General Data Descriptions

1. **How is this table intended to be used?** This event-level table, describing inpatient hospital admissions, is most meaningful when used in conjunction with either the Recipient or Provider table. This will require the user to have the skills and data environment to summarize the data and join the results to Recipient and/or Provider tables.

2. **How can my organization analyze the inpatient hospital admission data of our target population?** We will deliver the hospital admission data based on the same criteria used to generate the Recipient and Provider Summary tables. Inpatient hospital admissions, costs associated with these admissions, average length of admissions are some of the ways to analyze this data.

3. **Does the table have any relationship with data sets available from the Illinois Department of Public Health (IDPH)?** In creating this table, we have noted the existence of discharge data from IDPH. We have loosely based our work on the discharge data. Wherever possible, we have matched the data elements previously available.

4. **What IDPH fields are excluded from the table?** IDPH fields not included in our data are missing because they are either unavailable in our data warehouse, or irrelevant because of the nature of HFS data. Data collected by IDPH that are not collected by HFS include information on Do Not Resuscitate (DNR) orders, employment-related health conditions and accidents, crime victim status, and the birth weights of newborns.

   We provide information specific to a given hospital claim, including specifications of payer and insurance groups. These fields do not match IDPH data closely because our data uses Medicaid recipient status as an inclusion criterion, prompting formatting changes with respect to data presentation. We nonetheless include a variety of information on insurance payers.

5. **Does the hospital number included in the table match the Illinois Department of Public Health's hospital numbers?** The hospital numbers in our data are assigned irrespective of other organizations' numbering systems. While there is a significant degree of matching between the IDPH data and ours, the match is imperfect. We advise data users to avoid doing inner joins of HFS and IDPH data by hospital number, as this would result in many dropped records.

Recipient and Providers

1. **What recipients are included in the data?** The hospital recipient population includes all recipients with full benefits and with at least one inpatient hospital event during the calendar year, irrespective of age and geographic location.

2. **How are Medicare recipients included in the data?** Medicaid recipients who also receive

Medicare are included in all our data. Medicare Paid Amount is a data field in Hospital. Payments are largely from Medicare Part A (hospital insurance) and Medicare Advantage (which is also known as Medicare Managed Care, and which supersedes Parts A and B combined). Medicare Part B (clinical care insurance) and Part D (pharmacy insurance) are not relevant to this data.

3. **What provider types are included?** The provider types included in the data are general hospitals (provider type 030), rehabilitation hospitals (provider type 032) private psychiatric hospitals (provider type 031), and state-operated psychiatric hospitals (provider type 034).

   This table provides data with respect to the institutional service charges associated with inpatient hospital admissions. A wide variety of providers operate in hospital settings. These providers bill services separately from inpatient hospitalization institutional claims. Such services are not included in this table.

Types of Service

1. **What Types of Service are included in this table?** In this table, we have captured all the Types of Service that are institutionally delivered as inpatient care. The "TOS" field indicates the corresponding Type of Service from the Recipient and Provider tables.

2. **Are all inpatient hospital admissions included in this table?** No. Admissions paid for by managed care organizations and known to HFS via "encounter claims" (see the Glossary on the MPARK webpage) are not included in the table.

Diagnoses and Procedures

1. **What does the field "DRG 1995" mean? Are up-to-date Diagnostic Related Groups (DRGs) included in the data?** *The DRGs included in this data are not the most current available DRGs.* This data includes Version 12 DRGs, which were originally created in 1995. These codes are obsolete and are not used in most hospitals currently. HFS persists in using these DRGs on its hospital claims because these DRGs are defined by Illinois law as the basis of our payment system. To emphasize that the codes are outdated, we have included the year they originated, 1995.

2. **How many diagnostic codes are included per claim?** We include up to 25 diagnostic codes for a hospital claim. Additional diagnostic codes, where present, are simply indicated (by a 1/0 indicator) in an accompanying column. For series bills (which are submitted over time for a single hospitalization that lasts longer than thirty days), a primary diagnosis code is carried across all the claims for that hospitalization, and all additional diagnoses are dropped after the first claim.

3. **What does "Present on Admission" (POA) mean?** Present on Admission is an additional data field included for each diagnostic code. Present on Admission, as defined by Section 5001(c) of the Deficit Reduction Act (DRA) of 2005, is an indicator applied to each diagnostic code as part of a reimbursement determination. The intention of POA indicators is to encourage the prevention of conditions acquired in hospital (nosocomial infections and preventable injuries) by reducing or eliminating payment of the conditions that are not present on admission. POA codes are folded into diagnostic groupers, and payments are made on the basis of this grouper.

4. **Why are some Diagnosis fields and "Present on Admission" fields blank?** We record up to 25 diagnoses per claim. For each of these, a POA code should be present. Many recipients will not have this many diagnoses, however, and all unused diagnostic and POA fields will be blank.

