®. Numbers of reports vary by ECR® category. ECR® name in the file name is omitted)	
Chronic ECR® Reports	
DATA_FLOW	This table shows how patients with trigger claims are filtered through enrollment, eligibility, and exclusion criteria to generate final ECR® datasets with relevant claims. Number of unique patients and corresponding claims, total/average allowed amounts, standard deviations, and allowed amount distribution at each major filtering step are included. The final rows of the output table describe the counts and associated costs for 1) all relevant claims in an ECR®, 2) for “typical” services and 3) for potentially avoidable complications (PACs); each broken down by inpatient stay, outpatient facility, professional, and pharmacy claims. This output is a summary of the patient level intermediate SAS table that gets generated based on the actual number of patients, their claims experience, and how they were classified using the Prometheus ECR® process. The proportion of total dollars spent for care of PACs is calculated at the end of the report as the “PAC rate”.
DATA_FLOW_OVERVIEW	This is the overview of all relevant episodes in the final ECR® datasets. Total / average allowed amount, and standard deviations are calculated based on the total number of all episodes for the medical condition under study. This represents an actuarial analysis to study the proportion of costs contributed by each subgroup within the ECR®.
TYPICAL_STAY	This report shows the frequency and percentage of typical risk factors that are flagged among typical inpatient stay claims. All diagnoses, procedure, and revenue codes on these claims are searched for flagging typical risk factors. For chronic conditions, only GERD and CAD, which allow “typical” inpatient stays, have this report. For the other five chronic conditions (hypertension, diabetes, CHF, COPD and Asthma), all stays are regarded as PACs, therefore, they have no typical stays.
TYPICAL_PROF	This report shows the frequency and percentage of typical risk factors that are flagged among typical professional, outpatient facilities, other ancillary, and pharmacy claims. All diagnoses, procedure, and NDC codes on these claims are searched for flagging risk factors.
PAC_STAY	For ECRs® including DM, Asthma, CHF, COPD, and HTN, this report shows

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Name of Report File	Contents
	<p>the frequency and cost based on the principal diagnosis for PAC inpatient stays. Stays are counted only once and the principal diagnosis may belong to a typical or a PAC category, but identifies the reason a patient was admitted for the stay.</p> <p>For GERD and CAD, this report shows the frequency and cost of each type of PAC event that occurred in the PAC inpatient stay claims.</p>
PAC_PROF	<p>This report shows the frequency and cost of each type of PAC event that occurred in the professional, outpatient facilities, and other ancillary claims. All diagnoses and procedure codes on the claims are searched for PAC events and included in the PAC count, therefore counting the same patient for more than one PAC category is allowed.</p>
CORE_PRICE	<p>This report shows the user-specific cost of core services for the ECR®. It is calculated based on the average unit cost and the number of services recommended based on evidence informed guidelines during the episode period for each ECR®.</p> <p>This report is generated only for the chronic medical conditions and helps determine the underuse / care coordination amount for these ECRs®.</p>
Inpatient Procedural/Inpatient Medical ECR® Reports	
DATA_FLOW	<p>This table shows how patients with trigger claims are filtered through enrollment, eligibility, and exclusion criteria to generate final ECR® datasets with relevant claims. Number of unique patients and corresponding claims, total/average allowed amounts, standard deviations, and allowed amount distribution at each major filtering step are included. The final rows of the output table describe the counts and associated costs for 1) all relevant claims in an ECR®, 2) for “typical” services and 3) for potentially avoidable complications (PACs); each broken down by inpatient stay, outpatient facility/professional, and pharmacy claims. The last two rows in the report show data for typical and PAC inpatient readmissions. This output is a summary of the patient level intermediate SAS table that gets generated based on the actual number of patients, their claims experience, and how they were classified using the Prometheus ECR® process. The proportion of total dollars spent for care of PACs is calculated at the end of the report as the “PAC rate”.</p>
DATA_FLOW_OVE RVIEW	<p>This is the overview of all relevant episodes in the final ECR® datasets. Total / average allowed amount, and standard deviations are calculated based on the total number of all episodes for the medical condition under study. This represents an actuarial analysis to study the proportion of costs contributed by each subgroup within the ECR®.</p>
TYPICAL_INDEX_ STAY	<p>This report shows the frequency and percentage of typical risk factors that are flagged among typical index inpatient stay claims. All diagnoses, procedure, and revenue codes on these claims are searched for flagging typical risk factors.</p>
TYPICAL_READMI T_STAY	<p>This report shows the frequency and cost based on the principal diagnosis for “typical” inpatient stay readmissions. Stays are counted only once. The principal diagnosis identifies the reason a patient was readmitted for the stay.</p>

