HealthFacts RI

Rhode Island All Payer Claims Database

User Guide

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History

HealthFacts RI is Rhode Island's All-Payer Claims Database (RI APCD), a large-scale database that systematically collects healthcare claims data from a variety of payer sources, including Medicare, Medicaid, and RI's largest commercial payers. In 2008, RI passed legislation to enable a healthcare database to collect healthcare claims data from payers. In 2013, the Regulations were issued to provide data collection guidelines and data release policies and procedures. The goals of HealthFacts RI are (1) to identify areas for improvement, growth, and success across the healthcare system; (2) to understand and quantify health system performance and healthcare transformation; and (3) to provide meaningful comparison and actionable data and reports to help inform policy and consumer decisions. HealthFacts RI is a multi-agency initiative between the RI Department of Health, the Office of the Health Insurance Commissioner, the Executive Office of Health and Human Services, and Health Source RI.

Data Collected

HealthFacts RI includes data from commercial, Medicare, and Medicaid payers who have more than 3,000 covered lives in Rhode Island. Data collection has been ongoing since 2014. Payers are required to regularly submit types of files to the database.

File Type	File Description
Eligibility	Includes medical, dental, and pharmacy enrollment information for the members covered by each payer during the reporting period. Files include member demographic information and information regarding an individual's plan and coverage type.
Medical Claims	Includes information on the medical services rendered to covered individuals during the reporting period. This file contains a wealth of useful cost and utilization data, such as diagnosis and procedure codes, charge amount, paid amount, copay amount, deductible amount, type of setting, and rendering/billing provider information, etc.
Dental Claims	Includes information on the dental services rendered to covered individuals during the reporting period. Among the data elements submitted in this file are procedure code, charge amount, paid amount, copay amount, deductible amount, rendering/billing provider information, dental quadrant, and tooth surface codes, among other data.
Pharmacy Claims	Includes information on pharmacy services rendered to covered individuals during the reporting period. Among the data elements submitted in this file are National Drug Code, national pharmacy ID, prescribing provider information, generic/brand drug indicator, plan paid amount, copay amount, and deductible amount.
Provider	Includes information on the providers associated with the medical, dental and pharmacy services submitted during the reporting period. These files contain data related to healthcare providers themselves, including elements such as National Provider Identifier, provider name, provider specialty, and provider geographic information (e.g., city, ZIP code, etc.)
Alternative Payment Model (APM)	Includes non-fee-for-service (non-claims) payments. APM data supplements claims payment data to provide a full picture of healthcare payments. Types, amounts, and covered services under APMs vary across contracts and payers. Examples of APM (non-claims) payments are care management fees, incentive payments, infrastructure and operations payments, shared savings payments and risk settlements, and population-based payments.
CurrentCare	Includes supplemental Race and Ethnicity data provided by the state's HIE.

HealthFacts RI APCD Snapshot

Data is made data available for release on an annual basis once a full year of new data is complete and fully processed by HealthFacts RI. The State aims to release each new full year of data during the second half of the following year. For example, complete 2021 data is available for release in the second half of 2022.

Data available in the HealthFacts RI ACPD can be found on the State of Rhode Island website, Snapshot, and is updated quarterly. The snapshot is provided through Tableau Public dashboards and includes the following information:

- **Data Overview** – Provides a high-level view of the volume of data available in the APCD, what products are being submitted, and how the volume of data has changed over time.
- **Data Availability** – Provides insight into how much claims and enrollment data is available and what gaps, if any, exist in that data.
- **Medical Procedures** – Presents the top 25 services from medical claim lines that can be sorted by claim volume, total, and average cost and supports search for specific procedures and categories of interest.
- **Drug Prescriptions** – Presents the top 25 prescribed drugs from pharmacy claim lines that can be sorted by claim volume, total, and average cost and support search for specific dugs and categories of interest.

Privacy and Security

Privacy and Security policies are in place to protect the HealthFacts RI database and ensure that member data remains confidential and secure. All HealthFacts RI data is de-identified, in that payers remove all information that could directly identify an individual. For a full list of identifiers that are excluded from the database, see the Identifiable Data section of this guide. De-identification is accomplished in part by using an independent “Lockbox Services Vendor.”

