Frequently Asked Questions- Provider and Recipient
Medical Programs Analytic & Reporting Knowledgebase (MPARK)

General Description

1. **What is the purpose of this data set?**

   MPARK is summary data with respect to recipients, providers, hospital admissions, prescription drugs, and emergency room visits. The data can be used to understand population enrollment and demographic characteristics, to understand which providers provide care for a population, to understand population costs, and to assess the population potential for care coordination. MPARK data cannot be used for coordinating care of a specific recipient, for quality of care measurements, and for longitudinal analysis other than year to year.

2. **Why are recipient identities masked?**

   For planning and pricing purposes, we have created a data set which does not have any directly identifiable information and which has a relatively low risk of identification. (Per HIPAA, this is a 'limited data set.') Because there is some risk of identification, data users must sign a Letter of Intent and a Data Use Agreement.

3. **Why is detailed enrollment and claims data not provided?**

   The data set contains summarized enrollment and claims data. The enrollment and claims data is summarized in such a way that analysts should be able to very quickly gain population-level and sub-population insights into their population of interest. Were we to pass detailed enrollment and claims data to data users, it would likely take months for the data users to sort the data and create meaning. Additionally, every data user would do it their own way. We want our partners to have an easy and consistent understanding of the data.

4. **Why aren't we supplying more current data?**

   It takes approximately a year before we can more or less reliably describe a year of enrollment and claims. We supply the most current years for which we can provide reliable data.

Data Security

1. **Why is a Data Use Agreement required? What identifying data is included in the data set?**

   The Data Use Agreement is required because the data set includes information that Health Insurance Portability and Accountability Act (HIPAA) regulations classify as Protected Health Information (PHI). Specifically, because the data set associates recipients with counties and zip codes, the data set is considered 'potentially identifiable'. A data set containing potentially identifiable information is referred to under HIPAA as a 'limited data set;' a limited data set requires a Data Use Agreement under current law.

2. **What security standards are appropriate for this data?**

   First, consult the Data Use Agreement and your own counsel. In general, the data should be securely stored, you should not try to identify the data, and only authorized users may use the data for authorized purposes. Since the data is not 'identified' as per Health Insurance

Portability and Accountability Act (HIPAA) standards, it does not require the same standard of care as clinical and other identified data. Applying clinical data standards is, however, acceptable.

3. **Can the recipient and provider tables be linked together?**

   Yes, if you have the Recipient-Provider Crosswalk table.

Technical Details

1. **How is data delivered?**

   Typically, we will deliver data via secure file transfer protocol (ftp). Other methods may be possible or necessary depending on the size of the files to be transferred and your organization's ability to receive the data.

2. **What software can be used to analyze data?**

   Data will be provided as a .txt file. Most data set users will need load the data set into database software. While portions of the data may be easily extracted to Excel, Excel-alone will not be sufficient. Unless a data user specifically requests data on a small population, the data is bigger than what Excel can conveniently manage and, furthermore, it is often necessary to join tables. Excel is not a good tool for joining tables. SQL, Access, SPSS, SAS, Stata, and other statistical analysis programs may be good choices. The choice of program is up to the organization receiving data.

   We recommend that you set up your data environment so that new source tables can be easily loaded and, when necessary, replace current tables. This will save you considerable effort if we need to re-release data to correct an error or if you request a new data set in order to modify an attribute used to select your population of interest.

3. **What tech support is available to partner organizations?**

   A limited amount of technical support is available from Healthcare and Family Services (HFS). The support is primarily intended to ensure that data conforms to partner organizations' requests and is delivered in useable condition. HFS has limited resources available to provide further support.

4. **How much assistance can HFS give my organization in accessing, understanding, and analyzing the data?**

   Healthcare and Family Services (HFS) has created documentation on the contents of the data set; the data set exclusions and limitations; and some business terminology underlying data categories. This documentation is intended to ensure clarity as to what various data fields signify. Please see the complete FAQ sheets, glossary, and data dictionary for more information. As noted in the previous question, we have limited resources for providing further support. Furthermore, if the data has been provided to you so that you can prepare a bid in response to a

solicitation, we cannot unfairly advantage any potential bidder by providing individual assistance. That said, we endeavor to do what we can.

Please email any questions or comments about MPARK to HFS.data@illinois.gov.

Data Use and Analysis

1. **Can the data be used for cost modeling?**

   Yes, and this is our intention.

2. **Can the data be used for insight into distribution of diseases among the population of interest?**

   Yes, the data set can be used to examine for this purpose to a limited extent. This information has obvious value for clinical planning for a particular population. With that said, we recognize that our method of compiling diagnoses eliminates specific ICD-9 codes, and therefore limits the analyses that can be successfully completed with this data.

   Please see Chronic Illness and Disability Payment System (CDPS) documentation found on the MPARK website for details.

3. **Can the data be used to analyze social, cultural, or economic aspects of a patient population?**

   Several organizations have voiced an interest in examining the social, economic or cultural factors that correlate with healthcare needs or disease risk. The data set is highly limited with regard to this type of information, and we do not expect that prospective partner organizations will be able to complete analyses of public health issues related to clinical care needs. For example, the data does not indicate who is homeless.