Table 9: ECR® Reports	
Name of Report File	Contents
	Not all ECRs are allowed to have typical readmissions.
TYPICAL_PROF	This report shows the frequency and percentage of typical risk factors that are flagged among typical outpatient facility, professional, other ancillary, and pharmacy claims. All diagnoses, procedure, and pharmacy codes on these claims are searched for flagging typical risk factors.
PAC_INDEX_STAY	This report shows the frequency and cost of each type of PAC event that occurred in the PAC index inpatient stay claims.
PAC_READMIT_STAY	Not all readmissions are PACs. This report looks at the readmissions that were classified as PACs and shows the frequency and cost of each type of PAC event that occurred. If the stay did not have a pre-defined PAC event, the readmission is identified by the principal diagnosis code on the readmission.
PAC_PROF	This report shows the frequency and cost of each type of PAC event that occurred in the PAC outpatient facility and professional claims.
Outpatient Procedural ECR® Reports	
DATA_FLOW	<p>This table shows how patients with trigger claims are filtered through enrollment, eligibility, and exclusion criteria to generate final ECR® datasets with relevant claims. Number of unique patients and corresponding claims, total/average allowed amounts, standard deviations, and allowed amount distribution at each major filtering step are included. The final rows of the output table describe the counts and associated costs for 1) all relevant claims in an ECR®, 2) for “typical” services and 3) for potentially avoidable complications (PACs); each broken down by inpatient stay, outpatient facility, professional, and pharmacy claims. This output is a summary of the patient level intermediate SAS table that gets generated based on the actual number of patients, their claims experience, and how they were classified using the Prometheus ECR® process.</p> <p>The proportion of total dollars spent for care of PACs is calculated at the end of the report as the “PAC rate” for the given ECR®.</p>
DATA_FLOW_OVERVIEW	This is the overview of all relevant episodes in the final ECR® datasets. Total / average allowed amount, and standard deviations are calculated based on the total number of all episodes for the medical condition under study. This represents an actuarial analysis to study the proportion of costs contributed by each subgroup within the ECR®.
TYPICAL_INDEX_STAY	This report shows the frequency and percentage of typical risk factors that are flagged among typical index inpatient stay claims. All diagnoses, procedure, and revenue codes on these claims are searched for flagging typical risk factors.
TYPICAL_INDEX_FACI	This report shows the frequency and percentage of typical risk factors that are flagged among typical index outpatient facility claims. All diagnoses and procedure codes on these claims are searched for flagging typical risk factors.
TYPICAL_PROF	This report shows the frequency and percentage of typical risk factors that are flagged among professional, other ancillary, and pharmacy claims. All diagnoses, procedure, and pharmacy codes on these claims are searched for flagging typical risk factors.

Table 9: ECR® Reports

Name of Report File	Contents
TYPICAL_ASSOC_ADMIT_STAY	This report shows the frequency and cost based on the principal diagnosis for “typical” inpatient stay claims that are associated with the index. Stays are counted only once. The principal diagnosis identifies the reason a patient was admitted for the stay. Not all ECRs are allowed to have typical IP readmissions.
TYPICAL_ASSOC_ADMIT_FACI	This report shows the frequency and cost based on the principal diagnosis for “typical” outpatient facility claims that are associated with the index. Claims are counted only once. The principal diagnosis identifies the reason a patient was admitted for the facility.
PAC_INDEX_STAY	This report shows the frequency and cost of each type of PAC event that occurred in the PAC index inpatient stay claims.
PAC_INDEX_FACI	This report shows the frequency and cost of each type of PAC event that occurred in the PAC index outpatient facility claims.
PAC_ASSOC_ADMIT_STAY	Admissions prior to the index admission as well as those after discharge are called associated admissions. This report shows the frequency and cost of each type of PAC event that occurred in the associated admissions that got classified as a PAC. If the stay did not have a pre-defined PAC event, the associated admission is identified by the principal diagnosis code on the stay.
PAC_ASSOC_ADMIT_FACI	This report shows the frequency and cost of each type of PAC event that occurred in the PAC outpatient facility claims that are associated with the index.
PAC_PROF	This report shows the frequency and cost of each type of PAC event that occurred in the PAC professional claims.

ECRs®		
ECR® Category	ECR® Description	ECR® Name
Chronic Medical ECR® (CH)	Asthma	ASTHMA
	Chronic Obstructive Pulmonary Disease	COPD
	Congestive Heart Failure	CHF
	Coronary Artery Disease	CAD
	Diabetes	DM
	Hypertension	HTN
	Gastro-esophageal Reflux Disease	GERD
Inpatient Procedural ECR® (IPP)	Hip Replacement	HIPR
	Knee Replacement	KNEE
	Coronary Artery Bypass Graft	CABG
	Bariatric Surgery	BARI
	Colon Resection	COLON
Inpatient Medical ECR® (IM)	Acute Myocardial Infarction	AMI
	Pneumonia	PNE
	Stroke	STR
Outpatient Procedural ECR® (OPP)	Coronary Angioplasty	PCI
	Cholecystectomy	GALL

	Hysterectomy	HYST
	Knee Arthroscopy	KNRP
	Colonoscopy	COLOS
	Pregnancy and Delivery	PREG

SAMPLE