Before sending any data to the APCD, payers submit member data (with identifiable information) to the Lockbox Services Vendor. The Lockbox Services Vendor assigns a unique APCD-specific ID to each individual and sends this Unique Member ID back to each payer. Payers then use this Unique Member ID instead of any identifiable information in the healthcare claims data sent to HealthFacts RI. This method ensures that neither the State nor any APCD vendor ever has access to both the claims data and the patient identifying information. This protects member privacy and reduces the chance of identifying an individual using the HealthFacts RI data. Members have the option to “opt-out” of having their data submitted to the APCD at any time, though all HealthFacts RI data is de-identified.

All individuals or organizations that access HealthFacts RI data must follow strict security measures that comply with HIPAA, the HITECH Act, and U.S. Department of Health and Human Services guidance. Security measures include encryption for transmitted and stored data; strict access, roles, and permissions standards; and storage on secure servers with appropriate backup, recovery, and disaster plans. These security measures are ensured and codified through contractual agreements with the State.

Data Management

HealthFacts RI is governed by an Interagency Staff Workgroup comprised of representatives from RIDOH, EOHHS, OHIC, and HSRI. The ISW oversees HealthFacts RI data vendors who collect data, and store, host, and manage the database. The Data Management Vendor is responsible for collecting, aggregating, and enhancing the data, as well as sending fully processed data extracts to the State. The Lockbox Services Vendor is responsible for de-identifying enrollment data by assigning a unique member ID to everyone, maintaining the opt-out website, and flagging any members who have opted-out so that their information is not submitted to the APCD.

Data Validation

To ensure that the HealthFacts RI data is as correct and complete as possible, the data undergoes three rounds of validation and quality assurance checks. Tier 1 validation checks are automated checks used to identify common data errors. The results of the Tier 1 validation checks are sent back to each payer as files are processed. Payers are required to correct any errors and re-submit the files. Hundreds of checks are run against data files as they are submitted by payers to ensure that the incoming data meets quality standards

Tier 2 validation checks are also automated and performed quarterly but occur once the data has passed the Tier 1 checks and entered the system. The purpose of this level of validation is to check for the reasonableness of the submitted data, and to compare it against past submissions, including month-over-month trend analyses and consistency in data volume and quality. Payers are notified of any issues identified as part of Tier 2 checks within ten days and are required to respond and/or re-submit data accordingly. Additionally, the Data Management Vendor produces quarterly post-Level 2 validation reports. These reports offer an additional level of quality assurance, as they are used to identify trends in submitted data and any significant deviations.

Tier 3 validation checks are annual, post-processing validation reports. These reports are sent back to payers within thirty days of annual data being processed and enhanced and show the degree to which HealthFacts RI data aligns with the submitters' internal metrics. These reports include information on how this year's data compares to past years' data and compare the data to database-wide averages. The Data Management Vendor works with the submitters to investigate any data issues, determine reasons for discrepancies, and identify remediation strategies for the current submission and submissions going forward.

Data Request Process

Published HealthFacts RI Reports

More than twenty interactive reports have been developed using HealthFacts RI data. Reports include those related to COVID, rates on firearms injuries, behavioral health, preventive services, and more.

Interactive reports that the State has published can be found on the HealthFacts RI webpage:
https://health.ri.gov/data/healthfacts-ri-database

Standard Claims Extracts

Standard extracts are pre-built, claims-line level extracts with individual member detail that may be used for statistical and other complex analyses. As these extracts contain a high level of detail, they are intended for research purposes and require a full application and review process. As part of the application, requesters must justify why claims-level detail is necessary for their project. Requesters must pay a fee, sign a Data Use Agreement, and be approved by the Director of the Department of Health to receive standard claims extracts. There are two types of standard extracts available for request for both medical claims and pharmacy claims:

- **Core Extract**– Contains data elements related to member enrollment and demographics, medical and/or pharmacy claims, and provider information associated with the requested claims. The Core Extract contains moderate level of detail as full service and eligibility dates are confined to months and years, member city is removed, and only the first three digits of the ZIP code are released.
- **Extended Extract**– Contains all data elements from the Core Extract, plus the full dates of service and eligibility as well as member city and the full five-digit ZIP code offering a higher level of detail. Requesters requiring Extended Extracts must justify why this higher level of detail is necessary for their project.

