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## Care Coordination Claims Data (CCCD) Glossary

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The following terms will have the meanings as detailed below whenever used in any part of the data extracts or data dictionary. Please email any questions or comments about the Care Coordination Claims Data to [HFS.data@illinois.gov](mailto:HFS.data@illinois.gov)

**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. *See also* Claim.

**Adjustments Dataset:** A dataset provided with the CCCD which includes detailed information on changes made to the net liability amount for previous claims. *See also* Main Claims Dataset.

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

**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. Also known as Illinois All Kids. *See also* Children's Health Insurance Program.

**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](#).

**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).

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

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

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**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 Enrollee.

**Category of Service:** A variable describing the service that was provided to a recipient. *See also* Provider Type and Type of Service.

**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 state 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.

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

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

**Code Description Dataset:** A dataset provided in the CCCD which includes detailed descriptions for the various codes used throughout the CCCD. *See also* Main Claims Dataset.

**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.

**Compound Drug Detail Dataset:** A dataset provided in the CCCD which includes detailed information on compound prescription drugs used by Medicaid recipients. Compound drugs can be identified through 'CompoundCd' in the Pharmacy dataset. *See also* Pharmacy Dataset.

**Cornerstone Immunization Dataset:** A dataset provided in the CCCD which includes detailed information on immunizations provided to Medicaid recipients.

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

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

**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

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terminology is used for filing claims to Medicaid. *See also* Healthcare Common Procedure Coding System and Procedure Codes.

**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.

**Dataset:** A data table or several related data tables designed for a specific purpose.

**Date of Service:** A date associated with healthcare services rendered to a given recipient, expressed in the form YYYY-MM-DD. 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.

**Diagnosis Dataset:** A dataset provided with the CCCD which includes detailed information on the diagnoses associated with the services provided to Medicaid recipients. *See also* Main Claims Dataset.

**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. DRGs are applicable to the Institutional datasets. 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* Category of Service and Type of Service.

**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* Claim and Encounter Rate Claims.

**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.

**Enrollee:** A recipient who is eligible and completed any additional processes necessary to be enrolled in an HFS program. Enrollees are also known as recipients and sometimes clients. *See also* Recipient and Client.

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**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 an 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.

**Fee for Service (FFS):** The method of billing under which a Provider charges and HFS pays for each encounter or service rendered.

**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.

**Health Care Financing Administration (HCFA):** The federal agency that administers the Medicare, Medicaid and Child Health Insurance Programs.

**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.

**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.

**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 the CCCD.

**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

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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 and Procedure Codes.

**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.

**ICARE Immunization Dataset:** A dataset provided in the CCCD which includes detailed information on immunizations provided to Medicaid recipients.

**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.

**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.

**Institutional Dataset:** A dataset provided in the CCCD which includes detailed information on hospital (inpatient and outpatient) and institutional care provided to Medicaid recipients. *See also* Main Claims Dataset and Revenue Codes Dataset.

**International Classification of Diseases (ICD):** An official classification system used to categorize diseases and health conditions diagnoses and procedures associated with healthcare. HFS currently uses the 9<sup>th</sup> revision.

**Lead Dataset:** A dataset provided in the CCCD which includes detailed information on lead testing performed on Medicaid recipients.

**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.

**Main Claims Dataset:** A dataset provided in the CCCD which provided information on all services provided to Medicaid recipients with the exception of prescription drugs. The claims can be linked to other datasets to obtain detailed information on the service provided. *See also* Adjustments Dataset, Code Description Dataset, Diagnosis Dataset, Non-Institutional Provider Services (NIPS) Dataset, Procedure Dataset, Recipient Prior Authorization Dataset, and Revenue Codes Dataset.

**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 and Health Maintenance Organization.

**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).

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

**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.

**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.

**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.

**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* Third Party Liability.

**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.

**Non-Institutional Provider Services (NIPS) Dataset:** A dataset provided in the CCCD which includes detailed information on services rendered by care providers to Medicaid recipients. Excludes, institutional care, inpatient hospital care, and prescription drugs. *See also* Main Claims Dataset.