5. **What are the codes for "Present on Admission" fields 2 through 25?** They are the same as the codes for the first Present on Admission item (DiagPOAClaimCd1). The data sources are also the same.

6. **How many procedure codes are included per claim?** We include up to 25 ICD-9 procedure codes per claim. Additional procedures (>25) are indicated by a separate indicator. If the recipient had less than 25 procedures during a hospitalization, the excess fields will be blank.

7. **Why do so many procedure date fields show the date January 1, 1901?** It is possible to have fewer than 25 procedure codes, and therefore fewer than 25 corresponding procedure dates. The date 01/01/1901 is the default value for those procedure date fields that have no corresponding procedure code. We include this value in order to assist the users of software programs that do not easily accommodate "null" values in date fields.

Billing, Costs, and Payments

1. **What bills are included in the data?** HFS recognizes a variety of different bills: those created at the beginning of a hospitalization; interim bills representing each 30-day period a recipient remains in the hospital (also known by the synonyms "series bills" or "interim bills"); discharge bills, with the specialized charges associated with the ending of a hospitalization; and bills for additional charges, which typically reflect adjustments to previous bills. This information is contained in the field Bill Type Code.

2. **If a claim includes series bills (covering a continuous hospitalization of more than 30 days), which bill is used to gather data about this hospitalization?** Most of the claims that involve series bills conclude with a discharge bill (BillTypeCd = 4). Where possible, this bill is used as the source for the patient status code, DRG1995 codes, admission diagnosis, admission source code, admission type code, pricing code, outlier day cost indicator, and Type of Service description. Additionally, diagnostic codes, diagnostic POA claim codes, procedure codes, and procedure dates (up to 25 total in each case) are pulled from this bill.

Some hospitalizations extend past the final day of the experience period, and for this reason do not include a discharge bill in the data. (These claims can include a discharge date after the end of the experience period, but will not include further information originating after that time).

For these claims, we use the final bill submitted (BillTypeCd = 3) to pull the patient status code, DRG1995 codes, admission diagnosis, admission source code, admission type code, pricing code, outlier day cost indicator, and Type of Service description. We pull up to 25 diagnostic codes, diagnostic POA codes, procedure codes, and procedure dates from the first interim bill submitted (BillTypeCd = 2).

3. **What is included in a cost?** The cost fields in the data are like the ones present in the data previously released: they reflect Medicaid's net liability for a given claim. The data separately describes the charge the provider originally sought; copayments; sum Third Party Liability (TPL); Medicaid charges; Medicare charges; Disproportionate Share Hospital payments, Medicaid Percentage Adjustment and High Volume Adjustments; Add On, Capital and Covered Charge payments; and a variety of other payments. It does not include static payments to hospitals that are not related to a specific hospital admission.

4. **How are hospital payments determined?** Hospital payments are determined via a calculation that incorporates multiple facts about a particular inpatient visit. Please see the downloadable DRG calculator spreadsheet on the HFS website for more information. The payments generated by this worksheet are Medicaid's net liability including any costs that may be covered by Medicare or Third Party Liability for recipients who have such coverage.

5. **What is the DRG calculation worksheet?** The DRG calculation worksheet allows a data user to figure out the total cost associated with a particular admission. You can find this worksheet as a download on the HFS Data Releases webpage. The download includes instructions.

6. **How are Disproportionate Share Hospital payments included in the data?** Disproportionate Share Hospital (DSH) payments are intended to support hospitals that serve a large percentage of low-income/indigent patients. These hospitals are 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 (MIUR), or serving low-income patients at a rate of 25% per annum. A complete listing of criteria and eligible facilities is available on the HFS website. DSH payments are calculated for each claim, and can therefore be included as a line item towards a total payment.

7. **What is a Medicaid Percentage Adjustment Add-On Payment? How does it differ from DSH payments and MHVA payments?** Medicaid Percentage Adjustment (MPA) Add-On Payments are 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 Code). MPA payments are paid in increments per claim, and can therefore be included as a line item towards a total payment. (A complete listing of criteria and eligible facilities is available on the HFS website.) These payments are provided incrementally, per claim. This field is recorded separately to the net liability and other payment fields.

8. **What is a Medicaid High Volume Adjustment Add-On Payment? How does it differ from DSH payments and MPA payments?** Medicaid High Volume Adjustment (MHVA) Add-On Payments 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. The last of these specifically states that MHVA-eligible must "not be a county- owned hospital…. or a hospital organized under the University of Illinois Hospital Act… in the MHVA rate period." This is the major difference between MPA and MHVA payments. MHVA payments, like MPA payments, are defined by criteria additional to those that are applied to DSH payments. A complete listing of criteria and eligible facilities is available on the HFS website.