There are three options for requesting Standard Claims Extracts:

- **Single use, single agency**– This is for a single project within one organization and includes all approved file types

(medical and pharmacy claims, enrollment, and provider information) and all approved years of data, including new years of data when available.

- **Multi-use, single agency**– If you anticipate using standard extracts for multiple projects within your organization, we recommend applying for a multi-use, single agency license. This license includes all approved file types (medical and pharmacy claims, enrollment, and provider information) and all approved years of data, including new years of data when available.
- **Multi-use, multi-agency**– If you anticipate using standard extracts for multiple projects across multiple agencies through a formal partnership or coalition, we recommend applying for a multi-use, multi-agency license. This license includes all approved file types (medical and pharmacy claims, enrollment, and provider information) and all approved years of data (including new years of data when available).

To qualify for a Multi-Use, Multiple Agencies license, agencies must agree to the following conditions:

- License is limited to those entities with the capacity to properly protect the data, manage user requests, and oversee internal users.
- Agency signs a Data Use Agreement and is liable for any misuse of the data by any of their users
- Users may include staff, researchers, and other partners affiliated with the agency.
- After requests are vetted, applications go to the Rhode Island Data Release Review Board for final review and approval. Requests may qualify for a "mini" review by the DRRB and Director when the project falls under the institutional license.

The HealthFacts RI Data Element Dictionary provides a full description of the data elements available in each extract. On average, medical claims extracts are 70GB, and pharmacy extracts are 25GB. The size of an extract varies based on the types of data (i.e. medical, pharmacy or both) and the number of years requested. Because of the large size of standard extracts, users will need robust database infrastructure (e.g., SQL Service, Oracle, with 1–2 TB storage) in which analytic files can be prepared for use with statistical software, such as SAS or R, to use standard extracts. If approved for use, standard extracts are delivered to users as flat text files via SFTP with PGP encryption.

Custom Requests

Custom requests are for data that is not already available on the HealthFacts RI website and for which standard claims extracts are not appropriate. This may include custom aggregated reports, or custom extracts, and may require custom analytics to be applied. Requesters define the type of data, data elements, and any custom analytics needed. All custom requests require an application. Custom requests require review by the Data Release Review Board and approval by the Director of the Department of Health when individual claims with member-level detail are included (e.g., member ID, five-digit ZIP code, etc.) or results of cells based on fewer than 11 members are displayed. Requests for custom aggregate data in which cells based on fewer than 11 members are not displayed do not require a full review and approval process. Explore Data Release Products to see what is best for your request in Appendix 1.

Data Release Review Board

The RI APCD Data Release Review Board (DRRB) is an eleven-member, multi-disciplinary advisory board to the Director of RIDOH. The DRRB is comprised of members representing health insurers, healthcare facilities, healthcare consumers, physicians, privacy advocacy organizations, researchers, and RI state agencies.

The purpose of the DRRB is to advise the Director about whether requests are consistent with HealthFacts RI member privacy guidelines. The DRRB meets monthly, and meetings are open to the public. The annual meeting schedule, agendas, and minutes are available on the Secretary of State website. Applications are reviewed in the order received and must be posted

for public comment for at least 10 business days before they can be reviewed. DRRB members consider all public comments as part of their review.