4. **Can the data be used for risk adjustment purposes?**

   Yes, but that is not our intention. We are providing Chronic Illness and Disability Payment System (CDPS) flags that allow partners to view recipients by condition should a data user be targeting a population with a specific condition and so that all data users understand the co-morbidities of their population of interest. We have not assigned risk prediction costs to the flags.

   Please see CDPS documentation on the MPARK website for details.

5. **Can the data be used to assess service gaps?**

   No. The data set is insufficient to assess service gaps.

6. **Can data be used to identify trends and to make projections?**

   Only somewhat. Currently only two years of data is available. Partners are welcome to use the data set or supplementary information to support projected needs of patient populations. We advise partners to note that Medicaid fee schedules have historically been mostly fixed. Should

fee schedules change we plan to re-price historical data to be comparable to new prices for purposes of determining shared savings.

7. **What errors are in the data set?**

   We have made every attempt to compile quality data, but it is unlikely to be perfect. Our underlying data is far from perfect and is limited by the inaccuracies in diagnosis, record-keeping, and client self-reporting that plague any data set. In addition, we may have made errors in compiling the data. We appreciate your feedback with respect to any data anomalies that are not already described in the documentation. If it is something that we can correct, we will; otherwise we will include the anomaly in the documentation.

Demographics

1. **What information on demographics is provided?**

   Demographic data contains information on age, gender, race, and ethnicity. The data set does not include dates of birth, but does include death dates for recipients who have died in the experience period. Ages are presented in 'age bands' (where age is in integers, rounded down) condensed from the ages of recipients as of the anchor date or last eligibility date: aged 0 (less than one year), 1 to 18 years, 19 to 20 years old, 21 to 44 years old, 45 to 64 years old, and 65+ years old.

2. **What information on geography is provided?**

   Geographic data is included two ways: as zip codes, and as counties. The data set includes the five-digit zip code on file as of the anchor date of the experience period. HFS does not clean zip codes, which means null and incorrectly reported zip codes may be found in the data set. County information is recorded at beginning of the recipients most recent eligibility span in Medicaid and reflects the county of the public aid office where the individual's eligibility was processed. When an office serves several (rural) counties, we have attempted to increase data specificity by assigning counties based on recipient zip codes. Recipients do not necessarily go to the office in their county or change offices when they move. County attribution should therefore be considered imperfect.

3. **What is the anchor date?**

   The anchor date refers to the last day of the experience period. Over the course of a year recipients can enroll and disenroll from Medicaid, change program status, qualify for waiver programs, change their address, be born, die, and undergo other changes. This transience can make data analysis difficult. We have summarized most enrollment data by anchor or the nearest available date, such as the last date enrolled prior to the anchor date or the first day of the eligibility span closest to the anchor date. Our data dictionary defines the applicable date for each data field.

4. **How many years does the data set cover?**

Each data set's experience period is one year: January 1 to December 31. We currently have calendar years 2010 and 2011 available.

Providers

1. **What information on providers is included in the data set?**

   Provider information includes the Primary Care Provider (PCP) for each recipient. In addition the data set includes a provider table which provides information concerning each provider, PCP or otherwise, that served any recipient in the recipient table over the course of the experience period.

   As providers are a non-protected group under Health Insurance Portability and Accountability Act (HIPAA), HFS is able to release providers' names, zip code and county, and National Provider Identifier (NPI). Additional information on specialty, Primary Care Case Management (PCCM) enrollment, Critical Access status, and reimbursement type is also included.

   The data set also includes event-level data for hospital admissions, emergency room visits, and prescription drugs that will contain information on the providers utilized for each healthcare event.

2. **Are there any discrepancies between the recipient and provider tables?**

   No. If you find the totals for total recipients, costs, service events, or units of service vary between the recipient and provider tables, contact Healthcare and Family Services (HFS) using the contact information included with your data set.

3. **How are provider types included in the data set?**

   Provider types are included in the data set two ways. First, they are a data point that can be viewed directly in the provider portion of the data set. Second, they are one of two components that are most often used to define Types of Service; information as to which provider type occurs in which Type of Service can be found in the data dictionary.

4. **How are Nursing Facilities identified in the data set?**

   Nursing Facilities in Illinois often change ownership. This causes them to change provider IDs. Therefore, Healthcare and Family Services (HFS) maintains a building ID code that is used for tracking Nursing Facilities across ownership changes. This information is not included in the data set. We might add this as a supplement to provider number for future releases, and we invite your feedback on this point.

Enrollment and Eligibility

1. **How are 'eligibility' and 'enrollment' defined?**

   Please refer to the Glossary on the MPARK webpage to better understand these and many other terms. Eligibility and enrollment refer not only to the Medicaid program in its entirety, but to various programs within Medicaid. Eligibility (when used correctly) refers to whether a person

meets the criteria for a program and enrollment refers to whether they are actually enrolled in the program. So, for example, a recipient may be eligible for voluntary HMO enrollment, but not enrolled in a voluntary HMO. The terms are sometimes used incorrectly as a matter of habit. For example, a 'dual eligible' recipient is in fact dually *enrolled* in Medicare and Medicaid.