9. **How are Per Diem payments represented in the data?** Per Diem payments are designed to reimburse hospitals based on the total number of days of a given admission, in addition to payments derived from the specific DRG. Only University of Illinois at Chicago hospital, Cook County hospital, rehabilitation hospitals, psychiatric hospitals, children's hospitals, long-term acute-care (LTAC) hospitals and certain rural hospitals are eligible for Per Diem payments. (Out-of-state non-cost-reporting hospitals are also paid via this method, but are not included in this or any other data.)

10. **What is the Medicaid co-pay? How is this dollar amount determined?** Under Title XIX, Medicaid recipients are assessed a co-payment for each day they are inpatients. This figure is $3.00 per day at hospitals billed under DRG methodology; $3.00 per day at hospitals with a Per Diem reimbursement rate of $325 or more; $2.00 at hospitals with a Per Diem reimbursement rate of $275-325; and $0.00 at hospitals that have a Per Diem reimbursement rate of less than $275.

11. **What is a non-covered charge?** This is the amount of a bill that is not covered by any of the benefits program available to the person receiving the healthcare service. This amount is not the responsibility of the patient (although the patient can be liable for cost-sharing amounts, which are in separate fields).

Data Use

1. **What is an event?** An event is one hospital admission.

2. **What is a unit?** A unit is one day of a hospital admission.

3. **Is there an overall count for events, units and costs for the claims data included here?** No. To easily access this information, please use the Recipient and Provider summary tables, which provides this information for the same population in the same timeframe. Partners can also easily calculate counts for recipients and providers.

4. **What is a covered day? What is a non-covered day?** On occasion, a person can become eligible or enrolled while in the hospital, or can lose Medicaid eligibility while in this hospital. On other occasions, a person may enter the hospital with an authorization for Medicaid payment for a limited number of days. These situations can results in a number of days for which Medicaid will reimburse costs ("covered days"), and a number of days for which Medicaid does not pay ("non-covered days"). This data field contains these counts for those recipients to which it applies. Each day is counted as one unit irrespective of whether or not the recipient was covered by Medicaid on that day.

5. **How are inpatient hospitalization days and Length of Stay (LOS) counted in the data?** HFS uses the traditional health insurance calculation for total inpatient days: Discharge Date – Admission Date = total number of inpatient days (Length of Stay). (Equivalently, one may consider this as counting only the nights of a stay, or as disregarding the day of discharge.) Under this formula, a person who is admitted to the hospital on a Monday and discharged the next Monday has a seven- day (not eight-day) inpatient stay. Length of stay (LOS) in the data is calculated this way. This figure should equal the sum of covered and non-covered days.

   An exception occurs for interim (series) bills, which use the formula Discharge Date – First Date of Bill +1 to ensure proper payment of all the days in the bill. This can include the first bill in a series of bills for a hospital stay, and is therefore relevant to Bill Type 2 (first bill in a series) and Bill Type 3 (continuing bills in a series). The first date of the bill will be the admission data for Bill Type 2, and will be the first date of the bill (typically the first day of the month) for Bill Type 3.

   Please note the data will report an inpatient stay of one day for a person who checked into and out of the hospital on the same day, even though the formula would generate an inpatient stay of zero days.

6. **Does this data include information on mortality?** Death during hospitalization is not included as a separate data field in the data. However, Patient Status Code includes several classifications of "Expired," which is synonymous with deceased. Please consult this field for information on death. Further, Death Date was included in the data. Please note that no element of any of the data includes specifics as to the cause of death.

7. **Does the data include information on a patient's destination after discharge?** Yes. The data field called "Patient Status Code" conveys the patients' immediate destination after a discharge, including codes such as "left against medical advice/discontinued care" and "expired."

8. **Does the data include a readmission indicator? Is it possible to calculate readmission rates using the data?** There is no readmission indicator in the data. However, the hospital claims data documents multiple admissions over the experience period, and it is therefore possible to calculate the rate of readmission within 7, 30, or any other number of days.

9. **Is comparing the data or joining the data to an outside source acceptable**? This data is deliberately arranged to mimic typical discharge data available from Illinois Department of Public Health to the largest extent possible. This is intended to allow data-savvy organizations to work with a familiar format, but also to allow for the insights that can arise from the comparison of a Medicaid-only data and a data that includes all payers.

   While comparing this data to other data is acceptable, joining this data to any other data in a way that reveals the identity of any person represented in the data is a violation of HIPAA law. This is grounds for termination of the Data Use Agreement and therefore a termination of your organization's data access.

10. **Can the data in this data release be used to create baselines for quality measures defined by HFS as important to care coordination?** We know that our partner organizations have an interest in the use of our data to analyze recipients' use of specific services important to quality measures. We recognize some hospital claims data could possibly be useful towards this end. In particular, this data is useful for assessing 30-day readmission rates. However, please note that the table has not been designed expressly for this function.