The DRRB reviews requests for standard extracts and custom requests for aggregate data in which small cells are displayed or for individual claims. The DRRB reviews applications to ensure that:

- Appropriate privacy and security protections are in place to protect member privacy
- Applicant will adhere to the HealthFacts RI cell size suppression policy
- Access to data is necessary to achieve the project's intended goals
- Applicant is qualified to protect and responsibly handle HealthFacts RI data

The DRRB makes a recommendation to the Director as to whether the application should be approved. The RIDOH Director has the ultimate authority to approve or deny requests for HealthFacts RI data.
The DRRB Data Security Committee is a subcommittee of the Data Release Review Board that reviews data management plans in advance of the full Board for adherence to HealthFacts RI data security standards. The Data Security Committee also meets monthly, and meetings are open to the public.

Interpreting Claims Data

HealthFacts RI contains healthcare claims data, which may be different from other data sets users have worked with in the past. This section explains some important concepts for working with claims data, and certain nuances unique to the RI APCD.

Designation of Primary Coverage

The designation of primary coverage is a two-step process as outlined below:

- **Step 1.** This initial step designates the primary coverage within each plan type (i.e., commercial, Medicaid, and Medicare). If a member had coverage under more than one plan type, the primary insurance indicator is used to determine which plan was reported as primary:

Table 2. Primary Coverage Tie-Breaker Logic Within Each Plan Type

Plan Type	Payer 1	Payer 2	Deemed Primary	Example
Commercial	Major Medical	TPA	Major Medical	• A member has reported coverage by both a major medical payer (e.g., UnitedHealthcare) and a TPA/PBM (e.g., United Behavioral Health), both of which report a primary insurance indicator value of '1' (primary). • The major medical plan reported by UnitedHealthcare is deemed primary.
Medicaid	Medicaid Managed Care	Medicaid FFS	Medicaid Managed Care	• A member has reported coverage by both Medicaid FFS and a Medicaid managed care plan, both of which report a primary insurance indicator value of '1' (primary). In this case, the claims also are reported by the Medicaid managed care plan. • The Medicaid managed care plan is deemed primary for eligibility reporting.
Medicare	Medicare Advantage	Medicare FFS	Medicare Advantage	• A member has reported coverage by both Medicare FFS and a Medicare Advantage plan, both of which report a primary insurance indicator value of '1' (primary). In this case, the claims also are reported by the Medicare Advantage plan. • The Medicare Advantage plan is deemed primary for eligibility reporting.

- **Step 2.** If a member has more than one plan deemed as primary (primary_insurance_indicator = '1') across plan types, additional tie-breaker logic is applied as outlined below in Table 3.

Table 3. Primary Coverage Tie-Breaker Logic Across Plan Types

Plan Type	Plan Type Tie-Breaker Order
Commercial	1
Medicare	2
Medicaid	3

Two additional notes:

1. **Commercial and Medicare:** If both a commercial and a Medicare plan report the member's coverage as primary for the month, the commercial plan is deemed primary over Medicare. Since many Medicare beneficiaries and/or their spouses continue to work after becoming a Medicare beneficiary, there are more Medicare beneficiaries now covered under both an employer's commercial plan and Medicare. Under the Medicare Secondary Payer (MSP) rules established by the U.S. Centers for Medicare & Medicaid Services (CMS), the determination of which plan is primary — the commercial plan or Medicare — is specific to each individual's case. Since many data points (e.g., the employer's number of employees) are not available to determine each individual's case, logic that deems the commercial plan as primary is applied. Please note that Medicare supplemental coverage (product_code = 'SP') reported by commercial plans is always designated as secondary even if reported as primary, with Medicare being elevated to primary.
2. **Medicaid:** Medicaid is considered the payer of last resort and so is always deemed secondary or tertiary to the other plan types.

Claims Lag

It is important to understand that claims data is not real-time clinical data. After a healthcare service is performed (or a prescription is filled), it takes insurance companies time to receive, process, and pay for the procedure on behalf of their covered members. In addition, a claim may also be adjusted several times prior to being finalized. Over the course of a year, the database also collects submissions that include claims submitted by insurance companies retrospectively for previous quarters' dates of service. Over time, this collection slowly completes the data. When we refer to Closure Lag, Claims Lag, or Claims Runout, they all describe the amount of time between when a service was rendered, and when the claim was paid.