2. What information on eligibility is provided?

We have included an eligibility indicator for Seniors and (adult) Persons with Disabilities (SPDs). A value of 1 indicates that the recipient is a Senior or Person with Disabilities as of the anchor date. A value of 0 indicates that the recipient is not a Senior or Person with Disabilities.

The Seniors and Persons with Disabilities (SPD) indicator is set according to the recipient's age as of the anchor date (if the person is over 65 years of age) or his or her disability status as of his or her most recent full benefit eligibility date within the experience period (if the person is 19 to 64 years of age). SPD indicators are applied to all recipients in the data set, irrespective of current eligibility.

Likewise, the Medicare dual eligibility indicator is according to the recipient's most recent full benefit eligibility date within the experience date. The data user can therefore clearly differentiate between dual and non-dual recipients, even for those recipients not currently eligible.

The data Current Eligibility refers to full benefit eligibility as of the anchor date. Recipients are included in the data if they were eligible for full benefits (and enrolled in one or more programs) any time during the year. The Current Eligibility flag is 1 if they were still eligible on the anchor date; otherwise, it is 0. Recipients are included in the data if they were eligible for full benefits (and enrolled in one or more programs) any time during the year.

Eligibility flags are included in the data set for Primary Care Case Management (PCCM) eligibility. These are marked if a recipient was eligible at any point during the experience period. Eligibility flags for ICP (Integrated Care Program) and ACE (Accountable Care Entity) are also included.

Finally, a categorical item denotes the Enrollment Program Group as of the last day of the experience period. For definitions of eligibility and enrollment, please see the Glossary.

3. What information on enrollment is provided?

The data set includes enrollment flags for Primary Care Case Management (PCCM). (Please note that PCCM enrollment does match PCCM eligibility, due in part to enrollment process lag time and in part due to recipients' selection of voluntary Health Maintenance Organization (HMO) in place of PCCM enrollment.)

We also provide an indicator for Management Care Organization (MCO) enrollment at any time during the year. This category combines recipients who enrolled in a Voluntary Health Maintenance Organization (HMO), a single current Managed Care Community Network (MCCN), and Reaching Elderly across Chicago's Horizon (REACH). The MCO category is mutually exclusive with the Fee for Service (FFS) category, which is also flagged in the data set. The distinction

MCO and FFS recipients is highly significant for Type of Service data as healthcare services paid for by the MCO and submitted to HFS as "encounter claims" (see the glossary on the MPARK webpage) are not included in the Recipient and Provider table Type of Service data (indicators, RINS, events, units of service, and cost fields).

Number of Enrolled Days indicates how many days a recipient was enrolled during the experience period; it will be less than 365 for recipients who are not currently eligible and for those who enrolled after the start of the experience period.

4. **Where can I find more information about Type of Service?**

   Please refer to the Type of Service documentation on the MPARK webpage.

5. **Are there circumstances in which eligibility and enrollment data are inaccurate?**

   Yes. Primary Care Case Management (PCCM) eligibility is determined using current eligibility tables which describe what a client's eligibility status was on the anchor date. Some factors that affect whether or not a client is eligible for the PCCM program can be updated retroactively. In some cases, this results in a client appearing ineligible for the program when they were enrolled on the anchor date. In other cases, it will appear that a client was eligible on the anchor date but not enrolled.

   Generally speaking, benefits programs allow for retroactive enrollment, under which Healthcare and Family Services (HFS) will pay for services that the newly enrolled recipient used in the 90 days prior to their enrollment. This makes HFS responsible for paying claims during a period when management of the recipient's care was impossible.

6. **What if the eligibility and enrollment data don't meet your analysis needs?**

   Please inform us. We have attempted to distill multiple eligibility and enrollment layers into a simple recipient-level summary. Eligibility and enrollment can change for each recipient over the course of the experience period. We are open to suggestions on how to better meet your needs.

Recipients

1. **What recipients are included in the data set?**

   All recipients with full Medicaid or Medicaid-like benefits who are not otherwise excluded from the data set are included in the data mart from which the data set is extracted. It includes recipients who did not have any claims during the experience period. If a recipient did not have any claims, they by definition, also do not have any Chronic Illness and Disability Payment System (CDPS) condition or drug flags. Partners can request sub-populations of the data set. Likewise we may provide subsets of the data set for certain uses.

2. **Are recipients with partial benefits-related data included in the data set?**

   No. Only data associated with recipients with full benefits, not otherwise excluded from the data set, are included. Anyone receiving partial benefits is excluded.

3. **Are recipients who disenrolled from Medicaid during the experience period included in the data set?**

   Yes. Recipients who had full benefits for any part of the experience period are included in the data set. They are in the data set with the claims from their enrollment period. Their current eligibility indicator will be "0" and their Total Enrolled Days will be less than 365.

4. **How many recipients' records are in the data set?**

   Over three million recipients are included in the data set. As some of these persons enrolled, disenrolled, or died during the experience period, the total number of recipients at any one point in time is approximately 2.8 million.

