The following terms will have the meanings defined below whenever used in any part of the data release, including the data sets and their accompanying documentation, HFS Web site, and business documents. For any questions regarding definitions, please contact us at HFS.Data@Illinois.gov.

1. **AABD Adults:** A historical term (an acronym for 'Aid to the Aged, Blind and Disabled') for individuals now called Seniors and Persons with Disabilities (SPD). *See also* Seniors and Persons with Disabilities (SPD) and Disabled Adults (DA).

2. **Abortion:** A medical or surgical procedure intended to terminate a pregnancy; a medical procedure included as a unique category within the data set in keeping with federal guidelines on type of service classifications.

3. **Adjudication:** A process prior to reimbursement in which Medicaid officially determines whether a service for which payment is requested (a claim) is covered, medically necessary, and properly documented and approved for payment; only those claims for services rendered within the experience period and that are approved for payment (fully adjudicated) are included in the data sets. *See also* Claim.

4. **Admission Date:** The date (expressed in the form MM/DD/YYYY) that a recipient enters a healthcare facility as an inpatient or long-term care facility as an institutionalized patient.

5. **Adult with Disabilities:** An individual who is over 18 and under 65 years of age, who meets the definition of blind or disabled under Section 1614(a) of the Social security Act (42 U.S.C.1382), and whose Medicaid eligibility is based on meeting that definition. *See also* Disabled Adult.

6. **Affordable Care Act:** The health insurance reform legislation President Obama signed into law on March 23, 2010, Public Law 111-148, as amended through May 1, 2010 by Public Law 111-152.

7. **Age Band:** A range of ages (where age is in integers, rounded down) condensed from the ages of recipients as of the anchor date or last eligibility date. Age bands divide recipients into those aged less than 1 year old; 1 to 18 years old; 19 to 20 years old; 21 to 44 years old; 45 to 64 years old; and 65+ years old.

8. **Aged Waiver:** A full benefits program for low-income elderly persons (aged 60+), providing services, including in-home services, designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. *See also* Aged Waiver Claims and Waiver Program. For more information on this waiver click here.

9. **Aged Waiver Claims:** Payment requests submitted by a waiver provider and adjudicated under the aged waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* Aged Waiver and Waiver Program.

10. **AIDS Drug Assistance Program:** A program available to persons living with HIV/AIDS whose income is equal to or less than 300-500% of the Federal Poverty Level, offering monthly benefits towards the cost of prescription drugs used for the treatment of HIV/AIDS and AIDS-related opportunistic infections. A partial benefit program that is not represented in the data sets. *See also* Partial Benefit Plan.

11. **All Kids:** A program providing comprehensive, affordable health insurance to all children in Illinois aged 0 through 18 years who meet income-level eligibility criteria, regardless of health condition. This program currently covers 1.6 million Illinois children and combines a Medicaid recipient population, an Illinois' Children's Health Insurance Program population, and a population covered only under the state-funded program. Benefits are stratified by income level, as calculated by percentage of the federal poverty level (FPL). Also known as Illinois All Kids. *See also* Children's Health Insurance Program.

12. **Ambulatory Procedures Listing (APL):** A listing of procedures that a hospital or Ambulatory Surgical Treatment Center (ASTC) can provide; the listing groups Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes and assigns a price to each grouping. The APL codes are updated each year and lists are publicly available. APL codes are not included in Hospital, as they refer to ambulatory procedures rather than inpatient care.

13. **Ambulatory Surgical Treatment Center (ASTC):** A category of healthcare facility defined under 89 Illinois Administrative Code as "any distinct entity that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization. Such facilities shall not provide beds or other accommodations for the overnight stay of patients; however, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients for up to 23 hours following admission. Individual patients shall be discharged in an ambulatory condition without danger to the continued well-being of the patients or shall be transferred to a hospital or other similar environment. This provision shall include any place which meets the definition of an ambulatory surgical treatment center under the regulations of the Federal Health Care Financing Administration (42 CFR 416)." A facility to which some rules governing hospital reimbursements also apply, but which is not included in Hospital in any way.

14. **Anchor Date:** The date used to report information is subject to change over time. For this data set, the anchor date is the last day of the experience period, the last day of the calendar year. *See also* Last Eligibility Date.

15. **Average Wholesale Price (AWP):** a price reported by First Data Bank and various other healthcare data corporations, conveying a cost for a given drug ostensibly based on the mean price of this drug at wholesale. This figure was previously used to calculate the reimbursement price of a particular drug but is now being replaced pursuant to legal agreements. AWP was in use during the experience period of the data sets and is therefore applicable to the cost data contained therein.

16. **Beneficiary:** A recipient. *See also* Recipient.

17. **Benefits:** Assistance that provides payment for services rendered by a provider to a recipient. *See also* Covered Services.

18. **Benefits Program:** Any program that provides healthcare coverage. *See also* Benefits and Recipient.

19. **Bid:** A proposal. *See also* Proposal.

20. **Brain Injury Waiver:** A full-benefits program for persons who have experienced brain injuries, providing services designed to allow individuals who fit criteria for institutionalization to remain

in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. Also referred to as a 'Traumatic Brain Injury (TBI) Waiver.' *See also* Brain Injury Waiver Claims and Waiver Program. For more information on this waiver, click here.

21. **Brain Injury Waiver Claims:** Payment requests submitted by a waiver provider and adjudicated under the brain injury waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. Also referred to as a 'Traumatic Brain Injury (TBI) Waiver claim.' *See also* Brain Injury Waiver and Waiver Program.

22. **Bridge Subsidy Program:** A housing assistance program managed by the Department of Mental Health. No data on this program, its recipients, or any other aid program that focuses exclusively on housing assistance is included in the data sets.

23. **Capital Cost:** A cost associated with the construction or purchase of facilities and equipment necessary for providing services. Some hospitals are eligible for reimbursements of capital costs under Medicaid regulations on a per diem or per case basis, based on the regulations found in the 89 Illinois Administrative Code Section 149.150(c)(1)(A); the payments provided are separated into charges per claim and are included in a column in Hospital.

24. **Care Coordination Entity (CCE):** A CCE is a collaboration of providers and community agencies, governed by a lead entity, which receives a care coordination payment in order to provide care coordination services for its Enrollees.

25. **Case Mix Index:** A figure representing the average Diagnosis Related Group (DRG) weight for all of a hospital's Medicaid volume; this figure is useful for calculating costs of care and for comparisons between hospitals. *See also* Diagnosis Related Groups (DRG) and Diagnosis Related Groups (DRG) Weights.

26. **Category of Service:** A variable describing the service that was provided to a recipient. Category of Service does not directly appear in the Data Set but is used to determine Type of Service. *See also* Provider Type and Type of Service.

27. **Centers for Medicare and Medicaid Services (CMS):** The federal agency that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program (CHIP), and HIPAA. *See also* Children's Health Insurance Program (CHIP) and the Health Insurance Portability and Accountability Act (HIPAA).

28. **Child:** For the purposes of the data sets, a person who has not yet reached their nineteenth birthday. Please note that age classification for portions of the data sets (including diagnostic and waiver information) create age groups that vary from this age classification.

29. **Children's Health Insurance Program (CHIP):** A federal program, authorized in Illinois by the Children's Health Insurance Program Act, that provides matching funds to states' Medicaid programs for children (aged 0 to 18 years) who qualify as members of families who meet eligibility criteria based on income. *See also* All Kids.

30. **Children with Complex Healthcare Needs:** A category of recipients aged 0 to 18 years for whom HFS has not yet developed a definition. Please see further information to be released during subsequent solicitations. *See also* Children with Special Healthcare Needs.

31. **Children with Special Healthcare Needs (CSHCN):** People under the age of 18 years, defined by the federal Department of Health and Human Services as those "who have or are at increased risk for a chronic physical, development, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." *See also* Children with Complex Healthcare Needs.

32. **Chronic Illness:** Also referred to as a chronic disease or chronic condition. A term used to refer to a pathological condition that is long-lasting or permanent in nature, whether or not it is communicable. A term for which a variety of parameters (such as six months, 12 months, or some other time period) may be applied. HFS has no one set parameter for the threshold duration of a chronic illness.

33. **Chronic Illness and Disability Payment System (CDPS):** A system for assigning chronic disease indicators to Medicaid recipients' data, based on diagnosis and pharmacy codes and demographic data. *Please see CDPS documentation for further information.*

34. **Chronic Renal Care:** *See* State Chronic Renal Disease Program.

35. **Claim:** A request for payment for a service. Unless otherwise specified, this refers to adjudicated claims. *See also* Adjudication.

36. **Claims Payment:** A payment associated with a specific recipient and healthcare service that flows through our claims system. Because they are associated with a particular recipient and service, these payments *are* included in the data sets as a component of the costs in the Total Cost field. *See also* Non-Claims Payments and Supplemental Payments.

37. **Client:** Any individual receiving benefits; only those clients who receive full benefits are included in the data set. A term not used in the data release; the term "recipient" is favored in its place. *See also* Recipient.

38. **Community Integrated Living Area (CILA):** A facility defined by the Section 3(d) of the Community-Integrated Living Arrangements Licensure and Certification Act as an arrangement where a group of up to eight persons with mental disabilities live together and are provided services under agency supervision; a program about which no specific indicator is included in the data sets, although recipients who qualify for full benefits may in fact reside in a CILA.

39. **Compound Drug:** a prescription drug preparation that contains more than one pharmacologically active agent. This category is mutually exclusive with a "simple" drug, which has only one active ingredient. *See also* Simple Drug.

40. **Comprehensive Benefits:** *See also* Full Benefits Plan.

41. **Condition flag:** A 0 or 1 value associated with a CDPS chronic condition indicator, where 1 indicates that a diagnosis or drug code was found related to that chronic condition for a service rendered during the experience period.

42. **Contract:** The Contract entered into between the State and the awardee to provide the services requested by the Solicitation.

43. **Cost:** The financial expenditure associated with a particular health care service or encounter, expressed in US dollars.

44. **County:** One of 102 geographic and administrative areas within the state of Illinois, denoted by a proper name; data that is not cleaned or revised by HFS prior to data release. This is typically based on the county of the public aid office where the recipient is enrolled, but when the aid office is not associated with a specific county, this information reflects the county associated with the recipient's zip code. The county may be inaccurate, outdated, or incorrectly reported with respect to the recipient's true current address. Please note that county codes included in the data sets are not FIPS codes or Environmental Protection Agency codes.