There are several analytical considerations when using claims data within date ranges that are still within the runout period. Due to potential claim adjustments, which are generally changes to paid amounts by the insurance company, we suggest performing analyses on service dates which allow for adequate runout periods. The table provided below is designed to aid in determining the amount of runout time required for the time period of service dates of interest and to understand the percentage of claims which are considered completely paid. This is helpful because there can be lags between the time a service was provided and when a payment was received, due to adjustments and disputes. The table reports these completeness percentages by claim type (medical, pharmacy, and dental) and by product (Commercial, Medicaid and Medicare). This distribution is not expected to vary much from extract to extract. It is typical to see only a small number of claims paid in the same month their service was rendered (0 months of runout), and more common to see this "pay out" process take several months (1-9 months of runout).

A few examples of how to interpret the table follow:

- After 9 months of runout, across all product types, >90% of claims are considered completely paid.
- 72.94% of the Medicare Medical claims were considered completely paid 1 month after their respective service dates. Whereas, after 9 months, 98.27% of Medicare Medical claims are considered complete or "final."

Medical	Percent of Total Paid			
Months of Runout	COMMERCIAL	MEDICAID	MEDICARE	Total
0	34.94%	12.21%	20.44%	21.7%
1	79.58%	59.88%	72.94%	70.16%
3	91.42%	75.72%	90.34%	85.37%
6	95.76%	85.21%	96.12%	92.07%
9	97.51%	91.44%	98.27%	95.58%

Pharmacy	Percent of Total Paid			
Months of Runout	COMMERCIAL	MEDICAID	MEDICARE	Total
0	87.76%	92.23%	96.97%	92.68%
1	98.52%	95.89%	99.58%	98.41%
3	99.14%	96.86%	99.7%	98.89%
6	99.39%	98.63%	99.79%	99.4%
9	99.59%	99.06%	99.85%	99.59%

Dental	Percent of Total Paid			
Months of Runout	COMMERCIAL	MEDICAID	MEDICARE	Total
0	73.15%	48.51%	62.15%	68.1%
1	93.32%	88.02%	92.56%	92.28%
3	97.74%	94.46%	97.09%	97.09%
6	99.22%	97.36%	98.87%	98.85%
9	99.68%	99.04%	99.54%	99.55%

Claim Adjustments

As part of their monthly or quarterly submission, payers may also submit any claim adjustments to previously submitted claims. These adjusted claims replace or supplement any previously submitted versions of the same claim. To accomplish this, the Data Management Vendor performs "claims consolidation," in which multiple versions of the same claim are combined into one record. Only the final version of the claim is included in the database. When the data is processed each quarter, the Data Management Vendor sends the full, most recent version of the database.

One exception to this rule is what is called an "orphaned" claim. This occurs when a claim adjustment is submitted to the APCD, but the original claim that is being adjusted was never submitted. These orphaned claims have negative dollar amounts because they are reversals of a previously paid claim; however, there can be no consolidation of this adjustment claim since its original (or "parent") claim was never submitted. This happens most often in the early months of the data collected by HealthFacts RI when health plans began sending payment information for services that took place prior to the start of the APCD. For example, consider a scenario where a claim with a service date of 9/1/2010 is originally paid on 11/15/2010. The claim is then reversed/adjusted in January 2011, and this adjustment is therefore submitted to HealthFacts RI in 2014 as part of the historical data submission (which consisted of the reporting of claims data from 2011-2013). Because the original claim was paid prior to the HealthFacts RI reporting start date of 1/1/2011, it is never submitted. Therefore, the reversed/adjusted claim is the only claim in the database for that service and has a negative dollar amount. These instances are flagged as "Orphaned claims" in the database and make up about 0.1% of the claims in HealthFacts RI. Users can choose to exclude orphaned claims by using the orphaned adjustment flag field.