5. **How are children included in the data set?**

   People of all ages are included in the data set. Age bands include information on three sets of children: age 0 (under age 1), people aged 1 to 18, and people aged 19-20. HFS generally classifies anyone under 19 (0-18 years of age) as a child, but certain specific programs extend the pediatric category up to include 19 years olds. Additionally, some waivers for developmentally disabled persons place children and young adults (aged 3 to 21 years) into one group. When analyzing data on pediatric populations, please be mindful of rules on age categories specific to the waiver or program of interest.

6. **What recipients will be included in the data an organization receives?**

   Your particular data set will have only the recipient populations that you have requested. We will extract your data set from our state-wide data set based on the specifications of a prospective data user. An organization's specifications, however, have to be based on data attributes that we have available.

Waiver

1. **What is a waiver?**

   Illinois' nine Home and Community Based Services (HCBS) waivers cover services that normally are not covered by Medicaid. Generally, waivers are intended to allow people with serious disabilities or illnesses to avoid institutionalization by increasing their access to services within their homes and communities. Waivers are a cost-saving measure, designed to provide care to a given population at a lower cost than care rendered in a hospital, nursing facility, or intermediate care facility.

   Each waiver offers a set of services specific to individuals who have a given disability or illness. Most, but not all, waiver populations are seniors or adults with disabilities. Various waiver programs include different types and levels of benefits.

   For a list of all waivers, please view the data dictionary and glossary on the MPARK webpage, or you can view a list of all waivers online.

2. **How are waiver populations included in the data set?**

Waivers are a category of benefits that cover services that normally are not covered by Medicaid. Generally, waivers are intended to allow people with serious disabilities or illnesses to avoid institutionalization by increasing their access to services within their homes and communities. Most waiver populations are seniors or adults with disabilities. (For more information on waiver definitions, please consult the Glossary on the MPARK webpage.)

All recipients of Medicaid waivers were first qualified to receive full Medicaid benefits. As a result, their healthcare data are included in the data set. This includes information on any services they have received that do not require a waiver.

We acknowledge a long-standing issue with waiver enrollments: recipients who are institutionalized, deceased, no longer eligible, or otherwise no longer using waiver services typically remain enrolled. This results in an overestimation of the total number of waiver recipients, and an underestimate of their average healthcare service use. We ask data users to consider interpreting those waiver recipients who have no claims during the year or who are institutionalized as possibly inappropriately enrolled.

3. How are services given to waiver recipients included in the data?

All recipients of Medicaid waivers were first qualified to receive full Medicaid benefits. As a result, their healthcare data are included in the data set. This includes information on any services they have received that do not require a waiver.

4. What information in the data set is provided on waiver enrollments?

We supply three waiver enrollment data points for each waiver program: enrollment as of the anchor date, enrollment anytime during the experience period, and claims. This allows assessment of the total number of persons who received waivers during the year; those who retained their enrollment at the end of the period; and their pattern of healthcare service use. (We have an additional field that contains information on long-term care institutionalization as of the anchor date.)

Please note that enrollment data may not represent all the people who are eligible for waivers, as some waivers have waiting lists. Additionally, the waiver enrollment process is separate from enrollment in Medicaid generally; some Medicaid recipients who are appropriate candidates for waiver services may not be enrolled in a waiver.

5. What limitations are there in the data on waivers?

We acknowledge a long-standing issue with waiver enrollments: recipients who are institutionalized, deceased, no longer eligible, or otherwise no longer using waiver services often remain enrolled. This results in an overestimation of the total number of waiver recipients, and an underestimate of their average healthcare service use. Our best advice to data users is to rely upon the waiver claim indicators to indicate who is using a waiver and who is not; those who are no longer enrolled will stop submitting claims even if their records are not properly updated. We ask data users to consider interpreting those waiver recipients who have

no claims during the year or who are recorded as receiving services in an institution as possibly inappropriately enrolled.

6. **How are ages recorded in waivers, and how does this differ from age banding in the data set?**

   Age bands in the data are 0-18 years old, 19-20 years old, 21-44 years old, 45-64 years old, and 65+ years old.

   In some cases, waivers use different age brackets as eligibility criteria. These include ages 0 to 21 years (MFTD waiver), 3 to 21 years (residential and supportive Developmental Disability waivers for children and young adults), 19 and over (Developmental Disability waivers for adults), 0 to 59 years (Physical Disability waiver), 60 years and over (Supportive Living Facilities waiver), 65 years and over (Aged waiver), and all ages (Brain Injury and AIDS waivers).

   Some of these age brackets overlap the age bands available in the data set. Therefore, data users wishing to compare waiver populations to non-waiver populations of similar age may wish to select the closest representative age band(s).

7. **How are waiver claims represented in the data?**

   All waiver claims are indicated as such. Please see the Type of Service documentation on the MPARK webpage for more information.

   Please note that some waiver claims are included in the data set for persons who are not indicated as being enrolled at the anchor date or any point during the experience period. This is related to incorrect management of enrollment data. HFS is working to correct the issue, but is not able to retroactively apply these corrections to our experience period. We advise data users to regard waiver claims data as the most accurate information on waiver recipients.

8. **Can a waiver recipient also receive non-waiver services?**

   Yes, in some cases. A person may begin receiving waiver services during the experience period; any non-waiver services they received prior to their enrollment will be included in the data set in addition to their waiver services.