45. **County Trauma Center Adjustment Program:** A program funded by traffic citations that allows hospitals that deliver Level I or Level II trauma care to receive additional payments from HFS for those services. This static payment is not included in the data sets.

46. **Covered Services:** Benefits and services provided to medical assistance Clients as defined under the Illinois State Plan and HCBS Waivers. *See also* Benefits.

47. **Critical Access Hospital:** A hospital, defined by the Balanced Budget Act of 1997, as a facility located in a rural area that provides emergency services, 25 or fewer inpatient beds, and inpatient care typically lasting 96 hours or less; a facility entitled to specialized payments not available to other healthcare facilities. This item is recorded as provider information.

48. **Critical Access Hospital Adjustment Payment (CHAP):** An additional payment made to a Critical Access Hospital under Illinois Administrative Code, Section 148.295. This adjustment was implemented in 2011 and is therefore not found in the HFS data sets which cover the calendar year 2010. *See also* Critical Access Hospital.

49. **Current Eligibility Indicator:** Indicates that the recipient was eligible for Medicaid or other full-benefit medical program as of the anchor date.

50. **Current Procedural Terminology (CPT):** Nomenclature for medical procedures and services for insurance reporting purposes; used for assigning type of service for a select number of services captured in the data set. A uniform coding system published and revised annually by the American Medical Association that consists of numeric codes and descriptive phrases for a wide variety of services provided by medical doctors and other healthcare professionals; this terminology is used for filing claims to Medicaid, and is included in the data sets as part of Type of Service data. *See also* Healthcare Common Procedure Coding System (HCPCS) and Procedure Codes.

51. **Data Release:** HFS's provision in 2012 of data sets to health organizations who will integrate this information into proposals.

52. **Data Set:** A data table or several related data tables designed for a specific purpose, such as providing information to help prepare proposals. For this project, a grouping of multiple data tables, encompassing information including emergency services, long-term care, transportation, pharmacy, and other services.

53. **Data Table:** A set of information, akin to a spreadsheet, that is arrayed in columns (denoting specific attributes) and rows (denoting individual observations of these attributes). Concretely, HFS data tables are delivered as tab-delimited text files (.txt) which allows them to be easily imported into a variety of data and statistical software packages.

54. **Data Use Agreement (DUA):** A contractual document used for the transfer of data that has been developed by nonprofit, government or private industry, where the data is nonpublic or is otherwise subject to some restrictions on its use.

55. **Data Users:** Someone who has signed a Data Use Agreement or is a named user in the Data Use Agreement.

56. **Date of Birth:** The date on which a recipient was born; the basis for determination of the age of a recipient as of the anchor date. Date of birth will not be included in the data sets that HFS releases.

57. **Date of Death:** The date on which a recipient died, where available. Date of death will be included in the data sets for recipients who are recorded as deceased as of the anchor date. For those recipients who have not died, a death date of 12/31/2099 will be entered in the data sets. For recipients who died after the anchor date, death date will be populated with 12/31/9999.

58. **Date of Service:** A date associated with healthcare services rendered to a given recipient, expressed in the form MM/DD/YYYY. For services that occur within a single day only, date of service is the date the service was rendered. For most inpatient hospital stays, date of service is the date of admission. For long-term inpatient hospital stays, dates of service are the admission date for the first claim and the first date of the billing period for all subsequent claims. For long-term care stays, the dates of service are the admission date and the first day of the month for every month thereafter, until the patient is discharged.

59. **Deaf:** Lacking the ability to hear, either partially or completely. *See also* Hard of Hearing and Statewide Coordinator of Deaf and Hard of Hearing Services.

60. **Deliverable Data:** The data that healthcare organizations can receive upon submitting a Letter of Intent and a Data Use Agreement.

61. **Department of Children and Family Services (DCFS):** The Illinois state agency responsible for providing social services to children and their families, and public child welfare services. Services delivered by DCFS are set forth in 89 Illinois Administrative Code, Parts 302 and 304, and include the capacity to remove children from parental custody, at which point they and their guardians can become eligible for Medicaid by virtue of their DCFS statuses. Several programs are recognized, including Adoption Assistance, Foster Care, Subsidized Guardianship, and Other cases administered and enrolled; these full-benefits programs are included in data sets.

62. **Department of Human Services (DHS):** The Illinois state agency responsible for the provision of various social service programs. The Divisions of Rehabilitation Services (DHS-DRS), Developmental Disabilities (DHS-DDD), Mental Health (DHS-DMH), and Alcohol and Substance Abuse (DHS-DASA) are located within DHS. Although DHS has responsibility for some functions associated with Medicaid, the data sets released by HFS do not contain most data the DHS collects.

63. **Department of Juvenile Justice:** A state governmental entity concerned with appropriate treatment of youth in Illinois correctional facilities; a small number of people under age 18 who are not incarcerated but are under the supervision of the court are eligible for Medicaid benefits. These enrolled individuals are captured in the data sets.

64. **Developmental Disabilities:** Physical or mental impairments that are lifelong, apparent before age 18, and disabling to a person's capacity for independence, self-sufficiency, self-expression, self-direction, self-care, learning, and/or mobility; a category of disabilities that makes recipients eligible for HCBS Waivers via MR/DD claims. *See also* MR/DD claims; Home and Community Based Services Waivers; and Waiver Program.

65. **Developmental Disabilities Residential Waivers for Children and Young Adults:** A full benefits program to developmentally disabled persons aged 3 through 21 years who require specialized residential care; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. This category covers services not covered by Developmental Disabilities Supportive Services Waivers for Children and Young Adults. *See also* Developmental Disabilities Supportive Services Waivers for Children and Young Adults. For more information on this waiver, click here.

66. **Developmental Disabilities Supportive Services Waiver Claims:** Payment requests submitted by a waiver provider and adjudicated under the waiver for any of the three subcategories of Developmental Disabilities waivers; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* Developmental Disabilities Supportive Services Waivers for Children and Young Adults, Developmental Disabilities Residential Waivers for Children and Young Adults, Developmental Disabilities Waivers for Adults, and Waiver Program.

67. **Developmental Disabilities Supportive Services Waivers for Children and Young Adults:** A full-benefits program to developmentally disabled persons aged 3 through 21 years, providing specialized services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. This category covers services not covered by Developmental Disabilities Residential Services Waivers for Children and Young Adults. *See also* Developmental Disabilities Residential Services Waivers for Children and Young Adults. For more information on this waiver, click here.

68. **Developmental Disabilities Waivers for Adults:** A full benefits program to developmentally disabled persons over 18 years old, providing specialized services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. For more information on this waiver, click here.

69. **Diagnosis Related Groups (DRG):** A series of groups used to categorize medical diagnoses and services as a means of determining appropriate reimbursements for care delivered to hospital inpatients, based on the intensity of required care. Category of Service and Type of Service will determine if the service is priced by DRG using Hospital reimbursement methodology. The DRG reimbursement, similar to the system used by the federal Medicare program, is based on the average cost of providing services for the specific diagnosis group, regardless of how long a specific patient may have actually been in the hospital. HFS currently uses DRG Grouper

Version 12, which was effective October 1, 2004, but is soon likely to upgrade to a more current grouper such as APR-DRG. *See also* Case Mix Index, Category of Service, Diagnosis Related Group (DRG) Pricing, Diagnosis Related Groups (DRG) Weights, and Type of Service.

70. **Diagnosis Related Groups (DRG) Pricing:** A pricing method set forth in the 89 Illinois Administrative Code that ties reimbursements to hospitals to specific DRG codes. *See also* Case Mix Index, Diagnosis Related Groups (DRG) and Diagnosis Related Groups (DRG) Weights.

71. **Diagnosis Related Groups (DRG) Weights:** A figure unique to each DRG that assigns it a particular price. This figure is derived from the relative cost of providing healthcare to a patient with a particular diagnosis. *See also* Case Mix Index, Diagnosis Related Groups (DRG) and Diagnosis Related Groups (DRG) Pricing.

72. **Disabled Adult:** For purposes of the Solicitation and the data sets an individual who is over 18 and under 65 years of age, who meets the definition of blind or disabled under Section 1614(a) of the Social security Act (42 U.S.C.1382), and who is eligible for Medicaid; this definition does not include Seniors (those over age 65). This definition differs from the CDPS term for Disabled Adults (DA) and from the term Seniors and Persons with Disabilities. *See also* Disabled Adults (DA), Seniors and Persons with Disabilities (SPD), and AABD Adults.

73. **Disabled Adult (DA):** A term used by CDPS to describe people 18 and above whose eligibility is based on either their disability or being older than age 65, a population equivalent to those encompassed by the term 'Aid to the Aged, Blind and Disabled (AABD).' 'Seniors and Persons with Disabilities' is a near-synonym to this term and the two terms are treated as synonyms within the current data release. This meaning of the term 'Disabled Adult' will always be accompanied by the acronym 'DA,' to distinguish it from other meanings of the term. *See also* Disabled Adults, Seniors and Persons with Disabilities (SPD), and AABD Adults. *Please see CDPS documentation for further information*.

74. **Disabled Child (DC):** A CDPS classification describing an individual under the age of 18 who is disabled; a distinction affecting only a few of the CDPS chronic condition assignments found in the data set, that was not used in setting CDPS flags for this data set. All CDPS flags for children were set as if the children were Non-disabled children (AC). This meaning of the term 'Disabled Child' will always be accompanied by the acronym 'DC,' to distinguish it from other meanings of the term. *See also* Non-Disabled Child (AC). *Please see CDPS documentation for further information*.

75. **Disability:** An umbrella term for impairments and restrictions in behavior or action arising from a physical, mental, emotional, or developmental cause. *See also* Adult with Disabilities, Disabled Adult, Disabled Adult (DA), Disabled Child (DC), Disabled Status, Non-Disabled Adult (AA), Non-Disabled Child (AC), and Persons with Disabilities.

76. **Disabled Status:** A descriptor for any person who is contextually defined, under law and/or program regulations, as having a disability. Disabled people do not necessarily have disabled status. Most references to disability and 'disabled' in the Solicitation and data sets are with respect to people with disabled status. *See also* Disability.