Denied Claims

Payers report all processed claims to HealthFacts RI. This includes claims for which the insurer denied payment. Claims that were denied from the start and never paid are typically excluded from submissions. Claims that were originally paid and reported to the APCD before being partially/fully denied, however, are required to be reported. Denials may occur if the member was not covered by the insurer at the time at which the service was performed or the insurer does not cover the service that was performed. Depending on when the claim is denied and whether the member has another insurance carrier that will pay for the services, the denied claim may or may not be reported to HealthFacts RI. Certain payers are exempt from reporting data to HealthFacts RI per the RI APCD Regulations. See the *Submitter Exemptions* section of this guide for a list of exemption characteristics.

Scenario A
Payer A initially denies the claim because the member is no longer covered by Payer A, instead the member is now covered by Payer B. Payer A denies the claim and it is not reported to HealthFacts RI. Payer B pays the claim and reports it to HealthFacts RI as a paid claim. **Result:** The claim is included in HealthFacts RI as a standard, paid claim from Payer B.
Scenario B
Payer A initially pays the claim but then reports it as denied because the member is no longer covered by Payer A, rather they are covered by Payer B. Payer A reports the claim as being paid and then submits the adjustment of this claim, reporting to HealthFacts RI that this claim was denied. The claim is included in HealthFacts RI as a denied claim for Payer A. Payer B pays the claim and reports it to HealthFacts RI. The claim is included in HealthFacts RI as a paid claim for Payer B. **Result:** The same services for the same member are reported to HealthFacts RI twice, once as a denied claim by Payer A and once as a paid claim by Payer B.

*In scenario A and B, what if Payer B is not required to report data to HealthFacts RI?

In Scenario A, the claim is never included in HealthFacts RI since Payer A will not report an originally denied claim and Payer B does not report to HealthFacts RI. Therefore, no version of the claim is available in the database. In Scenario B, the claim from Payer A is included in HealthFacts RI as a denied claim, but the claim from Payer B is not reported to HealthFacts RI.

Scenario C
Payer A initially pays the claim and then subsequently reports it as denied because the service should not have been covered by Payer A. Payer A reports the claim as being paid and then submits the adjustment of this claim, reporting to HealthFacts RI that this claim was denied. This claim is included in the database as a denied claim. Since the reason for the denial is that the service is not covered, there will not be a new claim for the same service from a different payer. **Result:** The only claim for these services included in HealthFacts RI will be the denied claim from Payer A.

Given these different scenarios and their outcomes, users should carefully consider whether to include denied claims when designing their analyses. For financial analyses, such as total cost of care and total healthcare spending, denied claims generally should not be included because these claims were ultimately not paid by the insurer. Denied claims can be excluded using the denied claim flag field.

When measuring utilization, some users may want to include denied claims as the services were in fact performed, they were just not paid by the insurer. If including denied claims in analyses, users may need to include logic to account for when the same services are reported twice (as in Scenario B) to avoid over-counting utilization.

Duplicate Eligibility Records

All payers report eligibility records for all members who are enrolled during the reporting period. In certain cases, one individual may have more than one eligibility record for the same timeframe. This happens if:

- A person is covered by more than one insurer at the same time
- A person has more than one plan under the same payer—for example, if a person is covered by Payer A through their employer and by Payer A through their spouse's family plan

- A payer uses a third-party vendor to administer certain benefits to members—knownas “carving out” certain services.

For example, United Health Care may use United Behavioral Health to process behavioral health benefit claims. This third-party vendor, United Behavioral Health, may submit data directly to HealthFacts RI on behalf of their “parent” payer (i.e., United Health Care). In these cases, a member eligibility record is being reported twice for the same payer and timeframe—one eligibility record for the carve-out behavioral health services submitted by United Behavioral Health and the other eligibility record for all other services submitted by United Health Care.

Users should consider which eligibility record(s) to include in their analyses depending on the type of analysis being performed. For example, if a user is counting unique members with medical coverage in a given year, the user should only count one eligibility record per person. If a user is analyzing behavioral health claims for United Health Care, the user would link to the eligibility record for United Behavioral Health.