   A person may also receive non-waiver Types of Service in addition to waiver services. Since it is not possible to enroll in a waiver without having first enrolled in full Medicaid benefits, all waiver recipients are also entitled to receive medically necessary non-waiver services. Please note that many services that are available as non-waiver services are also available as waiver services. These are often with specialized providers or extensions in Medicaid coverage. In these cases, the services that a waiver recipient receives are billed only as waiver services.

9. **Can a person who is not a waiver recipient receive waiver services?**

   No. Our data may contain some instances in which waiver services claims are submitted by a person without a waiver. In these cases, the data is in error.

10. **What is Money Follows the Person, and how is it included in the data set?**

Money Follows the Person (MFP) is a program that assists persons in Nursing Facilities and other institutions to transition to living in the community. The program funds special care that is otherwise not available to Medicaid recipients for the transitional period. In this way, it is similar to a waiver. Additionally, the Types of Service available to waiver recipients are also available to MFP recipients. For these reasons, MFP is included with waiver services in the data set, although it may be considered 'not quite' a waiver. We also provide three data points on MFP: enrollment as of the anchor date, enrollment at any point during the experience period, and a claims indicator.

Types of Services

1. **What Type of Service data is included in the data set?**

   Type of Service is a category that encompasses information on the provider type and the category of service provided to a recipient on a given date. It is a complex classification developed from federal reporting standards and several important caveats and limitations. Please refer to the Type of Service documentation on the MPARK webpage.

2. **How is prescription drug information captured in the data set?**

   Data on prescription drugs is captured in three ways: implicitly, in Chronic Illness and Disability Payment System (CDPS) diagnostic information; in aggregate as a Type of Service; and explicitly, in the event-level data.

   In the first case, national drug codes (NDCs) for prescription drugs are used to augment ICD-9 diagnostic codes. In other words, a cancer diagnosis flag can exist in the data set due to the recipients' healthcare record containing the relevant ICD-9 diagnostic code. Alternately, a cancer diagnosis flag can exist for that recipient because they were prescribed a drug classified as a cancer treatment, even if this recipient's data lacked other information on the malignancy. The cancer prescription will be incorporated into the CDPS data for this recipient, increasing the overall accuracy of the data. CDPS has some rather complex rules for combining the diagnosis and drug flags so that they don't contain redundant information. We have applied the rules. See the CDPS documentation on the MPARK webpage.

   Event-level data will include pharmaceutical use, recorded as events and units.

3. **What is an event?**

   An event is a term used in the data set to quantify the services rendered to recipients. In some informal contexts, an event may be referred to as a "visit." Generally, this is the healthcare use that occurs by one recipient, on one day, with one provider. Exceptions occur for emergency room care (where the event includes one recipient, on one day, in one emergency room); inpatient care or institutionalization (for which the event is admission); and pharmacy use (for

which each individual prescription is an event, even if multiple prescriptions are filled on the same day). Please see the table below in the next question.

4. What is a unit?

A unit is the number of itemized services (generally defined by procedure codes) associated with a given healthcare service event. It is a term used in the data set together with "event" to quantify the services rendered to recipients. For the healthcare use that occurs by one recipient, on one day, with one provider, a unit is each single procedure completed. For emergency care, all procedures are recorded as one unit. For a single event that spans multiple days, such as inpatient hospitalization or long-term care, the units recorded are equal to the number of days the event lasts. For a pharmaceutical prescription, the number of units is the number of days the prescription lasts. Please see the table below:

Table 1: Descriptions of Events and Units by Type of Service

Type of Service	What is an Event?	What is a Unit?
Inpatient Hospitalization	One hospital stay is one event.	Each day of the hospital stay is one unit.
Other Institutionalization Care	One month is one event. The first and last months may be counted as partial events.	Each day of the stay is one unit.
Pharmacy	One prescription is one event.	Each day of prescription drug use is one unit.
Emergency Room (ER)	One recipient, one ER facility, on one day is one event.	Each ER visit is one unit (therefore events=units unless there is more than one visit in one day).
All Other Services	One recipient, one provider, on one day is one event.	Each paid procedure is counted as one distinct unit.

5. How are hospital services included in the data set?

Inpatient hospital care is found in six Types of Service. These types are Maternity Delivery, Maternity Non-delivery, Psychiatric care, Substance Use Disorders, and 'Other' Services (all other hospital care), all of which are preceded by 'IP Hosp' in the data set. The sixth inpatient

Type of Service is Emergency Care to Undocumented Aliens. (Please see below for further information on the care included in this Type of Service.)

All outpatient care is included in other Types of Service. Please see our data dictionary for more detail.

6. What Types of Service are included under 'Emergency Services to Undocumented Aliens'?

This Type of Service involves two components: care to undocumented aliens who are incarcerated, and care to undocumented aliens who are experiencing labor and delivery. Those who are incarcerated are considered 'partial benefits recipients,' and like all other such recipients are excluded from the data set. Those who are giving birth, however, are full benefits recipients. For this reason, the Emergency Services to Undocumented Aliens recorded in the data set are only Labor and Delivery-related inpatient care services.