77. **Disenrollment:** The process by which an individual enrolled in a benefits program ceases participation, either voluntarily or by loss of eligibility. As with enrollment, the program from which the recipient disenrolled must be specified. *See also* Eligibility and Enrollment.

78. **Disproportionate Share Hospital (DSH):** A hospital that treats at least one-half a standard deviation above the mean Medicaid inpatient utilization rate (MIUR) or that serve low-income patients at a rate of 25% per annum. *See also* Disproportionate Share Hospital (DSH) Payment and Medicaid Inpatient Utilization Rate (MIUR).

79. **Disproportionate Share Hospital (DSH) Payment:** A category of supplemental payments made to ensure the financial sustainability of qualifying hospitals that treat a large number of Medicaid patients. This payment defined by the Omnibus Budget Reconciliation Act of 1981; later encoded in section 1923 of the Social Security Act and the 89 Illinois Administrative Code, Chapter 1, Section 148.120; and currently undergoing revisions pursuant to the Patient Protection Affordable Care Act of 2010. DSH payments are available to those hospitals ruled eligible for such payments by HFS. Payments are provided per claim. *See also* Medicaid Inpatient Utilization Rate (MIUR), Medicaid High Volume Adjustment (MHVA), Medicaid Percentage Adjustment (MPA), and Disproportionate Share Hospital (DSH).

80. **Division of Developmental Disabilities (DDD):** The Division within the DHS that operates programs for persons with developmental disabilities.

81. **Division of Specialized Care for Children (DSCC):** An Illinois healthcare agency, organized under the Title V Program for Children with Special Health Care Needs (CSHCN), funded by the Federal Title V Maternal and Child Health Block Grant and operating at the University of Illinois at Chicago that coordinates care for children with special health care needs throughout the state of Illinois. *See also* Children with Special Healthcare Needs (CSHCN).

82. **Drug Detail File:** A data table provided that includes more detailed information on the prescription pharmaceuticals used by Medicaid recipients during the experience period.

83. **Drug Enforcement Agency (DEA):** A federal government agency charged with maintaining regulation of specific illicit chemical substances, according to legal restrictions on their production, sale, and use for reasons of their potential for misuse and abuse, their street value as intoxicants, and/or their associated risk of death. Regulations include standards on the prescription and dispensation of some pharmaceuticals; specific regulatory categories are reflected in a data field in Pharmacy.

84. **Dual Diagnosis:** A term describing a person who has a diagnosis of mental illness and also a diagnosis of substance use disorder; a near-synonym to the preferred term 'Mental Illness/Substance Abuse (MISA).' This term has no relationship with the term 'dual eligible,' and for this reason the shortened term 'dual' should be clearly explicated or replaced. Additionally, it is not a synonym to the more inclusive term 'co-morbidity,' and should not be used as such.

85. **Dual Eligible:** A Client who receives services through both the Medicare (Parts A and/or B) and the Medicaid Program; within the database, a recipient who has enrolled in both types of benefits during the experience period. Sometimes referred to as 'duals.' This category excludes recipients for who we pay for only Medicare premiums and Medicare cost sharing, but do not directly cover any services, as well as persons who receive limited services but who are not Medicaid recipients (a 'partial benefits recipient'). *See also* Partial Benefit Plans.

86. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):** A free program provided to all children who are enrolled in an HFS medical benefits program, consisting of scheduled periodic visits with a pediatrician to assess a child's overall well-being and provide preventive care, treatment and referrals to specialists; a category of service folded into the appropriate types of services in the data sets.

87. **Early Intervention Program:** A program designated under Part C of the Individuals with Disabilities Education Act; a state system of services for children aged 0 to 3 with disabilities or risk conditions that that have a high probability of resulting in developmental delay. Under Part C. Healthcare providers are required to make a referral to Early Intervention no more than seven days after the child has been identified as having a development disability or risk of developmental delay. A Type of Service not clearly delineated in the data sets.

88. **Eligible/Eligibility:** A) The accepted possession of any characteristic(s) that allow one to enroll in a Medicaid program or other health program; OR B) The assumed eligibility of a recipient for healthcare services by virtue of being enrolled in a Medicaid program or other health program. Although eligibility can be imputed for enrollment, eligibility is distinct from enrollment. This data set only examines the recipients eligible and enrolled for full benefit programs. *See also* Potential Enrollee, Enrollee, and Eligibility Span.

89. **Eligibility Criterion:** A personal or family characteristic that makes an individual able to enroll into a benefits program that bears entry restrictions. Eligibility always requires meeting income standards. It may require meeting standards with respect to assets, family structure, disability, and/or other family or individual circumstances.

90. **Eligibility Determination:** Assessment of all financial and non-financial information needed to establish an individual's qualifications to receive program benefits, and, when appropriate, to establish the benefits for which a person can enroll; of those who have passed eligibility determination, only individuals who enroll in a full benefits programs are included in the data set.

91. **Eligibility Span:** A misnomer for the period of time, as expressed by a start date and end date, that a recipient was enrolled in a program; recipients may experience several non-overlapping full benefit eligibility spans over time and the current span may be ongoing as of the last day of the data set's experience period. Eligibility spans are associated with both Medicaid enrollment and with individual Medicaid programs, such as waiver programs.

92. **Eligible Non-Priority Population:** Persons who are eligible for full benefits under Medicaid and other included programs, who are considered to be members of neither priority populations nor excluded populations for this solicitation. Non-priority recipients are children (under age 19), irrespective of disability status, who are family members of priority adults; and adults aged 19 to 64 who have Medicaid eligibility, irrespective of their disability status, and who may be referred to as 'Other IHC Adults.' HFS does not have a reliable way to link priority adults to the children in their families. Therefore for purposes of the data sets all children who are otherwise eligible are coded as 'non-priority population' even though many are not family members of priority adults. *See also* Other IHC Adults.

93. **Emergency Services Program:** A program that covers the cost of emergency services for noncitizens who meet qualifications for benefits as Seniors and Persons with Disabilities or low-income recipients, except that they lack qualifying immigration status; a partial-benefits program that is not included in most HFS data sets.

94. **Emergency Room (ER) Detail File:** A data table that includes information on emergency room/trauma utilizations by Medicaid recipients during the experience period.

95. **Encounter Claims:** Services paid for by a Managed Care Organization (MCO) under their at-risk contract with HFS. The MCO in turn submits a record of the service to HFS for informational purposes. The record is referred to as an encounter claim. Technically encounter claims are not claims as they are neither adjudicated nor paid by HFS. These differ greatly from Encounter Rate Claims. *See also* Claims and Encounter Rate Claims.

96. **Encounter Rate Claims:** Claims paid by HFS that are based on a flat rate per healthcare event, irrespective of the specific contents of the healthcare event. Federally qualified health centers, rural health centers, and Cook County Health and Hospital System Pharmacy are paid on such a basis. These differ greatly from Encounter Claims. *See also* Claim and Encounter Claims.

97. **Enrollee:** A recipient who is eligible and completed any additional processes necessary to be enrolled in an HFS program. Any reference to enrollee should specify the program. Enrollees are also known as recipients and sometimes clients. Any proposal using the term Enrollee should make clear which definition is intended. *See also* Potential Enrollee, Recipient, and Client.

98. **Enrollment:** The bureaucratic process by which an individual found to be eligible can commence receiving healthcare services funded by Medicaid or another program at the appropriate level of benefits; a criterion for the inclusion of data on such individuals in the data set. Any use of the term enrollment should specify the program.

99. **Enrollment Period:** The twelve (12) month period beginning the effective date of enrollment in a CCE/MCCN. Since most HFS benefit programs do not have defined enrollment periods, this period is not relevant to enrollment in Medicaid or any other benefits program.

100. **Enrollment Program Group:** A description of the most comprehensive program in which the enrollee is enrolled; since only recipients with full benefits are included in the data set, the enrollment program group description in the data set will be a full benefit program**.** Please note that this program is the program which allows the recipient to be eligible for other programs.

101. **Enterprise Data Warehouse (EDW):** An HFS central facility that stores and manages electronic data on Medicaid recipients, healthcare providers, and their claims; the facility from which deliverable data sets will be obtained.

102. **Ethnicity:** The recipient's self-reported identification with the Hispanic/Latino ethnic group; a distinct category from race. No information on any other ethnicity is included in the data set. *See also* Race.

103. **Event:** A term used together with "unit" to quantify the services rendered to recipients. Generally, this is the healthcare use that occurs by one recipient, on one day, with one provider (or, in the case of emergency care, one recipient, on one day, in one emergency room). Exceptions occur for inpatient care (for which the event is admission), institutionalization (for which one month is one event) and pharmacy (for which each prescription is an event). Sometimes informally referred to as "visits." *See also* Unit. *Please see the FAQ for more information on Events and Units.*

104. **Experience Period:** The dates associated with the eligibility spans within the overall period included in the data set. The beginning of the calendar year to the end of the calendar year. See also Service Period.

105. **Family Care:** A full-benefits program that offers health insurance to the parents and caretaker relatives of children 18 years old or younger who meet income and other guidelines; benefits are provided at various levels of income under subprogram names "Assist," "Share," "Premium Level 1," and "Rebate." Some recipients in the "Assist" subprogram (for those at lowest income) may also receive monthly cash assistance. A full-benefits program included in the data sets.

106. **Family Case Management (FCM):** A program administered by Department of Human Services (DHS) which is available to some low-income Medicaid recipients. No data on this program is included in the data sets.

107. **Federally Qualified Health Center (FQHC):** A health center that meets the requirements of 89 IL Admin Code 140.461(d) and provides services similar to those of Rural Health Centers (RHCs) including primary preventive services. *See also* Rural Health Center.

108. **Federal Poverty Level (FPL):** An income threshold that the US federal government updates yearly; multiple federal, state and local agencies commonly use this threshold and percentages thereof to determine individuals' and families' eligibilities for benefits.

109. **Fee for Service (FFS):** The method of billing under which a Provider charges and HFS pays for each encounter or service rendered; a flag applied to recipients in the data set who were not enrolled in HMO plans.

110. **Flag:** A synonym for indicator. *See also* Indicator.

111. **Full Benefit Plan:** A Medicaid or Medicaid-like plan (e.g., Children's Health Insurance Plan), administered by HFS, which provides comprehensive health insurance, including hospital, physicians, and pharmacy, for essentially all medical problems that the recipient may have; a level of benefits that all recipients in the data sets receive, via a variety of specific programs. Also referred to as 'full benefits,' 'full benefits program' or 'comprehensive benefits.' HFS does not necessarily, however, pay for comprehensive benefits as recipients with full benefit plans may have significant other insurance coverage via Medicare or Third Party Liability. *See also* Dual Eligible and Third Party Liability.