Data Limitations

While HealthFacts RI is a robust source of high-quality healthcare cost and utilization data, it is important to understand its limitations to make informed decisions about how to best use the data.
HealthFacts RI is governed by Rhode Island All-Payer Claims Database (216-RICR-10-10-5) Regulations the which specify who is required to submit data, what data should be submitted, and data release guidelines.

Regulation Exemptions

HealthFacts RI does not include data from the following sources:

- Commercial insurance plans with fewer than 3,000 covered lives in Rhode Island
- Federal programs including TRICARE, Federal Employees Health Benefits Program, Department of Veterans Affairs, and the Indian Health Service
- Uninsured individuals and other payments made out-of-pocket
- Insurance coverage exempted from the Rhode Island All-Payer Claims Database (216-RICR-10-10-5) Regulations

HealthFacts RI only collects data from Rhode Island insurers with at least 3,000 Rhode Island covered lives. For the definition of “Insurer” and other terms, refer to the RI APCD Regulations. Additionally, the following insurance coverages are exempt from the Regulations:

- Hospital confinement indemnity
- Disability income
- Accident only
- Long-term care
- Medicare supplement
- Limited benefit health insurance
- Specified disease indemnity
- Sickness or bodily injury or death by accident or both
- Other limited benefit policies.

De-identified Data

According to Rhode Island law, the State may collect only de-identified healthcare claims data from insurers. This means that HealthFacts RI cannot collect or store any of the following “direct personal identifiers” for members/subscribers as defined in

the Regulations:

- Names
- Business names when that name would serve to identify a person
- Elements of patient birth dates, except for year of birth or year of birth within an age band
- Postal address information other than town or city, state and 5-digit ZIP code
- Latitude, longitude, or other geographic information that would be used to derive postal address
- Telephone and fax numbers
- Electronic mail addresses
- Social Security numbers
- Vehicle identifiers and serial numbers, including license plate numbers
- Medical record numbers
- Health plan beneficiary numbers
- Patient account numbers
- Personal Internet protocol (IP) addresses and uniform resource locators (URL), including those that identify a business that would serve to identify a person
- Biometric identifiers, including finger and voice prints
- Personal photographic images
- Any other unique patient identifying number or characteristic, but not including the Encrypted Unique Identifier

Self-Insured Data

In March 2016, the U.S. Supreme Court issued a decision in *Gobeille v. Liberty Mutual Insurance Company* that substantially changed the nature of state APCDs. *Gobeille* held that self-insured employers and third-party administrators operating health plans regulated under ERISA could not be compelled by state governments to submit data to APCDs. As of 2020, an estimated 67 percent of workers covered by employer-sponsored health insurance were enrolled in self-funded plans (Kaiser Family Foundation, 2020). Not all self-funded plans were affected by Gobeille, as self-funded employee health coverage offered by state and local governments or by churches is regulated under state law rather than ERISA. Because ERISA regulates essentially all self-funded plans at private sector employers, however, Gobeille significantly limited the completeness of APCD data for the employer-sponsored insurance sector. In the absence of a federal requirement, state APCDs have had to rely on voluntary data submissions from self-funded ERISA plans. The voluntary nature of these submissions represents an important challenge for research, benchmarking, and price transparency because ERISA plans represent a large portion of the commercial insurance market. Furthermore, the exclusion of large segments of the population makes it more difficult to follow individuals over time as they move across insurers and generally make it impossible to distinguish between individuals who move from one insurance program (such as Marketplace or Medicaid) to uninsured and those who move to a non-submitting ERISA plan. This decision affects 2016 and forward years of RI APCD data. About 10% of APCD members were part of self-insured ERISA plans and are therefore no longer included in submissions beginning in 2016. Values reported to the APCD include plans underwritten by the insurer, self-insured, and short-term nonrenewable health insurance descriptions to identify members by their coverage type. To learn more, please review the Data Dictionary.

Opt-Out Provision

According to the Rhode Island All-Payer Claims Database (216-RICR-10-10-5) Regulations, all members who are covered by insurers that are required to report data to HealthFacts RI must have the ability to “opt out” of having their information submitted. Members may opt-out or opt back in at any time. Payers are required to notify existing and any new members that join their plans of the option to opt out. Members may opt out of the database by visiting a centralized RI APCD Opt-Out Portal maintained by the Lockbox Services Vendor or by calling a hotline maintained by the State. About 2% of members choose to opt-out, excluding their data from HealthFacts RI.