7. What is the difference between a 'public' and 'private' ICF/MR provider?

Intermediate Care Facilities for Mentally Retarded individuals (ICF/MR) are included in the data set as a unique Type of Service. These facilities' services are further divided into 'private providers' and 'public providers.' Public ICFs/MR are those operated by a unit of government (state, county, municipality, etc.). Private ICFs/MR are all others. There are about 300 private ICF/MR facilities in Illinois, while eight public ICF/MR facilities are operated by the Department of Human Services (Choate, Fox, Jacksonville, Kiley, Ludeman, Mabley, Murray, and Shapiro Developmental Centers). In addition, 'regular' Nursing Facilities may serve a Developmentally Disabled recipient, and therefore may submit claims for private ICF/MR services.

8. How are services to Managed Care Organization (MCO) recipients included in the data set?

Managed Care Organizations (MCOs) receive capitation payments, paid 'per member per month (PMPM), irrespective of what services have been provided that month. (This differs from Fee for Service claims, which are paid based on each service rendered.) Recipients who were enrolled with an MCO will have the services they received from the MCO represented as 'encounter claims.' These provide proof of the provision of services rather than requests for payment, and do not further detail the Type of Service provided.

Some Types of Service have historically been excluded from our voluntary MCO contracts, however. These include services from dentists, pharmacists, optometrists, mental health clinics (via community behavioral health providers), substance use disorder rehabilitation service providers, vision testing providers, Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded/Developmentally Disabled, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service providers, and school-based clinics. Specific restrictions apply to the provision of abortion, sterilization, and hysterectomy.

Services excluded from MCO coverage are represented elsewhere in the data set. For example, a recipient enrolled in MCO who gets dental care from another Medicaid-affiliated provider will

have this service recorded as a distinct Type of Service, irrespective of their MCO encounter claims data.

Additional Types of Service excluded from MCO payments are also excluded from other Medicaid programs found in the data set. These Types of Service are those services funded by the Juvenile Rehabilitation Services Medicaid Matching Fund; experimental or investigational services; non-authorized services from an unaffiliated provider; services delivered without an appropriate referral or prior authorization; and medical and surgical services for cosmetic purposes. As these are not represented in the data set, they are therefore not associated with costs or any other values in the data set.

Recipients who enrolled in an MCO at some point in the experience period will have the services they received prior to their MCO enrollment recorded in the data set as various Types of Service. The premiums paid to MCOs will be listed under The Type of Service 'Health Insurance Payments: MCOs.'

9. How are Institutes for Mental Diseases (IMDs) included in the data set?

Per 42 U.S.C. §1396d(i), an Institute for Mental Diseases is "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services." These facilities offer a Type of Service for which federal financial participation in Medicaid coverage is prohibited, a unique distinction. For this reason, Institutes for Mental Diseases are not included in federal reporting. They are, however, included in the data set, under 'Nursing Facilities'.

Many other Types of Service to persons with mental illness (including substance use disorders) are found in the data set. They include Rehabilitative Services - Mental Illness, Rehabilitative Services - Substance Abuse, FQHC /RHC Mental Health Services, Inpatient Hospital: Psychiatric, Inpatient Hospital: Substance Abuse, and Mental Health Facility Services - Regular Payments. Additional Types of Service provided to specific groups of patients, such as waiver recipients, can group care for mental health together with other services.

10. Is Illinois Health Connect represented in the data set? If so, where can I find it?

Illinois Health Connect (IHC) is a program that enrolls the Medicaid recipients into medical homes with a specific primary care physician (PCP). This program is mandatory for many full benefits recipients of Medicaid and All Kids. Exclusions include some children, waiver recipients, and others, as described on the IHC Web site.

The data set refers to this program as "Primary Care Case Management (PCCM)." Items in the provider file gives you the number of patients a given provider saw who were PCCM (IHC) patients, plus figures for events, units, and costs for this Type of Service. Matching fields can be found in the recipient file. All such fields use the acronym "PCCM" as an element of the name.

(None use "IHC."). In addition we provide the KeyID and name of the recipients PCCM assigned Primary Care Provider (PCP).

Costs

1. **What is a claim?**

   In most cases, a claim is a request for payment from a healthcare facility or provider for healthcare services rendered to a benefits recipient.

2. **Is claims-level data included in the data set?**

   Claims level data is not included in the Provider and Recipient Summary tables or the Recipient Provider Crosswalk table. Summarized claims data is provided for these tables. Claims are summarized by Type of Service and within Type of Service by events, units, and total costs. The event level tables contain data that is quite similar to claims level data and includes in-patient, emergency room, and prescription drug events.

3. **How are costs calculated?**

   Cost information in the data set does not reflect the total cost of services or the process by which costs are set. Rather, the cost data included in the data set reflects the net liability of Medicaid. In other words, wherever relevant, it reflects the cost of the claim after any cost-reducing negotiations with the healthcare providers; after any private insurance has paid the claim; and/or after Medicare has contributed the portion for which it has liability. The costs therefore reflect the net liability of Medicaid towards charges it deems reasonable and customary.