112. **Gender:** The self-reported gender of an individual; classified as male, female or unknown.

113. **Hard of Hearing:** Having deficient ability to hear; having a hearing impairment. *See also* Deaf and Statewide Coordinator of Deaf and Hard of Hearing Services.

114. **Health Benefits for Workers with Disabilities (HBWD):** A program providing comprehensive health care coverage to disabled individuals who are working, in replacement of Medicaid for which they are ineligible as a result of their income. Recipients with this benefit are an excluded population for this Solicitation, and therefore healthcare records from this program are not included in the data release.

115. **Healthcare Effectiveness Data and Information Set (HEDIS):** A grouping of quality assurance measures established by the National Committee for Quality Assurance (NCQA) and used by

many American healthcare organizations; often analyzed as a means of improving care and service delivered by physicians, hospitals, and health plans. Data on HEDIS, HEDIS-like and other quality measures is not included in the data release but will be used by the State to assess CCE and MCCN performance.

116. Healthcare and Family Services (HFS): The Illinois Department of Healthcare and Family Services and any successor agency. A department of the State of Illinois that provides healthcare coverage to Illinois adults and children via Medicaid and other programs and assists families in ensuring Illinois children are supported financially by both parents; the department releasing data sets.

117. Healthcare Common Procedure Coding System (**HCPCS**): A standardized coding system used to identify health care services, procedures and products. The system has two levels (I and II), where level I is Current Procedural Terminology (CPT) and level II is additional codes identifying items not included under CPT. *See also* Current Procedural Terminology (CPT) and Procedure Codes.

118. Health Insurance Portability and Accountability Act (HIPAA): Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191, the federal law that makes a number of changes that have the goal of allowing persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA provides the Department of Health and Human Services (DHHS) with the authority to mandate the use of standards for electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, Providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. A law affecting health data privacy and security that affects the manner and specificity with which HFS can release data and how data recipients can use and must protect the data. *See also* Limited Data Set.

119. Health Maintenance Organization (HMO): A health maintenance organization as defined in the Health Maintenance Organization Act (215 ILCS 125/1-1 et seq.). A healthcare organization licensed by the Department of Insurance to provide a combination of healthcare to a defined subpopulation for predetermined capitated premiums, utilizing various cost-saving strategies to optimize healthcare quality and manage risk. *See also* Managed Care Organization and Voluntary Managed Care.

120. HIV/AIDS Waiver: A full benefits program to persons living with HIV/AIDS of any age, providing services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. *See also* HIV/AIDS Waiver Claim and Waiver Program. For more information on this waiver, click here.

121. HIV/AIDS Waiver Claim: Payment requests submitted by a waiver provider and adjudicated under the HIV/AIDS waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* HIV/AIDS Waiver and Waiver Program.

122. Home and Community-Based Services Waivers (HCBS): Waivers under Section 1915(c) of the Social Security Act that allow Illinois to cover home and community services and provide programs that are designed to meet the unique needs of individuals with disabilities who qualify

for the level of care provided in an institution but who, with special services, may remain in their homes and communities. *See also* Waiver Program.

123. Home Healthcare: A wide range of services, including nursing, allied health, and social services, delivered to recipients in their residences rather than inside a healthcare facility.

124. Hospital Acquired Conditions (HAC): An infection, injury, or other undesirable health condition that arises in the course of a hospitalization. The designation of a condition as "hospital-acquired" is regarded as the opposite of being "present on admission"; these mutually exclusive attributes will be a determinant of reimbursements to hospitals as of July 1, 2012, pursuant to the Deficit Reduction Act of 2005, but were not so applied in the data sets (which cover calendar year 2010 and 2011). *See also* Present on Admission.

125. Hospital Detail File: A data table that includes more detailed information on hospital admissions during the experience period**.**

126. Illinois Breast and Cervical Cancer Program (**IBCCP**)**:** A program providing free mammograms, breast exams, pelvic exams and Pap tests to eligible women, as well as treatment benefits to women in whom reproductive or breast pathology is present; a program excluded in the data release.

127. Illinois Cares Rx: A partial-benefits program that provides assistance with prescription drug costs for low-income disabled persons between 16 and 65 years old and low-income seniors; a program from which no data has been captured in the data set.

128. Illinois Client Enrollment Broker (ICEB): The entity contracted by the Department to conduct enrollment activities for Potential Enrollees, including providing impartial education on health care delivery choices (MCOs, CCEs, MCCNs, etc.) providing enrollment materials, assisting with the selection of a PCP and MCO, CCE, or MCCN, and processing requests to change MCOs, CCEs or MCCNs. The ICEB also processes Recipient enrollment into the Integrated Care Program. *See also* Integrated Care Programs.

129. Illinois Comprehensive Health Insurance Plan: A program offering health insurance coverage to some Illinois residents on a temporary basis (until 2014) under a variety of plans, based in part on a person's high-risk status and resulting ineligibility for other insurance plans; programs from which *no* data is captured for inclusion in the data set. *See also* Illinois Preexisting Condition Insurance Pool (IPXP).

130. Illinois Health Connect (IHC): The State's Primary Care Case Management Program; a statewide program, mandatory for most recipients, whereby the recipients must choose or are assigned to a PCP as their medical home, unless they otherwise are eligible and enrolled in a voluntary MCO. This program operates through a State Plan Amendment pursuant to 42 CFR Section 438. *See also* Primary Care Case Management.

131. Illinois Healthy Women: A partial-benefits program that covers family planning (birth control) and various other reproductive health services for female Illinois residents ages 19-44 who meet income requirements and are not pregnant; a program excluded from the data release.

132. Illinois Hemophilia Program: A partial-benefits program providing coverage of anti-hemophilic factors, annual comprehensive medical visits and other medical expenses for hemophiliacs; a

program for which no data has been captured in the data set. The data set, however, does contain data for hemophiliacs who are enrolled in full benefit (Medicaid and CHIP) programs.

133. Illinois Immunization Program: A partial-benefits program providing immunizations to Illinois children less than 18 months old; a program for which no data has been captured in the data set.

134. Illinois Preexisting Condition Insurance Pool (IPXP): A federally-funded temporary high risk pool that will provide, from mid-2010 to January 2014, health insurance to uninsured residents of Illinois who are ineligible for other insurances due to pre-existing conditions. This program has no relationship with the data sets. *See also* Illinois Comprehensive Health Insurance Plan.

135. Illinois Rx Buying Club: A program available to Illinois residents whose income is equal to or less than 300% of the Federal Poverty Level, offering discounts on a wide variety of prescription drugs. Data collected from this program is not included in the data sets.

136. Illinois Sexual Assault Survivors Emergency Treatment Program: A partial-benefits program for individuals who have experienced rape and/or related forms of sexual violence; a program for which no data has been captured in the data sets.

137. Illinois Veterans Care: A program providing care to veterans and their dependents if they are eligible under rules on income level; this program is captured in the data sets.

138. Illinois Warrior Assistance Program: A post-deployment partial benefits transitional program for veterans; data from this program is not included in the data release.

139. Immigrant: A person who has migrated from their country of origin to reside in another country for an indefinite or indeterminate period; a person whose eligibility for Medicaid and other benefits programs may be impacted by their citizenship or residence status, irrespective of other attributes that qualify them for benefits. No data on immigration status is included in the data sets.

140. Indicator: The term used in the data sets to refer to a data field that can contain '1,' to signal that the given attribute is present, or '0,' to signal that the attribute is absent, from a given observation. The word 'flag' is a synonym with 'indicator' with respect to the data sets; however, 'indicator' is the preferred term and is used in the data set output files. *See also* Flag.

141. Indigent: Lacking in access to essential goods or services; impoverished. With respect to Medicaid, indigent persons are typically those who qualify by virtue of their income status; however this term is applied only to specific aspects of hospital billing in Hospital Detail file.

142. Indirect Medical Education (IME) Costs: A reimbursement source intended to offset the expenses of medical education that occurs in the context of delivering healthcare service to Medicaid recipients at teaching hospitals, as described in 89 Illinois Administrative Code 149.100(a)(2)(B)(i). This item is *not* included as a reimbursement item in Hospital Detail file *See also* Teaching Hospital.

143. Individual: A neutral term, indicating any recipient and any other single person; use of this term does not imply any more specific status within the data sets or accompanying documentation.

144. Individual Care Grant Program: A partial-benefits program governed by 59 Illinois administrative code 135 that permits access to services for pediatric patients aged 0 to 18 years

who have mental illness requiring residential or intensive community-based treatment; data for this program is not included in the data release.

145. **Institution:** Any facility providing long-term care to a recipient who is considered unable to receive treatment of similar quality via home or community-based services; typically, a nursing facility or similar healthcare entity.

146. **Institutionalization:** A) Residence in a facility that provides long-term care to individuals who are unable, due to disease, disability, or advanced age, from efficiently and safely performing a significant amount of activities of daily living; B) The administrative and clinical process by which such residence begins.

147. **Integrated Care Programs:** The program under which the Department contracted with HMOs (Aetna Better Health or the IlliniCare Health Plan) to provide the full spectrum of Medicaid Covered Services through a risk-based integrated care delivery system to Seniors and Persons with Disabilities (aged 19+) who are eligible for Medicaid or Medicaid-like programs, but not eligible for Medicare, and who reside in suburban Cook (non 606 zip codes), DuPage, Kane, Kankakee, Lake and Will Counties. The data release excludes those recipients who would have been mandated to enter ICP based on their attributes in 2010. *See also* Medical Home and Primary Care Provider.

148. **Inter-Governmental Transfer (IGT):** A category of reimbursement used to augment federal funding to state governments for certain healthcare services provided at those hospitals that operate under Per Diem payments; an item that is included in Hospital in the Add-on Code field, but that has not been dispensed since March 2011.

149. **Interim bills:** Bills (typically submitted on form UB-92) that represent a thirty-day period during which a long-term hospitalization neither starts nor ends; also known as a "series bill."