Data Element Completeness

Occasionally, payers are unable to provide certain elements at the specified HealthFacts RI threshold level if they do not collect the field or have system limitations. Payers can request variances exempting them from reporting on these elements altogether or permitting them reduced reporting levels. Certain data elements are subject to more variance requests than others and therefore may not be as well populated.
For a full list of the completeness of each HealthFacts RI data element by payer line of business, please email doh.healthfactsri@health.ri.gov. Data requesters should consider how completeness rates may affect their intended analyses.

Pharmacy Data

While all insurers and pharmacy benefits managers (PBMs) with more than 3,000 Rhode Island members are required to submit pharmacy data to HealthFacts RI, pharmacy data (eligibility and claims) is less complete than the medical data in the database. This is because many health plans use a separate “carve out” PBM or third-party administrator to administer pharmacy benefits, and many of these PBMs have fewer than the required 3,000 members to mandate data submission to HealthFacts RI.

Paid and Billed Amounts

Payers report both fee-for-service claims payments and non-fee-for-service payments to HealthFacts RI. Payments associated with alternative payment models, which are not at the claims-line level—such as bundled payments or performance incentive payments—are collected in HealthFacts RI but are not available for release. As a result, some fee-for-service claims in HealthFacts RI may have zero-dollar paid amounts. For example, a payer pays $1,000 at the onset of maternity-related services under a bundled services arrangement and pays $0 for each subsequent prenatal visit. Data users are cautioned against assuming these fee-for-service claims payment values to be the full cost of providing healthcare service(s).

Medicaid Billed Amounts

Users are cautioned against using the Medicaid billed amounts in analyses as they do not necessarily reflect the actual billed amount for the claim. Rate changes for Medicaid providers require the Medicaid program to make mass adjustments to many claims at once. As part of these mass adjustments, Medicaid changes the billed amounts on these claims to the highest existing billed amount for any Medicaid claim as a placeholder to ensure that the billed amount is sufficient for what the paid amount will be. This results in a variance between the amount that is billed and the actual amount that is paid.

Data Release Restrictions

Unavailable Data Elements

In order to protect member privacy, the Rhode Island All-Payer Claims Database (216-RICR-10-10-5) Regulations specify certain data elements collected in HealthFacts RI as “unavailable” for release. “Unavailable” data elements cannot be released in any data set or report for any reason. These elements include:

- Insurance group or policy number
- Insurance plan contract number
- Certain provider ID numbers, such as provider Tax ID
- Certain provider identifiable information, such as provider date of birth and street address.

Data Display and Reporting Policy

To prevent identification of members in HealthFacts RI, all HealthFacts RI users (including employees of state agencies) must adhere to the *RI APCD Data Display and Reporting Policy* for any publications derived from HealthFacts RI data. Requesters who are approved to receive claims-level data from HealthFacts RI data must sign a Data Use Agreement certifying that they will adhere to this policy. The policy states:

1. All RI APCD Data Outputs (reports, analyses, displays, products, tables, manuscripts, presentations, and other data uses derived from APCD Data) must adhere to the CMS cell suppression policy, as stated in the Agreement for Use of Centers For Medicare & Medicaid Services (CMS) Data Containing Individual Identifiers Section 9: “This policy stipulates: that no cell (e.g. admittances, discharges, patients, services) 10 or less may be displayed. Also, no use of percentages or other mathematical formulas may be used if they result in the display of a cell 10 or less.”
2. Outputs must use complementary cell suppression techniques to ensure that cells with 10 or fewer observations cannot be identified by manipulating data in the output.
3. Member-level records may not be disseminated or published in any form.
4. Further description of the CMS cell size suppression policy and examples of common scenarios and possible options is available here: https://resdac.org/articles/cms-cell-size-suppression-policy