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**Partner:** Any health care entity that has requested and received data. This term refers to HFS's relationship with the organization requesting data, rather than the relationships of organizations within a proposed Care Coordination Entity (CCE) or Managed Care Community Network (MCCN).

**Patient:** In general usage, a person who receives healthcare services from a healthcare provider; for the purposes of the data sets, a recipient. *See also* Beneficiary and Recipient.

**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 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.

**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.

**Pharmacy Dataset:** A dataset provided in the CCCD which includes detailed information on the prescription drugs used by Medicaid recipients. *See also* Compound Drug Detail Dataset and Pharmacy Prior Authorization Dataset.

**Pharmacy Prior Authorization Dataset:** A dataset provided in the CCCD which includes specific information used to determine if a Medicaid recipient is able to receive a prescription drug that requires prior authorization before payment is made. *See also* Pharmacy Dataset.

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

**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.

**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. An indicator code for POA can be found in the Diagnosis dataset.

**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

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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.

**Procedure Codes:** Codes used to describe healthcare services. This category can include Diagnostic Related Groupings (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.

**Procedure Dataset:** A dataset provided with the CCCD which includes detailed information on the medical procedures performed on Medicaid recipients. *See also* Main Claims Dataset.

**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.

**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 Provider ID predates NPI and is embedded in HFS records keeping.

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

**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 CCCD. *See also* Client.

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

**Recipient Prior Authorization Dataset:** A dataset provided with the CCCD which includes specific information used to determine if a Medicaid recipient is able to receive a medical procedure that requires a prior authorization before payment is made. *See also* Main Claims Dataset.

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

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**Revenue Codes Dataset:** A dataset provided with the CCCD which includes detailed revenue related information for hospital and institutional care provided to Medicaid recipients. *See also* Institutional Dataset and Main Claims Dataset.

**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.

**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* Unit and Event.

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

**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.

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

**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.

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

**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.

**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.

**Type of Service:** A classification of the healthcare services rendered by providers to recipients. *See also* Provider Type and Category of Service.

**Unit:** The number of itemized services (generally defined by procedure codes) associated with a given healthcare service event; used together with ‘event’ to 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

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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.

**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.

**Acronyms Used Throughout CCCD and Glossary**

**APL:** Ambulatory Procedures Listing  
**ASTC:** Ambulatory Surgical Treatment Center  
**CCCD:** Care Coordination Claims Data  
**CCE:** Care Coordination Entity  
**CHIP:** Children Health Insurance Plans  
**CPT:** Current Procedural Terminology  
**DAW:** Dispensed as Written  
**DRG:** Diagnosis Related Groups  
**FFS:** Fee for Service  
**FQHC:** Federally Qualified Health Center  
**HCBS:** Home and Community-Based Services Waivers  
**HCFA:** Health Care Financing Administration  
**HCPCS:** Healthcare Common Procedure Coding System  
**HFS:** HealthCare and Family Services  
**HIPAA:** Health Insurance Portability and Accountability Act  
**HIV:** Human Immunodeficiency Virus  
**HMO:** Health Maintenance Organization  
**ICARE:** Illinois Comprehensive Automated Immunization Registry Exchange  
**ICD:** International Classification of Diseases  
**LTC:** Long-term Acute Care (Hospital)  
**MCCN:** Managed Care Community Network  
**MCO:** Managed Care Organization  
**NDC:** National Drug Code  
**NIPS:** Non-institutional providers  
**NPI:** National Provider Identifier  
**PCP:** Primary care provider  
**PMPM:** Per Member per Month  
**POA:** Present on Admission  
**RHC:** Rural Health Center  
**TPL:** Third Party Liability  
**WHCP:** Women's Health Care Provider