150. **Intermediate Care Facilities for the Mentally Retarded (ICFs/MR):** A public or private facility that is designed to provide care for Mentally Retarded or Developmentally Disabled persons who require long-term care for multiple disabilities and health conditions and who are Medicaid-eligible.

151. **Language:** A grouping of words combined with their systems of use, specific to a particular culture, geographical area, or community. No specific information on languages spoken or understood by recipients or providers is included in any HFS data set.

152. **Last Eligibility Date:** The last day during the experience period on which a recipient was enrolled in a Medicaid program or other full-benefit health program, used to capture data items that are subject to change on recipients who were no longer enrolled as of the anchor date. *See also* Eligibility Span.

153. **Letter of Intent:** An initial response to a Solicitation and to convey limited information.

154. **Limited Data Set:** A level of confidentiality, defined by HIPAA as excluding names, addresses, and other direct identifiers, but including information that allows for the possible identification of individuals through indirect identifiers; a category of data confidentiality to which the data sets belong as a result of the included geographic information. (For more information on HIPAA, see "Summary of the HIPAA Privacy Law." For the text of the law to which this section refers,

please see "164.514: Other requirements relating to uses and disclosures of protected health information" [PDF].)

155. **Long-Term Acute Care Hospital (LTAC, LTACH, or LTCH):** A category of hospital regulated by the 2004 Health Facilities Planning Act of Illinois but not clearly defined under any state law. This type of facility is typically understood as being intended to provide acute medical care as well as rehabilitation services for patients whose average length of stay is in excess of 25 days. These hospitals are reimbursed via per diem payments, as recorded in the Hospital Detail file. They are not included as a separate field in any HFS data set.

156. **Long-Term Care (LTC):** A category of healthcare services compliant with the state Nursing Home Care Act and regulated and licensed by the Illinois Department of Public Health, involving provision of primary and specialty medical care, social services, and additional services to disabled or chronically ill recipients over an extended period of time within a nursing home, another institution, or a home and community setting.

157. **Lump Sum Payments:** Payments, additional to fees for services or capitation payments, paid to healthcare providers or organizations that treat Medicaid recipients.

158. **Managed Care Community Network (MCCN):** A MCCN is an entity, other than a health maintenance organization, that is owned, operated, or governed by Providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department. MCCNs are regulated and licensed by HFS and not the Department of Insurance. While they may operate much like a HMO, they are not considered HMOs. *See also* Managed Care Organization, Health Maintenance Organization, and Voluntary Managed Care.

159. **Managed Care Organization (MCO):** A Health Maintenance Organization (HMO) or Managed Care Community Network (MCCN). *See also* Health Maintenance Organization (HMO) and Managed Care Community Network (MCCN).

160. **Medicaid:** The program under Title XIX of the Social Security Act that provide medical benefits to groups of low-income people.

161. **Medicaid High Volume Adjustment:** Payments that are intended to help support hospitals who serve a high volume of Medicaid patients. Eligibility for these payments is determined on a hospital-by-hospital basis and is based on the hospitals' matching the criteria set forth in Section 148.120, 148.122 and 148.290(d) of the 89 Illinois Administrative Code. MHVA payments, like MPA payments, are defined by criteria additional to those that are applied to DSH payments. *See also* Disproportionate Share Hospital (DSH), Medicaid Percentage Adjustment (MPA), and Medicaid Inpatient Utilization Rate (MIUR).

162. **Medicaid-Like Program:** Any program administered by HFS providing state-funded or federally funded health insurance benefits to a selected population; a program that is not a part of Medicaid, but is administered in a similar way.

163. **Medicaid Percentage Adjustment:** Reimbursement adjustments intended to supplement income to hospitals that provide service to a relatively high rate of Medicaid patients (defined by Section

148.120 of the 89 Illinois Administrative Code as serving at least one-half a standard deviation above the mean Medicaid utilization rate, or serving low-income patients at a rate of 25% per annum, plus meeting a sufficient number of six additional criteria identified in Section 148.122 of the 89 Illinois Administrative Code). MPA payments are paid in increments per claim, and can therefore be included as a line item towards a total payment. *See also* Disproportionate Share Hospital (DSH), Medicaid High Volume Adjustment (MHVA), and Medicaid Inpatient Utilization Rate (MIUR).

164. Medicaid Presumptive Eligibility (MPE): A program available to pregnant women based on income level, irrespective of their immigration status; the program provides extensive primary health care and hospital services, including labor and delivery to expectant mothers not otherwise eligible for Medicaid. It is however a partial-benefits program that is excluded from the data set. This program is sometimes referred to as Presumptive Eligibility (PE), although this is also a separate program. *See also* Moms and Babies and Presumptive Eligibility.

165. Medicaid RX (MRX): A section of Chronic Disability and Illness Payment System (CDPS) that is designed to categorize pharmaceuticals per National Drug Codes for use in risk adjustment, use in predicting healthcare service use, and related analyses. *See also* Chronic Disability and Illness Payment System (CDPS) in this glossary and our documentation on CDPS elsewhere.

166. Medicaid Inpatient Utilization Rate (MIUR): The percentage of all inpatient days that were provided to Medicaid patients. This term is more precisely defined by Illinois Public Act 93-0040(5-5.02)(h) as "a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period."

167. Medical Home: A healthcare facility that a benefit recipient must select as their first point of contact for non-emergent medical needs; a healthcare strategy intended to allow for improved quality of care by ensuring an ongoing relationship between a particular recipient and his or her primary care provider. *See also* Primary Care Provider.

168. Medically Fragile, Technology Dependent (MFTD) Children: Individuals under 21 years of age who are eligible for Home and Community-Based Services waivers under 89 *Ill. Adm. Code* 120.530, entitling them to special services not normally granted to Medicaid recipients; a category of patients who are identified as such as in the data set. A patient group for who care is coordinated by the Division of Specialized Care for Children (DSCC), a Title V agency operating at the University of Illinois at Chicago. Sometimes called The Home Care Program**.**

169. Medicare Crossover Admission: The occasion on which a Medicaid recipient entering the hospital is also eligible for and enrolled in Medicare benefits; services received by this recipient are therefore reimbursed first by Medicare, and then by Medicaid (up to Medicaid's maximum reimbursement rate only), through a Medicare crossover payment. *See also* Medicare Crossover Payments and Medicare Crossover Rate.

170. Medicare Crossover Payments: Payments made for claims reimbursing services provided to dual eligible patients for whom Medicare has already contributed some amount of reimbursement. These claims are excluded from the fee-for-service billing methodology and are subject to the regulations described in 89 Illinois Administrative Code section 140.20(c).

171. **Medicare Crossover Rate:** The percentage of patients at a particular hospital who are eligible for both Medicare (under Title XVIII of the Social Security Act) and Medicaid (under Title XIX of the Social Security Act), in relations to the total number of patient days provided to Medicaid and Medicaid-like program recipients; this figure is derived from HFS' adjudicated claims data and can be calculated using information in the Hospital Detail file. *See also* Medicare Crossover Admission and Medicare Crossover Payments.

172. **Mental Health Screening Only:** *See* Screening, Assessment and Support Services (SASS).

173. **Mental Illness and Substance Abuse (MISA):** A term referring to patients who are both psychiatrically ill and dependent on drugs or alcohol. These recipients are commonly referred to as 'dual diagnosis' patients. A group of patients who are not specifically flagged as such, but who can be identified via the CDPS chronic condition flags and/or the use of certain types of services. Occasionally, the equivalent acronym "MHSA" ("mental health and substance abuse") is used.

174. **Moms & Babies:** A program covering all outpatient healthcare and inpatient hospital care, including labor and delivery, for women not otherwise eligible for Medicaid during pregnancy and for 60 days following the birth of their infant. This program is not included in the data sets. *See also* Medicaid Presumptive Eligibility.

175. **Money Follows the Person (MFP):** Also known as the Money Follows the Person (MFP) Rebalancing Demonstration. A five-year (2007-2011) demonstration program, now extended to 2016, designed to assist disabled Medicaid recipients in the state of Illinois to transition from long-term care to home- and community-based service use, using specialized transitional services. A program captured in the data sets in much the same way as the waiver programs.

176. **MR/DD:** An acronym for Mentally Retarded/Developmentally Disabled, used by agencies that receive federal funding under Title XIX of the Social Security Act of 1965; a code for a category of claim included in the data set. *See also* Developmental Disabilities, *See also* Developmental Disabilities, Supportive Services Waivers for Children and Young Adults, Developmental Disabilities Residential Waivers for Children and Young Adults, Developmental Disabilities Waivers for Adults and Waiver Program.

177. **National Committee for Quality Assurance (NCQA):** A private 501(c) 3 not for profit organization dedicated to improving health care quality and has a process for providing accreditation, certification and recognition, e.g., health plan accreditation.

178. **National Drug Code (NDC):** A numeric code 11 digits in length that identifies a specific prescription drug; a code used by Medicaid to process claims. A code used with the data release to augment Chronic Illness and Disability Payment System data on specific illnesses. *See also* Chronic Illness and Disability Payment System.

179. **National Provider Identifier (NPI):** a 10-digit numeric identifier assigned to an individual health care provider and mandated for use in all administrative and financial transactions covered by HIPAA; the numerical ID assigned to providers included in the data set, provided they are assigned such a number as a part of their licensing and certification and have provided this number to Medicaid. *See also* Provider ID.

180. **Net Liability:** The amount of money that Medicaid is ultimately responsible for paying for a claim; as the payer of last resort, Medicaid is typically liable for the portion of claims that is not covered by additional insurance or Medicare. *See also* Dual Eligible and Third Party Liability.

181. **Non-Claims Payments:** A payment that is not associated with a specific recipient and healthcare service or otherwise does not flow through our claims system. These payments include but are not limited to hospital Supplemental Payments. The payments are also known as C-13 voucher payments. Because they cannot be associated with a particular recipient and service these payments are NOT included in the data sets as a component of the costs in the Total Cost field. *See also* Claims Payments and Supplemental Payments.