4. **Are non-claims payments included in the data set?**

   Non-claims payments refer to payments that cannot be linked to a specific service(s), on a specific date(s), or for a specific recipient, and are not paid through our claims system.

   Some data on non-claims payments are included in the data set, but this information is not the comprehensive total of all non-claims payments Healthcare and Family Services (HFS) may make to a provider. Non-claims payments are found in the data set as encounter claims; add-on payments; and capitation payments to Managed Care Organizations (MCOs), Federally Qualified Health Centers (FQHC) for their Managed Care-enrolled populations, and Primary Care Case Management (PCCM) organizations.

5. **What are add-on payments?**

   Add-on (supplemental or 'kick') payments are payments to hospitals to augment the fees paid per service by managed care organizations.

   These payments affect claims for inpatient care, including labor and delivery.

   Add-on payments are included as a separate data point. Total Costs include service costs and add-on payments.

6. **What are encounter claims, and how are they included in the data set?**

Encounter claims refer to documentation of services provided by a Managed Care Organization (MCO) that receives a capitation payment from Healthcare and Family Services (HFS). In this case, a 'claim' is not defined as 'a request for payment from a healthcare facility or provider for healthcare services rendered to a benefits recipient.' Rather, 'encounter claim' is a euphemistic term for notification of the provision of services to the recipients enrolled in the MCO. Encounter claims generally don't appear in our dataset. The only two places that they appear are "encounter claims" (a count of encounter claims) and "hospital encounter add on payment".

7. **Are encounter rate claims included in the data set?**

   Encounter rate claims refer to claims made by organizations that Healthcare and Family Services (HFS) pays a fixed price for each service, regardless of the specifics of that service. Federally qualified healthcare centers are paid on such a basis. These claims are a subset of total claims and are usually included in total claim counts and payments.

8. **Are Disproportionate Share payments in the data set?**

   Disproportionate Share payments to Hospitals (DSH payments) are intended to provide additional revenue to the hospitals that routinely treat a greater-than-average number of Medicaid patients. These hospitals receive set sums of money from Healthcare and Family Services (HFS), calculated based on the cost of care for Medicaid and charity care patients. Managed Care Organizations (MCOs) and other healthcare organizations do not receive DSH payments.

   DSH payments are included in the net liability of the specific claims to which they were added.

9. **What does 'Total Costs' represent?**

   The Total Costs column totals all the preceding categories that include the word 'cost.' This includes add-on payments, Disproportionate Share to Hospitals (DSH) payments, and all other payments for services. It includes capitation payments to Managed Care Organizations (MCOs), Federally Qualified Health Centers (FQHCs), Primary Care Case Management (PCCM), or any other organization paid via capitation.

Diagnostic Information

1. **How is diagnostic information captured in the data set?**

   Diagnostic information is included in the data set in the form of Chronic Illness and Disability Payment System (CDPS) classifications. CDPS is a diagnosis-based risk adjustment method that compiles ICD-9 codes, augmented in a limited number of cases by National Drug Codes (NDCs), into 20 categories based on a specific body system (for example, the cardiovascular system) or a highly prevalent, complex disease (such as HIV/AIDS). Within a category, CDPS provides a hierarchy of health needs ranging from "super low" to "extra high."

   For more information on CDPS, please see the CDPS documentation found on the MPARK webpage.

We welcome the addition of auxiliary data sources addressing epidemiological aspects of the populations our prospective partner organizations wish to serve. Please provide full references for all included data.

2. **What is Serious Mental Illness, and how is it represented in the data set?**

   The term "Serious Mental Illness (SMI)," refers to persons with the disorders listed in the table below. This list is derived from 89 Illinois Administration Code Part 145.10.

   SMI disorders do not cleanly overlap any severity level within the Chronic Illness and Disability Payment System (CDPS) system. Rather, the disorders listed in the Serious Mental Illness definition fall within five distinct levels of healthcare service use within CDPS, ranging from "high" to "super low."

   To allow data users to analyze data specific to the SMI category, we have added an indicator to the data set. In addition, data users can examine CDPS data on psychiatric diagnoses at multiple levels of severity, and can choose to analyze a CDPS severity level that most closely matches a population of interest.

   CDPS classifications and the SMI definition table

3. **What are Substance Use Disorders (SUD), and how are they represented in the data set**?

   Substance Use Disorders (SUDs) are a defined category within the data set, Chronic Illness and Disability Payment System (CDPS) diagnostic system information and in the data set Types of Service data. This diagnostic category includes but is not limited to drug dependence, alcohol dependence, substance misuse, and alcohol- and drug-induced mental disorders.

   While the ICD-9 classifies Substance Use Disorders (SUDs) as a subset of Psychiatric disorders, the CDPS diagnostic system separates them as a distinct category. This permits data users to analyze mental illness and substance use disorder co-morbidities (also known as 'dual diagnosis,' or 'MISA' diagnoses). Approximately half of the recipients with SUD diagnoses at the CDPS levels "low" and "very low" have a concurrent Serious Mental Illness (SMI) indicator.