182. **Non-Disabled Adult:** A term used by HFS to refer to adults aged 19 to 64 whose Medicaid eligibility is not based on their disability status, irrespective of any disabilities or health problems they may experience; typically, parents or other primary caregivers of Medicaid-eligible children**.**

183. **Non-Disabled Adult (AA):** A term used by CDPS (and abbreviated 'AA') to describe people 18 and above whose eligibility is based neither on their disability nor age. This definition is nearly the same as the HFS definition of 'non-disabled adult,' except for persons aged 18 or those persons 65 and above who qualify as caregivers of children rather than as aged individuals. Within the current data release, CDPS AA logic applies to all recipients who HFS has classified as non-disabled adults. This meaning of the term 'Non-Disabled Adult' will always be accompanied by the acronym 'AA,' to distinguish it from other meanings of the term. *See also* Non-Priority Adult, and 'Other' Adult. *Please see CDPS documentation for further information.*

184. **Non-Disabled Child (AC):** A CDPS classification describing an individual under 18 years of age who is not disabled. Within the current data release CDPS AC logic is applied to all HFS children through age 18, irrespective of disability status. This meaning of the term 'Non-disabled Child' will always be accompanied by the acronym 'AC,' to distinguish it from other meanings of the term. *Please see CDPS documentation for further information.*

185. **Non-Institutional Provider Services (NIPS):** Services rendered to a recipient by a care provider licensed under the Medical Practice Act of 1987 to offer services that do not require medical licensing, such as transportation, as well as services provided by licensed healthcare providers, including physicians; a term encompassing all care provided other than inpatient hospital, institutional care, and prescription drugs.

186. **Non-Priority Adult:** Any recipient over age 18 and under age 65 whose Medicaid eligibility is not based on their disability status, irrespective of any disabilities or health problems they may experience; adults who do not qualify as a Senior or Person with Disability (SPD). A term synonymous with 'Other' Adult and Non-Disabled Adult (AA).' Typically, these are parents or primary caregivers of Medicaid-eligible children.

187. **Open End Date:** A term used to describe an attribute, classification, or circumstance that is applicable from the present moment to an undefined point in the future. Those eligibilities, enrollments, and other attributes within the data set that have an open end date are treated the same as those that end on the last day of the experience period.

188. **Open Enrollment:** A time period during which recipients can elect in and out or between the FFS programs, HMOs, MCCNs, and CCEs for which they are eligible for enrollment.

189. **'Other' Adult:** Any recipient aged 19 to 64 whose Medicaid eligibility is not based on their disability status, irrespective of any disabilities or health problems they may experience; adults who do not qualify as a Senior or Person with Disability (SPD). A term synonymous with 'non-priority adult' and similar to 'TANF adult' and 'non-disabled adult (AA).' Typically, these are parents or primary caregivers of Medicaid-eligible children. *See also* Non-Priority Adult and Non-Disabled Adult.

190. **Other IHC Adults:** Illinois Health Connect (IHC) adults whose eligibility for Medicaid is not based on a disability and are between the ages of 19 and 64 years of age. See also 'Other' Adult.

191. **Over the Counter (OTC):** A designation of a pharmaceutical that is available to the public without a prescription; generally, this designation is for drugs considered particularly benign with respect to their capacity to intoxicate, poison, or otherwise harm the user. A classification found in the Drug Detail File.

192. **Partial Benefit Plans:** A program administered by HFS that provides less than comprehensive benefits (such as IL Cares Rx), restrict the recipient to treatment of only a certain condition (such as rape victim services), or pays the premiums and/or cost sharing for another insurance program (including Medicare) but does not directly cover any services; those benefit plans that are excluded from this data release.

193. **Partner Organization:** Any health care entity that submits a Letter of Intent and has requested and received data derived from the data sets. This term refers to HFS's relationship with the organization requesting data.

194. **Patient:** In general usage, a person who receives healthcare services from a healthcare provider; for the purposes of the data sets, a recipient. In any document using the term "patient," we advise all data users to clarify the intended meaning. *See also* Beneficiary and Recipient.

195. **Pediatric Outpatient Adjustment Payments:** An additional payment given to providers who serve a relatively large amount of care to pediatric Medicaid recipients, as defined by 89 Illinois Administrative Code, Chapter 1, Section 148.297. This item is not included in the data sets.

196. **Pending Asylees or Torture Victims:** A category of Medicaid-eligible persons who qualify for benefits by virtue of their seeking asylum via the federal Department of Homeland Security, as well as their low-income status.

197. **Per Diem Payments:** Reimbursements to hospitals for inpatient stays on a "per day" basis. These payments are regulated by 89 Illinois Administrative Code, Chapter 1, Section 149.25(b)(4)(A), and are can be made only to University of Illinois Health and Hospital System, Cook County hospital, rehabilitation hospitals, psychiatric hospitals, children's hospitals, long-term stay hospitals and certain rural hospitals. Per diem payments are included in the Hospital Detail file. *See also* Inter-governmental Transfer.

198. **Per Member per Month (PMPM):** A metric for healthcare costs that averages costs across all recipients of a particular health benefit program or other healthcare service for a given month. A figure not specifically included in the data release cost data.

199. **Person:** Any individual, corporation, proprietorship, firm, partnership, trust, association, governmental authority, vendor, or other legal entity whatsoever, whether acting in an individual, fiduciary, or other capacity.

200. **Person with Disabilities:** *See also* Adult with Disabilities, Disabled Adult (DA), Disabled Adult, and Disability.

201. **Pharmaceutical:** *See* Prescription Drug.

202. **Physical Disabilities Waiver:** A full benefits program to disabled persons aged 0 to 59 years old, providing services designed to allow individuals who fit criteria for institutionalization to remain in their homes and communities; one of several categories of benefits that provide payment for more services than are typically covered by Medicaid. *See also* Disabilities claim and Waiver. For more information on this waiver, click here.

203. **Physical Disabilities Waiver Claim:** Payment requests submitted by a waiver provider and adjudicated under the disabilities waiver; typically, claims for services that Medicaid would not pay for a recipient not enrolled in a waiver. *See also* Waiver Program.

204. **Physician:** A person licensed to practice medicine in all its branches under the Medical Practice Act of 1987.

205. **Potential Enrollee:** A Client who may be eligible for enrollment in a benefits program, but who is not yet an enrollee in such a program; a person who fits the first criterion, but not the second criterion, of the definition of Eligibility. A proposal using this term should make clear which meaning is intended. *See also* Programs and Enrollee.

206. **Prescription Drug:** The preferred term for any therapeutic chemical preparation prescribed to a recipient by a licensed healthcare provider and dispensed by a licensed pharmacist; this category is inclusive of all drugs for which Medicaid reimburses, whether they are over-the-counter or prescription. Also known as a pharmaceutical.

207. **Present on Admission (POA):** A descriptor applied to any diagnosis recorded during inpatient hospital care, indicating that the diagnosis was not acquired during the hospital stay but rather existed in advance of the admission date. This descriptor is intended to augment a pay-for-performance healthcare environment by reducing payments for qualifying preventable conditions that the recipient contracts while in the hospital; the Deficit Reduction Act of 2005 mandated its use with all hospital records. *See also* Hospital-Acquired Condition.

208. **Presumptive Eligibility (PE):** A program available to children (aged 0 to 18) based on income level, irrespective of their immigration status; the program provides extensive primary health care and hospital services. It is however a partial-benefits program that is excluded from the data set. This program is maybe referred to as Temporary All Kids benefits or similar names. It should not be confused with Medicaid Presumptive Eligibility (MPE), a separate program for expectant mothers. *See also* Medicaid Presumptive Eligibility.

209. **Primary Care Case Management (PCCM):** A system of primary managed care based on designating an office-based primary care provider as a "medical home" for a Medicaid recipient, mandated for most recipients who have full benefits, are not dual eligible, and are not enrolled in managed care (including the Integrated Care Program).

210. **Primary Care Provider (PCP):** A health care provider, including physicians, Federally Qualified Health Center (FQHCs), Rural Health Clinics (RHCs), nurse practitioners, hospital-based clinics, local health departments, school based clinics, and Women's Health Care Providers (WHCPs), who within the Provider's scope of practice and in accordance with State certification requirements or State licensure requirements, is responsible for providing all preventive and primary care services to his or her assigned Enrollees in the CCE or MCCN. *See also* Medical Home.

211. **Prioritization of Urgency of Need for Services (PUNS):** A registration system that allows families of persons with developmental disabilities to access necessary services and to enroll in waiting lists for services; a type of data excluded from the data release.

212. **Procedure Codes:** Codes used to describe healthcare services. This category can include Diagnostic Related Groups (DRGs), Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT), and others. Although Provider Type and Category of Service are more commonly used, procedure codes are sometimes used to designate Type of Service. *See also* Type of Service and Category of Service.

213. **Program of All-Inclusive Care for the Elderly (PACE):** A program that provides comprehensive, community-based services to individuals over the age of 60 who are Medicaid-eligible and qualified by their health conditions to enter long-term care; this program is administered in Illinois by a nonprofit called REACH. *See also* Reaching the Elderly Across Chicago's Horizon (REACH).

214. **Programs:** Various assistance plans that the State of Illinois administers to individuals who qualify, based on various eligibility criteria; variances between programs include type and level of benefits, target population, intended outcomes, and funding source. Medicaid itself is a program. One person may therefore be in multiple programs, such as Medicaid, a waiver program, and (in the future) coordinated care.

215. **Proposal:** A Bidder's response to a Solicitation, consisting of the technical Proposal and all required forms and certifications. All required forms and certifications must be completed, signed, and returned by the Bidder. A term that is preferred to 'bid.'

216. **Protected Health Information:** Information about the health conditions, healthcare needs, and healthcare services rendered to individuals that, under the Health Insurance Portability and Accountability Act, is considered worthy of special protections (such as identity masking and secure storage) to ensure that it remains private. *See also* Health Insurance Portability and Accountability Act (HIPAA).

217. **Provider:** A person enrolled with the Department to provide Covered Services to a Client; any individual who provides health care services to recipients, including but not limited to medical doctors, nurse practitioners, registered nurses, home health workers, pharmacies, and transportation providers; any person who has provided care to a recipient and received payment under Medicaid or another medical program.

218. **Provider ID:** Medicaid-specific number that all providers must have, even those providers who do not have a NPI for reasons related to professional licensing standards. Use of this ID predates

NPI and is embedded in HFS records. The Provider ID for some providers is a Social Security number and therefore must be masked.

219. **Provider Key ID:** A 10-digit number assigned at random to any provider who does not have a NPI or who has not provided this figure to Medicaid. This number has no relationship with the Provider ID, which may include a provider's social security number or other direct identifiers and is therefore unsuitable for wide release.

220. **Provider Summary File:** A data table provided that identifies health care providers by name, specialty or scope of care, and address and summarizes the services provided by the Types of Service provided, and a single address for the primary location at which the provider renders services.

221. **Provider Type:** A classification of providers as defined by their role (and typically their license) in the healthcare system.

222. **Provider Visit:** Any single event, typically associated with a single date of service, in which a healthcare provider gives care to a Medicaid recipient; the data associated with such an event, as reflected in the data set. *See also* Event.

223. **Qualified Individual-1 (QI-1):** An individual with countable income over 120- 135% of the federal poverty level (FPL) with assets at or below $6,600 for an individual or $9,910 for a couple, for whom Medicaid will pay the monthly Medicare Part B premium or an equivalent sum towards a Medicare Advantage (Part C) plan.

224. **Qualified Medicare Beneficiaries (QMB):** A category of recipients who are eligible to receive Medicaid assistance with the costs of Medicare, including the Medicare Part B premium, annual Part B deductible, coinsurance costs and Medicare Part A premium, plus an amount equal to the Medicare Part B premium, deductible and coinsurance for those Medicare recipients who opt to enroll in a Medicare Advantage Plan (Part C). A partial benefits program.

225. **Quality Assurance (QA):** A formal set of activities to review the quality of services by one or more healthcare provider(s), plus corrective action to remedy deficits identified in the quality of patient, administrative and support services.

226. **Quality Measure:** A quantifiable measure to assess how well an organization carries out a specific function or process or achieves desired outcomes. Information on quality measures is not found in the data sets.

227. **Race:** the recipient's self-reported identification with one or more groups within the following list: White; African-American; American Indian or Alaskan Native; Asian or Pacific Islander; Multiracial; or Refused to Answer/Unknown. This term is distinct from the term "Ethnicity." *See also* Ethnicity.

228. **Reaching the Elderly Across Chicago's Horizon (REACH):** A nonprofit organization that provides medical care, social service, rehabilitation, and recreation to seniors in their community setting through a PACE program for Illinois seniors (aged 60+) who are eligible for Medicaid and qualified by their health conditions to enter long-term care. A program that is included in the data sets. *See also* Program of All-Inclusive Care for the Elderly (PACE).

229. **Recipient:** An individual of any age who is enrolled in a Medicaid program or other full-benefit health program at any point during the experience period; in many cases, this term describes an individual who has received and claimed, although in any given period some recipients do not claim services. The term favored for use with regard to the data set. *See also* Client.

230. **Recipient Key ID:** An ID assigned to the recipient for identification purposes within this data table only; a series of digits that neither reflects any other ID number assigned to the recipient nor identifies any other characteristic of the recipient.

231. **Recipient Provider Crosswalk:** A data table describing services received by recipients performed by providers which include types of services, costs, number of events, and total units of services aggregated for service years.

232. **Recipient Summary File:** A data table describing attributes of recipients, including enrollment status, eligibilities, demographic attributes, chronic conditions, healthcare services, and costs of services received; all data is specific to the calendar year for enrollment and services.

233. **Refill Too Soon:** A program designed to reduce drug misuse and abuse by flagging prescription refills that are sought prior to the time when the refill request would be appropriate (calculated as a function of the total length of time that the prescription was intended to last), and rejecting these prescription refills at the point of sale. A program that is not included in the data sets.

234. **Refugee:** An individual who has sought asylum and been granted refugee status in a country outside his or her country of origin due to fear of persecution due to his or her race, religion, nationality, political opinion, or social group membership; a type of individual who is not specifically flagged in the data sets, but who may receive full benefits for a limited time under the Refugee and Repatriation Assistance program. *See also* Refugee and Repatriation Assistance.

235. **Refugee and Repatriation Assistance (RRA):** A program, consisting of the Refugee Resettlement Program (RRP) and Repatriate Program, that provides short-term full medical benefits to refugees and selected others; a program that is captured in the data sets. *See also* Refugee.

236. **Reimbursement:** Payment for medical services rendered to a benefit recipient on a fee for service basis. *See also* Fee for Service and Claim.

237. **Route:** The way in which a drug is consumed by a patient; this can include oral, intravenous, transdermal, and many other methods of consumption.

238. **Rural Health Center (RHC):** A healthcare facility located in a geographic location that the Bureau of the Census describes as rural and the Department of Health and Human Services defines as medically underserved; an entity similar to but not synonymous with a Federally Qualified Health Center. *See also* Federally Qualified Health Center.

239. **Screening, Assessment and Support Services (SASS):** A partial-benefits program that serves children 0 to 18 years who are experiencing mental health crises and who may need hospitalization for mental health care; a program not specifically indicated in the data release, but possibly providing services to some full-benefit pediatric Medicaid or All Kids recipients.

240. **Series Bills:** Bills (typically submitted on form UB-92) that represent a thirty-day period during which a long-term hospitalization neither starts nor ends; also known as an "interim bill."

241. **Seniors:** A Client who is 65 years of age or older. Only seniors who were enrolled in Medicaid within the experience period are represented in the data set.

242. **Seniors and Persons with Disabilities (SPD):** A term favored by HFS to refer to recipients over age 65 and adults 19-64 who are eligible for Medicaid by virtue of disability; a near-synonym for the CDPS term Disabled Adult (DA). This is a priority population for this solicitation. See also Disabled Adult and Disabled Adult (DA).

243. **Serious Mental Illness (SMI):** A Client who is at least 18 years of age and whose emotional or behavioral functioning is so impaired as to interfere with their capacity to remain in the community without supportive treatment. The mental impairment is severe and persistent and may result in a limitation of their capacities for primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation. The mental impairment may limit their ability to seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services. For purposes of enrolling Target Populations, the following diagnoses will be used schizophrenia (295.xx), schizophreniform disorder (295.4), schizo-affective disorder (295.7), delusional disorder (297.1), shared psychotic disorder (297.3), brief psychotic disorder (298.8), psychotic disorder (298.9), bipolar disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90), cyclothymic disorder (301.13), major depression (296.2x, 296.3x), obsessive compulsive disorder (300.30), anorexia nervosa (307.1), and bulimia nervosa (307.51).

244. **Services:** assistance provided as part of a benefits program; includes health care, social services, and other forms of aid to eligible individuals.

245. **Service Units:** A term that can be used in place of 'units,' in the context of itemized services provided associated with a given healthcare service event. *See also* Units and Events.

246. **Service Year:** See Experience Period and Service Period.

247. **Service Period:** Also known as experience period. Starts at the beginning of the calendar year and goes through the end of the calendar year. All of our data sets are aggregated by service year.

248. **Simple Drug:** A prescription drug preparation that contains only one pharmacologically active agent. This category is mutually exclusive with a "compound" drug, which has more than one active ingredient. *See also* Compound Drug.

249. **Specified Low-Income Medicare Beneficiaries (SLIB):** Recipients with monthly countable income between 100% and 120% of the federal poverty level (FPL) with assets at or below $6,600 for an individual or $9,910 for a couple, for whom Medicaid will pay the monthly Medicare Part B premium or an equivalent sum towards a Medicare Advantage (Part C) plan.

250. **Solicitation:** A document requesting proposals, plus any additional documents and/or clarifying questions and answers the State may publish.

251. **Spend-Down:** The policy that allows an individual to qualify for Medicaid by incurring medical expenses at least equal to the amount by which his or her income or assets exceed eligibility

limits. It operates similarly to deductibles in private insurance as the spend-down amount represents medical expenses the individual is responsible to pay.

252. **Spend-Down Recipients:** Individuals who are eligible for Medicaid despite having income in excess of the limit defined by law within a given time period, by consideration of their income minus medical expenses for which they must bear personal responsibility. Even though they have full benefits when eligible, these recipients have eligibilities that cycle on and off, often monthly. They are excluded from the solicitation and this data release.

253. **State:** The State of Illinois, as represented through any agency, department, board, or commission.

254. **State Chronic Renal Disease Program:** A category of Medicaid benefits provided to persons who are experiencing renal impairment to such a degree that dialysis is necessary to maintain life. A partial-benefits program that covers only dialysis treatments received in a dialysis treatment center, hospital outpatient setting and at home, for people who have chronic renal diseases requiring lifesaving care, but who do not qualify for Medicaid, spend-down Medicaid, or All Kids.

255. **State-Operated Developmental Centers:** Public or private facilities that provide long-term care services to people with developmental disabilities who have severe medical and/or behavioral needs who are Medicaid-eligible.

256. **State Plan:** The Illinois State Plan filed with the Centers for Medicare & Medicaid Services, in compliance with Title XIX and Title XXI of the Social Security Act.

257. **Statewide Coordinator of Deaf and Hard of Hearing Services:** A program organized under the Department of Rehabilitation Services that provides free counseling, rehabilitation and referrals to people who are deaf or hard of hearing; a program for which no data is included in the data release.

258. **Static Payment:** *See* Supplemental Payments.

259. **Sterilization:** This item includes outpatient sterilizations only. For this data set, facility charges for sterilizations performed at the time of labor and delivery are categorized as "Inpatient Hospital: Maternity," while physicians' charges will group to "Sterilizations."

260. **Substance Use Disorders:** A category of diagnoses connected with a specific subset of Types of Services; this category includes but is not limited to drug dependence, alcohol dependence, substance misuse, and alcohol- and drug-induced mental disorders. In specific contexts, this term may be appropriately substituted with 'substance abuse,' 'addiction,' and a wide variety of other terms; therefore, proposals analyzing Substance Use Disorder data and/or describing target population needs should clarify the intended meaning of this terms and related terms they use.

261. **Supplemental Nutrition for Women, Infants and Children (WIC):** A Department of Human Services (non-HFS) program providing food assistance to women with children aged 0 to 5 years old; a program excluded from the data release. Commonly referred to as WIC. *See also* WIC.

262. **Supplemental Payments:** One form of a non-claims payment. Payments (also known as static payments) that are made to hospitals and that are not linked to either capitation payment or fee-

for-service payments; in other words, payments unrelated to current utilization of healthcare services by Medicaid recipients. These payments make up approximately 40% of payments to hospitals annually, and are *not* included in the data sets as a component of the costs in the Total Costs fields. *See also* Non-Claims Payments.

263. Supplemental Security Income (SSI): A federal program that pays benefits to disabled adults and children who have limited income and resources.