   This category of diagnoses is also connected with a specific subset of Types of Services. These include Inpatient Hospital-Substance Abuse and Rehabilitative Services-Substance Abuse. Recipients may be treated for SUDs in the course of other treatment as well (in this case, no Type of Service might directly describe their SUD diagnosis). We find that Types of Services for SUD map well to CDPS levels "low" and "very low" (SUDL and SUDVL). They do not map well to the CDPS level "Not Well Defined" under SUD. "Not Well Defined" SUD diagnoses include cigarette smoking, marijuana use, substance abuse not elsewhere classified, and other miscellaneous diagnoses. We recommend that SUD-diagnosed recipients be identified using the CDPS "low" and "very low" levels of severity within the SUD category.

   For more information, please see the CDPS documentation found on the MPARK webpage.

4. **How can Developmental Disabilities be identified in the data set?**

Developmental Disability can be identified via the Chronic Illness and Disability Payment System (CDPS) diagnostic indicator 'Developmental Disability.' For more information on diagnostic indicators, please see the CDPS documentation on the MPARK webpage.

Those individuals who are recipients of Developmental Disability-related Home and Community Based Services (HCBS) waivers may also submit claims for many HCBS waiver Types of Services. Individuals may receive the Children's Residential DD Waiver and/or the Children's Supportive DD Waiver (for persons aged 3 to 21) or the Adult DD Waiver (age 19 and up). They may receive Types of Service that include Adult Day Health, Case Management, Day Habilitation, Residential Habilitation, Supported Employment, and Extended State Plan Services.

Developmental Disability can also be identified via the Types of Service 'Intermediate Care Facility – Public Provider' and 'Intermediate Care Facility – Private Provider.' These Types of Service are not related to Home- and Community-Based Services waivers.

Exclusions

1. **What recipient populations are excluded from the data set?**

   Partial benefits population, population with spend down, and population with no medical benefits are excluded from HFS's state-wide data set. Your specific data set may contain other exclusions.

2. **Are there any providers categorically excluded from the data set?**

   No. However, the only providers who are eligible for inclusion are receiving payments from Medicaid by providing services to recipients of full benefits. Providers who do not serve these recipients are not included. The number of providers in the Provider table and the Type of Service data for each provider are dependent upon the population the data user organization selects to be in the Recipient table.

3. **What data is not included in the data set?**

   Exclusions include recipient demographic information on immigration status, languages spoken, prison records, home address, homeless status. We don't provide geographical data other than county and zip codes (such as city or town). Eligibility does not include information on persons who are entitled to benefits but not enrolled; partial-benefits patients; and those who have been removed from the Medicaid rolls due to incarceration. Exclusions within the diagnostic set include limited information on health conditions such as obesity, dental needs, and social factors influencing health needs.

   Provider-level data is likewise incomplete. We cannot provide all addresses at which a given provider operates; rather, we substitute a primary provider address, which may be outdated or inaccurate. Likewise, we do not have complete National Provider Identifier (NPI) records, as some providers (such as personal attendants and small transportation companies) not entitled to an NPI under licensing law. For this reason, we provide randomized Key IDs where needed,

with the caveat that these are not useful with respect to outside the data set. Finally, we cannot provide information as to the quality of a particular provider.

4. **Is housing status described in the data set?**

   No data on the housing status of recipient is recorded. Some subtle exceptions exist with regard to institutionalized and waiver populations, who receive services that imply their housing location. Flags for inadequately housed or homeless populations are not in the data set because we don't have such information.

5. **How are imprisoned and post-prison populations included in the data set?**

   There are a very small number of people in prison who can receive full Medicaid benefits. These individuals are included in the data set. Incarcerated individuals who are partially eligible or who have lost eligibility due to their imprisonment are not included in the data set.

6. **How are quality measures and measures of recipient and provider satisfaction included in the data set?**

   No quality measures (Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise) are in the data set. No data on recipients', providers', or any other persons' subjective impressions of the quality of Medicaid, other health insurance programs, or clinical care are included in the data set.

7. **Does the data set include Prioritization of Urgency of Need for Services (PUNS) data?**

   Prioritization of Urgency of Need for Services (PUNS) is a waiting list for services to persons with Developmental Disability, managed by the Illinois Department of Human Services (DHS) Division of Developmental Disabilities.

   The current data set does not include this information. The data release that has been developed from Healthcare and Family Services (HFS) enrollment and claims data, is not linked to the DHS-managed PUNS system, and therefore does not contain PUNS data.

8. **Does the data set include ROCS service data?**

   The Community Reporting System (identified by the acronym ROCS) is a system of reporting claims data for community mental health services. The Department of Human Services (DHS) uses this system to monitor grants to service providers.

   ROCS data is not linked to the Healthcare and Family Services (HFS) data release. However, data concerning mental health claims appears in the HFS data set. Data for such claims appears in the following Types of Service: Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Mental Health Services, Inpatient Hospital: Psych, Mental Health Facility Services - Regular Payments, and Rehabilitative Services - Mental Health.

   People with mental health issues, irrespective of whether they have received DHS services, can also be identified by the Chronic Illness and Disability Payment System (CDPS) diagnostic

indicators 'Psychiatric' (including all diagnoses except Substance Use Disorders) and 'Substance Use Disorders' (including all chemical dependencies and substance abuse problems).