264. Supportive Living Facility (SLF): A housing option combining apartment-like living with specialized medical, social, and housekeeping services, for low-income Seniors and Persons with Disabilities who would otherwise dwell in a nursing facility or other institutional setting; a cost covered only through the SLF waiver program. *See also* Supportive Living Facility (SLF) Waiver Claims and Supportive Living Facility (SLF) Waiver.

265. Supportive Living Facility (SLF) Waiver: A special dispensation unavailable to Medicaid recipients as a whole that permits low-income elderly and disabled individuals to receive specialized medical, social, and housekeeping services in an apartment-like housing facility rather than dwelling in a nursing home. See also Supportive Living Facility (SLF) and Supportive Living Facility (SLF) Waiver Claims.

266. Supportive Living Facility (SLF) Waiver Claims: Claims submitted by a waiver provider and adjudicated under the SLF waiver; typically, claims for services that would not be paid for by Medicaid for a recipient not enrolled in a waiver. *See also* Supportive Living Facility (SLF) and Supportive Living Facility (SLF) Waiver.

267. TANF Populations: A historical term, no longer in common use, for Temporary Aid to Needy Families (welfare). To the extent that it is still used, it refers to Medicaid children and their Medicaid-covered parents, guardians, or other primary caregivers. It excludes adults who qualify for Medicaid by virtue of being elderly and adults and children who qualify by virtue of disability. See also Non-Priority Adult and 'Other' Adult.

268. Teaching Hospital: A hospital that offers education to medical students, nursing students, and/or students of any of the allied health fields; these facilities are often, but not always, recipients of significant amounts of Disproportionate Share Hospital (DSH), Medicaid High Volume Adjustment (MHVA), and Medicaid Percentage Adjustment (MPA) payments and may be referred to in descriptions of these reimbursements. Additionally, these hospitals may receive reimbursement for indirect medical education (IME) costs. A category of hospital that does *not* have a specific definition or inclusion in Data Set I, Data Set IIB: Hospital nor any other HFS data set. *See also* Disproportionate Share Hospital (DSH), Indirect Medical Education (IME) Costs, Medicaid High Volume Adjustment (MHVA), and Medicaid Percentage Adjustment (MPA).

269. Third Part Liability (TPL): Health insurance plans that are liable for covering healthcare costs prior to Medicaid's final contribution to a claim. Although Medicare is conceptually a third party health plan, the term refers to non-Medicare plans. *See also* Cost.

270. Third Party Administrator (TPA): An organization providing health insurance or care coordination administrative functions without bearing risk, properly licensed by the State of Illinois.

271. **Title XIX:** The portion of Social Security Amendments of 1965 (Public Law 89-97) that created Medicaid and Medicare.

272. **Title XXI:** Portion of the Federal Social Security Act that created the Children's Health Insurance Program, the federal program that funded a portion of Illinois All Kids. *See also* All Kids.

273. **Total Enrolled Days:** The total number of days, inclusive of any and all eligibility spans, during the experience period that a particular individual was enrolled in Medicaid or other full-benefit health programs.

274. **Transitional Assistance (City of Chicago):** A partial-benefits program providing temporary assistance to very low-income persons who live within the city of Chicago only; a program that is not included in the data sets.

275. **Transitional Medical Assistance (TMA):** A program that allows families who have recently become ineligible for Medicaid due to increased earnings to access benefits for a limited amount of time; a program that provides full benefits and is included in the data sets.

276. **Transportation Services:** Services that provide specialized vehicular transit (via medivans, ambulances, and other vehicles) to healthcare facilities for recipients with impaired mobility or emergency transport needs.

277. **Traumatic Brain Injury Waiver:** *See* Brain Injury Waiver.

278. **Type of Service**: A classification of the healthcare services rendered by providers to recipients; a classification used to describe healthcare service patterns of both providers and recipients. This classification is largely determined from a combination of provider type and the category of service. *See also* Provider Type and Category of Service.

279. **Unborn Child State Plan Amendment (SPA):** A program funded by the State Children's Health Insurance Plan that allows Family Care plans (which approve recipients for benefits based on their income level) to offer full-benefits plans to undocumented aliens, incarcerated women and those with income less than 200% of the federal poverty level (FPL).

280. **Undocumented Alien:** A person originating from another country who is residing in the United States without legal permission for such residence; an individual who, in specific circumstances, is eligible for benefits. In the data sets, these circumstances are confined to labor, delivery, and emergency services. For more information, please see Type of Service documentation.

281. **Unit:** The number of itemized services (generally defined by procedure codes) associated with a given healthcare service event; used together with "event" quantify the services rendered to recipients. For most services, one unit is one distinct procedure code; for emergency room (ER) services, one unit is one ER visit. Given a single event spanning multiple days, such as an inpatient hospitalization, long-term care institutionalization, and prescription drug use, the units recorded are equal to the number of days the event lasts. *See also* Service Units and Event.

282. **Upper Payment Limits (UPL):** The federally-defined maximum dollar amount that a particular healthcare facility can be reimbursed for Medicaid services; a figure that is not contained in any HFS data set.

283. Veterans Service Officers/Veterans Care: An administrative program assisting veterans with benefits enrollment.

284. Voluntary Managed Care: An optional medical home program available for the recipients of All Kids, Moms & Babies and FamilyCare who wish to enroll. This program makes use of Managed Care Organizations (MCOs). *See also* Managed Care Organizations (MCOs).

285. Waiver Program: One of several programs offering services that allow Medicaid recipients to remain in their homes and in the community, despite fitting criteria for nursing facility or long-term care residence by providing benefits not normally covered by Medicaid. *See also* Home and Community-Based Service Waivers.

286. Waiver Recipient: A recipient who is enrolled in a waiver program. Waiver enrollment is secondary to Medicaid enrollment. *See also* Waiver Program and Enrollment.

287. WIC: *See* Supplemental Nutrition for Women, Infants and Children.

288. Women's Health Care Provider (WHCP): A healthcare provider specializing by certification or training in primary care, obstetrics, or gynecology, whose practice focuses on care to adult females. A provider type included in a few Types of Service in the data sets.

289. Zip Code: The five-digit geographic identifier on file for the recipient as of the anchor date or last eligibility date, including any inaccurate, null, or incorrectly reported zip codes; data that is not cleaned or revised by HFS prior to data release.

Acronyms Found in this Glossary

AA:	Non-Disabled Adult
AABD:	Aid to the Aged, Blind and Disabled
AC:	Non-Disabled Child
ACA:	Affordable Care Act
AIDS:	Acquired Immunodeficiency Syndrome
APL:	Ambulatory Procedures Listing
ASTC:	Ambulatory Surgical Treatment Center
AWP:	Average Wholesale Price
CCE:	Care Coordination Entity
CDPS:	Chronic Illness and Disability Payment System
CHAP:	Critical Access Hospital Adjustment Payment
CHIP:	Children Health Insurance Plans
CILA:	Community Integrated Living Area
CMS:	Centers for Medicare and Medicaid Services. Also known as Federal CMS.
CPT:	Current Procedural Terminology
CSHCN:	Children with special healthcare needs
DA:	Disabled Adult
DC:	Disabled Child
DEA:	Drug Enforcement Agency
DRG:	Diagnosis Related Groups
DSCC:	Division of Specialized Care for Children

DSH:	Disproportionate Share Hospital
EIS:	Eligibility Information Systems
EPSDT:	Early and Periodic, Screening, Diagnosis and Treatment
ER:	Emergency Room
FFS:	Fee for Service
FQHC:	Federally Qualified Health Center
FCM:	Family Case Management
HAC:	Hospital Acquired Condition
HCBS:	Home and Community-Based Service
HCFA:	Health Care Financing Administration
HCPCS:	Healthcare Common Procedure Coding System
HEDIS:	Healthcare Effectiveness Data and Information Set
HFS:	HealthCare and Family Services
HIPAA:	Health Insurance Portability and Accountability Act
HIV:	Human Immunodeficiency Virus
HMO:	Health Maintenance Organization
HBWD:	Health Benefits for Workers with Disabilities
IBCCP:	Illinois Breast and Cervical Cancer Program
ICEB:	Illinois Client Enrollment Broker
ICFs/MR:	Intermediate Care Facilities for the Mentally Retarded
IGT:	Inter-Governmental Transfer
IHC:	Illinois Health Connect
IPXP:	Illinois Preexisting Condition Insurance Pool
LOI:	Letter of Intent
LTAC:	Long-Term Acute Care
LTC:	Long-Term Care
LTCH:	Long-Term (Acute) Care Hospital
MCO:	Managed Care Organization
MCCN:	Managed Care Community Network
MFTD:	Medically Fragile, Technology Dependent (children)
MFP:	Money Follows the Person
MHVA:	Medicaid High Volume Adjustment
MI:	Mental Illness
MISA:	Mental Illness and Substance Abuse
MIUR:	Medicaid Inpatient Utilization Rate
MPA:	Medicaid Percentage Adjustment
MPE:	Medicaid Presumptive Eligibility
MR/DD:	Mentally Retarded/Developmentally Disabled
MRX:	Medicaid RX (a part of CDPS)
NCQA:	National Committee for Quality Assurance
NDC:	National Drug Code
NIPS:	Non-institutional providers
NPI:	National Provider Identifier
OTC:	Over the Counter (drug)
PE:	Presumptive Eligibility
POA:	Present on Admission
PCCM:	Primary Care Case Management
PCP:	Primary Care Provider
PMPM:	Per Member per Month
PUNS:	Prioritization of Urgency of Need of Services

QA:	Quality Assurance
QI-1:	Qualified Individual-1
QMB:	Qualified Medicare Beneficiaries
REACH:	Reaching the Elderly across Chicago's Horizon
RHC:	Rural Health Center
RRA:	Refugee and Repatriation Assistance
RRP:	Refugee Resettlement Program
SASS:	Screening, Assessment and Support Services
SLF:	Supportive Living Facility
SLIB:	Specified Low-Income Medicare Beneficiaries
SMI:	Serious Mental Illness
SPA:	State Plan Amendment
SPD:	Seniors and Persons with Disabilities
TANF:	Temporary Aid to Needy Families
TMA:	Transitional Medical Assistance
TPL:	Third Party Liability
UPL:	Upper Payment Limit
WIC:	Supplemental Nutrition for Women, Infants and Children
WHCP:	Women's Health Care Provider